CLOSING THE GAPS:
Psychosocial Services to Improve Maternal and Child Health

Introduction

Infant mortality impacts every community in California, with significant disparities among racial/ethnic groups. For example, after many years of improvement in the overall rate, African-American babies in California still die more than twice as frequently before their first birthday as white babies do.[1] Sacramento County is especially hard hit.[2]

In addition, African-American women in California are still three to four times as likely to die from pregnancy-related causes than other racial/ethnic groups, despite significant declines in California's maternal mortality rate from 2008-2013[3] (with an uptick beginning again in 2012).[4] In 2014, researchers working with the California Department of Public Health (DPH) reviewing data from 1999-2005 concluded that pregnant women got sicker during that time, suffering from conditions such as chronic hypertension, diabetes, obesity, mental health problems, and tobacco use." The prevalence of maternal comorbidities before and during pregnancy has risen substantially in California and demonstrates racial/ethnic disparity *independent of demographic shifts*" (emphasis added).[5]

To respond to this situation,"it's clear that effective approaches must address the many factors that impact the health and well-being of mothers and children, as well as communities[,] [including] social determinants of health [SDOH] …"[6] The World Health Organization defines SDOH as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[7] The latest research from California's Maternal and Infant Health Assessment survey shows the prevalence of SDOH affecting low-income pregnant women with Medi-Cal as well as disproportionate impacts on African American women.

MATERNAL INFANT HEALTH ASSESSMENT (MIHA)
Social Determinants Of Health 2013-14

Factors	Medi-Cal	Private Insurance	Income 0-100% FPL*	100-200% FPL	>200 FPL	Hispanic %	Black %	White %	Asian/ Pacific Islander %
Food insecurity during pregnancy	27.5	4.8	30.1	16.3	2.5	22.3	20.8	12.4	6.2
Physical or psychological IPV (intimate partner violence)	10.7	2.8	12.5	5.1	2.4	9.1	11.1	4.2	4.5
Homeless or no regular place to sleep	4.8	0.7	5.4	1.7	0.5	3.1	9.1	2.1	1.1*
Moved due to problems paying rent or mortgage	10.3	2.9	11.8	5.7	1.9	8.4	13.4	5.3	2.6
Woman or partner lost job despite wanting to go on working	21.5	7.4	22.8	16.2	5.5	18.2	19.8	12.2	6.7
Became separated or divorced (during pregnancy)	11.6	2.9	13.0	7.6	1.6	10.5	14.8	4.2	1.7*
Obese before pregnancy	25.7	15.5	26.2	25.2	12.4	26.8	25.1	16.1	7.0
Had no practical or emotional support	6.7	1.8	8.1	2.7	1.5	6.7	3.6	1.6	3.2
Any smoking 3rd trimester**	4.3	0.8	5.0	3.3	0.6	1.6	5.9	5.0	1.8*
Mistimed or unwanted pregnancy	41.2	20.0	43.3	34.7	15.8	38.4	40.3	23.3	21.1
Initiated prenatal care in 1st trimester	84.2	96.8	83.7	89.0	97.2	87.2	85.9	92.0	94.3
Did not complete high school (or GED)	29.4	2.4	31.5	12.9	0.7	28.7	12.9	4.6	2.5
Daily folic acid use, month before pregnancy	21.7	44.9	22.0	26.3	47.4	24.8	25.0	41.4	44.5

Source: MIHA Snapshot, California by Prenatal Health Insurance and by Income, 2013-14.
*FPL = Federal Poverty Level
**Measure/definition changed for this indicator and is not comparable to prior years.

Medi-Cal's Comprehensive Perinatal Services Program (CPSP) Is Designed To Address SDOH For Pregnant Women

Interventions to address SDOH may include a broad range of services: for example, arranging rides to medical appointments for patients who don't have a car or access to public transportation; helping patients get enough food for proper nutrition; covering utility bills to counteract extreme temperatures; eliminating rodents or mold from housing; connecting a survivor of intimate partner violence to a shelter, support groups, job training or higher education; and similar kinds of non-clinical assistance, including to reduce stress.[8] By some estimates, 60% of preventable deaths are rooted in modifiable behaviors and exposures that occur in the community.[9] At its core, then, addressing SDOH involves effective partnerships among medical care, social services, public health, and community-based organizations, along with a reimbursement structure and sustainable payment model(s) to support such partnerships for preventing and addressing SDOH.

California emerged as an early pioneer in tackling SDOH for pregnant women in the 1980s, when

the Legislature enacted the Comprehensive Perinatal Services Program (CPSP) as part of the state's Medi-Cal law.[10] This followed a groundbreaking state pilot project[11] that not only facilitated access to an obstetrician or other clinician for prenatal care but also coordinated non-clinical psychosocial services, health education, and nutrition counseling for pregnant women as part of Medi-Cal's insurance benefit package and reimbursement structure.[12] Among the reasons for this approach, the Legislature expressly found, was the significant cost-savings to taxpayers by preventing low birth weights and lifelong health problems for newborns.[13] Over three decades later, according to a July 2017 study published in the journal *JAMA Pediatrics,* national data indicate that"[i]nterventions to further reduce the rate of preterm birth among black infants appear the most promising option for reducing black infant mortality and the absolute inequality between black and white infants."

Pediatricians point to the urgency of addressing SDOH for children's health.[14] An approach similar to CPSP in pediatrics has recently shown results: interventions to address identified SDOH "significantly decreased families' reports of social needs and significantly improved children's overall health status as reported by caregivers. These findings support the feasibility and potential effect of addressing social needs in pediatric health care settings."[15]

Major Gaps in State Department of Health Care Services (DHCS) Oversight and Monitoring of Plan and Provider Compliance with CPSP:

Chart 1 at the end of this Issue Brief highlights several of the major psychosocial benefits that all pregnant women in Medi-Cal should have access to through CPSP to address SDOH. Chart 2 identifies the major gaps in the oversight and monitoring process, both on the managed care side as well as the fee-for-service (FFS) side of Medi-Cal.

As the charts highlight, DHCS's Medi-Cal managed care plan reviews are incomplete for CPSP, while the more robust CPSP FFS information collected by individual county CPSP Perinatal Services Coordinators (PSCs) under DPH is not analyzed by either DPH or DHCS.

As a result of these gaps in oversight and monitoring, the promise and potential to promote healthy birth outcomes through CPSP, and particularly its psychosocial benefits, is being missed. ***Chief among the reasons for this is the failure of State DHCS to properly oversee and monitor whether women who need them actually receive CPSP's full range of psychosocial and other benefits in either managed care or FFS.*** Some of the key reasons for this are:

- DHCS allocates most of its policy and monitoring energies by far to Medi-Cal managed care plans, even though when it comes to pregnancy coverage, most of Medi-Cal is in FFS — 58% in 2013 — not managed care;[16]

- the DHCS Medi-Cal managed care division's chart review process for maternity care does not include some of the key psychosocial and other services that the CPSP statute guarantees for women who need them;
- while local county PSCs generally apply robust CPSP protocols in their chart reviews of Medi-Cal FFS providers, neither DHCS nor DPH collects this information, much less uses it to assess whether pregnant women in FFS are missing out on the CPSP psychosocial services they need. In addition, local PSCs have been given limited tools for ensuring that Medi-Cal providers, whether contracted with health plans or in the FFS delivery system, conduct the required CPSP assessments, prepare individual case plans for women with identified psychosocial risks, and either provide or arrange for covered psychosocial services to address identified risks.

A better system is possible. For example, the charts below compare the psychosocial supports provided to low-income women participating in the Black Mothers United (BMU) project of the Center for Community Health and Well-Being, Inc., in Sacramento County. The BMU program does assessments based on CPSP's protocols, prepares individual care plans, and most critically, ensures that the services needed to help address a woman's psychosocial risks are made available to her, typically through a non-clinical "peer advocate." The program also tracks the specific services received by the woman for her identified psychosocial risks — transportation to prenatal visits, getting help with utility bills or finding a safe place to live, referrals for immigration issues, and more — and, if services were not received, why not. The project is designed to reach 550 women by June 30, 2018. By the end of the project's first 18 months, 36 of the initial 75 participants had already delivered their babies, and birth outcomes were significantly better than for African-American women in Sacramento County generally.[17]

Recommendations

Improve Transparency, Oversight, and Monitoring

- Ensure that chart reviews are conducted for all Medi-Cal managed care plans ("Plans") and Medi-Cal fee-for-service (FFS) providers. Include review for all of CPSP's assessments, individual care plans, and required follow up services, including psychosocial services;
- Make public each Plan's policies and procedures on CPSP's psychosocial services;
- Deploy county CPSP Perinatal Services Coordinators (PSCs) to work with FFS providers under DPH (current practice) but also with the plans under DHCS on both chart and administrative reviews;
- Require all plan and FFS providers to use DPH's sample assessment, individual care plan, and follow up forms;
- Use random sampling instead of the current practice in some counties of allowing providers to select which charts are to be reviewed;
- Adopt an online interactive database for PSCs to report the results of their Medi-Cal CPSP chart reviews for both FFS providers and Plans to State DPH/DHS. Both the Plan and FFS provider data should be analyzed on a regular basis, for example, by DPH's Center for Family Health, to identify best practices as well as which plans and providers are not rendering robust CPSP services; and
- Use such data to inform policy decisions designed to ensure that all pregnant women, regardless of whether in Medi-Cal managed care plans or covered by FFS Medi-Cal, receive full CPSP assessments and robust follow up services for identified psychosocial risks.

Remove Access Barriers

- Count visits for providing or arranging CPSP psychosocial services as a separate encounter for Federally Qualified Health Centers and Rural Health Centers, regardless of whether the visit occurs on the same day as a medical prenatal care visit; and
- Establish a task force to assess options for incorporating the BMU model of coordinating psychosocial supports through community-based organizations into the CPSP program in a financially sustainable manner.

1—SCREENING FOR SELECT PSYCHOSOCIAL AND OTHER CPSP BENEFITS[1]

	Chart Reviews Conducted for CPSP?	Transportation To Services?[2]	Dental Screen & Refer?[3]	Mental Health Screen & Refer?[4]	Domestic Violence Screen & Refer?	Breastfeeding Support?[5]	Food Security?	Housing?
1. Managed care plans (DHCS)	Review sample	Not before 7/17	Screen. Refer only for certain 'immediate' needs[3]	Limited[6]	Yes	WIC referral and minimum ACA benefits.	Yes	No
2. FFS (DPH)	Review sample	No (asked re: health ed only).	Yes	Yes[7]	Yes	Yes	Yes	General
3. BMU (both plan and FFS providers)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

[1] CPSP benefits are mandatory for all pregnant women in Medi-Cal. This is so regardless of whether a woman's coverage is through FFS Medi-Cal or through a Medi-Cal managed care plan. Welf. & Inst. C. §§ 14132(u), 14134.5. DHCS regulations implementing CPSP are at Title 22, Calif. Code of Regulations, §§ 51179, 51179. 10, 51348, 51348.1.

[2] CPSP requires transportation to medical visits for pregnant women who lack it, regardless of whether Medi-Cal covers transportation for other adults. AB 2394 (Stats. 2016, c. 615), implemented in July 2017, now covers transportation for all other adult Medi-Cal beneficiaries.

[3] Boilerplate Contract (Ex. A, # 11, ¶ 15) and e-mail from DHCS 9/29/17. CPSP requires dental screenings and referrals for pregnant women, regardless of whether Medi-Cal covers dental for other adults. Pregnant women continued to be covered for some dental even after the elimination of dental benefits for other adults in July 2009 and beyond the partial restoration in May 2014. Starting January 1, 2018, dental will be restored for all adults.

[4] Including substance use disorders (SUDs). Urgent need for adoption of Maternal Safety Net Bundle in CPSP Protocols for mental health and SUD issues, which exceed hemorrhage and hypertensive disorders as a cause of maternal mortality. Maternal Mental Health Safety Bundle: An Opportunity for Public Health-Provider Partnership in California

[5] CPSP requires comprehensive breastfeeding support, continuing beyond the postpartum period when desired and needed.

[6] Referrals are out-of-plan for specialty mental health. Plans cover mild to moderate mental health concerns but only with DSM diagnosis (APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services). Services for other risk factors are not required, such as all relational problems requiring family therapy, stress, and anxiety or depression amenable to peer supports in early stages.

[7] For more information about Medi-Cal coverage of mental health and SUDS for pregnant women in FFS, see MCHA's May, 2017, "Mental Health and substance use disorder treatment services now covered under Pregnancy-Related Medi-Cal and MCAP."

2—MONITORING PROCESS FOR CPSP PSYCHOSOCIAL BENEFITS[8]

	Assessments At Initial, Interim & Postpartum Visits?	Preparation Of Individual Care Plan (ICP)?	ICP With Coordinator?	Whether ICP Services Received Or Why Not Received?[9]	How Is Data Collected?	Recommendations
1. DHCS—Medi-Cal managed care[10]	All three assessments. Each Medi-Cal health plan uses its own perinatal screening criteria. Plan perinatal screening forms not available. Assessment for "life-style changes" required only once a year for adults.	No	Yes	Yes, but vague[11]	By health plans from providers, for sample reviews by DHCS. No public reporting.	Adopt standardized interactive internet-based platform to input & update risk assessments, case plans, services tracking and birth outcomes for monitoring & oversight. Incorporate county PSCs into this process, with plan resources. Public reporting for program compliance and DHCS accountability.
2. DPH—Medi-Cal FFS[12,13]	All three assessments (See question #4b)[12,14] Generally follows DPH CPSP screening criteria.	Yes (#8)[12]	Yes (#12)[12]	Yes, but vague[11]	Manually by the 58 county PSCs. Not forwarded to state DPH. Providers choose charts for review. No public reporting.	As above, adopt standardized interactive internet-based platform to input and update risk assessments, case plans, services tracking, & birth outcomes for monitoring & oversight. Public reporting for program compliance and DHCS accountability.
3. BMU—Sacto County Medi-Cal managed care enrollees[15]	All three assessments. Generally follows DPH CPSP screening criteria.	Yes	Yes	Detailed documentation on whether each ICP service was actually received, & if not received, why not.	CCHWB staff input to database for all clients. Published data reports on assessed psycho-social needs, follow up services. & birth outcomes.	Adopt policies to incorporate the BMU model into CPSP, with sustainable funding for high quality community groups. Monitoring & oversight. Public reporting for program compliance and DHCS accountability.

[8] As noted, under state law DHCS is responsible for ensuring that pregnant women receive CPSP benefits regardless of whether a woman has Medi-Cal in FFS or through a managed care plan. For women whose Medi-Cal is in FFS, DHCS has delegated certain responsibilities for CPSP administration to DPH. Template Protocols for CPSP are available here: DPH CPSP Protocols (2017). And CPSP's psychosocial benefits in DPH's "Steps to Take" Manual (2015) are available here: PSY Section 5: Steps to Take (2015). And the Medi-Cal plans are required to coordinate with their local health department PSCs in the delivery of CPSP. See, DHCS Medi-Cal Managed Care Division, Policy Letter No. 12-003 (June 26, 2012).

[9] CPSP providers "shall track the patient to verify whether services have been received."Welf. & Inst. C. § 14134.5(d).

[10] Policy Letter No. 14-004 (May 22, 2014), pp. 76-77: OB/CPSP Preventive Reviewer Guidelines.

[11] "Staying Healthy Assessment" form (p.2) does not require tracking. DHCS Medi-Cal Managed Care Division Policy Letter 13-001 (Revised) and DHCS 7098 (Rev 12/13).

[12] The numbers in this row refer to the questions in DHP's chart review tool for CPSP, available by contacting MCHA.

[13] According to DHCS, 45% of Medi-Cal deliveries are covered by FFS. DHCS has delegated to DPH the responsibility to review charts for FFS providers. That responsibility has in turn been delegated by DPH to the 58 county PSCs, who conduct sample chart reviews.

[14] DPH's intial, interim and postpartum screening and individual care plan forms and Template Protocols are available here: Initial and Trimester , Postpartum, and Individual Care Plan. Found at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Assessment-and-Care-Plan-Forms.aspx, accessed 3-6-2018.

[15] CCHWB's comprehensive screening and follow up monitoring forms are available on request by contacting MCHA.

Endnotes for Pages 1-5

[1] Kaiser Family Foundation (2011-2013 data) and California Department of Public Health, Profile, *Black Infant Health,* undated, accessed 3-2-18.

[2] Caiola, Sammy. "Black children die at alarming rate in Sacramento County, and here's why." Sacramento Bee, July 10, 2016.

[3] Twachtman, Gregor. "California bucks trend of rising U.S. maternal mortality." Ob. Gyn. News, November 19, 2016; California Maternal Quality Care Collaborative's, CA Pregnancy-Associated Mortality Review (CA-PAMR) Project; and MCAH Bulletin, California Maternal Mortality Rates (CADPH May 2015).

[4] Id, pp. 1, second chart.

[5] Fridman, M., Korst M. L., Lawton E., Mitchell C., Gregory K. (2014). "Trends in Maternal Morbidity Before and During Pregnancy in California." *American Journal of Public Health*, February 2014. Supplement 1:S49-57. doi: 10.2105/AJPH.2013.301583.

[6] Christopher G., Simpson P. (2014). "Improving Birth Outcomes Requires Closing the Racial Gap." *American Journal of Public Health,* February 2014. Supplement 1: S10-2. doi: 10.2105/AJPH.2013.301817 citing Social Determinants of Health, World Health Organization.

[7] See, A Framework for Educating Health Professionals to Address the Social Determinants of Health. Institute of Medicine, March 2016, pp. 1.

[8] O'Donnell, Jayne. "Social service shortfalls hinder health, boost medical spending." USA Today, May 2, 2016.

[9] McGinnis J.M., Williams-Russo P., Knickman J. R. (2002). The case for more active policy attention to health promotion. Health Aff (Millwood) 2002; 21:78-93.

[10] Welf. & Inst. C. §§ 14132(u), 14134.5.

[11] Lennie A., Klun J., Hausner T. "Low-birth-weight rate reduced by the obstetrical access project." Health Care Finance Rev.1987 Spring; 8(3): 83–86. Kinsler, Sarah."Supporting High Performance in Early Entry into Prenatal Care: Spotlight on California's Comprehensive Perinatal Services Program." *National Academy for State Health Policy*, August 29, 2014. Rosenbaum S., Hurt C., Dorley M., Rothenberg S., Lopez N. (2014) "Access to Comprehensive Perinatal Services among Pregnant Women Enrolled in Both Medi-Cal and Covered California: Aligning and Integrating," October 31, 2014, pp. 3.

[12] The original "OB pilot" also included health education, nutritional counseling, and dental screening and referral, as does today's CPSP benefit package. We focus here, however, primarily on CPSP's psychosocial benefits in the context of SDOH.

[13] Stats 1987, c. 1387, § 1(m).

[14] American Academy of Pediatrics, "Poverty and Child Health in the United States." *Pediatrics* April 2016 Issue, March 9, 2016.

[15] Gottlieb L.M., ete al, "Effects of Social Needs Screening and In-Person Service Navigation on Child Health: A Randomized Clinical Trial." JAMA Pediatrics, September 6, 2016.

[16] DHCS Chart, 2007-2013 (Attachment A). The percent of pregnant women whose Medi-Cal is in FFS will likely decrease once the full impact of the expansion to full scope, and therefore plan enrollments, to 138% of the federal poverty level hits the data. Even then, very large numbers of pregnant women will continue to be in Medi-Cal FFS during their pregnancies.

[17] LPC Consulting Associates. BMU Evaluation Report, January 1, 2014-June 30, 2015, pp. 7-9. CCHWB hopes to be able to continue and expand its program to other groups of low-income women.

1111 West Sixth Street, Fourth Floor • Los Angeles, CA 90017-1800
tel: 213.749.4261 • fax: 213.745.1040
www.mchaccess.org • info@mchaccess.org

Lynn Kersey, Executive Director, *lynnk@mchaccess.org* • Lucy Quacinella, Multiforum Advocacy Solutions, *lucyqmas@gmail.com*

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