



PERINATAL SERVICES NETWORK GUIDELINES 2009

FOR NON DRUG MEDICAL PERINATAL PROGRAMS



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PERINATAL SERVICES NETWORK GUIDELINES

Introduction

In 1993, the Department of Alcohol and Drug Programs (ADP) combined the perinatal program requirements from the federally funded Options for Recovery pilot project, the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant Perinatal Set-Aside, and the State General Fund Perinatal Treatment Expansion Program (PTEP) into the Perinatal Services Network (PSN). This seamless service delivery system, under the standards of the Perinatal Services Guidelines, Fall 1993, ensured that programs provided consistent and quality services and adhered to the federal and state regulations.

In 1995, ADP revised the Perinatal Services Network Guidelines to reflect the need for contractual agreements among the state, counties, and providers. The PSN Guidelines were revised again in 1997 and 2004 in response to technical changes and to be consistent with terminology used throughout ADP. All PSN programs, regardless of fund source, are required to comply with the PSN Guidelines as specified in Part I, Article I(B)(7) of the Negotiated Net Amount (NNA) contract or NNA and Drug Medi-Cal (D/MC) combined contract between the state and the counties.

The PSN Guidelines are divided into two sections. Part I describes the perinatal program requirements and governing citations from the Code of Federal Regulations (CFR), California Health and Safety Code (HSC), and ADP Policy Letters. Part II lists the continuum of treatment modalities and service options that can be provided with perinatal funding.

In 2009, the PSN Guidelines were updated to clarify the requirement for therapeutic services for children and for consistency of terminology used throughout ADP. In 2010, the following typographical error was corrected on page six, section II, paragraph two; *each client for two or more hours* was corrected to *each client for three or more hours*.

Program requirements specific to Perinatal Drug Medi-Cal (DMC) are contained in the California Code of Regulations (CCR), Title 22, Division 3, Health Care Services.

I. PERINATAL PROGRAM REQUIREMENTS

A. Target Population (45 CFR 96.124 and HSC 10.5, 11757.59(a))

To be eligible for perinatal funding, a program must serve women who are either:

- pregnant and substance using; or
- parenting and substance using, with a child(ren) ages birth through 17.

Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

B. Admission Priority (45 CFR 96.131)

Priority admission for all women in perinatal funded services must be given in the following order:

1. pregnant injection drug users;
2. pregnant substance users;
3. parenting injection drug users; and
4. parenting substance users.

A program's admission criteria must comply with the Americans with Disabilities Act (ADA) of 1990. Specific information regarding the ADA is contained in each county's NNA contract.

C. Referral to Other Programs and Interim Services (45 CFR 96.121 and 96.131)

1. When a program is unable to admit a substance-using pregnant woman because of insufficient capacity or because the program does not provide the necessary services, referral to another program must be made and documented.

Pregnant women must be referred to another program or provided with interim services no later than 48 hours after seeking treatment services. Pregnant women receiving interim services must be placed at the top of the waiting list for program admission.

2. Injection drug-using women must be either:
 - a. admitted to a program no later than 14 days after making the request; or
 - b. admitted to a program within 120 days after making the request, if interim services are provided.
3. To assist programs in making appropriate referrals, each county must make available a current directory of its community resources.
4. Interim services are defined as:
 - a. Counseling and education about human immunodeficiency virus (HIV) and tuberculosis (TB), the risk of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
 - b. Referrals for HIV or TB treatment services, if necessary.
 - c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
 - d. Referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case

management, children's services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

D. Women-Specific Treatment and Recovery Services (45 CFR 96.124 and HSC 11757.59(b)(2)(H))

Programs must provide or arrange gender-specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, and parenting.

E. Case Management (45 CFR 96.124 and HSC 11757.59(b)(2)(A))

Programs must provide or arrange sufficient case management to ensure that women and their children have access to primary medical care, primary pediatric care, gender-specific substance abuse recovery and treatment, and other needed services.

F. Transportation (45 CFR 96.124 and HSC 11757.59(b)(2)(I))

Transportation must be provided or arranged to and from the recovery and treatment site, and to and from ancillary services¹ for women who do not have their own transportation.

G. Therapeutic Services for Children (45 CFR 96.124 and HSC 11757.59(b)(2)(F))

Programs must provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

H. Child Care (45 CFR 96.124 and HSC 11757.59(b)(2)(F))

Child care must be available for program participant's children while the women are participating in on-site treatment program activities and off-site ancillary services. Child care may be provided on-site, either through a licensed program or a licensure-exempt cooperative.² Children may also be referred to licensed or licensure-exempt child care facilities off-site,³ except as noted in (1) below.

¹Ancillary services include, but are not limited to, off-site child care, primary medical care, primary pediatric care, dental care, social services, community services, and educational and vocational training.

²On-site cooperative child care is defined by the following elements:

- the mothers are on-site and the children are under their care and supervision;
- the number of children is limited to 12 or less at any one time; and
- child development staff provide the mothers with parenting skills training, child development education, and supportive role modeling. For more information on cooperative child care, refer to the California Health and Safety Code '1598.792(e).

³Off-site child care facilities must be either licensed or licensure-exempt since the children are not under the care and supervision of their mothers. For further information on this requirement, refer to the California Child Day Care Facilities Act, ' 1596.792(k)(1) and (2) of the Health and Safety Code.

Depending on the age of the child, the following requirements apply:

1. Child care must be on-site for participant's children between birth and 36 months while the mothers are participating in the program (unless a waiver is approved by ADP).
2. Child care may be provided on-site or off-site for participants children who are between 37 months and 12 years of age.
3. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children.

The Pro-Children Act of 1994 (20 United States Code 6081 et. seq.) prohibits smoking in any indoor facility where services for children are federally funded or where the facility is constructed, operated, or maintained by federal funds.

I. Education Components (HSC 11757.59)

Programs must provide or arrange for the following services:

- educational/vocational training and life skills resources;
- TB and HIV education and counseling;
- education and information on the effects of alcohol and drug use during pregnancy and breast feeding; and
- parenting skills building and child development information.

J. Primary Medical Care and Pediatric Care (45 CFR 96.126 and HSC 11757.59(b)(1))

Programs are required to provide or arrange primary medical care for women in treatment, including referrals for prenatal care. They also must provide or arrange primary pediatric care, including immunizations, for dependent children.

Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare, and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees providing the county approved schedule of fee assessment and collection is applied. State General Funds cannot be used to provide medical treatment.

K. Administration

1. Reporting Requirements (45 CFR 96.122(f))

Once admitted into a perinatal program, a woman's participation must be documented on the California Outcomes Measurement System (CalOMS) Participant Record or a substitute form approved by ADP. Contact the ADP Data Management Section for instructions on completing these forms.

2. Fund Source Requirements

- a. Counties must implement procedures to ensure the requirements of the SAPT Block Grant, the Perinatal Set-Aside (45 CFR 96.124), and the Perinatal State General Fund (HSC 11757.59) are met.
- b. Effective July 1, 1995, only pregnant and postpartum women are eligible for Perinatal DMC benefits.⁴ For program requirements and reimbursable services specific to Perinatal DMC, see CCR, Title 22, Division 3, Health Care Services.

3. Public Notice and Outreach (45 CFR 96.131)

Counties must publicize that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them. Public notice may include street outreach, printed materials, multimedia messages (including public service announcements), interagency collaboration, and/or networking. Additional information about outreach services is provided in Part II, Perinatal Treatment Modalities and Services.

4. Program Monitoring (HSC 11983.2(b)(5))

Counties are responsible for contracting with providers, ensuring that all perinatal programs meet their contractual requirements, and ensuring that quality perinatal services are provided. Monitoring plans may include, but are not limited to, the following:

- site visits to the program;
- provider monthly, quarterly, and/or year end progress reports;
- regular telephone contacts with the providers; and
- program participant satisfaction surveys.

Staff from ADP's Program Services Division, Licensing and Certification Division, and Audit Services Branch may conduct site visits to ensure compliance with the specific regulations monitored by each division.

⁴The postpartum period is defined as a 60-day period beginning on the last day of pregnancy. Perinatal DMC eligibility ends on the last day of the calendar month in which the 60th day occurs. Perinatal DMC certified providers may either transfer non-pregnant, non-postpartum women to treatment slots paid for with other perinatal funds or refer the women to non-Perinatal DMC treatment programs if they are eligible.

5. Program Start-Up Costs

Fifteen percent of a programs first year total budget can be used for start-up costs. These costs can only be incurred 90 days before the first participant is admitted for recovery and treatment. Start-up costs incurred more than three months before the first participant is served must be capitalized as deferred charges and amortized over a number of benefiting periods.

II. PERINATAL TREATMENT MODALITIES AND SERVICES

Outpatient Drug Free (ODF) Treatment

This modality provides alcohol and other drug (AOD) treatment services, with or without medication, in a non-residential setting. There is no minimum number of treatment hours prescribed. No licensing is required, but a program providing ODF services must be certified by ADP's Licensing and Certification Division to be reimbursed with DMC funds for services provided to Medi-Cal eligible clients.

Daycare Rehabilitative (DCR) Treatment

This modality provides AOD treatment services in a non-residential setting to each client for three or more hours, but less than 24 hours per day, for three or more days per week. No licensing is required, but a program providing DCR services must be certified by ADP's Licensing and Certification Division to be reimbursed with DMC funds for services provided to Medi-Cal eligible clients. DMC reimbursement for DCR services is only available for pregnant or postpartum women in a perinatal DCR program.

Narcotic Treatment Program (NTP)

This modality combines AOD treatment services with one of the following approved narcotic replacement drugs:

- *Methadone* treatment provides AOD treatment services in a non-residential facility along with methadone as prescribed by a physician to alleviate the symptoms of withdrawal from opiates (maintenance) or in decreasing amounts in a planned withdrawal from opiate dependence (detoxification).
- *LAAM* (levoalphacetylmethadol) treatment provides AOD treatment services in a non-residential facility, along with LAAM as prescribed by a physician to alleviate the symptoms of withdrawal from opiates.

All narcotic treatment programs must be licensed by ADP's Licensing and Certification Division and comply with the requirements set forth in CCR, Title 9, Chapter 4, commencing with Section 10000.

Outpatient Detoxification Treatment (Other than Narcotic Treatment Detoxification)

This modality provides AOD treatment services, with or without medication, for safe withdrawal from alcohol or drugs in a non-residential, ambulatory setting for less than 24 hours per day.

Residential Treatment (Detoxification or Recovery)

This modality provides AOD treatment services in a residential, non-acute care setting. Residential programs that provide AOD detoxification, educational counseling, individual or group counseling, or treatment/recovery planning must be licensed by ADP's Licensing and Certification Division and comply with requirements set forth in CCR, Title 9, Chapter 5, commencing with Section 10500. Residential perinatal programs must also be certified by ADP's Licensing and Certification Division to be reimbursed with DMC funds for services provided to Medi-Cal eligible clients. DMC reimbursement for residential treatment is only available for pregnant and postpartum women in perinatal residential treatment programs.

Transitional Living Center (TLC)⁵

A facility designed to help women maintain an alcohol and drug-free lifestyle and transition back into the community. TLC activities are supervised (although not necessarily 24 hours per day) within an alcohol and drug-free environment. Attendance at recovery and treatment services is mandatory, although those services need not be on-site. TLCs are not required to provide the perinatal services described in Part I of these guidelines since the provision of those services is the responsibility of the perinatal treatment program the resident attends. TLCs do not require ADP licensure if they do not provide any of the following services on-site: AOD detoxification, educational sessions, individual or group counseling, or treatment/recovery planning.

Alcohol and Drug-Free Housing (ADFH)⁶

A facility designed to help recovering women maintain an alcohol and drug-free lifestyle. Residents are free to organize and participate in self-help meetings or any other activity that helps maintain sobriety. The house or its residents do not and cannot provide any treatment, recovery, or detoxification services; do not have

⁵State General Funds can be used for TLCs provided that the residence has paid staff or approved volunteer staff, residents are required to attend a perinatal recovery and treatment program, and the TLC documents each participant's attendance at the recovery and treatment program. Federal funds **cannot** be used to fund TLCs. Providers should contact ADP's Licensing and Certification Division to determine if licensure is required.

⁶Only the start-up phase of ADFH can be funded with State General Funds. Start-up costs are limited to the following one-time expenditures that prepare the residence for occupancy: first and last months deposit to secure a property; security and utilities deposits; and furniture that meets basic needs. Federal funds **cannot** be used to start or fund ADFH on an ongoing basis.

treatment or recovery plans or maintain case files; and do not have a structured, scheduled program of AOD education, group or individual counseling, or recovery support sessions.

Outreach

An element of service that identifies eligible pregnant and parenting women in need of treatment services and encourages them to take advantage of these services. Outreach may include engagement of prospective program participants by informing them of available treatment services, and can serve as “pre-treatment” by reinforcing prevention and education messages prior to enrollment in treatment. Outreach also may be used to educate the professional community on perinatal services so that they become referral sources for potential clients. Additional information on outreach is provided in Part I, Section K(3).

Interim Services

These are services provided to pregnant women or injection drug using women seeking substance abuse treatment who cannot be admitted to a program due to capacity limitations. Additional information on interim services is provided in Part I, Section C(4).

Case Management

A participant-centered, goal-oriented process for assessing the needs of an individual for particular services; assisting the participant in obtaining those services; and reviewing participant accomplishments, outcomes, and barriers to completing recovery goals. Case management may be either an element of a recovery and treatment modality or a free-standing service. This service is a required component of a perinatal program, as specified in Part I, Section E.

Aftercare

Aftercare provides structured services in an outpatient setting to individuals who have completed treatment to support the gradual transition of the individual back into the community, prevent relapse, and ensure successful recovery. Aftercare may be either an element of a recovery and treatment modality or a free-standing service.