

# Division of Public Health

## Agreement Addendum

### FY 08-09

\_\_\_\_\_  
**Local Health Department Name**

101 Maternal Health (HMHC)

\_\_\_\_\_  
**Activity Number and Description**

06/01/2008-05/31/2009

\_\_\_\_\_  
**Service Period MM/DD/YYYY-MM/DD/YYYY**

07/01/2008-06/30/2009

\_\_\_\_\_  
**Payment Period MM/DD/YYYY-MM/DD/YYYY**

\_\_\_\_\_  
**Women's and Children's Health/Women's Health  
 DPH Section/Branch Name**

Phyllis C. Johnson, (919) 707-5715  
 phyllis.c.johnson@ncmail.net

\_\_\_\_\_  
**DPH Program Contact Name, Telephone  
 Number (with area code) and Email**

\_\_\_\_\_  
**DPH program signature (only required for  
negotiable agreement addendum)**

- Original Agreement Addendum**  
 **Agreement Addendum Revision # \_\_\_\_\_ (please do not put the Aid to County revision # here)**

**I. Background:**

The Maternal Health program is administered within the Women's Health Branch, Perinatal Health and Family Support Unit. The primary mission of the Maternal Health Program is to ensure that all low income pregnant women have access to early and continuous prenatal and postpartum care. Every local health department, including districts, is eligible to receive funding for maternal health services in their community. The provision of high quality, risk appropriate perinatal care is a means of reducing maternal and infant morbidity and mortality.

**II. Purpose:**

The purpose of this agreement addendum is to assure that local health departments will provide and/or assure pregnant women in NC access to early and continuous prenatal care. Prenatal care services include outreach, case management, nutrition counseling, and psychosocial assessment and intervention counseling. In addition, local health departments work to enhance public education and community awareness regarding risk prevention and reduction strategies.

**III. Scope of Work and Deliverables:**

\_\_\_\_\_  
 Health Director Signature (use blue ink)

\_\_\_\_\_  
 Date

Local Health Department to complete:  
 (If follow up information is needed by DPH)

LHD program contact name: \_\_\_\_\_  
 Phone number with area code: \_\_\_\_\_  
 Email address: \_\_\_\_\_

**Signature on this page signifies you have read and accepted all pages of this document.**

**Instructions: Read the entire Agreement Addendum and fill in the blanks. Complete, sign and return all relevant pages. Appendix 1: DHHS T1503 FY 08-09 Healthy Mothers/Healthy Children Block Grant Funds. County Health Director signature required on Page One and DHHS T1503.**

The Maternal Health program has a negotiable Agreement Addendum. Please complete the Non-Medicaid Services and Other Program Services section below along with the appropriate worksheets (attached). Women’s Health Branch staff will review and approve.

Non-Medicaid Services (Attachment A) Amount \$ \_\_\_\_\_

The Health Department will provide Non-Medicaid Service Deliverables in FY09 that meet or exceed the total dollar value of all services budgeted. Health Services Information System (HSIS) and/or Health Information system (HIS) service data as of August 31, 2008 will provide the documentation.

Other Program Services (Attachment B) Amount \$ \_\_\_\_\_

The Health Department’s estimated cost of non-Medicaid service deliverables is less than the total amount of Department of Health and Human Services (DHHS) funds budgeted in the Maternal Health Activity 101 budgetary estimate (HMHC)/DPH Aid to Counties Database (WIRM). Subject to WHB approval, my Health Department will use the remaining DHHS funds to further the program’s goals and objectives. Information describing how these funds are to be used should be completed on Attachment B and returned.

Total Maternal Health Budget Estimates (Attachment A + Attachment B) Total Amount \$ \_\_\_\_\_

“A local health department shall provide, contract for the provision of, or certify the availability of maternal health services for all individuals within the jurisdiction of the local department.” (10A NCAC 46.0205 (a))

Health departments who do not provide prenatal care must submit an assurance plan that clearly outlines how women who reside in their respective county(s) shall receive prenatal care services. This plan must be included with the signed Maternal Health Agreement Addenda and will be reviewed by WHB staff.

All Health Departments shall ensure the following (1- 9), whether they provide Prenatal Care or not:

1. Provide pregnancy testing, examination and referral as appropriate.
2. Provide ongoing prenatal care to all pregnant women, not served by another health care resource, through one or more of the following mechanisms:
  - (a) referral to other health care providers;
  - (b) contracts with other health care providers; or
  - (c) provision of prenatal services. (10A NCAC 46.0205 B (i)(ii)(iii))
3. The Health Department shall have written policies in place for facilitating early entry into prenatal care, which includes the following:
  - (a) Follow-up of positive pregnancy test to assure patient has access to health care provider.

- (b) For health departments that provide prenatal services and have a three-week or greater waiting list, the women must be triaged to assess adverse pregnancy risk factors for purposes of scheduling first visit. Adverse pregnancy risk factors must be included in this policy.
  - (c) Referral to WIC upon making contact with a pregnant woman. (*Federal WIC Regulations, 246.4*)
  - (d) Referral for Medicaid eligibility determination or completion of presumptive eligibility along with referral to the Maternity Care Coordination Program (MCCP) upon making contact with a pregnant woman.
  - (e) A description of the target population for maternal health services provided by the local health department, including eligibility criteria. The local health department shall emphasize provision of maternal health services to individuals who would not otherwise have access to these services.
  - (f) A description of fees, if any, for maternal health services provided by the local health department.
  - (g) Provision of community and patient maternal health education services within the jurisdiction of the local health department. Education services shall promote healthy lifestyles for good pregnancy outcome. (*10A NCAC 46.0205 (2)(3)(b)*)
4. The Health Department shall offer Maternity Care Coordination Program (MCCP) services to Medicaid eligible patients. The health department shall have written policies in place for providing MCC services (and MOW services, if applicable) to Medicaid eligible patients. (*DMA Clinical Coverage Policy No.:1M-8, and DMA Clinical Coverage Policy No.:1M-7*)
  5. The Health Department shall provide the 5A method for tobacco cessation to all pregnant and postpartum women using the 5As (ask, advise, assess, assist, arrange) as recommended by ACOG and referral made to appropriate community resource or the NC Tobacco Use Quit Line at 1-800-QUIT-NOW. (*Guidelines for Perinatal Care, Sixth Edition (ACOG), p. 94-96*)
  6. The Health Department shall refer all women receiving MCC services for a postpartum check-up to LHD services (prenatal or family planning clinics) or to a physician. (*DMA Clinical Coverage Policy No.:1M-8*)
  7. The Health Department shall provide or shall make referrals for nutrition consultation, education on infant feeding, childbirth and parenting education for low-income families. These referrals must be documented in the MCC chart or other client record. (*ACOG, p.84-92*)
  8. The Local Health Department may provide Maternal Care Skilled Nurse Home Visits (MCSNHV). They will be made upon the request of the prenatal care provider to those women who experience medical high-risk condition(s) during their pregnancy. MCSNHV requires a registered nurse who is skilled in the care of high risk pregnancy and cannot be provided in the clinic. The request must be made in the form of a written medical order with the specific risk condition(s) identified and requested skilled nursing interventions per patient plan of care and as indicated per established MCSNHV protocol. (*DMA Clinical Coverage Policy No.:1m-6*)
  9. The Health Department shall have written policies and protocols in place that appropriately address the following:

- (a) Follow-up of missed prenatal and Maternity Care Coordination appointments (*DMA Clinical Coverage Policy No.: 1M-8*)
- (b) Postpartum follow-up of women who received no prenatal care based upon information received from birth certificates or other appropriate sources.
- (c) Follow-up of pregnant women who express interest in permanent sterilization or contraception. (*ACOG, p. 163*)
- (d) Identification, follow-up and referral as indicated for pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs.) (*ACOG, p. 96-97*) Policies must include confidentiality and release of information/medical records. (*Women's Health Resource Manual, Vol. One, Section 2-A, 5/2001 or Responding to Prenatal Substance Use-A Guide for Local Health Departments, 6/2000*)
- (e) Follow-up and referral as indicated of patients with positive HIV (*ACOG, p. 316-320*) or hepatitis B (*ACOG, p. 305-310*) test for both women and infants. (*10A NCAC 41A.0203 (d)(1)*)
- (f) Identification, follow-up and referral as indicated for pregnant and postpartum women who are experiencing domestic violence. The minimum standard for identification is the use of the three recommended ACOG screening questions for all pregnant women, administered at the first prenatal contact, each trimester and postpartum. (*Responding to Violence Against Women, A Guide for Local Health Departments, 8/04;*, *ACOG screening questions, p.99; ACOG, p. 98-100, [http://www.acog.org/departments/dept\\_notice.cfm?recno=17&bulletin=585](http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585)*)
- (g) Collaboration with local Obstetricians and Emergency Physicians, local emergency hospital staff and tertiary care center staff is required to formulate a community wide accepted policy between the local health department and the physicians who will provide care for pregnant women exposed to varicella with no immunity.
- (h) Use of interpreter services for all maternal health programs.
- (i) Increasing staff awareness of disparities in health status and service delivery, especially disparities related to race, ethnicity, disability, education, and socioeconomic status. (*Healthy People 2010; ACOG, p.84*).
- (j) Promoting customer friendly services that meet the needs of populations that are underserved. (*Healthy People 2010*).
- (k) Universal Prenatal Screening for vaginal and rectal Group B Streptococcal colonization of all pregnant women at 35-37 weeks gestation to include documentation, transfer of results to delivering hospital, and follow-up regarding treatment of the mother and infant. Collaboration with local obstetricians and pediatricians, local hospital staff, and tertiary care center staff is required to formulate a community wide accepted policy. (*ACOG, p. 326-331; MMWR, August 16, 2002, v.51, #RR-11*) All prenatal clinics providing prenatal care through 35-37 weeks are required to have this policy.
- (l) Referral to a high-risk maternity clinic or obstetrician for identified high-risk conditions. (*ACOG, p. 6-13*)

- (m) Provision of Rubella (*ACOG, p. 324*) and recommendation for Varicella (*ACOG, p. 327*) vaccine post-delivery if patient “not immune”.

10. The Health Department Maternity Program shall provide the following services to all persons enrolled in prenatal care, and provision of these services shall be documented in their medical records. These requirements reflect minimum expectations. The actual content of care, beyond these minimal standards, provided to any individual client must be governed by appropriate clinical practice and the specific needs of the client.

- (a) After informed consent for prenatal services is signed (*ACOG, Committee Opinion, No. 237, June 2000: ACOG Today, Nov/Dec 2004, p.6*), the following health history components at the initial prenatal visit shall be assessed: medical; family; surgical; neurologic; immunity and immunization (TD, Rubella, Hepatitis B, Varicella); substance use, including alcohol, tobacco, and illicit drugs; current medications (prescription and non-prescription); menstrual; contraceptive; infection; gynecologic and obstetrical; psychosocial; nutrition; genetic history (both maternal and paternal including cystic fibrosis); domestic abuse and violence; risk factors for STDs; assessment of socioeconomic, educational, and cultural context; and environmental exposures, including environmental tobacco smoke (ETS). (*ACOG, p. 4, 83-85, 371-372*)
- (b) The following physical examination components shall be assessed: HEENT, thyroid; lungs; breasts; heart; abdomen; extremities; skin; lymph nodes; pelvic (uterine size or fundal height); and blood pressure. (*ACOG, p. 372-375*)
- (c) The following components on all subsequent routine scheduled visits shall be assessed: interim history/routine screening questions (fetal movement, contractions, leakage of fluid, vaginal bleeding); weight; blood pressure; fetal heart rate; fundal height (after 14 weeks); and fetal presentation greater than or equal to 36 weeks. (*ACOG, p. 100-101, 373-379*)
- (d) Nutrition screening shall be performed by a nurse, nutritionist, physician or physician extender at first visit. Based on this screening, an appropriate care plan or referral to a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)\*will be documented by the initial exam. (*ACOG, p. 89-93*) \*(Licensed by the North Carolina Board of Dietetics)
- (e) Weight and height for all pregnant women shall be documented at the initial prenatal visit. (*ACOG News Release, August 31, 2005; ACOG, p.89*)
- (f) Pre-pregnancy weight shall be determined and body mass index (BMI) calculated to identify gestational weight gain recommendations as per the Institute of Medicine guidelines. For obesity class III patients (BMI 40+), gaining less than the minimum weight gain recommendation may be appropriate. (*ACOG, p. 89-93; 191-192*)
- (g) The Health Department nutritionist shall assess the following high risk conditions and patients will receive education that addresses their specific condition(s) and referral as appropriate: (*Division of Medical Assistance Bulletin June 2001*)
- (1) Conditions which impact on length of gestation or birth weight where nutrition is the underlying cause such as severe anemia (Hgb<10gm/dl or Hct <30%); underweight preconceptionally (<19.8 BMI) complicated by inadequate weight gain during

pregnancy, and intrauterine growth retardation, very young maternal age (under the age of 16), multiple gestation, substance use.

- (2) Metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU or other inborn errors of metabolism.
  - (3) Chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes or renal disease.
  - (4) Autoimmune diseases of nutritional significance such as systemic lupus erythematosus.
  - (5) Eating disorders such as severe pica, anorexia nervosa or bulimia nervosa.
- (h) The Health Department shall provide prenatal supplement containing folic acid and iron. If the patient has Medicaid or third party insurance, a prescription for prenatal vitamins will be provided. For those patients without third party reimbursement, the health department shall provide the prenatal vitamins containing folic acid and iron. (*ACOG, p. 90-92*) The health department shall document that each patient has obtained prenatal vitamins on the subsequent prenatal visits after the initial prescription is given and refilled.
- (i) Psychosocial screening shall be performed by a nurse, social worker, physician, or physician extender at the first visit. Based on this screening, an appropriate care plan or referral to a licensed clinical social worker, other mental health provider, maternity care coordinator or other appropriate resource will be documented by the initial exam. (*ACOG, p. 4, 84, 124-125*)
- (j) Patients with abnormal clinical findings shall be appropriately followed. (*ACOG, p. 2, 7-8, 385-388*)
- (k) Patients with a high-risk condition shall receive consultation from or be referred to an obstetrician or high-risk maternity clinic. (*ACOG, p. 7-8*)
- (l) All maternal health clients shall be referred for a postpartum check-up. (*ACOG, p. 171-172*)
- (m) Health departments shall develop a policy concerning use of fetal fibronectin testing for asymptomatic clients at high risk for preterm delivery due to a previous preterm delivery or a current multifetal gestation and for clients with symptoms suggestive of preterm labor. There is no requirement that the fetal fibronectin test be utilized in the clinic, but agencies may elect to do so in consultation with their Medical Directors. It should be noted that it is not appropriate to utilize this test for routine screening in asymptomatic low risk women, nor should it be utilized in any event before 24 weeks and 0 days, no later than 34 weeks and 6 days of gestation, in the presence of ruptured membranes or when cervical dilation is greater than or equal to 3 cm. (*ACOG Committee Opinion, No. 187, Sept, 1997*)
- (n) Syphilis screen on the initial visit and a repeat Syphilis screen between 28 and 30 weeks. (*10A NCAC 41A.0204(e), CDC-MMWR, September 22, 2006/V. 55/No. RR-14; ACOG, p. 101*)
- (o) Screening for hepatitis B on the initial visit, unless known to be infected, and follow-up of an infant born to an infected mother to assure he/she receives prophylactic treatment. (*10A NCAC 41A.0203 (d)(1) and CDC-MMWR, 9/22/06 ACOG, p. 101*)

- (p) HIV testing at the initial visit and the third trimester (preferably before 36 weeks of gestation) unless she declines the tests (i.e., opt-out screening). Documentation of refusal must be in the patient's record. (10A NCAC 41A.0202 (14); CDC-MMWR, (September 22, 2006/V. 55/No. RR-14; ACOG, p. 101).
- (q) Screening for Gonorrhea on initial visits and repeated in the third trimester if <25 years of age (10A NCAC 41A.0204 (e), CDC-MMWR, (September 22, 2006/V. 55/No. RR-14) (ACOG, p. 332-333).
- (r) Screening for Chlamydia on the initial visit and repeated in the third trimester if less than 25 years of age (CDC-MMWR; Sexually Transmitted Disease Treatment Guidelines September 22, 2006; 10A NCAC 41A.0204(e); ACOG, p. 101, 334-335)
- (s) Quadruple serum screening will be offered, optimally between 15-20 weeks of gestation, to clients who give informed consent for the test. Clients who refuse the test should have this informed refusal documented in the chart. (ACOG, p. 106-107)
- (t) Screening at initial visit for Blood Group, RH Determination, and Antibody Screen (repeated as indicated). Antibody Titer will be done if positive Antibody Screen and repeated as indicated. (ACOG, p. 101)
- (u) Screening at initial visit for Rubella and Varicella immune status, unless previous vaccinations or laboratory test for disease indicate immunity or disease. This information must be documented in patient's record. Immunization dates must be completed and verifiable. (ACOG, p. 101)
- (v) Pap Test (if indicated) (ACOG, p. 101)
- (w) Urine Dipstick for glucose and protein at each visit. (ACOG, p. 100, 373)
- (x) Urine culture specific for GBS will be done at initial visit, and repeated if needed. (ACOG, p. 328, 374) Women with any quantity of GBS bacteria during pregnancy should be treated according to current standards of care for urinary tract infection in pregnancy. (MMWR, August 16, 2002, V. 51, No. RR-11, p. 11; ACOG, p. 327-330)
- (y) Hgb/Hct screening on initial visit and in third trimester. Hgb/Hct screen in second trimester as needed. (ACOG, p. 101, 374-375)
- (z) Screening at 24-28 weeks for diabetes with 50 grams glucose and 3 hours Oral Glucose Tolerance Test (OGTT) if indicated. (ACOG, p. 104, 375)
- (aa) Screening if indicated for Hgb electrophoresis with informed consent documented in the chart, or documentation that the client refused test. (ACOG, p. 84) Screening for other genetic disorders (e.g. beta thalassemia, alpha thalassemia, Tay-Sachs disease, Canavan disease and familial dysautonomia, (Ashkenazi Jews)) should be provided based on the client's racial and ethnic background and the family background (e.g. cystic fibrosis, Duchenne's muscular dystrophy, fragile X syndrome, and mental retardation) (ACOG p.84-85)
- (bb) The health department shall offer influenza vaccine to all pregnant women during influenza season as defined by the Immunization Branch and document the date the vaccine was given or

refused included in the client chart. ([www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430a1.htm); *ACOG Today*, Vol. 48, Issue 6, July 2004; *ACIP, Prevention and Control of Influenza*, April 2004; *Vaccinate Women*, Vol. 3 – No. 1, Aug. 2004, pg. 1.; *ACOG*, p. 103)

- (cc) Screening for Group B Strep at 35-37 weeks. (*ACOG*, p. 326-330; *MMWR*, August 16, 2002, V. 51, #RR-11)
- (dd) The Health Department shall complete the Pregnancy Outcome Summary for all Maternal Health patients, including MCC clients, within 30 days of discontinuation of services and submit this summary through the Health Services Information System (HSIS) (*DMA, Clinical Coverage Policy No.: 1M-8, pg.7 HSIS User's Manual, 5.L-1 Revised July 1, 1991*)
- (ee) The Health Department shall have a plan of care developed for all maternity patients, based on medical, nutritional, psychosocial and educational needs of the patient and her family and revised as appropriate. (*ACOG*, p. 87)

11. The Health Department shall document prenatal education in the medical record as follows:

- (a) All patients shall receive specific education about their individual risk condition(s). (*ACOG*, p. 88-99)
- (b) Provision of basic prenatal education shall be clearly documented in the medical record. It may be provided in an individual or group format. Any appropriately trained member of the maternal health team can provide the education components. These include nurse, nutritionist, social worker, physician, certified nurse midwife, nurse practitioner, physician assistant, health educator, etc. For example, if the social worker or the nutritionist provides education on a given topic, this education need not be repeated by another member of the health team.

Educational topics to be offered to each patient shall include the *following* (*ACOG*, p. 85-124, 221, 232, 235)

- Scope of care provided (including what is expected at the first prenatal visit and anticipated schedule of visits); lab studies that may be performed; options for intrapartum care; office policies; emergency coverage and cost; and expected course of pregnancy.
- Physician coverage for labor and delivery
- Adverse signs and symptoms to report (e.g. bleeding, rupture of membrane, decreased fetal movement).
- Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety\* and daily activity; travel; alcohol and tobacco consumption, caution about drugs (illicit, prescription, and non-prescription); use of safety belts; sauna and hot tub exposure; vitamin and mineral toxicity; prevention of HIV infection and other STDs; environmental exposure; and nausea and vomiting during pregnancy.
- Educational programs available (refer to childbirth education classes, which should provide information on labor, pain relief, delivery, breastfeeding, infant care, postpartum period).
- Importance and benefits of breastfeeding

- Advise on avoiding eating certain fish with high levels of mercury, including shark, swordfish, king mackerel and tilefish (*ACOG, p.90-92*) and advise not to eat hot dogs or luncheon meats unless they are steaming hot and to avoid unpasteurized soft cheeses. (*ACOG, p. 331*)
- Options for intrapartum care
- Planning for discharge and child care; choosing the child's physician.
- Cost to the patient for prenatal care and delivery (e.g. insurance plan participation). (*ACOG, p. 88-94*)
- Safe sleep education must be provided to all maternity patients. (Free educational materials are available at <http://www.nchealthystart.org/index2.html>) (*ACOG, p. 232-233*)
- Education on Family Planning.

\*Warning signs to terminate exercise while pregnant include: chest pain, vaginal bleeding, dizziness, headache, decreased fetal movement, amniotic fluid leakage, muscle weakness, calf pain or swelling, preterm labor, or regular uterine contractions (*ACOG, p. 94*)

12. Interruption of services or inability to meet quality assurance deliverables will be reported within 14 days to the WHB Regional Nurse Consultant.

All Health Departments providing Maternal Health services shall comply with the following training requirements:

13. At least one staff person (or contractor) shall attend the required Women's Health Branch SIDS Basic Training, annual update and provide appropriate grief counseling for bereaved families in the county. Each county and/or district is also required to have a backup SIDS Counselor for their primary Counselor. This back-up does not have to reside in the county, but should be available in cases when the primary Counselor is unavailable to provide services for prolonged periods of time.
14. The maternity nurse supervisor, MCC, and HBI supervisors and SIDS Counselors shall have active electronic mail membership and direct access to the Internet. HMHC funds can be used to finance and maintain hardware, software and subscription linkage to current local market values. The Internet connection enables participation in Women's Health Branch List Serves, access to other technical resources and to maternal health materials.

15. Maternal Health Nurse Training

- (a) Certain low-risk clients may receive designated services from public health nurses who have received special Maternal Health Enhanced Role Training and the Adult Physical Assessment course. See Enhanced Role specifications (Vol. II of the Women's Health Resource Manual).

Health Departments shall maintain an up-to-date roster of all nurses practicing as an enhanced role nurse; who serves as the highest level provider to low-risk prenatal clients. The roster must include date of completion of the Enhanced Role Nurse Training, the number of client contact hours yearly (combination of time spent as a nurse interviewer, highest level care provider

and/or post counseling nurse) and the number of accrued Educational Contact Hours. This information must be submitted by August 15th to the Women's Health Branch. Mail to: Women's Health Branch, Family Planning Nurse Consultant, 1929 Mail Service Center, Raleigh, NC 27699-1929.

16. Public Health Social Worker/Maternity Care Coordinator Training

- (a) All new Maternity Care Coordinator must complete provider training as required by the DMA Policy for the MCCP (*DMA Clinical coverage Policy No.: IM-8*). Regional social work consultants must be notified within 30 days of hiring new staff.
- (b) All new Maternity Care Coordinator social workers and Health and Behavior Intervention Licensed Clinical Social Workers (LCSWs), without previous public health experience or education, are recommended to complete within one year of hire date, the Introduction to Principles and Practices of Public Health Training.
- (c) All new Maternity Care Coordinator social workers without a bachelor's or master's degree in social work are recommended to complete, within one year of hire date, the Introduction to Principles and Practices of Public Health Social Work.

17. Maternal Outreach Worker Training

- (a) All new Maternal Outreach Workers shall complete provider training as required by the DMA Policy for MOW services. (*DMA Clinical Coverage Policy No.: IM-7*) Regional social work consultants must be notified within 30 days of hiring new staff.
- (b) All new Maternal Outreach Workers are required to complete the Introduction to Principles and Practices of Public Health Training within one year of hire date.

\*Please note: Dates of reference materials that contain updated guidance, especially DMA Bulletins, are subject to change based on publication revisions.

**IV. Performance Measures/Reporting Requirements:**

Benchmarks will be reflected by county in the process outcome objectives (Attachment D).

1. Increase the percentage of women having live births who had adequate prenatal care as defined by Kessner Index during the period of June 2008 – May 2009.
2. Increase the percent of women with live term singleton births who gain weight within the National Academy of Sciences –Institute of Medicine (IOM) recommended total weight gain ranges during pregnancy (*ACOG, Committee Opinion, No. 315, September 2005*) during the period of June 2008 – May 2009.
3. Decrease the percentage of women having live births who smoked during pregnancy during the period of June 2008 – May 2009.
4. Increase the percentage of Medicaid enrolled pregnant women who receive MCC services during the period of June 2008 – May 2009.

5. Increase the percentage of Medicaid enrolled pregnant women who receive WIC services during the period of June 2008 – May 2009.
6. Increase the percentage of infants enrolled in WIC who breastfed at 6 weeks during the period of June 2008 – May 2009.
7. Increase the percentage of Medicaid enrolled pregnant women who deliver and receive a postpartum home visit during the period of June 2008 – May 2009.

**Reporting Requirements:**

Local health departments will enter program service data at least quarterly into the Health Services Information System (HSIS) and/or a compatible reporting system.

**V. Performance Monitoring and Quality Assurance:**

The Regional Nurse Consultants (RNC) and Regional Social Work Consultants (RSWC) will utilize a team approach for the monitoring process. Efforts will be made to jointly plan pre-monitoring and on-site activities. These activities will include: development of a pre-monitoring plan 4-6 months prior to the designated monitoring month; on site monitoring visits every other year; technical assistance visits via phone or email as needed; review of audit charts; and clinic observations.

A written report is completed for each monitoring visit. The follow-up report, which includes corrective action plan (CAP), is emailed 2-4 weeks after the monitoring site visit to the local Health Director and lead agency staff.

Additionally, WHB will review data outcomes including a focus on health disparities and inform the health director of unique or adverse trends. Site visits will be conducted to assist in a local assessment and planning process.

**Consequences:**

The county must respond to the corrective action plan within 30 days after the follow-up report is emailed. If a response has not been received, then the county does not have monitoring closure, which is defined as the county being notified that their final CAP is acceptable or that they are being referred for continuing technical assistance.

For local health departments that do not meet the level of non-Medicaid service deliverables (Attachment A) for a two year period or expend all Healthy Mothers/ Healthy Children (HMHC) funds for a two-year period, this may result in a loss of up to 5% of funds.

**VI. Funding Guidelines or Restrictions: (if applicable)**

**Attachment A**  
**Non-Medicaid Services**

**Instructions:** Enter the total dollar value of all non-Medicaid clinical service (Section B deliverables). Local agencies must use the reimbursement rates for each service type in estimating the total cost of Section B deliverables. Note: The CPT rates listed are based on present figures in 2007. Please use most current figures when completing this attachment.

Total Estimated Cost of Non-Medicaid Services: \$ \_\_\_\_\_

**Worksheet Instructions:** See **WORKSHEET below**. The worksheet is included for your use, but does not have to be returned with signature page. However this worksheet should be retained in the health department files. Local agencies must use reimbursement rates for each service type in estimating the total cost of Section B services.

<b>MATERNAL HEALTH WORKSHEET</b>						
<b>CPT Code*</b>	<b>Service Type</b>	<b>Estimated # of services</b>	<b>X</b>	<b>CPT Rate</b>	<b>=</b>	<b>Total</b>
99201	Office/Outpatient Visit, New			\$62.10		
99202	Office/Outpatient Visit, New			\$93.15		
99203	Office/Outpatient Visit, New			\$132.48		
99204	Office/Outpatient Visit, New			\$194.58		
99205	Office/Outpatient Visit, New			\$244.26		
99211	Office/Outpatient Visit, Est.			\$34.16		
99212	Office/Outpatient Visit, Est.			56.93		
99213	Office/Outpatient Visit, Est.			\$78.66		
99214	Office/Outpatient Visit, Est.			\$122.13		
99215	Office/Outpatient Visit, Est.			\$182.16		
59425	Antepartum Care Only 4-6 visits			\$338.53		
59426	Antepartum Care Only 7 or more visits			\$593.54		
59025	Non-stress Test			\$ 26.87		
76815	Ultrasound, limited, Fetal size, heart beat, position.			\$ 78.81		
76805	Ultrasound > 14 weeks 0 days, single or first gestation, fetal & maternal evaluation, includes interpretation			\$ 120.48		
S9442	Childbirth Class			\$19.09		
T1017	MCC, 6 units per month/ per patient			\$29.30		
90384	RG,IG Full Dose, IM			\$99.00		
90385	RG, IG Minidose, IM			\$11.84		
99501	Home Visit for Postnatal Assessment			\$ 60.00		
96152	Health & Behavior Intervention			\$ 19.97		
S9445	MOW, 7 units per month/ per patient			\$ 16.50		
81025	Pregnancy Test			\$8.84		
97802	Medical Nutrition Therapy, Initial, each 15 min.			\$ 15.80		
97803	MNT, Reassessment, each 15 min.			\$ 15.80		
T1001	Maternal Care Skilled Nurse Home Visit			\$ 88.00		

## Attachment A (continued)

MATERNAL HEALTH WORKSHEET						
CPT Code	Service Type	Estimated # of services	X	CPT Rate	=	Total
57452	Colposcopy w/o Biopsy			\$ 94.18		
87070	GBS culture specimen, bacteria, must precede 87077			\$ 12.03		
87077	GBS culture, bacteria, aerobic isolates, confirmation test for GBS			\$ 11.29		
36415	Venipuncture, DMA Only			\$ 3.00		
J3490	17P/per one unit of coverage			\$ 20.00		
85013	Hematocrit			\$ 3.31		
85018	Hemoglobin			\$ 3.31		
81000	Urinalysis, Non-Auto w/scope			\$ 4.43		
81001	Urinalysis, Auto w/scope			\$ 4.43		
81002	Urinalysis, Non-Auto w/o scope			\$ 3.57		
87210	Wet mount, simple stain, for bacteria			\$ 5.33		
87086	Urine culture, colony count			\$ 11.28		
87591	GenProbe-GC Culture			\$ 34.26		
87491	GenProbe-Chlamydia			\$ 34.26		
82947	Glucose, Fasting Blood Sugar (FBS)			\$ 5.48		
82948	Glucose, blood reagent strip			\$ 4.43		
82950	Glucose (post glucose dose, includes glucose)			\$ 6.64		
82951	GTT (3 specimens + glucose)			\$ 17.99		
82270	Fecal occult blood			\$ 4.54		
83986	Assay of fluid acidity			\$ 5.00		
86580	TB intradermal			\$ 8.09		
90772	Administration code for 17P			\$ 16.62		

(Current as of 07/07)

**Other Tests**

<u>CPT Code</u>	<u>Service Type</u>	<u>Estimated # of services</u>	<u>X</u>	<u>CPT Rate</u>	<u>=</u>	<u>Total</u>

## Attachment B Other Program Services

**Instructions:** If the total estimated cost of non-Medicaid service deliverables is less than the total amount of DHHS funds budgeted in the Maternal Health activity 101 budgetary estimate (HMHC) / DPH Aid to County Database (WIRM), provide information on how the local agency will use the remaining DHHS funds to further the program's goals and objectives. List only activities that are not Medicaid reimbursable and not part of the cost of the service deliverables in Attachment A. The total estimated cost of Attachment A and Attachment B deliverables must equal or exceed the total DHHS funds budgeted. Make copies as needed.

Best Practices:	Other C's Which May Be Considered WITH APPROVAL:
<ul style="list-style-type: none"> <li>Smoking Cessation</li> </ul>	<ul style="list-style-type: none"> <li>Computer Hardware/Software/Internet needed to meet requirements of Maternal Health Agreement Addenda</li> </ul>
<ul style="list-style-type: none"> <li>Breastfeeding</li> </ul>	<ul style="list-style-type: none"> <li>Incentives</li> </ul>
<ul style="list-style-type: none"> <li>SIDS Reduction / Safe Sleep</li> </ul>	<ul style="list-style-type: none"> <li>Prenatal Vitamins</li> </ul>
<ul style="list-style-type: none"> <li>Weight Management Counseling</li> </ul>	
Reduction Barriers:	<ul style="list-style-type: none"> <li>Staff Development (must be prorated to % of staff time assigned to Maternal Health Clinic)</li> </ul>
<ul style="list-style-type: none"> <li>Transportation</li> </ul>	<ul style="list-style-type: none"> <li>Equipment: Specify</li> </ul>
<ul style="list-style-type: none"> <li>Interpreter Services</li> </ul>	<ul style="list-style-type: none"> <li>Pap Test Kits</li> </ul>

1. Best Practice Deliverable: \_\_\_\_\_  
 Brief Description of Proposed Project and Outcome(s) to be achieved:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Timeline: \_\_\_\_\_  
 Position, Title, and FTEs required to achieve this deliverable: \_\_\_\_\_  
 \_\_\_\_\_  
 New Deliverable?  Yes  No Estimated Cost: \$ \_\_\_\_\_

Other C's which may be considered:

2. Other C Deliverable: \_\_\_\_\_  
 Brief Description of Proposed Project and Outcome(s) to be achieved:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Timeline: \_\_\_\_\_  
 Position, Title, and FTEs required to achieve this deliverable: \_\_\_\_\_  
 \_\_\_\_\_  
 New Deliverable?  Yes  No Estimated Cost: \$ \_\_\_\_\_

**Attachment C**  
**Sudden Infant Death Syndrome**

The following **local person(s)**\* has attended the Women’s and Children’s Health Section sponsored SIDS Basic Training and will provide SIDS grief counseling and information to bereaved families in the county:\*\* This page must be completed and returned by the Health Director. Submit with all other required Addenda pages.

<u>Name of Trained SIDS Counselor</u>	<u>County</u>	<u>Agency</u>	<u>Email Address</u>

\***Local person(s)** is defined as an individual who resides or works in the county who is not a DHHS Regional or Central Office employee. Counties that average less than one SIDS death per year for the **last four years** may designate a grief counselor from a neighboring county or neighboring SIDS counselor if a letter of agreement is obtained. It is recommended that all counties have a backup grief counselor for their primary counselor.

\*\*"The local SIDS counselor, Chief Medical Examiner's Office, Local Medical Examiner, Regional Pathologist or other appropriate source will notify the SIDS Central Office about the SIDS events." (NC Sudden Infant Death Syndrome, March 2005, II-6.) SIDS Counselors "will mail the completed SIDS Home Visit/Contact (DHHS 3723) to the Central Office." (NC Sudden Infant Death Syndrome, March 2005, II-7.)