I. Background

- 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, Nurse, Nutritionist, Social Worker, Finance Officer, and Administrator) to understand how discipline specific care is integrated into prenatal and postpartum care. Members of the multi-disciplinary team should read this Agreement Addendum's Sections I. Background, II. Purpose, and III. Scope of Work and Deliverables.

I. Background (continued)

- Discipline-specific paragraphs of importance to particular staff types are as follows:
  - Clinician/Nursing staff should focus on Paragraphs C., D., F., I., and J.
  - Laboratory staff should focus on Paragraph E.
  - Nutrition staff should focus on Paragraph G.
  - Social Work staff should focus on Paragraph H.
  - Finance Officer should focus on Attachment A, and
  - Appropriate designated local health staff should complete Attachments B and C.

ADDITION: Guidance for team members to more easily identify discipline-specific content in the AA
III. Scope of Work and Deliverables

• B. High Risk Maternity Clinic Patients (Attachment B) The Local Health Department will provide Non-Medicaid Service Deliverables in FY20. 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.

Local Health Department-Health Service Analysis (LHD-HSA) data or compatible reporting system as of August 31, 2020 will provide the documentation to substantiate services that the Local Health Department has provided for this FY20 Agreement Addenda.

CHANGE: The Local Health Department Health Services Analysis (LHD-HSA) replaces the former Health Information System (HIS)

B. Quality Assurance

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

CLARIFICATION: Expected level of medical supervision in the clinic based on ACOG guidelines

B. Quality Assurance

• B3 Provide experienced licensed healthcare professionals 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. (JOGNN, No. 44, pp. 683-686; (2015); ACOG Practice Bulletin, No 145, pp. 1-9, July 2014, Reaffirmed 2016; Guidelines for Perinatal Care, 8th ed., pp. 48-49)

CLARIFICATION: LHDs providing NST services, RNs are required to complete re-training every two years
B. Quality Assurance

- B4 Provide comprehensive clinical assessments for all patients and counseling as indicated by a Licensed Clinical Social Worker (LCSW).
- B5 Provide nutrition assessments for all patients and counseling as needed by a Registered Dietitian or Licensed Dietitian/Nutritionist (RD or LDN).

**CLARIFICATION:** Comprehensive clinical assessments are required for all patients as indicated.

C. Policies/Procedures

- C7 Use of the modified 5P’s validated screening tool, at the initial prenatal visit, to identify and refer (if indicated) for subsequent follow-up (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)

**CLARIFICATION:** Reflects full screening tool name; ensures patients are screened at initial prenatal visit with a validated tool.

C. Policies/Procedures

- C8 Laboratory testing for the presence of drugs 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 and a conversation with patients. 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. (JOGNN, No. 44, pp. 155-157 (2015); ACOG Committee Opinion, No. 633, June 2015; Guidelines for Perinatal Care, 8th ed., pp. 136-137, 176-182)

**CLARIFICATION:** Reiterate best practice for routine screening for substance use disorders, routine laboratory testing is NOT best practice.
C. Policies/Procedures

• C9 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 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)

UPDATE: Revised the use of “Domestic” to “Interpersonal” based on best practice guidelines to provide an increased scope & clarity in variation of violence that may be experienced.

C. Policies/Procedures

• C16 Completion of the following validated screening tools: (1) PHQ-9 at the initial prenatal visit and as indicated in the 2nd or 3rd trimester and (2) PHQ-9 or Edinburgh Postnatal Depression Screen (EPDS) at postpartum visit. Policy should include referral and follow-up processes, if indicated by the screening tools. (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)

CLARIFICATION: Guidance for use of screening tools and criteria for timing.

D. Prenatal and Postpartum Services

• D7 Complete the Maternal Health History form, Part C-1 (DHHS 4158 or 4159), which includes the PHQ-9 screening tool at the initial prenatal visit. If indicated on the Maternal Health History form, Part C-2 (DHHS 4160) in the 2nd or 3rd trimester, repeat the PHQ-9. Facilitate referral and follow-up, as indicated. (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)

REITERATE: Where the PHQ-9 is found and when it should be completed; Part C-2 (DHHS 4160)
D. Prenatal and Postpartum Services

- Postpartum Clinic Appointment
  - i. Refer to a primary care provider at the conclusion of obstetrical care as indicated. (ACOG Committee Opinion, No. 666, June 2016; Healthy People 2020 AHS-3; Guidelines for Perinatal Care, 8th ed., p. 470)

  **REITERATE:** Importance of identifying and facilitating a referral with a Primary Care Provider (Internist, Family Medicine, or Pediatrician) at the conclusion of pregnancy.

E. Laboratory and Other Studies

- E1 Syphilis screening should be performed at one of the following periods: (1) at the initial appointment, (2) between 28 and 30 weeks, or (3) 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)

  **CLARIFICATION:** Updated standard of practice re: timing of screening.

- 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)(v); Guidelines for Perinatal Care, 8th ed., pp. 159, 485-492)

  **CLARIFICATION:** FY 20 AA removed reference to “follow-up care of the neonate”. The neonate should be followed in the child health clinic or by a pediatrician.
E. Laboratory and Other Studies

- E5 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); ACOG Committee Opinion, No. 632, June 2015; Guidelines for Perinatal Care, 8th ed., pp. 159-162, 532-534)

CLARIFICATION: Specificity of patient population re: criteria to be considered for testing

- E8 Rubella immunity status assessment at initial appointment as evidenced by: written documentation of vaccination with one dose of live rubella or MMR vaccine. (ACOG Committee Opinion, No. 718, September 2017; Guidelines for Perinatal Care, 8th ed., pp. 135, 166, 519-524)

CLARIFICATION: Criteria considered as evidence of immunity status

- E9 Varicella immunity status assessment at initial appointment as evidenced by: written official documentation of vaccination with two doses of varicella vaccine; laboratory evidence of immunity or laboratory confirmation of disease. (ACOG Committee Opinion, No. 741, June 2018; Guidelines for Perinatal Care, 8th ed., pp. 135, 166, 522-524)

CLARIFICATION: Criteria considered as evidence of immunity status
E. Laboratory and Other Studies

• E10  Cervical cytology screening for cancer, as indicated according to ACOG Cervical Cytology Guidelines. (ACOG, Practice Bulletin, No. 168, October 2016, Interim Update; Guidelines for Perinatal Care, 8th ed., pp. 510-511)

  CLARIFICATION: Removed “should begin at 21 years old” based on ACOG guidelines

E. Laboratory and Other Studies

• E15  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 Oral Glucose Tolerance Test (OGTT). Patients with abnormal testing results should be referred to the appropriate provider for follow up. (http://www.ncdei.org/ADA-diabetes-management-guidelines-diabetes-in-pregnancy-GDM.aspx.html) ACOG Practice Bulletin, No. 180, July 2017; Guidelines for Perinatal Care, 8th ed., pp. 163-164, 310-313)

  CLARIFICATION: Specificity of patient population re: criteria to be considered for testing and its timing


  CLARIFICATION: Specific form (Lead and Pregnancy Risk Questionnaire) used when screening
G. Nutrition Services

• Gestational Weight Management
  - 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). (ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; Guidelines for Perinatal Care, 8th ed., pp. 189-190)

  CLARIFICATION: Re-worded, no practice change

G. Nutrition Services

• Gestational Weight Management
  - Document weight gain or loss at routine appointments and assess weight status as per assigned gestational weight gain range (e.g., plot weight on prenatal weight gain graph). If indicated, document counseling provided to encourage gestational weight gain within the appropriate weight gain range. (ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; Guidelines for Perinatal Care, 8th ed., pp. 188-190, 583)

  CLARIFICATION: Re-worded, no practice change

H. Psychosocial Services

• Psychosocial Screening
  - H1 Utilize psychosocial risk screening tools and validated screening tools to identify psychosocial risks as follows: Complete the Maternal Health History form, Part C-1 (DHHS 4158 or 4159), which includes the PHQ-9 at the initial prenatal visit. If indicated on the Maternal Health History form, Part C-2 (DHHS 4160) in the 2nd or 3rd trimester, repeat the PHQ-9. Facilitate referral and follow-up of patients, as indicated. In postpartum, complete the Edinburgh Postnatal Depression Screen (EPDS) or PHQ-9 validated screening tool. Facilitate referral and follow-up of patients (if indicated). (JOGNN, No. 44, pp. 887-889, 2015; ACOG Committee Opinion, No. 630, May 2015, Reaffirmed 2016; ACOG Practice Bulletin, No. 52, April 2008, Reaffirmed 2016; Guidelines for Perinatal Care, 8th ed., pp. 175-176, 324)

  CLARIFICATION: Screening tools to be utilized, with form #s to assist with locating faster on website
IV. Performance Measures/Reporting Requirements
• A. 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 Women’s Health Branch website at https://whb.ncpublichealth.com/provPart/agreementAddenda.htm

CHANGE: Outcome Objectives (OO) are agency data points used to track/measure county-specific outcomes; they replace the Process Outcome Objectives (POO)

IV. Performance Measures/Reporting Requirements:
• A.
  − 1. Increase the number of high risk maternal health patients during the period of June 2019 - May 2020.
  − 2. Increase the number of high risk maternal health patients who receive 7 or more antepartum care visits during the period of June 2019 - May 2020.
  − 3. Decrease the percentage of high risk maternal health patients who report tobacco use during the period of June 2019 - May 2020.

NEW PERFORMANCE MEASURES: Data points that are linked to CPT codes, which can be extracted using the LHD-HSA system

V. Performance Monitoring and Quality Assurance
• A. The High Risk Maternity Clinic Program Supervisor, Regional Nurse Consultants, Women’s Health Branch Nutritionist and Clinical Social Work Consultant will utilize a team approach for the monitoring process. The monitoring activities will include the development of a pre-monitoring plan 4-6 months prior to the designated monitoring month, and on-site monitoring visits at least every three years; and technical assistance via phone or email, or on-site visits, as needed. On-site 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. The monitoring report includes any needed corrective action plan (CAP) and is emailed within 30 days after the monitoring site visit to the local Health Director and lead agency staff.

CHANGE: Additional areas that may be reviewed during monitoring site visit; new timeline for submitting report
Attachment A

Budget and Justification Form

- Applicants must complete the Open Window Budget Form for FY 19-20. Refer to FY 18-19’s approved budget narrative as a reference for completing FY 19-20’s budget narrative. Upon completion, the Open Window Budget Form must be emailed to phyllis.johnson@dhhs.nc.gov no later than 30 days after this Agreement Addendum is signed and returned to DPH. The Open Window Budget Form requires a line item budget and a narrative justification for each line item. This form can be downloaded from the Women’s Health Branch website at http://whb.ncpublichealth.com/provPart/agreementAddenda.htm.

NEW GUIDANCE: Advises agencies to refer to approved budget narrative from FY 18-19 when drafting new budget narrative for FY 19-20.

Attachment A

- Administrative Personnel Fringe Costs
  - Budget Narrative 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.

NEW GUIDANCE: This example was added to illustrate Administrative Personnel Fringe Costs.

Attachment A

- Detailed Budget Instructions and Information
  - Travel
    - Mileage and subsistence rates are determined by the State of North Carolina Office of State Budget and Management (OSBM) and the rates are available on the OSBM website at https://www.osbm.nc.gov/budman5-travel-policies. The LHD can calculate travel and subsistence rates equal to or below the current state rates.

CLARIFICATION: LHD rates must be equal to or lower than current state rates.
Attachment A

• Detailed Budget Instructions and Information
  - Travel
    • Current Mileage Rates: For informational purposes, the OSBM lists the standard mileage rate set by the Internal Revenue Service as $0.58 cents per mile, effective January 1, 2019.

CHANGE: Includes current standard mileage rate. It increased from $0.545 cents per mile to $0.58 cents per mile

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 should be entered into your signed Agreement Addendum. Refer a copy of the Attachment B to the Local Health Department for your reference.

Un duplicated 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:

NEW GUIDANCE: *High Risk Maternity Clinic Patients* table replaces *Non-Medicaid Services* table from FY 18-19 AA