

TCS BIRTHING SUPPORTS COORDINATION/REFERRAL CHECKLIST (PRENATAL – POSTPARTUM PERIOD)

Background and Instructions (For Managed Care Plan (MCP) Reference)

As part of the Birthing Care Pathway, the Department of Health Care Services (DHCS) identified key areas to strengthen support for birthing individuals, including updating the Transitional Care Services (TCS) policy to require specific services and supports for pregnant and postpartum members. TCS is required for all members experiencing transitions of care, which occur when a pregnant or postpartum member transfers from one setting or level of care to another, including but not limited to discharges from hospitals to home or community-based settings, or Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Under Pregnancy and Postpartum TCS, pregnant and postpartum members are eligible for these specific TCS services with any transition of care during their pregnancy and through 12 months postpartum. Transitional care events include discharges as well as the end of pregnancy.¹ DHCS' Pregnancy and Postpartum TCS policy, which is outlined in the [Population Health Management \(PHM\) Policy Guide](#), requires completion of this TCS Birthing Supports Checklist for all pregnant and postpartum members. MCPs are responsible for ensuring their contracted or assigned providers complete this checklist. The timeline for beginning and completion of TCS birthing supports are described below.

Purpose:

The purpose of this checklist is to ensure all members who are pregnant or postpartum are connected to a minimum standard of appropriate medical, behavioral health, and

¹“End of pregnancy” is defined as the last day of the pregnancy (irrespective of whether the pregnancy ends in a live or stillbirth, or spontaneous or therapeutic abortion (SAB/TAB)).

whole person services and supports.² MCPs are already responsible for informing, referring, and connecting members to many of these services through existing Comprehensive Perinatal Services Program (CPSP) and PHM requirements, as well as national guidelines from the American College of Obstetricians and Gynecologists (ACOG), United States Preventive Task Force (USPSTF), and American Academy of Physicians (AAP) Bright Futures.

Who Must Use This Checklist:

MCPs must ensure that all pregnant and postpartum members and their infants receive TCS care coordination supports according to the requirements outlined in the [PHM Policy Guide](#). Care coordination requirements differ between pregnancy and postpartum TCS categories – moderate- and high-intensity³, but both categories include referral and/or warm handoff to all services and supports on this TCS Birthing Supports Checklist for which a member has needs, meets eligibility, and aligns with their preferences.⁴ This includes access to culturally and linguistically aligned services and supports, consistent with Medi-Cal policy.

- » **High-Intensity Pregnancy and Postpartum TCS:** MCPs must assign a TCS care manager, a single point of contact, for each member who meets criteria for high-intensity Pregnancy and Postpartum TCS. The TCS care manager is responsible for delivering high-intensity TCS and is the single responsible entity responsible for coordinating care for the member, including all items on this checklist. Postpartum members who are re-engaged in high-intensity TCS must be

² Pregnancy and postpartum TCS includes limited support related to the infant(s) – as applicable for pregnancies resulting in live births in which the member maintains custody of the infant(s) – with the intent of assisting the pregnant or postpartum member in ensuring their infant attends well-child visits and is enrolled in health insurance. If additional TCS is needed for the infant, under high-risk or lower-risk criteria, it would be provided directly to the infant as a member, if enrolled or deemed eligible in the MCP.

³ For members who experience an end of pregnancy event not resulting in a live birth (i.e., stillbirths, SABs, TABs), it is important the MCP and/or the contracted care coordination entity use emotionally and culturally sensitive communication when engaging the member and consider the supports that are most appropriate/responsive to their needs.

⁴ DHCS' Closed Loop Referral (CLR) [policy](#) requires MCPs to close the loop for Enhanced Care Management (ECM) and Community Supports services.

reassigned to the same care manager, who should revisit/ensure completion of relevant items in the TCS Birthing Supports Checklist.

- » **Moderate-Intensity Pregnancy and Postpartum TCS:** MCPs may satisfy TCS requirements through assignment of a care coordination entity; this can be fulfilled via a contracted entity (e.g., doula, a birthing provider's clinic) or by MCP staff⁵. The care coordination entity does not need to be a single point of contact. Instead, within the care coordination entity, care coordination responsibilities may be distributed across multiple provider roles (e.g., nurse, social worker, Community Health Worker (CHW), case manager, scheduling staff) and can be done as part of normal perinatal care provided by the contracted entity. The care coordination entity is responsible for delivering moderate-intensity TCS, including coordinating care for the member, which encompasses all items on this checklist.⁶

This TCS Birthing Supports Checklist is designed to be used by the primary body responsible for care coordination – either the TCS care manager or the care coordination entity. The TCS Birthing Supports Checklist can be used by both licensed (e.g., registered nurse (RN), certified nurse midwife (CNM), licensed midwife (LM), licensed clinical social worker (LCSW)) or unlicensed (e.g., CHWs, doulas, case managers) individuals on the care team. If a TCS care manager/care coordination entity is not within their scope or able to perform a specific activity/referral, they must ensure a warm handoff (to the extent possible) to a qualified care team member who is able to deliver the services (e.g., refer the member to a qualified care team member for postpartum depression screening and ensure timely follow-up based on results of the screening).

Timeline for Completing the Checklist:

Because the end of pregnancy and any hospital or SNF discharge are considered care transitions, all pregnant and postpartum members must receive TCS birthing supports for eligible transitional events during pregnancy and postpartum (e.g., the 12-month

⁵ Providers and care coordination entities may serve in this contracted role if their MCP contract supports it.

⁶ If an MCP is designating TCS care coordination responsibilities to an outside entity for moderate-intensity members, MCPs are still responsible for ensuring their contracted or assigned providers complete this checklist.

period following the end of pregnancy).⁷ Coordination for the services on this checklist is encouraged throughout the full pregnancy and postpartum periods. For example, coordination for services such as lactation, food, or transportation supports should start as early in the pregnancy as possible, when the need is identified. However, PHM policy requires TCS care managers or care coordination entities to provide care coordination for the services and supports on this checklist per the timeline below:

- » **Pregnancy and Postpartum TCS Support Begins:** Aligned with PHM TCS policy, pregnancy and postpartum TCS services begin **before** a transitional care event to support a successful transition. For all members, including those who meet criteria for high- and moderate-intensity pregnancy and postpartum TCS, coordination of services and supports by the TCS care manager or care coordination entity must start no later than the beginning of the third trimester (if pregnancy status is not known until later, engage as soon as pregnancy is known). For members with transitional events that are hospital or Skilled Nursing Facility (SNF) discharges unrelated to the end of pregnancy, TCS begins at the time of admission (if they are not already engaged in TCS). Additional details by intensity category are outlined below:
- » *High-Intensity Pregnancy and Postpartum TCS:* TCS must begin as soon as high-intensity criteria is determined to be met at any time in the pregnancy or postpartum period, and no later than the beginning of the third trimester. For pregnant and postpartum members categorized as high-intensity for TCS due to an admission for reasons other than for delivery – and that member is not already engaged in high-intensity TCS Services – high-intensity TCS begins at the time of admission.
- » *Moderate-Intensity Pregnancy and Postpartum TCS:* No later than the beginning of the third trimester (see above).
- » **Post-Discharge/Post-Pregnancy Outreach, with Successful Connection with Member:** TCS care managers or care coordination entities must complete post-discharge outreach/follow-up per the timeline below. During this outreach,

⁷ DHCS extended Medi-Cal coverage from 60 days postpartum to 12 months postpartum as of April 1, 2022. All Medi-Cal eligible individuals who report a pregnancy are automatically eligible for the 12 month postpartum coverage period.

synchronous connection with the member must be achieved, and activities on this checklist appropriate for post-pregnancy care must be completed.

- » *High-Intensity Pregnancy and Postpartum TCS*: The TCS Care Manager must outreach and successfully connect⁸ with the member within seven calendar days of discharge or following the end of pregnancy.
 - *Moderate-Intensity Pregnancy and Postpartum TCS*: The TCS care coordination entity must outreach and successfully connect⁸ with the member at least within 21 calendar days following the end of pregnancy (or sooner based on member needs), aligned with ACOG guidelines.
- » **Completion of Care Coordination Activities**: TCS care coordination must be provided for a minimum of 30 days after discharge and 60 days following the end of pregnancy, whichever is later. In addition, the following three minimum requirements must be completed⁹:
 - Postpartum visit with medical provider (ACOG Guidelines)
- » Two-month well-child visit with medical provider (USPSTF Guidelines)
 - Any recommended follow-up from discharge instructions and/or discharge summary

MCP Coordination:

Entities that are assigned or contracted by the MCP to complete TCS care coordination activities for their members may always contact the MCP for assistance in completing any of the below activities through the TCS call line, as the MCP is responsible for ensuring their contracted or assigned providers complete this checklist. If the entity does not have or know the TCS call line information, they may connect through the [plan's member service department](#).

⁸ Successful connection requires synchronous communication with the member.

⁹ Care coordination or referral requirements for infants only apply when the postpartum member retains primary caregiving responsibility for the infant. These requirements do not apply when the infant is no longer in the member's custody, such as in cases of adoption, foster care placement, or infant death.

TCS Birthing Supports Checklist (For Use by TCS Care Managers & Care Coordination Entities)

TCS Birthing Supports Coordination Checklist (Pregnant – Postpartum Period)

The care manager or care coordination entity must ensure referral and/or warm hand off of the following services if the member has needs, meets eligibility for referral, and aligns with their preferences¹⁰:

Medical Supports

- » Perinatal/Postpartum visits according to ACOG/USPSTF Guidelines
 - Validated Behavioral Health Screenings
 - Intimate Partner Violence (IPV) Screening Using Evidence-Based Tool
 - Reproductive Life Planning
- » Pediatric visits according to American Academy of Pediatrics (AAP) Bright Futures schedule through two-month well-child visit
- » Other follow-up visits recommended by a provider or included in the discharge summary/instructions
- » Primary Care Provider visit scheduled (if no visit scheduled within the past one year)

Whole Person Needs

Food, Nutrition Education, and Breastfeeding Supports

- » Women, Infants, and Children (WIC)
- » CalFresh
- » Lactation Services

¹⁰ This includes access to culturally and linguistically aligned services and supports, consistent with Medi-Cal policy.

Managed Care Plan (MCP) Benefits

- » Transportation Services
- » Doula Services
- » Appointment Assistance
- » Breast Pumps
- » Enhanced Care Management (ECM)¹¹
- » Community Supports¹¹
- » Community Health Worker (CHW) Services

Family Support Services

- » Paid Family Leave
- » Home Visiting¹²
- » Parenting Resources¹³

Infant Support

- » Health Insurance for Infants
- » WIC (including infant formula)

Behavioral Health Needs

- » Behavioral Health Supports (e.g., Non-Specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), Drug Medi-Cal (DMC))

¹¹ DHCS' Closed Loop Referral (CLR) policy requires MCPs to close the loop for Enhanced Care Management (ECM) and Community Supports services.

¹² Home Visiting services include (but are not limited to) California Department of Public Health (CDPH) California Home Visiting Program (CHVP), California Department of Social Services (CDSS) California Work Opportunity and Responsibility to Kids Home Visiting Program (CaWORKs HVP), American Indian Maternal Support Services (AIMSS), and county First 5s, as eligible.

¹³ Parenting resources include (but are not limited to) Home Visiting services, MCP educational information, First 5, and Black Infant Health.

- » Dyadic Services

TCS Birthing Supports Checklist Resource Guide (For TCS Care Managers & Care Coordination Entities Reference)

Medical Supports: Must ensure scheduling, referral and/or warm handoff to follow-up appointments with the member's clinical team for both the member and their infant (as eligible) based on discharge instructions and appropriate guidelines as listed below following the end of pregnancy. For support identifying the member's clinical team, please contact the member, the member's discharging facility or their MCP.

- » Complete the perinatal and postpartum medical visits according to [ACOG Guidelines](#), including but not limited to completion of the following services:
 - Validated Behavioral Health Screenings for Perinatal Mood and Anxiety Disorders (PMADs), including Postpartum Depression, and Substance Use Disorder (ACOG Resources: [Perinatal Mental Health Patient Screening; Substance Use Disorder in Pregnancy](#)¹⁴; [Opioid Use and Opioid Use Disorder in Pregnancy](#))
 - Screening for Intimate Partner Violence using an Evidence-Based Tool ([USPSTF IPV Screening](#); [IPV Screening](#))
 - [Reproductive Life Planning](#)
- » Complete pediatric visits according to [AAP Bright Futures/Periodicity Schedule](#) through completion of the two-month well-child visit (e.g., three to five day visit, one-month visit, and two-month visit)

¹⁴ ACOG does not recommend routine urine drug screening testing be performed without the patient's consent and advises that a positive test not be a deterrent to care, a disqualifier for coverage under publicly-funded programs, or the sole factor in determining family separation.

- » Complete any other recommended follow-up visits included in the discharge summary/ instructions¹⁵ (e.g., specialty provider)
- » Schedule a Primary Care Provider (PCP) visit for the birthing person (if no visit occurred within the last year)

Whole Person Needs: Must ensure members are referred and/or connected with the following Medi-Cal covered benefits or services (*), other state supported programs or social services (^), or other community resources (+), based on need, as eligible. For support identifying and helping members access MCP-specific services, please contact the member’s MCP. In addition to the specific programs and services listed below, the care manager or care coordination entity should know the resources in their local communities and connect members to services and supports specific to their needs and local resources¹⁶.

Food, Nutrition Education, and Breastfeeding Supports

- » [Women, Infants, and Children \(WIC\)](#), ^ (Provides nutrition education, breastfeeding/chestfeeding support, benefits to buy healthy foods, and referrals to health care/community services)
- » [CalFresh](#) (California’s Supplemental Nutrition Assistance Program (SNAP)), ^ (provides monthly food benefits)
- » Lactation Services (E.g., provided by a licensed midwives (LMs)*, certified nurse midwives (CNMs)*, physicians*, RN*, certified lactation consultant (CLC), International Board Certified Lactation Consultant (ICBLC) or dietician*, or through programs like [WIC](#) ^, [Comprehensive Perinatal Services Programs](#)

¹⁵ The TCS care manager or care coordination entity must review the discharge summary and/or discharge instructions to guide post-discharge outreach. For high-intensity members, the TCS care manager is responsible for coordinating with the discharging facility, including ensuring discharge summary and instructions are appropriately shared with providers. For moderate-intensity members, the entity providing care coordination should work with the discharging facility, pregnancy provider, or MCP to obtain a copy of the discharge instructions/summary if they do not receive a copy themselves.

¹⁶ The TCS care manager or care coordination entity can refer to the Office of Community Partnerships & Strategic Communications (OCPSC) [California Community Resource Guide](#) to search for State services, resources, and assistance and/or get and manage benefits via [BenefitsCal](#) (e.g., [CalFRESH](#), [CalWORKs](#), and [Medi-Cal](#)).

(CPSP)*, or [Black Infant Health](#)⁺; [International Lactation Consultant Association](#)⁺; [CLC– Community of Practice](#)⁺)

MCP Benefits (Leverage a plan’s TCS call line or the [plan’s member service department](#) to request assistance or warm handoff to any of the below services)

- » [Transportation Services](#)* (Includes [Nonmedical Transportation](#) (NMT) and [Nonemergency Medical Transportation](#) (NEMT). Members or their representatives can contact the MCP or their health care provider directly to schedule NMT if they have their contact information)
- » [Doula Services](#)* (Emotional and physical support provided during pregnancy, labor, birth, and for one year postpartum, as well as support for and after miscarriage and abortion)
- » Appointment Assistance* (Support with scheduling medical appointments)
- » Breast pumps* ([All MCPs must provide](#) medically necessary breast pumps/breast pump kits to breastfeeding members. To obtain a breast pump, a licensed medical provider must order and follow Durable Medical Equipment (DME) requirements outlined in the DME Equipment section [of the Part 2 provider manual](#). Refer to the MCP-specific requirements for ordering DME)
- » [Enhanced Care Management](#)* (For specific resources contact member’s MCP)¹⁷
- » [Community Supports](#)* (Leverage the [Community Supports Search Tool](#) to understand community supports MCPs offer in each county)¹⁷
- » [Community Health Worker Services](#)* (Preventive health services with public health workers to promote physical and mental health and well-being)

Family Support Services

- » [Paid Family Leave](#)[^] (*Short-term wage replacement benefits to people who need to take time off work to bond with a new child*)
- » Home Visiting (e.g., [CDPH California Home Visiting Program \(CHVP\)](#)[^], [CDSS CalWORKs Home Visiting](#)[^], [American Indian Maternal Support Services \(AIMSS*\)](#)^{*)})

¹⁷ DHCS’ Closed Loop Referral (CLR) [policy](#) requires MCPs to close the loop for Enhanced Care Management (ECM) and Community Supports services.

- » Parenting Resources (potentially as part of Home Visiting Programs, [Black Infant Health](#)⁺, [First 5](#)⁺, MCP educational information*)

Infant Support:

- » [WIC](#)[^] (including infant formula)
- » [Enrollment in Health Insurance for Infant](#)*

Behavioral Health Needs: Please coordinate with the Member’s clinical team to determine the results of screening and/or follow-up of behavioral health appointments. Refer and/or connect member to follow-up services, as eligible. For support identifying the members’ behavioral health care provider or Medi-Cal non-specialty or specialty behavioral health services, please contact their MCP, county Behavioral Health Plan (BHP), Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS).

- » [Behavioral Health Supports](#) (With the [No Wrong Door policy](#), individuals can self-refer or be referred by a provider through contacting either their [county behavioral health plan](#) or [MCP](#))
 - MCPs: [Non-Specialty Mental Health Services](#) (NSMHS)
 - [County BHPs: Specialty Mental Health Services](#)
 - [DMC/DMC-ODS](#)
- » [Dyadic Services](#)* (*Family/caregiver focused care model that addresses developmental/ behavioral health conditions of children and includes services for parent(s)/caregiver(s) (“dyad”)*)