

# Maternal Health Agreement Addenda (MH AA) Changes from 09-10 to 10-11

INSTRUCTIONS: New changes are in **bold**.

<u>09/10</u>	<u>Changes for 10/11</u>
<p>Re: Clinical (Change #1)</p> <p>II. The purpose of this agreement addendum is to assure that local health departments will provide and/or assure pregnant women in NC access to early and continuous prenatal care. Prenatal care services include outreach, case management, nutrition counseling, and psychosocial assessment and intervention counseling. In addition, local health departments work to enhance public education and community awareness regarding risk prevention and reduction strategies.</p>	<p>(Change #1)</p> <p>II. The purpose of this agreement addendum is to assure that local health departments will provide and/or assure pregnant women in NC access to early and continuous prenatal <b>and postpartum care</b>. Prenatal care services <b>also includes</b> outreach, case management, nutrition counseling, and psychosocial assessment and intervention counseling. In addition, local health departments work to enhance public education and community awareness regarding risk prevention and reduction strategies.</p>
<p>Re: Clinical (Change #2)</p> <p>III. Throughout this document, the following words are defined as follows: “shall” indicates a mandatory program policy; “should” indicates a recommended program policy; and “can” or “may” indicates a suggestion or consideration.</p>	<p>(Change #2)</p> <p>No change, just moved up, and service deliverables was boxed in.</p>
<p>Re: Clinical (Change #3)</p> <p>Did not have the added change</p>	<p>(Change #3)</p> <p>III. A. The local Health Department shall:  A. Demonstrate compliance with the NC Administrative Rules 10A NCAC 46.0205(a) and Title V’s Maternal and Child Health Block Grant funds for the provision of Maternal Health Services.</p> <p><i>NC Administrative Rules (10A NCAC 46.0205) require assurances for the provision of selected maternal health services. Each local health department must “provide, contract for the provision of, or certify the availability of maternal health services for all individuals within the jurisdiction of the local health department.” In addition, agencies supported by state Title V Maternal and Child Health Block Grant funds are required to provide access to maternal services and referral for primary care services as appropriate.</i></p>

	<p>If the Health Department is not providing routine periodic prenatal care as evidenced in Health Services Information System/Health Information System (HSIS/HIS) data and program review audit, <u>but is instead assuring these services</u>, the agency shall submit the following documents. Please refer to “Guidance for Local Health Department Assurance of Maternal Health Services.” (<a href="http://whb.ncpublichealth.com/">http://whb.ncpublichealth.com/</a>)</p> <ol style="list-style-type: none"> <li>1. A statement by the Health Director describing how the Health Department assures routine periodic pregnancy care as defined in 10A NCAC 46; and</li> <li>2. A Memorandum of Understanding (MOU) with local health care provider(s) documenting how these services are provided. Visit the following website for MOU samples: <a href="http://whb.ncpublichealth.com/provPart/agreementAddenda.htm">http://whb.ncpublichealth.com/provPart/agreementAddenda.htm</a>.</li> </ol>
<p><a href="#">Re: Clinical (Change #4)</a>        III. Health departments who do not provide prenatal care must submit an assurance plan that clearly outlines how women who reside in their respective county(s) shall receive prenatal care services. This plan must be included with the signed Maternal Health Agreement Addenda and will be reviewed by WHB staff.</p>	<p><a href="#">(Change #4)</a>        Paragraph deleted and replaced with above protocol</p>
<p><a href="#">Re: Clinical (Change #5)</a>        III. All Health Departments shall ensure the following (1-9), whether they provide Prenatal Care or not</p>	<p><a href="#">(Change #5)</a>        III. All Health Departments shall ensure the following (1-8), whether they provide prenatal care or not</p> <p>Items #6 and #7 were merged into #6, which revised the numbering in this section.</p>
<p><a href="#">Re: Clinical (Change #6)</a>        8. (d) Identification, follow-up and referral as indicated for pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs.) (ACOG, p. 96-97) Policies must include confidentiality and release of information/medical records. (<i>Women’s Health Resource Manual, Vol. One, Section 2-A, 5/2001 or Responding to Prenatal Substance Use-A Guide for Local Health Departments, 6/2000</i>)</p>	<p><a href="#">(Change #6)</a>        8. (d) Identification, follow-up and referral as indicated for pregnant women who have a past or current substance use issue (including alcohol, nicotine, and other drugs.) <b>Informed consents shall be obtained before performing a drug screen test.</b> (ACOG, p. 96-97) Policies must include confidentiality and release of information/medical records. (<i>Women’s Health Resource Manual, Vol. One, Section 2-A, 5/2001 or Responding to Prenatal Substance Use-A Guide for Local Health Departments, 6/2000</i>)</p>

<p><b>Re: Clinical (Change #7)</b>  9. (a) After informed consent for prenatal services is signed (<i>ACOG, Committee Opinion, No. 237, June 2000: ACOG Today, Nov/Dec 2004, p.6</i>), the following health history components at the initial prenatal visit shall be assessed: medical; family; surgical; neurologic; immunity and immunization (TD, Rubella, Hepatitis B, Varicella); substance use, including alcohol, tobacco, and illicit drugs; current medications (prescription and non-prescription); menstrual; contraceptive; infection; gynecologic and obstetrical; psychosocial; nutrition; genetic history (both maternal and paternal including cystic fibrosis); domestic abuse and violence; risk factors for STDs; assessment of socioeconomic, educational, and cultural context; and environmental exposures, including environmental tobacco smoke (ETS). (<i>ACOG, p. 4, 83-85, 371-372</i>)</p>	<p><b>(Change #7)</b>  9 (a) After informed consent for prenatal services is signed (<i>ACOG, Committee Opinion, No. 237, June 2000: ACOG Today, Nov/Dec 2004, p.6</i>), the following health history components at the initial prenatal visit shall be assessed: medical; family; surgical; neurologic; immunity and immunization (TD, Rubella, Hepatitis B, Varicella); substance use, including alcohol, tobacco, and illicit drugs; current medications (prescription and non-prescription); menstrual; contraceptive; infection; gynecologic and obstetrical; psychosocial; nutrition; genetic history (both maternal and paternal including cystic fibrosis); domestic abuse and violence; risk factors for STDs; assessment of socioeconomic, educational, and cultural context; and environmental exposures, including environmental tobacco smoke (ETS) <b>and lead</b>. (<i>ACOG, p. 4, 83-85, 371-372</i>)</p>
<p><b>Re: Clinical (Change #8)</b>  9. (c) Weight and height for all pregnant women shall be documented at the initial prenatal visit (<i>ACOG News Release, August 31, 2005; ACOG, p.89</i>) and <u>weight plotted on prenatal weight gain chart</u> at routine visits. Nutrition consultation should be offered to all obese women; pre-pregnancy BMI<math>\geq</math> 30. (<i>ACOG, p.89; 191-192</i>) This may be accomplished, for example, by a referral to WIC.</p>	<p><b>(Change #8)</b>  9. (c) Weight and height for all pregnant women shall be documented at the initial prenatal visit (<i>ACOG News Release, August 31, 2005; ACOG, p.89</i>) and at routine visits. Nutrition consultation should be offered to all obese women; pre-pregnancy BMI<math>\geq</math> 30. (<i>ACOG, p.89; 191-192</i>) This may be accomplished, for example, by a referral to WIC.   Change: Information underlined in previous AA was deleted.</p>
<p><b>Re: Clinical (Change #9)</b>  9. (d) Pre-pregnancy weight shall be determined and body mass index (BMI) calculated to identify gestational weight gain recommendations as per the Institute of Medicine guidelines. (<i>ACOG, p.90; 191-192</i>) For obesity class III patients (BMI 40+), gaining less than the minimum weight gain recommendation may be appropriate. (<i>ACOG, p. 89-93; 191-192</i>)</p>	<p><b>(Change #9)</b>  9. (d) Pre-pregnancy weight shall be determined and body mass index (BMI) calculated to identify gestational weight gain recommendations as per the Institute of Medicine guidelines. (<a href="http://www.iom.edu/Object.File/Master/68/230/report%20brief%20-%20Weight%20Gain%20During%20Pregnancy.pdf">http://www.iom.edu/Object.File/Master/68/230/report%20brief%20-%20Weight%20Gain%20During%20Pregnancy.pdf</a>) (<i>ACOG, p.90; 191-192</i>)</p>

<p><b>Re: Clinical (Change #10)</b></p> <p>9. (e) The following components on all subsequent routine scheduled visits shall be assessed: interim history/routine screening questions (fetal movement, contractions, leakage of fluid, vaginal bleeding); weight; blood pressure; fetal heart rate; fundal height (after 14 weeks); and fetal presentation greater than or equal to 36 weeks. (ACOG, p. 100, 373)</p>	<p><b>(Change #10)</b></p> <p>9.(e) The following components on all subsequent routine scheduled visits shall be assessed: interim history/routine screening questions (fetal movement, contractions, <b>ruptured membranes</b>, vaginal bleeding); weight; blood pressure; fetal heart rate; fundal height; and fetal presentation greater than or equal to 36 weeks. (ACOG, p. 100, 373)</p>
<p><b>Re: Clinical (Change #11)</b></p> <p>9. (f) Nutrition screening shall be performed by a nurse, nutritionist, physician or physician extender at first visit. Based on this screening, an appropriate care plan or referral to a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)* will be documented by the initial exam. (ACOG, p. 89-93) *(Licensed by the North Carolina Board of Dietetics)</p>	<p><b>(Change #11)</b></p> <p>9. (f) Nutrition screening shall be performed <b>or reviewed</b> by a nurse, nutritionist, physician or physician extender at the first visit <b>and updated at subsequent visits as needed</b>. Based on this screening, an appropriate care plan or referral to a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)* will be documented. (ACOG, p. 89-93) *(Licensed by the North Carolina Board of Dietetics)</p>
<p><b>Re: Clinical (Change #12)</b></p> <p>9. (f) MNT Info Only:  When Medical Nutrition Therapy is provided, nutrition counseling (assessment and management) shall be performed as per DMA guidelines, by a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN)*. *Licensed by the North Carolina Board of Dietetics/Nutrition (<i>Medical Nutrition Therapy (MNT)</i>). (<i>DMA Clinical Coverage Policy No. 1-I January 2008</i>). Nutrition counseling, or a referral, is provided for patients with any high risk condition listed below. (<i>Medical Nutrition Therapy (MNT) as per DMA Clinical Coverage Policy No. 1-I January 2008</i>). A nutrition care plan and appropriate follow-up is documented for each identified nutrition problem.  MNT Info Only:  (1) Conditions which impact on length of gestation or birth weight where nutrition is the underlying cause such as severe anemia (Hgb&lt;10gm/dl or Hct &lt;30%);  underweight preconceptionally (&lt;19.8 BMI) complicated</p>	<p><b>(Change #12)</b></p> <p>MNT info removed</p>

<p>by inadequate weight gain during pregnancy, and intrauterine growth restriction, very young maternal age (under the age of 16), multiple gestation, substance use.</p> <p>(2) Metabolic disorders such as diabetes, thyroid</p> <p>(3) dysfunction, maternal PKU or other inborn errors of metabolism.</p> <p>(4) Chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes or renal disease.</p> <p>(5) Autoimmune diseases of nutritional significance such as systemic lupus erythematosus.</p> <p>(6) Eating disorders such a severe pica, anorexia nervosa or bulimia nervosa.</p> <p>(7) Obesity.</p> <p>(8) 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.</p>	
<p><b>Re: Clinical (Change #13)</b></p> <p>9. (h) Psychosocial screening shall be performed by a nurse, social worker, physician, or physician extender at the first visit. Based on this screening, an appropriate care plan or referral to a licensed clinical social worker, other mental health provider, maternity care coordinator or other appropriate resource will be documented by the initial exam. (ACOG, p. 4, 84, 124-125)</p>	<p><b>(Change #13)</b></p> <p>9. (h) Psychosocial screening shall be performed <b>or reviewed</b> by a nurse, social worker, physician, or physician extender at the first visit <b>and is recommended each trimester</b>. Based on this screening, an appropriate care plan or referral to a licensed clinical social worker, other mental health provider, maternity care coordinator or other appropriate resource will be documented by the initial exam. (ACOG, p. 4, 84, 124-125) (ACOG Committee Opinion, August 2006)</p>
<p><b>Re: Clinical (Change #14)</b></p> <p>10. (d) Screening for Gonorrhea on initial visits and repeated in the third trimester if &lt;25 years of age or greater than 25 years old participating in high risk behaviors such as a new partner, multiple partners, little or no prenatal care, recent STD or substance use. (10A NCAC 41A.0204 (e), CDC-MMWR, (August 4, 2006/V. 55/No. RR-14) (ACOG, p. 332-334)</p>	<p><b>(Change #14)</b></p> <p>10. (d) Screening for Gonorrhea on initial visits and repeated in the third trimester if 25 years of age <b>or younger</b> or greater than 25 years <b>of age and</b> participating in high risk behaviors such as a new partner, multiple partners, little or no prenatal care, recent STD or substance use. (10A NCAC 41A.0204 (e), CDC-MMWR, (August 4, 2006/V. 55/No. RR-14) (ACOG, p. 332-334)</p>

<p>10. (e) Screening for Chlamydia on the initial visit and repeated in the third trimester if less than 25 years of age or greater than 25 years old participating in high risk behaviors such as a new partner, multiple partners, little or no prenatal care, recent STD or substance use . (CDC-MMWR; Sexually Transmitted Disease Treatment Guidelines August 4, 2006; 10A NCAC 41A.0204(e); ACOG, p. 101, 332-334)</p>	<p>10. (e) Screening for Chlamydia on the initial visit and repeated in the third trimester if 25 years of age <b>or younger</b> or greater than 25 years <b>of age and</b> participating in high risk behaviors such as a new partner, multiple partners, little or no prenatal care, recent STD or substance use. (CDC-MMWR; Sexually Transmitted Disease Treatment Guidelines August 4, 2006; 10A NCAC 41A.0204(e); ACOG, p. 101, 332-334)</p>
<p><b>Re: Clinical (Change #15)</b> 10. (h) Screening at initial visit for Rubella and Varicella immune status, unless previous vaccinations or laboratory test for disease indicate immunity or disease. This information must be documented in patient’s record. Immunization dates must be completed and verifiable. (ACOG, p. 101, 374)</p>	<p><b>(Change #15)</b> 10. (h) Screening at initial visit for Rubella and Varicella immune status as evidenced by written documentation of age-appropriate vaccination or laboratory evidence of immunity. Patients with no evidence of immunity should have laboratory test for immunity performed. (ACOG, p. 101, 374)</p>
<p><b>Re: Clinical (Change #16)</b> 10. (o) The health department shall offer influenza vaccine to all pregnant women during influenza season as defined by the Immunization Branch and document the date the vaccine was given or refused included in the client chart. (www.cdc.gov/mmwr/preview/mmwrhtml/rr53e430al.htm; ACOG Today, Vol. 48, Issue 6, July 2004; ACIP, Prevention and Control of Influenza, April 2004; Vaccinate Women, Vol. 3 – No. 1, Aug. 2004, pg. 1.; ACOG, p. 103)</p>	<p><b>(Change #16)</b> 10. (o) Offer influenza vaccine to all pregnant women during influenza season (<b>October through May</b>), 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/mmwr/preview/mmwrhtml/rr53e430al.htm; ACOG Today, Vol. 48, Issue 6, July 2004; ACIP, Prevention and Control of Influenza, April 2004; Vaccinate Women, Vol. 3 – No. 1, Aug. 2004, pg. 1.; ACOG, p. 103)</p>
<p><b>Re: Clinical (Change #17)</b> 13. (1<sup>st</sup> bullet) Scope of care provided (including what is expected at the first prenatal visit and anticipated schedule of visits); lab studies that may be performed; options for intrapartum care; office policies; emergency coverage and cost; and expected course of pregnancy</p>	<p><b>(Change #17)</b> 13. (1<sup>st</sup> bullet) Scope of care provided (including what is expected at the first <b>and subsequent prenatal visits including</b> anticipated schedule of visits); lab studies that may be performed; office policies; emergency coverage and cost; and expected course of pregnancy</p>

<p><b>Re: Clinical (Change #18)</b>  13. (4<sup>th</sup> bullet) Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety* and daily activity; travel; alcohol and tobacco consumption, caution about drugs (illicit, prescription, and non-prescription); use of safety belts; sauna and hot tub exposure; vitamin and mineral toxicity; prevention of HIV infection and other STDs; environmental exposure; and nausea and vomiting during pregnancy. *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 (<i>ACOG, p. 94</i>)</p>	<p><b>(Change #18)</b>  13. (4<sup>th</sup> bullet) 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, <b>such as second hand smoke and lead exposure</b>; and nausea and vomiting during pregnancy. *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. (<i>ACOG, p. 94</i>)</p>
<p><b>Re: Clinical (Change #19)</b>  13. (last bullet) Education on Family Planning</p>	<p><b>(Change #19)</b>  13. (last bullet) Education on Family Planning <b>method options</b></p>
<p><b>Re: Clinical (Change #20)</b>  V. (1<sup>st</sup> paragraph) The Regional Nurse Consultants (RNC) and Regional Social Work Consultants (RSWC) will utilize a team approach for the monitoring process. Efforts will be made to jointly plan pre-monitoring and on-site activities. These activities will include: development of a pre-monitoring plan 4-6 months prior to the designated monitoring month; on site monitoring visits every other year; technical assistance visits via phone or email as needed; review of audit charts; and clinic observations.</p>	<p><b>(Change #20)</b>  V. (1<sup>st</sup> paragraph) The Regional Nurse Consultants (RNC) and Regional Social Work Consultants (RSWC) will utilize a team approach for the monitoring process. Efforts will be made to jointly plan pre-monitoring and on-site activities. These activities will include: development of a pre-monitoring plan 4-6 months prior to the designated monitoring month; on site monitoring visits every other year; technical assistance visits via phone or email, or <b>site visits</b>, as needed; review of audit charts; and clinic observations.</p>