Division of Public Health
Agreement Addendum
FY 23-24

	Women, Infant and Community Wellness Section / Maternal Health Branch
Local Health Department Legal Name	**DPH Section / Branch Name**
	Tara Owens Shuler, (919) 707-5708 tara.shuler@dhhs.nc.gov
746 High Risk Maternity Clinics **Activity Number and Description**	**DPH Program Contact** (name, phone number, and email)
06/01/2023 – 05/31/2024 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable Agreement Addendum)
07/01/2023 – 06/30/2024 **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 individuals who are low-income, high risk and, pregnant. 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. 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 the reference used throughout this document to aid in setting the standards of care is: (2017) *Guidelines for Perinatal Care*, Eighth Edition, Elk Grove Village, IL: Washington, DC, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. A supplemental resource list to help with guidelines, implementation, and management of the requirements outlined in this activity can be found on the Women, Infant and Community Wellness Section (WICWS) website with the current year Agreement Addendum.

Health Director Signature (use blue ink or verifiable digital signature) _____ Date _____

LHD to complete:
[For DPH to contact in case follow-up information is needed.]
LHD program contact name: _____
Phone and email address: _____

The High Risk Agreement Addendum is a multi-disciplinary document that should be thoroughly read by each member of the multi-disciplinary team (i.e., Medical Provider, Board Certified OB, Nurse, Nutritionist, Social Worker, Finance Officer, and Administrator) to understand how discipline-specific care is integrated into prenatal and postpartum care.

II. Purpose:

This Agreement Addendum assures that local health departments provide individuals who are low-income, pregnant, and who have been pregnant identified as medically high risk in North Carolina, access to early and continuous prenatal care. Prenatal care services include management of their high risk medical conditions, screenings for psychosocial and nutrition problems, behavioral health intervention, 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 Maternal Health Branch and the Local Health Department.

The Local Health Department is required to complete the High Risk Maternity Clinic Patients table (Attachment B) and return it with the signed and dated Agreement Addendum. In addition, a detailed budget must be submitted, as described below in Paragraph 1, with instructions provided in Attachment A.

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

1. **Detailed Budget** (Instructions provided in Attachment A)
   A detailed budget must be emailed by April 14, 2023 to Tara.Shuler@dhhs.nc.gov to document how the Local Health Department intends to expend funds awarded for FY24. **The budget must equal funds allocated to the Local Health Department** (Refer to the FY 23-24 Activity 746 Budgetary Estimate, included with this Agreement Addendum, for the total funding allocation). List only activities that are not Medicaid reimbursable. 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).

2. **High Risk Maternity Clinic Patients** (Attachment B)
   The Local Health Department will provide Non-Medicaid Service Deliverables in FY24. On Attachment B, indicate the number of unduplicated Non-Medicaid patients to be served and the estimated total number for all Non-Medicaid clinical services. Local Health Department-Health Service analysis (LHD-HSA) data or compatible reporting system as of August 31, 2024 will provide the documentation to substantiate services that the Local Health Department has provided for this FY24 Agreement Addendum. Provide the names, specialties, and contact information (telephone, email) for all providers who approve or sign off on maternal health clinic protocols at your facility.

3. **HRMC Budget Requested to be Transferred to Maternity Clinic ACT 101**
   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.

Budget amount <u>from</u> Activity 746 High Risk Maternity Clinics
requested to be transferred <u>to</u> the budget for Activity 101 Maternal Health $ _____

Total additional patients to be served in Activity 101 Maternal Health _____

4. 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.

5. If the Local Health Department subcontracts out its high risk maternity clinic services to another provider, the Local Health Department must provide a letter from the health director with the name and contract information of the subcontractor when returning the signed Agreement Addendum. The letter should describe how the funds are being used to support the Local Health Department's high risk maternity patients.

6. The Local Health Department shall demonstrate compliance on patient and third party fees:
   a. If a local provider imposes any charges on patients for high risk maternity services, such charges:
      1. Will be applied according to a public schedule of charges;
      2. Will not be imposed on low-income individuals or their families;
      3. Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
   b. If patient fees are charged, providers must make reasonable efforts to collect from third party payors.
   c. 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.

7. To be eligible for services provided by a high risk maternity clinic, patient must meet the following:
   a. Financial eligibility requirements, if any, established by the clinic; these requirements shall not be more restrictive than the official Federal Poverty Guidelines; and
   b. Medical eligibility requirements established by the clinic. Any changes in medical eligibility criteria must be approved by the Division of Public Health Women, Infant and Community Wellness Section.
      1. 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.

8. The Local Health Department shall:

A. General Services

A1 Obtain informed consent (receipt of patient signature) for prenatal services.

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 WICWS 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 Local Health Department-Health Service Analysis (LHD-HSA) and/or a compatible data system.

A7 Maintain a breastfeeding-friendly clinic environment. Local agencies that have a WIC clinic on site must follow the established federal standards for breastfeeding promotion and support.

B. Quality Assurance

Provide the following as indicated by policy, procedure, or documentation:

B1 Assure the clinic is operated under the direct, on-site supervision of a board-certified OB/GYN and have an identified perinatologist available for referral.

B2 Augment care with advanced practice practitioners as prescribed by a physician.

B3 If the local health department offers NST services, these services must be provided by an experienced licensed healthcare professional to perform a Non-Stress Test (NST) when indication warrants. These healthcare professionals include: Registered Nurses (RNs), Certified Nurse-Midwives, Nurse Practitioners, Clinical Nurse Specialists, Physicians, and Physician Assistants. Documentation of fetal monitoring training is required every two years for RNs.

B4 Provide comprehensive clinical assessments for all clients by a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Social Worker – Associate (LCSW-A) as indicated by Maternal Health History Forms C1 & C2 in combination with validated screening tools.

B5 Provide nutrition assessments for all clients and counseling as needed by a Registered Dietitian or Licensed Dietitian/ Nutritionist (RD or LDN).

B6 Provide services in accordance with ACOG guidelines on high risk maternity care.

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

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

B9 Demonstrate excellence in customer friendly services as evidenced by annual patient satisfaction surveys.

B10 Have all its staff, clinical and non-clinical, 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.

B11 Have the 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.

B12 Use interpreter services for all high risk programs when appropriate.

C. Policies/Procedures

C1 Develop and follow a policy/procedure/protocol that describes the agency's 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.

C2 Develop and follow a policy/procedure/protocol that describes the agency's system for assuring 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.

C3 Develop and follow a policy/procedure/protocol for mechanisms for patient referral and coordination of services among agencies, hospitals, other providers and written agreements with referring agencies.

C4 Develop and follow a policy/procedure/protocol that lists the high-risk conditions the HRMC accepts on referral and describe the agency's outpatient management of the prenatal conditions served.

C5 Develop and follow a policy/procedure/protocol that describes the agency's 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.

C6 Develop and follow a policy/procedure/protocol that describes the agency's completion of the modified 5Ps validated screening tool, at the initial prenatal visit and at the postpartum visit to identify patients with substance use concerns and refer (if indicated) for subsequent follow-up. If the Pregnancy Risk Screen is completed at the initial prenatal visit, the modified 5Ps screening is included. The modified 5Ps may be repeated at any point during pregnancy at the provider's discretion.

C7 Develop and follow a policy/procedure/protocol for routine use of validated screening tools for substance use disorder among all prenatal patients and for specific circumstances in which urine drug testing will be used and how the information will be used if the agency uses laboratory testing. Signed informed consent for urine drug testing should be obtained from each patient prior to testing. This document should inform patients that the test results will be shared with the delivering hospital, and that refusal of a urine drug screen will not impact their ability to continue receiving prenatal care. Laboratory testing for the presence of drugs is not recommended universally. Routine screening for substance use disorder is accomplished by way of validated questionnaires and a conversation with patients. Routine screening for substance use disorders should be applied equally to all people, regardless of age, sex, race, ethnicity, and socioeconomic status. Routine laboratory testing of biologic samples is not best practice. If risk indicators are identified, the testing process must include assurance of confidentiality and an informed written consent shall be obtained

C8 Develop and follow a policy/procedure/protocol for the identification, follow-up and referral as indicated for pregnant and postpartum patients who are experiencing interpersonal violence.

The minimum standard for identification is the use of the screening questions found on Maternal Health History Forms C1(DHHS form 4158) and C2 (DHHS form 4160). Screening questions should be administered at the first prenatal contact, each trimester and postpartum.

C9 Develop and follow a policy/procedure/protocol for documenting the universal prenatal screening of vaginal/rectal Group B Streptococcal (GBS) colonization of all patients at 36-38 weeks gestation unless already diagnosed with positive GBS bacteriuria. If Group B Strep (GBS) is identified during routine urine culture, repeat screening at 36-38 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]. (ACOG Committee Opinion, No. 797)

C10 Develop and follow a policy/procedure/protocol for assessing prenatal clients for immunity to rubella and varicella and a process for provision or referral for rubella and varicella vaccine during postpartum if patient not immune. Rubella and varicella immunity status must be assessed at the initial prenatal appointment. Patients who have written official documentation of vaccination with 1 dose of live rubella, MMR, or MMRV vaccine at age 1 year or older, or who have laboratory evidence of immunity are considered to be immune to rubella.

Patients who have written official documentation of vaccination with 2 doses of varicella vaccine, initiated at age 1 year or older and separated by at least one month; laboratory evidence of immunity or laboratory confirmation of disease or history of healthcare provider diagnosis of varicella or herpes zoster disease are considered to be immune to varicella. Patients who are not immune to rubella and/or varicella must be referred for or provided appropriate vaccination during the postpartum period. (CDC *Pink Book*, Chapter 20 & 22)

C11 Develop and follow a policy/procedure/protocol for 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 patients without the risk of preterm delivery, 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)

C12 Develop and follow a policy/procedure/protocol for 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.

C13 Develop and follow a policy/procedure/protocol for documenting services for persons receiving continuing care in HRMCs in the client's 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.

C14 Develop and follow a policy/procedure/protocol for completion of a validated depression screening tool: (1) at the initial prenatal visit and as indicated by patient's response to the interval psychosocial screening in the 2nd or 3rd trimester and (2) at postpartum visit. Validated screening tools include the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS). Policy should include which tools are being used, which scores are considered positive, and referral and follow-up processes.

C15 Develop and follow a policy/procedure/protocol for providing the 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine

delivery systems for all patients. Process must include facilitation of a referral to Quitline NC (1-877-QUIT-NOW) or a community resource.

C16 Develop and follow a policy/procedure/protocol for 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.

D. Prenatal and Postpartum Services

Prenatal:

D1 Assess and document the following minimum health history components at the initial prenatal visit. Documentation of additional components should be clearly stated in the medical record:

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 delivery systems, prescription medications and all illegal drugs);
f. Current medications (prescription, non-prescription, and herbal supplements/remedies);
g. Menstrual/last menstrual period;
h. Contraceptive;
i. Infection;
j. Gynecologic and obstetrical;
k. Behavioral health conditions;
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 delivery systems and lead exposure).
r. Estimated date of delivery (EDD)

D2 Assess and document the following minimum physical examination components. Documentation of additional components should be clearly stated in the medical record:

a. Head, ears, nose and throat (HENT);
b. Eyes
c. Teeth
d. Thyroid;
e. Lungs;
f. Breast;
g. Heart;
h. Cervix:
i. Abdomen;
j. Extremities;

k. Skin;
l. Lymph nodes;
m. Pelvis (including uterine size or fundal height);
n. 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.

D3 Assess and document the following minimum components on all subsequent routine scheduled visits. Documentation of additional components should be clearly stated in the medical record:

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;
f. Fetal presentation greater than or equal to 36 weeks by Leopold's Maneuver.
g. Other assessments if indicated (cervix, edema, etc.)

D4 Complete and document the following psychosocial screening:

a. The 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine delivery systems for all pregnant patients.
b. The Pregnancy Risk Screening form or the modified 5Ps validated screening tool at the initial visit to evaluate for substance use and refer for subsequent follow-up if indicated.
c. The Maternal Health History form, Part C-1 (DHHS 4158 or 4159), and either the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS) at the initial prenatal visit.
d. The PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) should be repeated if indicated on the Maternal Health History form, Part C-2 (DHHS 4160) in the 2nd and 3rd trimesters; the PHQ-9 or Edinburgh Postnatal Depression Scale (EDPS) and IPV screening may be repeated at any point during pregnancy at provider's discretion.

D5 Follow-up and document:

a. Missed appointments (re-schedule as indicated)
b. Referrals
c. Patient was referred for postpartum examination

D6 Hospitalize patients when needed in order to treat/monitor their high risk conditions.

D7 Assure delivering hospital is able to provide a level of care appropriate to the patient's high risk condition.

<u>Postpartum Clinic Appointment:</u>

D8 A comprehensive postpartum exam should be done preferably by 6 weeks and no later than 12 weeks after delivery. Complete and document the following, including which clinic the postpartum clinical appointment occurred (Maternal Health or Family Planning):

a. Follow-up for missed postpartum 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.

c. The 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine delivery systems for all postpartum patients.

d. Screen for postpartum depression with either the Edinburgh Postpartum Depression Scale (EPDS) or PHQ-9 validated screening tool.

e. Screen for Interpersonal Violence.

f. Screen for substance use with the modified 5Ps validated screening tool to identify, refer (if indicated) for subsequent follow-up.

g. Postpartum Gestational Diabetes Mellitus (GDM) follow-up testing for all GDM patients defined by ACOG as a 4- to 12-week postpartum Fasting Blood Glucose or 75-g 2hr Oral Glucose Tolerance Test. Appropriate long-term sequela counseling should also be performed.

h. 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.

i. Refer to a primary care provider at the conclusion of obstetrical care as indicated.

E. Laboratory and Other Studies

Provide and document the following:

E1 Syphilis screening must be performed at the following: the initial appointment, between 28-30 weeks, and when symptomatic. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 43-65; 10A NCAC 41A.0204 (d))

E2 Hepatitis B screening at the initial appointment, unless known to be infected. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 43-65; 10A NCAC 41A. 0203 (d)(l))

E3 Hepatitis C screening on all pregnant women during each pregnancy. This testing can be done at the initial obstetrical lab appointment and specimens sent to the State Lab of Public Health. If the patient is already known to have hepatitis C screening is not necessary. The North Carolina State Laboratory of Public Health has authorized no cost hepatitis C testing for all pregnant women aged 18 and older. Pregnant women below the age of 18 can still be tested, however, these specimens will need to be sent to a commercial laboratory. Screening during pregnancy is recommended unless prevalence is <0.1%. Prevalence in <18 years of age is <0.1% in North Carolina at present time. Given the information on prevalence rate for those <18 years of age in the state, agencies will not be held out of compliance of the Agreement Addendum when HCV testing is not performed on those under 18. (North Carolina Communicable Disease Branch Hepatitis B/C Surveillance Report August 2019; CDC MMWR, April 10, 2020, v. 69 No RR-2 pp 1-17)

E4 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 752, Aug. 2018 *Guidelines for Perinatal Care*, 8th ed., pp. 159-161, 502-510)

E5 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))

E6 Chlamydia trachomatis 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 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))

E7 Counseling about fetal genetic and aneuploidy screening tests ideally prior to 20 weeks of gestation. Offer or refer appropriate fetal genetic screening tests to patients who give informed consent for the test. Patients who refuse the test should have this informed refusal documented in the medical record.

E8 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) who may be carrying an RhD-positive fetus must be given Rho(D) immune globulin (RhoGam) to decrease the risk of alloimmunization.

E9 Rubella immunity status assessment at initial appointment. If immunity status cannot be obtained as stated in C10, titers can be drawn.

E10 Varicella immunity status assessment at initial appointment. If immunity status cannot be obtained as stated in C10, titers can be drawn.

E11 Cervical cytology screening for cancer s as indicated according to American Society for Colposcopy. and Cervical Pathology (ASCCP), ACOG and USPSTF guidelines.

E12 A baseline urine dipstick for protein content to assess renal status at the initial appointment and at subsequent appointments as indicated.

E13 Urine culture completed at initial appointment, and at subsequent appointments as indicated.

E14 Group B Strep (GBS) screening at 36-38 weeks if no GBS bacteriuria previously identified in current pregnancy.

E15 Hemoglobin/Hematocrit screening at the initial appointment, in the second trimester (as indicated), and in the third trimester. Patients that meet the criteria for anemia (hematocrit levels <33% and hemoglobin levels <11.0 in the 1st and 3rd trimesters, and hematocrit <32% and hemoglobin <10.7 in the 2nd trimester) should be appropriately managed.

E16 Patients with risk factors for Type 2 diabetes may be screened at the initial visit according to American Diabetes Association and ACOG guidelines. For patients who are not screened at the initial visit, or those who do not meet criteria for gestational diabetes at the initial visit, screen at 24-28 weeks for gestational diabetes in one of the following two options: (1) 50 grams Oral Glucose Challenge test, followed by a 3-hour, 100g Oral Glucose Tolerance Test (OGTT), if indicated; or (2) perform a 75-gram glucose 2 hours OGTT. Patients with abnormal testing results should be referred to the appropriate provider for follow up.

E17 Counseling about patient carrier screening options and testing for patients who give informed consent. Offer or refer for appropriate testing, including hemoglobin electrophoresis, cystic fibrosis and spinal muscular atrophy carrier screening for all patients who have not been previously screened. Screening for other genetic disorders as indicated (e.g., β-thalassemia, α-thalassemia; Tay-Sachs disease, Canavan disease, and familial dysautonomia [Ashkenazi Jews]) based on the patient's racial, ethnic background and family background. Patients who

decline carrier screening or who have previously undergone carrier screening should have this documented in the medical record.

E18 Lead exposure screening using the Lead and Pregnancy Risk Questionnaire (DHHS 4116E, 4116S). Provide lead testing for those who have positive screening results.

E19 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])

E20 Follow-up for abnormal findings:

a. Manage abnormal findings as indicated.
b. Consult with other specialists as indicated.

F. Medical Therapy

Provide and document the following:

F1 Influenza vaccine provided for all pregnant patients during influenza season 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 medical record.

F2 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 medical record.

F3 Recommended use of low-dose aspirin (81 mg) initiated after the 12th week of pregnancy in patients with a high risk of developing preeclampsia per U.S. Preventive Services Task Force Guidelines including those with a history of preeclampsia in prior pregnancy.

F4 Discussion of 17 α-Hydroxyprogesterone caproate (17P) and agreed upon plan of care for patients at very high risk of preterm birth.

F5 SARS-CoV-2 mRNA vaccination should be recommended for all individuals who have not yet been vaccinated and for those eligible for a booster vaccine. The CDC and ACOG recommend that all pregnant and breastfeeding individuals and people thinking about becoming pregnant get vaccinated. Patients should be provided with information about how to access vaccine doses. Document the dates the vaccine was recommended and/or given and/or refused in the medical record. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/pregnancy.html)

G. Nutrition Services

<u>Gestational Weight Management:</u>

G1 Record weight and height for all patients at the initial prenatal appointment.

G2 Determine pre-pregnancy weight and calculate body mass index (BMI). Use BMI to classify patient as underweight, normal weight, overweight or obese and assign the appropriate gestational weight gain range. Educate patient about their recommended gestational weight gain range (patient specific).

G3 Document weight gain or loss at routine appointments and assess weight status as per assigned gestational weight gain range (i.e., document weight gain in accordance with IOM guidelines).

If indicated, document counseling provided to encourage gestational weight gain within the appropriate weight gain range.

G4 Offer and document nutrition consultation to all underweight or obese patients (pre-pregnancy BMI of < 18.5 or ≥ 30). This consultation may be accomplished by a referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) or Women, Infants, and Children (WIC).

Nutrition Screening:

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. Based on this overall nutrition screening, an appropriate nutrition care plan and/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

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 high-risk conditions 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.

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.

G12 Refer all patients categorically eligible for the WIC Program to that program (using appropriate referral platforms) for nutrition education, lactation support, eligible breastfeeding supplies and supplemental foods. Refer all individuals needing other supplemental food/nutrition resources (SNAP; school meals, emergency foods, etc.) to other local resources as appropriate.

H. Psychosocial Services

Psychosocial Screening:

H1 Utilize the Maternal Health History Forms C-1 & C-2 in combination with psychosocial risk screening tools and validated screening tools to identify psychosocial risks as follows:

a. Complete the Maternal Health History form, Part C-1 (DHHS 4158 or 4159), which includes the PHQ-9 or EPDS at the initial prenatal visit.

b. Repeat the PHQ-9 or EPDS if indicated on the Maternal Health History form, Part C-2 (DHHS 4160) in the 2nd or 3rd trimester.

c. Facilitate referral and follow-up of patients, as indicated in the prenatal period.

d. In postpartum, complete the Edinburgh Postnatal Depression Screen (EPDS)or PHQ9 validated screening tool.

e. Facilitate referral and follow-up of patients as indicated in the postpartum period.

H2 Complete the modified 5Ps validated screening tool, evaluate for substance use and refer for subsequent follow-up if indicated.

H3 Refer to a Licensed Clinical Social Worker (LCSW), licensed by the North Carolina Social Work Certification and Licensure Board or an LCSWA, for a comprehensive clinical assessment and care plan in response to any psychosocial risks identified by Maternal Health History Forms C1 & C2 in combination with validated screening tools. Consideration for referral based off significant behavioral health history is also recommended.

Psychosocial Counseling (Assessment and Management):

H4 Provide a comprehensive clinical assessment by a LCSW for any patient referred from H3.

H5 Develop a patient-centered care plan, based on the psychosocial assessment, for each identified psychosocial problem.

H6 Provide counseling services by a LCSW for the identified psychosocial problems and/or refer for outside services. All referrals for outside services should be documented and include the name of the referral and contact information.

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 CMHRP Care Manager, as applicable. If the patient is not engaged with a CMHRP Care Manager, refer patient for services if Medicaid eligible or if the LHD receives grant funding from Division of Public Health (DPH) to provide CMHRP services that are eligible and uninsured.

I. Patient Education

Provide and document the following:

I1 Education specific to high risk condition(s).

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.

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.

I4 Provider coverage for labor and delivery services.

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

I6 Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety and daily activity; travel; alcohol and tobacco consumption or use of electronic nicotine delivery systems, 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.

I7 Warning signs to terminate exercise while pregnant which 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.

I8 Educational programs available (such as childbirth education, which should provide information on labor, pain relief, delivery, infant care, and postpartum period, car seat safety, or breastfeeding).

I9 Benefits of breastfeeding and risks of not breastfeeding.

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.

I11 Planning for discharge and childcare; choosing the newborn's physician.

I12 Financial responsibility to the patient for prenatal care and hospitalization (e.g., insurance plan participation, self-pay).

I13 Safe sleep education for all maternity patients.

I14 Education on family planning method options.

I15 Provide education on postpartum warning signs and symptoms and when to alert provider or to seek care at the nearest emergency department.

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 Lactation Area Training Centers for Health (LATCH). The lead Regional Lactation Trainer for Eastern Area Health Education Center (EAHEC) can help facilitate training needs. Initial training for all maternal health staff is encouraged; on-going training as needed is recommended.

IV. Performance Measures / Reporting Requirements:

1. The Local Health Department shall improve birth outcomes and health status of women during pregnancy by meeting county specific Outcome Objectives. Local Health Department outcomes data will reflect only the services provided and reported in Local Health Department-Health Service Analysis (LHD-HSA). These Outcome Objectives are listed below and the actual county-specific numbers are located in the Agreement Addenda section on the WICWS website at https://whb.ncpublichealth.com/provPart/agreementAddenda.htm.

a. Improve the timeliness of prenatal care received in the high risk clinic, with initiation of care prior to 14 weeks gestation.
b. Increase the number of high risk maternal health patients who receive 7 or more antepartum care visits.
c. Decrease the percentage of high risk maternal health patients who report tobacco use and electronic nicotine delivery systems use.
d. Increase the percentage of maternal health patients who receive 5As counseling for tobacco and electronic nicotine delivery systems cessation.
e. Increase the percentage of high risk maternal health patients who receive a postpartum visit within the first 7-42 days post delivery.

2. Reporting Requirements: The Local Health Department will enter all program service data at least quarterly into the Local Health Department-Health Service Analysis (LHD-HSA) or a compatible reporting system.

V. Performance Monitoring and Quality Assurance:

1. The State Maternal Health Nurse Consultant, WICWS Regional Nurse Consultants, WICWS Nutritionist and Clinical Social Work Consultant will utilize a team approach for the monitoring process. The monitoring activities will include:

   a. the development of a pre-monitoring plan 4-6 months prior to the designated monitoring month
   b. monitoring visits at least every three years
   c. technical assistance via phone, email, or on-site visits, as needed.

   Monitoring visits include a review of audited charts, policies/procedures/protocols, and standing orders, and a billing and coding assessment. A pre-monitoring visit is optional. A written report is completed for any monitoring site visit and is emailed within 30 days after the monitoring site visit to the local Health Director and lead agency staff. If a corrective action plan (CAP) is warranted, it will be included in the monitoring report.

2. 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:

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

   a. 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.

   b. Frequency: Supplements will be generated as the Division of Public Health 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 23-24**. Upon completion, the Open Windows Budget Form must be emailed by April 14, 2023 to Tara.Shuler@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 WICWS website at https://wicws.dph.ncdhhs.gov/provpart/agreement-addenda.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. Refer to the approved budget narrative from FY 22-23 as a reference for completing this FY 23-24 budget narrative.

Narrative Justification for Expenses
A narrative justification must be included for every expense listed in the FY 23-24 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 WICWS website at https://wicws.dph.ncdhhs.gov/provpart/agreement-addenda.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 WICWS is $2,000. An equipment item that exceeds $2,000 shall be approved by the WICWS 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.

Justification Example: FICA at 7.65% of budgeted salary; Retirement at 10% of budgeted salary; Unemployment at 2% of budgeted salary; and Other at 3% (includes life insurance, AD&D and liability insurance) of budgeted salary. Health insurance is $6,000 per individual.

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
The Local Health Department can calculate travel and subsistence rates equal to or below the current state rates.

Current Subsistence Rates— Subsistence rates are determined by NCDHHS. The current rates are posted on the DPH website's "For Local Health Departments" page, https://www.dph.ncdhhs.gov/lhd/index.htm.

For informational purposes, NCDHHS lists the following schedule, effective October 2022:

	In-State	Out-of-State
Breakfast	$ 13	$ 13
Lunch	$ 15	$ 15
Dinner	$ 26	$ 26
Lodging (actual, up to)	$ 98	$ 98
Total	$ 152	$ 152

Justification Example:
Overnight accommodations for Maternal Health Nurse Supervisor and 1 PHN II to attend XYZ Training:
2 nights' lodging x $98 (excludes tax) = $196
2 breakfast x 2 staff @ $13/person = $52
2 lunches x 2 staff @ $15/person = $60
2 dinners x 2 staff @ $26/person = $104
Total cost: $196 lodging + $216 meals = $412

Current Mileage Rate—For informational purposes, the OSBM lists the standard mileage rate set by the Internal Revenue Service as $0.625 cents per mile, effective July 1, 2022. The current rate is posted on the OSBM website at https://www.osbm.nc.gov/.

Attachment B

High Risk Maternity Clinic Patients

Instructions: Using the chart below, enter the total number of estimated patients to be served in the High Risk Maternity Clinic and enter the estimated percent of those patients that will be uninsured. This Attachment B must be completed and be returned with your signed Agreement Addendum.

Unduplicated number of patients to be served in the High Risk Maternity Clinic:	
Estimated percent of uninsured patients to be served in the High Risk Maternity Clinic:	**%**

Instructions: Using the chart below, provide the names, specialties, and contact information (telephone, email) for all providers who approve or sign off on high risk maternal health clinic protocols at your facility.

Provider Name	Provider Specialties	Telephone Number	Email Address