# Division of Public Health
# Agreement Addendum
# FY 24-25



| Field | Value |
|---|---|
| **Local Health Department Legal Name** | |
| **DPH Section / Branch Name** | Women, Infant, and Community Wellness Section / Maternal Health Branch |
| **Activity Number and Description** | 101 Maternal Health |
| **DPH Program Contact** (name, phone number, and email) | Tara Owens Shuler, (919) 707-5708, tara.shuler@dhhs.nc.gov |
| **Service Period** | 06/01/2024 – 05/31/2025 |
| **DPH Program Signature** (only required for a negotiable Agreement Addendum) / **Date** | |
| **Payment Period** | 07/01/2024 – 06/30/2025 |

☒ Original Agreement Addendum
☐ Agreement Addendum Revision # ___

## I. <u>Background</u>:

The Maternal Health Program is administered in the Division of Public Health (DPH), within the Women, Infant and Community Wellness Section (WICWS), Maternal Health Branch. The primary mission of the Maternal Health Program is to ensure that all individuals who are pregnant and low-income 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 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 WICWS website.[1]

[1] https://wicws.dph.ncdhhs.gov/provpart/docs/AAResource%20Page.pdf

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: | |

**Signature on this page signifies you have read and accepted all pages of this document.** 

**II. Purpose:**

This Agreement Addendum assures that local health departments provide access to early and continuous prenatal and postpartum care for individuals who are pregnant and low-income in North Carolina (NC). Prenatal care services include screenings, counseling, and referrals for psychosocial and nutrition problems; behavioral health intervention; and Care Management for High-Risk Pregnancies (CMHRP). In addition, local health departments will work to enhance public education and community awareness regarding risk prevention and reduction strategies.

**III. Scope of Work and Deliverables:**

The Activity 101 Maternal Health Agreement Addendum requires further negotiation between the Maternal Health Branch (MHB) and the Local Health Department.

For this Agreement Addendum, the Local Health Department shall complete the Maternal Health Patients and Physicians Contact 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 and the Detailed Budget, 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 12, 2024 to Tara.Shuler@dhhs.nc.gov to document how the Local Health Department intends to expend funds awarded for FY25. **The budget must equal funds allocated to the Local Health Department**. (Refer to the FY 24-25 Activity 101 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 Maternal Health Clinic).

2. **Maternal Health Patients and Physicians Contact** (Attachment B)
   On Attachment B, indicate the number of unduplicated patients to be served and the estimated percentage of those patients that will be uninsured. Local Health Department-Health Service Analysis (LHD-HSA) service data or compatible reporting system as of August 30, 2025, will provide the documentation to substantiate services that the Local Health Department has provided for this FY25 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. 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.

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

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

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

   a. Provide pregnancy testing and referral as appropriate.

   b. Ensure ongoing prenatal care to all pregnant women through one or both of the following mechanisms:

      1. Provision of prenatal services (10A NCAC 46.0205 B (i)(ii)(iii))
      2. Referral to other health care providers.

6. **Provision of Maternal Health Services** (Attachment C)
   If the Local Health Department is **not** providing routine prenatal care but **is instead assuring** these services, the Local Health Department shall complete the Provision of Maternal Health Services (Attachment C) and return it with the signed and dated Agreement Addendum.

7. The Local Health Department shall:

### A. General Services

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

A2 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.

A3 Provide or make referrals for nutrition consultation (see G. Nutrition Services under this Paragraph 7), education on infant feeding, childbirth, and parenting education for 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 bills to Medicaid or provides to non--Medicaid patients as part of their use of Healthy Mothers, Healthy Children funding must provide these services in accordance with the NC Medicaid Clinical Coverage Policies. *(NC Medicaid 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 conditions 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 maternity care, 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 agency MCSNHV protocol. (*NC Medicaid Clinical Coverage Policy No: 1M-6, Maternal Care Skilled Nurse Home Visit*)

A5 Provide or assure the provision of Care Management for High-Risk Pregnancies (CMHRP) services to Medicaid eligible patients, in accordance with CMHRP program requirements. With the onset of Medicaid Managed Care, local health departments are subcontracted by Prepaid Health Plans (PHP) to provide CMHRP services. The CMHRP population is comprised of two distinct categories: individuals who are eligible for services and PHP priority members. Each PHP uses an internal, proprietary algorithm to determine which of their members would benefit from intensive CMHRP services and identifies them as PHP priority members. Those individuals identified as PHP priority members must receive CMHRP services through pregnancy and the duration of their postpartum period. Individuals identified as eligible for CMHRP services include those having a Maternal Infant Impactability Score (MIIS) of 200 or greater, provider request, care manager professional judgement, community referral, self-referral, or hospitalization ADT reports. Individuals who are eligible for CMHRP services but who are not designated as a PHP priority member may be closed to services once their needs are met. Individuals who are not aligned with a PHP but receive Presumptive Eligibility (PE) coverage should also be referred to CMHRP services, as applicable.

A6 The Local Health Department may provide Health and Behavior Intervention (HBI) services. HBI is a short-term counseling service provided to pregnant patients or patients who are less than 60 days postpartum, who meet the eligibility requirements outlined in the clinical coverage policy. Services must be provided by a Licensed Clinical Social Worker in the Local Health Department or in the patient's home and may include the involvement of the patient's significant other or other service providers. Local health departments that provide HBI services to Medicaid enrollees and bill to Medicaid, must provide these services in accordance with the NC Medicaid Clinical Coverage Policies. (*NC Medicaid Clinical Coverage Policy No: 1M-3, Health and Behavior Intervention*)

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 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 WICWS 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 Physicians, Advanced Practice Practitioners and/or Enhanced Role Registered Nurses as appropriate.

B7 If the Local Health Department offers Non-Stress Test (NST) services, these services must be provided by an experienced licensed healthcare professional who will perform a 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.

## C. Policies/Procedures

C1 Develop and follow a policy/procedure/protocol for follow-up on a positive pregnancy test to assure patient has access to a health care provider.

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

C3 Develop and follow a policy/procedure/protocol for referring patients to Women, Infants and Children (WIC) upon confirmed results of a positive pregnancy test. (Federal WIC Regulations, 246.4)

C4 Develop and follow a policy/procedure/protocol for completing presumptive eligibility determination for all patients not currently covered by Medicaid. Presumptive eligibility determination should occur in a manner in which patients are not delayed in receiving Medicaid. This includes presumptive eligibility determination at the first prenatal appointment, at the time of positive pregnancy test (regardless of where patients will receive their prenatal care), or when the patient requests presumptive eligibility based on attestation of pregnancy. For agencies that assure maternal health services through a rural health center, Federally Qualified Health Center (FQHC), or other entity that is permitted to complete presumptive eligibility, presumptive eligibility may be completed by the assuring provider at the initial prenatal appointment.

C5 Develop and follow a policy/procedure/protocol for referring all pregnant patients for Medicaid (Medicaid for Pregnant Women or full Medicaid) eligibility determination.

C6 Develop and follow a policy/procedure/protocol that describes the completion of the Pregnancy Risk Screening (PRS) Form and making a referral to the CMHRP program as indicated. PRS forms should be completed on Medicaid, Medicaid-eligible or presumptively eligible Medicaid patients.

C7 Develop and follow a policy/procedure/protocol that describes the agency's target population for receiving 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.

C8 Develop and follow a policy/procedure/protocol or fee schedule that describes the agency's fees for maternal health services provided by the Local Health Department.

C9 Develop and follow a policy/procedure/protocol that describes the agency's 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))

C10 Develop and follow a policy/procedure/protocol that describes the follow-up of missed prenatal appointments.

C11 Develop and follow a policy/procedure/protocol that describes the referral of pregnant patients who express interest in permanent sterilization or contraception.

C12 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, and to identify patients with substance use concerns and refer (if indicated) for subsequent follow-up. If the Pregnancy Risk Screening Form 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.

C13 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 should be 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.

C14 Develop and follow a policy/procedure/protocol for referring a patient with a positive hepatitis B result for care, if indicated, and assuring appropriate notification of Local Health Department staff responsible for follow-up of the neonate after birth. (10A NCAC 41A.0203 (d)(1))

C15 Develop and follow a policy/procedure/protocol for referring a patient or neonate with a positive hepatitis C result for care, if indicated, and for appropriate notification of Local Health Department staff responsible for follow-up of the patient and neonate.

C16 Develop and follow a policy/procedure/protocol for coordination of care for HIV positive patients as needed to assure appropriate care. (10A NCAC 41A.0202)

C17 Develop and follow a policy/procedure/protocol for 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 C-1 (DHHS form 4158) and C-2 (DHHS form 4160).[2] Screening questions shall be administered privately at the first prenatal contact, each trimester, and postpartum.

C18 Develop and follow a policy/procedure/protocol for referring patients to a high-risk maternity clinic or provider for identified high-risk conditions.

[2] https://wicws.dph.ncdhhs.gov/provpart/forms.htm

C19 Develop and follow a policy/procedure/protocol for assessing prenatal clients for immunity to rubella and varicella, and for provision of or referral for the rubella and varicella vaccine postpartum if the patient is 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. (CDC *Pink Book*, Chapter 20 & 22) Patients who are not immune to rubella and/or varicella must be referred for or provided appropriate vaccination during the postpartum period.

C20 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 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]. Policy should include process for transferring results to delivering hospital. All prenatal clinics providing prenatal care through 36-38 weeks are required to have this policy. (ACOG Committee Opinion, No. 797)

C21 Develop and follow policy/procedure/protocol for completing a validated depression screening tool: (1) at the initial prenatal visit and as indicated by patient's responses to the Maternal Health History Forms C-1 [Form 4150] and C-2 [Form 4160], (2) later in the pregnancy (second or third trimester), and (3) 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. Follow-up processes should include procedure/protocol for assessing the severity and immediacy of suicide risk when someone answers a self-harm or suicide question affirmatively.

C22 Develop and follow policy/procedure/protocol for completing a validated anxiety screening tool: (1) at the initial prenatal visit, (2) later in the pregnancy (second or third trimester), and (3) at postpartum visit. Validated screening tools include the General Anxiety Disorder-7 [GAD-7] and EPDS-3A. Policy should include which tools are being used, which scores are considered positive, and referral and follow-up processes.

C23 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 QuitlineNC (1-877-QUIT-NOW) or a community resource.

C24 Follow all standing orders or protocols developed for nurses in support of this program; standing orders 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

<u>Prenatal:</u>

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

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 medication list (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;

o. 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 screenings:

a. The Pregnancy Risk Screening Form or the modified 5Ps validated screening tool at the initial visit.
b. The 5As counseling approach for tobacco and electronic nicotine delivery systems cessation for all patients.
c. The Maternal Health History form Part C-1 (DHHS 4158 or 4159), either the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS), and either the GAD-7 or EPDS-3A at the initial prenatal visit.
d. The Maternal Health History form Part C-2 (DHHS 4160) and GAD-7 later in pregnancy after the initial visit (second or third trimester). The PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) should be repeated if indicated by the Maternal Health History form, Part C-2 (DHHS 4160). The PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) and Interpersonal Violence screening may be repeated at any point during pregnancy at the provider's discretion.

D5 Follow-up and document missed appointments and referrals. Re-schedule missed appointments as indicated.

<u>Postpartum Clinic Appointment:</u>

D6 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) (ACOG Practice Bulletin 736):

a. Follow-up for missed postpartum 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.
c. The 5As (Ask, Advise, Assess, Assist, and Arrange) counseling approach for tobacco cessation and electronic nicotine delivery systems for all patients.
d. Screen for postpartum depression with either the Edinburgh Postpartum Depression Scale (EPDS) or PHQ-9 validated screening tool.
e. Screen for anxiety using either the GAD-7 or EPDS-3A.
f. Screen for interpersonal violence.

g. Screen for substance use with the modified 5P's validated screening tool to identify, refer (if indicated) for subsequent follow-up.
h. 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 test or 75-g 2-hour oral glucose tolerance test. Appropriate long-term sequela counseling should also be performed.
i. 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.
j. 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 on the initial appointment, unless known to be infected. (CDC MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 125-129; 10A NCAC 41A.0203 (d)(1))

E3 Hepatitis C screening on all pregnant women during each pregnancy. This testing can be done at the initial obstetrical lab appointment and specimens are sent to the State Lab of Public Health. If the patient is already known to have hepatitis C, screening is not necessary. The NC 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 NC 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. (NC Communicable Disease Branch Hep B/C Surveillance Report Aug 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 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))

E5 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)

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 recent Sexually Transmitted Infection or substance use. (CDC-MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 11-13; 10A 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, and antibody screening at the initial appointment. Rh D-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 Rh D-negative patients with a negative initial antibody screening. Unsensitized Rh D-negative patients (Rh D-negative patients with a negative antibody screen at 26-28 weeks gestation) who may be carrying an Rh D-positive fetus must be given Rho(D) immune globulin (e.g., Rhogam) to decrease the risk of alloimmunization.

E9 Rubella immunity status assessment at initial appointment. If immunity status cannot be obtained as stated in C19, titers can be drawn.

E10 Varicella immunity status assessment at initial appointment. If immunity status cannot be obtained as stated in C19, titers can be drawn.

E11 Cervical cytology screening for cancer, 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 second trimester (as indicated), and in third trimester. Patients that meet the criteria for anemia (hematocrit levels <33% or hemoglobin levels <11.0 in the first and third trimesters, and hematocrit <32% or hemoglobin <10.7 in the second 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 screening, 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. Refer for Nonstress Test (NST), if indicated

E20 Follow-up for abnormal findings:

a. Manage abnormal findings as indicated
b. Consult with specialist as indicated

## F. Medical Therapy

***Provide and document the following:***

F1 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 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 declined in the medical record.

F3 Recommend 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 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.[3]

## 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) based on single or multiple gestations.

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 $\geq 30$). This consultation may be accomplished by a referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) or Women, Infants, and Children (WIC).

<u>Nutrition Screening and Referral:</u>

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 made. The plan of

[3] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/pregnancy.html

care will be documented in the patient's maternal health record. The LDN should be licensed by the NC State Board of Dietetics

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.

G7 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

H1 Complete initial, interval, and postpartum screenings for substance use, depression, anxiety, interpersonal violence, and tobacco/electronic nicotine delivery systems and refer as indicated.

H2 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 Local Health Department receives grant funding from Division of Public Health for provision of CMHRP services for those that are eligible and uninsured.

## I. Patient Education

***Provide and document the following:***

I1 Education specific to patient's risk conditions.

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.

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.

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 all drugs (illegal, prescription, non-prescription, vitamins and supplements); use of safety belts; sauna and hot tub exposure; prevention of HIV infection and other STIs; environmental exposure such as secondhand smoke and lead.

I7 Educational programs available such as childbirth education, infant care, car seat safety, and breastfeeding.

I8 Benefits of breastfeeding and risks of not breastfeeding.

I9 Nutrition Counseling; special diet; dietary precautions (mercury, listeriosis).

I10 Planning for discharge and childcare; choosing the newborn's physician.

I11 Financial responsibility to the patient for prenatal care and hospitalization (e.g., insurance plan participation, self-pay).

I12 Safe sleep education for all patients

I13 Education on family planning method options.

I14 Provide education on the postpartum period including postpartum warning signs and symptoms and when to alert provider or to seek care at the nearest emergency department.

## J. Staff Requirements and Training

J1 The Maternity Nurse Supervisor, CMHRP Care Managers and Supervisors, Health and Behavior Intervention Supervisor, and Clinical Social Workers 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 WICWS listservs, use of the VirtualHealth documentation system, and CareImpact, as well as access to other technical resources and to maternal health materials.

J2 Enhanced Role Registered Nurse (ERRN) Requirements: Certain low-risk patients may receive designated services from public health nurses who have received special Maternal Health (MH) Enhanced Role Registered Nurse Training. In local 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 MH ERRN training, number of patient contact hours (combination of time spent as a nurse interviewer and highest-level care provider) and accrued maternal health educational contact hours. ERRNs must fulfill requirements listed below by June 30th each year or they will lose enhanced role status. The MH ERRN program has been discontinued with the exception of those currently active.

a. Any MH ERRN who is seeking re-rostering must submit a competency checklist completed by the agency's Medical Director/Medical Consultant responsible for the Maternal Health Program and the Director of Nursing for the agency. Other requirements include the completion and documentation of 100 clinical hours and 10 educational contact hours, directly related to maternal health, during the fiscal year, July 1, 2024–June 30, 2025. The documents required for re-certification will be sent via email to the MH ERRN at each participating agency for completion. The documentation for the prior state fiscal year (July 1, 2023–June 30, 2024) must be submitted by August 15, 2024, to the State Maternal Health Nurse Consultant in the Maternal Health Branch. MH ERRN's who have remained rostered continuously may perform maternal health assessments through the direction of precise, written Standing Orders, reviewed, and signed annually by the Program Medical Director. The standing order should be submitted along with the re-rostering documents every other year (on even years), beginning August 15, 2024.

b. The Local Health Department shall advise their WICWS Regional Nurse Consultant of any ERRNs who have either retired or are no longer functioning as an ERRN and they

will be removed from the current roster and will not be required to complete the documents. Once removed they cannot be readded.

J3 CMHRP Manager Staffing and CMHRP Training

a. Any changes in CMHRP Care Manager or CMHRP Care Management Supervisor positions shall be electronically submitted[4] as soon as possible. However, the changes must be submitted no later than 7 days after the staff change including hiring new staff, position vacancy, position elimination, or other staff changes. Additionally, the WICWS Regional Social Work Consultant shall be notified of new staff as soon as possible but no later than 7 days after hire date.

b. In the event of a staff vacancy or an extended absence, the Contingency Plan for Staff Absence or Vacancy Form found in the CMHRP Program Toolkit must be completed and submitted as outlined in the form instructions. The Local Health Department 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 (but no later than 7 days) to the WICWS Regional Social Work Consultant.

d. All social workers hired as CMHRP Care Managers after September 1, 2011, must have a Bachelor of Social Work (BSW, BA in SW, or BS in SW) or Master of Social Work (MSW, MA in SW or MS in SW) from a Council on Social Work Education accredited social work degree program per the Program Guide for Care Management for High-Risk Pregnancies and At-Risk Children in Managed Care. Nurses that are hired to fill the positions must be a registered nurse (RN). [Note: non-degreed social workers cannot provide care management, even if they qualify as a social worker under the Office of State Personnel guidelines.]

e. All new CMHRP Care Managers are required to complete the Care Management for High-Risk Pregnancies New Hire Orientation as outlined in the Care Management for High-Risk Pregnancies New Hire Orientation checklist located in the CMHRP Program Toolkit, adhering to the specified timeframes in the document.

J4 Clinical Social Work Staffing and Training

a. Written notification about staff changes shall be submitted to the WICWS 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 are required to complete the LCSW orientation materials located on the WICWS website[5] within two months of hire date. Additionally, the WICWS Clinical Social Work Consultant shall be notified of course completion within 14 days of course completion.

J5 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.

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[4] https://survey.alchemer.com/s3/7111130/CMARC-and-CMHRP-Staffing-Information

[5] https://wicws.dph.ncdhhs.gov/provpart/training.htm

## IV. **Performance Measures / Reporting Requirements:**

1. The Local Health Department shall improve birth outcomes and health status of individuals 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).
    a. Improve the timeliness of prenatal care (initiation of care prior to 14 weeks gestation).
    b. Increase the number of maternal health patients who receive 7 or more antepartum care visits.
    c. Decrease the percentage of maternal health patients who report tobacco use and electronic nicotine delivery systems.
    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 maternal health patients who receive a postpartum visit within the first 7-42 days post-delivery.
2. Reporting Requirements: The Local Health Department shall 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 Regional Nurse Consultants (RNC), the Regional Social Work Consultants (RSWC) and the WICWS Clinical Social Work Consultant conduct performance monitoring and quality assurance activities.
    a. The RNCs conduct activities for maternal health services which include development of a pre-monitoring plan 4 to 6 months prior to the designated monitoring month; monitoring visits every 3 years; and technical assistance via phone, email, or 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.
    b. The RSWCs conduct performance monitoring and quality assurance activities for the Care Management for High-Risk Pregnancies program. These activities include oversight of performance through the review of county and health plan level reports generated from VirtualHealth and CareImpact reporting, chart reviews, and site visits for performance review.
    c. The WICWS Clinical Social Work Consultant will provide 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.
    d. A written monitoring report is completed for all monitoring site visits and is emailed within 30 days of the monitoring site visit to the local Health Director and lead agency staff. It will include information on whether a corrective action plan (CAP) is needed.
2. Consequences:
    a. If a CAP is required, the Local Health Department must prepare and submit the CAP to the DPH Program Contact within 30 days of receiving the monitoring report. The DPH Program Contact will notify the Health Director whether the final CAP is acceptable within 30 days of having received the CAP. If the final CAP is acceptable, monitoring closure is reached. All CAPs will

include a date of the next internal follow up monitoring. Depending on the CAP deficiencies, the RNC may request a copy of the internal monitoring to ensure the issues have been resolved. If final CAP is not acceptable, the DPH Program Contact will provide technical assistance to help complete the CAP. If a final CAP is still unacceptable in 90 days, the Local Health Department will be placed on high-risk status with ongoing technical assistance, and annual follow up monitoring pending approval by WICWS Chief. If at annual monitoring the agency meets program requirements, they will resume the 3 year monitoring cycle.

b. A loss of up to 5% of funds may result for a Local Health Department if it does not meet the level of Maternal Health Patient deliverables (Attachment B) 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 24-25**. Upon completion, the Open Windows Budget Form must be emailed by April 12, 2024 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 Women, Infant and Community Wellness Section (WICWS) website.[6]

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 23-24 as a reference for completing this FY 24-25 budget narrative.

### Narrative Justification for Expenses

A narrative justification must be included for every expense listed in the FY 24-25 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. 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.

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[6] https://wicws.dph.ncdhhs.gov/provpart/agreement-addenda.htm

**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**
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.[7]

For informational purposes, NCDHHS lists the following schedule, effective January 2023:

| | In-State | Out-of-State |
|---|---|---|
| Breakfast | $ 13 | $ 13 |
| Lunch | $ 15 | $ 15 |
| Dinner | $ 26 | $ 26 |
| Lodging (actual, up to) | $ 107 | $ 107 |
| Total | $ 152 | $ 152 |

Justification Example:
Overnight accommodations for Maternal Health Nurse Supervisor and 1 PHN II to attend XYZ Training:
2 nights' lodging x $107 (excludes tax) = $214
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: $214 lodging + $216 meals = $430

Current Mileage Rate—For informational purposes, the OSBM lists the standard mileage rate set by the Internal Revenue Service as $0.655 cents per mile, effective January 1, 2023. The current rate is posted on the OSBM website.[8]

[7] https://www.dph.ncdhhs.gov/lhd/index.htm
[8] https://www.osbm.nc.gov/

**Attachment B**

## Maternal Health Patients and Physicians Contact

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

| | |
|---|---|
| **Unduplicated number of patients to be served in the Maternal Health Clinic:** | |
| **Estimated percent of uninsured patients to be served in the Maternal Health Clinic:** | **%** |

Instructions: Using the chart below, 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.

| Provider Name | Provider Specialties | Telephone Number | Email Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Attachment C**

## Provision of Maternal Health Services

Attachment C is to be completed **only** by the Local Health Department that **plans to assure routine prenatal clinic services**. This Attachment C is to be included as part of the signed Agreement Addendum.

1. **Assure Provision** – For the Local Health Department to demonstrate its compliance with the state requirement of either providing or assuring the provision of maternal health services.

   ☐ Checking this box indicates that the Local Health Department plans to assure provision of routine prenatal clinic services for maternal health patients. If checked, the Local Health Department shall:

   a. Submit a copy of all Memoranda of Understanding (MOUs) with local health care providers which have been executed within the last three years and which are still in effect.
      1. Each MOU must document how these services are provided and mention the time frame that the MOU is in effect.
      2. Each MOU must contain information stipulating that patients at or below 100% of the Federal Poverty Level will not be charged for prenatal services by the assurance provider.

   b. Include a sliding fee scale schedule or other fee schedule to show how other uninsured patients will be charged for services by the assurance provider. This can be included in the MOU or attached to it.

   c. Provide a letter from the health director with each MOU stating *either* that the MOU will be effective for the duration of this Agreement Addendum *or*, if the MOU is to end before May 31, 2024, that the Local Health Department will enter into another MOU with the local health care provider before the MOU ends.

2. **Provide –** The boxes checked below indicate which maternal health services the Local Health Department will be providing, not assuring, for maternal health patients. The budget and budget justification submitted by the Local Health Department will need to align with these services.

   (Services are described in Section III, Paragraph 7, by these categories: A. General Services, D. Prenatal and Postpartum Services, G. Nutrition Services, and H. Psychosocial Services.)

   ☐ Provide nutrition consultation (A3; G1–G7)

   ☐ Provide Maternal Care Skilled Nurse Home Visits. (A4)

   ☐ Provide the provision of Care Management for High-Risk Pregnancies (CMHRP) services to Medicaid eligible patients, in accordance with CMHRP program requirements. (A5)

   ☐ Provide Health and Behavior Intervention (HBI) services. (A6)

   ☐ Provide postpartum services (D6)

   ☐ Provide nutrition screening and referral for services (G5 and G7)

   ☐ Provide psychosocial screening and referral for services (H1 and H2)

   ☐ None

   Maternal Health Assurance Plan for MOU samples and the "Guidance for Local Health Department Assurance of Maternal Health Services" are available online.[9]

[9] https://wicws.dph.ncdhhs.gov/provpart/docs/Final_AP-MOU-ModelSample.pdf