LOB #146:

MATERNAL HEALTH

Purpose

The Maternal Health Program serves to promote the health of women and infants and to reduce infant mortality and morbidity. The program provides an entry point to prenatal care for low-income and uninsured women who reside in the County and have difficulty accessing prenatal care through other means. These services support two of the five core functions of the Health Department – promoting and encouraging healthy behaviors, and assuring the quality and accessibility of health services. Comprehensive obstetric care and support services are provided in partnership with Inova Cares Clinic for Women. This collaborative practice model provides quality early public health services and continuous prenatal clinical care which is critical to improving pregnancy and birth outcomes.

Description

The Maternal Health Program provides services to low-income pregnant women in an effort to improve pregnancy outcomes and reduce infant morbidity and mortality. Public health nurses provide clinical services that include pregnancy testing for a flat fee and follow-up education on a walk-in or an appointment basis at all five district offices. Services are offered Monday to Friday from 8:00am to 4:30pm and during weekly extended clinic hours. Pregnant women are then provided a free public health assessment (PHA) which identifies tuberculosis risk, immunizations, and risk factors that may negatively impact pregnancy outcomes. In FY 2015, there were 3,240 pregnant women who received a PHA. Family Assistance Workers (FAWs) assess client eligibility for a number of programs, assist with finding a medical home, and connect clients to appropriate services.

Although the Maternal Health Program has been in place for decades, the program service model is continuously evolving. The most recent change involved the transition of clinical maternity care services to the Inova Cares Clinic for Women (ICCW). In FY 2015, the number of births through ICCW was 2,516. The number of births is lower than the number of PHAs (3,240) because of several factors including clients who were deemed ineligible for ICCW services, delivery occurred after the end of the fiscal year and/or clients moved prior to delivery. The Health Department continues to provide public health assessments, care coordination and public health field case management for high-risk maternity clients. The ICCW provides the full scope of obstetric care from entry through delivery on a sliding fee schedule for income-eligible clients. Public Health Nurse Liaisons coordinate care between the Health Department and ICCW. Pregnant women also receive comprehensive clinical management and support services, such as nutrition services, social work and care coordination. Following delivery, high risk clients and their babies are referred back to the Health Department where field public health nurses provide post-partum public health services, as discussed in Child Health Services.

Benefits

The Health Department strives to improve the wellbeing of mothers, infants and children, an important public health goal for the United States according to Healthy People 2020. Their wellbeing determines the health of the next generation and can help prevent future public health challenges for families, communities and health care systems.

The Health Department in partnership with InovaCares Clinic for Women (ICCW) is the safety net for the pregnant women who are medically indigent and/or have limited access to prenatal care. Services available through this program provide this vulnerable population with essential maternal health care. The transition of prenatal maternity care to the ICCW provides for continuity of care, eliminates the need for clients to transition services mid-pregnancy, ensures that the health department remains the entry point of care for this high risk population, and maximizes community resources

Pregnancy testing is provided to any community member regardless of income in an effort to educate and counsel clients regarding the importance of early prenatal care and/or family planning services. Pregnancy is an opportunity to identify existing health risks in women and prevent future health problems for women and their children. The Maternal Health Program screens all pregnant women entering the Health Department, regardless of their income and eligibility for maternity care services. Conducting a public health assessment identifies health and behavioral risks important for all pregnant women, and provides an opportunity to connect women to needed nurse home visiting programs and/or other resources available within the County's communities.

A common barrier to a healthy pregnancy and birth is lack of access to appropriate health care before and during pregnancy. The target population for referral to Inova Cares Clinic for Women (ICCW) for prenatal care is the medically indigent who is at a higher risk for poor pregnancy outcomes due to health disparities. According to the U.S. Department of Health and Human Services, Maternal and Child Health Bureau, babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, as compared to infants whose mothers received prenatal care. Access to the Health Department's prenatal care collaboration with ICCW can increase the proportion of pregnant women who receive early and adequate prenatal care, and reduce the incidence of preterm births, low birth weight births, and maternal and infant mortality, leading to better long-term health outcomes for both mothers and their children.

Mandates

Maternal Health services are state mandated per Virginia Code § 32.1-77 which guides state plans for maternal and child health services and children's specialty services.

Trends and Challenges

The Health Department's goal is to help ensure that all women have a safe and healthy pregnancy. The Center of Disease Control's (CDC) Safe Motherhood At A Glance 2015 identifies a trend of an increasing number of pregnant women in the United States who have chronic health conditions such as high blood pressure, diabetes, and/or heart disease that may put them at higher risk of adverse pregnancy outcomes. The CDC states that women who take steps to prevent and control these chronic conditions before and during pregnancy have the best chance for a healthy outcome. By assuring the provision of maternity care, the Health Department can improve health outcomes for mothers and their children.

According to Trends and Emerging Needs Impacting the Fairfax County Human Services System (Rev. January 2015) , in 2013, an estimated 129,716 (or 11.6 percent) Fairfax County residents did not have health insurance and upwards of 46,000 of these residents were at or below 200 percent of the FPL (Federal Poverty Level). This report also identified that poverty has increased in the County, and with it, so has the demand for services such as the Women, Infant and Child (WIC), supplemental nutrition program. The early consequences of poverty and pregnancy include both short term risks (preterm birth, low birth weight, infant mortality) and long term risks (delayed cognitive development, poor school performance, emotional and behavioral problems). Maternal Health services (maternity care and WIC) are essential to improving birth outcomes and providing a healthy foundation in childhood.

The population served in the Maternity Health Program (MHP) is culturally diverse, mirroring the population shifts in the County demographics. This diversity poses special challenges in the provision of health care. Language and the ability to communicate are major concerns, and unique cultural and religious beliefs have an impact on how care is given and received. The MHP strives for delivering culturally competent care with the desired outcomes of a full-term pregnancy without unnecessary interventions, the delivery of a healthy infant, and a positive environment after delivery that supports the physical and emotional needs of the woman, infant, and family.

Resources

Category	FY 2014 Actual	FY 2015 Actual	FY 2016 Adopted
LOB #146: Maternal Health			
FUNDING			
Expenditures:			
Compensation	$925,218	$908,833	$1,008,873
Operating Expenses	79,485	62,466	66,952
Total Expenditures	$1,004,703	$971,299	$1,075,825
General Fund Revenue	$1,392,748	$607,041	$610,199
Net Cost/(Savings) to General Fund*	($388,045)	$364,258	$465,626
POSITIONS			
Authorized Positions/Full-Time Equivalents (FTEs)			
Positions:			
Regular	14 / 14	14 / 14	14 / 14
Total Positions	14 / 14	14 / 14	14 / 14

* Historically, the Health Department functioned as the entry point for pregnancy testing and prenatal care through the second trimester at which time clients were transferred to Inova Cares Clinic for Women for the remainder of their prenatal care and delivery. However, beginning in July 2013, a new service delivery model was implemented in partnership with the Inova Cares Clinic for Women. While the Health Department remains the entry point for pregnancy testing and prenatal care (public health nurses conduct public health assessments on pregnant women needing maternity services), the clients continue to receive their entire prenatal care and delivery at the Inova Cares Clinic for Women clinic. This ensures continuity of care and eliminates the need for clients to transition services mid-pregnancy. The allocation methodology applied to VDH revenue was adjusted as a result of this service delivery change and accounts for the reduction in revenue in this LOB between FY 2014 and FY 2015. A corresponding increase in revenue appears in the Child Health LOB.

Metrics

Metric Indicator	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Estimate	FY 2017 Estimate
Number of pregnant women provided a public health assessment visit	NA	2,984	3,240	3,300	3,300
Percent of high-risk pregnant women who received home visiting services	NA	52%	47%	52%	52%
Percent of pregnant women served who deliver a low birth weight baby	5.0%	5.5%	8.4%	8.0%	8.0%

Prior to FY 2014, pregnant women receiving prenatal care through the Health Department were seen until 26 weeks gestation after which they were transitioned to the Inova Cares Clinic for Women (ICCW) for third trimester care and delivery. High risk pregnancies and clients starting prenatal care after 26 weeks gestation were immediately transitioned to ICCW in the old service model and did not receive maternity services through the Health Department. Since FY 2014, all clients, including those entering care in the third trimester (after 26 weeks) and high risk clients receive a public health assessment by the Health Department. Clients also receive care coordination and case management services by public health nurses throughout the prenatal and postpartum period. After the initial public health assessment, clients are then referred to ICCW for the full scope of clinical care from entry into maternity services through delivery.

The number of pregnant women provided a public health assessment (PHA) increased in FY 2015 by 8 percent in comparison with FY 2014. This increase in PHAs was primarily a result of transition to the new service delivery model in mid FY 2014 and FY 2015 being the first full year of operation at four Health Department sites. The increase in pregnant women receiving services was also influenced by the inclusion of all eligible pregnant women regardless of gestation and risk status. There was also a slight increase in the population of Fairfax County in FY 2015 (0.4 percent) per the Economic, Demographic and Statistical Research branch, Department of Neighborhood and Community Services.

The percent of high risk pregnant women who received home visiting services decreased in FY 2015 by 5 percent. The Health Department's nurse home visiting staff had 2.5 vacant positions for FY 2015. This decrease in staffing reduced the ability to reach as many clients via a home visit as the previous fiscal year. The percent of high risk pregnant women receiving home visiting services is anticipated to increase in the next fiscal year due to stabilization in staffing.

The percent of pregnant women served who delivered a low birth weight baby increased from 5.5 percent to 8.4 percent in FY 2015. This result is due to the increased number of high risk women included in the total number of women served in FY 2015. In previous years, the women who entered care after 26 weeks gestation and those seen in the high risk maternity clinic at ICCW were not included in the total number of deliveries, as they were not considered Health Department clients. With the new Health Department-ICCW model of maternity care delivery, all clients are included in the total number of clients, no longer separating low/moderate risk and high risk maternity clients. Maternity clients with high risk medical conditions are more likely to deliver a low birth weight infant. This data is now provided to the Health Department by ICCW per the partnership contract. Given that the population served by the Health Department is generally at higher risk for poor birth outcomes, the FCHD and Inova will closely monitor and collaborate to decrease this low birth weight rate, aiming for the national goal established in Healthy People 2020 which is 7.8 percent.