

Division of Public Health

Agreement Addendum

FY 25-26

Master Local Health Department Legal Name	Women, Infant, and Community Wellness Section / Maternal Health Branch DPH Section / Branch Name
101 Maternal Health Activity Number and Description	Tara Owens Shuler, (919) 707-5708, tara.shuler@dhhs.nc.gov DPH Program Contact (name, phone number, and email)
06/01/2025 – 05/31/2026 Service Period	DPH Program Signature Date (only required for a negotiable Agreement Addendum)
07/01/2025 – 06/30/2026 Payment Period	
<input checked="" type="checkbox"/> Original Agreement Addendum <input type="checkbox"/> Agreement Addendum Revision # _____	

I. Background:

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

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 15, 2025 to Tara.Shuler@dhhs.nc.gov to document how the Local Health Department intends to expend funds awarded for FY26. **The budget must equal funds allocated to the Local Health Department.** (Refer to the FY 25-26 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 a percentage 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, 2026, will provide the documentation to substantiate services that the Local Health Department has provided for this FY26 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 for prenatal services and document consent with a patient signature.
- 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 section E. Nutrition Services), education on infant feeding, childbirth, and parenting education for families. Referrals must be documented in the Maternal Health record for patients receiving prenatal care.
- A4 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*).²

² Maternal Support Services 1M-2 NC Medicaid Clinical Coverage Policy Childbirth Education Amended Date: August 15, 2023

- A5 The Local Health Department may provide Home Visits for Postnatal Assessment and Follow-up Care and Maternal Care Skilled Nurse Home Visits (MCSNHV) per NC Medicaid clinical coverage policies 1M-5³ and 1M-6.⁴
- A6 Provide or assure the provision of Care Management for High-Risk Pregnancies (CMHRP) services to Medicaid eligible patients, in accordance with CMHRP program requirements and NC Medicaid Coverage Policy 1E-6.⁵ Individuals who are not aligned with a Prepaid Health Plan (PHP) but receive Presumptive Eligibility (PE) coverage should also be referred to CMHRP services, as applicable.
- A7 The Local Health Department may provide Health and Behavior Intervention (HBI) services in accordance with NC Medicaid Clinical Coverage Policy No: 1M-3, Health and Behavior Intervention.⁶

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 Local Health Department 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 a Non-Stress Test (NST), it must be provided by a trained, licensed healthcare professional who will perform the NST when indication warrants. These healthcare professionals may include Registered Nurses (RNs), Certified Nurse-Midwives, Nurse Practitioners, Clinical Nurse Specialists, Physicians, and Physician Assistants. The NST should be interpreted by a trained, licensed healthcare provider. Documentation of fetal monitoring training is required every two years for all professionals who perform and/or interpret this test.

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 scheduling first appointment

³ Maternal Support Services 1M-5 NC Medicaid Clinical Coverage Policy Home Visit for Postnatal Assessment and Follow-up Care Amended Date: August 15, 2023

⁴ Maternal Support Services 1M-6 NC Medicaid Clinical Coverage Policy Maternal Care Skilled Nurse Home Visit Amended Date: August 15, 2023

⁵ Obstetrics & Gynecology 1E-6 NC Medicaid Clinical Coverage Policy Pregnancy Management Program Amended Date: April 1, 2023

⁶ Maternal Support Services 1M-3 NC Medicaid Clinical Coverage Policy Health and Behavior Intervention Amended Date: August 15, 2023

and/or triaging patients based on the presence of any identified adverse pregnancy risk factors. 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, which should 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), or when the patient requests presumptive eligibility based on attestation of pregnancy. Patients are not to be delayed in receiving Medicaid. 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 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 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 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 or a community resource.
- C13 Develop and follow a policy/procedure/protocol that describes the agency's completion of the modified 5Ps validated screening tool for substance use disorder 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. Policy should include referral processes for those who are diagnosed with substance use disorder.

- C14 Develop and follow a policy/procedure/protocol 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. Universal laboratory testing for the presence of drugs is not recommended. Use of laboratory testing for presence of drugs should not be used to screen for substance use disorder (see C13).
- C15 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))
- C16 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.
- C17 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)
- C18 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).⁷ Screening questions shall be administered privately at the first prenatal contact, each trimester, and postpartum.
- C19 Develop and follow a policy/procedure/protocol for referring patients to a high-risk maternity clinic or provider for identified high-risk conditions that are not within the scope of practice for the Local Health Department.
- C20 Develop and follow a policy/procedure/protocol for assessing prenatal clients for immunity to rubella and varicella at the first prenatal visit, and for provision of or referral for the rubella and varicella vaccines postpartum if the patient is not immune.
- C21 Develop and follow a policy/procedure/protocol for documenting appropriate universal screening and treatment for vaginal/rectal/urinary Group B Streptococcal (GBS). Unless already diagnosed with positive GBS bacteriuria, all patients should be screened via vaginal/rectal swab at 36-38 weeks gestation or within 5 weeks of planned early delivery. Patients who are penicillin allergic, need sensitivity testing.. Policy should include process for transferring results to delivering hospital. (ACOG Committee Opinion, No. 797)
- C22 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.

⁷ <https://wicws.dph.ncdhhs.gov/provpart/forms.htm>

- C23 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.
- C24 Develop and follow policy/procedure/protocol on how the agency maintains a breastfeeding-friendly clinic environment in accordance with the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion titled "Optimizing Support for Breastfeeding as Part of Obstetric Practice,". If the Local Health Department has a WIC clinic on site, it must follow the established federal standards for breastfeeding promotion and support.
- C25 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 Services

Clinical Services: Components of clinical services for maternal health visits are found in Attachment D.

E. Nutrition Services

- E1 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 (in accordance with IOM guidelines) based on single or multiple gestations.
- E2 Offer and document nutrition consultation to all underweight or obese patients (pre-pregnancy BMI of <18.5 or ≥ 30). This consultation may be accomplished by a referral to a Registered Dietitian (RD), Licensed Dietitian/Nutritionist (LDN) or Women, Infants, and Children (WIC).
- E3 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 care will be documented in the patient's maternal health record. The LDN should be licensed by the NC State Board of Dietetics
- E4 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.
- E5 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.

F. Psychosocial Services

- F1 Complete initial, interval, and postpartum screenings for substance use, depression, anxiety, interpersonal violence, and tobacco/electronic nicotine delivery systems, as indicated in policies found in section C. Policies/Procedures.

- F2 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.
- F3 Refer to appropriate behavioral health professional for a comprehensive clinical assessment and care plan in response to any psychosocial risks identified by Maternal Health History Forms C-1 (DHHS form 4158) and C-2 (DHHS form 4160) in combination with validated screening tools. Consideration for referral based off significant behavioral health history is also recommended.

G. Postpartum Services

- G1 The Local Health Department should contact all patients within 3 weeks after delivery.
- G2 A comprehensive postpartum exam should be done 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. Document follow-up attempt, if postpartum appointment is missed.
 - 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. Document plan for ongoing primary care, including referral to a primary care provider as indicated.

H. Staff Requirements and Training

- H1 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.

- H2 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, 2025–June 30, 2026. 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, 2024–June 30, 2025) must be submitted by August 15, 2025, 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.
- H3 CMHRP Manager Staffing and CMHRP Training
- a. Any changes in CMHRP Care Manager or CMHRP Care Management Supervisor positions shall be electronically submitted⁸ 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

⁸ <https://survey.alchemer.com/s3/7111130/CMARC-and-CMHRP-Staffing-Information>

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.

H4 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 website⁹ 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.

H5 Recommend maternal health staff receive task appropriate breastfeeding promotion and support training from Breastfeeding Coordinators in health departments or from the Lactation Area Training Centers for Health (LATCH). The lead Regional Lactation Trainer for Eastern Area Health Education Center (EAHEC) can help facilitate training needs. Initial training for all maternal health staff is encouraged; on-going training as needed is recommended.

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

1. The Local Health Department shall improve birth outcomes and health status of 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 percentage of maternal health patients who are screened for perinatal mood disorders during pregnancy.
 - c. Increase the percentage of maternal health patients who are screened for substance use.
 - d. Increase the percentage of maternal health patients who receive a postpartum visit within the first 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.
3. **Reporting Required Subcontract Information**
In accordance with revised NCDHHS guidelines effective October 1, 2024, the LHD must provide the information listed below for every subcontract receiving funding from the LHD to carry out any or all of this Agreement Addendum's work.

This information is not to be returned with the signed Agreement Addendum (AA) but is to be provided to DPH when the entities are known by the LHD.

⁹ <https://wicws.dph.ncdhhs.gov/provpart/training.htm>

- a. Subcontracts are contracts or agreements issued by the LHD to a vendor (“Subcontractor”) or a pass-through entity (“Subrecipient”).
 1. Subcontractors are vendors hired by the LHD via a contract to provide a good or service required by the LHD to perform or accomplish specific work outlined in the executed AA. For example, if the LHD needed to build a data system to satisfy an AA’s reporting requirements, the vendor hired by the LHD to build the data system would be a Subcontractor. (However, not all Vendors are considered Subcontractors. Entities performing general administrative services for the LHD (e.g., certified professional accountants) are not considered Subcontractors.
 2. Subrecipients of the LHD are those that receive DPH pass-through funding from the LHD via a contract or agreement for them to carry out all or a portion of the programmatic responsibilities outlined in the executed AA. (Subrecipients are also referred to as Subgrantees in NCAC.)

The following information must be provided to the DPH Program Contact listed on Page 1 of this AA for review prior to the entity being awarded a contract or agreement from the LHD:

- Organization or Individual’s Name (if an individual, include the person’s title)
- EIN or Tax ID
- Street Address or PO Box
- City, State and ZIP Code
- Contact Name
- Contact Email
- Contact Telephone
- Fiscal Year End Date (of the entity)
- State whether the entity is functioning as a pass-through entity Subcontractor or Subrecipient of the LHD.

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. **Federal Funding Requirements:** where federal grant dollars received by the Division of Public Health (DPH) are passed through to the Local Health Department (LHD) for all or any part of this Agreement Addendum (AA).
 - a. **Requirements for Pass-through Entities:** In compliance with 2 CFR §200.331 – *Requirements for pass-through entities*, DPH provides Federal Award Reporting Supplements (FASs) to the LHD receiving federally funded AAs.
 1. **Definition:** A FAS discloses the required elements of a single federal award. FASs address elements of federal funding sources only; state funding elements will not be included in the FAS. An AA funded by more than one federal award will receive a disclosure FAS for each federal award.
 2. **Frequency:** An FAS will be generated as DPH receives information for federal grants. FASs will be issued to the LHD throughout the state fiscal year. For a federally funded AA, an FAS will accompany the original AA. If an AA is revised and if the revision affects federal funds, the AA Revision will include an FAS. FASs can also be sent to the LHD even if no change is needed to an AA. In those instances, the FAS will be sent to provide newly received federal grant information for funds already allocated in the existing AA.
 - b. **Required Reporting Certifications:** Per the revised Uniform Guidance, 2 CFR 200, if awarded federal pass-through funds, the LHD as well as all subrecipients of the LHD must certify the following whenever 1) applying for funds, 2) requesting payment, and 3) submitting financial reports:

“I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812.”

Attachment A**Detailed Budget Instructions and Information****Budget and Justification Form**

Applicants must complete the **Open Windows Budget Form for FY 25-26**. Upon completion, the Open Windows Budget Form must be emailed by April 12, 2025 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.¹⁰

The Open Windows 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 24-25 as a reference for completing this FY 25-26 budget narrative.

Narrative Justification for Expenses

A narrative justification must be included for every expense listed in the FY 25-26 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. Examples of line item descriptions and sample narrative justifications are below.

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. $\$1,500/3 = \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.

¹⁰ <https://wicws.dph.ncdhhs.gov/provpart/agreement-addenda.htm>

Incentives

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

Justification Example:

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

Travel

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

Mileage Rate

The Office of State Budget and Management adopts the IRS mileage reimbursement rate. The North Carolina Department of Health and Human Services (NCDHHS) and DPH follows this guidance. Mileage rates are typically updated annually. Effective January 1, 2024, the mileage reimbursement rate is 67 cents per mile.

Subsistence Rates

DPH follows the NCDHHS Travel Policy for meals and lodging reimbursement. NCDHHS has issued the following schedule, effective October 1, 2024:

	<u>In-State</u>	<u>Out-of-State</u>
Breakfast	\$ 16	\$ 16
Lunch	\$ 19	\$ 19
Dinner	\$ 28	\$ 28
Lodging (actual, up to)	<u>\$ 110</u>	<u>\$ 110</u>
Total	\$ 173	\$ 173

Justification Example:

Overnight accommodations for Maternal Health Nurse Supervisor and 1 PHN II to attend XYZ Training:

- 2 nights’ lodging x \$110 (excludes tax) = \$220
- 2 breakfast x 2 staff @ \$16/person = \$64
- 2 lunches x 2 staff @ \$19/person = \$76
- 2 dinners x 2 staff @ \$28/person = \$112
- Total cost: \$220 lodging + \$252 meals = \$472

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 <u>percent of uninsured</u> 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, 2026, 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, Number 7, by these categories: A. General Services, E. Nutrition Services, F. Psychosocial Services, G. Postpartum Services)

- Provide nutrition consultation (A3; E1–E5)
- Provide Maternal Care Skilled Nurse Home Visits. (A5)
- Provide the provision of Care Management for High-Risk Pregnancies (CMHRP) services to Medicaid eligible patients, in accordance with CMHRP program requirements. (A6)
- Provide Health and Behavior Intervention (HBI) services. (A7)
- Provide postpartum services (G1 and G2)
- Provide nutrition screening and referral for services (E5)
- Provide psychosocial screening and referral for services (F1 and F2)
- None

Maternal Health Assurance Plan for MOU samples and the “Guidance for Local Health Department Assurance of Maternal Health Services” are available online.¹¹

¹¹ https://wicws.dph.ncdhs.gov/provpart/docs/Final_AP-MOU-ModelSample.pdf

Attachment D

Prenatal Services

Prenatal Health Clinical Services Initial Visit

Assess and document the following minimum health history components at the initial prenatal appointment.

1. Medical History: including surgeries and family medical history ¹²	7. Teratogen Exposure: including environmental tobacco, nicotine, and lead exposure ^{13,16}
2. Immunization history: including history of immunity ¹⁴	8. Patient and Partner Genetic Risk ¹⁶
3. Medications: including prescription and non-prescription	9. Social Determinants of Health: including psychological needs, social needs, education level ¹⁵
4. Menstrual: including last menstrual period with Estimated Date of Delivery (EDD) ¹⁴	10. Nutrition status ¹⁶
5. Pregnancy History ¹⁴	11. Substance usage ¹⁴
6. Infection History ¹⁶	12. Other pregnancy risk factors ¹⁷

Prenatal Health Clinical Services Initial Visit

Assess and document the following minimum physical examination components.¹⁸

1. Height/Weight/BMI	8. Cervix
2. HEENT	9. Abdomen
3. Teeth	10. Extremities
4. Thyroid	11. Skin
5. Lungs	12. Lymph nodes
6. Breast	13. Pelvis (including uterine size or fundal height)
7. Heart	14. Blood pressure

Prenatal Health Clinical Services Subsequent Prenatal Visits¹⁹

Assess and document the following minimum components on all subsequent routine scheduled visits.

1. Interim history/routine screening questions: fetal Interim movement, contractions, rupture of membranes, vaginal bleeding	6. Fetal presentation greater than or equal to 36 weeks
2. Weight: documenting gain or loss in accordance with IOM guidelines with counseling of appropriate weight gain range	7. Psychosocial screening ²⁰
3. Blood pressure	8. Refer or provide Nonstress Test (NST) if ordered
4. Fetal heart rate as applicable per gestational age	9. Consult with a specialist if as indicated per order
5. Fundal height as applicable per gestational age	

¹² DHHS 4154 Maternal Health History, Part A

¹³ DHHS 4116 Lead in Pregnancy

¹⁴ DHHS 4156 Maternal Health History, Part B

¹⁵ DHHS 4158 Maternal Health History, Part C-1

¹⁶ DHHS 4161 Maternal Health History, Part D

¹⁷ DHHS 4095 Maternal Health Risk Guide

¹⁸ DHHS 3964 Physical Exam

¹⁹ DHHS 3967 Maternal Flow

²⁰ DHHS Maternal Health History, Part C-2

Prenatal Laboratory Services²¹

Provide and document the following:

1. Syphilis screening must be performed at the following: the initial appointment, between 28-30 weeks, and when symptomatic.	11. Varicella immunity status assessment at initial appointment. If immunity status cannot be obtained titers can be drawn.
2. Hepatitis B screening on the initial appointment, unless known to be infected.	12. Cervical cytology screening for cancer according to American Society for Colposcopy and Cervical Pathology (ASCCP), ACOG and USPSTF guidelines.
3. Hepatitis C screening on all pregnant women during each pregnancy unless already known to be infected. Screening during pregnancy is recommended unless prevalence is <0.1%. NC prevalence in <18 years of age is <0.1%.	13. A baseline urine dipstick for protein content to assess renal status at the initial appointment and at subsequent appointments as indicated.
4. HIV testing at the initial appointment and the third trimester (preferably before 36 weeks of gestation) unless there is documentation in the medical record that the patient declines.	14. Urine culture completed at initial appointment, and at subsequent appointments as indicated.
5. Gonorrhea testing at the initial appointment and repeated in the third trimester if 25 years of age or younger; or greater than 25 years of age based on client risk factors.	15. Group B strep (GBS) screening at 36-38 weeks if no GBS bacteriuria previously identified in current pregnancy.
6. Chlamydia testing at the initial appointment and repeated in the third trimester if 25 years of age or younger; or greater than 25 years of age based on client risk factors.	16. Hemoglobin/hematocrit screening at the initial appointment, in second trimester (as indicated), and in third trimester.
7. Counseling about fetal genetic and aneuploidy screening tests ideally prior to 20 weeks of gestation. Offer or refer for appropriate fetal genetic screening tests to patients who give informed consent for the test. Patients who decline the test should have this documented in the medical record.	17. Patients with risk factors for Type 2 diabetes may be screened at the initial visit according to American Diabetes Association and ACOG guidelines.
8. 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.	18. Patients who are not screened at the initial visit, and those who were screened and did 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.
9. Repeat antibody screening should occur at 26-28 weeks gestation for Rh D negative patients with a negative initial antibody screening. 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.	19. Counseling about patient carrier screening for genetic disease 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

²¹ DHHS 4010 Laboratory Data

	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.
10. Rubella immunity status assessment at initial appointment. If immunity status cannot be obtained titers can be drawn.	20. Lead exposure screening using the Lead and Pregnancy Risk Questionnaire (DHHS 4116E, 4116S). Provide lead testing for those who have positive screening results. For all patients with elevated lead levels (>5mcg/dl), appropriate follow-up should be completed.

Prenatal Medical Therapy²¹

Provide and document the following:

1. Influenza vaccine provided for all pregnant patients during influenza season (October through May).	3. 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. Documentation of use should be found on the medication list.
2. Tetanus, diphtheria, and pertussis (Tdap) vaccine should be administered with each pregnancy, preferably between 27- and 36-week gestation.	4. Updated SARS-CoV-2 mRNA vaccination should be recommended to protect against severe COVID infection.

Prenatal Patient Education²²

Provide and document the following:

1. Education specific to patient's risk conditions.	8. Benefits of breastfeeding and risks of not breastfeeding.
2. Basic prenatal education in an individual or group format by appropriately trained members of the maternal health team.	9. Nutrition Counseling; special diet; dietary precautions (mercury, listeriosis).
3. 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.	10. Planning for discharge and childcare; choosing the newborn's physician.
4. Provider coverage for labor and delivery services.	11. Financial responsibility to the patient for prenatal care and hospitalization (e.g., insurance plan participation, self-pay).
5. Adverse signs/symptoms of pregnancy to report to provider, including vaginal bleeding, rupture of membranes, nausea/vomiting, and decreased fetal movement.	12. Safe sleep education for all patients
6. 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;	13. Education on family planning method options.

²² DHHS 3966 Maternal Health Education

sauna and hot tub exposure; prevention of HIV infection and other STIs; environmental exposure such as secondhand smoke and lead.	
7. Educational programs available such as childbirth education, infant care, car seat safety, and breastfeeding.	14. 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.