

**DIVISION OF PUBLIC HEALTH
AGREEMENT ADDENDA**

<<Health Dept>>

Contractor Name

January 2006

Date

Women's & Children's Health / Women's Health Branch
Section/Branch

746 High Risk Maternity Clinic

Activity Number and Title

Kathy Blue 919-707-5683

Program Contact Name and Telephone Number

July 1, 2006 to June 30, 2007

Effective Period (Beginning and Ending Date)

Revision #

Instructions: Read the entire Agreement Addenda and fill in the blanks. Complete, sign, and return pages one & two and Section C if needed. County Health Director signature needed on page one and Section C page only.

SECTION B: NON-MEDICAID CLINICAL SERVICE DELIVERABLES (see pages 2-3) Amount \$ _____

My Health Department will provide Section B Maternity **Non-Medicaid** Clinical Service Deliverables in FY07 that meet or exceed the total dollar value of all services budgeted. Health Services Information System (HSIS) service data as of August 31, 2006 will provide the documentation. Failure to provide this level of services for a two-year period or to expend all HRMC funds for a two-year period may result in the loss of up to 5% of funds. Administrative code 10A NCAC 43C is to be followed. It states: "(a) If a local provider imposes any charge on clients for high risk maternity clinic services such charges: (1) Will be applied according to a public schedule of charges; (2) Will not be imposed on low income individuals (equal or less than 100% of Federal Poverty level) or their families; (3) Will be adjusted to reflect income, resources, and family size of clients" (**.0304 Client and Third Party Fees**) and "(a) ...client must meet following: (1) financial eligibility requirements, if any, established by the clinic; these requirements shall not be more restrictive than the official Federal Poverty Guidelines; and (2) medical eligibility requirements established by the clinic...." (**.0305 Client Eligibility**).

SECTION C: OTHER PROGRAM DELIVERABLES (see page 4) Amount \$ _____

My Health Department's estimated COST OF SECTION B NON-MEDICAID CLINICAL SERVICE DELIVERABLES is less than the total amount of Department of Health and Human Services (DHHS) funds budgeted in the HIGH RISK MATERNITY CLINIC BUDGETARY ESTIMATE/DPH Aid to Counties Database (WIRM). Subject to Women's Health Branch (WHB) approval, my Health Department plans to 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 Section C and attached to this signature page.

SECTION D: QUALITY ASSURANCE DELIVERABLES (see pages 5-11)

My Health Department will meet or exceed the quality assurance deliverables listed in Section D. A HRMC will provide high risk maternity clinic services to patients referred by local health departments, at a minimum, from the agreed upon multi-county area. HRMCs must meet NC Administrative Code requirements found in 10A NCAC 43C. Any interruption of services or inability to meet required quality assurance deliverables will be reported within 14 days to our Women's Health Branch Regional Nurse Consultant. I agree to provide my maternity nursing supervisor and Licensed Clinical Social Worker active electronic mail membership and direct access to the Internet. Maternal Health funds can be used to finance and maintain hardware, software and subscription linkage to current local market values. I agree to conduct systematic internal monitoring as required by the Women's Health Branch and make this information available to the HRMC monitoring team.

TOTAL HRMC BUDGET ESTIMATES

(Section B + Section C)

Total Amount \$ _____

County Health Director's Signature

Date

DPH/WCHS Program Approval

Date

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SECTION B: NON-MEDICAID CLINICAL SERVICE DELIVERABLES

Instructions: Complete and return the worksheet to calculate non-Medicaid clinical service deliverable costs. Retain a copy in health department files for your reference. Local agencies must use the reimbursement rates for each service type in estimating the total cost of Section B deliverables.

TOTAL ESTIMATED COST OF SECTION B DELIVERABLES: \$ _____

_____ Non-Medicaid patients (unduplicated number) will be served in the High Risk Maternity Clinic. (HSIS Report "Maternal Health Patient Characteristics" Item XII-A through C).

(Attach worksheet of clinical items)

| MATERNAL HEALTH WORKSHEET | | | | | | |
|----------------------------------|---|-------------------------|---|-----------|---|-------|
| CPT Code | Service Type | Estimated # of services | X | CPT Rate | = | Total |
| 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 | | | \$ 338.72 | | |
| 59426 | Antepartum Care Only 7 or more visits | | | \$ 593.77 | | |
| 59025 | Non-stress Test | | | \$ 36.73 | | |
| 76815 | Ultrasound, limited, Fetal size, heart beat, position, placenta placement, amniotic fluid volume for one or more fetuses, includes interpretation | | | \$ 80.07 | | |
| 76805 | Ultrasound 14 weeks 0 days, single or first gestation, fetal & maternal evaluation, includes interpretation | | | \$ 119.75 | | |
| S9442 | Childbirth Class | | | \$ 19.09 | | |
| T1017 | MCC, 6 units per month/ per patient | | | \$ 29.30 | | |
| 90384 | RG,IG Full Dose, IM | | | \$ 95.04 | | |
| 90385 | RG, IG Minidose, IM | | | \$ 32.94 | | |
| 99501 | Home Visit for Postnatal Assessment | | | \$ 60.00 | | |
| 99502 | Home Visit for Newborn Assessment | | | \$ 60.00 | | |
| S9445 | MOW, 7 units per month/ per patient | | | \$ 16.50 | | |
| 81025 | Pregnancy Test | | | \$ 8.84 | | |

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SECTION B: NON-MEDICAID CLINICAL SERVICE DELIVERABLES (Continued)

| MATERNAL HEALTH WORKSHEET | | | | | | |
|----------------------------------|--|-------------------------|---|--------------------|---|-------|
| CPT Code | Service Type | Estimated # of services | X | CPT Rate | = | Total |
| 97802 | Medical Nutrition Therapy, Initial, each 15 min. | | | \$ 16.70 | | |
| 97803 | MNT, Reassessment, each 15 min. | | | \$ 16.70 | | |
| T1001 | Maternal Care Skilled Nurse Home visit | | | \$ 88.00 | | |
| 57452 | Colposcopy w/o Biopsy | | | \$ 102.07 | | |
| G0001 | Venipuncture, DMA Only | | | \$ 3.00 | | |
| 85013 | Hematocrit | | | \$ 3.31 | | |
| 85018 | Hemoglobin | | | \$ 3.31 | | |
| 81000 | Urinalysis, Non-Suto 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 | | |
| 87081 | GC Cultures | | | \$ 8.06 | | |
| 82947 | Glucose, 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 | | | \$ 9.02 | | |
| 53670 | (No longer applicable – no available code or rate for LHDs) | | | | | |
| 87070 | GBS Culture specimen, Bacteria (must precede 87077) | | | \$ 12.03 | | |
| 87077 | GBS Culture, bacteria, Aerobic isolates, additional methods required (confirmation test for GBS) | | | \$ 11.29 | | |
| xxxxx | Medical Nutrition therapy, obesity counseling | | | \$ 16.70 | | |
| | | | | Grand Total | | |

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SECTION C: OTHER PROGRAM DELIVERABLES

Instructions: If the TOTAL ESTIMATED COST OF SECTION B SERVICE DELIVERABLES is less than the total amount of DHHS funds budgeted in the HIGH RISK MATERNITY CLINIC BUDGETARY ESTIMATE/DPH Aid to Counties Databse (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 SECTION B. No staff or physician time can be billed. For HRMC in local health departments, all program deliverables listed must reflect activities provided for high risk patients. Services that are not specifically high risk in nature should be shown in the Maternal Health Agreement Addenda or prorated by the amount spent on high risk patients only. The total estimated cost of all SECTION B and SECTION C 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: |
|----------------------------------|---|
| • Smoking Cessation | • Incentives |
| • Breastfeeding | • Prenatal Vitamins |
| • SIDS Reduction / Back to Sleep | • Staff Development |
| Reduction Barriers: | • Equipment: Specify |
| • Transportation | • Pap Test Kits |
| • Interpreter Services | |

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. **Regular Maternity Clinic services:**
- My Health department requests to transfer HRMC funds to HMHC funds. These funds will be utilized to serve additional maternity patients by providing Section B maternity non-Medicaid clinical service deliverables that meet or exceed the dollar value of all services budgeted.*
- Number of additional maternity patients to be served:** _____
Amount requested to transfer: \$ _____

_____ County Health Director’s Signature

_____ Date

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SECTION D: QUALITY ASSURANCE DELIVERABLES

1. All pregnant women will be assessed for smoking using the 5As (ask, advise, assess, assist, arrange) as recommended by ACOG and referral made to appropriate community resource, the Smoking Quit Line for the National Cancer Institute at 1-877-44U-QUIT, or Great Start at 1-866-66-Start, if needed. (*ACOG, p. 84-85*)
2. All clients will be referred for postpartum check up.
3. All High Risk Maternity Clinics will have a physician as the lowest level of provider for medical clinical services.
4. Women's Health Branch funded HRMCs may serve patients with very high risk and moderately high risk medical conditions. A HRMC may provide a single consultative visit, continuing care, or co-managed care between the HRMC and the referring health department or private physician.
5. Persons referred to the HRMC for a single consultative visit (rather than continuing care) need only be provided with services to address the specific referral concern. A policy and protocol detailing the high risk conditions the HRMC accepts on referral, and with whom the responsibility of follow-up lies should be developed. A memorandum of understanding should be developed between the HRMC and the referring care provider to assure that the client's comprehensive prenatal care needs are met. A follow-up evaluation report will be sent to the referring source.
6. A policy delineating responsibility for all components of prenatal care needs to be developed to guide the care provided to clients being co-managed by the HRMC and another provider. Follow-up reports are required to be sent to the referring source of care.
7. Persons receiving continuing care in HRMCs will have the following services documented in their HRMC or current low risk prenatal medical record. 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. The following health history components at the initial prenatal visit will be assessed: medical; family; surgical; immunization (Td, Rubella); substance use, including alcohol, tobacco, and illicit drugs; medications; menstrual; contraceptive; infection; obstetrical; psychosocial; nutrition; genetics (including cystic fibrosis); physical abuse; and environmental exposures, including environmental tobacco smoke (ETS). (*Guidelines for Perinatal Care, Fifth Edition (ACOG), p. 4, 74-75, 355-362*)
 - B. The following physical examination components: HEENT thyroid, lungs, breast, heart, abdomen, extremities, pelvis (including uterine size or fundal height), blood pressure. (*ACOG p. 356*) Record weight and height for all women at the initial prenatal visit to allow BMI calculation. (*ACOG News Release, August 31, 2005*)

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

- C. The following interim history and basic service components will be documented in the record on routine scheduled visits:
- Interim history / screening questions (fetal movement, leakage of fluid, vaginal bleeding, symptoms of preterm labor)
 - Blood pressure / Edema
 - Weight
 - Fundal height or uterine size after 14 weeks
 - Fetal Heart tones
 - Fetal presentation greater than or equal to 36 weeks (*ACOG, p 89-90, 357*)
- D. The following Laboratory studies will be documented in the record:
- (1) Syphilis Screen on the initial visit and a repeat STS between 28 and 30 weeks. (*HIV/STD Prevention and Care Branch, ACOG, p. 320; CDC-MMWR, 5/10/02, 10A NCAC 41A.0204 (e)*)
 - (2) 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); *CDC-MMWR, 5/10/02; ACOG, p. 288*)
 - (3) HIV pre-test counseling on all pregnant women at the initial visit. Pregnant women shall be tested for HIV with consent or documentation in the chart that the client refused HIV testing. (*ACOG, p. 91; 10A NCAC 41A.0202(14); CDC-MMWR, (5/10/02)*)
 - (4) Screenings for Gonorrhea (culture) on initial visit and repeated in the third trimester. (10A NCAC 41A.0204(e), *CDC-MMWR, (5/10/02)*)
 - (5) Screening for Chlamydia on the initial visit and repeated in the third trimester if “less than 25 years of age and women at increased risk of exposure, i.e., women who have new partner or more than one partner or whose partner has other partners shall be tested.” (*CDC STD Treatment Guidelines. MMWR 5/10/02; 10A NCAC 41A.0204 (e)*)
 - (6) Screening for alpha-fetoprotein (AFP) will be offered, optimally between 15-18 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. For client’s who present between 19-21 weeks, the possible benefits of the AFP screening should be discussed and an informed decision about testing should be documented. (*ACOG, p. 95*)
 - (7) 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. 90*)
 - (8) Screening at initial visit for Rubella immune status, unless previous vaccinations or laboratory test indicating immunity is documented in patient’s record. Immunization dates must be completed and verifiable. (*ACOG, p. 74*) Policy and Protocol for providing Rubella vaccine post-delivery if patient “not immune” are required.

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

- (9) Pap Test (if indicated).
 - (10) Urine Dipstick for glucose and protein at each visit. (*ACOG, p. 89, 361*)
 - (11) Urine culture (specific for GBS) will be done at initial visit, and repeated if needed. (*ACOG, p. 90, 358*)
“Women with any quantity of Group B Streptococcal Bacteriuria 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*)
 - (12) Hgb/Hct screening on initial visit and in third trimester. Hgb/Hct screen in second trimester as needed. (*ACOG, p.90, 358*)
 - (13) Screening at 24-28 weeks for diabetes with 50g. glucose and 3hr. Oral Glucose Tolerance Test (OGTT) if indicated. (*ACOG, p. 93*)
 - (14) Screening if indicated for Hgb electrophoresis with informed consent documented in the chart, or documentation that client refused test. (*ACOG, p. 74*) Screening for other genetic disorders (e.g. beta thalassemia, alpha thalassemia, Tay-Sachs disease, etc.) should be provided based on the client’s racial and ethnic background (*ACOG p. 75*) and the family background (e.g. cystic fibrosis, Duchenne’s muscular dystrophy, etc.). (*ACOG p. 75*)
 - (15) HRMCs should 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 is not appropriate to utilize this test for routine screening of asymptomatic low risk women, nor should it be utilized in any event before 24 weeks 0 days, and no later than 34 weeks 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, 187, Sept 1997; ACOG, p. 164*)
 - (16) Screening for Group B Strep at 35-37 weeks. Develop policies and protocols on Universal Prenatal Screening for vaginal and rectal Group B Strep colonization of all pregnant women at 35-37 weeks gestation: to include documentation, transfer of results to delivery hospital, and follow-up regarding treatment of the mother and infant. Collaboration with local OB’s and pediatricians, local hospital staff, and tertiary care center staff is required to formulate a community wide accepted policy. (*ACOG, p. 310-311; MMWR, August 16, 2002, V. 51, #RR-11*)
- E. All pregnant women during influenza season shall be offered an influenza vaccine, with documentation of date the vaccine was given or refused included in the client chart.
(www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430al.htm; *ACOG Today, Vol 48, Issue 6, July 2004*; *ACIP, Prevention and Control of Influenza, April 2004*; *Vaccinate Women, Vol. 3-No 1, August 2004, p.1*)

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

F. The presence of abnormal findings, there will be documentation that (*ACOG, p. 77, 90-92*):

- Significant problems identified (medical, nutrition, psychosocial, etc.)
- A plan of care was identified for each of these problems
- Patients were managed for abnormal findings
- Consultation with other specialists was sought if indicated
- Indicated diagnostic / monitoring tests were completed:
 - Fetal Activity-Non Stress
 - Fetal Activity-Stress
 - Ultrasound
 - Amniocentesis
 - Blood glucose surveillance
- Patients were hospitalized when needed in order to treat / monitor their high risk conditions (*ACOG, p. 92, 367-368*)
- The hospital delivery was providing a level of care appropriate to the patient's high risk condition. (*ACOG, p. 6-12, 17-29*)

G. Nutrition components will include documentation of:

- (1) Record weight and height for all women at the initial prenatal visit to allow BMI calculation. (*ACOG News Release, August 31, 2005*)
- (2) Screening performed by a nutritionist, nurse, physician, or physician extender. If there is no record of screening prior to admission to High Risk Maternity Clinic, it will be done at the initial HRMC visit.
 - Dietary recall, food frequency or trigger questions may be used to screen at the initial visit.
 - Weights at routine visits plotted on weight gain grid; determination of a pre-pregnancy weight is required.
 - Identification of significant nutrition problems at any time during pregnancy will result in referral to the nutritionist for a complete assessment (anthropometric, biochemical, clinical, dietary, eco-social), and care plan development. (*ACOG, p. 79-83*)
- (3) Management
 - Plans for nutrition intervention for each identified nutrition problem were outlined.
 - Patient received follow-up for identified nutrition problem(s).
 - Patients with any high risk conditions listed below were counseled by a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)*. *Licensed by the North Carolina Board of Dietetics/Nutrition.
 - (a) Conditions which impact on length of gestation or birth weight where nutrition is the underlying cause such as severe anemia (Hgb <10gm/dl; Hct <30%), underweight preconceptionally (<19.8 BMI) complicated by inadequate weight gain during pregnancy, intrauterine growth retardation, very young maternal age (under age of 16), multiple gestation, substance use.
 - (b) Metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU or other inborn errors of metabolism.
 - (c) Chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease.
 - (d) Autoimmune diseases of nutritional significance such as systemic lupus erythematosus.

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

- (e) Eating disorders such as severe pica, anorexia nervosa or bulimia nervosa. (*Division of Medical Assistance Medicaid Bulletin June 2001*)
- (f) Prenatal supplement containing folic acid and iron was provided. (*ACOG, p. 79-83*)
- (g) Patient referred to WIC services at initial visit if not already enrolled.

H. Social components will include documentation in the record of:

- (1) The completion of a risk screening tool. The agency may use the recommended state tool, DHHS 3965 (Revised 7/03), or they may elect their own screening form, as long as it contains **all** components of the state screening form (DHHS 3965, Revised 7/03). The agency may add additional items to their own screening tool.
- (2) Management and Follow-up of psychosocial conditions
 - A psychosocial assessment was conducted on a patient with positive findings from the psychosocial screening and these results were referenced in the Licensed Clinical Social Worker's assessment.
 - A plan of care for each identified psychosocial problem was documented (*ACOG, p. 77*)
 - Patient received follow-up for identified psychosocial problems
 - (a) Psychosocial disorders, either chronic or episodic, such as depression, psychosis, and behavioral disorders
 - (b) Suicidal / homicidal tendencies
 - (c) Intense negative feelings about current pregnancy
 - (d) Intense negative feelings about previous poor pregnancy outcome such as fetal death, stillborn, infant death, or congenital abnormalities
 - (e) HIV infection, AIDS and other life threatening medical problems
 - (f) Pending incarceration during pregnancy
 - (g) Moderate and very high risk medical conditions that are directly affected, complicated or intensified by psychosocial and/or social variables

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

- I. (1) All patients will receive specific education about their individual risk condition(s). (*ACOG, p. 75*)
- (2) Provision of basic prenatal education must be clearly documented in the medical record. It may be provided in an individual or group format. Appropriately trained members of the maternal health team can provide the education components. These include Nurse, Nutritionist, Social Worker, MD, CNM, 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:
- Scope of care provided; (including what is expected at the first prenatal visit and anticipated schedule of visits); lab studies that may be performed
 - Physician coverage for labor and delivery
 - Adverse signs and symptoms to report (e.g., bleeding, rupture of membranes, decreased fetal movement)
 - Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety and daily activity; alcohol and tobacco consumption, caution about drugs (illicit, prescription and non-prescription); use of safety belts; sauna and hot tub exposure; vitamins and mineral toxicity; preventing HIV infection and other STDs; environmental exposures
 - Educational programs available (refer to childbirth education classes, which should provide information on labor, pain relief, delivery, infant care, postpartum period)
 - Encourage breastfeeding
 - Options for intrapartum care
 - Planning for discharge and child care; choosing the child's physician
 - Cost to the patient of prenatal care and delivery (e.g. insurance plan participation). (*ACOG, p. 74-75, 78-79, 221*)
 - Education on Family Planning will be provided to all maternity patients. (DMA Medical Policy IM-8 effective 9/1/05)
- J. Follow-up and tracking components will include documentation in the record of:
- Follow-up for missed appointments
 - Follow-up of referrals indicating patient received services for which referred (inter and intra-agency) (*ACOG, p. 6-8*)
- K. Post delivery components will include documentation in the record that:
- Patient was referred for postpartum examination
 - Postpartum follow-up for specific high risk condition was provided or patient was referred for this service (*ACOG, p. 158-159*)
 - Pregnancy outcome summary was completed on all Maternal Health patients. (*ACOG, p. 14*)

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SECTION D: QUALITY ASSURANCE DELIVERABLES (continued)

8. The High Risk Maternity Clinic has written policies in place that address the following:
 - A. A list of high risk conditions that are considered indications for acceptance to the high risk clinic and approved by the Perinatal Health and Family Support Unit.
 - B. A list of high risk conditions that are considered indications for consultation from and /or referral to other providers and approved by the Perinatal Health and Family Support Unit. (*ACOG, p. 367-368*)
 - C. A system for flagging charts of patients who need special diagnostic tests or therapeutic services, or who have an abnormal laboratory result for which follow-up must be assured.
 - D. Protocols and procedures for the outpatient management of prenatal conditions served in the clinic.
 - E. Procedures and guidelines for provision of social work (including licensed clinical social worker) and nutrition services to high risk maternity patients.
 - F. Procedures for assuring that the multiple disciplines function as a team.
 - G. Mechanisms for patient referral and coordination of services among agencies, hospital, and other providers. and written agreements with referring agencies.
 - H. Follow-up and referral as indicated of pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs). (*ACOG, p. 84-87*) 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*)
 - I. Identification (using formal assessment tool in an ongoing basis), follow-up and referral as indicated of pregnant women who are experiencing domestic violence. (*Responding to Violence Against Women, A Guide for Local Health Departments 8/04, ACOG, p. 87-89*)