REPORT OF THE
MATERNAL AND CHILD HEALTH COUNCIL ON

Ways to Create and Maintain Effective Maternal Health Services for Pregnant Women in Crisis

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 45

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COMMONWEALTH of VIRGINIA

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TO: The Honorable Lawrence Douglas Wilder
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The Members of the General Assembly of Virginia

I am pleased to transmit this report which constitutes the response of the Maternal and Child Health Council to Senate Joint Resolution No. 329 of the 1993 Session of the General Assembly of Virginia.

This report offers the results of the Council's study of ways to create and maintain effective maternal health services for pregnant women in crisis. The study was conducted under the direction of former Secretary of Health and Human Resources Howard M. Cullum, MCH Council Chair, and Donald Harris, citizen member and chair of the Council's subcommittee on Maternal Health.

Respectfully submitted,

B. Norris Vassar
Acting Secretary of Health and Human Resources

Enclosure

SENATE JOINT RESOLUTION NO. 329

A STUDY OF WAYS TO CREATE AND MAINTAIN EFFECTIVE MATERNAL HEALTH SERVICES FOR PREGNANT WOMEN IN CRISIS

Prepared by:

The Prenatal Subcommittee of the Maternal and Child Health Council

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EXECUTIVE SUMMARY

SJR 329 **Requesting the Maternal and Child Health Council to study ways to create and maintain effective maternal health services for pregnant women in crisis.**

I. PURPOSE

The purpose of this report is to "study ways to create and maintain effective maternal health services for pregnant women in crisis."

II. PREGNANT WOMEN IN CRISIS

For some women a pregnancy, especially if unplanned or unwanted, creates a crisis or may contribute to an already existing crisis situation resulting from personal problems, medical conditions, or financial difficulties. Examples include homelessness, being too young, inadequate health insurance, and substance abuse.

- In 1992, 40,000 homeless women of reproductive age requested shelter.[24]
- In fiscal year 1993, 279 pregnant women served by shelters were victims of domestic violence.[35]
- In 1991, 8% of pregnant women receiving health services in the Virginia Department of Health reported using illegal drugs.[29]
- In 1991, 45.4 per 1000 teens were pregnant.[36]
- In 1991, 15% of women in Virginia had no health insurance.
- In 1991, 36% of female-headed, single parent households were living in poverty.[21]

In 1991, of the 136,000 pregnancies in Virginia, it is estimated that 68,000 were unplanned; 32,000 ended in induced termination of pregnancies and only 244 infant adoptions occurred.[5,12,36] Of the 96,000 births annually in Virginia, it is unknown how many are to women in crisis.

Crisis during pregnancy can have serious and long-term consequences for the woman and her child. The lack of adequate shelter and financial resources can interfere with the woman's ability to maintain a healthy pregnancy. Pregnancy occurring in the teen years usually leads to an interruption in education and, subsequently, is associated with joblessness and poverty. Substance abuse is not only detrimental to the women's general health but contributes to the incidence of fetal anomalies, low birthweight, infant mortality, and child abuse.

III. SERVICES

A pregnant women in crisis may need counseling about her options including parenthood, adoption, and abortion. Counseling services are provided by private physicians, family planning clinics, maternity clinics, and some private organizations. The women's decision about her pregnancy will depend upon her religious beliefs, culture and personal values, financial concerns, and/or health status.

Pregnant woman in crisis often require additional health services as well as supplemental resources to address identified problems. The women who choose parenthood or adoption will need a level of prenatal care based upon needs as assessed by a health care provider. Prenatal care is provided by private physicians, medical schools, clinics, and the Virginia Department of Health. Case management or care coordination is an effective method to address substance abuse and high-risk medical conditions. Support services, such as shelters for homeless and battered women, or other counseling services are also needed.

Maldistribution and/or inadequate supply of health care providers, lack of child care, lack of perceived need for care by women, and lack of adequate reimbursement for services are barriers to health care for pregnant women in crisis.

Although the focus of this study is on the services for pregnant women in crisis, the study acknowledges the need for prevention. Prevention programs and services that provide women and their families with the knowledge and skills to avoid unintended and unwanted pregnancies need to be broad-based within the community, culturally sensitive, family-centered and based upon behavioral principles. Preventive services in Virginia include the Family-Life Education programs in public schools, school-based/school-linked health clinics, Better Beginnings and family planning services.

IV. MODEL PROGRAMS IN THE NATION AND VIRGINIA

Nationally and in Virginia, several programs exist to address the needs of pregnant women at risk for or in crisis. Preconceptional Health Risk Appraisal of Kentucky and Healthy Start in Hawaii are examples of programs in other states. Healthy Start/Family Resource Center in Hampton adopted from the Healthy Start in Hawaii is a comprehensive system of services for pregnant women aimed at preventing child abuse and neglect. Lay-

home visiting programs, such as Resource Mothers and the Elizabeth Project, target pregnant teens. Project LINK focuses on coordinating existing services for substance abusing women. Private/public partnerships have been created in two localities to provide maternal health services for women who had limited delivery services in their geographic areas. These programs are effective but benefit a minimum number of pregnant women because of limited resources.

V. CONCLUSIONS AND RECOMMENDATIONS: SJR 329

The study has defined a crisis pregnancy and identified what services pregnant women need. Women at risk for a crisis in pregnancy are often poor, young, homeless, and addicted to drugs. These same women are also often at risk for not receiving services.

Maternal health and other supportive services are not universally available across the state sometimes leaving the needs of pregnant women in crisis unmet. A number of strategies if initiated would provide the support needed by women in crisis pregnancies to lead to a successful resolution of the crisis.

Recommendations

1. Programs that serve pregnant women in crisis should be expanded, and should provide or assure risk-appropriate health care.
   a. Support funding to expand the three existing programs: Healthy Start, Resource Mothers and Project LINK.
   b. Encourage private and volunteer organizations that provide shelter for women in crisis to increase the number of pregnant women they serve, and to develop appropriate systems to refer for prenatal care.
   d. Encourage the expansion of existing efforts of private organizations that provide support and education for all pregnant women.
2. Maternity health services, including family planning, should be included in primary health care for women, and should be culturally sensitive, community based, easily accessible and family-centered.

   Expand Medicaid eligibility to 185% of poverty for maternity and family planning services.
3. Pregnancy planning or preconceptional care should be a standard service in primary care, and be included in the training of health care professionals.
4. Adoption should be made more accessible to a

pregnant woman in crisis.

a. Request the General Assembly to take steps to streamline the adoption process.
b. Request the Departments of Health and Social Services to provide adoption training to local health department maternity and family planning staff.
c. Encourage the expansion of the One Church, One Child Program, the adoption program for African-American children.

5. There should be an increased utilization of mid-level health care providers, specifically nurse practitioners and certified nurse midwives.
   a. Request that insurers and Medicaid extend third party reimbursement to all nurse practitioners who provide primary care to women.
   b. Encourage health professional organizations and medical schools to provide programs on the utilization of nurse practitioners and nurse midwives in provision of primary care of women.
   c. Encourage the medical schools to include in their curriculum and practice the nurse midwife model for obstetric care.
6. The Regional Perinatal Coordinating Councils should address pregnant women in crisis in their region by identifying the gaps in delivering comprehensive prenatal services, providing perinatal outreach education, and encouraging the coordination of care.

SJR 329 **Requesting the Maternal and Child Health Council to study ways to create and maintain effective maternal health services for pregnant women in crisis.**

The purpose of this report is to "study ways to create and maintain effective maternal health services for pregnant women in crisis." This study does not attempt to determine how specific barriers to services may impact on a woman's choice when experiencing a crisis pregnancy. Rather, this report defines and generally discusses the causes and consequences of crisis as they affect the decision of a woman to continue or terminate her pregnancy, and the maternal/reproductive health services and other fundamental and support services pregnant women in crisis may need. Recommendations to the General Assembly about service implementation and improvements are made in the conclusion.

II. PREGNANT WOMEN IN CRISIS: DEFINITION, CAUSES, SCOPE OF THE PROBLEM, AND CONSEQUENCES.

A. Definition and Causes

The definition of a crisis according to Webster's Dictionary, is "a condition of instability...leading to a decisive change." Pregnant women in crisis are those who consider a pregnancy to be "a condition of instability" because of personal problems, medical conditions, or financial difficulties. These factors all influence a woman's decisions regarding her pregnancy. Some women may be thrown into a crisis by an unwanted or unplanned pregnancy. For other women, a pregnancy may add to a crisis situation already present in her life, such as extreme poverty.

1. Personal Problems

Personal problems include:

- being a victim of domestic violence, rape, or incest;
- experiencing an unwanted pregnancy or birth control failure;
- being too young physically or emotionally to bear a child;
- being addicted to drugs or alcohol;
- being incarcerated;
- lacking an emotional support system;
- homelessness;
- and lack of child care.

2. Medical Conditions

Medical conditions include factors in the patient's lifestyle, a preexisting illness or a present complication which can place the woman and/or the fetus at high risk. Three complications of particular concern are genetic disorders, HIV/AIDS, and substance abuse.

Genetic Disorders

Many congenital anomalies and other genetic disorders can be diagnosed before the baby is born allowing parents to terminate a pregnancy if a debilitating fetal anomaly has been identified or to plan ahead for the infant's special needs. In 1991, the incidence of congenital anomalies in Virginia was approximately 1,400 or 15 per 1000 live births.[36]

HIV/AIDS

HIV/AIDS may present medical problems that may contribute to a crisis pregnancy, and is a problem for both the pregnant woman and her child. The rate of transmission of the AIDS virus from mother to child is about 30%. Since 1989, 18 infants have been born with HIV in Virginia.[18]

Substance Use

The negative effects of substance abuse in a pregnancy are problems for both mother and child. The use of alcohol, tobacco and other drugs during pregnancy contributes to low birthweight, congenital anomalies and other medical problems for the infant. The incidence of substance use in pregnant women receiving services in local health departments ranges from 8% for illegal drugs to 32% for cigarettes.[29]

3. Financial

Financial difficulties may be inherent in any personal or medical problems, or may be the source of a crisis situation. In 1991, 15% of women in Virginia had no health insurance and 9% were underinsured. (Joint Commission on Health Care) Through Medicaid, indigent women can receive medical care, but the eligibility process can be confusing and inconvenient. The number of physicians who accept Medicaid is inadequate in some geographic areas.

Many women who are experiencing a crisis pregnancy are living at some level of poverty, particularly those who are single, African-American, Hispanic or have less than a high school education. In Virginia, 36% of female-headed, single parent households are living in poverty.[21]

B. Scope of the Problem

Because the term "in crisis" is not uniformly defined, and accurate data on the populations of drug addicted, sexually assaulted, homeless and battered pregnant women are not available, the number of pregnant women in crisis can only be estimated.

One characteristic of many crisis pregnancies is that they are unintended or unplanned. Both national and Virginia figures for unplanned pregnancies are approximately 50% of all pregnancies.[5,12] Therefore, half or 68,000 of the 136,000 reported pregnancies in Virginia in 1991 were unintended.[36]

It is difficult to determine how many of these unintended pregnancies are unwanted. The only data available to estimate the number of unwanted pregnancies are the number of abortions and adoptions.

There were 31,578 induced terminations and approximately 250 newborn adoptions in Virginia in 1991; therefore, the best estimate of unwanted pregnancies is 32,000 or 23% of all pregnancies. Of the pregnancies which are terminated, approximately 80% are to single women; 21% are in teenagers. Since not all unwanted pregnancies end in abortion or adoption, the 32,000 is a low estimate for unwanted pregnancies.[36]

Seventy per cent of all pregnancies in Virginia result in a live birth. Of the 96,777 live births in Virginia in 1991, it is unknown how many were to women in crisis.[36]

C. Consequences

For a young woman, a pregnancy can curtail her education. There are no data on the number of teens that drop out of school due to pregnancy in Virginia. Nationally, 55% of women who first became pregnant at age 15 did not complete high school. The younger the pregnant teen, the more likely she will not return to school.[15]

Loss of employment due to pregnancy may intensify the financial difficulties. In 1993, the national Family and Medical Leave Act (FMLA) was passed. It requires that a woman have worked for the same covered employer for at least a year and allows 12 weeks of unpaid leave with her job guaranteed

upon return if her position is designated as "non-key" to the employer. However, there are many families which could not survive for 12 weeks without the woman's income, especially when considering the population of women most at risk for crisis pregnancies. Poor, uneducated, and young women are likely to be employed part-time by several employers in one year; thus, they are not eligible for leave. The new policy may help some pregnant women by guaranteeing their jobs after the leave period, but women in crisis pregnancies are likely to be left without jobs and with the need to support a new baby.

A crisis pregnancy has an emotional effect on a woman, increasing her need for a support system including counseling. If the woman decides to relinquish her child for adoption for example, she may continue to need extra emotional support and counseling throughout the pregnancy and after delivery. Pregnant teens may experience tension with their families, interruption of education or isolation from their peers.[15]

The problems of substance abuse, poverty, teen pregnancy and poor nutrition, which may be part of a crisis pregnancy, have an effect on the developing fetus and contribute to the incidence of congenital anomalies, low birthweight and fetal and infant mortality.

The effects of crisis pregnancy may reach beyond the perinatal period and increase the risk for child abuse, especially in an unstable family environment. Some common problems and characteristics associated with child abusers, such as alcoholism and financial difficulties, may also be associated with crisis pregnancy.[16]

III. SERVICES

A variety of services are required by a woman in a crisis pregnancy to meet her needs for support. These services must start with a pregnancy test and continue beyond the conclusion of the pregnancy. Although the purpose of this study focuses on services a pregnant woman in crisis needs, the study acknowledges that resources must be available to prevent unintended and unwanted pregnancies.

A. Options for Pregnant Women in Crisis

Much of the literature regarding an unintended pregnancy focuses on teenagers. For pregnant teenagers, their mothers and boyfriends are very influential when deciding among their options. Male partners had more influence on the decision of adolescents who decided to have and keep the baby than on those that had an abortion.

One study found that 90% of the African-American, urban, teenagers who lived with their mothers confided in them at some point before making a decision about their pregnancy. Eighty-one per cent of the teenagers chose the pregnancy outcome that their mothers supported.[38]

Women who seek health care to confirm a pregnancy may also seek other advice on whether to terminate or continue a pregnancy. "Options counseling" is a discussion of all the various courses of actions available relative to the crisis pregnancy. "Directive counseling" is utilized by some crisis pregnancy centers. These centers do not support the option of abortion and may either counsel women against this option, or may not include abortion in discussions with women in crisis pregnancies. A study conducted by the Family Planning Council of Central Pennsylvania found that women who underwent options counseling were less likely to terminate their pregnancy as compared to women who had not had any counseling.[11,37]

It is impossible to generalize the reasons women choose alternatives to parenthood. The influences on a woman's decision concerning a crisis pregnancy are many and impossible to define for all cases. For many women, not having anyone with whom to discuss their pregnancy increases stress and intensifies the crisis. Other women, particularly teenagers, may be confused by having too many people influencing their decisions. Decisions about a pregnancy are related to religious beliefs, financial circumstances, mental status, wishes of the partner, ambitions for the future and/or medical conditions.

Parenthood

The choice to maintain a pregnancy and parent the child involves an emotional and financial commitment for prenatal care and then to the child for many years. A woman in a crisis pregnancy may not have the ability or resources to take on this responsibility regardless of whether or not she wants the child.

Once a woman decides to continue her pregnancy, prenatal care can maintain the woman's general health and decrease the chances of an adverse pregnancy outcome. Comprehensive prenatal care should be early and continuous and include three major elements: risk assessment, health promotion, and intervention or treatment. The level of care needed by a pregnant woman during her pregnancy is proportional to the degree of risk involved. Health promotion includes counseling to promote and support healthy behaviors and to provide general knowledge about pregnancy and parenting. Medical

intervention may be required for a pre-existing condition or one which develops during the pregnancy.[17]

Adoption

A pregnant woman in crisis may decide to maintain the pregnancy, but place the child for adoption. Adoption is regulated by state law, but must comply with a number of federal statutes and constitutional principles. According to current Virginia law, a child may be placed for adoption by a licensed child-placing agency, a local board of public welfare or social services, the child's parent or legal guardian if the placement is a parental placement, or any agency outside the Commonwealth which is licensed or authorized to place children for adoption. Regardless of how the child is placed, the adoption must be authorized through the Virginia Department of Social Services.

In Virginia in 1992, there were a total of 2,634 adoptions most of which were step-parents adopting their spouses's children. Only 244 of the total adoptions were of infants (birth to 11 months old).[35]

A major factor in the small number of infant adoptions is the apparent preference of single mothers to keep their babies. The low number of adoptions in 1992 is the continuation of a trend that began in the early 1970s and continues today.[4]

There is a growing number of children in foster care awaiting adoption. These children are generally older, nonwhite, members of sibling groups, and may have emotional, physical, or mental disabilities related to neglect and abuse.[4]

Referrals to adoption agencies for indigent women seeking services in local health departments are made through social workers, but the availability of social workers and their knowledge of adoptive services varies among clinic sites. In the private sector, referral to appropriate adoption services depends upon the knowledge of the individual health care provider. It is reported that the inconsistent availability of information and counseling in service settings may be a contributing factor to the low number of infant adoptions.[4] Other factors will include the woman's personal or family values, and cultural or community influences.

Financial support during pregnancy for indigent women who have decided to place an unborn child for adoption is a serious consideration for many women in crisis. The law allows the prospective parents to pay for the biological mother's

medical, transportation and legal expenses related to the pregnancy. They may also pay for her living expenses if the mother is unable to work during the pregnancy, as determined by a physician. If such arrangements are not readily available, other financial support may be required.

Abortion

Abortion refers to any termination of a pregnancy before the fetus is viable and capable of extrauterine existence, usually less than 21-22 weeks of gestation. The method of termination is dependent upon the age of the fetus and the services available to the woman. The earlier the abortion is performed, the safer the procedure is for the woman. Once the pregnancy enters the late second trimester, most physicians will not perform an abortion unless it is recommended for serious medical reasons. The Code of Virginia § 18.2-71 - 18.2-76.2 specifies that it is lawful for any physician licensed by the Board of Medicine to perform an abortion. Any termination of pregnancy beyond the first trimester must be performed in a hospital licensed by the State Department of Health or under control of the State Board of Mental Health, Mental Retardation and Substance Abuse Services.

There were 31,578 abortions performed in Virginia in 1991. One hundred and seven abortions were performed because of congenital anomalies detected in the fetus.[36]

Currently in Virginia, there are six providers in the major metropolitan areas. All facilities that perform abortions are members of the National Abortion Federation. In addition, some physicians provide abortion services in their private practices.

Follow up medical care is usually provided as part of the procedure. Though research has not found evidence that abortion itself has an emotional effect, some women may wish to receive counseling. This service may or not be provided by the abortion provider, but is generally available through private or public counseling services.

Although many insurance companies cover abortions, many women choose to pay from private funds. Medicaid covers an abortion if it is necessary to save the life of the mother. State funds are available for abortions for women through the Virginia Department of Health. The Code of Virginia §32.1-92-32.1-92.2 specifies that a woman is eligible for this funding if she meets the eligibility requirements for Medicaid and the pregnancy is the result of rape or incest, or if there is evidence that the fetus will be born with a gross and totally incapacitating mental deficiency. In 1992, three

abortions were funded through this mechanism.[28]

B. Health Services for Pregnant Women in Crisis in Virginia

Maternity Services

Prenatal care for the pregnant woman in crisis is especially important, and its intensity should be greater than that provided for other women. Outreach services may be required to identify women in crisis, convince them of the need for services and recruit them into programs.

Prenatal services are provided by private physicians, the medical schools, the Virginia Department of Health, or in a combination involving both public and private providers.

Prenatal care is provided predominantly by obstetricians/gynecologists (OB/GYNs). Several jurisdictions in Virginia are served by only one or two obstetricians. In some rural areas, family practice physicians provide the prenatal care and delivery services.[22,30,31]

Local health departments in Virginia provide prenatal services to 20,000 women annually. The health department does not provide delivery service so other arrangements are made through hospitals, private physicians and medical schools. Local health departments also provide postpartum services which include family planning education, counseling, and the provision of contraceptives.

If the pregnant woman is diagnosed as medically high-risk, she is referred to the nearest referral center or to another physician based upon local arrangements. Depending upon the complexity of the problem, the pregnant woman may be referred to the regional perinatal center.

Women with a nutrition risk living below 185% of poverty are eligible for the Supplemental Food Program for Women, Infants, and Children (WIC). The program, funded by the U.S. Department of Agriculture and administered by the Virginia Department of Health, provides food vouchers, nutrition education and health care referrals. Nutrition risks include anemia, overweight or underweight and high-risk medical conditions. All local health departments participate in the WIC program through the services of an on-site nutritionist.[27]

For certain high-risk groups, the use of home visiting programs such as Resource Mothers and Project LINK have been beneficial in assisting pregnant women. Both of these services are described under model programs.

Substance Abuse Treatment

Substance abusing pregnant women are at risk for receiving late or no prenatal care and are not always knowledgeable about the dangers of addiction to their children. In Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services has made residential and day treatment programs available to pregnant women through Community Services Boards. Five programs which give priority to pregnant women are in Lynchburg, Fairfax, Fredericksburg, Petersburg and Culpeper.[34]

The only residential program specifically for pregnant women is the Center for Perinatal Addiction (CPA) at the Medical College of Virginia in Richmond. It is a comprehensive, interdepartmental clinical research project funded by the National Institute of Drug Addiction and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The program provides intensive outpatient treatment for addicted women who are pregnant or have infants under 6 months of age. The services include detoxification, psychotherapy, family involvement and education on addiction to prevent relapse and help the mother achieve ongoing abstinence. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services collaborates with other state and private agencies which provide services to the pregnant substance abusing population.

Payment is a major issue in the treatment of pregnant women with a substance abuse problem because private insurance may not include coverage for substance abuse treatment, or may limit the amount of treatment. The deductibles and copayment required may also be prohibitive. Medicaid offers coverage for only limited substance abuse treatment. For the uninsured, publicly-funded treatment facilities are rare.[34]

In response to the lack of available and affordable substance abuse treatment specific for pregnant women and their children, Project LINK was formed. It is a community-based, coordinated system of interagency screening, referral, service delivery and follow-up for substance-abusing pregnant and postpartum women and their infants up to age two years. Additional information is provided under model programs.

Access to Care

The lack of access to primary health care services, especially prenatal and pediatric services, is a major problem in the Commonwealth.[26] All or part of 41 counties and 6 cities in Virginia have Health Professional Shortage Area designations

as defined by federal criteria, and over half of the counties and almost half of the cities in Virginia meet criteria to be Medically Underserved Areas. (Virginia Department of Health) Additionally, a majority of localities continue to report area physicians who either do not accept or limit the number of Medicaid and indigent patients.

In recent years the number of OB/GYNs willing to attend deliveries has declined. The high liability insurance premiums and the risk of malpractice action are the reported reasons for leaving obstetric practice.[14]

Some women do not perceive the need for prenatal care, or others find the available services unacceptable. Obtaining a convenient appointment may be a barrier at some clinics. Most women can obtain an appointment within two weeks of their initial contact, but this is not always the case. In some areas of the state, particularly in the Northern Virginia and Eastern Shore areas, language barriers hinder the provision of care. Lack of cultural sensitivity of the provider to a woman's needs may also be a barrier.

Reimbursement

For some pregnant woman in crisis, obtaining Medicaid coverage for their prenatal care may be enough to relieve the crisis situation.

In 1990, the Omnibus Reconciliation Act mandated that all states offer Medicaid coverage to pregnant women up to 133% of poverty with an option to increase to 185% of poverty. Thirty-two states and the District of Columbia, including all the states bordering Virginia, have increased their eligibility level above the national mandate.[20] In Virginia in 1992, 29,575 pregnant women were on Medicaid, and the eligibility level remained at 133% of poverty. In addition, family planning services are covered at this level for only 60 days following delivery. Subsequently, Medicaid covers family planning services for those women eligible for Aid to Families with Dependent Children (AFDC) which is those women living at less than 38% of poverty.

A shortened application form is being used for pregnant women and is ideally processed within 10 days. In 1992, outstation workers were located in local health departments and hospitals to make Medicaid more accessible. Under a program called BabyCare, services have been expanded to include risk assessment, case management, nutrition counseling, health education, transportation, home health and homemaking services. An important service of BabyCare is care coordination, under which a nurse or social worker ensures the client receives necessary services.

Virginia has taken steps to increase the participation of providers in the Medicaid program. Major increases in reimbursement rates for obstetric services have occurred. However, in 1991, only 43.1% of all OB/GYNs accepted Medicaid.[33] Stated reasons why OB/GYNs do not participate in Medicaid are low reimbursement, cost of liability, fear of litigation, and cumbersome paperwork and eligibility requirements.[7]

Mid-level Practitioners

There has been an underutilization of nurse practitioners and nurse midwives for prenatal services in Virginia. Other states have successfully used mid-level providers to increase access to obstetrical care. In Virginia, there are 141 OB/GYN nurse practitioners and 84 certified nurse midwives; 17% of these are not currently practicing as nurse practitioners.[3,32]

Nurse practitioners and nurse midwives identify lack of affordable liability insurance, third-party reimbursement, prescriptive authority and hospital privileges as barriers to practice in Virginia. The attitude of other health professionals, especially those who have not worked with mid-level practitioners, remains a significant barrier, causing some nurse practitioners and many nurse midwives difficulty finding collaborating physicians in order to practice.[6] In a 1992 legislative study, two-thirds of the responding physicians listed increased liability as a disincentive to enter into collaborative practice with a nurse practitioner/nurse midwife.[6]

In 1991, the General Assembly enacted a statute that allowed limited prescriptive authority for nurse practitioners, and in 1992, legislation passed to prevent exclusion of nurse-midwives from obtaining hospital privileges.

There is a role for certified nurse midwives and nurse practitioners in providing care to pregnant women in crisis. Studies have shown that nurse practitioners are adept at providing services that depend on communication with patients and focus on preventive care. They are also educated to work with low-income, high-risk, young and minority patients, and are skilled in supportive care and health promotion.[13,31]

Limited access to providers is not just a problem of undersupply; it is also a problem of maldistribution, particularly in rural areas or urban areas with large numbers of indigent pregnant women. Only 7% of nurse practitioners are working in non-metropolitan underserved areas; over 50% provide care in hospital settings.[32]

C. Other services for pregnant women in crisis

Housing is a problem for some women in crisis, namely those who are homeless, substance abusers or victims of domestic violence. In 1992, approximately 40,000 homeless women between the ages of 18 and 45 requested shelter in Virginia. Seventy percent of homeless families are young, single women with three children.[24] Pregnancy creates the need for additional services which emergency housing may not offer. In fiscal year 1993, shelters funded by the Department of Social Services served 3,300 women who were victims of domestic violence, and turned away 1,261 for lack of space. Of the women sheltered, 279 or 8% were pregnant.[35]

The lack of available day care is frequently a problem for the pregnant woman in crisis by interfering with accessing early and continuous prenatal care as well as other support services. In 1991, there were about 600,000 children under age 13 years with mothers in Virginia's workforce. Over 130,000 of these children are of single, working mothers.[25] Information is not available on the number of children not being served.

Lack of adequate transportation for women to access reproductive health services continues to be a problem in Virginia. There are some rural areas where women must travel long distances for care. In urban areas where the distance is not so critical, there may not be affordable or available public transportation systems. Medicaid funding is available for cab or bus fares for medical appointments. Several localities have provided creative programs, such as subsidized bus services, volunteer cab programs or church-sponsored projects.

D. Prevention Services

The purpose of this study is to focus on effective maternal health services. An important and critical service is the prevention of another crisis pregnancy, especially future unintended and unwanted pregnancies. To be effective, prevention services must: be community-based, family-centered, culturally sensitive, and educationally sound; reach a wide variety of people outside the traditional health care setting; recognize the inter-relationships between behavior and the environment including cultural and family differences; be based upon appropriate learning and behavioral principles; and involve the unified efforts of many broad-based community agencies, both public and private.[23]

E. Prevention Services in Virginia

Preventive services in Virginia include the Family Life Education programs in Virginia's public schools, school-based/school-linked health clinics, Better Beginnings and family planning services.

Family Life Education

Since attitudes about sexuality and responsibility are formed at a very early age, services and education to prevent unwanted pregnancies must reach the young. In 1988, legislation was passed in Virginia requiring all public schools to implement a Family Life Education program. The curriculum begins in kindergarten and continues through 12th grade. Each school division was provided with the Standards of Learning Objectives to be covered in each grade, but has the freedom to move content between grades and to individualize the curriculum for its community.[2,8]

School-Based/School-Linked Clinics

Access to health services for school-age children and adolescents can be increased with school-based/school-linked clinics. The models for delivering comprehensive primary and preventive clinical services are: screening and referral by school nurses, nurse practitioners providing primary care and school-based clinics. Each of these approaches can be an effective means of providing children and adolescents increased access to comprehensive health care services, including reproductive health care, by providing services for school children at the school site.[9]

The majority of school health services in Virginia are provided by school nurses through screening and referral, although not all school divisions have school nurses. There are three school-based health centers, located in Norfolk, Eastern Shore and Roanoke, and one school-linked health center in Alexandria. In 1992, the General Assembly appropriated funding through the Department of Education for six school/community health services pilot projects, in Accomack, Chesterfield, Lunenburg, Richmond Region, Smyth and Wise. The 1993 General Assembly allocated second year funding to continue these six pilot projects and money to plan six more pilot projects in the state.

Reproductive health care has a comparatively minor place in the spectrum of services the health centers deliver. The Robert Wood Johnson Foundation's health centers report that reproductive health prompts 10% of students' visits.[1] The school-based health centers are the ideal vehicle for health

promotion and disease prevention activities. They are designed to overcome barriers to adolescent health care use including concerns over confidentiality, lack of transportation, inconvenient appointment times, cost, lack of insurance and general apprehension or disinterest among adolescents about discussing personal health problems, including sexual activity, and its consequences.[19]

Better Beginnings

Better Beginnings is a community-based prevention program whose goal is to reduce the number of teen pregnancies in Virginia. The mode of operation is broad-based local coalitions that foster widespread community involvement. State funding for the coalitions is distributed by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and is directed toward areas with high teen pregnancy rates. Currently, the 18 coalitions serving 42 localities each receive $5000 per year. Other areas have formed coalitions that receive technical support from the state. The teen pregnancy rate in Virginia decreased from 48.5 per 1000 adolescents in 1990 to 45.4 in 1991. The rate of decline for teen pregnancy for the localities that had Better Beginnings coalitions during the same period was 4.5, while the rate of decline for localities without coalitions was only 1.9.[34]

Examples of activities of the coalitions in various areas are: Established Families Involved Together for Teens Program, Postponing Sexual Involvement series for young people, Human Diversity workshop for area professionals, abstinence training at area churches, Project Alpha Programs for teen males and their fathers, parenting workshops, Teen Pregnancy Prevention summit and a video about teen sexuality concerns. Many of the Better Beginnings Coalitions collaborate to provide services to pregnant and parenting teens such as schools for pregnant teens and classes for teen mothers and fathers.[34]

Family Planning Services

Family planning is an important reproductive service which involves "the process of establishing the preferred number and spacing of children in one's family and selecting the means by which this objective is achieved."[23] Family planning services include education and counseling on a variety of issues related to women's reproductive health, such as pregnancy planning or preconceptional care, childbearing, adoption, abstinence and the use of contraceptive methods; the provision of contraceptives; and treatment or referral for infertility. Other services include screening, monitoring and treatment of medical conditions.

An important component of family planning services should be pregnancy planning or preconceptional care. Since the developing fetus is most vulnerable during the early weeks of pregnancy, every woman should be at her optimal health at the time of conception. Preconceptional care includes risk assessment, health promotion and intervention. When a history of hereditary disorders is identified, genetic testing and counseling are provided. Medical conditions are treated or stabilized reducing the severity of the problem in pregnancy. Dietary practices or work environments can be altered to promote optimum health at conception. Smoking, drug usage, or alcohol consumption are identified and interventions undertaken to alter these activities prior to conception. Economic crises including housing, food and living conditions also need stabilization. Because of limited resources and minimal training, preconceptional counseling is not a routine component of family planning.[17]

Family planning services are provided by private physicians, the Virginia Department of Health, Planned Parenthood and various other clinics. Most women in Virginia seek family planning services from private physicians.

The Virginia Department of Health provides 156 family planning clinics in local health departments. In fiscal year 1992, 82,355 women received family planning services.[28] This number represents 25% of the estimated women in need of subsidized family planning services.[12]

Family Planning services are also provided by Planned Parenthood, a private, non-profit organization. There are 10 Planned Parenthood affiliate offices located in the urban areas of Virginia. A full range of gynecological services are offered along with counseling on pregnancy options. All services are confidential, and charges are based on the ability to pay. Planned Parenthood provides education to the community through its resource center and programs taught by trained staff and volunteers.

IV. MODEL PROGRAMS IN THE NATION AND VIRGINIA

A. Hawaii's "Healthy Start" Family Support System

"Hawaii's Healthy Start/Family Support System is a community-based, multi-disciplinary program designed to prevent child abuse and neglect, enhance parent functioning and enhance child development in a multi-ethnic/cultural environment."[10] It is funded primarily by state dollars and is administered by the Maternal and Child Health Branch of the Hawaii Department of Health. The program involves four major components: early identification of families "at risk" for

child abuse, home based intervention services, linkage to a "medical home" and referral and coordination with other community agencies.

Mothers of newborns are assessed using a screening tool called the Family Stress Checklist and, if discovered to be at risk, are encouraged to enter a system of support services, including home visiting. Those families that agree are involved in a multi-faceted program of support services, many of which are conducted in the home. Nationally accepted screening tools are used for identifying in more detail the needs in relation to parenting skills, parent/infant bonding and interaction. The degree of intervention is determined by the need. Families are assisted in obtaining a primary care provider for well child care as well as episodic care. Standardized tests are used to assess for child growth and development. Referrals are made to community services for the family as needed.

B. Healthy Start/Family Resource Center in Hampton

The Healthy Start/Family Resource Center in Hampton started in the fall of 1992 and is built upon the Hawaii model to prevent child abuse and neglect and enhance parent functioning. The program is multi-funded from federal, state, local and private contributions. The Hawaii program screens all infants at birth for risk of child abuse, whereas the Hampton plan initiates home visits to at-risk families during the prenatal period. The emphasis of the Hampton project is to improve child development, prevent child abuse and neglect, and assure that all children in Hampton reach school healthy and ready to learn. It is a multidisciplinary interagency project that uses case management to provide comprehensive care to families. The target population for the initial activities of the program is pregnant women and their families attending the prenatal clinics in the Hampton Health Department. The Program is expected to improve access to prenatal care, support service and pregnancy outcomes. Parent education is a major component of the program and is provided through classes, brochures, newsletters and other written materials.

C. Project LINK

Project funding is a combination of federal Alcohol, Drug Abuse and Mental Health Services substance abuse block grant funds, U.S. Drug-Free Schools and Communities Act funds, and federal Child Care and Development block grant funds. The project uses a supportive, nonpunitive approach to preventing and treating perinatal substance abuse.

The program has been piloted in Charlottesville, Newport News,

Rappahannock, Roanoke and Virginia Beach. In each site, Project LINK provides a mechanism to coordinate the services of the community services board, local health department, department of social services, cooperative extension service, infant development program services, hospitals and other local human service providers. Besides early identification, cross-agency referrals and follow-up for the women and children, the goals of this project include increasing interagency collaboration in service provision, enhancing accessibility of prevention and early intervention services, decreasing alcohol and other drug use in pregnant women, and optimizing the health of the infants born to substance abusing women. One of the most critical components of Project LINK is the use of social support through the lay home visitor/outreach worker. These are paraprofessionals from the community, trained and supervised by local professionals, who serve as specialized "resource mothers" to assist the women in obtaining and complying with needed services, provide basic health advice, instruct about child care and nutrition, model positive adult-infant interaction, offer emotional support and help the women establish a support system.

An evaluation of the project will be completed in the summer of 1994. Problems already identified are lack of adequate child care, insufficient supply of lay visitors and transportation.

D. Resource Mothers Program

The Resource Mothers Program is administered by the Virginia Department of Health, and funded by Medicaid and the federal Maternal and Child Health Services block grant. The goals of the program are to reduce infant mortality and low birthweight, prevent school drop-out, delay repeat pregnancy, and facilitate good health practices and utilization of health care services among teenagers, particularly those delivering and raising an infant for the first time. One responsibility of the resource mothers is to assist teens/women in obtaining Medicaid and other community services. The 15 grantee programs presently in place train and supervise paraprofessional women to serve as a social support system for pregnant teenagers and teenage parents of infants. The program is recognized for its role in bringing low-income pregnant teenagers into prenatal care, and providing them with the support needed to make use of health care and other community services, to begin using contraception and to continue in school. In fiscal year 1993, approximately 500 new teens were enrolled.[28]

The percent of low birthweight infants born to Resource Mothers Program participants is significantly lower than the percent born to all teens in the same locality. The infant

death rate is also lower, and the percentage of teens in Resource Mothers Program returning to an education setting (67%) is greater than the national average (50-60%). The state-supported programs are limited to 40 counties with high teen pregnancy rates and/or high infant mortality rates. The statistics generated through Resource Mothers Programs show that intense home visiting and outreach strategies can make a difference in pregnancy outcome and be cost effective over time.

Resource Mothers is only one of several lay home-visiting program models used in the state to improve the health and well-being of women and infants. At present, there is no formal coordinated statewide approach to community-based maternal and infant lay home visiting through an interagency, public/private partnership. In the private sector, some religious groups have established similar lay home visitor programs.

E. Elizabeth Project

The Elizabeth Project, based on a Biblical friendship between Elizabeth and Mary, provides a means for the religious community to address the problem of children having children. Its purposes are to encourage self-care leading to the birth of a healthy baby, and to discourage additional pregnancies until a more appropriate time in the woman's life. The project pairs pregnant teens who are in need of support with adult women willing to be partners during pregnancy and birth. They work together in a 12-week program that provides information on prenatal care, childbirth and parenting, with a strong emphasis on responsible decision-making and building self-esteem. Through group activities, videotapes and personal visits, a supportive relationship develops that usually continues beyond the birth of the baby. The Elizabeth Project began as a United Methodist response to Virginia's high rate of infant mortality. It is now administered through the Virginia Council of Churches and has volunteers from a number of denominations. There are Elizabeth Projects established at 15 sites across the Commonwealth, with a dozen more slated to begin in 1994.

F. One Church, One Child

One Church, One Child Organization is a national minority adoption recruitment program designed to find adoptive homes for African-American children. The Virginia One Church, One Child Program, Inc. is a nonprofit corporation under the direction of a statewide Board of Pastors, and funded by the Virginia Department of Social Services. The Department provides a full-time staff member as technical advisor and coordinator to the One Church, One Child Board of Pastors and

its member churches. The primary goal of the program is to have one African-American family in every church adopt an African-American child. Congregations are made aware of the numbers of Afro-American children awaiting adoption by disseminating adoption literature throughout the church community. Interested families are provided with guidance and counseling throughout the adoption process.

At this time in Virginia, 450 churches are participating in the program. Nationally, the program is in 40 states and has placed over 40,000 children in adoptive homes since 1981.

G. Public/private Partnerships for Prenatal Care

Some areas in our state are not in close proximity to the state-supported hospitals for delivery services. Arrangements have been made between the local health department and local private physicians to provide obstetrical care to indigent clients.

In Loudoun County, the Health Department, local OB/GYN's and family practice physicians have developed a program to encourage women to seek early prenatal care by linking them with a private physician in the first months of pregnancy. Women are enrolled in the health department where eligibility for Medicaid is determined. Following assessment for medical and social risks, referrals may be made to WIC or BabyCare. The client attends prenatal visits on an alternating basis, seeing the nurse practitioner at the local health department and the private physician in the office. That physician attends delivery at Loudoun Health Care Center.

In the Lynchburg area, Virginia Baptist Hospital with the Lynchburg Health Department provides a program of maternity care for the medically indigent by using a nurse midwife group practice. The nurse midwives care for all the low risk patients with supervision of a perinatologist. High-risk patients are referred to the hospital's high-risk clinic.

H. Preconceptional Health Risk Appraisal and Counseling of Kentucky

The Kentucky program is based upon the "Preconceptional Health Promotion" efforts of Robert C. Cefalo and Merry K. Moos, Department of OB/GYN, Division of Maternal and Fetal Medicine, University of North Carolina. The goal is to help the woman eliminate or minimize risk factors prior to conception. A desired result is that women plan their pregnancies, and thus actively become as healthy as possible prior to pregnancy. The program started in the health department family planning clinics and has expanded to all clinics. For example, the

mother of a pediatric patient can participate in this program. The program is administered by the Department of Health Services of the Commonwealth of Kentucky and involves a comprehensive risk screening with appropriate counseling, education and referral for any needed laboratory tests or specialized counseling as may be required for genetic disorders. The education portion includes community-based training for a variety of groups and a general public awareness campaign. A Preconceptional Health Care Coordinator is designated for each service area of the state.

I. Regional Perinatal Coordinating Councils

In an effort to improve the system by which perinatal health care is provided within the state, the Virginia Department of Health in 1992 established seven Regional Perinatal Coordinating Councils (RPCCs). The goal of these councils is to create a collaborative network among providers of perinatal services to ensure risk appropriate care to all perinatal clients in Virginia. Each region has convened and organized its council according to the needs and characteristics of that region. All seven RPCCs are comprised of representatives from hospital perinatal services, local health departments, private physicians, other health-related agencies and consumers within their regions. The issues and problems the RPCCs address include: access to care, transportation, both consumer and professional perinatal education, teenage pregnancy, perinatal data collection and analysis, substance abuse, infant mortality and standards of care. Since fiscal year 1993 was the first grant year of the councils, most of their efforts have focused on needs assessment and planning.

V. CONCLUSIONS AND RECOMMENDATIONS: SJR 329

A. Conclusions

This study has examined the various situations experienced by pregnant women, and includes a consideration of the special needs of pregnant women in crisis. The study has defined a crisis pregnancy, determined services pregnant women in crisis need and why they need them. Many factors associated with crisis are related to the pregnancy being unintended and/or unwanted. Personal problems, medical conditions or financial difficulties contributing to the crisis situation, if unresolved may have long-term impact on the woman and the future health and well-being of the children. Women at risk for a crisis in pregnancy are often poor, young, homeless and addicted to drugs. These same women are most at risk for not receiving services.

Maternal health and other supportive services are not universally available, and the needs of all pregnant women in crisis are not being met. Maternal health services can be expanded by increasing medicaid eligibility, utilizing more nurse practitioners and nurse midwives, and including maternity and family planning services in primary care for women. The number of shelters for homeless, battered or substance abusing pregnant women need to be increased. Lack of other support services, such as transportation and child care, are barriers for pregnant women seeking maternity services.

Selected model programs have demonstrated positive impact on pregnant women in crisis. Healthy Start, Project LINK and Resource Mothers are successful programs available in Virginia but need to be extended statewide.

B. Recommendations

1. **Programs that serve pregnant women in crisis should be expanded, and should provide or assure risk-appropriate health care.**

   a. **Support funding to expand the three existing programs: Healthy Start, Resource Mothers and Project LINK.**

   b. **Encourage private and volunteer organizations that provide shelter for women in crisis to increase the number of pregnant women they serve, and to develop appropriate systems to refer for prenatal care.**

   d. **Encourage the expansion of existing efforts of private organizations that provide support and education for all pregnant women.**

Rationale: Many services for women are not available for pregnant women in crisis. Such services provided by a wide variety of community service organizations include drug treatment programs, homeless shelters and shelters for battered women. Model programs in Virginia, such as Hampton's Healthy Start/Family Resource Center, Resource Mothers Program and Project LINK should be expanded. Initiatives by private organizations, such as the Elizabeth Project, should be encouraged. Pregnant women in crisis need comprehensive services. Programs with limited services need to have linkage to other services for appropriate referral.

2. **Maternity health services, including family planning, should be included in primary health care for women, and should be culturally sensitive, community based, easily accessible and family-centered.**

Expand Medicaid eligibility to 185% of poverty for maternity and family planning services.

Rationale: Primary care is health care that is given at the point of entry into the health care system. For many women, the concerns related to pregnancy precipitate the initial visit to a health care provider. In order to improve the health care given to the women of Virginia, efforts need to concentrate on getting all women of reproductive age into primary care. Some of the barriers to that care include language and culture, finances, transportation and a lack of integration of family-centered concepts into health care. Expansion of Medicaid eligibility would increase the number of pregnant women who can afford prenatal care. Studies indicate that funds spent on maternity services will save costs associated with the complications of pregnancy.

Efforts to expand payment sources for family planning, and to encourage primary care providers to include reproductive or family planning services in their care package would remove a major barrier to availability and accessibility.

3. **Pregnancy planning or preconceptional care should be a standard service in primary care, and be included in the training of health care professionals.**

Rationale: Preconceptional care is the identification of risks prior to pregnancy and interventions to reduce the risks which lead to poor outcomes. Awareness and education concerning preconceptional care need to be improved in both the public and private sector.

4. **Adoption should be made more accessible to a pregnant woman in crisis.**

   a. Request the General Assembly to take steps to streamline the adoption process.

   b. Request the Departments of Health and Social Services to provide adoption training to local health department maternity and family

planning staff.

c. **Encourage the expansion of the One Church, One Child Program, the adoption program of African-American Churches.**

Rationale: Although changes in adoption laws have occurred, they remain complex. Information and counseling about adoption is inconsistent and underemphasized in some practice sites. Training of professionals is necessary to update and reinforce the need for adoption counseling.

There is a growing number of children in foster care awaiting adoption. Children of color are overrepresented in this group. Efforts such as the One Church, One Child Program have demonstrated one way to successfully place some of these children in adoptive homes.

5. **There should be an increased utilization of mid-level health care providers, specifically nurse practitioners and certified nurse midwives.**

   a. **Request that insurers and Medicaid extend third party reimbursement to all nurse practitioners who provide primary care to women.**

   b. **Encourage health professional organizations and medical schools to provide programs on the utilization of nurse practitioners and nurse midwives in provision of primary care of women.**

   c. **Encourage the medical schools to include in their curriculum and practice the nurse midwife model for obstetric care.**

Rationale: Utilization of mid-level providers, in accordance with their scope of practice, could provide care where there is lack of physicians. The barriers to nurse practitioner and certified nurse midwifery full practice have been identified as liability constraints, limitations on hospital privileges, reimbursement issues and attitudes of other health care providers. Some progress has been made in expanding hospital privileges and prescriptive authority, but further efforts are necessary. Certified Nurse Midwives, pediatric and family nurse practitioners can receive Medicaid reimbursement, but Obstretrical/Gynecologic and Women's Health Nurse Practitioners cannot. Medical schools should adopt models of interdisciplinary cooperative

practices into their curriculum and practice.

6. **The Regional Perinatal Coordinating Councils should address pregnant women in crisis in their region by identifying the gaps in delivering comprehensive prenatal services, providing perinatal outreach education, and encouraging the coordination of care.**

Rationale: The assessment and organization of the services provided for crisis pregnancies are appropriate at the local level. The goal of the Regional Perinatal Coordinating Councils (RPCCs) is to address the issues of access to perinatal care, transportation, pregnancy outcomes and perinatal education. The Regional Perinatal Coordinating Councils have been involved in perinatal needs assessment, perinatal outreach education, and have made efforts to ensure communication exists among all perinatal providers.

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APPENDIX A: SENATE JOINT RESOLUTION 329

1993 SESSION

LD9412649

SENATE JOINT RESOLUTION NO. 329
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Rules
on February 19, 1993)
(Patron Prior to Substitute—Senator Earley)

Requesting the Maternal and Child Health Council to study ways to create and maintain effective maternal health services for pregnant women in crisis.

WHEREAS, protecting the health and welfare of all citizens is a primary concern of the Commonwealth; and

WHEREAS, although the issues involving the performance of abortions are complex and highly personal, abortion is nonetheless universally recognized as a difficult choice warranting serious consideration; and

WHEREAS, many pregnant women in crisis due to personal, medical, or financial concerns may seek an abortion due to insufficiency of maternal health services; and

WHEREAS, the availability of appropriate maternal health services, which may include shelter for homeless women, prenatal care, counseling and training in parenting skills, and other services, may provide many pregnant women the necessary care and stable environment in which to carefully weigh personal decisions regarding pregnancy, parenting, health, and well-being; and

WHEREAS, further exploration of existing initiatives as well as the creation and expansion of maternal health services is necessary to promote the delivery of these vital services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Maternal and Child Health Council be requested to study ways to create and maintain effective maternal health services for pregnant women in crisis. In conducting its study, the Council shall consider, among other things, current maternal health service initiatives, the role of the state in the provision of these services, maternal health programs in other states, and ways of funding the creation or expansion of these services in Virginia.

The Council shall submit its findings and recommendations to the Governor and the 1994 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Official Use By Clerks

Agreed to By The Senate		Agreed to By The House of Delegates	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the Senate		Clerk of the House of Delegates	

APPENDIX B: FUNDING FOR SELECT RECOMMENDATIONS

Appendix B

Funding for Select Recommendations

Resource Mothers

15 current programs @ $40,000 =	$ 600,000
Funding needed for expansion:	
Monies to bring 8 programs to full funding	$ 86,000
Request 19 new programs	$ 760,000
FY 94-95	**FY 95-96**
$846,000	**$ 846,000**

Project LINK

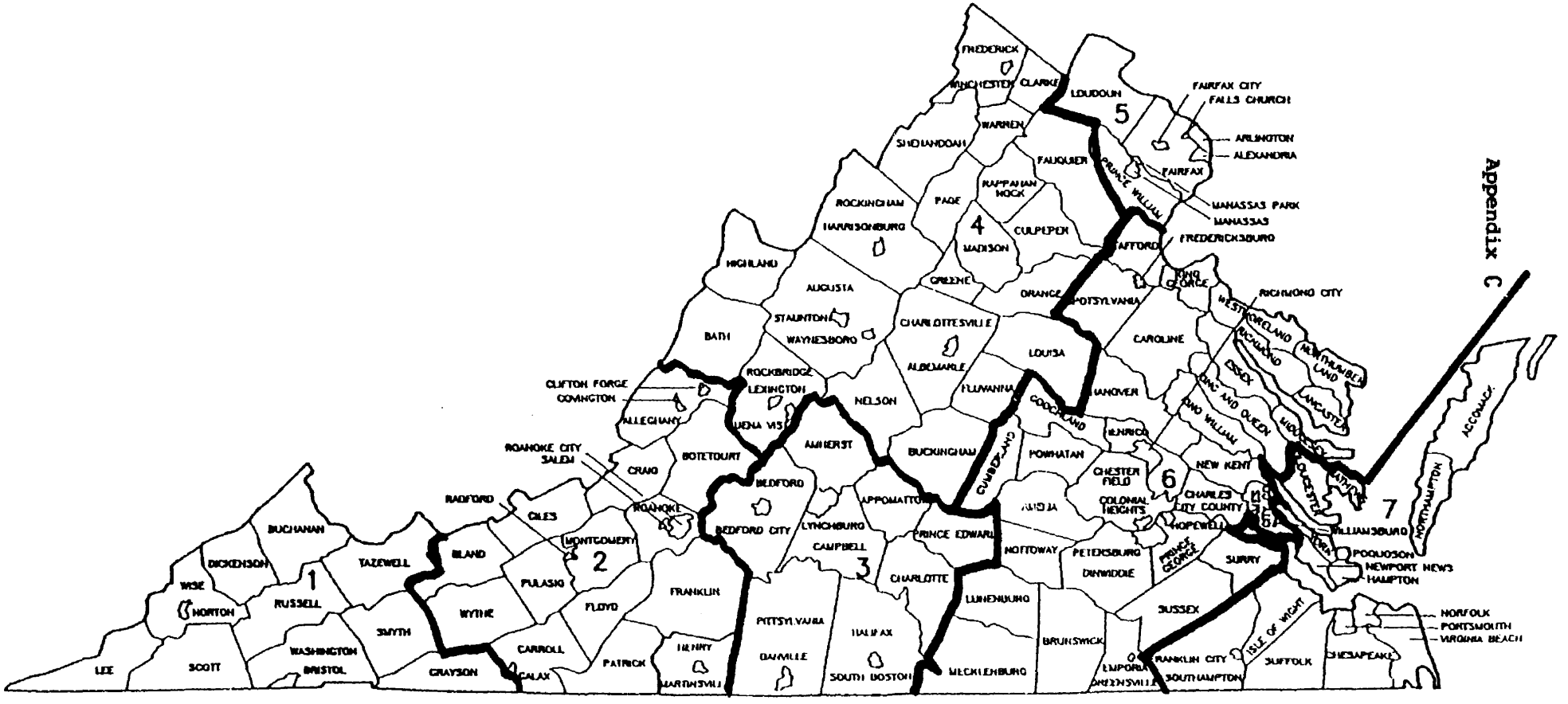
5 current programs @ $85,000 =	$ 425,000
Funding needed for expansion:	
Monies to bring 5 programs to full funding	$ 75,000
Request 5 programs per year to total of 40 programs	$ 500,000
FY 94-95	**FY 95-96**
$575,000	**$1,500,000**

Healthy Start

1 current program @ $375,000 (cost is $2,000-$25,000/family/year for 5 years - cost will double the second year and increase by 50% for the following 3 years)	
Funding needed for expansion:	
Request 3 new programs per year to total of 35 programs	$ 600,000
FY 94-95	**FY 95-96**
$600,000	**$1,800,000**

APPENDIX C: PERINATAL REGIONS AND THEIR COMPONENT COUNTIES AND INDEPENDENT CITIES

PERINATAL REGIONS AND THEIR COMPONENT COUNTIES AND INDEPENDENT CITIES COMMONWEALTH OF VIRGINIA



The Heavy Lines And Numbers In The Map Identify The Perinatal Regions, The Light Lines And Names The Counties And Independent Cities.

SOURCE: Virginia Department Of Health