Division of Public Health
Agreement Addendum
FY 16–17

Generic	Women's and Children's Health/Women's Health
Local Health Department Legal Name	**DPH Section/Branch Name**
746 High Risk Maternity Clinic	Phyllis C. Johnson, (919) 707-5715 phyllis.c.johnson@dhhs.nc.gov
Activity Number and Description	**DPH Program Contact** **(**name, telephone number with area code, and email)
06/01/2016 – 05/31/2017	
Service Period	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2016 – 06/30/2017	
Payment Period	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** ___ (Please do not put the Budgetary Estimate revision # here.)

I. Background:

The High Risk Maternity Clinic (HRMC) program provides funds for tertiary-level prenatal care services for low-income, high-risk, pregnant women. These clinics assure medically complicated pregnancies have access to risk-appropriate perinatal services, according to the American College of Obstetrics and Gynecology (ACOG) clinical guidelines. The High Risk Maternity Clinic provides care to women referred from another clinic at this Local Health Department and from other local health departments that do not operate a HRMC within their designated catchment area.

Each year in North Carolina, about ten women die from pregnancy related conditions, and hundreds of babies are born premature and with birth defects. High Risk Maternity Clinics provide care for the conditions that cause maternal and infant mortality and morbidity.

Throughout this Agreement Addendum, the following words are defined as follows: "shall" and "must" indicates a mandatory program policy; "should" indicates a recommended program policy; and "can" or "may" indicates a suggestion or consideration. Also, the full citation for one of the references cited throughout this document is: *Guidelines for Perinatal Care*, Seventh Edition, October 2012, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.

II. Purpose:

The purpose of this Agreement Addendum is to assure that local health departments provide low-income pregnant women with identified medical high-risk conditions in North Carolina, access to early and continuous prenatal care. Prenatal care services include management of their high risk medical conditions, screenings for psychosocial and nutrition problems, behavioral health intervention,

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.

nutritional counseling, and referrals for those patients with serious medical, nutritional, and psychosocial needs.

III. Scope of Work and Deliverables:

The Activity 746 High Risk Maternity Clinic Agreement Addendum requires further negotiation between the Women's Health Branch (WHB) and the Local Health Department.

The Local Health Department is required to complete a Detailed Budget (Attachment A), Non-Medicaid Services pages (Attachment B), and return the Non-Medicaid Services pages with the signed and dated Agreement Addendum.

The information provided by the Local Health Department will be reviewed by the WHB. When the WHB representative and the Local Health Department reach an agreement on the information contained in these sections, the WHB representative will sign the Agreement Addendum to execute it.

A. Detailed Budget (Attachment A)
A detailed budget must be emailed to Phyllis.C.Johnson@dhhs.nc.gov to document how the Local Health Department intends to expend funds awarded for FY17. **The budget must equal or exceed the total DHHS funds budgeted.** List only activities that are not Medicaid reimbursable and not part of the cost of the service deliverables in Attachment B. Billable items may include, but are not limited to Community Education, Patient Transportation, Staff Time, Equipment, Incentives, and Staff Development (must be prorated to percent of staff time assigned to High Risk Maternity Clinic).

B. Non-Medicaid Services (Attachment B)
The Local Health Department will provide Non-Medicaid Service Deliverables in FY17. Enter the total number of estimated services for all Non-Medicaid clinical services. Health Information System (HIS) service data or compatible reporting system as of August 31, 2017 will provide the documentation to substantiate services that the Local Health Department has provided.

C. HRMC Budget Requested to be Transferred to Low Risk
As part of the policy and procedures, Local Health Departments are required to define high risk conditions that qualify pregnant and postpartum women to receive the High Risk services. Since this is defined locally, there may be variations by county as to whether women are being served in High Risk or Low Risk Maternity Clinics. Therefore, Local Health Departments can move funds from High Risk to Low Risk.

Total HRMC Budget Requested to be Transferred to Low Risk Total Amount $ _____

Total Additional Patients to be Served in Low Risk Clinic _____

D. The Local Health Department shall ensure that maternal health services are provided to low-income women, regardless of their ability to pay. There will be no charge for women from households with incomes at less than 100% of the poverty level. Women with an identified medical risk are eligible for this program. Special emphasis is placed on addressing racial disparities, in order to close the gap in fetal and infant death, as well as to promote healthier behaviors to reduce the number of high-risk pregnancies.

E. If the Local Health Department subcontracts out their high risk maternity clinic funds to another provider, they must provide a letter with the name and contract information of the subcontractor when they return their signed Agreement Addendum. These subcontractors are required to meet all requirements outlined in this Agreement Addendum.

F. The Local Health Department shall demonstrate compliance on client and third party fees:

1. If a local provider imposes any charges on clients for high risk maternity services, such charges:
   a. Will be applied according to a public schedule of charges;
   b. Will not be imposed on low-income individuals or their families;
   c. Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
2. If client fees are charged, providers must make reasonable efforts to collect from third party payors.
3. Client and third party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.

G. To be eligible for services provided by a high risk maternity clinic, clients must meet the 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. Any changes in medical eligibility criteria must be approved by the Division.
   a. A high risk maternity clinic shall provide in writing its financial and negotiated medical eligibility criteria with all referring prenatal providers in the area served. These providers shall also be informed in writing of any changes in clinic financial and medical eligibility criteria.

H. The Local Health Department shall:

A. General Services

A1 Informed consent (receipt of client signature) for prenatal services. (ACOG Committee Opinion, No. 439, Aug. 2009)

A2 Provide high risk maternity clinic services to patients referred by local health departments, at a minimum, from the agreed upon multi-county area. Interruption of services or inability to meet required quality assurance deliverables shall be reported within 14 days to the Women's Health Branch Regional Nurse Consultant.

A3 Serve patients with very high risk and moderately high risk medical conditions and provide a single consultative visit, continuing care, or co-managed care between the HRMC and the referring health department or private physician.

A4 Maintain written agreements between the HRMC and all contracted providers and agencies detailing the duties, responsibilities and privileges in relationship to the goals and contracted services required by the HRMC. This includes written agreements with other local health departments from which the HRMC receives referrals in the catchment area, as well as agencies that are responsible for any part of the contracted services.

A5 Provide services only to address the specific referral concern for persons referred to the HRMC for a single consultative visit (rather than continuing care). Develop a memorandum of understanding 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 shall be sent to the referring source.

A6 Provide data on the demographics and number of clients served reporting through the state's Health Information System (HIS) and/or a compatible data system.

A7 Recommend maintenance of a breastfeeding-friendly clinic environment to (US DHHS. *The Surgeon's General Call to Action to Support Breastfeeding*; 2011, Action 6, p. 43):

a. Avoid passive promotion of formula feeding. Printed materials, posters, audio-visual materials and office supplies should be free of formula product names.
b. Store supplies of formula, baby bottles, and nipples, out of the sight of clients.
c. Avoid direct promotion of formula feeding. Do not give out formula company discharge bags or other free items to clients.
d. Create or use educational materials that incorporate positive, culturally friendly, and consistent breastfeeding messages in all relevant educational materials, outreach efforts, and educational activities.
e. Create or use materials that are free of formula company advertising (company names, logos).
f. Create or use materials that are free of language that may undermine a mother's confidence in her ability to breastfeed.

B. Quality Assurance

B1 Provide all medical services by a board-certified OB/GYN and have an identified perinatalogist available for referral. (G.S. 10A NCAC 43C.0308.)

B2 Augment care with mid-level health professionals as prescribed by a physician.

B3 Provide psychosocial assessments and counseling by a Licensed Clinical Social Worker (LCSW).

B4 Provide nutrition assessments and counseling by a Registered Dietitian or Licensed Dietitian/ Nutritionist (RD or LDN).

B5 Assure that women at high risk of infant or fetal death receive appropriate prenatal care as determined by site visit and record review.

B6 Provide services in accordance with ACOG guidelines on high risk maternity care as determined by site visit and record review.

B7 Conduct quarterly quality assurance review to assure policies and procedures are carried out.

B8 Report interruption of services or inability to meet quality assurance deliverables within 14 days to the Maternal Health Nurse Consultant.

B9 Promote customer friendly services that meet the needs of populations that are underserved.

B10 Increase staff awareness of disparities in health status and service delivery, especially disparities related to race/ethnicity, disability, education, and socioeconomic status. (Healthy People 2020; *Guidelines for Perinatal Care*, 7th ed. p.3-4; ACOG Committee Opinion, No. 493, May 2011)

C. Policies/Procedures

Develop and follow policies or procedures for the following:

C1 List of high risk conditions the HRMC accepts on referral (*Guidelines for Perinatal Care*, 7th ed. p. 477-480).

C2 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.

C3 Assurance that the multi-disciplinary staff function as a team. Policies for provision of multidisciplinary team meetings, including all the disciplines (e.g., social work, nutrition, nursing) providing care within the HRMC.

C4 Mechanisms for patient referral and coordination of services among agencies, hospitals, other providers and written agreements with referring agencies.

C5 Outpatient management of prenatal conditions served in the clinic.

C6 Psychosocial and nutritional risk screening process, referrals to the HRMC LCSW and RD/LDN, and the provision of clinical social work services and nutrition services to high risk maternity patients.

C7 Identification, follow-up and referral as indicated of pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs). (*Guidelines for Perinatal Care*, 7th ed. p. 127-130) Policies must include confidentiality and release of information / medical records. Informed written consents shall be obtained before performing a drug screen test (*Guidelines for Perinatal Care*, 7th ed. p.128). (http://whb.ncpublichealth.com/Manuals/section2confidentiality.pdf)

C8 Identification, follow-up and referral as indicated for pregnant and postpartum women who are experiencing intimate partner violence. The minimum standard for identification is the use of the three recommended ACOG screening questions administered at the first prenatal contact, each trimester and postpartum. (*Guidelines for Perinatal Care*, 7th ed. p. 131-132; ACOG Committee Opinion No. 518 Feb 2012)

C9 Universal Prenatal Screening for vaginal and rectal Group B Streptococcal colonization of all pregnant women at 35-37 weeks gestation to include documentation unless already diagnosed with positive GBS bacteriuria, 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. (*Guidelines for Perinatal Care*, 7th ed. p.117; CDC MMWR, Nov 19, 2010, v.59, #RR-10) All prenatal clinics providing prenatal care through 35-37 weeks are required to have this policy.

C10 Provision of Rubella and Varicella (*Guidelines for Perinatal Care*, 7th ed. p. 410) vaccine post-delivery if patient not immune.

C11 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. (Prediction and Prevention of Preterm Birth, ACOG Practice Bulletin Number 130, October 2012; *Guidelines for Perinatal Care*,7th ed. p. 257)

C12 Provision of active electronic mail membership and direct access to the Internet for the maternity nurse supervisor, licensed clinical social worker, and nutritionist. HRMC funds can be used to finance and maintain hardware, software and subscription linkage to the current local market values.

C13 Regular communication and follow-up for prenatal patients co-managed by the HRMC and another provider. Follow-up reports are required to be sent to the referring source of care.

C14 Documentation of services for persons receiving continuing care in HRMCs (in 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.

D. Prenatal and Postpartum Services

Prenatal:

D1 Assess the following health history components at the initial prenatal visit:

a. Medical (including family medical history);
b. Surgical;
c. Neurologic;
d. Immunity and immunization (Seasonal Influenza, Tdap, Rubella, Hepatitis B, Varicella);
e. Substance use (including alcohol, tobacco, and illicit drugs);
f. Current medications (prescription and non-prescription);
g. Menstrual;
h. Contraceptive;
i. Infection;
j. Gynecologic and obstetrical;
k. Depression and intimate partner violence ;
l. Nutrition;
m. Genetic history (both maternal and paternal including cystic fibrosis);
n. Risk factors for STDs;
o. Socioeconomic status;
p. Education level;
q. Environmental exposures (including environmental tobacco smoke (ETS) and lead exposure.) (Guidelines for Perinatal Care, 7th ed. p. 107-108, 112-117); (http://www.cdc.gov/nceh/lead/publications/Leadand Pregnancy2010.pdf)

D2 Assess the following physical examination components (*Guidelines for Perinatal Care*, 7th ed. p. 257, p. 4642):

a. HEENT;
b. Teeth
c. Thyroid;
d. Lungs;
e. Breast;
f. Heart;
g. Abdomen;
h. Extremities;
i. Skin;
j. Lymph nodes;
k. Pelvis (including uterine size or fundal height);
l. Blood pressure.
m. Weight and height for all women shall be recorded at the initial prenatal visit. Pre-pregnancy weight shall be determined so body mass index (BMI) can be calculated and appropriate gestational weight gain guidance can be identified, documented and shared with patient. (*Guidelines for Perinatal Care*, 7th ed. p. 136-137, 216-217)

D3 Assess the following components on all subsequent routine scheduled visits (*Guidelines for Perinatal Care*, 7th ed. p. 108):

a. Interim history/routine screening questions (fetal movement, contractions, rupture of membranes, vaginal bleeding);
b. Weight;
c. Blood pressure;
d. Fetal heart rate;
e. Fundal height;
f. Fetal presentation greater than or equal to 36 weeks.

D4 Provide the 5As method for tobacco cessation to all pregnant 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 1-877-QUIT-NOW (http://whb.ncpublichealth.com/provPart/pubmanbro.htm) (*Guidelines for Perinatal Care*, 7th ed. p. 128-129)

D5 Follow-up and document:
- Missed appointments
- Referrals indicating patient received services for which referred (inter and intra-agency) (*Guidelines for Perinatal Care*, 7th ed. p. 6-8)
- Patient was referred for postpartum examination

D6 Hospitalize patients when needed in order to treat / monitor their high risk conditions. (*Guidelines for Perinatal Care*, 7th ed. p. 8-13, 243-244)

D7 Assure delivering hospital is able to provide a level of care appropriate to the patient's high risk condition. (*Guidelines for Perinatal Care*, 7th ed. p. 8-13, 243-244)

Postpartum Clinic Visit:

D8 Provide the 5As method for tobacco cessation to all 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 1-877-QUIT-NOW. (*Guidelines for Perinatal Care*, 7th ed. p. 128-129)

D9 Follow-up and document:
a. Missed appointments.
b. Postpartum follow-up for specific high risk condition was provided or patient was referred for this service. (*Guidelines for Perinatal Care*, 7th ed. p. 257, p. 199-200)
c. Depression screening and referral for services as indicated. (*Guidelines for Perinatal Care*, 7th ed. p. 130-131)
d. Screening for Intimate Partner Violence. (ACOG Committee Opinion No. 518, Feb. 2012)
e. Screening for alcohol, tobacco and other drug use (*Guidelines for Perinatal Care*, 7th ed., pp. 207 – 208)
f. Postpartum GDM follow-up testing recommendation for all Gestational Diabetes Mellitus (GDM) patients defined by ACOG as a 6-12 week postpartum Fasting Blood Glucose or 75-g 2hr Oral Glucose Tolerance Test; appropriate long term sequela counseling should also be performed. (*Guidelines for Perinatal Care*, p. 117; ACOG Practice Bulletin, No. 137, Gestational Diabetes)
g. Reproductive life planning counseling to include plans for future childbearing and selection of a contraceptive method to prevent pregnancy and /or promote healthy birth

spacing. (*Guidelines for Perinatal Care*, 7th ed. p. 98, 208; HP 2020 FP-1 and FP-5; www.cdc.gov/preconceptionhealth/women.html)

h. Referral to a primary care provider as indicated. (HP 2020 AHS-3)

E. Laboratory and Other Studies

Provide and document the following:

E1 Syphilis screening on the initial visit and a repeat syphilis screen between 28 and 30 weeks. (CDC MMWR, Dec 17, 2010, v. 59, No. RR-12; *Guidelines for Perinatal Care*, 7th ed. p. 114; 10A NCAC 41A.0204 (e))

E2 Hepatitis B screening 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, Dec 17, 2010, v. 59, No. RR-12; *Guidelines for Perinatal Care*, 7th ed. p. 114)

E3 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, Dec 17, 2010, v. 59, No. RR-12; *Guidelines for Perinatal Care*, 7th ed. p. 112)

E4 Gonorrhea screening on initial visit and repeated in the third trimester if 25 years of age or younger or greater than 25 years of age and participating in high risk behaviors such as having a new partner, multiple partners, little or no prenatal care, a STD during the current pregnancy or substance use. (10A NCAC 41A.0204 (e CDC MMWR, Dec 17, 2010, v. 59, No. RR-12; *Guidelines for Perinatal Care*, 7th ed. p. 115)

E5 Chlamydia screening on the initial visit and repeated in the third trimester if less than or equal to 25 years of age and for those participating in high risk behaviors such as having a new partner, multiple partners, little or no prenatal care, a STD during the current pregnancy or substance use. (CDC MMWR, Dec 17, 2010, v. 59, No. RR-12; *Guidelines for Perinatal Care*, 7th ed. p. 115)

E6 Genetic serum screening (offered or referred), prior to 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. Clients should be offered or referred for additional genetic and aneuploidy screening tests including first screen, as area resources allow. (*Guidelines for Perinatal Care*, 7th ed. p. 119-126)

E7 Blood Group, RH Determination, and Antibody screening at the initial visit and Antibody screen repeated as indicated. Antibody Titer will be done if positive Antibody Screen and repeated as indicated. (*Guidelines for Perinatal Care*, 7th ed. p. 113)

E8 Rubella and Varicella immune status assessment at initial visit as evidenced by written documentation of age-appropriate vaccination or laboratory evidence of immunity. Patients with no evidence of immunity shall have laboratory test for immunity performed. (*Guidelines for Perinatal Care*, 7th ed. p. 118, 410) Policy and Protocol for providing Rubella and Varicella vaccine post-delivery if patient "not immune" are required. (*Guidelines for Perinatal Care*, 7th ed. p. 118-119)

E9 Cervical Cytology (if indicated, follow new ACOG Cervical Cytology Guidelines). (ACOG, Practice Bulletin, No. 131, November 2012)

E10 Urine dipstick for glucose and protein at initial visit and as indicated by risk factors. (*Guidelines for Perinatal Care*, 7th ed. p. 114)

E11 Urine culture will be done at initial visit, and repeated as indicated. (*Guidelines for Perinatal Care*, 7th ed. p. 113) If Group B Strep is identified during routine urine culture, repeat screening at 35-37 weeks is not indicated {excepting patients who are penicillin allergic, needing sensitivities}. GBS in routine urine culture is treated per normal culture guidelines [>100K colony count]. (CDC MMWR, November 19,2010, v. 59, No. RR-10)

E12 Group B Strep screening at 35-37 weeks if no GBS bacteriuria diagnosed in current pregnancy. (*Guidelines for Perinatal Care*, 7th ed. p. 117; CDC MMWR, November 19, 2010, v. 59, No. RR-10, p. 1-32)

E13 Hgb/Hct screening on initial visit and in third trimester. Hgb/Hct screen in second trimester as needed. (*Guidelines for* Perinatal *Care*, 7th ed. p. 113,224)

E14 Screening at 24-28 weeks for gestational diabetes with 50 grams of glucose and a 3 hour Oral Glucose Tolerance Test (OGTT) if indicated. (*Guidelines for Perinatal Care*, 7th ed. p. 116) or test for gestational diabetes as per 2011 American Diabetes Association guidelines: perform a 75-gram glucose 2 hours Oral Glucose Tolerance Test (OGTT) at 24-28 weeks gestation. (American Diabetes Association, Diabetes Care, January 2011, page 7. http://care.diabetesjournals.org/content/34/Supplement_1/S62.full.pdf+html)

E15 Hgb electrophoresis screening or document if client refused test. (*Guidelines for Perinatal Care*, 7th ed. p. 214) 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 (cystic fibrosis, Duchenne's muscular dystrophy, fragile X syndrome, mental retardation). (*Guidelines for Perinatal Care*, 7th ed. p. 119-124; ACOG Committee Opinion No. 442, Oct. 2009)

E16 Screening with Bilingual Lead and Pregnancy Risk questionnaire which is posted on the Women's Health Branch website. Provide lead testing for those who have positive screening results. (*Guidelines for Perinatal Care*, 7th ed. p. 107-108, 112-117) . (http://www.cdc.gov/nceh/lead/publications/LeadandPregnancy2010.pdf)

E17 Diagnostic / monitoring tests completed (when indicated) (*Guidelines for Perinatal Care*, 7th ed. p. 145-146):

- Assessment of Fetal Movement (i.e. Kick Counts)
- Nonstress Test (NST)
- Biophysical Profile (BPP)
- Modified BPP (NST plus an amniotic fluid index [AFI])
- Contraction Stress Test (CST)
- Doppler Studies

E18 Follow-up for abnormal findings (*Guidelines for Perinatal Care*, 7th ed. p. 6-8, 477-480):

- Patients were managed for abnormal findings.
- Consultation with other specialists was sought if indicated.

F. Medical Therapy

Provide and document the following:

F1 Provision of 17P for women at very high risk for developing preterm labor, such as a history of previous spontaneous birth at less than 37 weeks. (*Guidelines for Perinatal Care*, 7th ed. p. 257; ACOG Committee Opinion, No. 419, Oct. 2008)

F2 Influenza vaccine provided for all pregnant women during influenza season (October through May), as defined by the NC Immunization Branch which follows the definition of influenza

season put forth by the Centers for Disease Control and Prevention (CDC). Document the date the vaccine was given or refused in the client chart. (www.cdc.gov/vaccines/adult/rec-vac/pregnant.html; *Guidelines for Perinatal Care*, 7th ed. p. 405)

F3 Tdap vaccine provided each pregnancy. (ACOG Committee Opinion No. 566, June 2013; CDC MMWR 2011; 60 (no.2); 26)

F4 Recommend use of low dose aspirin (81 mg) initiated after the 12th week of pregnancy in women with a history of preeclampsia in prior pregnancy. (USPTF: Low Dose Aspirin to Prevent Preeclampsia: Preventive Medication, September 2014)

G. Nutrition Services

Gestational Weight Management:

G1 Record weight and height for all women at the initial prenatal visit. (*Guidelines for Perinatal Care*,7th ed. p. 136-137)

G2 Determine pre-pregnancy weight and calculate body mass index (BMI) to identify gestational weight gain recommendations (*Guidelines for Perinatal Care*, 7th ed. p. 137)

G3 Plot weight on prenatal weight gain chart at routine visits.

G4 Offer nutrition consultation to all underweight and obese women; pre-pregnancy BMI of < 18.5 or ≥ 30. (*Guidelines for Perinatal Care*, 7th ed. p. 102, 216-217).

Nutrition Screening:

G5 Provide nutrition screening to identify nutrition problems by (or if self-administered, reviewed by) a nutritionist, nurse, physician, or physician extender at the initial visit and updated at subsequent visits as needed (unless a nutrition screening record was received prior to admission to HRMC).

G6 Refer to a nutritionist for an assessment and care plan in response to significant nutrition problems identified at anytime during pregnancy.

Nutrition Counseling (Assessment and Management):

G7 Provide nutrition counseling by a Registered Dietitian (RD) or LDN.G8 Provide nutrition counseling for patients with any high risk condition listed below (Medical Nutrition Therapy; (DMA Clinical Coverage Policy No.1-I January 2008):

a. Conditions which impact length of gestation or birth weight where nutrition is the underlying cause such as severe anemia (Hgb <10gm/dl; Hct <30%), underweight prior to pregnancy (<18.5 BMI), inadequate weight gain during pregnancy, intrauterine growth restriction very young maternal age (under age of 16), multiple gestation, and 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.
e. Eating disorders such as severe pica, anorexia nervosa or bulimia nervosa.
f. Obesity.
g. Documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease, such as

sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, and higher (than) ideal body weight.

G9 Develop a nutrition care plan for each identified nutrition problem.

G10 Document appropriate follow-up for each identified nutrition problem.

G11 Provide a 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. (*Guidelines for Perinatal Care*, 7th ed. p. 132-136) 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.

G12 Refer to WIC at initial visit, if not already enrolled.

H. Psychosocial Services

Psychosocial Screening:

H1 Utilize a psychosocial risk screening tool to identify psychosocial risks. Psychosocial risk screening can be performed by a social worker, nurse, physician or physician extender and is to be completed at the initial HRMC visit. This should include screening, counseling and/or referring as indicated for pregnant and postpartum women who are experiencing depression. A validated tool for depression screening during pregnancy should be used each trimester and at the postpartum visit. (ACOG Committee Opinion, Number 630, May 2015)

H2 Refer to a Licensed Clinical Social Worker (LCSW), licensed by the North Carolina Social Work Certification and Licensure Board, for an assessment and care plan in response to any psychosocial risks identified.

Psychosocial Counseling (Assessment and Management):

H3 Provide a psychosocial assessment by a LCSW for any patient with one or more psychosocial risks identified through the psychosocial risk screening.

H4 Develop a care plan, following the psychosocial assessment, for each identified psychosocial problem.

H5 Provide counseling services by a LCSW for the identified psychosocial problem(s) and/or refer for outside services.

H6 Document appropriate follow-up for each identified psychosocial problem, inclusive of both those addressed by the LCSW and those referred for outside services.

H7 Coordinate the plan of care with the patient's Pregnancy Care Manager if applicable. If the patient is not engaged with a Pregnancy Care Manager, refer patient for services if she is Medicaid eligible and has a priority risk factor.

I. Patient Education

Provide and document (Guidelines for Perinatal Care, 7th ed. p. 107-108, 132-144, 156-161):

I1 Specific education about individual risk condition(s). (ACOG, p. 88-99)

I2 Basic prenatal education in an individual or group format. Appropriately trained members of the maternal health team can provide the education. 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.

I3 Scope of care (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.

I4 Physician coverage for labor and delivery.

I5 Adverse signs and symptoms to report (e.g. bleeding, rupture of membrane, decreased fetal movement).

I6 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 such as second hand smoke and lead; and nausea and vomiting during pregnancy.

I7 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. (*Guidelines for Perinatal Care*, 7th ed. p. 137-138)

I8 Educational programs available (refer to childbirth education classes, which should provide information on labor, pain relief, delivery, breastfeeding, infant care, and postpartum period).

I9 Benefits of breastfeeding and risks of not breastfeeding. (US DHHS, The Surgeon's General Call to Action to Support Breastfeeding; 2011, Appendix 2, pg 79; ACOG Committee Opinion, No. 570, August 2013)

I10 Dangers of eating certain fish with high levels of mercury, including shark, swordfish, king mackerel and tilefish (Guidelines *for Perinatal Care*, 7th ed. p. 140) and risks associated with eating unpasteurized cheese and milk; hot dogs or luncheon meats (unless they are steaming hot); or refrigerated smoked seafood, pâtés or meat spreads. (*Guidelines for Perinatal Care*, 7th ed. p. 140-141, 421-422)

I11 Options for intrapartum care.

I12 Planning for discharge and child care; choosing the newborn's physician.

I13 Cost to the patient for prenatal care and delivery (e.g. insurance plan participation). (*Guidelines for Perinatal Care*, 7th ed. p. 107)

I14 Safe sleep education to all maternity patients. (*Guidelines for Perinatal Care*, 7th ed. p. 311-312)

I15 Education on family planning method options

I16 Medically accurate information regarding umbilical cord stem cells and umbilical cord blood banking that is sufficient to allow a pregnant woman to make an informed decision about whether to participate in a public or private umbilical cord blood banking program. (§130A-128.1) Visit http://whb.ncpublichealth.com/Manuals/CordBloodFinal-122209.pdf for a brochure which can be printed and distributed.

J. Staff Training

J1 Recommend maternal health staff receive task appropriate breastfeeding promotion and support training from Breastfeeding Coordinators in health departments or from the six Regional Breastfeeding training Centers in North Carolina at no cost. This training includes information on the clinic environment, goals and philosophies regarding breastfeeding, as well

as task appropriate breastfeeding information, such as anticipatory guidance for the breastfeeding infant, the benefits of and the risks of not breastfeeding, anticipatory guidance related to breastfeeding and birth spacing/family planning, contraindications to breastfeeding, and information for referring clients for additional breastfeeding support services. Initial training for all maternal health staff is encouraged; on-going training as needed is recommended. Training certificates per person or per agency are available. (US DHHS**.** *The Surgeon's General Call to Action to Support Breastfeeding;* 2011, Action 9, pg 46; ACOG Committee Opinion, No. 570, August 2013).

IV. Performance Measures/Reporting Requirements:

A. Benchmarks will be reflected by county in the process outcome objectives (POOs). These can be located in the Agreement Addenda section on the Women's Health Branch website at http://whb.ncpublichealth.com/provPart/agreementAddenda.htm.

1. Increase the percentage of women having live births who had adequate prenatal care as defined by the Kessner Index during the period of June 2016 – May 2017.
2. Increase the percentage of women during the period of June 2016 – May 2017 with live term singleton births who received WIC Program services during pregnancy and who gained recommended/excessive/inadequate weight according to the National Academy of Sciences – Institute of Medicine (IOM) Recommended Total Weight Gain Ranges During Pregnancy:
   a. Recommended prenatal weight gain
   b. Excessive prenatal weight gain
   c. Inadequate prenatal weight gain
3. Decrease the percentage of women having live births who smoked during pregnancy during the period of June 2016 – May 2017.

B. Reporting Requirements: The Local Health Department will enter all program service data at least quarterly into the Health Information System (HIS) or a compatible reporting system.

V. Performance Monitoring and Quality Assurance:

A. The High Risk Maternity Clinic Program Supervisor, Maternal Health Nurse Consultant, Women's Health Branch Nutritionist and Clinical Social Work Consultant will utilize a team approach for the monitoring process. The monitoring activities will include the development of a pre-monitoring plan 4-6 months prior to the designated monitoring month, and on-site monitoring visits at least every three years. Technical assistance via phone, email, and on-site is conducted annually. On-site monitoring visits include a review of policies and procedures. A pre-monitoring visit is optional. A written report is completed for any monitoring site visit. The monitoring report includes any needed corrective action plan (CAP) and is emailed 2 to 4 weeks after the monitoring site visit to the local Health Director and lead agency staff.

B. Consequences:
The Local Health Department must respond to the corrective action plan within 30 days after the follow-up report is emailed. If monitoring has not closed within 90 days, then the agency will be placed on high risk monitoring status which will require annual monitoring of the Local Health Department. Monitoring closure is defined as the Local Health Department being notified that their final CAP is acceptable or that they are being referred for continuing technical assistance.

A loss of up to 5% of funds may result for Local Health Department if it does 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.

VI. Funding Guidelines or Restrictions:

A. Requirements for pass-through entities: In compliance with *2 CFR §200.331 – Requirements for pass-through entities*, the Division provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda.

1. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.

2. Frequency: Supplements will be generated as the Division receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

Attachment A

Detailed Budget Instructions and Information

Budget and Justification Form
Applicants must complete the **Open Windows Budget Form** for **FY16-17**. Upon completion, the Open Windows Budget Form must be emailed to **Phyllis.C.Johnson@dhhs.nc.gov**. The Open Windows Budget Form requires a line item budget and a narrative justification for each line item. The Open Windows Budget Form can be downloaded from the Women's Health Branch website at http://whb.ncpublichealth.com/provPart/agreementAddenda.htm.

Narrative Justification for Expenses
A narrative justification must be included for every expense listed in the FY16-17 budget. Each justification should show how the amount on the line item budget was calculated, and it should be clear how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** is posted on the Women's Health Branch website at http://whb.ncpublichealth.com/provPart/agreementAddenda.htm.

Equipment
Expenses for any equipment to be purchased may not exceed $2,000 per item.

Administrative Personnel Costs
Provide position title, staff FTE and a brief description of the positions that shall be funded by this Agreement Addenda.

Incentives
Incentives may be provided to program participants in order to ensure the level of commitment that is needed to achieve the expected outcomes of the program. While there is no maximum amount of funding that may be used to provide incentives for program participants, the level of incentives must be appropriate for the level of participation needed to achieve the expected outcomes of the program.

Travel
Mileage should be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Effective January 1, 2015, the business standard mileage rate is $0.575 cents per mile.

Effective July 1, 2015, the travel subsistence rates are as follows:

	In-State	Out-of-State
Breakfast	$ 8.30	$ 8.30
Lunch	$ 10.90	$ 10.90
Dinner	$ 18.70	$ 21.30
Lodging (actual, up to)	$ 67.30	$ 79.50
Total	$ 105.20	$ 120.00

Attachment B

Non-Medicaid Services

Instructions: Enter the total number of estimated services for all non-Medicaid clinical services. Retain a copy in the Local Health Department files for your reference. This information should be returned with your signed Agreement Addendum. Health Information System (HIS) service data or compatible reporting system as of August 31, 2017 will provide the documentation to substantiate services that the Local Health Department has provided.

Unduplicated number of Non-Medicaid patients to be served in the High Risk Maternity Clinic _____.

CPT Code*/ Modifier	Service Type	Estimated # of services
99201	Office/Outpatient Visit, New	
99202	Office/Outpatient Visit, New	
99203	Office/Outpatient Visit, New	
99204	Office/Outpatient Visit, New	
99205	Office/Outpatient Visit, New	
99211	Office/Outpatient Visit, Est.	
99212	Office/Outpatient Visit, Est.	
99213	Office/Outpatient Visit, Est.	
99214	Office/Outpatient Visit, Est.	
99215	Office/Outpatient Visit, Est.	
59425	Antepartum Care Only 4-6 visits	
59426	Antepartum Care Only 7 or more visits	
59025/TC	Non-stress Test (technical component only)	
59025/26	Non-stress Test (professional component only)	
59025	Non-stress Test (complete)	
76815/TC	Ultrasound, limited, Fetal size, heartbeat, position,	
76815	Ultrasound, limited, Fetal size, heartbeat, position, includes interpretation	
76805/TC	Ultrasound ,14 weeks 0 days, single or first gestation, fetal & maternal evaluation, includes interpretation	
76805	Ultrasound ,14 weeks 0 days, single or first gestation, includes interpretation	
S9442	Childbirth Education Classes/One Unit = 1 hour	
J2790	RG,IG Full Dose, IM	
J2788	RG, IG Minidose, IM	
99501	Home Visit for Postnatal Assessment	
96152	Health & Behavior Intervention	
81025	Pregnancy Test	
90396	Varicella Zoster Immune Globulin	
97802	Medical Nutrition Therapy, Initial, each 15 min.	
97803	MNT, Reassessment, each 15 min.	

Attachment A (continued)

CPT Code*/ Modifier	Service Type	Estimated # of services
99406	Tobacco cessation counseling – intermediate visit 3-10 minutes	
99407	Tobacco cessation counseling – intensive visit > 10 minutes	
T1001	Maternal Care Skilled Nurse Home Visit	
57452	Colposcopy of the cervix w/o Biopsy	
87070	GBS culture specimen, bacteria, must precede 87077	
87077	GBS culture, bacteria, aerobic isolates, confirmation test for GBS	
36415	Venipuncture, DMA Only	
J3490	Hydroxyprogesterone Caproate, 250 mg injection (Makena)	
85013	Hematocrit	
85018	Hemoglobin	
81000	Urinalysis, Non-Auto w/scope	
81001	Urinalysis, Auto w/scope	
81002	Urinalysis, Non-Auto w/o scope	
81003	UA, dipstick or tab, automated (w/o microscopy)	
87210	Wet mount, simple stain, for bacteria	
87086	Urine culture, colony count	
87591	GenProbe-GC Culture	
87491	GenProbe-Chlamydia	
82947	Glucose, Fasting Blood Sugar (FBS)	
82948	Glucose, blood reagent strip	
82950	Glucose (post glucose dose, includes glucose)	
82951	GTT (3 specimens + glucose)	
82270	Fecal occult blood	
83986	Assay of fluid acidity	
86580	TB intradermal	
90715	Tdap	
90686	Influenza – Preservative free	
90688	Influenza – Preservative containing	
96372	Administration code for 17P – cannot bill with 99211	
83655	Lead Test	

DPH-Aid-To-Counties For Fiscal Year:16/17 Budgetary Estimate Number : 0

Activity 746		AA	13A1 5746 00	Proposed Total	New Total
Service Period			06/01-05/31		
Payment Period			07/01-06/30		
01 Alamance			0	0	0
D1 Albemarle	*	0	86,599	86,599	86,599
02 Alexander			0	0	0
04 Anson			0	0	0
D2 Appalachian	*	0	60,149	60,149	60,149
07 Beaufort			0	0	0
09 Bladen			0	0	0
10 Brunswick			0	0	0
11 Buncombe			0	0	0
12 Burke			0	0	0
13 Cabarrus	*	0	26,413	26,413	26,413
14 Caldwell			0	0	0
16 Carteret			0	0	0
17 Caswell			0	0	0
18 Catawba	*	0	75,869	75,869	75,869
19 Chatham			0	0	0
20 Cherokee			0	0	0
22 Clay			0	0	0
23 Cleveland			0	0	0
24 Columbus			0	0	0
25 Craven	*	0	71,428	71,428	71,428
26 Cumberland			0	0	0
28 Dare			0	0	0
29 Davidson			0	0	0
30 Davie			0	0	0
31 Duplin			0	0	0
32 Durham			0	0	0
33 Edgecombe			0	0	0
34 Forsyth	*	0	102,225	102,225	102,225
35 Franklin			0	0	0
36 Gaston	*	0	100,387	100,387	100,387
38 Graham			0	0	0
D3 Gran-Vance			0	0	0
40 Greene			0	0	0
41 Guilford	*	0	27,903	27,903	27,903
42 Halifax			0	0	0
43 Harnett			0	0	0
44 Haywood			0	0	0
45 Henderson			0	0	0
46 Hertford			0	0	0
47 Hoke			0	0	0
48 Hyde			0	0	0
49 Iredell			0	0	0
50 Jackson	*	0	57,982	57,982	57,982
51 Johnston			0	0	0
52 Jones			0	0	0
53 Lee			0	0	0

54 Lenoir			0	0	0
55 Lincoln			0	0	0
56 Macon			0	0	0
57 Madison			0	0	0
D4 M-T-W			0	0	0
60 Mecklenburg			0	0	0
62 Montgomery			0	0	0
63 Moore			0	0	0
64 Nash			0	0	0
65 New Hanover			0	0	0
66 Northampton			0	0	0
67 Onslow			0	0	0
68 Orange			0	0	0
69 Pamlico			0	0	0
71 Pender			0	0	0
73 Person			0	0	0
74 Pitt			0	0	0
76 Randolph			0	0	0
77 Richmond			0	0	0
78 Robeson			0	0	0
79 Rockingham			0	0	0
80 Rowan			0	0	0
D5 R-P-M			0	0	0
82 Sampson			0	0	0
83 Scotland			0	0	0
84 Stanly			0	0	0
85 Stokes			0	0	0
86 Surry			0	0	0
87 Swain			0	0	0
D6 Toe Rriver			0	0	0
88 Transylvania			0	0	0
90 Union	*	0	60,293	60,293	60,293
92 Wake			0	0	0
93 Warren			0	0	0
96 Wayne			0	0	0
97 Wilkes			0	0	0
98 Wilson			0	0	0
99 Yadkin			0	0	0
Totals			669,248	669,248	669,248

Sign and Date - DPH Program Administrator 11/30/15	Sign and Date - DPH Section Chief 12/3/15
Sign and Date - DPH Contracts Office 12-4-15	Sign and Date - DPH Budget Officer 12/9/15 12/22/15