

Division of Public Health

Agreement Addendum

FY 21-22

Generic	Women’s and Children’s Health Section/Women’s Health Branch
Local Health Department Legal Name	DPH Section / Branch Name
101 Maternal Health	Phyllis C. Johnson, (919) 707-5715, Phyllis.c.johnson@dhhs.nc.gov
Activity Number and Description	DPH Program Contact (name, phone number, and email)
06/01/2021 – 05/31/2022	DPH Program Signature Date
Service Period	(only required for a <u>negotiable</u> agreement addendum)
07/01/2021 – 06/30/2022	DPH Program Signature Date
Payment Period	(only required for a <u>negotiable</u> agreement addendum)
<input checked="" type="checkbox"/> Original Agreement Addendum <input type="checkbox"/> Agreement Addendum Revision # ____	

I. Background:

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

Throughout this Agreement Addendum, the following words are defined as follows: “shall” and “must” indicates a mandatory program policy; “should” indicates a recommended program policy; and “can” or “may” indicates a suggestion or consideration. Also, the full citation for one of the references cited throughout this document is: *Guidelines for Perinatal Care*, Eighth Edition, October 2017, American Academy of Pediatrics and The American College of Obstetricians and Gynecologists.

The Maternal Health 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. 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.

Health Director Signature	(use blue ink)	Date									
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Local Health Department to complete:</td> <td style="width: 33%;">LHD program contact name: _____</td> <td style="width: 33%;"></td> </tr> <tr> <td>(If follow-up information is needed by DPH)</td> <td>Phone number with area code: _____</td> <td></td> </tr> <tr> <td></td> <td>Email address: _____</td> <td></td> </tr> </table>			Local Health Department to complete:	LHD program contact name: _____		(If follow-up information is needed by DPH)	Phone number with area code: _____			Email address: _____	
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	Email address: _____										

- Social Work staff should focus on Paragraph H.
- Finance Officer should focus on Attachment A, and
- Appropriate designated local health staff should complete Attachment B.

II. **Purpose:**

This Agreement Addendum assures that local health departments provide access to early and continuous prenatal and postpartum care for low-income pregnant women in North Carolina (NC). Prenatal care services include screenings, counseling and referrals for psychosocial and nutrition problems; behavioral health intervention; and 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 Women’s Health Branch (WHB) and the Local Health Department.

For this Agreement Addendum, the Local Health Department shall complete the Maternal Health 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 A, with instructions provided in Attachment A.

The information provided by the Local Health Department will be reviewed by the WHB. When the WHB representative and the Local Health Department reach an agreement on the information contained in these Sections and the Detailed Budget, the WHB representative will sign the Agreement Addendum to execute it.

A. **Detailed Budget** (Instructions provided in Attachment A)

A detailed budget must be emailed to Phyllis.C.Johnson@dhhs.nc.gov to document how the Local Health Department intends to expend funds awarded for FY22. **The budget must equal funds allocated to the Local Health Department.** (Refer to the FY 21-22 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).

B. **Maternal Health Patients** (Attachment B)

Include on Attachment B 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 31, 2022 will provide the documentation to substantiate services that the Local Health Department has provided for this FY22 Agreement Addendum.

C. 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.

- D. The Local Health Department shall demonstrate compliance with the NC Administrative Rules (10A NCAC 43B .0109) on client and third-party fees:
1. If a local provider imposes any charges on clients for maternal and child health services, such charges:
 - a. Will be applied according to a public schedule of charges
 - b. Will not be imposed on low-income individuals or their families
 - c. Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
 2. If client fees are charged, providers must make reasonable efforts to collect from third-party payors.
 3. Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.
- E. The Local Health Department shall ensure the provision of the following, whether they provide prenatal care or not:
1. Provide pregnancy testing and referral as appropriate.
 2. Ensure ongoing prenatal care to all pregnant women through one or more of the following mechanisms:
 - a. Provision of prenatal services (10A NCAC 46.0205 B (i)(ii)(iii))
 - b. Referral to other health care providers.
- F. If the Local Health Department is not providing routine periodic prenatal care as evidenced in Local Health Department-Health Service Analysis (LHD-HSA) data and program review audit, but is instead assuring these services, the Local Health Department shall submit the following document:
1. A Memorandum of Understanding (MOU) with local health care provider(s) documenting how these services are provided. If the Local Health Department has a current MOU they plan to continue in FY 21-22 and it contains all the required information, then the health director must submit a letter stating their MOU is still current as well as provide a copy of the current MOU.
 - a. The MOU with the assurance provider must contain information that stipulates that patients at or below 100% of the Federal Poverty Level will not be charged for prenatal services by the assurance provider. There should also be a sliding fee scale schedule or other fee schedule included in or attached to the MOU to show how other uninsured patients will be charged for services by the assurance provider.
 - b. Visit the following website under Maternal Health Assurance Plan for MOU samples and the “Guidance for Local Health Department Assurance of Maternal Health Services”: <https://whb.ncpublichealth.com/provpart/agreement-addenda.htm>.

G. The Local Health Department shall:

A. General Services

- A1 Obtain informed consent (receipt of patient signature) for prenatal services. (ACOG Committee Opinion, No. 439, Aug. 2009, Reaffirmed 2015)
- A2 Provide data on the demographics and number of patients served reporting through the state's Local Health Department-Health Service Analysis (LHD-HSA) and/or a compatible data system.
- A3 Provide or make referrals for nutrition consultation, 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. (Maternal Care Skilled Nurse Home Visit – NC Medicaid Clinical Coverage Policy No: 1M-6, Amended March 2019)
- 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. A Maternal Infant Impactability Score (MIIS) (0-1000) is assigned to each patient based on the Pregnancy Risk Screening Form, pregnancy assessment information and claims data which is used to prioritize patients for services. Patients with scores of 200-1,000 are the priority population for CMHRP services. Some women may be characterized as priority without an MIIS over 200 if the care manager identifies needs per professional judgement. Care Management for High Risk Pregnancies services may also be provided to Medicaid patients outside of the priority population provided the Local Health Department is fully capable of meeting the care management needs of the priority patient population.
- A6 Maintain a breastfeeding-friendly clinic environment (US DHHS. *The Surgeon General's Call to Action to Support Breastfeeding*; 2011, Action 9, p. 46; JOGNN, No. 44, pp. 145-150, (2015); ACOG Committee Opinion, No. 756, October 2018; Committee Opinion, No. 570, August 2013, Reaffirmed 2016; *Guidelines of perinatal Care*, 8th ed. Pp. 216-217, 297, 371-380, 427):
- a. Avoid passive promotion of formula feeding. Printed materials, posters, audio-visual materials and office supplies should be free of formula product names.
 - b. Store supplies of formula, baby bottles, and nipples, out of the sight of patients.
 - c. Avoid direct promotion of formula feeding. Do not give out formula company discharge bags or other free items to patients.

- d. Create or use educational materials that incorporate positive, culturally friendly, and consistent breastfeeding messages in all relevant educational materials, outreach efforts, and educational activities.
- e. Create or use materials that are free of formula company advertising (company names, logos).
- f. Create or use materials that are free of language that may undermine a patient's confidence in the ability to breastfeed.

B. Quality Assurance

- B1 Conduct annual quality assurance review of policies and procedures being implemented.
- B2 Report interruption of services or inability to meet quality assurance deliverables within 14 days to the WHB Regional Nurse Consultant.
- B3 Use interpreter services for all maternal health programs when appropriate.
- B4 Demonstrate excellence in customer friendly services as evidenced by annual patient satisfaction surveys.
- B5 All staff, clinical and non-clinical, shall participate in at least one training annually focused on health equity, health disparities, or social determinants of health to support individual competencies and organizational capacity to promote health equity.
- B6 Provide care by Physicians, Advanced Practice Practitioners and/or Enhanced Role Registered Nurses as appropriate.
- B7 If the Local Health Department offers NST services, these services must be provided by an experienced licensed healthcare professional who will 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, July 2014, Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp.198-202)

C. Policies/Procedures

- C1 Develop and follow a policy/procedure/protocol for follow-up of positive pregnancy test to assure patient has access to 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 can include presumptive eligibility determination at the first prenatal appointment, at the time of positive pregnancy test (regardless of where patients will receive their prenatal care), when the patient requests presumptive eligibility determination based on her attestation of pregnancy, or at any other time that does not cause a delay the patient in

receiving their Medicaid eligibility. 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 Form and making a referral to Care Management for High Risk Pregnancies program as indicated. Risk Screening forms should be completed on Medicaid, Medicaid-eligible or presumptively eligible Medicaid patients only.
- 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. (ACOG Committee Opinion, No. 695, April 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 291-294)
- 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 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. *JOGNN*, No. 44, pp. 155-157 (2015); ACOG Committee Opinion, No. 711, August 2017; Committee Opinion, No. 633, June 2015; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137)
- C13 Develop and follow a policy/procedure/protocol that describes the testing of prenatal patients for substance use if the agency uses laboratory testing for this purpose. 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, Reaffirmed 2018; *Guidelines of Perinatal Care*, 8th ed., pp. 136-137, 176-182)
- C14 Develop and follow a policy/procedure/protocol for referring a positive hepatitis B result for patient or neonate for care, if indicated, and assuring appropriate notification of local health

department staff responsible for follow-up for neonate after birth. (10A NCAC 41A.0203 (d)(1); *Guidelines for Perinatal Care*, 8th ed., pp. 486-492)

- 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. (CDC MMWR, April 10, 2020 v. 69 No RR-2 pp 1-17)
- 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; *Guidelines for Perinatal Care*, 8th ed., pp. 160-161, 502-510)
- 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 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, Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp. 183-185)
- C18 Develop and follow a policy/procedure/protocol for referring patients to a high-risk maternity clinic or provider for identified high-risk conditions. (*Guidelines for Perinatal Care*, 8th ed., 301-346)
- 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. (ACOG Committee Opinion, No. 741, June 2018; *Guidelines for Perinatal Care*, 8th ed., pp. 134-135, 166; 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. (ACOG Committee Opinion, No. 741, June 2018; *Guidelines for Perinatal Care*, 8th ed., pp. 164-166, 283, 519-524)
- 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 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]. (CDC MMWR, November 19, 2010, v. 59, No. #RR-10; *Guidelines for Perinatal Care*, 8th ed., pp. 160, 164) 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, Feb. 2020; *Guidelines for Perinatal Care*, 8th ed., pp. 160, 164)
- 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 (4158 on WHB website) & C-2 (4160 on WHB website) in the 2nd

or 3rd trimester and (2) at postpartum visit. A validated screening tool can be either the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS). Policy should include referral and follow-up processes, if indicated by the screening tools. (*JOGNN*, No. 44, 687-689, (2015); ACOG Committee Opinion, No. 757, November 2018; *Guidelines for Perinatal Care*, 8th ed., pp. 183, 294-298)

- C22 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. Another resource is the “Guide for Helping to Eliminate Tobacco Use and Exposure for Women, June 2016.”
<https://whb.ncpublichealth.com/docs/2016-GuideforCounselingWomenWhoSmoke.pdf>.
 (*JOGNN*, No. 46, pp. 794-796, (2017); ACOG Committee Opinion, No. 807, May 2020; Committee Opinion, No. 503, September 2011, Reaffirmed 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 136-137, 178-179)
- C23 Follow all standing orders or protocols developed for nurses in support of this program must be written in the NC Board of Nursing format. All local health departments shall have a policy in place that support nurses working under standing orders.
<https://www.ncbon.com/vdownloads/position-statements-decision-trees/standing-orders.pdf>

D. Prenatal and Postpartum Services

Prenatal:

- 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 disorders;
 - 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) confirmation (ACOG Committee Opinion, No. 700, May 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 154-156)
(<https://www.cdc.gov/nceh/lead/publications/LeadandPregnancy2010.pdf>)
(*Guidelines for Perinatal Care*, 8th ed., pp. 150-153, 581-589)
- D2 Assess and document the following minimum physical examination components. Documentation of additional components should be clearly stated in the medical record (*Guidelines for Perinatal Care*, 8th ed., pp. 151-153, 581-589):
- a. Head, ears, nose, and throat (HENT);
 - b. Eyes
 - c. Teeth
 - d. Thyroid;
 - e. Lungs;
 - f. Breast;
 - g. Heart;
 - h. Cervix;
 - i. 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. (*FASEB*, v. 30, No. 1, Supplement 152.4, (2016); ACOG Committee Opinion, No. 548, January 2013, Reaffirmed 2016; Reaffirmed 2020; [*Guidelines for Perinatal Care*, 8th ed., pp. 185-190](#))
- 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 consistency with EDD;
 - f. Fetal presentation greater than or equal to 36 weeks by Leopold's Maneuver. (*Guidelines for Perinatal Care*, 8th ed., p. 153)
- 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), and either the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS) at the initial prenatal visit.

- d. 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) should be repeated if indicated by the Maternal Health History form, Part C-2 (DHHS 4160) in the 2nd or 3rd trimester, the PHQ-9 or Edinburgh Postnatal Depression Scale (EDPS) 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. (*Guidelines for Perinatal Care*, 8th ed., pp. 7-8)

Postpartum Clinic Appointment:

- 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. (*Guidelines for Perinatal Care*, 8th ed., pp. 296-298)
 - 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. (See C 22)
 - e. Screen for Interpersonal Violence. (See C17)
 - f. Screen for substance use with the modified 5P's 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 4-12 weeks postpartum Fasting Blood Glucose or 75-g 2hr Oral Glucose Tolerance Test. Appropriate long-term sequela counseling should also be performed. (*Guidelines for Perinatal Care*, 8th ed., pp. 314-315)
 - 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. (ACOG Committee Opinion, No. 654, February 2016; Healthy People 2020 FP-1 and FP-5; www.cdc.gov/preconception/women.html; *Guidelines for Perinatal Care*, 8th ed., pp. 134, 288-294, 297)
 - i. Refer to a primary care provider at the conclusion of obstetrical care as indicated. (ACOG Committee Opinion, No. 755, October 2018; Committee Opinion, No. 736, May 2018; *Healthy People 2020* AHS-3; *Guidelines for Perinatal Care*, 8th ed., p. 298)

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); *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 542-548)
- 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); *Guidelines for Perinatal Care*, 8th ed., pp. 159-161, 485-492)

- 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. (NC Communicable Disease Branch Hep B/C Surveillance Report Aug 2019) (CDC MMWR, April 10, 2020 v. 69 No RR-2 pp 1-17, ACOG Practice Advisory April 2020)
- 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); ACOG Committee Opinion, No. 635, June 2015; ACOG Committee Opinion, No. 752, September 2018; Committee Opinion, No. 596, May 2014, reaffirmed 2019; Committee Opinion, No. 389, December 2007, Reaffirmed 2015; *Guidelines for Perinatal Care*, 8th ed. pp. 159-161, 502-510)
- 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 (e); *Guidelines for Perinatal Care*, 8th ed. pp., 159-162, 533-535)
- 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 STI or substance use. (CDC-MMWR, June 5, 2015, v. 64, No. #RR-3, pp. 11-13; 10A NCAC 41A.0204 (e); *Guidelines for Perinatal Care*, 8th ed., pp. 159-162, 532-533)
- E7 Genetic serum screening (referral or offered), prior to 20 weeks of gestation, to patients who give informed consent for the test. Patients who refuse the test should have this informed refusal documented in the medical record. Patients should be offered or referred for additional genetic and aneuploidy screening tests including first screen. (ACOG Committee Opinion, No. 693, April 2017; Committee Opinion, No. 691, March 2017; Practice Bulletin, No. 162, May 2016, Reaffirmed 2018; committee Opinion, No. 478, March 2011; *Guidelines for Perinatal Care*, 8th ed., pp. 139-141, 166-175)
- E8 Blood group, Rh determination, and antibody screening at the initial appointment. RhD-negative patients who have a positive antibody screening should be evaluated with an antibody titer. A repeat antibody screening should occur at 26-28 weeks gestation for RhD-negative patients with a negative initial antibody screening. Unsensitized RhD-negative patients (RhD-negative patients with a negative antibody screen at 26-28 weeks gestation) who may be carrying an RhD-positive fetus must be given Rh₀(D) immune globulin (RhoGam) to decrease the risk of alloimmunization. (U.S. Preventative Services Task Force, AHRQ Pub. No. 05-0566-A, November 2004; ACOG Practice Bulletin, No. 181, August 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 159, 163)
- E9 Rubella immunity status assessment at initial appointment.
- E10 Varicella immunity status assessment at initial appointment.
- E11 Cervical cytology screening for cancer, as indicated, according to ACOG Cervical Cytology Guidelines. (ACOG, Practice Bulletin, No. 168, October 2016, Interim Update; Practice Bulletin, No. 140, December 2013, Reaffirmed 2018; *Guideline for Perinatal Care*, 8th ed., pp.510-511)

- E12 A baseline urine dipstick for protein content to assess renal status at the initial appointment and at subsequent appointments as indicated. (*Guidelines for Perinatal Care*, 8th ed., pp. 153, 160)
- E13 Urine culture completed at initial appointment, and at subsequent appointments as indicated (*Guidelines for Perinatal Care*, 8th ed., pp. 153, 160)
- E14 Group B Strep (GBS) screening at 36-38 weeks if no GBS bacteriuria diagnosed in current pregnancy. (CDC MMWR, November 19, 2010, v. 59, No. #RR-10; ACOG Committee Opinion, No. 485, April 2011, Reaffirmed 2016; ACOG Committee Opinion, No. 797, Feb. 2020)
- E15 Hemoglobin/Hematocrit screening at the initial appointment, in second trimester (as indicated), and in third trimester. Asymptomatic patients that meet the criteria for anemia (hematocrit levels < 33% or hemoglobin levels < 11.0 in the 1st and 3rd trimesters, and hematocrit < 32% or hemoglobin < 10.7 in the 2nd trimester) should be evaluated. (ACOG Practice Bulletin, No. 95, July 2008, Reaffirmed 2017; Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp. 159, 306-307)
- 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 Oral Glucose Tolerance Test (OGTT). Patients with abnormal testing results should be referred to the appropriate provider for follow up. ACOG Practice Bulletin, No. 190, Feb. 2018; Reaffirmed 2019; *Guidelines for Perinatal Care* 8th ed., pp. 163-164, 310-314)
- E17 Hemoglobin electrophoresis screening, as indicated, or document if patient refused test. Screening for other genetic disorders (e.g., β -thalassemia, α -thalassemia, Tay-Sachs disease, Canavan disease, and familial dysautonomia (Ashkenazi Jews) should be provided based on the patient's racial and ethnic background and the family background (cystic fibrosis, Duchenne's muscular dystrophy, fragile X syndrome, intellectual disability). (ACOG Committee Opinion No. 691, March 2017; ACOG Practice Bulletin, No. 78, January 2007, Reaffirmed 2015; Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp. 139-141)
- E18 Lead exposure screening using the Lead and Pregnancy Risk Questionnaire (DHHS 4116E, 4116S). Provide lead testing for those who have positive screening results. (<https://www.cdc.gov/nceh/lead/publications/LeadandPregnancy2010.pdf>; ACOG Committee Opinion, No. 533, August 2012, Reaffirmed 2016; Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., p. 195)
- E19 Diagnostic/monitoring tests completed (when indicated):
- Assessment of Fetal Movement (i.e. Kick Counts)
 - Refer for Nonstress Test (NST), if indicated
- (*JOGNN*, No. 44, pp. 683-686, (2015); ACOG Practice Bulletin, No. 145, July 2014, Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp. 199-202)
- E20 Follow-up for abnormal findings:
- Manage abnormal findings as indicated
 - Consult with specialist as indicated
- (*Guidelines for Perinatal Care*, 8th ed., pp. 597-600)

F. Medical Therapy

Provide and document the following:

- F1 Discussion of 17 α -Hydroxyprogesterone caproate (17P) and agreed upon plan of care for patients at high risk of preterm birth.
- F2 Influenza vaccine provided for all pregnant patients during influenza season (October through May), as defined by the NC Immunization Branch which follows the definition of influenza season put forth by the Centers for Disease Control and Prevention (CDC). Document the date the vaccine was given or refused in the medical record. (CDC MMWR, August 23, 2019, v. 68, No. #RR-3; ACOG Committee Opinion, No. 732, April 2018, Reaffirmed 2019; *Guidelines for Perinatal Care*, 8th ed., pp. 164-166, 511-514)
- F3 Tetanus, diphtheria, and pertussis (Tdap) vaccine should be administered with each pregnancy, preferably between 27 and 36 weeks gestation. Document the date the vaccine was given or declined in the medical record. (ACOG Committee Opinion No. 772, March 2019; Committee Opinion, No. 741, June 2018; Committee Opinion 718, September 2017; *Guidelines for Perinatal Care*, 8th ed., pp. 164-166)
- F4 Recommend use of low dose aspirin (81 mg) initiated after the 12th week of pregnancy in patients with a history of preeclampsia in prior pregnancy. [LeFevre, M. L. (2014) Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine*, 161, 819-826, doi: 10.7326/M14-1884; ACOG Committee Opinion, No. 743, July 2018; *Guidelines for Perinatal Care*, 8th ed., pp. 152, 319-324]

G. Nutrition Services

Gestational Weight Management:

- G1 Record weight and height for all patients at the initial prenatal appointment. (*Guidelines for Perinatal Care*, 8th ed., pp. 153, 188-190)
- 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 2018; Reaffirmed 2020; *Guidelines for Perinatal Care*, 8th ed., pp. 188-190)
- G3 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 2018; Reaffirmed 2020; *Guidelines for Perinatal Care*, 8th ed., pp. 188-190, 583)
- 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). (*Guidelines for Perinatal Care*, 8th ed., pp. 185-190)

Nutrition Screening and Referral:

- G5 Nutrition screening shall be performed or reviewed by a nurse, nutritionist, physician, or advanced practice practitioner at the first appointment and updated at subsequent appointments as needed. Based on this screening, an appropriate care plan or referral to a Registered Dietitian (RD) or a Licensed Dietitian/Nutritionist (LDN) will be documented. The LDN

should be licensed by the NC State Board of Dietetics. (*Guidelines for Perinatal Care*, 8th ed., pp. 6-8)

- G6 Provide a prenatal supplement containing folic acid and iron. If the patient has Medicaid or third-party insurance, a prescription for prenatal vitamins will be provided. For those patients without third party reimbursement, the health department shall provide the prenatal vitamins containing folic acid and iron. The health department shall document that each patient has obtained prenatal vitamins on the subsequent prenatal visits after the initial prescription is given and refilled. (*Guideline for Perinatal Care*, 8th ed., pp. 185-188)
- G7 Refer to WIC at initial appointment, if not already enrolled.

H. Psychosocial Services

- H1 Complete initial, interval, and postpartum screenings for substance use, depression, interpersonal violence, and tobacco/electronic nicotine delivery systems and refer as indicated.
- H2 Coordinate the plan of care with the patient's Pregnancy Care Manager as applicable. If the patient is not engaged with a Pregnancy Care Manager, refer patient for services if Medicaid eligible.

I. Patient Education

Provide and document the following:

- I1 Education specific to individual risk conditions.
- I2 Basic prenatal education in an individual or group format. Appropriately trained members of the maternal health team can provide the education. These include nurse, nutritionist, social worker, physician, advanced-practice practitioner, and health educator. For example, if the social worker or the nutritionist provides education on a given topic, this education need not be repeated by another member of the health team. (*Guidelines for Perinatal Care*, 8th ed., pp. 6-8)
- I3 Scope of care (including what is expected at the first prenatal appointment and anticipated schedule of appointments); lab studies that may be performed; options for prenatal care; office policies; emergency coverage and cost; and expected course of pregnancy. (*Guidelines for Perinatal Care*, 8th ed., pp. 150-154)
- I4 Provider coverage for labor and delivery services.
- I5 Adverse signs/symptoms of pregnancy, including vaginal bleeding, rupture of membranes, nausea/vomiting, and decreased fetal movement, to contact provider.
- I6 Practices to promote health maintenance; balanced nutrition (ideal calorie intake and weight gain); exercise safety and daily activity; travel; alcohol and tobacco consumption or use of electronic nicotine 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 secondhand smoke and lead; and nausea and vomiting during pregnancy. (ACOG Committee Opinion, No. 746, August 2018, Reaffirmed 2019; Committee Opinion, No. 804, April 2020; Practice Bulletin, No. 189, January 2018; *Guidelines for Perinatal Care*, 8th ed., pp. 185-198)
- I7 Warning signs to terminate exercise while pregnant include chest pain, vaginal bleeding, dizziness, headache, decreased fetal movement, rupture of membranes, muscle weakness, calf pain or swelling, preterm labor, or regular uterine contractions. (ACOG Committee Opinion, No. 804, April 2020; *Guidelines for Perinatal Care*, 8th ed., pp. 190-191)

- I8 Educational programs available (such as childbirth education, which should provide information on labor, pain relief, delivery, breastfeeding, infant care, and postpartum period, car seat safety, or breastfeeding). (*Guidelines for Perinatal Care*, 8th ed., pp. 211-217)
- I9 Benefits of breastfeeding and risks of not breastfeeding. (Office of the Surgeon General, Centers for Disease Control and Prevention, and Office on Women’s Health. (2011). (US DHHS, *The Surgeon’s General call to action to support breastfeeding*; *JOGNN*, No. 44, 145-149, (2015); ACOG Committee Opinion, No. 570, August 2013; Reaffirmed 2018; Committee Opinion, No. 756, Oct. 2018 ; *Guidelines for Perinatal Care*, 8th ed., pp. 216-217, 371-379, 427)
- I10 Dangers of eating certain fish with high levels of mercury, including shark, swordfish, king mackerel and tilefish and risks associated with eating unpasteurized cheese and milk; hot dogs or luncheon meats (unless they are steaming hot); or refrigerated smoked seafood, pâtés or meat spreads. (*Guidelines for Perinatal Care*, 8th ed., pp. 194-195)
- I11 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). (*Guidelines for Perinatal Care*, 8th ed., pp. 150-151)
- I13 Safe sleep education for all patients. (*Guidelines for Perinatal Care*, 8th ed., pp. 398-399)
- I14 Education on family planning method options. (*Guidelines for Perinatal Care*, 8th ed., pp. 134, 288-294)
- I15 Provide education on postpartum warning signs and symptoms and when to alert provider or to seek care at the nearest emergency department. (ACOG Committee Opinion, No. 736, May 2018; AWHONN Post-Birth Warning Signs Education Program <https://www.awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/>)

J. Staff Requirements and Training

- J1 The Maternity Nurse Supervisor, Pregnancy 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 Women’s Health Branch listservs, use of the Virtual Health documentation system, and CareImpact, as well as access to other technical resources and to maternal health materials.
- J2 **Maternal Health Nurse Training**
Certain low-risk patients may receive designated services from public health nurses who have received special Maternal Health Enhanced Role Nurse Training. In 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 enhanced role nurse (ERN) training, number of patient contact hours (combination of time spent as a nurse interviewer and highest-level care provider) and accrued educational contact hours. Enhanced role nurses must fulfill all requirements by June 30th each year or they will lose enhanced role status due to elimination of program. There is no re-rostering component available.
- J3 Each ERN shall complete 100 clinical hours and 10 educational contact hours during the Agreement Addendum’s Service Period (June 1, 2021 through May 31, 2022), with the documentation for these hours maintained and updated at the Local Health Department.

Documentation for the hours completed under the prior year's (FY 20-21) Agreement Addendum must be submitted by August 15, 2021 to the Women's Health Branch, through completion of the WHB ERN Survey. (This FY 21-22 Agreement Addendum will have its hours-completed data submitted under the next Agreement Addendum, FY 22-23.) A link to the survey will be sent via email to the ERN as well as the Director of Nursing of the Local Health Department. The Local Health Department should advise the WHB of any ERNs who have either retired or are no longer functioning as an ERN and they will be removed from the current roster and will not be required to complete the survey. Additionally, any ERN who is seeking to re-roster must submit a competency checklist completed by the agency's Medical Director/Medical Consultant responsible for the Maternal Health Program.

J4 Pregnancy Care Manager Staffing and CMHRP Training

- a. Any changes in Pregnancy Care Manager or Pregnancy Care Management supervisor positions shall be electronically submitted to <http://childreneyouth.staffing.sgizmo.com/s3/> 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 WHB 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 Program Manual 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 WHB Regional Social Work Consultant.
- d. All social workers hired as Pregnancy Care Managers after September 1, 2011 must have a Bachelor's of Social Work (BSW, BA in SW, or BS in SW) or Master's 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 Services Agreement. 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 Pregnancy 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 Program Manual, adhering to the specified timeframes in the document.

J5 Clinical Social Work Staffing and Training

- a. Written notification about staff changes shall be submitted to the WHB Clinical Social Work Consultant within 14 days of staff change including hiring new staff, position vacancy, position elimination, or other staff change.
- b. All new Licensed Clinical Social Workers are required to complete the LCSW orientation materials located on the WHB website, <https://whb.ncpublichealth.com/provPart/training.htm>, within two months of hire date. Additionally, the WHB Clinical Social Work Consultant shall be notified of course completion within 14 days of course completion.

- J6 Recommend maternal health staff receive task appropriate breastfeeding promotion and support training from Breastfeeding Coordinators in health departments or from the six Regional Breastfeeding Training Centers in North Carolina at no cost. This training includes information on the clinic environment, goals and philosophies regarding breastfeeding, as well as task appropriate breastfeeding information, such as anticipatory guidance for the breastfeeding infant, the benefits of and the risks of not breastfeeding, anticipatory guidance related to breastfeeding and birth spacing/family planning, contraindications to breastfeeding, and information for referring patients for additional breastfeeding support services. Initial training for all maternal health staff is encouraged; on-going training as needed is recommended. Training certificates per person or per agency are available. (US DHHS. *The Surgeon's General Call to Action to Support Breastfeeding*; 2011, Action 9, pp. 46; ACOG Committee Opinion, No. 570, August 2013).

IV. Performance Measures/Reporting Requirements:

- A. 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>.
1. Increase the number of maternal health patients.
 2. Increase the number of maternal health patients who receive 7 or more antepartum care visits.
 3. Decrease the percentage of maternal health patients who report tobacco use and electronic nicotine delivery systems.
 4. Increase the percentage of maternal health patients who receive 5As counseling for tobacco cessation and electronic nicotine delivery systems.
 5. Increase the percentage of maternal health patients who deliver and receive a postpartum home visit.
- B. 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:

- A. The Regional Nurse Consultants (RNC), the Regional Social Work Consultants (RSWC) and the WHB Clinical Social Work Consultant conduct performance monitoring and quality assurance activities.
1. The RNCs will conduct activities for maternal health services. These activities include: development of a pre-monitoring plan 4 to 6 months prior to the designated monitoring month; monitoring visits every 3 years; and technical assistance via phone or 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.
 2. 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

administrative and care management VirtualHealth data, chart reviews, and site visits for performance review.

3. The WHB 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.
4. A written report is completed for all monitoring site visits. 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.
5. Additionally, WHB will review data outcomes including a focus on health disparities and inform the health director of unique or adverse trends. Site visits will be conducted to assist in a local assessment and planning process.

B. Consequences:

If a corrective action plan (CAP) is required, the Local Health Department must prepare and submit it within 30 days after the follow-up report is emailed to the Health Director by the DPH Program Contact. If a CAP has not been received within 30 days of the written report, then the Local Health Department does not have monitoring closure. If the monitoring is not closed within 90 days, the Local Health Department will be placed on high risk status which will require annual monitoring of that Local Health Department. Monitoring closure is defined as the Local Health Department being notified that their final CAP is acceptable or that they are being referred for continuing technical assistance.

A loss of up to 5% of funds may result for a Local Health Department if it does not meet the level of 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 21-22**. Upon completion, the Open Windows Budget Form must be emailed to **Phyllis.C.Johnson@dhhs.nc.gov**. The Open Windows Budget Form requires a line item budget and a narrative justification for each line item. The Open Windows Budget Form can be downloaded from the Women's Health Branch website at <https://whb.ncpublichealth.com/provPart/agreementAddenda.htm>.

The Open Window Budget Form consists of 3 tabbed sheets in a Microsoft Excel workbook. These sheets are: Contractor Budget worksheet (sheet 1), Salary and Fringe worksheet (sheet 2) and Subcontractor Budget worksheet (sheet 3). Enter information only in yellow, pink or white shaded cells. The blue shaded fields will automatically calculate for you. Information will carry over from sheets 2 and 3 to sheet 1. Refer to the approved budget narrative from FY 20-21 as a reference for completing this FY 21-22 budget narrative.

Narrative Justification for Expenses

A narrative justification must be included for every expense listed in the FY 21-22 budget. Each justification should show how the amount on the line item budget was calculated, and clearly justify/explain how the expense relates to the program. The instructions on **How to Fill Out the Open Windows Budget Form** is posted on the Women's Health Branch website at <https://whb.ncpublichealth.com/provPart/agreementAddenda.htm>. Below are examples of line item descriptions and sample narrative justifications:

Equipment

The maximum that can be expended on an equipment item, without prior approval from the WHB, is \$2,000. An equipment item that exceeds \$2,000 shall be approved by the WHB before the purchase can be made. If an equipment item shall be used by multiple clinics, you must prorate the cost of that equipment item and the narrative must include a detailed calculation which demonstrates how the agency prorates the equipment.

Justification Example: 1 shredder @ \$1,500 each for nursing office staff to shred confidential patient information. Cost divided between 3 clinics. $\$1500/3 = \500 .

Administrative Personnel - Fringe Costs

Provide position title, staff FTE, brief description of the positions, and method of calculating each fringe benefit that shall be funded by this Agreement Addenda. A description can be used for multiple staff if the duties being performed are similar. Do not prorate the salary and fringe amounts. The spreadsheet will prorate these amounts based on the number of months and percent of time worked.

Justification Example: P. Johnson/J. Scott, PHN III, 2.0 FTE – work as registered nurses in the Maternal Health Clinic. They take histories, make assessments, review labs, and administer medication to patients who present themselves for prenatal care. M. Apple and S. Hat, Community Health Assistants, 0.75 FTE – work as nursing assistants in the Maternal Health Clinic. They check vital signs of patients presenting themselves for prenatal care and chaperone medical providers. In addition to stocking and cleaning the exam rooms.

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

Incentives

Incentives may be provided to program participants in order to ensure the level of commitment that is needed to achieve the expected outcomes of the program. While there is no maximum amount of funding that may be used to provide incentives for program participants, the level of incentives must be appropriate for the level of participation needed to achieve the expected outcomes of the program. Examples of incentive items include: gift cards, diaper bags, diapers, baby wipes, parent’s night.

Justification Example: Diaper bags for 10 participants @ \$20/bag = \$200.

Travel

Mileage and subsistence rates are determined by the North Carolina Office of State Budget and Management (OSBM) 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.

Current Subsistence Rates—For informational purposes, the OSBM lists the following schedule, effective July 1, 2019:

	<u>In-State</u>	<u>Out-of-State</u>
Breakfast	\$ 8.60	\$ 8.60
Lunch	\$ 11.30	\$ 11.30
Dinner	\$ 19.50	\$ 22.20
Lodging (actual, up to)	<u>\$ 75.10</u>	<u>\$ 88.70</u>
Total	\$ 114.50	\$ 130.80

Justification Example:

Overnight accommodations for Maternal Health Nurse Supervisor and 1 PHN II to attend XYZ Training:
 2 nights’ lodging x \$75.10 (excludes tax) = \$150.00; 2 staff’s meals x \$78.00 = \$156.00
 = (2 breakfast @ \$8.60/person) + (2 lunches @ \$11.30/person) + (2 dinners @ \$19.50/person)
 Total cost: \$150.00 lodging + \$156 meals = \$306.00

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.

Attachment B

Maternal Health Patients

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 should be returned with your signed Agreement Addendum. Retain a copy of this Attachment B in the Local Health Department files for your reference.

Unduplicated number of patients to be served in the Maternal Health Clinic:	
Estimated <u>percent of uninsured</u> patients to be served in the Maternal Health Clinic:	%