Division of Public Health
Agreement Addendum
FY 18-19

Generic	Women's and Children's Health Section / Women's Health Branch
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, phone number, and email)
06/01/2018 – 05/31/2019	
Service Period	**DPH Program Signature** **Date** (only required for a negotiable agreement addendum)
07/01/2018 – 06/30/2019	
Payment Period	

☒ **Original Agreement Addendum**
☐ **Agreement Addendum Revision #** ___

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 36 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*, Eighth Edition, October 2017, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.

II. Purpose:

This Agreement Addendum assures 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

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: _____

psychosocial and nutrition problems, behavioral health intervention, 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 FY19. **The budget must equal funds allocated to the Local Health Department** (Refer to the FY 18-19 Activity 746 Budgetary Estimate, included with this Agreement Addendum, for the total funding allocation). 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. (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 FY19. Include on Attachment B the number of unduplicated Non-Medicaid patients to be served and the estimated total number for all Non-Medicaid clinical services. Health Information System (HIS) service data or compatible reporting system as of August 31, 2019 will provide the documentation to substantiate services that the Local Health Department has provided for this FY19 Agreement Addenda.

C. HRMC Budget Requested to be Transferred to Low Risk
As part of the policy and procedures, the Local Health Department is required to define high risk conditions that qualify pregnant and postpartum patients to receive the High Risk services. Since this is defined locally, there may be variations by county as to whether patients are being served in High Risk or Low Risk Maternity Clinics. Therefore, the Local Health Department 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 patients, regardless of their ability to pay. There will be no charge for patients from households with incomes at less than 100% of the poverty level. Patients 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 patient and third party fees:

1. If a local provider imposes any charges on patients 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 patient fees are charged, providers must make reasonable efforts to collect from third party payors.
3. Patient 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, patient 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 Obtain informed consent (receipt of patient signature) for prenatal services. (ACOG Committee Opinion, No. 439, Aug. 2009, Reaffirmed, 2015)

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 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 patient'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 patients served reporting through the state's Health Information System (HIS) and/or a compatible data system.

A7 Maintain 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 patients.
c. Avoid direct promotion of formula feeding. Do not give out formula company discharge bags or other free items to patients.
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 patients' confidence in the 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. (*Guidelines for Perinatal Care*, 8th ed., pp. 7-8)

B2 Augment care with advanced practice practitioners as prescribed by a physician. (*Guidelines for Perinatal Care*, 8th ed., pp. 43-48)

B3 Provide experienced licensed healthcare professionals who are current with bi-annual Fetal Monitoring training and will perform a Non-Stress Test (NST) when indication warrants. These healthcare professionals include: Registered Nurses, Certified Nurse-Midwives, Certified Midwives, Nurse Practitioners, Clinical Nurse Specialists, Physicians, and Physician Assistants. (*JOGNN*, No. 44, pp. 683-686; (2015); ACOG Practice Bulletin, No 145, pp. 1-9, July 2014, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 48-49)

B4 Provide comprehensive clinical assessments and counseling by a Licensed Clinical Social Worker (LCSW).

B5 Provide nutrition assessments and counseling by a Registered Dietitian or Licensed Dietitian/ Nutritionist (RD or LDN).

B6 Assure that patients at high risk for experiencing an infant or fetal death receive appropriate prenatal care as determined by site visit and record review.

B7 Provide services in accordance with ACOG guidelines on high risk maternity care as determined by site visit and record review.

B8 Conduct annual quality assurance review to assure policies and procedures are carried out.

B9 Report interruption of services or inability to meet quality assurance deliverables within 14 days to the Maternal Health Nurse Consultant.

B10 Demonstrate excellence in customer friendly services as evidenced by annual patient satisfaction surveys.

B11 All staff, clinical and non-clinical, shall participate in at least one training biannually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity.

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*, 8th ed., pp. 597-600)

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. (*Guidelines for Perinatal Care*, 8th ed., pp. 7-8)

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.

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

C7 Use of the signed 5 P's validated screening tool, to identify, refer (if appropriate) or prescribe subsequent follow-up of patients who have a current use or a history of substance use. Substances include: alcohol, nicotine, marijuana, cocaine, opioids, herbal remedies, prescriptions or over-the-counter (OTC) medications. (*JOGNN*, No 46, pp. 794-796 (2017); *JOGNN*, No. 44, pp. 155-157 (2015); ACOG Committee Opinion, No. 721, October 2017, Interim Update; Committee Opinion, No. 633, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137)

C8 Urine drug screen is not recommended universally. Routine screening for substance use disorders should be applied equally to all people, regardless of age, sex, race, ethnicity, and socioeconomic status. Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not best practice. If risk indicators are identified, the process must include assurance of confidentiality and an informed written consent shall be obtained. (*JOGNN*, No. 44, pp. 155-157 (2015); ACOG Committee Opinion, No. 633, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 176-182)

C9 Identification, follow-up and referral as indicated for pregnant and postpartum patients 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. (*JOGNN*, No. 44, pp. 405-408, (2015); ACOG Committee Opinion, No. 518, February 2012; *Guidelines for Perinatal Care*, 8th ed., pp. 183-185)

C10 Universal Prenatal Screening for vaginal and rectal Group B Streptococcal colonization of all pregnant patients 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 patient and infant. Collaboration with providers and pediatricians, local hospital/tertiary care center staff is required to develop a policy. (CDC MMWR, Nov 19, 2010, v.59, #RR-10; ACOG Committee Opinion, No. 485, April 2011, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 160, 164, 237) All prenatal clinics providing prenatal care through 35-37 weeks are required to have this policy.

C11 Provision of Rubella and/or Varicella vaccine postpartum if patient not immune. (*Guidelines for Perinatal Care*, 8th ed. pp. 283, 519-524)

C12 Fetal fibronectin testing for asymptomatic patients at high risk for preterm delivery due to a previous preterm delivery or a current multifetal gestation and for patients 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 patients, 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 Practice Bulletin, No. 171, October 2016; Practice Bulletin, No. 130, October 2012, Reaffirmed 2016; *Guidelines for Perinatal Care,* 8th ed. pp. 235-236, 339)

C13 Provision of active electronic mail membership and direct access to the Internet for the maternity nurse supervisor, LCSW, and nutritionist. HRMC funds can be used to finance and maintain hardware, software and subscription linkage to the current local market values.

C14 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.

C15 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 patient must be governed by appropriate clinical practice and the specific needs of the patient.

C16 Complete the Edinburgh or PHQ9 screening tool to, facilitate referral (if appropriate) and subsequent follow-up of patients who have a current diagnosis, symptomatic or have history of depression. (*JOGNN*, No. 44, pp. 687-689, (2015); ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 183, 294-298)

C17 All standing orders or protocols developed for nurses in support of this program must be written in the North Carolina Board of Nursing format. All local health departments shall have a policy in place that support nurses working under standing orders. http://www.ncbon.com/vdownloads/position-statements-decision-trees/standing-orders.pdf

D. Prenatal and Postpartum Services

Prenatal:

D1 Assess the following health history (hx) 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 or electronic nicotine devices, and illegal drugs);
f. Current medications (prescription and non-prescription);

g. Menstrual/last menstrual period;
h. Contraceptive;
i. Infection;
j. Gynecologic and obstetrical;
k. Depression and intimate partner violence;
l. Nutritional status, as per nutrition screening;
m. Genetic history (both maternal and paternal);
n. Risk factors for STIs;
o. Socioeconomic status;
p. Education level;
q. Environmental exposures (including environmental tobacco smoke [ETS] or electronic nicotine devices and lead exposure).
r. Medication list (prescription, OTC, and herbal supplements/remedies)
s. Estimated date of delivery (EDD) confirmation (ACOG Committee Opinion, No. 700, May 2017; *Guidelines for Perinatal Care* 8th ed., pp. 154-156)

(http://www.cdc.gov/nceh/lead/publications/leadandpregnancy2010.pdf)
(*Guidelines for Perinatal Care* 8th ed., pp. 150-153, 581-589)

D2 Assess the following physical examination components:
a. Head, ears, nose and throat (HENT);
b. Eyes
c. Teeth
d. Thyroid;
e. Lungs;
f. Breast;
g. Heart;
h. Cervix:
i. Adnexa;
j. Rectum;
k. Vulva;
l. Abdomen;
m. Extremities;
n. Skin;
o. Lymph nodes;
p. Pelvis (including uterine size or fundal height);
q. Blood pressure.

Pre-pregnancy body mass index (BMI) must be calculated to determine the recommended gestational weight gain range (patient specific) and shared with the patient to guide care. (*FASEB*, v. 30, No. 1, Supplement 152.4 (2016); ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; *Does Healthcare Provider Advice Matter for Gestational Weight Gain? http://www.fasebj.org/content/30/1_Supplement/152.4; Guidelines for Perinatal Care*, 8th ed., pp. 185-190)

D3 Assess the following components on all subsequent routine scheduled visits:

a. Interim history/routine screening questions (fetal movement, contractions, rupture of membranes, vaginal bleeding);
b. Weight, as per recommended gestational weight gain range (patient specific);;
c. Blood pressure;
d. Fetal heart rate;
e. Fundal height consistency with EDD;
f. Fetal presentation greater than or equal to 36 weeks.
(*Guidelines for Perinatal Care*, 8th ed., p. 153)

D4 Provide the 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine devices for all pregnant patients. Facilitate referral to QuitlineNC (1-877-QUIT-NOW) or community resource. Another resource is the "Guide for Helping to Eliminate Tobacco Use and Exposure for Women, June 2016." http://whb.ncpublichealth.com/docs/2016-GuideforCounselingWomenWhoSmoke.pdf. (*JOGNN*, No. 46, pp. 794-796 (2017); ACOG Committee Opinion, No. 721, October 2017; Committee Opinion, No. 503, September 2011, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 178-179)

D5 Complete the Community Care of North Carolina (CCNC) Pregnancy Medical Home Risk Screening Form if one has not been completed. Complete the 5 P's validated screening tool, to identify, refer (if appropriate) or prescribe subsequent follow-up of patients who have a current use or a history of substance use. Substances include: alcohol, nicotine, marijuana, cocaine, opioids, herbal remedies, prescriptions or over-the-counter (OTC) medications.

D6 Complete the Edinburgh or PHQ9 screening tool to facilitate referral (if appropriate) and subsequent follow-up of patients who have a current diagnosis, symptomatic or have history of depression. (*JOGNN*, No. 44, pp. 687-689, (2015); ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 183, 294-298)

D7 Document, follow-up, and re-schedule:
a. Missed appointments
b. Referrals (*Guidelines for Perinatal Care*, 8th ed., pp. 7-8)
c. Patient was referred for postpartum examination

D8 Hospitalize patients when needed in order to treat / monitor their high risk conditions. (*Guidelines for Perinatal Care*, 8th ed., pp. 8-33, 329-343)

D9 Assure delivering hospital is able to provide a level of care appropriate to the patient's high risk condition. (*Guidelines for Perinatal Care*, 8th ed. pp. 8-33)

Postpartum Clinic Appointment:

D10 Provide the 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine devices for all postpartum patients. Facilitate referral to QuitlineNC (1-877-QUIT-NOW) or community resource. Another resource is the "Guide for Helping to Eliminate Tobacco Use and Exposure for Women, June 2016." http://whb.ncpublichealth.com/docs/2016-GuideforCounselingWomenWhoSmoke.pdf (*JOGNN*, No. 46, pp. 794-796, (2017); ACOG Committee Opinion, No. 721, October 2017; Committee Opinion, No. 503, September 2011, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 178-179)

D11 Follow-up and document:
a. Missed appointments.

b. Postpartum follow-up for diagnosed high risk conditions. Documentation will indicate that the care provided, or referral facilitated (inter/intra-agency) to the appropriate provider. (*Guidelines for Perinatal Care*, 8th ed., pp. 294-298)

c. Complete the Edinburgh or PHQ9 screening tool to facilitate referral (if appropriate) and subsequent follow-up of patients who have a current diagnosis, symptomatic or have history of depression. (*JOGNN*, No. 44, pp. 687-689 (2015); ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 183, 294-298)

d. Screening for Intimate Partner Violence. (*JOGNN*, No. 44, pp. 405-408, (2015); ACOG Committee Opinion No. 554, February 2013; Committee Opinion, No. 518, February 2012; *Guidelines for Perinatal Care*, 8th ed., pp. 183-185)

e. Complete the 5 P's validated screening tool, to identify, refer (if appropriate) or prescribe subsequent follow-up of patients who have a current use or a history of substance use. Substances include: alcohol, nicotine, marijuana, cocaine, opioids, herbal remedies, prescriptions or over-the-counter (OTC) medications. (ACOG Committee Opinion, No. 721, October 2017; Interim Update; Committee Opinion, No. 633, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137)

f. Postpartum GDM follow-up testing recommendation for all Gestational Diabetes Mellitus (GDM) patients defined by ACOG as a 4-12 weeks postpartum Fasting Blood Glucose or 75-g 2hr Oral Glucose Tolerance Test; appropriate long term sequela counseling should also be performed. (ACOG Practice Bulletin, No. 180, July 2017; *Guidelines for Perinatal Care*, 8th ed., pp.163-164, 310-318)

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. (ACOG Committee Opinion, No. 654, February 2016; Health People 2020 FP-1 and FP-5; www.cdc.gov/preconception/women.html; *Guidelines for Perinatal Care*, 8th ed., pp. 134)

h. Referral to a primary care provider as indicated. (ACOG Committee Opinion, No. 666, June 2016; Healthy People 2020 AHS-3; *Guidelines for Perinatal Care*, 8th ed., p. 470)

E. Laboratory and Other Studies

Provide and document the following:

E1 Syphilis screening at the initial appointment, a repeat syphilis screen between 28 and 30 weeks, and when symptomatic. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 43-65; 10A NCAC 41A.0204 (d); *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 542-548)

E2 Hepatitis B screening at the initial appointment, unless known to be infected, and follow-up of an infant born to an infected patient to assure the neonate receives prophylactic treatment. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 43-65; 10A NCAC 41A. 0203 (d)(l); *Guidelines for Perinatal Care*, 8th ed., pp. 159, 485-492)

E3 Human Immunodeficiency Virus (HIV) testing at the initial appointment and the third trimester (preferably before 36 weeks of gestation) unless the patient declines the test (i.e., opt-out screening G.S. 130A-148(h)). Documentation of refusal must be in the medical record. CDC MMWR, June 5, 2015, v. 64, No. #RR-3; 10A NCAC 41A. 0202(14); ACOG Committee Opinion, No.635, June 2015, Reaffirmed 2016; Committee Opinion, No 389, December 2007, Reaffirmed 2015; ; *Guidelines for Perinatal Care*, 8th ed., pp. 503-506)

E4 Neisseria Gonococcal (Gonorrhea) screening on initial appointment 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 STI during the current pregnancy or substance use. (CDC MMWR, June 5, 2015, v.64, No. #RR-3, pp. 11-13; 10A NCAC 41A. 0204 (e); ACOG Committee Opinion, No. 645, November 2015; Committee Opinion, No. 632, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 532-534)

E5 Chlamydia trachomatis screening at the initial appointment 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 STI during the current pregnancy or substance use. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 11-13; 10 NCAC 41A.0204 (e); ACOG Committee Opinion, No. 632, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 532-534)

E6 Genetic serum screening (offered or referred), prior to 20 weeks of gestation, to patients who give informed consent for the test. Patients who decline the test should have this informed refusal documented in the chart. Patients should be offered or referred for additional genetic and aneuploidy screening tests including first screen, as area resources allow. (ACOG Committee Opinion, No. 693, April 2017; Committee Opinion, No. 478, March 2011; *Guidelines for Perinatal Care*, 8th ed., pp. 166-173, 209-210)

E7 Blood group, Rh Determination (RhD), and antibody screening at the initial appointment. RhD-negative patients who have a positive antibody screening should be evaluated with an antibody tier. A repeat antibody screening should occur at 26-28 weeks gestation for RhD-negative patients with a negative initial antibody screening. Unsensitized RhD-negative patients (RhD-negative patients with a negative antibody screen at 26-28 weeks gestation) carrying an RhD-positive fetus must be given Rh_o(D) immune globulin (RhoGam) to decrease the risk of alloimmunization. (U.S. Preventative Services Task Force, AHRQ Pub. No. 05-0566-A, November 2004; ACOG Practice Bulletin, No. 181, August 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 159, 163, 283)

E8 Rubella and Varicella immune status assessment at initial appointment as evidenced by written documentation of age-appropriate vaccination or laboratory evidence of immunity. Patients without evidence of immunity shall have laboratory test for immunity performed. Policy and Protocol for providing Rubella and Varicella vaccine post-delivery if patient "not immune" are required. (ACOG Committee Opinion, No. 718, September 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 135, 166, 519-524)

E9 Cervical Cytology screening for cancer should begin at age 21 years. (if indicated, follow new ACOG Cervical Cytology Guidelines). (ACOG, Practice Bulletin, No. 168, October 2016, Interim Update; *Guidelines for Perinatal Care*, 8th ed., pp. 510-511)

E10 A baseline urine dipstick for protein content to assess renal status at the initial appointment is required. (*Guidelines for Perinatal Care*, 8th ed., pp. 153, 160)

E11 Urine culture will be done at initial appointment, and repeated as indicated. If Group B Strep is identified during routine urine culture, repeat screening at 35-37 weeks is not indicated {except in 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; ACOG Committee Opinion, No. 485, April 2011, Reaffirmed 2016; *Guidelines for Perinatal Care* 8th ed., pp. 160, 164))

E12 Group B Strep screening at 35-37 weeks if no GBS bacteriuria diagnosed in current pregnancy. (CDC MMWR, November 19, 2010, v. 59, No. #RR-10; ACOG Committee Opinion, No. 485, April 2011, Reaffirmed 2016; *Guidelines for Perinatal Care* 8th ed., pp. 164, 237)

E13 Hemoglobin/Hematocrit screening at the initial appointment, in the second trimester (as indicated), and in the third trimester. Asymptomatic patients that meet the criteria for anemia (Hematocrit levels less than 33% in the 1st and 3rd trimesters, and < 32% in the 2nd trimester) should be evaluated. (ACOG Practice Bulletin, No. 95, July 2008, Reaffirmed 2017; *Guidelines for* Perinatal *Care*, 8th ed., pp. 159, 306-307)

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 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. Patients with abnormal testing results should be referred to the appropriate provider for follow up. (http://www.ncdei.org/ADA-diabetes-management-guidelines-diabetes-in-pregnancy-GDM.aspx.html) ACOG Practice Bulletin, No. 180, July 2017; *Guidelines for Perinatal Care,* 8th ed., pp. 163-164, 310-313)

E15 Hemoglobin electrophoresis screening, as indicated, or document if patient declines test. Screening for other genetic disorders (e.g., β-thalassemia, α-thalassemia, Tay-Sachs disease, Canavan disease, and familial dysautonomia (Ashkenazi Jews) should be provided based on the patient's racial and ethnic background and the family background (cystic fibrosis, Duchenne's muscular dystrophy, fragile X syndrome, intellectual disability). (ACOG Committee Opinion No. 691, March 2017; ACOG Practice Bulletin, No. 95, July 2008, Reaffirmed 2017; *Guidelines for Perinatal Care,* 8th ed., pp. 159, 306-307)

E16 Screening with 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. (http://www.cdc.gov/nceh/lead/publications/leadandpregnancy2010.pdf; ACOG Committee Opinion, No. 533, August 2012, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed. p. 195)

E17 Diagnostic / monitoring tests completed (when indicated):

a. Assessment of Fetal Movement (i.e. Kick Counts)
b. Nonstress Test (NST)
c. Biophysical Profile (BPP)
d. Modified BPP (NST plus an amniotic fluid index [AFI])
e. Contraction Stress Test or oxytocin challenge test (CST)
f. Doppler ultrasonography of umbilical artery blood flow velocity

(*JOGNN*, No. 44, pp. 683-686, (2015); ACOG Practice Bulletin, No. 145, July 2014, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 199-202)

E18 Follow-up for abnormal findings:

a. Patients were managed for abnormal findings.
b. Consultation with other specialists was sought if indicated. (*Guidelines for Perinatal Care*, 8th ed., pp. 159, 597-600)

F. Medical Therapy

Provide and document the following:

F1 Provision of 17 α-Hydroxyprogesterone caproate (17P) for patients at very high risk of preterm birth Patients eligible for this therapy include:

a. History of previous singleton spontaneous preterm birth between 20 weeks 0 days and 36 weeks and 6 days gestation.

b. History of "late preterm" singleton, defined as 34 weeks 0 days and 36 weeks and 6 days gestation.

c. Have a current singleton pregnancy.

The following are guidelines regarding the initiation of 17P:

d. Initiate treatment between 16 weeks 0 days and 21 weeks and 6 days gestation.

e. If an eligible patient presents to prenatal care late, this therapy may be initiated as late as 23 weeks 6 days.

(ACOG Committee Opinion, No. 713, August 2017, Interim Update; 419, October; ACOG Practice Bulletin, No. 130, October 2012, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 152, 338-343)

F2 Influenza vaccine provided for all pregnant patients 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 patient chart. (CDC MMWR, September 20,2013, v. 62, #RR-7; ACOG Committee Opinion, No. 608, September 2014, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 164-166, 283, 511-514)

F3 Tetanus, diphtheria, and pertussis (Tdap) vaccine should be administered with each pregnancy, preferably between 27 and 36 weeks gestation. Document the date the vaccine was given or refused in the patient chart. (ACOG Committee Opinion No. 718, September 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 164-166, 283, 511-514)

F4 Recommended use of low-dose aspirin (81 mg) initiated after the 12th week of pregnancy in patients with a history of preeclampsia in prior pregnancy. (LeFevre, M. L. (2014). Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia: U.S. Preventive Services Task Force recommendation statement. Annals of Internal Medicine, 161, 819-826. doi: 10.7326/M14-1884; ACOG Committee Opinion, No. 692, April 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 152, 206, 319-324)

G. Nutrition Services

<u>Gestational Weight Management:</u>

G1 Record weight and height for all patients at the initial prenatal appointment. (*Guidelines for Perinatal Care*, 8th ed., pp. 152, 189-190)

G2 Determine pre-pregnancy weight and calculate body mass index (BMI) to identify recommended gestational weight gain range (patient specific). (ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 189-190)

G3 Document weight gain assessment at routine appointments (e.g., plot weight on prenatal weight gain graph) based on recommended weight gain range (patient specific) and other patient symptoms. (ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 188-190, 583)

G4 Offer nutrition consultation to all underweight and obese patients (pre-pregnancy BMI of < 18.5 or ≥ 30) and/or patients gaining outside of their prescribed weight gain range. (ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 188-190)

Nutrition Screening:

G5 Provide nutrition screening to identify nutrition problem(s) by (or if self-administered, reviewed by) a nutritionist, nurse, physician, or advanced-practice practitioner at the initial appointment and updated at subsequent appointments as needed (unless a nutrition screening record was received prior to admission to HRMC). (*Guidelines for Perinatal Care*, 8th ed., pp. 185-190)

G6 Refer to a nutritionist for an assessment and care plan in response to significant nutrition problems identified at any time 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):

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.
(DMA Clinical Coverage Policy No.1-I, Sections 2.2.5 and 3.2.2, Amended October, 2015)

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. The health department shall document that each patient has obtained prenatal vitamins on the subsequent prenatal appointments after the initial prescription is given and refilled. (*Guidelines for Perinatal Care*, 8th ed., pp. 185-188)

G12 Refer to WIC at initial appointment, 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 advanced practice practitioner and is to be completed at the initial HRMC appointment. This should include screening, counseling and/or referring as indicated for pregnant and postpartum patient who are experiencing depression. A validated tool, such as Edinburgh or PHQ9, for depression screening during pregnancy should be used each trimester and at the postpartum appointment. (*JOGNN*, No. 44, pp. 687-689, (2015); ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; ACOG Practice Bulletin, No. 92, April 2008, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 175-176, 324)

H2 Complete the 5 P's validated screening tool to identify, refer (if appropriate) or prescribe subsequent follow-up of patients who have a current use or a history of substance use. Substances include: alcohol, nicotine, marijuana, cocaine, opioids, herbal remedies, prescriptions or over-the-counter) medications. (ACOG Committee Opinion, No. 721, October 2017, Interim Update; Committee Opinion, No. 633, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137)

H3 Refer to a Licensed Clinical Social Worker (LCSW~~)~~, licensed by the North Carolina Social Work Certification and Licensure Board, for a comprehensive clinical assessment and care plan in response to any psychosocial risks identified. (*Guidelines for Perinatal Care*, 8th ed., pp. 175-185)

Psychosocial Counseling (Assessment and Management):

H4 Provide a comprehensive clinical assessment by a LCSW for any patient with one or more psychosocial risks identified through the assessment.

H5 Develop a care plan, following the psychosocial assessment, for each identified psychosocial problem.

H6 Provide counseling services by a LCSW for the identified psychosocial problem(s) and/or refer for outside services.

H7 Document appropriate follow-up for each identified psychosocial problem, inclusive of both those addressed by the LCSW and those referred for outside services.

H8 Coordinate the plan of care with the patient's Pregnancy Care Manager, as applicable. If the patient is not engaged with a Pregnancy Care Manager, refer patient for services if Medicaid eligible.

I. Patient Education

Provide and document the following:

I1 Education specific to high risk condition(s). (*Guidelines for Perinatal Care,* 8th ed., pp. 145-150)

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, advanced practice practitioner, and a health educator. 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. (*Guidelines for Perinatal Care*, 8th ed., pp. 6-8)

I3 Scope of care (including what is expected at the first prenatal appointment and anticipated schedule of appointments); lab studies that may be performed; options for intrapartum care; office policies; emergency coverage and cost; and expected course of pregnancy. (*Guidelines for Perinatal Care*, 8th ed., pp. 150-154)

I4 Provider coverage for labor and delivery services.

I5 Adverse signs/symptoms of pregnancy, including vaginal bleeding, rupture of membranes, nausea/vomiting, and decreased fetal movement, to contact provider.

I6 Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety and daily activity; travel; alcohol and tobacco consumption or use of electronic nicotine devices, caution about drugs (illegal, prescription, and non-prescription); use of safety belts; sauna and hot tub exposure; vitamin and mineral toxicity; prevention of HIV infection and other STIs; environmental exposure such as second hand smoke and lead; and nausea and vomiting during pregnancy. (ACOG Practice Bulletin, No. 153, September 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 185-198)

I7 Warning signs to terminate exercise while pregnant include: chest pain, vaginal bleeding, dizziness, headache, decreased fetal movement, rupture of membranes, muscle weakness, calf pain or swelling, preterm labor, or regular uterine contractions. (ACOG Committee Opinion, No. 650, December 2015, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 190-191)

I8 Educational programs available (refer to childbirth education classes, which should provide information on labor, pain relief, delivery, breastfeeding, infant care, and postpartum period). (*JOGNN*, No. 44, pp. 145-149, (2015); *Guidelines for Perinatal Care*, 8th ed., pp. 211-217)

I9 Benefits of breastfeeding and risks of not breastfeeding. (Office of the Surgeon General, Centers for Disease Control and Prevention, and Office on Women's Health. (2011). (US DHHS, *The Surgeon's General call to action to support breastfeeding*; DC, MMWR, October 6, 2015, v. 64, #ER-1-6; *JOGNN*, No. 44, 145-149, (2015); ACOG Practice Bulletin, No. 92, April 2008, Reaffirmed 2016; ACOG Committee Opinion, No. 570, August 2013; Committee Opinion, No. 658, February 2016, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp .216-217, 297, 371-380-427)

I10 Dangers of eating certain fish with high levels of mercury, including shark, swordfish, king mackerel and tilefish 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*, 8th ed. pp. 194-195)

I11 Options for intrapartum care.

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

I13 Financial responsibility to the patient for prenatal care and hospitalization (e.g. insurance plan participation, self-pay). (*Guidelines for Perinatal Care*, 8th ed., pp. 150-153)

I14 Safe sleep education for all maternity patients. (*Guidelines for Perinatal Care*, 8th ed., pp. 398-399)

I15 Education on family planning method options. (*Guidelines for Perinatal Care*, 8th ed., pp. 134, 298)

I16 Provide education on umbilical cord blood donation/banking. (https://sites.duke.edu/ccbb/; www.bethmatch.org/cord; ACOG Committee Opinion, No. 648, December 2015; (*Guidelines for Perinatal Care*, 8th ed., pp. 215-216, 233)

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 patients 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, p. 46; *JOGNN*, No. 44, pp. 145-150; ACOG Committee Opinion, No. 570, August 2013, Reaffirmed 2016).

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 2018– May 2019.
2. Increase the percentage of women during the period of June 2018– May 2019 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 2018 – May 2019.

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 **FY 18-19**. 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.

The Open Window Budget Form consists of 3 tabbed sheets in a Microsoft Excel workbook. These sheets are: Contractor Budget worksheet (sheet 1), Salary and Fringe worksheet (sheet 2) and Subcontractor Budget worksheet (sheet 3). Enter information only in yellow, pink or white shaded cells. The blue shaded fields will automatically calculate for you. Information will carry over from sheets 2 and 3 to sheet 1.

Narrative Justification for Expenses
A narrative justification must be included for every expense listed in the FY 18-19 budget. Each justification should show how the amount on the line item budget was calculated, and clearly justify/explain 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. Below are examples of line item descriptions and sample narrative justifications:

Equipment
The maximum that can be expended on an equipment item, without prior approval from the WHB, is $2,000. An equipment item that exceeds $2,000 shall be approved by the WHB before the purchase can be made. If an equipment item shall be used by multiple clinics, you must prorate the cost of that equipment item and the narrative must include a detailed calculation which demonstrates how the agency prorates the equipment.

Justification Example: 1 shredder @ $1,500 each for nursing office staff to shred confidential patient information. Cost divided between 3 clinics. $1500/3 = $500.

Administrative Personnel – Fringe Costs
Provide position title, staff FTE, brief description of the positions, and method of calculating each fringe benefit that shall be funded by this Agreement Addenda. A description can be used for multiple staff if the duties being performed are similar. Do not prorate the salary and fringe amounts. The spreadsheet will prorate these amounts based on the number of months and percent of time worked.

Justification Example: P. Johnson/J. Scott, PHN III, 2.0 FTE – work as registered nurses in the Maternal Health Clinic. They take histories, make assessments, review labs, and administer medication to patients who present themselves for prenatal care. M. Apple and S. Hat, Community Health Assistants, .75 FTE – work as nursing assistants in the Maternal Health Clinic. They check vital signs of patients presenting themselves for prenatal care and chaperone medical providers. In addition to stocking and cleaning the exam rooms.

Attachment A (continued)

Incentives
Incentives may be provided to program participants 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. Examples of incentive items include: gift cards, diaper bags, diapers, baby wipes, parent's night.

Justification Example: Diaper bags for 10 participants @ $20/bag = $200.

Travel
Mileage and subsistence rates are determined by the North Carolina Office of State Budget and Management (OSBM). The LHD can calculate travel and subsistence rates equal to or below the current state rates. Effective January 1, 2017, the business standard mileage rate is 53.5 cents per mile and the subsistence rates (effective July 1, 2017) are as follows:

	In-State	Out-of-State
Breakfast	$ 8.40	$ 8.40
Lunch	$ 11.00	$ 11.00
Dinner	$ 18.90	$ 21.60
Lodging (actual, up to)	$ 71.20	$ 84.10
Total	$ 109.50	$ 125.10

Justification Example: Overnight accommodations for Maternal Health Nurse Supervisor and 1 PHN II to attend XYZ Training: 2 nights' x $71.20 (excludes tax) = $142.40; 2 staff's meals x $76.60 = $153.20 [(2 breakfast @ $8.40/person) + (2 lunches @ $11.00/person) + (2 dinners @ $18.90/person)]. Total cost is $142.40 lodging + $153.20 meals = $295.60

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	

CPT Code*/ Modifier	**Service Type**	**Estimated # of services**
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 Partial Dose, 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.	