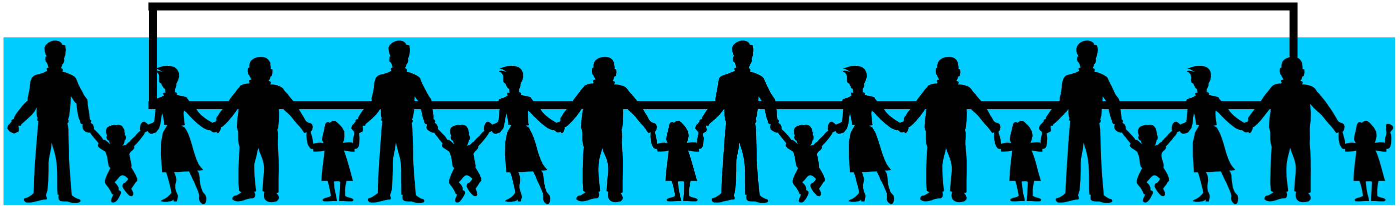

Colorado

Maternal and Child Health Program

Guidelines

Prevention Services Division
Center for Healthy Families and Communities
4300 Cherry Creek Drive South
Denver, CO 80246

Colorado Maternal Child Health Program Guidelines

TABLE OF CONTENTS

Introduction 4

PART I: MCH BACKGROUND 5

A. Maternal and Child Health 5
1. MCH Funding 5
2. Colorado MCH 6
3. MCH Accountability 6

B. MCH Performance Measures 9
1. Criteria for MCHB Performance Measures 9
2. 18 National Performance Measures (2006) 9
3. 6 MCH Outcome Measures 10
4. Colorado MCH State Measures 10

C. Core Public Health Services Provided by MCH Agencies 12
1. Local Core Public Health Services for the Prenatal Population 14
2. Local Core Public Health Services for Children and Adolescent Populations 15
3. Local Core Public Health Services for Children with Special Health Care Needs 16

D. MCH Essential Public Health Services 17

PART II: COLORADO'S MCH PLANNING AND REPORTING PROCESS 18

A. MCH Consultation to Local Health Agencies 19

B. Overview of the New Process 21
1. MCH Planning Timeline 21
2. MCH Flow Chart 21
3. Step-By-Step Guides for Local Health Agencies for 2008-2009 21

C. Assessment 23
1. MCH Data Sets 23
2. MCH Indicator Checklist and Instructions 23
3. MCH Agency Planning Meeting 24
4. MCH Prioritization Tool & Helpful Resources 24

D. Planning and Reporting 25
1. Action Guides: How to Use Them in Your Planning Process 25
2. MCH Operational Plan and Report template and Instructions 25
3. Core Public Health Services Forms 26
4. Numbers Served Reports: Tables I & II 27
5. Fiscal Forms and Instructions 27
6. Review and Feedback of Plans and Reports 29

E. Contractor Requirements 31
1. Key Contractor Responsibilities 31
2. MCH Requirements by Due Date for 2008-2009 32
3. Instructions for Annual Reports for FY 2008 34

PART III: ADDITIONAL RESOURCES FOR LOCAL MCH PROGRAMS 35

A. MCH Orientation and Resource Manual 35

Introduction

Welcome to the Colorado Maternal Child Health (MCH) Guidelines. These Guidelines have been updated to serve as a one-stop source of information for Colorado's MCH Program, and are organized in three parts:

- **Part I: MCH Background**

This provides background information about Maternal and Child Health and the Maternal and Child Health Services Block Grant (Title V).

- **Part II: Colorado's MCH Planning and Reporting Process**

Part Two serves as a guide to local health agencies in preparing MCH Plans and conducting MCH reporting as outlined in local agency contracts for Prenatal, Child/Adolescent, and Children with Special Health Care Needs.

- **Part III: Additional Resources for MCH Programs**

Part Three highlights additional resources for learning about various aspects of Maternal and Child Health, and includes orientation materials for those new to MCH.

The MCH Guidelines are posted online at www.mchcolorado.org and at www.hcpcolorado.org. The hyperlinks in the MCH Guidelines link to companion documents (such as forms, instructions, and guides) posted on those websites.

PART I: MCH BACKGROUND

A. Maternal and Child Health[1]

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).

MCH public health is distinctive among the public health professions for its lifecycle approach. This approach integrates theory and knowledge from multiple fields including human development, as well as women's, child and adolescent health. MCH professionals are from diverse backgrounds and disciplines, but are united in their commitment to improving the health of women and children. However, to meet this ambitious goal, it is essential that MCH professionals work with a broad group of other professionals and organizations.

1. MCH Funding

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

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

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

[1] Adapted from the Introduction to MCH 101 in-depth module at the HRSA MCH Timeline Retrieve November 2006 at http://www.mchb.hrsa.gov/timeline/

2. Colorado MCH

Every five years, Colorado completes an in-depth needs assessment and prepares a grant to receive federal Title V funding. For the next four years, annual grants are submitted to MCHB providing an update on progress and plans for the coming year.

In Colorado, Title V funds are primarily distributed to county health departments. The amount is dictated by a funding formula. The recipient health departments complete a plan that indicates how they will use the funding to address documented MCH needs within their community.

To assist agencies in the planning process, the state provides county specific MCH data reports and analysis (http://www.cdphe.state.co.us/ps/mch/data-reports.html). State consultants with expertise in various aspects of MCH are available to provide technical assistance as needed.

3. MCH Accountability[2]

Background and History
Accountability to the public has long been a component of Title V. However, by the 1990s both public and private health care systems were facing rapidly rising health care costs. Calls for health care reform were coupled with an increased emphasis on results that impacted the allocation of health care funding. Both public and private purchasers of health care, along with consumers and policymakers, require that health care programs achieve intended goals.

Within the public health sphere, accountability efforts focused on conducting thorough needs assessments to target programs to areas of greatest need, and developing a plan for improving health status. Documenting health care outcomes and measuring public health systems change were paramount. For the private sector, greater emphasis was placed on purchasing high quality services while controlling health care costs.

Some landmark efforts to improve accountability include:

- In 1979, Surgeon General Julius Richmond led an effort to develop the first quantitative public health objectives for the nation. These efforts resulted in **Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.** www.healthypeople.gov

- In 1981, Congress consolidated several categorical grants into one **MCH Block Grant**. The purpose was to create greater flexibility to address existing and emerging MCH issues. Concurrently, the federal MCH program began to require annual performance reporting about performance and outcome measures for the MCH Block Grant.

- In 1988, the Institute of Medicine released **The Future of Public Health**, a report that outlined the crisis in public health in the U.S. and established a framework of accountability for public health agencies focused on the three core public health functions—assessment, policy development, and assurance. http://fermat.nap.edu/books/0309038308/html

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[2] Adapted from the MCH Timeline: History, Legacy, and Resources for Education and Practice. MCH Performance and Accountability in-depth module http://mchb.hrsa.gov/timeline/. Retrieved 11/06.

- In 1989, Congress, through the **Omnibus Budget Reconciliation Act** (OBRA), linked greater MCH Block Grant flexibility with increased accountability. OBRA 89 required states to conduct a needs assessment every 5 years and submit annual progress reports.

- By 1994, the Centers for Disease Control and Prevention (CDC) took the lead in further refining the services outlined in the Future of Public Health report. A steering committee developed the **Ten Essential Public Health Services**, which describe key public health activities that should be undertaken in all communities. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. www.trainingfinder.org/competencies/background.htm

- The 1993 **Government Performance and Results Act** (GPRA), Public Law 103-62, required that "…each Federal program establish performance measures that can be reported as part of the budgetary process, thus linking funding decisions with performance and reviewing related outcome measures to see if there were improved outcomes for the target population." GPRA also linked budgets to strategic plans and the achievement of stated performance indicators. Following the federal lead, many states developed similar requirements. http://govinfo.library.unt.edu/npr/initiati/mfr/

- **Program Assessment Rating Tool** (PART) was developed in 2002 to assess the performance of every government program in order to improve program operations and inform budget decisions. Funding is directly linked with performance and every federal program is held accountable for improvement. Each program is assessed once every five years and rated according to the following categories: effective, moderately effective, adequate, ineffective, or results not demonstrated. Programs without performance measures are rated as "results not demonstrated," regardless of their score. www.expectmore.gov

MCH Performance and Accountability
MCH Programs are accountable for continually assessing needs, assuring that services are provided to the MCH population, and developing policies consistent with needs. MCH public health professionals are accountable to the public and to policymakers to assure that public dollars are being spent in a way that is aligned with priorities. Some of the factors for which MCH is accountable include: the core public health functions outlined in the 1988 Future of Public Health report; collecting and analyzing health data; developing comprehensive policies to serve the MCH population; and assuring that services are accessible to all.

There is general agreement that the quality of health care systems will improve through better performance measurement and expanded accountability. However, performance measurement has limitations. Priorities that are more easily measured may be more frequently chosen as it can be difficult to measure complex, community-based, or systems-building interventions. Performance measures only provide a snapshot, and must be combined with other data and evaluations to provide a fuller picture of what is occurring within an MCH program. Moreover, the measures tend to be driven by the available databases, and new databases can be expensive to initiate, which can hinder performance monitoring.

Legislative priorities, which are not always based on the best available evidence, must also be taken into account. Also, it can be difficult to change priorities, especially once a program is established and a constituency is developed. Additionally, when new priorities emerge, resources must be reallocated. Building accountable systems requires further development and refinement of tools and databases, which will allow better measurement.

Performance measurement and accountability are and will continue to be fundamental to MCH. The need for MCH to document accomplishments and prioritize future initiatives based on rigorous scientific evidence will not change. A comprehensive approach to program assessment that takes into account the challenges associated with measuring complex systems-based approaches is likely to emerge, but emphasis on performance measurement will remain.

B. MCH Performance Measures

A number of tools and measures have been developed to measure performance and document accountability. The Maternal and Child Health Bureau (MCHB) uses performance measurement and other program evaluation to assess progress in attaining goals, implementing strategies, and addressing priorities. Evaluation is critical to MCHB policy and program development, program management, and funding. Findings from program evaluations and performance measurement are part of the ongoing needs assessment activities of the Bureau.

At the state level, the MCHB performance and accountability cycle begins with a needs assessment that includes reporting on health status indicators. Analysis of these data and other information leads to the identification of priority needs. MCH performance and outcome measures are developed to address those needs, and resources are allocated. Program implementation, ongoing monitoring, and evaluation follow.

Currently the MCH Program has 18 National Performance Measures, 10 State Performance Measures, 6 Outcome Measures, Health Status Indicators, and 36 Discretionary Grant Performance Measures. Federal MCH Program staff, states, and other grantees jointly developed these consensus measures. In addition to the national performance measures, states develop and report on state priority needs and performance measures.

1. Criteria for MCHB Performance Measures

MCH Performance measures must meet the following criteria:

1. The measure should be relevant to major MCHB priorities, activities, programs, and dollars.
2. The measure should be important and understandable to MCH partners, policymakers, and the public.
3. Data are available across states.
4. A logical linkage can be made from the measure and the desired outcome.
5. Measurable change should be detectable within 5 years.
6. A potential for change in the measure should be realistic.
7. Process or capacity measures should logically lead to improved outcomes.
8. Measures should be prevention focused.

Performance measures help to quantify whether:

1. Capacity was built or strengthened;
2. Processes or interventions were accomplished;
3. Risk factors were reduced; and
4. Health status was improved.

2. 18 National Performance Measures (2006)

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

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

3. 6 MCH Outcome Measures

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

4. Colorado MCH State Measures

In addition to these national performance measures, states can identify their own state-specific measures. State-specific measures reflect local concerns that arise from a state needs assessment, required every 5 years.

Colorado's 10 State Performance Measures (2006)

1. The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers.
2. Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.
3. The percent of women with inadequate weight gain during pregnancy.
4. The rate of birth (per 1,000) for Latina teenagers age 15-17.
5. The motor vehicle death rate for teens 15-19 years old.

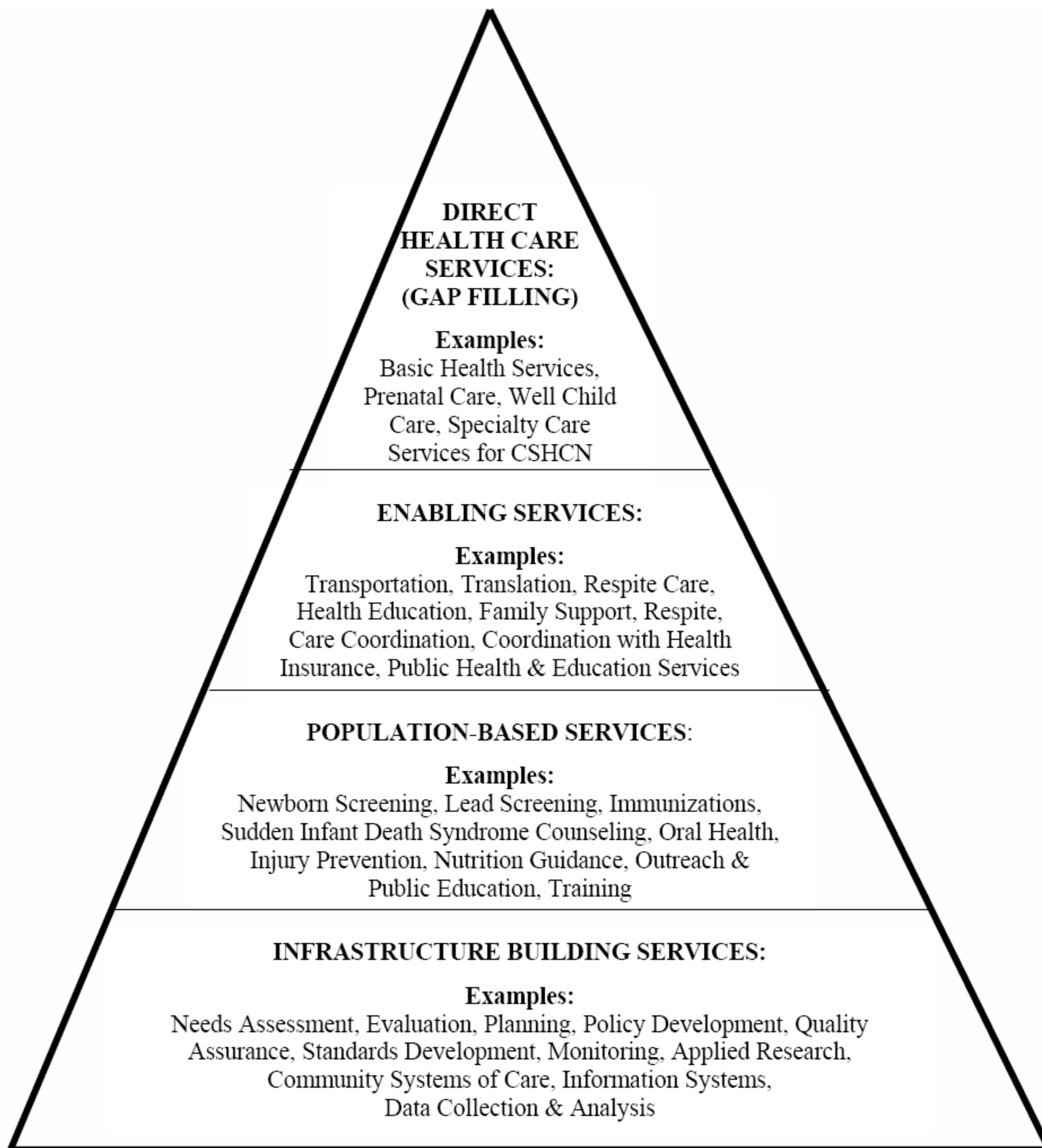
6. The percent of mothers smoking during the three months before pregnancy.
7. The proportion of all children 2-14 whose BMI > 85 percent normal weight for height.
8. Percent of children who have difficulty with emotions, concentration, or behavior.
9. Percent of center-based childcare programs using a childcare nurse consultant.
10. The proportion of high school students reporting binge drinking in the past month.

Colorado's Additional State Outcome Measure

1. The low birth weight rate per 1,000 live births.

C. Core Public Health Services Provided by MCH Agencies

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



Core Public Health Services Provided by MCH Agencies[3]

1. **Direct Health Care Services**
   Direct health care services are generally delivered "one on one" between a health professional and a patient in an office, clinic, or emergency room setting. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs may support services such as prenatal care, child health (including immunizations and treatments or referrals), school health, and family planning, by directly operating programs or by funding local providers. For CSHCN, these services include specialty and subspecialty care.

2. **Enabling Services**
   Enabling services are defined as services that allow or provide for access to and the derivation of benefits from the array of basic health care services. Enabling services include transportation, translation, outreach, respite care, home visiting health education, family support services (e.g., parent support groups, family training workshops, nutrition, and social work), purchase of health insurance, case management, and coordination of care with Medicaid, CHP+, and WIC. These kinds of services are especially necessary for low-income, disadvantaged, and geographically or culturally isolated populations, and for those with special and complicated health needs.

3. **Population-Based Services**
   Population-based services are defined as services that are developed and available for the entire population of the state, rather than in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn and genetic screening, lead screening, immunizations, oral health, injury prevention, outreach, and public health education. Population-based services are generally available for women and children regardless of whether they receive care in the public or private sector or whether or not they have health insurance.

4. **Infrastructure Building Services**
   Infrastructure building services are defined as those services that are directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health service systems, including standards/guidelines, training, data, and planning. Needs assessment, coordination, evaluation, policy development, quality assurance, information systems, applied research, development of health care system standards and systems of care are all contained within the infrastructure umbrella.

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[3] As defined by the Maternal And Child Health Bureau

1. Local Core Public Health Services for the Prenatal Population

Direct Services

- Provision of Prenatal Care Services (gap-filling)

Enabling Services

- Medicaid/Child Health Plan Plus (CHP+) Information and Outreach
- Translation and Transportation Services
- Prenatal Care/Resources, Referrals and/or Care Coordination
- Client Health Education regarding Breastfeeding, Seat Belts, Immunization, Prenatal Weight Gain and Smoking Cessation

Population-Based Services

- Public Education/Social Marketing Campaigns related to Prenatal Weight Gain, Smoking Cessation, and other Health Behaviors
- Unintended Pregnancy Prevention Projects
- Breastfeeding Promotion Campaign
- Medicaid/CHP+ Countywide Outreach

Infrastructure Building

- Community Needs Assessment, Planning and Evaluation
- Policy Development
- Monitoring and Quality Assurance
- Coalition Leadership and Collaboration
- Perinatal Periods of Risk Analysis
- Prenatal/Prenatal Plus/PRAMS Data Collection and Analysis
- Training Providers and Professionals

2. Local Core Public Health Services for Children and Adolescent Populations

Direct Services

- Well Child Care for Uninsured Children (gap filling)
- Primary Care in School-Based Health Centers
- Immunization Clinics (gap filling)

Enabling Services

- Health Education regarding Breastfeeding, Seatbelts, Immunization, Smoking Cessation, etc.
- Medicaid/Child Health Plan Plus (CHP+) Information and Eligibility
- Translation Services
- Transportation Health Care Resources, Referrals and/or Care Coordination
- Client Health Education re: Pregnancy Prevention, Fitness, Nutrition, Motor Vehicle Safety, Immunizations, Substance Abuse

Population Based Services

- Breastfeeding Promotion Campaign
- Medicaid/CHP+ County-wide Outreach
- Public Education/Social Marketing related to Child Abuse Prevention, Injury Prevention, Importance of immunizations
- Car Seat Safety Checks
- Working with Schools to improve Nutrition, Fitness and Health Education

Infrastructure Services

- Community Needs Assessment, Planning and Evaluation
- Policy Development
- Quality Assurance (working with private immunization providers and child care providers)
- Coalition Leadership and Collaboration
- Collaborate with School Health Team and Early Childhood Specialists to identify and plan to address unmet community needs
- Monitoring and Quality Assurance
- Training MCH staff, Parents and Community Professionals

3. Local Core Public Health Services for Children with Special Health Care Needs

Direct Services

- Provision of Specialty Care in HCP Specialty Clinics (gap filling)
- Diagnostic Services in Diagnostic and Evaluation (D&E) Clinics (gap filling)

Enabling Services

- Family Advocacy and Support
- Health Consultation for Medical Home, Specialty Care, Transition to Adult Health Care, Early Intervention and School Services.
- Individual and Family Care Coordination Services - Colorado Traumatic Brain Injury Trust Fund Program
- Health Care Resources, Referrals and Care Coordination for CSHCN, Families and Providers
- Medicaid/Child Health Plan Plus (CHP+) Information and Outreach

Population Based Services

- Follow-up of Newborn Hearing Screening
- Tracking and monitoring for Colorado Responds for Children with Special Needs (CRCSN) Notification program
- Medicaid/CHP+/Supplemental Security Income (SSI) Outreach
- Public and Provider Education – Medical Home, Newborn Hearing Screening, Early Vision Screening, Developmental Screening (including mental and emotional)
- Training Families, Community Partners and Providers

Infrastructure Services

- Community Needs Assessment, Planning & Evaluation
- Interagency Leadership and Collaboration – Medical Home, Community Systems, Early Intervention, Insurance, EPSDT, Respite, D&E Services, Developmental Screening and Transition to Adult Health
- Assist State in Development of Information Systems
- HCP/CHIRP Data Collection and Local Data Analysis
- Monitoring and Quality Assurance

D. MCH Essential Public Health Services[1]

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

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

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

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

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

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

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

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

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

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

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

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

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

PART II: COLORADO'S MCH PLANNING AND REPORTING PROCESS

The Maternal and Child Health (MCH) Block Grant comes with relatively broad state authority, without many specific requirements other than the need to impact the national and state MCH performance measures. The Colorado Department of Public Health and Environment (CDPHE) is responsible for ensuring that the approximately $7 million dollars Colorado receives through the block grant has a significant impact on these MCH performance measures. By focusing on population-based and infrastructure-building strategies, as opposed to direct and enabling services, state and local MCH programs can maximize the impact on the performance measures.

The ultimate goal for the MCH Planning Process is for local health agencies to design plans that have a measurable impact on the state and national MCH performance measures. These plans should be systematic, comprehensive and evidence-based. Likewise, these plans should include an evaluation component that measures the impact on one or more MCH performance measures.

Accomplishing this is a challenge in the context of limited funding. In 2006, the MCH Director convened a group of MCH staff from CDPHE with the purpose of improving the process in order to help move Colorado to the above goal. The workgroup used the questions and comments compiled during the 2006-07 MCH Plan Reviews to outline the discussion. Working from June through September 2006, the workgroup drafted 20 recommendations for how to support a process that will help Colorado impact the state and national MCH performance measures in the most efficient and effective way. In October 2006, the draft recommendations were presented to the Directors of Nursing of local health departments. Feedback from the Directors was generally supportive of the direction, so plans moved forward to realize these recommendations.

In February 2007, three workgroups were established with representation from local and state MCH programs to operationalize the recommendations into clear protocols and expectations for both state MCH staff and local MCH contractors. These workgroups worked steadily throughout the year to examine existing processes and to consider new ways to organize and support the MCH process. Transition toward the new process (which includes revised schedules, forms, and staffing structure, among other things) began even as the plans continued to be finalized. This transition will continue throughout 2008, 2009, and 2010, and the process will likely require periodic evaluation and revision to assure its relevance as Colorado's public health landscape changes.

A. MCH Consultation to Local Health Agencies

The goal of the new MCH Consultation model is to provide quality consultation to Local Health Agencies (LHAs), resulting in improved plans, programs, and ultimately improved MCH outcomes, as well as:

- consistent communication and expectations
- more efficient use of staff time
- greater expertise in CDPHE staff.

The **MCH Generalist Consultant** will guide LHA staff through the MCH Planning and Reporting Process. This includes broad planning activities, required planning and reporting forms, and other contract requirements. Generalists may also provide or coordinate training and technical assistance on general MCH issues, including skills-building sessions necessary for completing MCH work. The Generalist Consultant will strive to offer expertise on the following:

- Navigation of MCH processes
- Comprehensive knowledge of the agency and county
- MCH program areas, state priorities and related programs
- Current public health science and practice
- Data sources and interpretation
- Planning and evaluation
- Systems building and policy strategies

The **MCH Program Specialist** will provide resources, technical assistance, and training on specific program areas. The Program Specialist serves as a subject matter expert (SME) or content area specialist for their program or project.

The Generalist Consultants will work closely with Program Specialists from each of the three MCH areas. Please see the table below for further delineation of these separate roles.

Generalist Consultant	Program Specialist
Primary contact for local community assessment and agency planning meeting.	Steps in when priority issues are identified, assists in developing plan on identified issue.
Liaison between local staff and program specialists. Primary point of contact at CDPHE.	Specialized consultation prompted by Generalist.
Coordinates general MCH training programs	Coordinates specialized program training
Guides agencies through MCH Planning and Reporting processes	Provides guidance and feedback on specific program plans and reports.
Participates in Action Guide development as advocate for local partners	Leads MCH Action Guide development and serves as content expert for issue.
Assists local agency to identify data needs.	EPE staff works in a Program Specialist role with Generalist and local partners, providing expertise on data analysis and evaluation.

There is an important role for Epidemiology, Planning and Evaluation (EPE) staff to serve in a role similar to Program Specialists.

Communication and coordination between the Generalist Consultant, the Program Specialists, and local health agencies will require a well-developed protocol and consistent attention. The newly developed Generalist team will work on developing this system over the first year of implementation.

B. Overview of the New Process

The new MCH Planning and Reporting Process features a more streamlined calendar of events and due dates. A major change in this process is the move to a three-year planning cycle, making the period just before the first year of implementation a time of intense planning for the three years ahead. Two visual aids have been developed to assist in understanding this new process: the MCH Planning Timeline and the MCH Flow Chart.

1. MCH Planning Timeline

The MCH Timeline provides a visual overview of the major markers in the new MCH Planning and Reporting process. The timeframe represented is the year before the first of three years of implementation. State and local roles and responsibilities are presented together and include the following:

- Recommended time frames for planning activities
- Required due dates for completion of planning, reporting, and feedback forms.

The timeline is meant to present a "snapshot" view of the new process, and can be used in conjunction with other tools provided to build an understanding of the overall process.
Click here to view the MCH Planning Timeline.

2. MCH Flow Chart

The MCH Flow Chart is a conceptual model that presents the key processes that local health agencies undertake in the MCH Planning and Reporting Cycle. The model is an adaptation (specified for Colorado's local health agencies) of a common and widely used public health planning process. The key steps in this model include:

- Assessment and Data Gathering
- Data Analysis and Priority Setting
- Local Plan Development
- State Review and Approval of Plan
- Plan Implementation
- Evaluation and Reporting

The flow chart assists LHAs in considering the detailed components and the ongoing, cyclical nature of the MCH Planning and Reporting Process.
Click here to view the MCH Flow Chart.

3. Step-By-Step Guides for Local Health Agencies for 2008-2009

The fifteen local health departments and two HCP Regional offices will begin the new three-year cycle in three groups:

- Group 1 agencies (Boulder, Broomfield, Jefferson, San Juan Basin and Tri-County) will begin planning for a three-year plan in the spring of 2008.
- Group 2 agencies (El Paso, Larimer, Northeast, Pueblo and Weld) will begin planning for a three-year plan in the spring of 2009.
- Group 3 agencies (Delta, Denver, Las Animas/Huerfano, Mesa, Otero, HCP South Central Regional Office, and HCP Northwest Regional Office-NWVNA) will begin planning for a three-year plan in the spring of 2010.

Step-By-Step Guides are available for each of the three groups to help clarify the different requirements that each group must complete as they transition onto the new three-year cycle. Included in these one-page Step By Step Guides are specific requirements and recommendations for every aspect of the MCH Planning and Reporting process. The Step-By-Step Guides provided here cover the time period from March 2008 through early 2009,

spanning activities for FY 2008 and FY 2009. Step-By-Step Guides for subsequent years will become available each year.

- **Group 1** Step-By-Step Guide 2008-2009
- **Group 2** Step-By-Step Guide 2008-2009
- **Group 3** Step-By-Step Guide 2008-2009

C. Assessment

Local Health Agencies (LHAs) will conduct community assessment activities in the spring before submitting the three-year plan. These activities focus on the review and interpretation of MCH data, as well as the inventory of community resources and support in order to prioritize targeted public health issues. Collaboration and ongoing input from community partners is an integral part of this assessment process. Tools and resources helpful to this process are described in this section.

1. MCH Data Sets

(County Profiles, County Comparisons with Maps, Trend Reports)
MCH Data Sets are the primary resource for Colorado counties to view data related to MCH populations. Much of the data is available on Colorado Health Information Database (CoHID) at www.cdphe.state.co.us/cohid, but the MCH Data Sets are a one-stop place to view, compare, and understand data for each county. There are three main components to the Data Sets:

- County Profiles – This 10-12 page document is updated annually and is available online at www.cdphe.state.co.us/ps/mch/mchdatasets.html. Important MCH indicators are highlighted and information is provided on data source, timeframe of data, and Colorado and Healthy People goals related to the measure.

- County Comparisons with Maps – This resource is also updated annually and is available online at www.cdphe.state.co.us/ps/mch/mchdatasets.html. The maps show where counties or regions stand on select MCH indicators in relation to the Healthy People goals or the Colorado goals. The maps are accompanied by a listing of counties, grouped by the proximity or distance from the goal.

- Trend Reports – MCH County Trend Reports are updated every two to three years and provided to local health agencies via email. The Trend Reports include a one-page table illustrating the county or region's proximity or distance from the goal, followed by a narrative analysis of the important trends in MCH health status in the county or region.

2. MCH Indicator Checklist and Instructions

The MCH Indicator Checklist is a tool prepared by the state MCH program for each LHA to use in their assessment and planning process. The Checklist presents the most current local, state, and national data and goals on MCH indicators. The purposes of the Checklist are:

- To facilitate local MCH programs' review of MCH data indicators to determine implications for planning, and
- To map how MCH funding augments other resources in the community to support priorities concerning the MCH population.

Instructions for Completing the MCH Checklist are provided, and explain in detail the purpose and application of each field in the tool. Each agency will receive their Checklist via email no later than March of the year that planning occurs.

► Completion of the MCH Checklist is required during the assessment process. Submission of the MCH Checklist is due **July 1**.

3. MCH Agency Planning Meeting

During the spring before the first year of an agency's three-year cycle, state and local MCH staff plan, facilitate and participate in the MCH Agency Planning Meeting. The purposes of this meeting are to build relationships among state and local MCH program staff in order to improve program planning and evaluation, and to provide resources and technical assistance regarding the MCH planning process. The content of the meeting focuses on the following:

- Review of local and state data, resources and the MCH Indicator Checklist
- Discussion of possible program priorities, direction of programs and possible goals
- Discussion of potential evaluation methodologies

An optional but recommended tool that LHAs and their Generalist Consultant may use is the Uniform Minimum Standards Assessment.

To facilitate preparation for and participation in this meeting, the MCH Generalist Consultant will provide Guidelines for planning and conducting the meeting and will work closely with LHAs through this process. After completion of the meeting, the MCH Generalist provides a Feedback Form to LHAs that summarizes meeting outcomes and follow-up activities for state and local participants.

► Participation in the MCH Agency Planning Meeting is required during the assessment process, and should take place in April or May.

4. MCH Prioritization Tool & Helpful Resources

The MCH Prioritization Tool is meant to assist LHAs in prioritizing the performance measures that will be addressed in the MCH plan. The reverse side of the tool presents additional resources for use in a prioritization process, including links to websites with helpful tools and guidance.
Click here to view the MCH Prioritization Tool.

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

D. Planning and Reporting

This section of the Guidelines covers the new planning process and required forms, as well as the new reporting requirements, which often involve the same forms used for planning. All of the Planning and Reporting tools and documents were developed through the 2007 state and local workgroup process. Existing tools were reviewed and revised, and new tools were created.

Note: The Guidelines section "MCH Requirements by Due Date for 2008-2009" presents a schedule of requirements for FY 2008, using both old and new forms. Please refer to that section to confirm requirements as we transition to the new process over the next two years.

1. Action Guides: How to Use Them in Your Planning Process

As an agency wraps up its assessment process and begins to narrow priorities, it is highly recommended that a review of the Action Guides occurs. Even if an Action Guide is not available for the issues that the agency identifies as highest priority, a review of the Action Guides will provide information on expectations for the types and nature of MCH-funded strategies.

MCH Action Guides are developed by MCH Consultants from CDPHE, in conjunction with stakeholders from local communities and experts from around Colorado. Each Action Guide focuses on improving a high-priority health issue for the MCH population and provides background information, relevant data, evidenced based strategies, and a list of resources and tools. Local MCH programs will find them a crucial resource in developing their MCH plans. In addition, Action Guides can be informative tools to use with private and public agency partners and policy makers. At present, the number of Action Guides is limited, but development of more will be ongoing. LHAs that choose to address MCH indicators that do not have Action Guides are expected to research and utilize evidence-based practices, where available. MCH Consultants that developed the Action Guides are available for consultation as well.

Click here to view the MCH Action Guides.

2. MCH Operational Plan and Report template and Instructions

The MCH Operational Plan and Report template is a new user-friendly tool that allows local health agencies to write annual and final reports on the same document as the Operational Plan. Instructions for utilizing the template are provided. These instructions guide the user through the template by describing what information is needed in each field. In addition, the template has been loaded with "Help Text". Help Text is a feature of Microsoft Word that allows brief instructions for each field to be displayed at the bottom of the computer screen. Look for Help Text instructions at the bottom of the template.
Click here to view the MCH Operational Plan and Report template.
Click here to view the Instructions.

Planning: MCH Operational Plan
Once LHAs have determined their priorities and researched effective strategies, they begin drafting their three-year MCH Operational Plan on a customized template provided by their MCH Consultant. Each program area being addressed will develop at least one goal and one or more program objectives to drive the work.

MCH Operational Plans should include good goals and objectives that are S.M.A.R.T. (Specific, Measurable, Achievable, Realistic, and Time-phased). For more information on

writing good goals and S.M.A.R.T. objectives, please review an MCH Action Guide and visit the following website: http://apps.nccd.cdc.gov/dashoet/writing_good_goals/page002.html

► Initial submission of the MCH Operational Plan is due no later than **July 1**.

Reporting: MCH Operational Plan and Report (annual and final)
LHAs will also use this completed template as a reporting tool. Areas in gray indicate reporting fields, and will be completed, per the instructions, at the end of each fiscal year. Annual reports will be completed at the end of years one and two; final reports will be completed at the end of year three.

► Annual and final reports are due no later than **December 15**.

3. Core Public Health Services Forms

The Core Public Health Services Forms are completed as planning and reporting forms by MCH program staff. The purpose of the form is to estimate the extent to which MCH programs provide services at the different levels of the MCH Pyramid. Please see "Core Public Health Services Provided by MCH Agencies" for more information on the MCH Pyramid and the definitions of each level of service.

Planning: Application Estimate
Click here to view the MCH Core Public Health Services Application Estimate.
To complete this form, follow the general instructions provided on the report form and the specific instructions listed below.

1. Review the objectives and activities included in the agency's MCH Operational Plan for each population group (e.g., Prenatal, Child & Adolescent and Children with Special Health Care Needs) for the upcoming fiscal year.

2. Estimate the proportion of the plan that is devoted to each level of service (e.g. direct, enabling, population-based or infrastructure building service). Consider the amount of time and effort involved in completing the objective/activity when developing the estimate.

3. Enter the appropriate percentages for each population group (e.g., Prenatal, Child & Adolescent and Children with Special Health Care Needs) on the Core Public Health Services form.

► The Core Public Health Services Application Estimate is due no later than **July 1**.

Reporting: Final Report
Click here to view the MCH Core Public Health Services Final Report.
To complete this form, follow the general instructions provided on the report form and the specific instructions listed below.

1. Review the objectives and activities completed in the MCH Operational Plan for each population group (e.g., Prenatal, Child & Adolescent and Children with Special Health Care Needs) for the completed fiscal year.

2. Determine the proportion of the plan that was devoted to each level of service (e.g., direct, enabling, population-based or infrastructure building). Consider the amount of time and effort involved in completing the objective/activity when developing the final

percentage.

3. Enter the appropriate percentages for each population group (e.g., Prenatal, Child & Adolescent and Children with Special Health Care Needs) on the Core Public Health Services form.

► The Core Public Health Services Final Report is due no later than **December 15.**

4. Numbers Served Reports: Tables I & II

The Numbers Served Reports: Tables I and II are only used during the reporting process. The information in these reports is used to fulfill a requirement of Colorado's federal grant application.

Reporting: Table I: Numbers Served by Title V
Click here to view Table I: Numbers Served Reports.
To complete this form, follow the general instructions provided on the report form and the specific instructions listed below.

1. When determining numbers of women and children served under Title V, include anyone who receives either a direct, enabling or population-based service that is paid in full or part by Title V funds. Title V funds are the monies that your agency receives in Prenatal, Child/Adolescent and HCP contracts. Use the definitions for direct, enabling or population-based services outlined in the MCH Guidelines under "Core Public Health Services provided by MCH Programs".

2. Do not include WIC clients in the numbers unless they also received a service paid in full or part by Title V funds.

3. If data is not available, estimates are acceptable. HCP will send county HCP CHIRP data for CSHCN served in December.

4. If a person qualifies for more than one "Class of Individual Served" in a year, choose only one class category in which to report them. Do not report individuals in more than one class category. If data is entered under the "Class of Individual Served" category of "Pregnant Women Receiving Prenatal, Delivery or Postpartum Care/Services", make a note of the total number and complete Table II.

► Table I: Numbers Served by Title V is due no later than **January 15**.

Reporting: Table II: Number of Pregnant Women Served by Title V
Click here to view Table II: Number of Pregnant Women Served by Title V.

Note: HCP contractors are not required to complete this form.

This form is required if data were entered in the category entitled "Pregnant Women Receiving Prenatal, Delivery or Postpartum Care/Services" in Table I.

► Table II: Numbers of Pregnant Women Served by Title V is due no later than **January 15**.

5. Fiscal Forms and Instructions

Planning: Application Budget

Click here to view the MCH Application Budget.
Complete a separate budget for each of the following population groups: Child and Adolescent, Prenatal, and Children with Special Health Care Needs (CSHCN).

To complete this form, follow these instructions:

1. Complete the top portion of the form providing agency name, date the form was completed and the name and contact information for the person who prepared the Application Budget. Include the name and information for the Fiscal/Budget staff person who **reviewed and approved** the budget in the space provided. If the Fiscal/Budget contact for the agency is the person completing the form, indicate that by listing "same" in the Fiscal/Budget approval box.

2. Choose the applicable population group for the budget narrative.

3. Use the following descriptions/examples for each Expense Category.

    a. **Personnel Services:** List the name, title, annual salary and Full Time Equivalent (FTE) for each staff member who will be working on the Plan.
    b. **Operating Expenses:** Include expenses that are **not** included in the indirect rate for your agency, such as office supplies, copies, postage, telephone, computer network fees, project supplies and materials, professional development and training. Include funding for equipment, including computers and software.
    c. **Travel Costs**: Include travel costs to be incurred in completing the MCH Plan and/or travel to attend trainings.
    d. **Contractual Services:** List costs for contractors (personnel not employed by your agency) working on the MCH Plan.
    e. **HCP Inter-Disciplinary Team Costs:** This category is for HCP only. List each staff member or operating expense for the HCP Inter-Disciplinary Team.
    f. **Indirect Costs:** List your indirect rate. Indirect rates are capped per CDPHE agreement as follows: 25% of total direct costs; 27% of total direct salaries and/or fringe; 30% of total direct salaries and fringe where no other direct costs are charged. If your rate exceeds the indirect rate caps, identify those indirect costs above the allowed rate as match or in-kind contributions.
    g. **"Other" Funding:** List additional sources of MCH funding in this column.

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

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

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

► The Application Budget must be completed in conjunction with the Application Budget Narrative (see below) and submitted together no later than **July 1**.

Planning: Application Budget Narrative
Click here to view the Application Budget Narrative.
Complete a separate budget narrative for each of the following population groups: Child and Adolescent, Prenatal, and Children with Special Health Care Needs (CSHCN).

To complete this form, follow these instructions:

1. Complete the top portion of the form providing agency name, date the form was completed and the name and information for the person who prepared the Application Budget Narrative. Include the name and information for the Fiscal/Budget staff person who **reviewed and approved** the budget in the space provided. If the Fiscal/Budget contact for the agency is the person completing the form, indicate that by listing "same" in the Fiscal/Budget approval box.

2. Choose the applicable population group for the budget narrative.

3. Follow the instructions on the form for each expense category.

► The Application Budget Narrative must be completed in conjunction with the Application Budget (see above) and submitted together no later than **July 1**.

Reporting: Final Expenditure Report FY08
Click here to view the MCH Final Expenditure Report.

Complete a separate report for each of the following population groups: Child and Adolescent, Prenatal, and Children with Special Health Care Needs (CSHCN).

To complete this form, follow these instructions:

1. Complete the top portion of the form providing agency name, date the form was completed and the name and contact information for the person who prepared the Final Expenditure Report. Include the name and information for the Fiscal/Budget staff person who **reviewed and approved** the budget in the space provided. If the Fiscal/Budget contact for the agency is the person completing the form, indicate that by listing "same" in the Fiscal/Budget approval box.

2. Choose the applicable population group for the expenditure report.

3. Complete the report using your agency's FY08 Application Budget. In the box at the bottom right side of the form, indicate which methodology was used to calculate the source of funds in the "Other" column. Refer to the descriptions under the Application Budget.

► The Final Expenditure Report(s) must be submitted no later than **December 15**.

6. Review and Feedback of Plans and Reports

State MCH Consultants will review and provide feedback on all planning and reporting submissions by using the MCH Review and Feedback Tools. These tools provide a

transparent view of how the plans and reports are evaluated and what follow-up task may be required. There are three different versions of the tool that accommodate each of the required planning and reporting due dates:

Planning:

- Initial Plan Submission

This Review and Feedback Tool is completed by State MCH Consultants during the month of July and provided to LHAs no later than August 1 (one month after initial plan submission).

Reporting:

- Annual Report

This Review and Feedback Tool is completed by State MCH Consultants during the month of January and provided to LHAs no later than January 31 (at the end of the first and second years of the plan).

- Final Report

This Review and Feedback Tool is completed by State MCH Consultants during the month of January and provided to LHAs no later than January 31 (at the end of the third year of the plan).

E. Contractor Requirements

1. Key Contractor Responsibilities

The MCH Contract includes the complete scope of work for local health agencies. The contractor responsibilities highlighted here focus on the most important aspects of the MCH Contract.

1. The Contractor shall provide the core public health services of assessment, policy development, and assurance on behalf of the prenatal, child and adolescent, and children with special health care needs (CSHCN) populations as described and defined in the earlier section entitled “MCH Pyramid: Core Public Health Services Provided by MCH Agencies.”

2. The Contractor shall provide leadership, in coordination with public and private community partners, in the development and implementation of the Contractor’s Prenatal, Child/Adolescent, and Children with Special Health Care Needs Operational Plan.

3. The Contractor shall have access to technical assistance provided by State staff to support the implementation of the Contractor’s Prenatal, Child/Adolescent, and Children with Special Health Care Needs Operational Plan for the current fiscal year and for the development of the Contractor’s Local Prenatal, Child/Adolescent, and Children with Special Health Care Needs Operational Plan for the upcoming federal fiscal year.

4. The Contractor shall design the Prenatal, Child/Adolescent, and Children with Special Health Care Needs Operational Plans based on a community planning process that includes a review of the health status needs of the prenatal, child and adolescent, and CSHCN populations and of the health system resources of a community. These plans should:

   a. Contribute to the accomplishment of the national and state’s priorities, performance measures, and outcome measures, as identified earlier in the section entitled “MCH Performance and Outcome Measures;”

   b. Provide for the continuation of the core public health services of assessment, policy development, and assurance on behalf of the maternal and child health populations and in implementing the 10 essential services for this population in partnership with the state, as identified earlier in the section entitled “MCH Essential Public Health Services;”

   c. Include work with public and private community partners to plan for the development and maintenance of resources that assure access to direct care and 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;

   d. Facilitate outreach and enrollment efforts, including having information and applications on-site, to increase enrollment of eligible children and adolescents, including those with special health care needs, in Medicaid (Colorado Baby Care/Kid’s Care Program) or Child Health Plan Plus (CHP+) and Supplemental Security Income (SSI);

e. Refer families participating in any and all programs in its agency such as Women, Infants and Children (WIC); Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Immunization Clinics; Family Planning; HCP; etc., to appropriate enabling and direct care service programs in the community. All pregnant women in need of resources for prenatal medical care shall be provided with information about programs such as Prenatal Plus, Nurse Family Partnership, WIC, etc., as needed. The Contractor shall provide all individuals seeking reproductive health services with information about pregnancy planning and the consequences of unintended pregnancies, and referrals to comprehensive family planning services; and

f. Include work with public and private community partners to plan for the development and implementation of population-based approaches for addressing MCH performance measures and priority issues for women, children, adolescents, and children with special health care needs in the community.

5. The Contractor shall comply with all reporting requirements as defined in these MCH Guidelines.

2. MCH Requirements by Due Date for 2008-2009

All forms can be accessed at www.mchcolorado.org and www.hcpcolorado.org.

Please submit the completed reports by email to cdphe.psmchreports@state.co.us.

All reports are due no later than the date specified. Requests for extensions may be made for exceptional circumstances only. Extension requests must be submitted by email no less than five (5) business days prior to the due date. Submit requests to cdphe.psmchreports@state.co.us. Extension approvals will be confirmed by email.

Ongoing

HCP Monthly Pediatric Specialty Clinic Calendar
Note: Requirement of HCP Specialty Clinic Contractors Only

HCP Specialty Clinics are responsible for the timely posting of clinic dates, locations, specialties and attending physicians to the ***HCP Specialty Clinics Google Calendar***. This calendar is to be updated as changes occur. For instruction regarding access to and the use of the calendar, refer to the HCP Specialty Clinic Policy and Procedure C-20: Specialty Clinic Tracking available at http://www.cdphe.state.co.us/ps/hcp/form/policy/C-20SpecialtyClinics-SpecialtyClinicTracking.pdf.
For additional information, contact Paul Gillenwater at Paul.Gillenwater@state.co.us

July 1, 2008
All required planning forms (new) for FY09 (October 1, 2008 - September 30, 2009):

MCH Indicator Checklist
MCH Operational Plan
Core Public Health Services Application Estimate FY09
MCH Application Budget FY09
MCH Application Budget Narrative FY09

December 15, 2008
Required reporting forms (new and old) for FY08 (October 1, 2007 – September 30, 2008):

MCH Annual Operational Plan Report FY08
Prenatal & Child/Adolescent Annual Progress Report for Operational Plan FY08
HCP Annual Progress Report FY08
HCP Annual Performance Measure Report FY08
Core Public Health Services Final Report FY08
MCH Final Expenditure Report FY08

January 15, 2009
The remaining two reporting forms (new) for FY08 (October 1, 2007 – September 30, 2008):

Table I: Numbers Served by Title V FY08
Table II: Number of Pregnant Women Served by Title V FY08

3. Instructions for Annual Reports for FY 2008

The MCH Annual Reports for FY08 are due no later than **December 15, 2008** for the period of October 1, 2007 to September 30, 2008. The forms can be accessed at www.hcpcolorado.org or www.mchcolorado.org.

Please submit the completed reports by email to cdphe.psmchreports@state.co.us

All reports are due no later than the date specified. Requests for extensions may be made for exceptional circumstances only. Extension requests must be submitted by email no less than five (5) business days prior to the due date. Submit requests to cdphe.psmchreports@state.co.us. Extension approvals will be confirmed by email.

MCH Annual Operational Plan Report FY08
Note: Requirement of ALL Contractors
Click here to view form.

Review your FY08 Operational Plan and respond to each question listed on the report form regarding implementation of the plan for each of the three populations. One form may be used to respond to all questions for all three populations.

Prenatal & Child/Adolescent Annual Progress Report for Operational Plan FY08
Note: Requirement of Prenatal & Child/Adolescent Contractors Only

Using the Progress column in the electronic copy of your FY08 Operational Plan, provide a summary of your progress for the prenatal and child/adolescent populations. If you need a new electronic copy of your plan please email cdphe.psmchreports@state.co.us.

HCP Annual Progress Report for Operational Plan FY08
Note: Requirement of HCP Contractors Only
Click here to view form.

Review your FY08 Operational objectives, activities and plans prior to completing this report. This report requires a brief summary of your progress and accomplishments for each of the National Outcome Measures.

HCP Annual Performance Measures Report FY08
Note: Requirement of HCP Contractors Only
Click here to view form.

Respond to each of the Performance Measures listed following specific instructions provided on the form.

PART III: ADDITIONAL RESOURCES FOR LOCAL MCH PROGRAMS

A. MCH Orientation and Resource Manual

This document provides additional online educational resources that expand on the information in the Guidelines. These resources may be used to orient new staff as well as to provide expanded MCH information for all MCH Program staff. The sequence of the topical areas follows the flow of the MCH Guidelines. Note that the topical area in column one is followed by a brief description of the resource in column two and the actual link to the resource is available in column three.