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

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 access to early and continuous prenatal and postpartum care for low-income pregnant women in North Carolina (NC). Prenatal care services include screenings, counseling and referrals for psychosocial and nutrition problems; behavioral health intervention; and Pregnancy Care Management (OBCM). In addition, local health departments will work to enhance public education and community awareness regarding risk prevention and reduction strategies.

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.

III. <u>Scope of Work and Deliverables</u>:

The Activity 101 Maternal Health Agreement Addendum requires further negotiation between the Women's Health Branch (WHB) and the Local Health Department.

For this Agreement Addendum, the Local Health Department shall complete the Non-Medicaid Services table (Attachment B) and the Sudden Infant Death Syndrome Counselors page (Attachment C), and return these with the signed and dated Agreement Addendum. In addition, a detailed budget must be submitted, as described below in Paragraph A, with instructions provided in Attachment A.

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 and the Detailed Budget, 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 101 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 Maternal Health 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 Addendum.

C. **Sudden Infant Death Syndrome** (SIDS) **Counselors** (Attachment C)
   The Local Health Department must submit a completed Attachment C indicating the names of locally trained SIDS counselors. If a county averages <u>less</u> than one SIDS death per year for the last four years, then instead it may designate a grief counselor from a neighboring county or neighboring SIDS counselor if a letter of agreement is obtained and submitted with Attachment C.

D. The Local Health Department shall demonstrate compliance with the NC Administrative Rules 10A NCAC 46.0205(a) and the Title V Maternal and Child Health Block Grant funds for the provision of Maternal Health Services.

   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.

E. The Local Health Department shall demonstrate compliance with the NC Administrative Rules (10A NCAC 43B .0109) on client and third party fees:

   1. If a local provider imposes any charges on clients for maternal and child health 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.

F. The Local Health Department shall ensure the provision of the following, whether they provide prenatal care or not:

   1. Provide pregnancy testing and referral as appropriate.
   2. Ensure ongoing prenatal care to all pregnant women through one or more of the following mechanisms:
      a. Provision of prenatal services (10A NCAC 46.0205 B (i)(ii)(iii))
      b. Referral to other health care providers.

G. If the Local Health Department is not providing routine periodic prenatal care as evidenced in Health Information System (HIS) data and program review audit, <u>but is instead assuring these services</u>, the Local Health Department shall submit at least one of the following documents:

   1. A statement by the Health Director describing how the Local Health Department assures routine periodic pregnancy care as defined in 10A NCAC 46; and/or
   2. A Memorandum of Understanding (MOU) with local health care provider(s) documenting how these services are provided. Visit the following website under Maternal Health Assurance Plan for MOU samples and the "Guidance for Local Health Department Assurance of Maternal Health Services": http://whb.ncpublichealth.com/provPart/agreementAddenda.htm.
   3. The MOU with the assurance provider must contain information that stipulates that patients at or below 100% of the Federal Poverty Level will not be charged for prenatal services by the assurance provider. There should also be a sliding scale fee schedule or other fee schedule included in or attached to the MOU to show how other uninsured patients will be charged for services by the assurance provider. If a health department has a current MOU that they plan to continue in FY 18-19 and it contains all the required information, then they must submit a letter stating that their MOU is still current with a copy of the previously signed MOU.

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

A3 Provide or make referrals for nutrition consultation, education on infant feeding, childbirth and parenting education for low-income families. These referrals must be documented in the Maternal Health record for patients receiving prenatal care. The Local Health Department that provides childbirth education to Medicaid enrollees and billed to Medicaid or provided to non-Medicaid patients as part of their use of Healthy Mothers, Healthy Children funding must provide these services in accordance with the DMA Clinical Coverage Policies. *(DMA Clinical Coverage Policy 1M-2, Childbirth Education)* Childbirth education activities not being billed to Medicaid or funded through Healthy Mothers, Healthy Children funding, such as those supported by funders such as Smart Start, are not subject to these requirements, and may follow the standards agreed upon between the funder and the Local Health Department.

A4 The Local Health Department may provide Maternal Care Skilled Nurse Home Visits (MCSNHV). Patients experiencing high risk condition(s) during the course of care will be referred by the provider. The MCSNHV must be conducted by a Registered Nurse (RN) who is skilled in the care of high risk pregnancy, by providing one-on-one, face-to-face visits conducted in the patient's home. The provider must make the referral in the form of a medical order in the medical record identifying the specific diagnostic coding to the highest level of specificity that support medical necessity. Skilled nursing interventions are reflected in patient plan of care and as indicated per established MCSNHV protocol. (Maternal Care Skilled Nurse Home Visit – DMA Clinical Coverage Policy No: 1M-6, Amended October 2015)

A5 Provide or assure the provision of Pregnancy Care Management (OBCM) services to Medicaid eligible patients, in accordance with OBCM program requirements. Risk criteria include, but are not limited to the following: history of preterm birth (<37 weeks); history of low birth weight (<2500g); multiple gestation; fetal complications; chronic conditions which may complicate pregnancy (e.g., diabetes, hypertension, asthma, mental illness, HIV, seizure disorder, renal disease, systemic lupus erythematosus); unsafe living environment (e.g., homelessness, inadequate housing, family violence, sexual abuse/coercion); substance use; tobacco or electronic nicotine device use; unanticipated hospital utilization; provider request for care management. A Maternal Infant Impactability Score (0-1000) is assigned to each patient based on their risk criteria, pregnancy assessment information and claims data which is used to prioritize patients for services. Patients with scores of 200 – 1,000 are the priority population for OBCM services. Pregnancy Care Management services may also be provided to Medicaid patients outside of the priority population provided the Local Health Department is fully capable of meeting the care management needs of the priority patient population. NC Division of Medical Assistance Pregnancy Medical Home Clinical Policy 1E-6, January 2016 (https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E6_1.pdf)

A6 Maintain a breastfeeding-friendly clinic environment (US DHHS. *The Surgeon General's 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 a patient's confidence in the ability to breastfeed.

B. Quality Assurance

B1 Conduct annual quality assurance review of policies and procedures being implemented.

B2 Report interruption of services or inability to meet quality assurance deliverables within 14 days to the WHB Regional Nurse Consultant.

B3 Use interpreter services for all maternal health programs when appropriate.

B4 Demonstrate excellence in customer friendly services as evidenced by annual patient satisfaction surveys.

B5 All staff, clinical and non-clinical, shall participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity.

B6 Provide care by Advanced Practice Practitioners and/or Enhanced Role Registered Nurses as appropriate.

B7 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, July 2014, pp. 1-9, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp.48-49)

C. Policies/Procedures

Develop and follow policies or procedures for the following:

C1 Follow-up of positive pregnancy test to assure patient has access to health care provider.

C2 For health departments that provide prenatal care services and have a three-week or greater waiting list, the patients must be triaged to determine the presence of any adverse pregnancy risk factors for purposes of scheduling their first appointment. Adverse pregnancy risk factors must be included in this policy.

C3 Referral to Women, Infants and Children (WIC) upon confirmed results of a positive pregnancy test. (Federal WIC Regulations, 246.4)

C4 Completion of presumptive eligibility determination at the first prenatal appointment and referral for Medicaid eligibility determination for all pregnant patients, not just those who will remain in the Local Health Department for prenatal care services.

C5 Completion of the Community Care of North Carolina (CCNC) Pregnancy Medical Home Risk Screening Form and referral to Pregnancy Care Management program as indicated. Risk Screening Forms should be completed on Medicaid, Medicaid eligible or presumptively-eligible Medicaid patients only.

C6 A description of the target population for maternal health services provided by the Local Health Department, including eligibility criteria. The Local Health Department shall emphasize provision of maternal health services to individuals who would not otherwise have access to these services.

C7 A description of fees for maternal health services provided by the Local Health Department.

C8 Provision of community and patient maternal health education services within the jurisdiction of the Local Health Department. Education services shall promote healthy lifestyles for good pregnancy outcome. (10A NCAC 46.0205(3)(b))

C9 Follow-up of missed prenatal appointments.

C10 Referral of pregnant patients who express interest in permanent sterilization or contraception. (ACOG Committee Opinion, No. 695, April 2017; *Guidelines for Perinatal Care,* 8th ed., pp. 291-292)

C11 Use of 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. (*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)

C12 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 of Perinatal Care*, 8th ed., pp. 136-137, 176-182)

C13 Referral, due to a positive Hepatitis B and/or HIV result for patient or neonate and appropriate follow-up for neonate after birth. (10A NCAC 41A.0203 (d)(1); *Guidelines for Perinatal Care*, 8th ed., pp. 486-498, 503-510)

C14 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)

C15 Collaboration with local obstetricians, emergency physicians, advanced practice practitioners, hospital/tertiary care center staff is required to formulate a community-wide accepted policy between the Local Health Department and the physicians who will provide care for pregnant patients exposed to varicella with no immunity. (*Guidelines for Perinatal Care*, 8th ed., pp. 521-524)

C16 Referral to a high-risk maternity clinic or provider for identified high-risk conditions. (ACOG Practice Bulletin, No. 92, April 2008, Reaffirmed 2016; Practice Bulletin, No. 90, February 2008, Reaffirmed 2016; *Guidelines for Perinatal Care*, 8th ed., pp. 139, 175-176, 301-346)

C17 Provide or refer for Rubella and/or Varicella vaccine postpartum if patient not immune. (*Guidelines for Perinatal Care*, 8th ed., pp. 283, 519-524)

C18 Use of 17 α-Hydroxyprogesterone Caproate (17P) for patients at risk for developing preterm labor as defined by a history of a prior spontaneous birth at less than 37 weeks gestation. (*Guidelines for Perinatal Care*, 8th ed., pp. 152, 338-340)

C19 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 mother and infant. Collaboration with providers and pediatricians, local hospital/tertiary care center staff is required to develop a policy. All prenatal clinics providing prenatal care through 35-37 weeks are required to have this 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)

C20 Complete the Edinburgh or PHQ9 validated screening tool, facilitate referral (if appropriate) and subsequent follow-up of patients who have a current diagnosis, symptomatic or have history of depression. (*JOGNN*, No. 44, 687-689, (2015); ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; *Guidelines for Perinatal Care,* 8th ed., pp. 183, 294-298)

C21 All standing orders or protocols developed for nurses in support of this program must be written in the NC 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 components at the initial prenatal appointment:

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 all illegal drugs);
f. Current medication list (prescription, non-prescription, and herbal supplements/remedies);
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. 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

(*Guidelines for Perinatal Care*, 8th ed., pp. 151-153, 581-589):

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;
r. 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 Complete the 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.

D5 Provide the 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine devices for all patients. Facilitate referral to QuitlineNC (1-877-QUIT-NOW) or a 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 503, September 2011, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 178-179)

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)

<u>Postpartum Clinic Appointment:</u>

D8 Provide the 5As counseling approach for tobacco cessation and electronic nicotine devices for all postpartum patients. Facilitate referral to QuitlineNC (1-877-QUIT-NOW) or a community resource. (*JOGNN*, No. 46, pp. 794-796, (2017); ACOG Committee Opinion, No. 503, September 2011, Reaffirmed 2017; Committee Opinion No 721, October 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 178-179)

D9 Follow-up and document:

a. Missed appointments
b. Postpartum follow-up for diagnosed high risk conditions. Documentation will indicate that the care was 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 validated 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 medications.

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; Healthy 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 and 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 on the initial appointment, unless known to be infected, and follow-up of an infant born to an infected patient to assure neonate receives prophylactic treatment. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 125-129; 10A NCAC 41A.0203 (d)(1); *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 tests (i.e., opt-out screening G.S. 130A-148(h)). Documentation of refusal must be in the patient's medical record. (CDC MMWR, June 5, 2015/Vol. 64, No. 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 at the 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 recent STI 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 recent STI 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. 632, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 532-534)

E6 Genetic serum screening (referral or offered), prior to 20 weeks of gestation, to patients who give informed consent for the test. Patients who refuse 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. (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, and antibody screening at the initial appointment. RhD-negative patients who have a positive antibody screening should be evaluated with an antibody titer. 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 with no 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 ACOG Cervical Cytology Guidelines). (ACOG, Practice Bulletin, No. 168, October 2016, Interim Update; *Guideline 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 second trimester (as indicated), and in 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.ndei.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 refused 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. 78, January 2007, Reaffirmed 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 139-141, 166-175)

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. Refer for Nonstress Test (NST) if indicated

(*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 being managed for abnormal findings
b. Consultation with specialist as 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 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 6 days gestation.
b. History of "late preterm" singleton, defined as 34 weeks 0 days and 36 weeks 6 days gestation.
c. Have a current singleton pregnancy.

Following are guidelines regarding the initiation of 17P:

d. Initiate treatment between 16 weeks 0 days and 21 weeks 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; 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, No. #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 declined in the patient chart. (ACOG Committee Opinion No. 718, September 2017; *Guidelines for Perinatal Care,* 8th ed., pp. 164-166, 283, 511-514)

F4 Recommend 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

Gestational Weight Management:

G1 Record weight and height for all patients at the initial prenatal appointment. (*Guidelines for Perinatal Care*, 8th ed., pp. 153, 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 during the routine appointment. 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 $\geq$ 30) and/or patients gaining outside of their prescribed weight gain range. This may be accomplished by a referral to WIC. (*Guidelines for Perinatal Care*, 8th ed., pp. 185-190)

Nutrition Screening and Referral:

G5 Nutrition screening shall be performed or reviewed by a nurse, nutritionist, physician or advanced practice practitioner at the first appointment and updated at subsequent appointments as needed. Based on this screening, an appropriate care plan or referral to a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN) will be documented. The LDN should be licensed by the NC State Board of Dietetics. (*Guidelines for Perinatal Care*, 8th ed., pp. 6-8)

G6 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 visits after the initial prescription is given and refilled. (*Guideline for Perinatal Care*, 8th ed., pp. 185-188)

G7 Refer to WIC at initial appointment, if not already enrolled.

H. Psychosocial Services

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 visit. This should include screening, counseling and/or referring as indicated for pregnant and postpartum patients who are experiencing

depression. A validated tool, such as Edinburgh or PHQ9, for depression screening during pregnancy should be used each trimester, as indicated, and at the postpartum visit. (*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.

H3 Screen, counsel and/or refer 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 appointment, each trimester and postpartum. (*JOGNN*, No. 44, pp. 405-406, (2015); ACOG Committee Opinion, No. 518, February 2012; *Guidelines for Perinatal Care*, 8th ed., pp. 183-185)

H4 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 individual risk conditions. (*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 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 prenatal 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, 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*; CDC, 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 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.bethematch.org/cord; ACOG Committee Opinion, No. 648, December 2015; (*Guidelines for Perinatal Care*, 8th ed., pp. 215-216, 233)

J. Staff Requirements and Training

J1 At least one staff person (or subcontractor's staff person) shall attend the required Women's Health Branch Sudden Infant Death Syndrome (SIDS) Basic Training (one-time for new SIDS Counselors), annual or online update (http://www.nichd.nih.gov/SIDS/Pages/sidsnursesce.aspx) annually, and provide appropriate grief counseling for bereaved families in the county. Each county or district is also required to have a backup SIDS Counselor for their primary Counselor. This backup Counselor does not have to reside in the county, but should be available in cases when the primary Counselor is unavailable to provide services for prolonged periods of time.

J2 The Maternity Nurse Supervisor, Pregnancy Care Managers and Supervisors, Health and Behavior Intervention Supervisor, Clinical Social Workers and SIDS Counselors shall have active electronic mail membership and direct access to the Internet. HMHC funds can be used to finance and maintain hardware, software and subscription linkage to current local market values. The Internet connection enables participation in Women's Health Branch list serves,

use of the CCNC Case Management Information System (CMIS) and Informatics Center (IC), access to other technical resources and to maternal health materials.

J3 Maternal Health Nurse Training
Certain low-risk patients may receive designated services from public health nurses who have received special Maternal Health Enhanced Role Nurse Training. In health departments that have enhanced role screeners, a roster will be maintained and kept up-to-date. The roster shall include date of completion of the enhanced role nurse (ERN) training, number of patient contact hours (combination of time spent as a nurse interviewer and highest level care provider), and accrued educational contact hours. Enhanced role nurses must fulfill all requirements by June 30th each year or they will lose enhanced role status due to elimination of program. There is no re-rostering component available.

J4 The yearly completion of 100 clinical hours and the annual completion of 10 educational contact hours verification for the fiscal year corresponding to this Agreement Addendum (June 1, 2018 through May 31, 2019) shall be maintained and updated at the Local Health Department. This information must be submitted by August 15th of each year to the Women's Health Branch, through completion of the WHB ERN Survey. A link to the survey will be sent via email to the ERN as well as the Director of Nursing of the Local Health Department. The Local Health Department should advise the WHB of any ERNs who have either retired or are no longer functioning as an ERN and they will be removed from the current roster and will not be required to complete the survey.

J5 Pregnancy Care Manager (OBCM) Staffing and Training

a. Any changes in Pregnancy Care Manager or Pregnancy Care Management supervisor positions shall be electronically submitted to http://childrenyouth.staffing.sgizmo.com/s3/ as soon as possible but no later than 14 days after the staff change including hiring new staff, position vacancy, position elimination, or other staff change. Additionally, the WHB Regional Social Work Consultant shall be notified of new staff as soon as possible but no later than 14 days after hire date.
b. In the event of a staff vacancy or an extended absence, the OBCM and CC4C Contingency Plan for Staff Absence or Vacancy Form found in the Pregnancy Care Management Program Manual must be completed and submitted as outlined in the form instructions. LHDs shall maintain a contingency plan for any extended staff absence or vacancy to ensure that patients can access care management services in a timely manner and that there are no interruptions in service delivery. An extended staff absence is defined as longer than two weeks.
c. Interruption of services or inability to meet quality assurance deliverables must be reported as soon as possible (no later than 14 days) to the WHB Regional Social Work Consultant.
d. All social workers hired as Pregnancy Care Managers after September 1, 2011 must have a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW or MS in SW) from a Council on Social Work Education accredited social work degree program per the Pregnancy Care Management Services Agreement. Nurses that are hired to fill the positions must be a Registered Nurse (RN). [Note: non-degreed social workers cannot provide OBCM care management, even if they qualify as a Social Worker under the Office of State Personnel guidelines.]
e. All new Pregnancy Care Managers are required to complete the Pregnancy Care Management orientation as outlined in the Pregnancy Care Management Orientation

Timeline located in the North Carolina Community Care Networks (NCCCN) Informatics Center, adhering to the specified timeframes in the document.

J6 Clinical Social Work Staffing and Training

a. Written notification about staff changes shall be submitted to the WHB Clinical Social Work Consultant within 14 days of staff change including hiring new staff, position vacancy, position elimination, or other staff change.

b. All new Licensed Clinical Social Workers without previous public health experience are required to complete within two months of hire date, the *Introduction to Public Health in North Carolina* online course, https://nciph.sph.unc.edu/tws/intro_ph_nc/. Additionally, the WHB Clinical Social Work Consultant shall be notified of course completion within 14 days of course completion.

J7 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, pp. 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 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.
4. Increase the percentage of Medicaid enrolled pregnant women who receive prenatal WIC services during the period of June 2018 – May 2019.
5. Increase the percentage of infants enrolled in WIC who breastfed at 6 weeks during the period of June 2018– May 2019.
6. Increase the percentage of Medicaid enrolled pregnant women who deliver and receive a postpartum home visit during the period of June 2018 – May 2019.

B. Reporting Requirements: The Local Health Department shall 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 Regional Nurse Consultants (RNC), the Regional Social Work Consultants (RSWC) and the WHB Clinical Social Work Consultant conduct performance monitoring and quality assurance activities.

1. The RNCs will conduct activities for maternal health services. These activities include: development of a pre-monitoring plan 4 to 6 months prior to the designated monitoring month; on-site monitoring visits every 3 years; and technical assistance via phone or email, or site visits, as needed. On-site monitoring visits include a review of policies and procedures, review of patient records, and billing and coding assessments. A pre-monitoring visit is optional.
2. The RSWCs conduct performance monitoring and quality assurance activities for Pregnancy Care Management services, in collaboration with the North Carolina Community Care Networks (NCCCN) and the local CCNC networks. These activities include: oversight of performance through the review of county and network level reports generated from administrative and care management (CMIS) data, chart reviews, and site visits for performance review.
3. The WHB Clinical Social Work Consultant will provide on-site monitoring for health departments that provide Health and Behavior Intervention services every 3 years, in addition to technical assistance via phone, e-mail or site visits. Health and Behavior Intervention services provide intensive, focused counseling for pregnant and postpartum women who have serious psychosocial needs. Licensed clinical social workers employed by health departments may bill Medicaid for providing these services to Medicaid recipients.
4. 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.
5. Additionally, WHB will review data outcomes including a focus on health disparities and inform the health director of unique or adverse trends. Site visits will be conducted to assist in a local assessment and planning process.

B. Consequences:

If a corrective action plan (CAP) is required, the Local Health Department must prepare and submit it within 30 days after the follow-up report is emailed to the Health Director by the DPH Program contact. If a CAP has not been received within 30 days of the written report, then the Local Health Department does not have monitoring closure. If the monitoring is not closed within 90 days, the agency will be placed on high risk status which will require annual monitoring of that 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 a 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, 0.75 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.

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. 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, 2019 will provide the documentation to substantiate services that the Local Health Department has provided for this FY19 Agreement Addendum.

Unduplicated number of Non-Medicaid patients to be served in the Maternal Health 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 and material evaluation, includes interpretation	
76805	Ultrasound 14 weeks 0 days, single or first gestation, fetal & maternal evaluation, includes interpretation	
S9442	Childbirth Education Classes/One Unit = 1 Hour	
J2790	RG, IG Full Dose, IM	
J2788	RG, IG Partial, IM	
99501	Home Visit for Postnatal Assessment	
96152	Health & Behavior Intervention (one unit = 15 minutes)	

CPT Code/Modifier	Service Type	Estimated # of Services
90396	Varicella Zoster Immune Globulin, human, 125 units	
81025	Pregnancy Test	
97802	Medical Nutrition Therapy (MNT), Initial, each 15 min.	
97803	MNT, Reassessment, each 15 min.	
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	
Q9986	Hydroxyprogesterone Caproate, 1 mg injection (Makena)	
Q9985	17P/one unit-includes invoice & rebateable NDC number NOT LISTED	
85013	Hematocrit	
85018	Hemoglobin	
81000	Urinalysis, Non-Auto w/scope	
81001	Urinalysis, Auto w/scope	
81002	Urinalysis, Non-Auto w/o scope	
81003	Urinalysis, 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 or RhoGam– cannot bill with 99211	
83655	Lead Test	

Attachment C

Sudden Infant Death Syndrome Counselors

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

Name of Trained SIDS Counselor	County	Agency	Email Address

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

**The local SIDS counselor, Chief Medical Examiner's Office, Local Medical Examiner, Regional Pathologist or other appropriate source will notify the SIDS Central Office about the SIDS events. (NC Sudden Infant Death Syndrome, March 2010, II-6.) SIDS Counselors "will mail the completed SIDS Home Visit/Contact (DHHS 3723) to the Central Office." (NC Sudden Infant Death Syndrome, March 2010, II-7.)