Maternal and Child Health Needs Assessment
Table of Contents

EXECUTIVE SUMMARY 2

FOCUS GROUPS OF VIRGINIA'S REGIONAL PERINATAL COUNCILS 5

Introduction.......... 5

Summary of Findings 5

Overview of Focus Groups 7

Summary of Reponses 10

INTERVIEWS OF KEY STAKEHOLDERS 35

Introduction.......... 35

Summary of Findings 35

Participants.......... 37

Summary of Reponses 38

REGIONAL PUBLIC HEARINGS 65

Introduction.......... 65

Summary of Findings 65

Central Region 66

Southwestern Virginia.......... 70

Eastern Region.......... 72

Northern Virginia.......... 74

Northwestern Region 76

Maternal and Child Health Needs Assessment
Executive Summary

The Virginia Department of Health's (VDH) Office of Family Health Services (OFHS) contracted with the Central Virginia Health Planning Agency (CVHPA), a nonprofit organization with expertise in health planning and needs assessment, in September 2004 to perform a qualitative needs assessment of populations served by Title V (Maternal and Child Health Block Grant) funding. This needs assessment was comprised of three components: 1) a focus group conducted in each of the seven perinatal regions; 2) interviews of key health provider, governmental, and organizational stakeholders that are involved with maternal and child health issues; and 3) a public hearing held in each of the Virginia's five health planning regions to solicit community input relative to maternal and child health needs and resources.

While some community and/or regional differences were identified through this needs assessment, there were common themes that emerged from the various information sources utilized. These include the following:

Access to Care

Ensuring that appropriate health, dental, and behavioral health care is received by all women of child-bearing age and children, regardless of income or insurance status, was viewed as a primary, if not the most important, role of the OFHS. This includes ensuring that there are an adequate number of providers, particularly physicians, physician specialists, nurse midwives, and dentists, that will treat those who are uninsured or are enrolled in Medicaid and/or Virginia's health insurance program for children (FAMIS). Coordination and/or case management of services to ensure that women and children, including disabled children, get appropriate services in a timely manner was heavily supported as helping to improve health outcomes for the most vulnerable members of these populations. The local health departments that provide prenatal care and/or associated services were viewed as being particularly effective in producing good birth outcomes. Several other VDH initiatives, such as the Care Connection, Bright Futures, and the New Parents kit, were also seen as effective. Finally, issues such as inadequate transportation and/or the lack of culturally and linguistically appropriate care were viewed as substantial barriers to care in many areas of the State.

Cost of Health Care

There is widespread concern that the rapidly growing cost of health care and health insurance will increasingly limit the availability of needed care to women and children. Increased focus on the "bottom line" by hospitals, physicians, and dentists, particularly in geographic areas with limited economic resources to offset low or no reimbursement for services, has resulted in fewer services available for lower-income persons but also for all members of the community in these areas. The State's wide disparity in wealth between and within communities is reflected in increasing difficulties in receiving appropriate care for many populations. Recent increases in Medicaid reimbursement to obstetricians and dentists and increased Medicaid eligibility for pregnant women has been viewed positively. However, many mentioned that greater

reimbursement/eligibility needs to occur and that Medicaid and FAMIS reimbursement needs to be increased for pediatricians and specialty providers (such as child psychiatrists) serving young women and children.

Vulnerable Populations

Those populations seen as having the greatest unmet needs include low income, minority (African Americans, Hispanics and others), non-English speaking, and rural women and children. Also, teenagers, those with mental health and/or substance abuse problems, and those with limited transportation are viewed as vulnerable to not receiving appropriate services and/or having poor health outcomes. Many were concerned that the needs of the rapidly growing immigrant population were not being addressed to the extent required by their relative representation among Virginia's young women and children and that increased efforts need to be made to stress the importance of good personal health to all minority populations.

Prevention and Early Intervention

Assessment participants from across the State noted the need for increased prevention and early intervention services, particularly among the State's most vulnerable populations. Both the short-term and long-term cost savings were cited as reasons why there should be greater focus on evidence-based initiatives aimed at preventing or timely intervention of health problems among young women, infants, children, and adolescents. While the VDH appears to be doing a good job in traditional areas such as immunization and sexually transmitted disease treatment, there was widespread support for the OFHS to take a leadership role in ensuring adequate and timely prenatal care, better screening of infants and children for developmental problems, early behavioral health and dental treatment, and increasing case management and coordination of services to pregnant women and disabled children.

Coordination, Communication and Community-based Collaboration

Greater coordination and communication within and between State agencies, as well as with communities, was viewed as one of the greatest opportunities for improvement by the VDH. The State's regional perinatal councils, case management by Resource Mothers and other home visitation programs, and the Care Connection for Children were often given as examples of beneficial community-based services supported by the OFHS. There was significant support for increased collaboration between the State and local health departments and community-based organizations and providers to identify, plan for, and address specific community needs of young women and children. Participants felt that the State-level should provide consistent leadership, timely data and planning assistance, and increased resources to these initiatives while local governments and community-based organizations should participate in needs identification, planning, and resource development. It was felt that these organizations and local providers should be given responsibility for implementation and helping to ensure that all populations' needs are appropriately met. Actively communicating available resources and health education to vulnerable populations was viewed as another area for needed improvement.

Given that more than one hundred highly informed individuals participated in this needs assessment, this executive summary cannot begin to convey all of the important information and useful suggestions provided. We encourage all interested persons to read the entire report to gain greater insight into the community, regional, and statewide needs of Virginia's young women, infants, children, and adolescents.

Maternal and Child Health Needs Assessment
Focus Groups of Virginia's Regional Perinatal Councils

Introduction

From late October through the end of November 2004, the CVHPA staff conducted a focus group with representatives from each of Virginia's seven regional perinatal councils. Each focus group included a representative group of persons involved with each perinatal council to provide opinions on needs and gaps in service, as well as the current structure of perinatal service delivery in the State. The following provides an overall summary of the findings from the seven focus groups and then summarizes those focus groups, by question, in the order of when they were conducted. It is important to note that these reflect opinions and circumstances at a particular point in time and policies/practices/circumstances may have changed slightly since the focus groups were conducted.

Summary of Findings

The following is a summary of the findings statewide. Note that each perinatal group provided detailed information for their area relative to these and other issues and provided concrete suggestions on how to better meet the needs identified.

- **The primary concern was access to care overall**, but particularly for women with limited financial resources. Moreover, **between and within regions there is often great disparity in the availability of perinatal services from locality to locality**.
- Overall, **it appears that most low risk pregnant women are receiving services** but they **often are not getting them in a timely manner**. As a result of this wait, it was noted that some low risk pregnancies become high risk. Again, **access differs widely by demographic group, access to a payment source, and geographic residence.**
- **Most high-risk women are getting into appropriate care**, but sometimes care is delayed due to **transportation issues**, a **lack of specialty providers** in an area, or **patients not recognizing a need for services**. Specifically mentioned was a shortage of services for pregnant women who are **substance abusers and those with gestational diabetes**.
- **Overall, it is reported that most women who are referred for prenatal care continue to receive care. However, there are special populations and/or life situations that often result in missed appointments**.
- **Generally women are not receiving appropriate prenatal services**. Again, there is variation based on geographic location and socio-economic group**.**
- **Overall, neonates are getting appropriate services at birth but sometimes have difficulty receiving follow-up care**.

- The following **characteristics were associated with women and children not receiving appropriate care:**
    - Uninsured,
    - Medicaid recipients,
    - Low income,
    - African American,
    - Non-English speaking,
    - Teens,
    - Limited or no access to transportation,
    - Those with mental health or substance abuse problems, and/or
    - Those living in rural areas.
- All regions cited **premature and low birth weight infants and infant mortality**, particularly among African American mothers, **increased emergency department visits, more and longer hospitalizations**, **and delivery complications**, as consequences of mothers and/or infants not receiving appropriate care. The Social Services system can be overwhelmed by the ongoing needs of these infants and their families. This translates into **higher cost not only associated with the birth but ongoing costs associated with the health, welfare, and educational needs of the children born**.
- The biggest barrier appears to be the **lack of availability of timely access to an affordable health care financing system by all women, regardless of income and citizenship, which reimburses adequately for providers to be willing to deliver quality obstetrical and neonatal care, and associated support services, statewide.** This includes **culturally competent**, **comprehensive** (including behavioral health, dental services, and case management) and **coordinated care**.
- The **quality of the physicians and other health care providers, coordination of services/referrals between providers, and the educational programs** that were brought to community providers from the perinatal centers are seen as the greatest strength of the perinatal system across the State.
- **The lack of community-wide access in all regions to obstetricians and nurse mid-wives** was **cited as the primary weakness of the current perinatal system**.
- Overall, **Medicaid managed care plans often do not provide for coordination of care nor insure that all needed services are available in the community under their plan**.
- In the regions with **more competing hospital systems, patients are not always appropriately transferred** to the perinatal center, sometimes resulting in sicker mothers and/or infants.
- **Regionalization of perinatal care was seen to be valuable in all areas but with challenges to overcome in some regions.** It was seen as **particularly valuable in providing educational and referral sources** to local areas.

- All groups thought that the **regional perinatal councils had inadequate resources to meet the needs of their communities. Resources were needed for**:
  - Personnel to conduct outreach, screenings, and health education;
  - Increased technical assistance to document trends and outcomes;
  - Development of referral sources for substance abuse, mental health, etc;
  - Educational resources, such as training videos and support;
  - Public health education and pregnancy prevention; and
  - Research and implementation of "best practices."

Overview of Focus Groups

The **Central Commonwealth Perinatal Council Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on October 28, 2004, with the support of Elizabeth Farrell, the CVHPA's Assistant Director. The following stakeholders were in attendance:

Cheryl Bodamer, Virginia Commonwealth University Health System (VCUHS), Perinatal Council Coordinator
Mary Crawford, VCUHS-Outreach
Nancy Gauldin, Petersburg Health Department
Rachel Gillus, Petersburg District 19 (Community Services Board)
Charleen Huguet, Cross Over Ministry
Barbara Kahler, Richmond Pediatrics Association Northern Neck
Susan Lanni, VCUHS
Debbie Martin, Henrico Health Department
Rose Singleton, Richmond City Health Department
Curtis Thorpe, Director, Henrico Health Department

The **Eastern Virginia Perinatal Council Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on October 28, 2004. The following stakeholders were in attendance:

Edwina Gary, Peninsula Institute for Community Health (PICH)
Cathy Duggan, Portsmouth Health Department
Mary Elizabeth White, Nurse Manager, Hampton Health Department
Louise Bartlett, Hampton Health Department/Healthy Start
Marian Vollmer, Chesapeake Health Department
Sara Redmond, Nursing Supervisor, Virginia Beach Department of Public Health
Grace Myers, Director of Women's Services, Sentara Norfolk General
Jeanne Fink, OB Case Manager, Mid Atlantic Health Solutions
Beth Kavinsky, Eastern Virginia Perinatal Council
Ed Karotkin, M.D., Eastern Virginia Medical School, Children's Hospital of Kings Daughters
Valarie Stallings, Public Health Nurse, Norfolk Public Health Department
Kim Bogan, Eastern Virginia Perinatal Council

The **Northern Virginia Perinatal Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on November 4, 2004 with Sara Perron, the CVHPA's Health Planner, providing support. The following stakeholders were in attendance:

Gloria Collins, Assistant Director, Loudoun County Health Department,
Pamela Irby, Registered Nurse, Arlington and Loudoun Hospitals and George Mason University Nursing Student (observer)
Sherri Simons, Senior Director of Women's and Infant's Services, Virginia Hospital Center (formerly Arlington Hospital)
Susan Stephens, Patient Care Director, Women's Services at Virginia Hospital Center (formerly Arlington Hospital)
Dona Dei, Director, National Capital Area Chapter of March of Dimes
Anne Terrell, Patient Care Director, Prince William Department of Health
Marian Gutierrez, MD, Director, Inova Fairfax Hospital Regional High Risk OB Clinic
Fred Mecklenburg, MD., Chair, Department of Obstetrics and Gynecology, Inova Fairfax Hospital,
Joanna Hemmatt, Program Manager, Alexandria Health Department
Brenda Rolander, Director, Neonatal Intensive Care Unit, Inova Alexandria Hospital
Karin MacKinnon, Director, Northern Virginia Family Service
Debby Byrne, VDH FIMR Program Manager for Northern Virginia
Patricia Schmehl, Senior Director, Women's Services and Emergency Services, Inova Fairfax Hospital
Alan Silk, MD, Chair of Pediatrics and Director of Neonatology, Inova Fair Oaks Hospital
Florine Price, Director, Resource Mothers of Alexandria and Prince William Counties
Evy Duff, Director, Fairfax County Health Department
Sallie Eissler, Director of Outreach, Potomac Hospital Center
Jennifer Sedlmeyer, Director, Northern Virginia Perinatal Council

The **South Central Perinatal Council Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on November 9, 2004. The following stakeholders were in attendance:

Sam Willinger, M.D., Neonatalogist, Virginia Baptist Hospital
Genevia Barton, OB Nurse Manager, Southside Community Hospital
Katherine Nichols, Director of OB Services, Central Virginia Health Services
Carolyn Jakes, Director of Women's and Infants' Services, Centra Health
Joy Price, Nurse Practitioner, Piedmont Health District
Karen Wesley, Director, South Central Perinatal Council
Denise Kolody, FEMR Coordinator, South Central Perinatal Council

The **Southwest Perinatal Council Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on November 11, 2004. The following stakeholders were in attendance:

Vada Rose, RN NP, Director of Women's Services, Norton Community Hospital
Susan Gibson, LINC Project Director
Becky Cornett RN, Director of Women's Health, Smyth County Community Hospital
Kathi Kiser, Southwest Virginia Perinatal Council Education Coordinator
Mary Lou Hutton, Infant/Toddler Connection of Cumberland Mt. CSB
Merry McKenna RNC, Southwest Virginia Perinatal Council Consortium Coordinator
Michelle McPheron RN, Nurse Manager LENWISCO Health District
Nancy Bailey, Infant/Toddler Connection
Karen Davis, Infant/Toddler Connection, Frontier Health (CSB)
Dr. Tamara Kincaid, Norton Community Hospital OB/GYN
Della Price, OB Nursery Nurse Manager, Wellmont Lonesome Pine Hospital
Janie Dockery, Director of Children's Services, Mountain Empire Older Citizens, Inc. (AAA)

The **Blue Ridge Perinatal Council Focus Group** was facilitated by Elizabeth Farrell, Assistant Director of the CVHPA, on November 16, 2004. The following stakeholders were in attendance:

Barbara Pack, Registered Nurse, Outreach Ed Carilion Roanoke Community Hospital
Rebecca Walker, Registered Nurse, Women and Pediatrics
Angela Kinzie, ICCE, Carilion Roanoke Community Hospital
Robert Allen, Neonatology Physician Carilion Roanoke Community Hospital
Kathy Kesler, Registered Nurse
Beth Dowdy, Director Carilion Roanoke Community Hospital
Sharon Strattan, CNS Carilion Roanoke Community Hospital
Karolyn Givens, Registered Nurse
Donna Sams, Director, Carilion Roanoke Community Hospital
Karen Winstead, CNM, Carilion Roanoke Community Hospital
Phebe Cress, Coordinator
Rosemary Winslow, Registered Nurse
Larry Dennis, Physician Carilion Roanoke Community Hospital
Phyllis Tork, GYN Women's Healthcare
Tara West, FIMR Coordinator

The **Skyline Perinatal Council Virginia Focus Group** was facilitated by Karen Cameron, Executive Director of the CVHPA, on November 17, 2004. The following stakeholders were in attendance:

Sharon Veith, Perinatal Council Coordinator
Terri Smoot, SHINE Coordinator
William Herbert, MD, University of Virginia (UVA) OB/GYN
John Kattwinkel, MD, UVA Neonatologist
Robert Boyle, MD, UVA Neonatologist
Kelly Robins, PCSM, The Women's Place at UVA
Katherine Suez, PHN, Central Shenandoah Health District

Lee Perkins, Nurse Manager, Lord Fairfax Health District
Lisa Markowitz, PHN, Lord Fairfax
Joseph Troise, MD, Obstetrician, Lexington
Donna Sminikey, Certified Nurse Midwife, Harrisonburg
Lisa Roberts, Certified Nurse Midwife, UVA and Harrisonburg
Connie Corbin, Nurse Practitioner, Rappahannock/Rapidan Health District

Summary of Reponses

1. What is your primary concern relative to perinatal services in this region?

Statewide: **The primary concern was access to care overall**, but particularly for women with limited financial resources. Moreover, **between and within regions there is often great disparity in the availability of perinatal services from locality to locality**. Areas where local health departments are still providing prenatal services and/or those with a federally-qualified community health center appeared to have fewer access issues. **Specific concerns that were mentioned frequently include:**

- Lack of behavioral health services for pregnant women (substance abuse & mental health care);
- Lack of dental care services;
- Access to early and appropriate prenatal care for minorities (particularly Hispanics and African-Americans);
- Limited availability of and associated cost of translator services for immigrants;
- Reliable transportation to/from appointments; and
- Declining number of OB and pediatric providers and sub-specialists, driven by Virginia's relatively low reimbursement rates for Medicaid patients, decreased number of patients with third party, private insurance, and rising malpractice premium costs.

Central: The participants' primary concern was access to OB care and services. This concern with access focused on access from several perspectives: financial (lack of insurance); geographic (no labor & delivery and very limited prenatal services in certain areas, such as the Northern Neck or Greensville/Emporia); and specific population (care for undocumented immigrants). In addition, quality of care relative to limited access was an issue. It was noted that some women remain in the hospital longer than they need to because of the inability or limited ability to access care after they leave the hospital. Another concern was getting physicians to make referrals for pregnant substance abusing women before they deliver. Transportation and education were mentioned as concerns by one participant. Another participant noted that there was more demand for OB services than the organization could provide.

Eastern Virginia: This group's primary concern was access to care and disparities in care for minority women and working poor women, both for the women and their babies. PITCH (a federally funded community health center) provides the majority of the care to these populations with four full-time OB/GYN physicians. PITCH had 450 births last year and is up to 650-700 births this year (charge $500 for delivery; $15 for first visit with sliding scale thereafter). There is a need to increase access to care and interpreters for non-English speaking, uninsured women

(most undocumented). Interpretation services were noted to be very costly. When services are available, some clients, particularly the very poor, have difficulty accessing them. Some working women have insurance but can't take time from work to access them. There are few referral resources for women with mental health and substance abuse needs, as well as oral health.

There were concerns about physician shortages in certain geographic areas and physicians not choosing to take care of those with needs. As health departments have moved away from providing prenatal care and providing only pregnancy testing, there has been a delay and disconnect in receiving prenatal care and even testing prenatally for pregnancy and STDs/HIV. There are reported problems getting women into Healthy Families and other case management services prenataly either because of lack of knowledge about the programs or limited financial resources to provide these programs. Moreover, there was limited education prior to delivery around issues such as hypertension, baby care, etc. and limited GYN services to deal with abnormal PAP smears.

Northern Virginia: The primary concern of many providers was access to care. This included mainly prenatal care and follow-up after delivery. It was also mentioned that individuals who do not qualify for Medicaid and teen moms have particular access issues. Another issue was system capacity; there are services in the area, but they are overtaxed. Northern Virginia has a high number of multicultural families. They have complicated needs relating to language barriers and cultural differences in their expectations of the health care system. Among this multicultural group are many undocumented, uninsured individuals; they need specialized access to services and consultants. These people can be difficult to place in an appropriate medical home because they often have complicated, multidisciplinary problems. A few other concerns mentioned were the obstetrician malpractice crisis, prematurity, and support for NICU families. One member also stated that one in four deliveries in Northern Virginia is to a medically underserved family.

South Central: While access to care appears to vary widely throughout this region (with the Danville area being reported as the most poorly served), the primary concern was access to prenatal care, particularly for both uninsured women and Medicaid recipients. This limited access and most other concerns were related to concerns regarding the need for an increased number of OB providers. It was noted that parinatalogist fellowship trainings were not filling locally due to both supply and physician fit with the existing practitioners. A parinatalogist comes one time weekly to Lynchburg from the University of Virginia. Concerns included the need for culturally sensitive care for minorities (some undocumented Hispanics and Koreans; African Americans) and poor outcomes for black persons; few referral sources for mental health and substance abuse services; access to oral health for those 21 and over without financial resources (there is only one provider used by the Piedmont District, a CHC located in Brunswick County outside the area); lack of family planning services after delivery; and the need for more patient education services. It was noted that some physicians refer uninsured patients, particularly Latinos, to the emergency department (ED) who also have a tendency to use the ED if they have an unpaid physician bill.

Southwest: Substance abuse (including illegal drugs, alcohol, and tobacco use) among mothers is the primary concern in this relatively remote area of Virginia, followed closely by access to perinatal services. Access problems include inadequate and/or under funded treatment services for substance abuse and mental health, a relatively small and dwindling number of OB/GYN physicians and hospitals with obstetrical programs, lack of transportation and/or travel distances for care, and inadequate case management services in most areas. It was noted that this area had three OB department closings in an eight month period, the highest number of any area in the State between 2003 and 2004.

Many of the women and their families are struggling with the downturn in the economy, also resulting in scarce resources for perinatal educational services and/or the discontinuation of successful programs (example, smoking cessation program grant funding is ending). Inadequate housing and transitory nature of poor population makes it difficult to follow some patients. A general lack of health care personnel was a concern, including physicians, occupational therapists, and physical therapists. Inadequate Medicaid reimbursement for pediatricians has impacted the availability of pediatricians in some areas.

Blue Ridge: Four concerns were mentioned several times – education (preconception, prenatal) for patients and public; postpartum depression; lack of nurse midwives in the area; and limited access to care in some areas of the region. Other concerns identified included the following: fetal mortality; values system has changed; spending too much in high tech services for people who do not need it (need to concentrate on high risk); inadequate prenatal and OB care in rural areas (have "live-ins" at hospital because some women need care and live too far away to drive back and forth); need for family planning; availability of prenatal care in the southwest; lack of understanding by both public and providers as to what substance abuse is and how to deal with it; patients presenting late for prenatal care (could be related to access or transportation issues); closing of Alleghany Hospital means a lack of services in this area; growing immigrant population (Roanoke is a refugee resettlement area); and obesity.

Skyline: Financial and geographic access to care was the primary concern of most participants. Access issues included concerns about the growing Hispanic population not being eligible for public funding and not having adequate personal resources; a need for early and consistent care for all populations; a growing "working poor" population; the complexity of the health care reimbursement system and lack of understanding on how to "navigate" it; and a lack of professional capacity resulting in patients being turned away or having long waits. Related to access is the lost of prenatal care at many public health departments resulting in a lack of coordinated care in the community for many populations, particularly Hispanic patients who often require medical interpreters that are often not available at private physician's offices. Another large concern was the need to maintain regionalization and ensure that risk appropriate care is being delivered to mothers and infants. There was also a concern about increasing access to supervised mid-wifery (many people want to deliver in a less clinical setting) and the need to integrate birthing alternatives into the health care system.

2. Are low risk pregnant women getting to appropriate providers for prenatal care and delivery? Are they getting there in a timely manner? If not, what is needed to get them to appropriate care in a timely manner?

Statewide: Overall, **it appears that most low risk pregnant women are receiving services** but they **often are not getting them in a timely manner** (sometimes having long waits due to provider shortages and/or physicians won't see them until payment is assured – Medicaid card has been received or cash payment has been made by the uninsured). As a result of this wait, it was noted that some low risk pregnancies become high risk. Again, **access differs widely by demographic group, access to a payment source, and geographic residence.** The **recommendations for improvement include:**

- Use lay health promoters to educate young women about the importance of getting prenatal care and how to obtain care (including helping to apply for Medicaid or other programs, if qualified);
- Subsidize call support for obstetricians and/or OB groups (possibly linked to tertiary care facilities) to practice in rural areas;
- Improve transportation in rural areas;
- Develop community directories of services and give presentations to various "high risk" neighborhoods regarding perinatal services;
- Develop a risk assessment tool (both medical and social);
- Fund case managers to work with private physician offices;
- Examine "best practices" by other states in meeting immigrant women's health needs;
- Study ways to increase the use of nurse mid-wives to deliver services in areas with provider shortages; and
- Ensure locally available, coordinated care is available to all persons.

Central: For low risk, insured women, no problems exist in obtaining care. For low risk, uninsured, working women, some problems exist in obtaining care, but these women seem to be doing okay. For low risk, uninsured, immigrant women, several concerns exist – they tend to have smaller babies because they are small themselves; these women may need other services besides OB; and additional costs are being incurred because these women are not receiving timely prenatal care. Sometimes for these women, they have to "be dragged to care"; this is occurring because of their concern with the cost of care and because of their culture (they have babies at home in their country). It was noted that if pregnant women have other needs (e.g. substance abuse); it can be difficult to obtain these non-OB services.

For uninsured black women, prenatal care is not always a priority (their lives are in chaos and this is just one more thing to do). To encourage them to obtain care, it was suggested that prenatal care should be convenient for them and the importance of this care needs to be stressed to them. Many of these women are Medicaid eligible, but extreme poverty and/or violence often interfere with their ability to obtain Medicaid and care. For the black community, establishing solid relationships is critical. Lay health promoters are successful with these women.

For low risk, insured women residing in rural areas, some of them are not getting prenatal care because of the lengthy travel times to the providers and/or facilities. Some of these women, who

may have had no or very limited prenatal care, just show up at the closest community hospital. There is a need to get obstetrical care back in the rural areas. Two reasons for OBs not in these areas are malpractice costs and the limited number of insured patients (reimbursement concerns of providing OB care).

The group noted that self pay patients have not been addressed. There is a need to find payment sources for them. It was noted that by the end of 2004, two of the 13 hospitals in the region will close their OB units. In South Hill, all OBs have left the area. Community Memorial Healthcenter in South Hill contracts with Duke for OB care. However, many patients leave the area to receive OB care elsewhere; some also are dissatisfied with the care. The group knows that it is difficult to recruit OBs to rural areas because these areas usually have limited amenities (e.g. shopping, cultural opportunities). Rural areas are not likely to get a solo practitioner; therefore, a group of OBs is needed. Three recruitment suggestions were provided for rural areas: 1) find someone trained in GYN who could do some deliveries; 2) provide call support for the OBs in the rural areas; and 3) subsidize a group to provide care and link with a tertiary facility (one participant stated that there was no way to do this suggestion currently). The group noted that improved transportation is needed in the rural areas.

Services are provided by different agencies. People are unaware of what is currently available. Presentations to various neighborhoods were offered as a suggestion.

Eastern Virginia: Most (83-86%) of low risk women are receiving care but initial visit for privately insured women is scheduled 3-4 months out due to shortage of physicians. However, some become high risk because of a delay in getting care. Need risk assessment tool (both medical and social). There is no case management or support in private physician's offices – an outreach worker is needed to do risk assessment and provide resources to private offices. Norfolk already has CHIP and Resource Mothers while PICH has a perinatal case manager and prenatal classes that are open to other providers.

Northern Virginia: It was believed that many low risk women were not getting to appropriate providers and the point at which they received care was coming later in their pregnancy. In one county, Prince William County, there is a sixteen week delay at the health department to receive prenatal care. The Prince William Health Department is backed up because private obstetrical providers in the area will not care for uninsured patients. One other source of help for uninsured patients is an obstetrical clinic in Arlington. The demographics of Northern Virginia are changing. People are moving to Loudon and Prince William Counties. Loudon County is currently the fastest growing county in the country. But this growth in more outlying areas has not led to a reduction in the population for Fairfax, Falls Church, Arlington and Alexandria.

This explosion in population and births has caused a situation where there are not enough providers and facilities both for birthing and for other obstetrical care. The undocumented immigrant population creates a unique challenge. Providers in the areas must know many languages to effectively communicate with their patients. Many cultures from which the immigrants came do not stress prenatal care, so these women do not believe it is necessary. Undocumented immigrants can not be enrolled in most programs that would benefit them. The eligibility requirements create barriers to care because they often require a note from the

individual's employer stating their salary. Employers are not willing to do this if the person is undocumented, for fear of litigation. Documentation is often also required about one's residence and many undocumented people do not hold a lease in their name. The committee should look at other states to see if they have an organized approach to addressing the needs of large groups of immigrant women; these states may have outcomes that Northern Virginia could try to emulate. Even worse off, sometimes, are the working poor. They have no insurance provided through their employers and make too much money to qualify for Medicaid; these people consist of immigrants and native born persons.

South Central: Yes, outcomes are better than 2010 goals but there are pockets of need (especially Danville). District 11 (Lynchburg) depends upon private providers for care while the Prince Edward area uses a sliding fee scale at the CHC for the uninsured. However, the CHC charges for labs; whereas, if they are done at the local health department, they can be sent to the State's DCLS (Division of Consolidated Laboratory Services). The Blackstone Family Practice in Nottoway requires a person have a social security number for care. There is an increase in lay midwifery services in the area causing an increase in the number of mothers and children with complications. Some of this is because nurse clinical midwives are not available in most private practices because OB insurance rates are higher for practices with midwives. There are few services for homeless, unwed teenage and young mothers. Most are sent to St. Joseph's Villa in Richmond but a home with capacity for five pregnant teens is being opened in Lynchburg.

Southwest: Yes, but some get into care late.

Blue Ridge: Low risk pregnant women need to be seen prior to conception. There is a need to think more broadly about the childbirth experience – need to empower women more. Concern was expressed about the full acceptance of the C-section percentage rate. An access issue regarding insurance was mentioned. For most private providers, they require some payment at the time of the visit. However, if a woman has applied for Medicaid, she has to wait until it has been approved before she visits the doctor. It was noted that providers need to become more knowledgeable about resources, but they do not have the time to do so. Some clinics can give more care than private offices.

Skyline: No, particularly for the uninsured and those with large co-pays. Some don't have the up front money required for care. For example, Augusta County safety net system requires $500-800 up front before seeing a physician; there are no providers for the uninsured in Page County and some practices limit the number of Medicaid patients; and the safety net provider in Harrisonburg limits the number of uninsured women to nine and all others have to go to UVA physicians for care. Much of this is because of the fiscal stress on many OB physicians and nurse mid-wives. There is also a lack of knowledge by women of the need for prenatal care in a timely manner. There is a lack of transportation and local resources in many areas. In conclusion, the group indicated the need to have locally available, coordinated care available to all persons, regardless of income.

3. Are high-risk pregnant women getting to appropriate providers for prenatal care and delivery? Are they getting there in a timely manner? If not, what is needed to get them to appropriate care in a timely manner?

Statewide: **Most high-risk women are getting into appropriate care**, but sometimes care is delayed due to **transportation issues**, a **lack of specialty providers** in an area, or **patients not recognizing a need for services** (sometimes overwhelmed by other needs, such as housing). Specifically mentioned was a shortage of services for pregnant women who are **substance abusers and those with gestational diabetes**. Among the **suggestions to improve access include:**

- Need for increased education about importance of getting early and regular care, including public education using the mass media;
- More resources for behavioral health services, particularly substance abuse, for pregnant women;
- Prenatal clinic offering services regardless of Medicaid eligibility (modeled after the Mary Center in Washington, D.C.);
- Study and possibly implement best practice models for specialized prenatal care;
- Provide high risk medical care in local areas using rotating specialists from the perinatal centers;
- Make Medicaid application and required documentation of income easier and quicker.

Central: For women who are substance abusers, they may not be aware they are pregnant because their cycles are irregular due to the substances being abused. These women are dealing with other issues (e.g. housing). More education (including media education) is needed for these women.

Eastern Virginia: Varies based on what makes the patient high risk. Low risk pregnant women who don't get social supports become high risk. Most expected mothers go to Eastern Virginia Medical School (EVMS) for problem, but then to regular OBs for ongoing care. Some physicians won't refer to EVMS. Transportation may not be available for a woman to get to Norfolk.

Northern Virginia: Providers in Loudoun and Prince William Counties have been told that they can no longer send all of their at risk patients to the perinatologist at Inova Fairfax Hospital's OB Clinic. The volume of at risk patients from all over Northern Virginia is overburdening Fairfax. At risk patients are now defined in a medical sense. High-risk patients may still be sent to the Fairfax OB clinic, but lower-risk patients must be seen in the county in which they live. These lower-risk women in Loudoun and Prince William Counties find it hard to see a perinatologist.

One of the qualifications for referral to the Inova Fairfax OB Clinic that has changed is gestational diabetes. If a woman has insulin dependent diabetes, or diabetes with other risk factors, she may still be referred to the Clinic. Since the system has changed, there has been confusion over which diabetics may be referred and there have been delays in care for this condition. Some people with diabetes were diagnosed in their home country years ago, but never received treatment.

Another issue that puts pregnancies at high risk is substance abuse. In all of the counties of Northern Virginia, it is difficult for women to find treatment programs that will take pregnant women. The shortage of substance abuse treatment providers means that providers can choose not to see pregnant patients who may be more difficult to treat. This lack of providers has gotten so bad that some people in Northern Virginia are traveling to Richmond to receive substance abuse treatment. Child Protection Services and LINC are overwhelmed because of increased need for substance abuse and mental health treatment.

One proposed solution to these problems is the development of a non-profit clinic in Prince William County that would offer obstetrical care to keep patients from having to go to health departments (currently being worked on by the Secretary of Health). This clinic would be somewhat free of the limiting state eligibility regulations and is modeled after the Mary Center in Central Washington, D.C. People need to be taught how to access services; many insured people do not realize the signs when they are at risk. Best practice models would also help to determine the need for specialized prenatal care for all of these women.

South Central: Depends on where the woman lives in the region. The UVA clinic (a perinatologist once a week) started on September 3rd and provides appointments within one week after having seen a screening nurse (for a total of two weeks). Many OBs are treating high risk patients because of travel constraints or because patients have been referred back.

Southwest: Yes, most go to Roanoke or to Johnson City, Tennessee. The region has no perinatal center of its own. Transportation is a problem. Medicaid's transportation services work for those mothers with adequate time, sometimes rescue squads have to be used.

Blue Ridge: Carilion has been tracking low birth weight infants since 1991; the trend toward fewer low birth weight infants is improving. Concern was expressed about who talks to women about high-risk pregnancies and who talks to high-risk women after they have had a child because providers do not have time to talk much with them. Some high-risk pregnant women do not always understand issues associated with high risk. For high-risk pregnant teens, there had been a special school for them in the area; but now, the school has closed. Therefore, they do not have access to some information that they need. It was noted that the Hispanic population is growing and some of these women need many services.

Skyline: Need more providers (physicians, midwives, nurse practitioners) and well-advertised, local specialty care. Need easier Medicaid application and documentation of income so that women can get into care quickly.

4. Once women are referred to prenatal care, do they usually continue with that care? If no, why not?

Statewide: **Overall, it is reported that most women who are referred for prenatal care continue to receive care. However, there are special populations and/or life situations that often result in missed appointments**. These include women with:

- Substance abuse or mental health problems;
- Limited access to transportation;

- Working women who can't afford to miss time from work and/or who may have limited leave time available;
- African-American women without a strong support system;
- No health insurance and/or unaffordable co-payments (concerned about payment for services); and/or
- Older children who must be taken care of.

Suggestions for meeting these women's needs include:

- The State to partner with State and local chambers of commerce to have employee assistance programs available to all workers.
- The development of a method to continue insurance coverage if a pregnant woman becomes unemployed.
- Extended and/or weekend hours for prenatal care to accommodate working women and/or those with child care needs.
- Improve transportation services, particularly for Medicaid and uninsured women.
- Increase availability of interpreter services.
- Improve community support systems for African-American girls and women.

Central: Some continue with prenatal care, while others do not. Many reasons why some women do not continue with prenatal care, including transportation, getting off work for appointments, child care, insurance co-pays, do not like physician, and no choices. The group noted a concern with depression during pregnancy. It was reported that screening for depression is done by a few providers, but most do not screen for this. One participant reported that her agency just received part of a federal grant received by VDH to study perinatal depression. One public organization stated that not enough capacity exists to see all patients. Hispanic women are reliable in getting to their appointments; they have a good support system. The language barrier was seen as a uniting factor, not a divisive one. Black women do not have a support system like Hispanic women do.

Eastern Virginia: Most do. Some don't because: they don't feel a need for continual care, they are trying to save medical leave time for delivery and may work long shifts (evening and weekend hours aren't available), concerns about substance abuse services intervention, providers are not culturally sensitive, and/or mental health services aren't available (both overall and for those with limited financial means). A suggestion was for the State to partner with State and local chambers of commerce to have employee assistance programs available to all workers. Also noted was a need to build women's self-esteem from the time they are children to show that they're worthwhile and should find and receive needed services.

Northern Virginia: Most patients, other than the mentally ill, continue prenatal care once they are referred to a program. A barrier to this is if an undocumented immigrant family changes providers due to residence or other changes or if families lose their health insurance coverage. People who lose their health insurance should be covered by their company or by COBRA if they are pregnant.

South Central: Some. Travel distance and commuting time, lack of child care, and time at the appointment causes some high risk to miss appointments. Patients must be 15 years in older to be in a Medicaid taxi by themselves. The need for mothers to be back home when older children get off the bus is also a barrier.

Southwest: Most usually continue with their care. Some appointments are missed due to substance abuse or mental health problems or transportation problems. Sometimes families only have one vehicle and have to wait for husband to get home from work – there is a need for extended hours for these and other patients (pediatricians do have extended hours). Sometimes child care is a reason for missing appointments, often because mothers have to be home to meet children getting off of the bus.

Blue Ridge: The women who do not continue with prenatal care are those who abuse substances, have mental illness, or lack adequate transportation. It was reported that 70% of Project LINK's clients are dually diagnosed. With the increasing Spanish speaking population in the area, it can be difficult to communicate with them and some do not have transportation. One suggestion was to have a van transport women once a week to a clinic or to other providers in the area. Some working pregnant women have difficulty getting off from work (some employers do not want to let them off) for a doctor's visit. No clinics/providers in the region offer prenatal care after hours. The Health Department noted that although they have hired three part-time interpreters, they still are not meeting the language needs. It can be difficult to find certified interpreters. It was noted that since Latino women are not eligible for Medicaid, they do not seek care because of the cost.

Skyline: A majority of women stay with care but often make fewer than desired number of visits. The "no show" rate at UVA is 25% due to transportation difficulties, child care issues, or not being able to get off from work. There are problems with Medicaid transportation.

5. Do they receive appropriate prenatal services? What, if any, prenatal services do they have difficulty receiving?

Statewide: **Generally women are not receiving appropriate prenatal services**. Again, there is variation based on geographic location and socio-economic group**. Specific needs that appeared in several geographic areas include:**

- Amniocentesis and genetic testing;
- Testing that is not provided by the local health departments;
- Testing for sexually transmitted diseases and HIV (including follow-up);
- Mental health and substance abuse treatment;
- Dental care for mothers and children;
- Prenatal education services and materials (particularly culturally appropriate and convenient); and
- Case management services.

Central: Ultrasound and fetal surveillance can be difficult to obtain. Access to genetic testing, which is charged for at full price, is a concern. In addition, labor and delivery care is unavailable in the northeast and southwest portions of the region.

Eastern Virginia: Those without insurance often don't receive second level ultrasounds, amniocentesis, and genetic counseling because of the associated costs. Many support services are often not received including oral health, as well as mental health and substance abuse treatment services. Case management is often undervalued because it doesn't produce money (its cost/benefit is not routinely measured).

Northern Virginia: Uninsured and Medicaid patients often choose not to get the testing required for their care if it is not covered by the health department. Patients have difficulty reaching their appointments. If there is a choice of going to a medical appointment or going to work and making money, many people choose to go to work. Night appointments were tried, but there is low turnout and a lack of physicians that are willing to participate.

The Northern Virginia Perinatal Council approached businesses to help provide seminars to their workers about prenatal care. Only the large information technology businesses responded, so the lower income women were not reached. Employers, such as maid services, supermarkets, etc., did not want the seminars for their workers because it would often discourage them from working in poor conditions during pregnancy. Some classes are given in Spanish to reach Hispanic families, but it is hard for these women to attend all four sessions. Often, people are commuting two hours, via multiple forms of public transportation, to reach these seminars or their medical appointments. Some people also have long commutes to work and do not come home except on weekends. This means that they often are not present in the community in which they receive their medical care.

A final area of concern is access to specialists. It is hard to get a consultation for conditions such as gestational diabetes, cardiology, neurology, and nephrology. Some of these patients are sent to the state hospitals, but the VCU Health System requires social security numbers and the majority of these referred patients are undocumented.

South Central: Usually have all necessary lab tests but those going to the CHC sometimes have financial access issues. Some patients don't get group B strep (GBS) testing at week 35 or follow-up testing for chlamydia and gonorrhea. There were few resources for dental, mental health, and substance abuse services, even though it was estimated that half of the mothers who use safety net providers had depression. There is not a LINC program in the region but one CSB has an ARISE program. It was suggested that Medicaid provide dental coverage to pregnant women to prevent associated poor pregnancy outcomes.

Southwest: There is a need for more prenatal education services, such as "40 weeks to grow" project. Hospitals and health departments are doing some but there is a need for a health educator to follow-up and do education on a repetitive basis. There was a suggestion that the Governor's new parent educational package be given to all mothers at birth. Other services needed are dental care for mothers and children (there are no dentists in area that accept Medicaid) and mental health services. Currently it takes weeks to get an appointment.

Blue Ridge: Every person should receive HIV testing. Across the board emphasis by providers is needed for this to occur (it is understood that the person has to agree to be tested and some people have to pay out of pocket for the test, which may discourage them for being tested). Providers are under time crunch to provide good medical care as well as education. Two questions arose during the discussion: 1) how well are staff resources being utilized in doctors' offices; and 2) how to get education to people in rural areas and the clinics. The emphasis should be on prevention.

Skyline: There is a problem with distribution of providers, with shortages in many areas. For example, 30% of OB providers lost in Harrisonburg (due to increasing malpractice costs & decreasing third party payments). Dental care is not available for the uninsured; very limited behavioral health care (there is some substance abuse assistance through LINC in some areas); and waiting lists for case management. Prenatal education classes are sometimes difficult to access, particularly for women who have to get off time from work. Access to ultrasounds depends on payment source and some health districts (e.g. Lord Fairfax) don't provide lab services.

6. Are neonates getting to appropriate providers for care? Are they getting there in a timely manner? If not, what is needed to get them to appropriate care in a timely manner?

Statewide: **Overall, neonates are getting appropriate services at birth but sometimes have difficulty receiving follow-up care**. In some areas there is a concern whether neonates are receiving the most appropriate care at the closest appropriate facility, sometimes due to competition between health systems or lack of capacity (providers and bassinettes). Several concerns were cited regarding availability of pediatricians who will take children with Medicaid, particularly if the card hasn't been received yet.

Central: For the most part, neonates are receiving appropriate care. The very high risk neonates are transferred to MCV. Some neonates are being transferred to several hospitals before they are admitted to the most appropriate one. This situation is occurring more in the urban areas. Some patients have preferences for certain facilities (these may be based on the physician's suggestion). Better guidelines may be needed to ensure extremely low birth weight babies are being treated at the most appropriate facility. In short, for the critically ill and/or extremely low birth weight babies, the question is – are they receiving the most appropriate care at the closest appropriate facility? Stronger reinforcement by the Virginia Department of Health of the existing regulations is needed. Hospitals need to educate their medical staff about these regulations.

Eastern Virginia: Yes. No insurance barriers; therefore, physicians are willing to care for them.

Northern Virginia: Newborn Medicaid pending children have problems being seen after being discharged from the hospital and have conditions that need to be treated, such as jaundice. There is a need for physicians to have evening hours so that the caregivers of neonates can provide transportation to the medical site. Neonates are sometimes sent very far away because of delays in access to care; these places include Children's Hospital in Washington, DC, Georgetown University in Washington, Baltimore, and Philadelphia.

South Central: Yes. Transport of the infant occurs quickly but sometimes the mother checks out against medical advice to be with the infant.

Southwest: Yes, relative to getting to hospital services; most go to Johnson City. Neonates don't always get needed services when they go home and service availability varies from community to community. Home health services and professional resources (PT, respiratory therapy, and pediatricians) were among those that are difficult to receive in some areas. The perinatal council has done a survey regarding home health services available to the region. This information is being compiled and will be shared throughout the state to improve discharge services and networking.

Blue Ridge: It was mentioned that the time after delivery is very frantic and rushed time. There is a need to have someone visit the new mothers after they go home. Lewis Gale Hospital has a home visit program – it is the only hospital in the region which does. Concern was expressed about families having to make various appointments after they get home (e.g. do they remember? it is another thing to do when they are trying to adjust to the new baby). When severe problems are identified in neonates, appropriate referrals occur.

Skyline: Yes. If beds are full at UVA, occasionally neonates are sent to another center. UVA has an active education program with outlying providers. Sometimes there are problems with payers relative to paying for reverse transport to or care in the community hospital. There are also problems in getting babies on Medicaid a pediatrician in some areas and having babies seen in 24-48 hours after coming home if they are discharged on a weekend.

7. What are the characteristics of mothers and/or infants who aren't receiving appropriate care? (i.e. lack of insurance coverage, poverty, lack of transportation, educational level, racial or ethnic group)

Statewide: The following **characteristics were associated with women and children not receiving appropriate care:**

- Uninsured,
- Medicaid recipients,
- Low income,
- African American,
- Non-English speaking,
- Teens,
- Limited or no access to transportation,
- Those with mental health or substance abuse problems, and/or
- Those living in rural areas.

Central: These characteristics have been discussed in previous responses. They include: the uninsured, low income women; African American and some Hispanic women; and those with mental health and/or substance abuse issues.

Eastern Virginia: Characteristics of mothers not receiving appropriate care including poverty, lacking transportation, non-English speaking, and/or teens (due to self-denial and lack of Medicaid coverage because parents income is considered for eligibility).

Northern Virginia: Many of this population are undocumented or have a lack of financial resources. Some of them are also affected by domestic violence and mental health issues. The people who are documented and do have VISA's can not be seen at the health departments and hospitals. This motivates some people to let their VISA's lapse or not report them so that they can receive care. There are not enough doctors to serve the Medicaid patients for both pediatrics and obstetrics; this is especially true for specialists. This is starting to change, though, with changes in reimbursement. A practitioner commented that in Fairfax, obstetricians get paid almost as much from Medicaid as other payers. If doctors do take Medicaid, they might not speak the language of their clients. It can take months for an individual to find a Medicaid provider that meets their needs. There need to be case managers or navigators for high risk patients (or lay health promoters).

Doctors often do not take Medicaid patients because they take more time and may require an interpreter. The appointment time is an issue because that provider may be the individual's only link and guide to the health care system, and even basic concepts of how the U.S. health care system runs must be explained, so the appointments are longer. Another Medicaid disincentive is that the program systematically rejects many claims which then require the claim to be submitted again. Medicaid should also cover the costly service of having an interpreter for a patient. Pediatricians spend a great deal of time submitting bills that are rejected, only to be accepted later if they are submitted several times again. There needs to be very clear criteria for submitting bills and, also, distinct reimbursement levels for services.

South Central: Those with outstanding bills at physician offices and/or the health department, uninsured teenagers because Medicaid eligibility is based on household income, women who have applied for but not received Medicaid (need to increase speed of Medicaid processing, its suppose to take 10 days but doesn't occur), and those with financial access to care issues often don't get appropriate care or get it in a timely fashion. Requiring women to reapply for Medicaid is a problem but not for the children because renewal is automatic. It was suggested that a focus group of non-English speaking women be conducted to see what would be most helpful in providing interpretation and other needed services.

Southwest: Those needing dental and/or mental health and substance abuse services. The "working poor" who don't have access to Medicaid or employer based health insurance. One hospital even provides information to these women regarding ways to minimize their hospital bill including shorter stays, bringing supplies from home (such as diapers), and avoiding the use of anesthesia services. Migrant workers was another group not receiving appropriate care (Smith/Marion has case management services for migrants).

Blue Ridge: These characteristics already have been discussed in previous questions. However, a few additional responses were provided. Some mothers in the region appear to have limited understanding about life in general ("clueless"). Some women are not taking good care of themselves (e.g. obese, smoke, no dental care). Breastfeeding does not seem to be widely acceptable in the region.

Skyline: Hispanic, undocumented, and uninsured women, and those covered under Medicaid often aren't receiving appropriate care. Some families needing Healthy Families or CHIP services because the parents are afraid to enroll because they have substance abuse or other issues (some Eastern Europeans are particularly afraid). Some employers are not treating pregnant women working in blue collar fields well. Outreach with nurses at the plants has helped in some cases.

8. What has been the impact on your region of mothers and/or infants not receiving appropriate care?

Statewide: All regions cited **premature and low birth weight infants and infant mortality**, particularly among African American mothers, **and delivery complications**, occasionally even **maternal death**, as consequences of mothers and/or infants not receiving appropriate care. Another impact has been **increased emergency department visits** and **more and longer hospitalizations**, while the Social Services system can be overwhelmed by the ongoing needs of these infants and their families. This translates into **higher cost not only associated with the birth but ongoing costs associated with the health, welfare, and educational needs of the children born**.

Central: The impact has been neonatal deaths and poor birth outcomes (e.g. low birth weight and complications related to delivery).

Eastern Virginia: Low birth weight infants, infant mortality, maternal complications, mother's abandoning babies, increased cost associated with more and longer hospitalizations, more c-section deliveries.

Northern Virginia: There has been an increase in the number of NICU patients, a higher premature birthrate, and a slight increase in perinatal loss. There is also an increased demand on P.I. (parent intervention) programs in schools.

South Central: More "drop in" births at ED results in families that aren't prepared to take baby home and properly care for it and OBs are less willing to practice because of liability concerns. Much higher low birth weights and mortality among black babies.

Southwest: High rate of preterm and low birth weight infants. Some babies are being born addicted (although LINC programs have attempted to alleviate this) because some women fear that Social Services will take away their infants. There is a need for better advocacy for children of substance abusing parents and more foster homes for these children to remove them from environment until parent is able to properly care for the child. The Social Services system is overloaded.

Blue Ridge: The impact has been more morbidity and mortality. NICUs are well utilized; most babies in them are premature.

Skyline: Increase in pre-term births; increased morbidity of infants and mothers; and more emergency department visits and community cost.

9. What do you think are your biggest barriers to providing quality, risk appropriate care to obstetrical and newborn clients?

Statewide: The biggest barrier appears to be the **lack of availability of timely access to an affordable health care financing system by all women, regardless of income and citizenship, which reimburses adequately for providers to be willing to deliver quality obstetrical and neonatal care, and associated support services, statewide.** This includes **culturally competent**, **comprehensive** (including behavioral health, dental services, and case management) and **coordinated care**. Several groups noted that when the local public health departments used to, and where it currently does, provide prenatal services there were fewer delays and gaps in care and the outcomes were better. **A coordinating/case management role for the local health departments, with associated resources, appeared to be viewed quite positively in most locales.**

Central: The biggest barriers are system issues. The following examples of system issues were given: 1) integration between rural/urban hospitals and linkages; 2) private/public insurance linkages; 3) cooperative referrals between physicians; and 4) cultural competencies (how women are treated). It was noted that the Academy of Pediatrics is a good site for best practices. A program in Florida, Friendly Access, was mentioned as a best practice.

Eastern Virginia: Charging for pregnancy testing has resulted in clients buying own and then not being identified by the health department as needing prenatal services; Medicaid requiring women to apply for two year extension of Medicaid eligibility after a birth (automatic extension would help to prevent second pregnancy by giving mother access to family planning services), in addition to those previously mentioned.

Northern Virginia: Previously covered.

South Central: Financial access to care, transportation, supply of OBs/perinatologists, lack of financial resources for health departments, lack of cultural sensitivity (mistrust among patients).

Southwest: Inadequate financial resources, lack of health professionals, inadequate substance abuse and mental health services (LINC program in only two of the three CSBs – not available in Mount Rogers), limited dental services, and lack of transportation services.

Blue Ridge: The allocation of the funding needs to be reviewed. We need to look at how the money is being spent; for example, too much money is going to premature infant care nurseries which have some unrealistic expectations. It was mentioned that physicians have to request permission from Virginia Premier to move an infant back to a referring facility.

Skyline: Poor financial reimbursement; inability to provide immediate care at diagnosis; and lack of presumptive eligibility for Medicaid which would allow women to immediately enter into care.

10. What are the strengths of the perinatal system of care in your area?

Statewide: The **quality of the physicians and other health care providers** appeared to be seen as the greatest strength of the perinatal system across the State. In most areas the **coordination of services/referrals between providers** was also seen as very strong, as well as **the educational programs** that were brought to community providers from the perinatal centers.

Central: Strengths include the availability of physicians; the strong relationships built across the providers of care; expert physicians; some practicing midwives; and the presence of VCU Health System.

Eastern Virginia: System provides important education for physicians and nurses. All babies who need care get access to care in a timely manner. A full range of specialty services are available and there is no competition for clients. Communication is good (particularly with regional hospitals) and referral hospital visits and chart reviews occur.

Northern Virginia: The area has excellent physicians, nurses, and other medical personnel. There are also a large amount of public transportation and translation services available in the central part of Northern Virginia. The center of the region also has good infrastructure and programs, but all are at capacity and can no longer support the outlying counties of Loudoun and Prince William. These various services have often worked together to resolve issues in the region. The non-profit hospitals are providing adequate care to underserved patients, but the for-profit hospitals need to follow this example and help share the burden.

South Central: Referral/transportation system working well (< 60 minute response) and quality, competent, and caring professionals are at the perinatal center. The center has 24 hour in-house OB care. The OBs in Lynchburg take a lot of Medicaid patients.

Southwest: Good coordination of services in region and there is a good relationship between OBs and pediatricians in the community and those at the regional centers.

Blue Ridge: The existing Perinatal Council is a strength and provides a good forum for discussion. There is a willingness to try new things and to be flexible. Additional strengths include the following: good relationships between providers; familiarity with the referral system; history of collaboration; availability of specialists in the area; and physicians in outlying areas are comfortable referring patients to the region.

Skyline: Regional perinatal care system works well for inpatients; providers really care about their patients; the perinatal education program is outstanding; and there is access available to everyone, even if it's only through the emergency departments of hospitals.

11. What are the weaknesses of the perinatal system of care in your region?

Statewide: **The lack of community-wide access in all regions to obstetricians and nurse mid-wives**, caused by malpractice costs and legal requirements as well as inadequate financial reimbursement, was **cited as the primary weakness of the current perinatal system**. **Maternal transports** either to or back from a perinatal center was also cited as a concern in some regions. Finally, a **lack of comprehensive care**, including transportation services, in many areas was cited as a weakness of the system.

Central: Weaknesses include lack of OB and pediatric services/lack of infrastructure in rural areas; not enough midwives (especially in medically underserved areas); lack of appropriate support systems (e.g. shopping; school system; cultural activities) in rural areas for practitioners to set up as well as remain in practice; and no pediatric cardiothoracic surgeon in the region (send babies needing this service to UVA).

Eastern Virginia: Primary access to care is difficult. With military providers being outsourced from the area, it is difficult to plan and staff for fluctuations in demand. The region has lost OB physicians in the last year and a half.

Northern Virginia: Population growth has exceeded resource capacity. The programs to aid people are in place in the central counties, but are overwhelmed by the increase in population and by the needs of those coming from the outlying counties. Cultural differences prevent many women from seeking care. In addition, the academic medical centers are struggling financially. There needs to be a single point of entry and exit to the system or some sort of umbrella organization that coordinates perinatal services. There is a lack of follow-up care after delivery and case management or Healthy Families programs could help. Non-profit hospitals are the only ones providing care to at risk/uninsured/low income families. For example, Inova Fairfax Hospital's OB Clinic has the highest percentage of charity care in the state. But at the same time, the hospital is seeing its total number of deliveries increase to approximately 12,000 per year and they are overwhelmed. Private obstetricians at the other hospitals and in the other counties are providing care to high risk patients if they come to the hospital, but there needs to be some Good Samaritan protections for these providers who accept walk-in patients.

South Central: Areas outside of PD 11 need better access to care (financial access and providers). Medicaid allows 60 days of traditional Medicaid and then patient gets transferred to managed care which might require them to switch providers which upsets continuity and/or may not be convenient for the patient (education of patients regarding plans needs to occur). There is a lack of comprehensive care and reliable transportation in rural areas.

Southwest: Because of malpractice rates it is difficult to recruit OBs (there is concern about replacement of physicians that will be retiring) and three hospitals have closed their OB units. These have contributed to reduced access to perinatal services in the region. There is a need to do transport reviews of more cases with all health professionals involved. It was noted that Johnson City will transport infants in 45 minutes using its helicopter.

Blue Ridge: Nurse midwives do not have access to physicians at Carilion because their malpractice will not cover them. Another weakness noted was the inability of some hospitals to do maternal transports.

Skyline: Need more local access to outpatient care; difficulties in sending inpatients back to their communities for care (third party limitations); need better distribution of resources within the region creating ready access to professionals in the community and better system for coordinating care on an outpatient basis (State could fund pilot projects in these areas).

12. What has been the impact of managed care or other payers on the referral or delivery of perinatal services in your region? What changes have occurred over the past 5 years relative to payers of perinatal services?

Statewide: Overall, **Medicaid managed care plans often do not provide for coordination of care nor insure that all needed services are available in the community under their plan**. Many felt that Medicaid could do a better job in paying promptly (under fee for service) and coordinating with their managed care plans. Some said that teenagers sometimes go without care or are forced to move out of their parent's home because **Medicaid eligibility** is based on the household income. Other consequences of managed care or payers have included**: difficulty in getting transports back to an individual's community, difficulty in getting needed services, increased administrative burden, and loss of provider continuity as women transition from Medicaid fee for service to managed care.**

Central: It was noted that Medicaid was one of the better payers (Medicaid reimbursement is similar to managed care). In reference to pregnant teenagers in Richmond and other areas across the region, a concern about Medicaid policy was mentioned. If the teenager is underage, eligibility is dependent upon her parents income; creating an impediment for accessing insurance and, thus, prenatal care. A comment was made that other states do not have this requirement. Another comment related to the need to reimburse programs providing support services to at risk mothers.

Eastern Virginia: There is a lack of coordination between Medicaid and managed care organizations. Managed care wants to keep their patients within their practices sometimes even if they can't meet the patient's needs. Each payer has its own administrative paperwork and own labs which adds to the cost for providers.

Northern Virginia: Some private insurance plans sometimes do not have a perinatologist on the list of providers. Parents-to-be and managed care providers often do not realize that women are entitled to go off of their provider list when certain risk factors are present. Payers are starting to allow cesarean sections on demand; however, the increasing cesarean section rate adds to the cost and length of stay for delivery. Some mothers are even requesting to schedule a cesarean section during pre-natal visits. Insurers pay the same amount of money whether delivery was through vaginal birth or cesarean section, therefore, increased or unnecessary cesarean sections can inflate the costs to hospitals for providing care.

South Central: Some insurance plans don't pay for well OB visits. Medicaid HMOs may not be accepted by local OBs or hospital resulting in ambulances needing to transport patients to other hospitals. Medicaid reimbursement for "at home" photo therapy services (bilirubin lights) has gone so low and the application for approval has to be submitted multiple times, resulting in a scarcity of this service in the community. As a result, infants have to stay in the hospital for longer periods.

Southwest: There is no managed care in the region. Coding errors from the state have been noted, causing reimbursement delays from Medicaid reimbursement. Low volumes and/or low Medicaid payments can cause OB units to close. Low Medicaid reimbursement is impacting local hospitals decisions to continue or discontinue OB services resulting in the loss of three OB units in an 8 month period (2003-2004). Medicaid payments will not cover a hospital's costs; therefore, hospitals may try to discourage Medicaid OB patients. High malpractice costs are impacting and influencing changes in practice for both private OBs and hospitals, often making recruitment difficult, if not impossible.

Blue Ridge: Medicaid should cover illegal immigrants. The group expressed several concerns with insurance companies, especially Anthem and Southern Health. These companies are putting pressure on providers to discount services, but they will not add services. An example was given of one insurance company that denies claims hoping that the provider will not refile. Another concern is the time it takes to deal with insurance companies. Many insurance companies will not cover transition to home care. From an insurance perspective, more regard for the mother and baby needs to occur.

Skyline: Recent changes have resulted in third party payers paying less for care and there has been difficulty getting payment for transports back to communities from the perinatal center (particularly with managed Medicaid). Some won't allow transfers back. (Sentara was noted as being a poor payer.) It was noted that critical access hospitals can't take referrals from other facilities to get Medicaid reimbursement and that Medicaid payment often is delayed. Offices have to employ a person just to manage the paperwork and deal with individual claims.

13. What impact have hospital systems had on the referral and/or delivery of perinatal services in your region?

Statewide: In the regions with **more competing hospital systems, patients are not always appropriately transferred** to the perinatal center, sometimes resulting in sicker mothers and/or infants. However, **overall infants and mothers are sent appropriately to the perinatal center.** Many hospital systems are looking at ways to limit financial losses in obstetrics, sometimes resulting in the shutting down of obstetrical services in rural areas.

Central: The impact is whether or not the patient is being treated a facility with the appropriate level of services to care for the patient's condition. Sometimes, patients are kept within a hospital system when they should be sent to another facility that is more appropriate for their needs. Additional information relative to competition was provided by the group. If physicians belong to a hospital system, they refer to their own group and may not refer to a regional facility. Also, with the increased Medicaid reimbursement, non-VCUHS physicians may compete for

Medicaid patients. It was noted that no statewide perinatal mandates exist for transferring due to acuity. A better system for referrals is needed.

Eastern Virginia: Most hospitals don't have front end clinics (DePaul only one); everyone is going private. Physician referrals for perinatal services don't appear to be influenced by hospital affiliation.

Northern Virginia: There are no uniform standards for referrals across the region. Community hospitals now have the ability to take care of sicker babies, but these hospitals are often taking on patients that are too advanced for their facility. The transports that do come to the larger subspecialty centers are much sicker than in the past. Situations have occurred where high risk mothers deliver at community health centers, even though their risk conditions were known before delivery. Therefore, there need to be transport protocols, but not state mandates, to make sure referrals are used appropriately. An annual review of transports would aide in these guidelines.

South Central: Hospitals are trying to limit their losses from "picking up the slack" for a lack of community based services.

Southwest: No impact mentioned.

Blue Ridge: Carilion and Lewis Gale have a very close relationship. Carilion treats more high risk patients.

Skyline: While this region has two hospitals with no delivery services, it has not experienced a closure of delivery services in quite some time. However, hospitals closing OB services in other regions then impact the census of hospitals in the Skyline region. For example, the closure of a hospital in the Roanoke region has almost doubled the monthly deliveries at Stonewall Jackson. A three hospital system has opened a NICU that has impacted referral patterns, but the perinatal center has a good working relationship with it. Hospitals also are unwilling to assist providers with malpractice problems.

14. Do you think that health care professionals in your region have appropriate competencies in perinatal care? If not, what is needed for an appropriate competency level to be reached?

Statewide: Overall**, health care professionals have appropriate competencies in perinatal care.** However, it is **sometimes difficult** for physicians and nurses to keep up with continuing education because of a **lack of time or coverage to attend training**, in addition to the requirement sometimes for professionals to pay for education out of their own pockets. Several groups suggested the **need to take evidence-based training directly to providers in their communities.**

Central: In immediate region, health care professionals' competencies are appropriate. However, in some outlying areas, professionals may not be keeping up with the most current guidelines. Education is not much of a focus at medical staff meetings. OBs need a certain number of CMEs; however, the courses to acquire the CMEs are their choice. Two suggestions

for continuing education were provided: 1) develop prepackaged education programs, lasting no more than 30 minutes each; and 2) do evidence-based education or case reviews. In short, for professionals to participate in continuing education programs, finding time is a critical component.

Eastern Virginia: Yes. EVMS and CHKD do regular outreach.

Northern Virginia: Health care professionals in this region generally have appropriate competencies, and are very good at continuing their training to stay current.

South Central: Yes.

Southwest: There needs to be a way for "grand rounds" to provide continuing education credits. There is a need for OB coverage so physicians can attend continuing education. The perinatal center helps train nurses (through coordinating services). Sometimes staffing needs prevent nurses from attending education.

Blue Ridge: Physicians are competent. No grant funding for perinatal outreach to educate staff exists. Hospitals need more nurses and more access to continuing education. Continuing education is critical. In small hospitals, this area gets cut. Physicians and nurses are not always willing to pay out of pocket of continuing education.

Skyline: Yes, but professionals need relief from liability and a coordinated system of care.

15. Is regionalization of perinatal care still a valuable and realistic goal in your region? In Virginia? If yes, why? If no, why not?

Statewide: **Regionalization of perinatal care was seen to be valuable in all areas but with challenges to overcome in some regions.** It was seen as **particularly valuable in providing educational and referral sources** to local areas. Some noted the need for additional resources either due to the large number of patients or geographic area covered.

Central: Yes, but it needs to be revitalized. Linkages with tertiary centers are crucial. Regionalization also is good for Virginia.

Eastern Virginia: Yes in the region but may differ statewide. In the region, its large geographic area and transportation issues make it difficult (large number of waterways to get around, limited public transportation in some areas, etc.). Rotation of a perinatologist to outlying areas was suggested. Assistance in helping professionals adhere to quality of care guidelines was cited as a valuable goal.

Northern Virginia: Yes, but managed care constraints often dictate referral patterns. There is a concern about the way money is allocated for perinatal care to the different regions. Currently, all regions receive the same amount regardless of the services that are needed in the area. Northern Virginia's population far exceeds the population in any of the other six regions.

South Central: Yes, although it is sometimes difficult in boarder areas not clearly in one region or another. The educational piece is really important to rural areas.

Southwest: In the region, regionalization of perinatal care is valuable being a good information and referral source. Statewide, it is valuable to an extent.

Blue Ridge: Yes, it is valuable and realistic for the region. The region's geography dictates the need for regionalization. To some extent, perinatal care is actually centralized in the region because of the geography. In reference to Virginia, regionalization can be problematic in the large metropolitan areas because of competition among hospitals. A comment was made about whether this region is getting its fair share of the perinatal resources. This region has an extremely large catchment area Sometimes people at the State level forget about the area beyond Roanoke.

Skyline: Yes, regionalization is valuable but probably not realistic in the entire state because of proliferation of NICUs, neonatologists, etc. therefore, there needs to be locally-focused solutions. It is a realistic goal for the Skyline region.

16. Are resources adequate for the regional perinatal councils? If not, what resources are needed and what are they needed for?

Statewide: All groups thought that the **regional perinatal councils had inadequate resources to meet the needs of their communities,** having gone through funding reductions over the years. It was felt that instead of State support being the same for all regions and not adjusted up to reflect increased work load from year to year, there ought to be a funding formula based on number of births, number of low birth weight infants, or some other formula. **Resources were needed for**:

- Personnel to conduct outreach, screenings, and health education;
- Increased technical assistance to document trends and outcomes;
- Development of referral sources for substance abuse, mental health, etc;
- Educational resources, such as training videos and support;
- Public health education and pregnancy prevention; and
- Research and implementation of "best practices."

Central: No, resources are not adequate. The Richmond Council currently is receiving half as much funding as it did 15 years ago. The following additional resources were identified: more personnel to conduct outreach, screenings, and health education; more epidemiologist support and technical assistance at the state level; more referral sources for women with depression, especially if they do not have private insurance; increased capacity for substance abusing women; and more residential therapy (more than once a week). The group briefly discussed the nursing shortage, occurring at hospitals and health departments. The State Board of Nursing does not require RNs to acquire a specific number of CEUs to maintain their license.

Eastern Virginia: No, resources are needed for community outreach and education (manpower and resources) which could be done by the perinatal council or through contract. Video or other ways to do outreach effectively needs to be examined. Need for increased documentation of

costs/benefits/outcomes of current system and interventions. There needs to be a standard amount of resources needed based on data (# births, # LBW births, infant mortality, etc.).

Northern Virginia: Resources for the regional perinatal councils are not adequate, and even their base funding is not enough. There needs to be money for the expansion of clinic services. There also needs to be more money for case management. At Virginia Hospital Center, there are 1.5 FTE faculty physicians, 6 part time nurse practitioners, 18 residents, and 1 perinatologist for 2,700 annual deliveries. It was noted that residents require a great deal of supervision. Perinatologists are in high demand; there are four at Inova Fairfax, three at Inova Alexandria, and one at Virginia Hospital Center. Nine hundred undocumented individuals were seen at the health department in Prince William County; they can not take Medicaid patients because of capacity issues. VCU Health System and the UVA Medical Center are too far away to send patients. Inova Fairfax Hospital sees some of these high risk patients, but does not receive state monies for doing so like the academic medical centers. But it makes more sense to take care of these patients at Inova Fairfax instead of transporting them for long distances. Low risk patients, especially, should be kept in the area. A forum that addresses access, specialty care, and high risk issues and pulls providers together could aide the region. This forum could be a planning hub that helps coordinate services. There are problems with physician attendance at these events, therefore there could be several satellite events at different practices/sites instead of one central event, or conference calls and videoconferencing could be used. Providers must be incentivised for attending these events Best practices should be researched and presented to physicians and health department personnel, but there must be away to overcome the time constraints that make it hard for physicians and health department personnel to take time to learn guidelines and implement best practices. For example, there are two hundred twenty obstetricians at Inova Fairfax Hospital and it is hard to educate this number of people. There are people from over 100 counties in Virginia. The health departments are staffed by a diversity of individuals, physicians, nurse practitioners, certified professional midwives, and others. There is a need to devise mechanisms to get best practices information to the health departments in a timely fashion that is efficient for providers. Those providing care to the uninsured of Northern Virginia are so busy with the volume that they do not have time to devise more efficient ways to provide care. Finally, issues with infertility doctors and their associated increased risks of multiple births should be addressed. Fairfax County leads the nation in births associated with infertility treatment.

South Central: No. Sometimes hospitals can't afford to reimburse nurses to attend inservices and/or there is a lack of staffing to cover for them. Use of a teleconferencing network at universities and local health departments might make training more feasible. Money is needed for outreach education (speakers, conferences, materials, etc) of consumers and providers. Teenage pregnancy prevention needs to occur in schools. There needs to be case management at the OB provider level. Community Services Boards (CSB) need resources to provide mental health and substance abuse services to women.

Southwest: No. There is a need for increased outreach education, including resources to continue projects specific to the region and increase grant funding to area. Fetal monitoring classes are needed twice a year (currently offered only once a year). The office currently operates with 2.4 staff people. The Perinatal Education Coordinator is also filling the FIMR role.

The Consortium Coordinator maintains/researches funding efforts, new initiatives, reporting and supports a 0.4 FTE Special Projects Coordinator. There is currently no administrative support. With increasing state mandates, it becomes increasingly difficult to fulfill requirements. Moreover, the Southwest Virginia Perinatal Council reports that it is the only council in the state that does not physically operate out of a perinatal center or university. This translates into operating expenses that other councils may not incur, including, but not limited to, rent and phone. This also limits access to support staff that other councils may benefit from. Despite Carillon's (the fiscal agent) best efforts to assist the Council, it is located two hours from the physical location.

Blue Ridge: No, resources are not adequate. More physician and RN education, especially evidence-based education, is needed. Questions were asked about how services are deleted (e.g. Maternal/Child Health program in Virginia) and how to get back some of the deleted services. More public input should occur, which could include educating the public about the issues and having current clients receiving perinatal services on the council. Virginia should be more in the area of public health education. A question was asked "Is Virginia in the maternal/child business and does it value it?"

Skyline: Barely, particularly given the increase in state mandates on what is needed. Three full time equivalent (FTEs) employees are needed for outreach, updating professionals, education, transportation, and research on outcomes. According to a public health nurse, MIC (Maternal Infant Care Coordination), a baby care program, is not getting referrals from providers for their patients. There should be a statewide perinatal services advisory board to set standards and have authority and a budget to make needed changes.

Other comments

Eastern Virginia: **The aging public health workforce is a concern**. Need to plan for mixing historical public health skills with new skills such as working with diverse populations, implementing best practices, outreaching to communities, etc.

South Central: **Virginia law does not require employers to make any accommodations for pregnant employees**. The result is often **birth complications, particularly for women working in blue collar fields**. The Resources Mothers program in the Piedmont Health District and the Teen Parent program in Lynchburg were cited as effective community-based programs.

Southwest: Southwest Virginia is different. **One program doesn't fit the needs of all Virginians. Travel time is a big issue, as is the associated isolation of many people**. The Southwest has to work across state lines for services which increase administration and coordination time. There is a lot of community commitment and community resources are working effectively. Nevertheless, **poverty is a major issue** and there is a need for economic development in the area.

Skyline: **Perinatal/prenatal services are not mandated to be provided by local health departments but care needs to be supervised on-site.**

Maternal and Child Health Needs Assessment
Interviews of Key Stakeholders

Introduction

The interviews of twenty-seven key stakeholders for this needs assessment were conducted from January through March 2005, by Karen Cameron, Executive Director, and Elizabeth Farrell, Assistant Director, of the Central Virginia Health Planning Agency, Inc. The same interview questions were asked of each stakeholder and their responses are detailed below under the major issue they pertain to (the issue is bolded). The bolded responses are in order of their relative frequency of mention by those interviewed and are not ordered based on total comments under each issue, since sometimes those interviewed had several specific comments associated with a particular issue. The number of times when more than one person made a similar comment is indicated by the number following the comment.

Summary of Findings

The interview protocol used to solicit input into this needs assessment of maternal and child health in Virginia was structured to illicit responses relative to the overall environment as it related to children and families, information relative to the specific populations served by Title V funding, the role of the OFHS relative to meeting the needs of these populations, and how could OFHS better work with those within and outside of the Virginia Department of Health. Several themes emerged from these interviews:

- **Growing numbers of persons**, particularly the uninsured and Medicaid recipients, are experiencing **limited access to medical and dental care services**.
- **Obstetrical and other perinatal services are particularly scarce for this generally low-income population but also for rural and minority residents** who may not necessarily be low-income.
- **The growing cost of health care** and the impact on health insurance costs **threatens to result in more people, particularly lower income, being uninsured.**
- **The growth in enrollment in Virginia's state children's health insurance program** (FAMIS) **has had a positive impact on getting needed services to children**, but there is a **critical shortage of pediatricians, pediatric specialists, support services, and dentists in many areas willing to serve these and children with Medicaid coverage**, generally because of low relative reimbursement.
- In addition to **dental care, mental health and substance abuse services are in particularly short supply for low-income women and children**.
- There is **growing concern regarding immigrants' access to the myriad of health related services,** particularly linguistically and culturally appropriate services.

- The **need for prevention and early intervention services** was often noted, particularly for infants and children, whereas education and initiatives regarding health issues, particularly those aimed at risky behaviors, was noted as being needed by adolescents.
- **Disabled children** particularly appeared to **need improved identification and coordination of needed services.**
- For women of child bearing age, **prenatal care and family planning services are viewed as critical needs.**
- As expected, **low income and/or uninsured people and minority populations were of particular concern relative to getting their health needs met**.
- For infants and children, the **VDH is viewed as doing a good job relative to immunizations and WIC/nutrition**, with the **Bright Futures program** and **New Parents kit** being specifically mentioned.
- **VDH's Care Connection for disabled children** was mentioned as being particularly **effective**.
- **Family planning, STD testing, and prenatal care (when available) at the local health departments** generally are **viewed favorably** by those interviewed.
- The **greatest areas for improvement by VDH** (relative to women's and children's services) overwhelmingly appear to be in **ensuring the availability of providers and services, as well as their coordination**, and in **increased collaboration** both internally and within communities.
- Specific suggestions centered on **increased and improved communication, leadership and improved planning, and developing additional resources** (financial, data/information, and services).
- Overwhelmingly, those interviewed identified **the state government as needing to provide resources and leadership in planning and creating partnerships** while **local governments** were viewed as being able **to provide collaborators, assisting in need identification and planning, and providing some resources**.
- **Communities** (including non-profit organizations, faith-based organizations, and others) were seen as **key to effective collaboration and implementation of services** whereas there appeared to be support for **private providers becoming partners and sharing in the provision of services and promoting health education** to all members of the community.
- The **greatest barriers** to accomplishing real improvement in the health of women and children are the **perceived lack of political will and commitment by leadership at all levels** (state, local, and community), largely because of changing priorities and leaders, **and the lack of and/or poor use of resources for health improvement**.
- When questions were asked specifically about the OFHS, sometimes it appeared that the answers were more about VDH than OFHS specifically, usually because the individual did not know the difference between the activities of one office versus another. However, the **OFHS activities that had the greatest support** included: **data**

surveillance, research, and program evaluation; fostering collaboration; developing coordinated services statewide; and community education and outreach.

- Ways in which **OFHS could better collaborate** included **significant support for increasing communication and/or outreach activities and increasing collaborative activities to address identified community needs.**
- Many organizations do not collect data and/or have specific databases concerning the population they are serving. Many noted the **need for easily accessible, specific data on the populations served by OFHS and the need to know about what data is being collected**.

Overall, it appears that there is **significant support for increased, focused planning and implementation using community collaboratives**. Those interviewed appeared to view **VDH/OFHS' role as needing to provide leadership to these efforts, particularly in the areas of planning, resource development, and communication. Selected service provision through local health departments was also supported**, **particularly in the role of coordination and case management in the provision of perinatal services.** However, **above all**, it appeared that most people interviewed believed that **it is VDH's responsibility to ensure that there is a "safety net" for all Virginians**, but not necessarily in providing all of the services comprising such net.

Participants

Amy Atkinson, Executive Director, Virginia Commission on Youth
Debra Baber, RN, PNP, Coordinator, Parish Nurse Consortium
Mimi Bender, CEO, Women's Health Virginia
Joann Bodurtha, M.D., VA GAC Chair, VCU Professor, Department of Human Genetics
Don Combs, Vice President of Planning and Development, Eastern Virginia Medical School
Terry Dickinson, Executive Director, Virginia Dental Association
Leslie Ellwood, M.D., President, American Academy of Pediatrics – Virginia Chapter
Pat Finnerty, Director, Department of Medical Assistance Services (DMAS)**
Chris Gabriel, M.D., Director, Children's Hospital of the Kings Daughters
Neal Graham, Executive Director, Virginia Primary Care Association
Jill Hanken, Attorney, Virginia Poverty Law Center
Steve Horan, PhD, Executive Director, Community Health Resource Center
Suzanne Johnson, President, Voices for Virginia's Children
Cindi Jones, Chief Deputy, DMAS**
Martha Kurgens, Child & Adolescent Specialist, Dept of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS)*
Jeff Lake, Deputy Commissioner for Community Health Services, Virginia Department of Health
Jack Lanier, PhD, Chairman, Virginia Board of Health
Marcus Martin, M.D., Chair, Department of Emergency Medicine, University of Virginia
Pricilla Mendenhall, Northern Virginia Area Health Education Center
Petra Menzel, Director, Virginia Emergency Medical Services for Children
Debbie Oswalt, Executive Director, Virginia Health Care Foundation

Shirley Rikes, Director of Child and Family Services, DMHMRSAS*
Cheryl Roberts, Deputy Director , DMAS**
Elena Serrano, Ph.D., Chair of Virginia Action for Healthy Kids Committee, Virginia Tech Assistant Professor
Therese Wolf, Foster Care Program Supervisor, Virginia Department of Social Services
Jane Woods, Secretary for Health and Human Services, State of Virginia
Dana Yarbrough, Director, Parent to Parent of Virginia

* Interview conducted together.
** Interview conducted together.

Summary of Reponses

OVERALL ENVIRONMENT

1. What major changes/emerging issues over the last five years have had the most impact upon the health of families and children in Virginia?

Limited availability of health care services to Medicaid and uninsured patients
- There are a growing number of self-pay patients/continued erosion of employer based insurance – 4
- Medicaid reimbursement is so low that pediatricians must limit or not take (one person noted that 60% of children in 40 counties are eligible for Medicaid) - 2
- Unavailability of health services (lack of providers/some do not take Medicaid) - 2
- Drive times have become significant for patients because of a shortage of practitioners that will accept Medicaid patients (especially for dental services).
- Reduction in care for indigent population
- Eligibility requirements for Medicaid could be raised

Lack of adequate resources generally
- Budget issues/funding of health services/lack of resources – 6
- Financial and geographic access to care (medical, mental health, and especially dental) - 2
- Growth of elderly and associated needs diverting limited resources from families

Obstetrical provider shortages & associated issues
- Limited number of OB/GYNs/access to OB/GYNs -3
- Availability of and requirement to do early intervention services (not all providers complying, used to get additional money) - 2
- Smaller community hospitals are closing their obstetrics departments.
- Obstetricians are seeing higher than average premium increases.
- Obstetricians are trying to limit their liability by not employing nurse midwives, and refusing to provide surgical back-up care for family practitioners in the case that cesarean sections are needed for their patients.
- Educating parents to have infants sleep on their backs

Growth in SCHIP (FAMIS) enrollment
- Emphasis to increase enrollment of children in health insurance programs/ SCHIP program implementation improvements (one person noted 116K children have been added in last 3 years) - 7
- Retention for child health insurance programs (how many enrolled are using services?)

Lifestyle issues
- Stressful lifestyle of people -2
- Childhood overweight and its consequences (awareness and activities have increased) - 2
- Anti-tobacco campaigns have made smoking less socially acceptable - 2
- Time for preventive care is limited (especially for women)
- Not doing enough education about need for self-care
- Public becoming less apathetic regarding nutrition & physical activity

Rising health care and health insurance costs
- Lack of affordable health care/rising health insurance cost (one noted that any child should be able to buy into FAMIS) – 3
- People losing employer-based insurance (one noted impact on the children) - 2

Mental health/substance abuse treatment needs and access
- Substance abuse (including during pregnancy) – 2
- Mental health services for all ages
- Limited number of mental health providers for children but insurers won't reimburse pediatricians for providing care

Other issues
- Growing number of immigrants & associated need for interpreter & other services (which is unaffordable by providers receiving Medicaid reimbursement & health plans won't reimburse for these services) - 3
- Unlicensed day care centers
- Welfare reform, especially getting women back to work (some good and some bad – e.g. still need child care)
- Sexually transmitted diseases
- Too many resources are used for administrative functions
- Gun law changes
- Social programs for vulnerable populations have not received priority relative to programs with corporate interests
- Special needs children - the method of accessing needs & awareness has changed
- Better disease stage management
- Growing incidence of chronic disease (e.g. AIDS, substance abuse, TB, diabetes, etc)
- Decline in teenage pregnancy

2. What are one or two most pressing needs of families and children that impact health status and what can be done to address them?

Limited access to health and dental care

- More funding for Medicaid (including pediatricians) – 4
- Affordable high insurance is decreasing (particularly impacts lower income worker) - 4
- Lack of financial access to primary care physicians and dentists for routine care – 3
- Financial and geographic access to health care - 3
- Access to dental care (still not enough providers) – 2
- Access to OB services - 2
- Lack of providers, especially for specialists and for those who live in rural areas - 2
- Free clinics (not enough of them and their hours are limited) - 2
- Non-citizens (many legal) don't have access to health services (need better coordination of safety net providers) - 2
- Limited transportation
- Low-income parents (many with chronic illness) don't have access to health insurance (need to improve eligibility)
- Underinsurance
- Medicaid eligibility requirements needs to be changed so more people are eligible
- Low Medicaid reimbursement and high malpractice costs
- Cost of medications
- Need more providers in rural areas
- Need for policies that promote access to coverage
- Need to coordinate services between agencies (eliminate duplication and turfism)

Mental health/substance abuse treatment needs

- Need for substance abuse treatment (lack of providers) – 3
- Children and adolescents (in foster care especially, noted by one) are at a high risk for mental illness (these children need to be identified as high risk and given case management) - 2
- Need for more recognition of and resources for young children with social and emotional issues that lead to mental health problems
- Mental health care

Lifestyle/educational issues

- How to educate people to understand what their child's health needs are (one noted link between physical activity/nutrition/unsupervised media use & obesity and school performance) - 2
- Diversity of culture has to be understood in order to get the appropriate message out to the respective populations – 2
- Financial management of families (e.g. increasing debt burden): provide education programs on managing finances
- Low-income families who are not served well by public programs have to make difficult choices, e.g. food vs. heat (need stronger support for child care, easier access to food stamps, and increase eligibility for Medicaid)
- More initiatives to educate people about insurance and how it works

- Many mothers leave hospital without information about WIC & available services
- Increased communication about current programs available to help families and children
- Develop more information and education programs that address needs of families as they perceive their needs, not as VDH perceives them (rethink how programs are conducted)
- Need for care coordination
- Need for increased support for education programs to increase opportunities for at risk populations
- Low utilization of well child visits and follow-up care by families

Need for prevention services
- General parenting issues
- Injury prevention (need more prevention)
- Cost of health care (need to invest more in prevention)
- Obesity (overeating but malnourished; need for physical activity)
- Nutrition (a lot of conflicting information; information needs to be consistent and available)

Services for special needs children lacking
- Children not getting identified for early intervention services by providers (ESPDT rates are low) - 2
- Special needs children don't have all the services they need (ex. Difficulty getting personal care and appropriate early diagnosis & screening services)

Other issues
- Poverty -2
- Current reimbursement system rewards wrong things (e.g. do more procedures)
- All payers need to reimburse for translator services
- Erosion of support of public institutions and public health
- Need to identify HIV positive women during prenatal care
- Advocacy (no voice for disenfranchised) – need people (also include those affected) who are working on the same issue to collaborate and find a common voice and goal

SPECIFIC POPULATIONS

3. What are your greatest health concerns relative to the following populations in Virginia? (e.g. access to dental services, mental health services, substance abuse, chronic disease, cancer, etc.)

<u>Infants</u>

Prenatal care
- Birth weight/increase in number of premature babies (one noted high income women with LBW infants because they refused to gain weight) - 6
- Prenatal care (lacking or late) - 5
- Crack/cocaine addicted babies; prenatal substance abuse by mother - 2
- Services available for future needs for very low birth weight babies -1
- Making a linkage between infant's health and mother's health

- Family planning
- Infant mortality

Prevention and intervention services

- Should be screened for developmental delays and problems/early intervention services needed (current system inadequate; one indicated that early intervention system needs to be looked at; long lists – priority should be based on actual function & not just prematurity) - 6
- Nutrition (appropriate) - 6
- Immunizations (need to receive all) - 5
- Injury prevention – 2
- Preventative services
- Breastfeeding (still are barriers, especially for working women)
- Support for at-risk families
- Need to figure out cause of autism

Medical care access

- Need to receive well child care (include getting to medical appointments) - 3
- Access to care - 3
- Control of infectious diseases
- Need to have a medical home
- Not enough pediatricians or specialists (particularly for Medicaid)
- System to make sure they get health insurance

Lifestyle issues

- Cost of or access to child care and the low quality of some providers - 2
- Social structure needs to support raising these children
- Mother's behaviors and lifestyle
- Help mothers and care providers get services needed for the infants
- More time with mothers and fathers

Other issues

- No central coordination of program services

<u>Children</u>

Prevention and intervention services

- Nutrition -8
- Obesity - 8
- Access to physical activity (including neighborhoods) – 5
- Continue to receive further immunizations/underimmunized -4
- Perform risk assessments and screenings/early intervention - 4
- Children should be protected against infectious agents -2
- Need to have school systems and others work together on health (e.g. schools should offer healthier foods) - 2
- Need to learn good health habits (nutrition and physical activity, safety)

- Preventive care
- Injury prevention
- Poison prevention
- Develop facilities so children can exercise

Access to medical and dental care
- Dental care/access to dental care – 10
- Access to medical providers (lack of medical home; particularly for Medicaid/FAMIS) - 5
- Need for scheduled pediatric visits (no incentive to promote regular visits) - 2
- Access to health insurance -2
- Educate parents about continued need for health care/medical home as child ages - 2
- Financial access to dental and medical care
- Need system that develops school health clinics (integrate health and education)

Mental health and substance abuse treatment service issues
- Access to mental health services (& early detection) - 5
- Substance abuse
- Mental health issues
- Eating disorders

Lifestyle issues
- Need for parental education
- Literacy
- Lack of quality child care providers
- Need more exercise and better nutrition

Children with special health needs

Identification & coordination of needed services
- There needs to be an integrated system of care (one mentioned family centered care needed & current system broken)/community linkages – 6
- Children at risk for needing special services are not being detected early (one questioned whether these should be done by DMHMRSAS) - 4
- School system (some problems in meeting these children's needs, e.g. not enough resources) - 2
- Recognize the range of needs for these children (one approach does not work for all)

Access to health and dental care
- Access to specialty care - 3
- Lack of primary care providers/physician manager (medical home) - 3
- Access, especially because of limited providers, to dental care - 2
- Access to services - 2
- Rehab services may be needed
- Reimbursement rates too low for acuity of care needed
- Lack of health insurance for all children (particularly those with special needs)

Family support & advocacy

- Support for families, including mental health support – 4
- Information about resources that are available - 2
- Families without adequate time and resources to provide care
- Flexible work places for families with these children
- Advocacy
- Need to manage parental expectations (relative to extent of services that can be provided)

Mental health services

- Mental health services, especially non-acute services

<u>Adolescents (up to age 21)</u>

Education and initiatives regarding risky behaviors

- Need the knowledge to make good, responsible health choices for general health, sexual behavior, and drug/alcohol abuse - 7
- Sex education/family planning - 5
- Smoking/tobacco use – 5
- Sexually transmitted diseases -4
- Need social support to help move them to adulthood (one noted lack of community – need community asset model) - 3
- Learn to respect themselves (including gender specific issues) – 3
- Injuries, especially involving cars and sports – 2
- Drugs

Mental health and substance abuse treatment

- Alcohol/substance abuse (including assessment for) – 8
- Mental health issues/treatment (including depression) -6
- Access to mental health care/services (including assessment) – 2
- Lack of community-based mental health services

Access to medical and dental services

- Dental care - 7
- Pregnancy services – 3
- Access to health care - 2
- No annual physical care (many insurers do not routinely cover)
- Not getting physician counseling

Prevention and intervention services

- Nutrition – 6
- Obesity -3
- Physical activity – 2
- Second round of immunizations
- Problems from not having received care earlier in life

Other issues
- Literacy
- Support for working parents with adolescents

<u>Women of child bearing age</u>

Prenatal care
- Early and regular prenatal care (particularly those at high risk) - 9
- Geographic and financial access to OB services -3
- They need to enter pregnancy healthy - 2
- Childbirth education

Family planning
- Availability of appropriate family planning counseling and education services (responsible sexuality) – 7
- Provision of folic acid -2
- Problems of deferring or delaying pregnancy
- Preconception services
- Impact of early sexual activities on physical and emotional health
- Stretching of child bearing age downward

Lifestyle issues
- Lifestyle issues (smoking, alcohol/drug use, stress) -4
- Not taking care of themselves -3
- Need maternal supports in taking care of children, particularly for single parents - 2
- Education -2
- Literacy
- Financial resources
- Translate health education into action (may need incentives).

Prevention and intervention services
- Nutrition -4
- Obesity -3
- Physical activity
- Preventative care (women not getting it for themselves)
- AIDS prevention (particularly for minority women)
- Case management for all populations that cut across all health and human services agencies, to reduce duplication and increase coordination of services.

Medical and dental care
- Routine access to primary care and dental care - 3
- Insurance
- Inadequate or lack of medical care
- Limited availability of medical care
- Advocacy, especially for those who cannot afford care

- Education on accessing and using medical services properly

Mental health and substance abuse treatment
- Substance abuse/access to substance abuse services - 2
- Car accidents related to alcohol
- Depression

All groups – ability to learn English and exposure to the community at-large.
Some communities have lots of physicians while others have none.

4. Are there specific groups within these populations that are of particular concern? (e.g. racial, ethnic, disabilities, low income, uninsured and underinsured, health status, etc.) (Follow up with who they are and why these populations are of concern)

Low income &/or uninsured people
- Low income, regardless of race and education - 9
- Uninsured/underinsured – 5
- Children, especially poor children, with special health care needs -2
- Low income individuals have problems accessing care (one factor is that they cannot take off from work to go to a doctor's appointment)
- Poor children with genetic conditions
- Medicaid population
- Children at or below 200% of the federal poverty level
- More economic disparities than racial disparities
- Poor women - contraception

Minority populations (in general)
- Many groups have a language barrier with caregivers/cultural awareness/cultural sensitive approaches -7
- Illegal/undocumented immigrants (they are lost in the system) – 4
- Overall cultural barriers (minority populations don't self-disclose problems) – 3
- Minority women - 2
- Immigrants
- Refugees after 8 months (lose of health insurance)
- Cultural/racial issues about diet and various behaviors
- Non-citizens/immigrants
- Cambodians are particularly underserved
- Infants of minorities and ethnic populations

Black persons/African Americans
- Black/African-American population (particularly women & infants) – 8
- Black population with Medicaid
- Black children – diagnosis & adherence with AD/HD meds
- Urban black population
- Somalian women – female circumcision

Hispanics/Latinos

- Hispanic/Latino population (one noted asthma & diabetes prevalence) – 8
- Latino infant mortality is lower than expected compared to African-Americans because of cultural differences pertaining to pregnancy (also not as much alcohol and substance abuse).
- People with high-risk pregnancies, in general, need to have access to obstetricians
- Hispanic women – prenatal care

Other population groups/issues

- Rural residents (one noted relative to access to services) – 3
- Young women who are targets of sexual predators
- Families of children with mental health issues, regardless of income level
- Autism – not enough funding and providers
- Special needs children – discrimination from the system
- Concern about quality of care in free health care centers
- Children coming out of foster care do not have insurance
- Those with less than a high school education
- Single parent households
- Pregnant women
- Adolescents who smoke

5. Of the populations you are familiar with, what does VDH do well in meeting the needs related to health of the following?

<u>*Infants up to one year*</u>

- Good with immunizations – 8
- Good/excellent job with WIC (but one person noted that it could be improved, e.g. nutrition; doing same thing each year) – 8
- Newborn hearing program – 3
- Medical outreach (where available at the local health dept; one noted Fairfax model is superb – good job getting grants) – 3
- Newborn screening program -2
- Well baby clinics -2
- Done better with hiring bilingual staff
- Perinatal councils
- Baby packet care information
- New Parent Kits – info and reading book
- Car seat safety program
- Resource mothers program
- Nutrition programs
- Medicaid program
- Education regarding appropriate use of antibiotics
- Breathe Baby program in Southwest Virginia

Children

- Immunizations (one noted need for registry) – 11
- Proper nutrition (eating healthy initiatives) – 3
- Bright Futures program – 3
- WIC -3
- Dental program/clinics (where available) – 3
- Outreach education/health promotion – 2
- Transitioning the child into school (early screening program) -2
- Good relationships with private providers
- Work with schools
- Lead screening programs
- Developmental clinics, if still being done
- Injury prevention (not sure how effective)
- Obesity program (for a specific local health department)
- Promoting the understanding that children are a priority
- Antibiotic resistance education
- Suicide prevention

Children with special health needs

- Care Connection, where available (5 centers in State; one noted need to get outcomes data to show effectiveness & build public support) – 3
- Referral to providers/placement into appropriate system -2
- Diagnostic evaluations
- Child development clinics
- Funding of Care Connections which provide advocacy
- Need to increase integration with other partners to enhance services
- Getting hearing aids and prosthetic services
- Promoting the understanding that children with special health needs should be a priority
- Working with medical schools to provide these services
- Some disease specific educational programs working with coalitions (asthma, sickle cell, diabetes)

Adolescents (up to age 21)

- Family planning (where available) and STD testing – 6
- Teen resource mothers' program-2
- Pregnancy related issues
- Pregnant teens through WIC program
- Preconception/family planning could be stronger
- Should have mental health counseling in high schools
- Suicide prevention
- Violence prevention
- Abstinence education (Not Me, Not Now)

Women of child bearing age

- WIC (but one person noted that it could be improved, e.g. nutrition; doing same thing each year) – 7
- Women get the best prenatal care at the local health departments where available (they are role models for providing care to diverse population) – 6
- Pregnancy related issues -2
- All persons can seek care at the VDH
- Provides access to some type of care
- Family planning and STD clinics
- Some of these women who receive services enter the system through bringing their children for care
- Perinatal councils
- OB/GYN clinics (including family planning and STD testing)
- Infectious disease clinic
- Tuberculosis management (but under funded – salaries bad for outreach workers)
- FAMIS expansion to cover mothers
- Local health department services
- Abstinence programs
- Risk avoidance programs (under TANF)
- Educational awareness for needed screenings

Other comments

- Information sharing across agencies is done well.
- The VDH is under funded for these and other services and no one is filling the gap; nothing has happened relative to public health and security.
- Bright Futures has impact on all age groups.
- Brochures are colorful.

6. What are opportunities for improvement (by specific population group) in general and/or by VDH specifically?

Ensure availability of providers/service capacity/coordination

- VDH needs to ensure that there are resources available in the private sector when people are referred to them (including all Medicaid & FAMIS participants) - 2
- Increase supply of providers (including NPs & Pas) in rural/underserved areas - 2
- Not enough comprehensive prenatal care to meet need (one noted it should be a mandated service) - 2
- Educating providers (open training to non-VDH employees, including awareness of substance abuse) – 2
- Language services (translation and interpretation); train providers to work with translators - 2
- Increase capacity for frequent appointments, especially for dental and mental health needs
- Placing some people in settings where they have more comprehensive care and a medical home (VDH cannot provide this)

- Universal primary health care coverage through coordination of resources (there is great disparity based on geography)
- Need to convince more providers to accept Medicaid and self-pay patients.
- Resource directory to locate what doctors/dentists are available
- VDH should provide more education to public and other organizations about what they do
- Impact of transportation relative to access to health care (develop creative programs)
- Increase pediatricians knowledge about Bright Futures program
- More case management to deliver appropriate services
- Need better identification & service coordination for children with special needs

Increase collaboration
- Increased collaboration within the OFHS's divisions and with the OFHS and the VDH (limited communication & cooperation between groups) - 3
- Involve people in the community who are affected by the issue and establish a relationship with them/proactively develop community collaboratives (one noted need to build on community assets) - 3
- Improve integration - local health department directors should meet with hospitals and physicians and free clinics to discuss what each does and what each party can do - 2
- Increased partnership/collaboration between VDH and other organizations -2
- Need to increase partnership between DMAS and VDH (needs to be priority)
- Adopt new paradigms of working with community services on different types of partnerships

Advocate for/increase mental health services
- More education/support/funding about mental health/substance abuse issues – 4
- Mental health needs (could be addressed through a partnership; one noted need to hook general practice providers with mental health services) - 2

Increase health promotion
- Need more health promotion efforts with the adolescent population.
- Better public relations about early intervention services & their importance
- Areas in Virginia where support of well child clinics could be improved
- More education on preventive care
- Educate people about how to use VDH's services
- Get more parents involved with medical and mental health care
- Educational materials need to be audience specific (appropriate)

Data sharing/outcomes orientation
- Lack of data sharing/coordination across departments in and services of VDH - 2
- Does VDH have a system to measure outcomes?/increase outcomes analysis - 2
- No or slow release of data

Other issues

- Need more systematic understanding of low income families in order to help them reach financial independence
- More emphasis on quality of child care services
- Improved funding for hearing aids for children
- Work on obesity issue
- Decrease amount of politics
- Health & social programs are not on governor's agenda, rather tax & fiscal issues are.
- Focus more on public health
- Look at current realities when funding (focus resources on things likely to occur)
- Address needs of women outside of childbearing age
- VDH needs to diversify workforce (management & administration) to build cultural competency
- Qualify undocumented children for public payment programs

7. What specific suggestions do you have for achieving needed improvements?

Improve communication, coordination and collaboration

- More collaboration with other organizations (one comment noted need to diversify organizations for collaboration, including for-profit sector & all faith communities & those outside local health depts); one noted need to collaborate on priorities) - 9
- Improved communications within VDH
- Regular meeting/communication between VDH and DMAS
- Develop pilot/demonstration projects
- Commitment from various organizations to work on issues
- Improved coordination of State agencies, both intra- and inter- agency.
- Educate organizations about what VDH does and who does what at VDH

Leadership/development of policy and strategic goals

- Direction for improvements needs to come from the top down -2
- More emphasis on long-term planning/prioritize initiatives - 2
- Statewide policy development (need more comprehensive approach)
- Develop long range vision by health planning region
- Develop services/programs in line with goals
- Set up 501(c)(3) organization to do many of its functions (State provide resources and have high level government, business, & consumer reps in governance role; make recommendations on health promotion and strategic activities, work with universities; it would de-polarize and serve as objective organization which would ensure that these functions were properly staffed and have adequate resources)
- More preparation for future (need to consider future implications if the system remains the same)
- Set priorities and elevate prenatal care of the list (provide resources)

More resources

- Need more/go after more resources - 3
- More resources for language services

- More state funding
- Do better job of seeking non-general fund dollars
- Improved reimbursement
- Provide bonus, coverage of malpractice costs, and/or debt repayment for providers working in rural areas

Improve health care services access/delivery
- Provision of interpreter services at clinics - 2
- More free clinics
- Address issue of 1 million uninsured Virginians
- Universal coverage for primary care services (stop relying on local funding)
- Plug holes in health services
- Wider distribution and training of providers regarding Bright Futures
- Physicians need more training and knowledge that EPSDT screening is mandated by Medicaid

Improve data collection, analysis and distribution
- Improve data/information distribution and awareness through effective communication (one noted particularly within HHS Secretariat) - 2
- Improve timeliness of data and data analysis
- Agencies should be required to collect data (results of screenings, number getting treatment, number needing case management)

More equality of and accountability to local health departments
- Greater standardization across local health departments
- Level funding across health departments
- Improved accountability from VDH to local health departments

Other issues
- Consider creative ways in incorporate health education in Standards of Learning
- Travel restrictions should be changed for DOH employees (cannot attend conferences outside Virginia limiting educational exposure)
- VDH must offer competitive salaries to get and retain quality personnel
- Recognize that diversity is here to stay and respond
- Need convenient methadone clinics for women on opiates
- Eliminate tax on food (disproportionately impacts poor people)

8. What would be needed to make this happen?

One respondent noted need for objective consultant to reorganize and evaluate activities and priorities. Another respondent noted the need to review VDH's organizational chart and revise, if necessary. Another suggested combining agencies to do a more effective job.

What role might state governments play?

Provide resources

- Additional resources (one noted need to plug holes) - 11
- More grants (particularly for partnerships) – 2
- Funding for demonstration projects
- Separate Medicaid payment for behavioral health screening
- Look at reimbursement to facilities and physicians for primary care, dental care, and mental health care
- More facilities for mental health and dental services
- Funding for obesity programs, including more education

Leadership/advocacy/planning

- Leadership role – 4
- Better planning to determine how best to serve families - 4
- Develop priorities (one noted services should be based on economic benefit) - 2
- Needs to be a catalyst/champion to give legitimacy to the issue -2
- Governor and legislators need to focus more on maternal and child health (one comment noted need to involve legislative branch in setting priorities & keeping them informed) - 2
- Change in policy
- Leadership and political will
- Develop materials and tool kits (could partner with support organizations) for use in legislative campaigns
- Set expectations
- Reassess Virginia's mental health system and facilities

Create partnerships/improve coordination & collaboration

- More receptive to working with others (need united approach) - 2
- Creative partnerships (develop mechanisms for these to occur)
- Require coordination for State funding
- Create public-private partnership – VA Health Institute
- Need to have across-the-department meetings
- Better coordination within Health & Human Services Secretariat
- Foster communication across agencies (need strategic plan for women's & infants' services)
- VDH could increase collaboration with other organizations to discuss ways they could work together
- Expand education VDH receives to others in the community
- More partnerships with universities

Data collection and provision/evaluation

- Improve data, which is shared, so better information is available
- More transparent financial data to track spending and funding
- Evaluation of programs (including annual customer evaluation surveys)

What role might local governments play?

Collaboration
- Collaboration/systems approach to collaboration – 7
- Engage more grass-roots people to help with implementation – 2
- MCCP model partnerships where county provides administration, businesses contribute money for model manager and case managers, physicians receive set payment for seeing needy patient
- Involve others outside the medical community
- Mechanism to bring people together

Identification of needs/planning
- Each local government will have different issues (they can identify their needs and how to make things work better) - 6
- Identify needs, resources, and gaps - 2
- Provide feedback on what is working
- Provide incentives for grocery stores in poor areas

Resources
- Matching state government funds/financial contribution – 4
- Could financially support some of the initiatives/pilot projects -2
- Look at health education more constructively (e.g. help fund demonstration projects)
- Fundraising for free clinics to increase capacity
- Funding of services for the uninsured

Advocacy/Leadership
- Commitment by community leaders - 2
- View health and well being as important as business development
- Sensitize and rally political will to fashion the agenda

Provide prevention and intervention services
- Increase screening programs at schools
- Increase opportunities for exercise

Support of local health departments
- Physical plant upgrades to allow for additional capacity
- Support local health departments

What role could communities contribute? (e.g. non-profit organizations, faith-based organizations, etc.)

Collaboration/implementation of services
- Provide education and implementation (several noted need to implement at community level) - 4
- More public/private partnerships (MCCP model noted by one) - 3
- Reduce turfism/cooperation across communities – 3

- Involve as many people (grass-roots level), not just the leadership, who are working on the issue - 3
- Partner with churches/faith community to screen, refer, and support services (child care, transportation, and mentoring) - 2
- Mechanism to bring people together - 2
- Healthy Families and CHIP programs need to communicate
- Free Clinics – promoting volunteerism by retired providers (no malpractice costs; state pay 7-year tail of malpractice coverage) and training ground for students
- VDH should let communities know resources they have available to help improve coordination and efficiency of resources
- Communities could help with implementation of state level initiatives

Advocacy/leadership
- Learn about and encourage systematic change rather than quick fixes; facilitate community change; organize to bring pressure for change - 4
- Use business community/chamber as a resource or to push initiatives - 2
- Encourage health promotion
- Advisory boards for various community organizations could raise awareness of need for funds for free clinics
- Work on consistent messages that unite not divide (e.g. bringing on new programs, while people still do not have insurance)
- Commitment by community leaders

Assist in planning/identification of needs
- Need to be part of the planning process - 3
- Needs assessments and follow-up (stop studying & then take action!) - 2

Resources
- Churches could provide volunteer and financial support
- Medical Society of Virginia Foundation could support initiatives
- Volunteers for initiatives
- Help develop resources

What role could private providers play? (e.g. hospitals and physicians)

Provide resources/health care services
- They need to be involved (because they deliver the care) - 4
- Recognize obligation to provide some level of indigent & Medicaid care/care across all income levels (one specifically mentioned dentists; only 670 of 4,300 dentists enrolled in Medicaid) – 3
- Providing money/volunteers to safety net providers - 2
- Charity care
- Need more physicians and free clinics
- Serve all members of the community – not just those that are profitable
- Hospitals could provide space and inpatient care for a MCCP model

- Have interpreter services available at free clinics
- Make reasonable contribution to patient safety

Promote patient, provider, and community education

- Be more involved in education (of patients & community) - 2
- Increase the amount of public service announcements to increase knowledge
- Concern with current advertising by private providers
- Improved education of the providers' staff
- VDH could offer educational programs to providers
- Find time to educate their patients about using health care system correctly
- Help determine how people use health information (e.g. where do they receive information?; who do they trust?)

Planning/research

- Assist in identification of needs and solutions - 2
- Research evidence-based practices
- Define limits of what providers can do and then VDH could target what is needed

Advocacy

- Foster election of officials who will invest in health
- Advocacy
- Some of the private providers' lobbyist groups should look at overall interests and not their narrow self-interests
- Think beyond themselves or their facilities

Collaboration/involvement in partnerships

- More participation in work groups (need to know their needs & realities)
- Willingness to talk about partnering
- Be a team player (not always taking a leadership role)

9. What are the barriers to making this happen in Virginia? (Interviewer will prompt relative to where barriers are – State, local, etc.)

Lack of political will/commitment

- Politics/turfism/philosophy is a huge barrier – 11
- Lack of commitment and leadership (one noted for need for maternal & child health council statewide; one noted need for leadership at regional and community level; constantly changing leaders and priorities) - 5
- Making the topic/issue important – 4
- Resistance to change – 3
- No advocate for particular program/service -2
- Not seeing family health promotion as an economic development initiative
- Political climate change (e.g. role of health in schools)
- Letting controversial issues (e.g. abortion) define the whole
- No commitment to fix mental health problem
- No payback to politicians of taking on public health advocacy
- People who need the most services and care aren't heard

- Conduct independent study of VDH's practices and present report to General Assembly
- Government has chance to help everyone and health, especially maternal and child health, should be the highest priority

Lack of adequate or poor use of resources
- Funding (one noted unwillingness to go after alternative funding; one noted lack of up front investment dollars from State) - 11
- Poor employee morale at VDH
- Funding streams
- Funding for private and public human services – more competition than cooperation

Lack of access to providers/services
- Unwillingness of some providers to see low-income and Medicaid patients -2
- Transportation is needed in some areas -2
- Over-reliance on VDH because it cannot serve as a good medical home
- Difficulty in VDH attracting nurses and dentists
- Need more providers in the community
- Lack of finances and incentives for hospitals and physicians to open more clinics and inpatient mental health beds
- Resource manual is needed

Little real collaboration/coordination
- Little time/staff to get people together – 4
- Unwillingness to share information
- Think more collaboratively
- Lack of knowledge and management of community development process
- Not enough staff to coordinate initiatives
- Lack of communication

Need for greater outcomes orientation
- Focus on end results
- Need incentives for people to stay employed with their initiative (continuity)/as administrators change, priorities change
- Need to determine cost/benefits of services

ROLE OF OFFICE OF FAMILY HEALTH SERVICES

10. How could the resources of the Office of Family Health Services be best used to improve the health planning status of women and children? (Specific areas might include planning, directly providing services at the local or state level, policy development and research, quality assurance, surveillance- monitoring data and trends, evaluation- of programs, etc., assurance that needed services are available, promoting and enforcing laws related to health, helping build coalitions and collaborations around specific health issues.) What should be the priorities?

Data surveillance, research provision and program evaluation
- Good data/expansion of current data collection - 6
- Share data - 3
- Program/service evaluation/outcomes assessment – 3
- Clearinghouse for "best practices" (evidence based)
- Technical education and assistance
- Study most cost-effective, quality approach
- Surveillance of what is occurring in local communities for those with no or little insurance
- Assessment of needs
- Data with demographic breakdowns

Foster collaboration
- Collaboration/coordination with internal and external VDH partners – 4
- Look at partnerships (e.g. how can smaller organizations participate in projects with OFHS?); State should drive formation of coalitions - 2
- Local coalitions could address some of the emerging health issues (e.g. obesity, teenage pregnancy) for their communities/support for localities & communities - 2
- Points in grants for collaboration (need interdisciplinary services for people)
- Provide technical and financial support, if possible, to local coalitions
- More internal dialogue between the OFHS' divisions (e.g. data sharing and collaborative efforts)
- OFHS does not have any transition between its programs – need to improve continuity between programs (view as an overall lifestyle program)

Develop coordinated services statewide
- Develop a real coordinated array of services statewide (at local level) - 2
- Resources must be spread around to all areas in order to ensure that all services are done well by the office
- Come up with minimal level of services in every area
- Bring talent on to coordinate services effectively
- Coordinate and share information with all State government agencies & departments
- Need links to the practice setting (local health departments, community physicians)
- Greater standardization of practice/educational materials
- Work with existing providers and develop providers
- Provide funding to local providers of services
- Hold contractors accountable
- Continue safety net services/programs
- Look at needs of all people
- Continue to improve quality and access
- Dental care
- Mental health care
- Preventive measures for obesity
- DMHMRSAS has draft of tool kit for perinatal providers to identify substance abuse

Community education and outreach

- More public health education (family health) & resources (share with those "in the field") - 6
- Educate/inform people about who they are and what they do – 4
- Need to get inside the family structure and work with the family to help improve health (the best way to help)
- More interaction with communities, especially the cultural communities

Comprehensive planning

- Provide leadership/continuity (one noted need to bring activities up to Governor's level) - 3
- Needs comprehensive planning approach to service delivery/know holistic needs of State/revise policies and work plans to come in line with current needs - 2
- Policy and goal development – 2
- OFHS needs to have a focus and concentrate on this

Expansion of and more effective use of resources

- Need more funding/using existing funding appropriately – 4
- More people (one noted VDH has too many grant funded staff) - 2
- Watch Federal government initiatives

COLLABORATION WITH VDH (not to be asked of VDH interviewees)

11. How could the Office of Family Health Services better collaborate with your organization to meet your mission and the needs of the populations you serve?
Ended her for DMHMRSAS interview input

Increase communication and/or outreach activities

- Obtain more input from various community and State organizations/agencies (e.g. listen to other organizations) – 4
- Hold semiannual meetings (or regularly scheduled meetings) with broad representation (e.g., could review data; identify gaps; discuss ways to cover the gaps; increase participation) -3
- Staff of various State departments involved with children and women/OFS to meet on quarterly/bi-annual basis to share priorities and programs - 2
- Better coordinate between local and State health departments and providers of services (example of Care Coordination program)
- Communicate with other organizations (e.g. hearing notices) so these organizations could help with the project/program in a timely manner
- Educate other organizations about what VDH does
- Have links to various organizations on the OFHS's website
- Send out information, by e-mail, on health trends or health care issues to various organizations
- Steady flow of information on family health status & effective programs at community level

- Develop educational materials for patients
- In general, OFHS is an excellent communicator

Increase collaborative activities
- Increase collaboration – 5
- Continue communication & collaboration on coalitions like RWJ Covering Kids & Families Coalition
- Publicly recognize what other groups are doing
- Partner with other organizations for funding
- VDH/OFS representatives should be involved in DMAS work groups (like PICs – prenatal, infant and children's services)
- Work together to provide language services and cultural competence, particularly through training employees
- Investigate opportunities for joint ventures and mutual interests

Pursue new initiatives to address community needs
- Continued willingness to try new initiatives
- Evaluate needs for dental and mental health care and consider ways to fund/provide care
- Focus on obesity issue and ways to address it
- Link with universities to deliver community services (such as tutoring minorities)

Improve data sharing and follow-up
- Increase data sharing
- Improve feedback and follow-up
- Timely data

Develop and evaluate use of resources
- Review funding streams
- Use resources in different ways (think outside the box)

12. What kind of data does your organization collect that is pertinent to family and children's health?

- Do not collect own data, use data from another source - 5
- Collect some qualitative data (e.g. quality of life, what is going well/what is not going well, how many blood pressure checks) - 2
- Basic data (e.g. total number of calls, total number of patients, referrals) -2
- Collect data in outreach projects, but data (total number, kinds of services, value of services) is limited due to resources
- Collect some health care data related to immunizations
- Research on pediatric and maternal health
- School readiness indicators
- Kids Count indicators
- Any data on number of children with disabilities, broken out by disability
- Uniform Data Standards report
- Data on newborn screenings

- Survey of women's use of health information and health concerns
- Research on health information used by women
- VDMHMRSAS has data on medically fragile children; those needing OT, PT, and speech; infant intervention services (CSB data collected twice a year)
- Data on obesity, heart disease, nutrition, school health, and adolescent health
- Capture data on patient's age, diagnoses, and occurrence of infectious disease
- Trauma registry
- VCU Survey, Research, & Evaluation center has a number of studies
- American Academy of Pediatrics has survey data on deafness and hearing aids (sent to Senator Woods), info available on multiple states
- DMAS has data on all Medicaid recipients (including encounters, claims, HEDIS measures, external quality) – annual report is on website
- Number of eligible uninsured children by locality
- Health access survey
- Outcomes data from grant funded projects
- Prescription information from Rx assistance program
- All Care Coordination program data

13. What kind of data would be mutually advantageous to share between your organization and the Office of Family Health Services? For those that have shared data in the past, what has been your experience?

Overall data /planning issues

- Need local data that is easily available, accessible, consistent, and meaningful -2
- VDH should develop a strategic plan and group of research questions regarding who they are serving.
- Data need depends on need being addressed, who is being served & outcomes data needed.
- Need to know what data OFHS has and what they need.
- Definition of age groups lacks consistency
- Statewide data (not just partial geographic data) needed.
- Any specific population data
- Research related data
- Outcomes data not being tracked
- OFHS could put their data on their website and allow data from other organizations to be placed on OFHS' website (need a central location for data)

Specific data sharing needs

- School health data (e.g. nutrition, injury, dental) -2
- Cross matching clients between OFHS and other organizations (one noted need to match Medicaid and VDH services recipients) - 2
- Data to develop better solutions (one comment noted need for information regarding effective community programs) - 2
- Any information on women's and girls' health issues to understand women's health needs - 2
- Immunization data (but it needs to be local, which it currently is not)

- Data on dental care/services
- Maps (especially by health districts)
- List of providers that participate in Medicaid
- Available physicians and facilities to care for patients with mental heath or dental needs
- Obesity data
- Children & adolescents using alcohol & drugs
- Children with hearing impairments
- Physicians & dentists that will serve kids with special needs
- Match premature infants with special care needs received
- More data sharing between health department, free clinics, & community health centers
- Better sharing of data between the early detection program and follow-up treatment of children (appears to be problem sharing information internally)
- Language services that are available at local health departments
- Track patient's language origin at local health departments
- Survey of workforce diversity

COLLABORATION WITHIN VDH (to be asked of VDH interviewees)

14. How could the Office of Family Health Services better collaborate with your Office or Division to meet the needs of the populations you serve?

- Collaboration with the Office of Family Health Services and community health services organizations (for strategic planning, etc.) to provide a perspective to all organizations involved
- Keep collaborative efforts going to leverage limited resources (example, New Parent Kit)
- Ensure that federal requirements are carried out.
- Push only slightly beyond available resources so that core services aren't lost.
- Be a bit more assertive about role and services.

Is there any additional information that you think would be helpful to address family and children's service needs in the State that we haven't talked about?

Planning Issues

- Focus on the long term -2
- A network of consumers (including churches) should be involved in planning at VDH to get feedback on what works and priorities - 2
- VDH should conduct a self-examination and ask the following questions: 1) With all VDH does, what have they done? 2) Have they made an impact? 3) Do they need to change? and 4) What could they do better?
- Virginia needs to take more of an integrated perspective to service delivery (there are too many departments and not enough coordination or collaboration)
- What percentage of those people who need VDH services receive them?
- VDH needs to be proactive and be involved with other agencies
- VDH should try new things and not keep doing things the same way
- Focus on the importance of public health approaches (sometimes, there is a focus that private is better)

- Need to focus on how the service impacts everyone in Virginia
- Youth Matters identified three challenges: 1) increased concentration of poverty & social isolation; 2) responding to risks associated with the decline in two parent families; 3) need to respond to racial disparities that negatively impact life chances.
- VDH has bright and passionate people – need to reorganize with “fresh eyes”

Communication Issues
- People in the central agencies need to be familiar with the local health departments.
- Develop a statewide resource center so people are aware of all the various resources
- Need to hear about the good things VDH does instead of just the bad
- VDH’s initiatives are not well known
- VDH’s image is an issue (some see it as substandard care)
- Additional educational materials to families with respiratory disorders, especially related to environmental toxins
- OFS needs to market itself and produce an annual report for women’s and infants’ services
- Develop a list serve for people interested in what VDH is doing
- E-mail newsletters periodically about what is happening at VDH
- Has done a good job on developing materials for individual emergency preparedness.

Funding Issues
- Current funding streams are complex and overlapping – simplify the funding and find more creative ways to use dollars more effectively -2
- Need resources
- Obtain more state funding
- It takes resources to impact social programs
- Consider mini-grants for local coalitions (have VDH be required to work with two local organizations or a faith-based organization)
- VDH should apply for more grants
- Grants applied for should fit in with VDH’s mission
- Money flowing from State to local health departments is difficult to track

Services Issues
- Ensure everyone gets access to basic services
- Improve and expand pediatric emergency care education systems
- Include pediatric issues in all aspects of clinical care
- Develop further support for prevention activities/programs
- More focus on lifestyle and prevention issues before disease occurs
- Adequate training programs for EMTs, physicians, and OB/GYNs
- Train medical students to identify and screen for domestic violence & educate providers about screening for domestic violence.
- Cover women up to 200% of the Federal Poverty Level under FAMIS.
- Cindy Fischer is local program coordinator for Care Connection and can provide information specific to that program

Collaboration Issues

- Need to involve communities to make a difference –everyone's voice needs to be heard and need to have "buy-in"
- VDH needs to promote what they do with other partners/providers
- Have an initiative where many organizations are working together
- Tap into churches as they know about health concerns in their congregations
- Bring community into the dialogue – how to get community input regarding what average person's needs are vs. VDH determining what is needed
- More joint ventures with DMHMRSAS to share information in a timely manner
- Annual conference that VDH sponsors same time each year to address emerging health issues

Leadership Issues

- Administration needs to support the program
- Laws on use of alcohol and tobacco – are they tough enough

Maternal and Child Health Needs Assessment
Regional Public Hearings

Introduction

Five public hearings were conducted during the month of April 2005. The CVHPA worked with the other four regional planning agencies to arrange a publicly accessible and convenient meeting place for each region's public hearing. An interested parties list was compiled by the OFHS, in cooperation with the regional planning agencies. A letter from the Director of the OFHS and a flyer, providing details about the public hearings, was sent to each party on the list. In addition, information was provided to the media throughout the State by the VDH's public information officer in advance of the public hearings. The following is a summary of the comments from each public hearing and the overall findings from the hearings.

Summary of Findings

Not only did these public hearings provide a forum for feedback from Virginia's communities into this maternal and child needs assessment, but it also appeared to provide an important vehicle for those present to learn about the populations served and the services available from the OFHS. There was a wide variety of concerns and suggestions regarding the health needs of women and children and the best ways to meet them. The following summarizes these needs and issues that were mentioned in more than one region of the State, ordered on their general frequency of mention (the areas where they were mentioned are shown in parentheses):

- **Increase the capacity for health services**, including the number of available providers to lower-income persons, increasing eligibility for Medicaid for pregnant women to 200% of the federal poverty level, consistent treatment for chronic illness, and increased prenatal services (Central, Southwest, Eastern, Northern, and Northwest).
- **Increase access to home visitation programs**, such as resource mothers**, to pregnant women and new mothers** (Central, Eastern, Northern, and Northwest).
- **Increase financial support for community partnerships** of local health departments and/or organizations to meet community needs (Central, Southwest, Northern, and Northwest).
- **Educate the community regarding resources available to meet their health needs**, including those for special needs children, pregnant women, and/or domestic violence and sexual abuse (Central, Southwest, Eastern, and Northwest).
- **Increase access to mental health services** for women and/or children (Central, Eastern, and Northwestern).

- **Increase access to dental services** for women and/or children (Southwest, Eastern, and Northwest).
- **Increase support for and availability of community-based specialized services** (including Community Care Connection) **for special needs children**, as well as special needs adult women (Central, Northern, and Northwest).
- **Increase services for non-English speaking and immigrant women and/or children**, including health services, translation services, and/or cultural awareness (Central, Southwest, and Northern).
- **Improve training of health professionals in screening for and identifying domestic violence and sexual abuse and increase access to forensic nurse examiners** (Southwest and Eastern).
- **Improve data collection and distribution.** Some specific suggestions included improving the timeliness and affordability of available data, collecting information relative to outcomes from childhood immunizations, and the need for state-wide FIMR data (Central and Northern).
- **Emphasize/educate women regarding the importance of health during pregnancy and early childhood** (Southwest and Eastern).

Other issues that were mentioned at only one public hearing are included within the regional summaries.

Central Region

The public hearing for the Central Region was held on Monday, April 11, 2005 in Chesterfield, Virginia. Those in attendance included the following:

Elisabeth Hutton, PhD; March of Dimes
Kilie Larkin; Care Connection for Children
Mike Welch, Richmond Health Department
Tavia Ware, Virginia Organizing Project
Cathy Woodson, Virginia Organizing Project
Rebecca Parsen, VDH, Chesterfield Health District
Linda Kendall, Fan Free Clinic
Paige Cecil, Chesterfield Health District
Allison Lawrence, M.H. West & Co., Inc.
Denise Daly, REACH
Rebecca Mendoza, Virginia Department of Medical Assistance Services (DMAS)
Travis Thigpen, Concerned Parent
Debbie Townsend, Crater Health District
Butch LeDoyen, Irvin Gammon Craig Health Center

Karen Cameron, Executive Director of the CVHPA, described the process being used to assess the needs of women and children in Virginia. She introduced Janice Hicks, PhD, Director of

Policy and Assessment at OFHS, who gave an overview of the services provided by OFHS. Additional information about Title V funding and the needs assessment for the five year grant currently underway was provided during her presentation. Dr. Hicks answered several questions posed by those in attendance. Ms. Cameron then proceeded to conduct the public hearing.

The following is a summary of those who spoke and their comments:

<u>Dr. Elisabeth Hutton, Ph.D, RN</u> –

Dr. Hutton noted that she is chair of the prematurity campaign for the Virginia Chapter of the March of Dimes, which in 2003 launched a campaign to address the increasing rate of preterm birth. She is a retiree from the Virginia Department of Health where she was a Public Health Nurse Consultant. Last summer, she served on the Governor's Work Group on Obstetrical Care. The focus of her presentation was to request additional support for prenatal home visiting programs.

Dr. Hutton presented that the numbers of preterm births and low birth weight babies are rising in Virginia. In fact, 7.9 % of all babies born in Virginia are low birth weight and 16.1% of all babies born in Virginia are preterm. Preterm birth is one of the leading causes of infant mortality and our infant mortality rate is 7.2%. She noted that there is a myriad of reasons and causes for preterm births and low birth weight but advocated for the expansion of home visiting programs to pregnant women and teens as a cost-effective method to improve birth outcomes.

Dr. Hutton noted that the Resource Mothers Program has been in Virginia for over 20 years and that the program has been successful in accomplishing the goals of reducing infant mortality, low birth weight, and pre-maturity. The Resource Mothers Program has a reduced rate of infant mortality, shows fewer preterm deliveries, higher birth weight, and higher rates of breastfeeding. The benefit of this program is based on the emphasis on prenatal care and education and the stress reduction impact of having individual support during a high-risk pregnancy. The March of Dimes recognizes home visiting programs such as Resource Mothers as an effective intervention in reducing preterm delivery rates and increasing the number of healthy babies born in Virginia. The Resource Mothers Program effectively intervenes in many behavioral and environmental risks to preterm delivery such as late or no prenatal care, smoking, alcohol and use of illicit drugs, domestic violence, lack of social support, and stress.

The March of Dimes considers expansion of home visiting a vital issue in reducing preterm deliveries, which Dr. Hutton noted will result in tremendous cost-savings to the state. According to Dr. Gary Gutcher of VCU, the average minimum daily cost in a NICU (neonatal intensive care unit) is $1,000. Consider that the estimated cost per teenager per year in the Resource Mothers program averages $1,700 (VDH). If one mother in the program delivers a normal birth weight baby instead of a baby needing several days in the NICU, the program more than pays for itself. Moreover, the Resource Mothers Program is also successful in delaying a second pregnancy with the enrolled teens and a high rate of returning to school after delivery.

On behalf of the March of Dimes, Dr. Hutton supports expanding the current Resource Mothers Program to provide additional funding for each of the 25 sites in operation. She noted that in

order to meet increased costs such as gas costs and hourly wages, each site needs a minimum of $5,000 each. These sites have received no funding increases since the program's inception in 1983. Rather than expand the program to include additional sites, the March of Dimes recommends that resources be used to improve the quality of each program to better serve each client. She noted that these programs have waiting lists of pregnant teens, which delay intervention. To improve the quality of these well-established programs, she requested an additional $5,000 per site. She also requested $50,000 per year for administrative expenses for evaluation of the program, making a total request of an additional $350,000 from the Title V grant.

Linda Kendall –

Ms. Kendall, a Nurse Practitioner with the Fan Free Clinic, is the parent of an adult who has had special needs since childhood. She stated that women with special needs are a vulnerable population for health care, particularly for gynecological care. She stated that women living in group homes may not be receiving preventive care such as pap smears and mammograms. Ms. Kendall states that if more support is received to help this population, the quality of life for these women would increase. Some of the concerns she noted for the women with special needs population include the following: limited staff education for this population group; short exam time; not enough equipment; inadequate referrals for screening; and inadequate interactions with parents or the patient's guardian. In short, women with special needs should receive the same standard of care as other women.

Paige Cecil –

Ms. Cecil, representing the Chesterfield Health District, expressed concerns about the needs of non-English speaking women. Because of the language barrier, extra time is required for each client. Translators as well as additional staff who speak different languages are needed.

Denise Daly –

Ms. Daly is the Executive Director of REACH, a nonprofit based in Richmond dedicated to increasing access to affordable healthcare for uninsured and underinsured persons in our community. REACH is a partnership of safety net providers and others working towards a more coordinated, integrated model of providing healthcare for uninsured persons in metro Richmond.

She commented on each component of the needs assessment, as follows:

Availability and Effectiveness of Current Maternal and Child Health Services (at Local Health Departments)

- ✓ Maternal and child health services appear effective, though there are capacity limitations from time-to-time, particularly for prenatal care and home visitor programs.
- ✓ Need to increase the number of providers that accept FAMIS/FAMIS Plus.

Needed Services and Support

- ✓ Expand case management services/home visitor programs, particularly for pregnant women to support additional families. Provide technical assistance to local health departments or contractors, as needed to develop or expand such programs.

Priority Needs

- ✓ Increase multilingual capacity – for clinical services and educational materials.
- ✓ Offer cultural awareness and medical Spanish training for clinical services and home visitor staff. Also, availability of interpreter training programs would be beneficial.
- ✓ Educate community-based organizations about prenatal care resources available through the Commonwealth. During early meetings of REACH's Access Prenatal Care Work Group, VDH staff shared lots of useful information about health services available to low-income Virginians that most community-based healthcare providers weren't knowledgeable about: genetic testing and family planning for Medicaid-eligible mothers 2 years post-partum. Some Richmond-area health providers were aware of these services, but noted difficulty in accessing them at times (e.g., difficult to identify correct contact person, limited availability of funds or services).
- ✓ Enhance resources for women of childbearing age with mental health problems, particularly depression.

Other Issues Related to Populations Served by the Grant

- ✓ Consider funding for partnerships of local health departments and community-based organizations to bridge cultural gaps and outreach to women to seek early prenatal care, including outreach for Medicaid for Pregnant Women and WIC (much like FAMIS/FAMIS Plus outreach). Early enrollment in Medicaid could result in increased revenue for health departments and would ensure a more consistent source of care during pregnancy, as the mother gets connected with a provider she stays with early in her pregnancy. Early WIC enrollment would ensure adequate nutrition for mom and baby.
- ✓ REACH suggests actively working with organizations in specific target communities and geographic areas that have easy access to women of childbearing age, who may or may not be pregnant. This could be a component of home visitor/case management programs, but does not have to be. Vernon J. Harris Health Center, for example, has a WIC office on-site and is able to refer all women who have a positive pregnancy test directly to the WIC office.

Connecting women with an affordable source of prenatal care early in their pregnancy is important. Listed below are some birth data VDH for metro Richmond (2002):

- ✓ 332 "self-pay moms" started prenatal care after the 4th month of pregnancy. Four times the late prenatal care rate of metro Richmond's privately insured moms.
- ✓ 120 babies born to "self-pay moms" were categorized as low-birth weight. Twice the low birth weight rate for babies born to metro Richmond's privately insured moms
- ✓ 17% (n = 150) of babies were born to "self-pay moms" 19 or younger
- ✓ Self-pay births had a higher proportion of extreme pre-maturity or were born with other complications, compared to women with Medicaid or private health insurance.
- ✓ Most self-pay births occur to women living in South Richmond or Chesterfield

Ms. Daly noted that women who enter prenatal care after their first trimester are more likely to deliver low-birth weight babies, that hospitals charge more to deliver low-birth weight babies because of potential complications; and, that tiny babies often have health problems that limit their educational success. In summary, supporting women and children is ensuring a healthy, bright future for Virginia.

Travis Thigpen –

Mr. Thigpen is a pastor of a local church and is a parent of a handicapped child. After his son had his second DPT shot, he had a reaction, similar to a stroke, which caused him to become handicapped. For fourteen years, they have carried the burden of caring for their son by themselves. The monthly health insurance for Mr. Thigpen and his son is $2,000. He suggests that data should be kept on what happens the first year after immunizations (follow the child for the first 18 months of life). The State should have some provisions to assist families of children who have experienced a bad reaction to an immunization.

Anne Thigpen –

Ms. Thigpen said that she has spoken to many physical therapists who knew that there was a bad batch of shots in the Richmond area in the 1990's. The State and/or Health Department should set aside funds to help families bear the costs for these children who had negative reactions to immunizations. Currently, no tracking system exists after children receive immunizations which are State mandated. The Thigpens have done all they can financially and they are not sure what will happen next. People do not know where to go for help when they have a child who has experienced a bad reaction to an immunization; it would be beneficial to have someone in the community who could assist them (and other families like them) in obtaining resources.

Southwestern Virginia

The public hearing for the Southwestern Virginia Region was held on Friday, April 15, 2005 in Wytheville, Virginia. Those in attendance included the following:

Laura H. Knapp, DMAS
Shannon May, Women's Resource Center
Tara Brewster, Women's Resource Center
Lee Ogle, Family Resource Center
Rhonda Seltz, Radford University Family Outreach Project
Erin Connors, Radford University Family Outreach Project
Sharon Stratton, RNC, MSN, Carilion Health System

Elizabeth Farrell, Assistant Director of the CVHPA, described the process being used to assess the needs of women and children in Virginia. She introduced Kim Barnes, Policy Analyst at OFHS, who gave an overview of the services provided by OFHS. Additional information about Title V funding and the needs assessment for the five year grant currently underway was provided during her presentation. Ms. Farrell then proceeded to conduct the public hearing.

The following is a summary of those who spoke and their comments:

<u>Lee Ogle -</u>

Ms. Ogle, Community Development Coordinator with the Family Resource Center, outlined four areas that need more attention from a domestic and sexual violence perspective. Each area was discussed and some statistics were provided to document the concern. Unless otherwise noted, the statistics are from a 2004 VDH study.

The first area is that health care providers need to be trained to screen for sexual assault and domestic violence so victims can receive appropriate referrals. She noted that 87% of primary care physician practices do not have a standard screening tool for sexual assault. In addition, 31% of primary care physicians self-assessed their practices as “fair” or “poor” at screening patients for sexual assault or rape and 34% of emergency rooms do not have a sexual assault training protocol for staff. Thus, a standard screening process is needed.

The second area is that women and children need their health care providers to provide information about sexual assault and domestic violence victim resources. Statistics provided found that 34% of emergency rooms do not directly refer sexual assault victims to sexual assault crisis center services. In addition, 43% of emergency rooms do not refer victims to safe housing. 30% of primary care physicians reported they never ask women patients about sexual assault and rape while 40% do not ask men.

The third area is that pregnant women are at a higher risk of being battered. Ms. Ogle stated that homicide is the leading cause of death for pregnant women (Family Violence Prevention Fund). She noted that women after birth also are at a higher risk of domestic violence.

The fourth area is that women and children need access to forensic nurse examiners across Virginia. Ms. Ogle reported that 59% of emergency rooms do not have forensic nurse examiners on staff, which affects victims of both domestic and sexual violence. Physicians need to be trained to collect evidence so it can be used to prosecute.

<u>Rhonda Seltze -</u>

Ms. Seltze, a coordinator for the Radford University Family Outreach Project, stated that with the increasing cost of employee sponsored health coverage, at least one (usually the women) or both parents are now uninsured. Her organization has tried to educate legislators about this. They requested that Medicaid guidelines be increased to 200% of the federal poverty level. Although this past year’s General Assembly did increase the guidelines to 150%, it still needs to be higher.

She said that local health departments (especially the WIC programs) are doing a great job. However, they need more resources as the needs for services continue to expand. Ms. Seltze noted that infant mortality is increasing and it will continue to increase if health departments do not receive more resources.

Ms. Seltze noted that if a child does not have a permanent resident card, he/she does not qualify for FAMIS or Medicaid. She said that Medicaid covers only emergency services for these children.

Another area of concern is dental services. She would like to see a dentist in the health department and is chairing a dental subcommittee for the area. Ms. Seltze was pleased to see the 30% increase in Medicaid reimbursement for dentists.

Sharon May –

Ms. May, an adult sexual assault counselor with the Women's Resource Center, noted that the forensic nurses with her organization have a good relationship with other nurses in the community. The forensic nurses, who provide top notch care, are good resources since they help the victims get connected with courts and other organizations. The number of domestic and sexual assault cases has quadrupled in the past eight years. Ms. May wants to see the forensic nurse program grow, but they need more training and resources. She noted that more referrals could be handled if they had additional resources.

Sharon Stratton -

Ms. Stratton, a perinatal specialist at Carilion Health System, said that Virginia needs to place a strong emphasis on health during pregnancy, childbirth, and early childhood. Virginia should support midwives as they can provide good care at a lower cost. Not all women need to have the services of OB/GYNs. In addition, Ms. Stratton stated that more support to encourage breastfeeding is needed as breastfeeding is good for the babies' health.

Eastern Region

The public hearing for the Eastern Region was held on Tuesday, April 19, 2005 in Newport News, Virginia. Those in attendance included the following:

Shawn M. Winfield, LMSW Clinic Social Worker, Lackey Free Family Medical Clinic
Cleriece Whitehill, Virginia Beach Department of Health
Elaine Perry, Peninsula Health District
Patricia Zorzoli, Samaritan House, Virginia Beach
Sandy Maltov, Pediatric Specialist, Chesapeake Health Department
Margaret Dismond Martin, March of Dimes
Cathy Duggan, RN, Portsmouth Health Department
Erica Booth, Avalon
Trisha Hunsaker, Avalon

Karen Cameron, Executive Director of the CVHPA, described the process being used to assess the needs of women and children in Virginia. She introduced Janice Hicks, PhD, Director of Policy and Assessment at OFHS, who gave an overview of the services provided by OFHS. Additional information about Title V funding and the needs assessment for the five year grant currently underway was provided during her presentation. Dr. Hicks proceeded to answer

several questions posed by those in attendance. Mike Byrnes, Associate Director of the Eastern Virginia Health Systems Agency, then proceeded to conduct the public hearing.

The following is a summary of those who spoke and their comments:

Patricia Zorzoli –

Ms. Zorzoli represented the Samaritan House of Virginia Beach, a homeless and battered women's shelter. Concerns that she mentioned included lack of medical care, which is a particular problem for those with chronic diseases. While services are provided by the Beach Clinic, there is a six-week waiting period for services. Ms. Zorzoli noted that there is a lack of dental care for women she works with, a lack of education about the importance of prenatal care, and the need for prescriptions, particularly high blood pressure medications. She also commented that provision of mental health care should be separate from where health care is delivered and that there is a need for consistent treatment of chronic diseases, especially high blood pressure and heart problems.

Margaret Martin –

Ms. Martin, assistant to the Dean of the Scipps Howard School of Journalism and Communications at Hampton University, provided comments on behalf of the March of Dimes, noting that she gave birth to two children, one in 2002 and one in 2003, neither of whom survived their premature births. She provided comments similar to Dr. Hutton's remarks in the Central region. Ms. Martin emphasized the success of the Resource Mothers program and the cost savings to the State of preventing premature births. She noted that her second child's 14 days in Riverside's neonatal intensive care unit cost $72,000, including $20,000 in medications. Ms. Martin supported an additional $5,000 in funding to each of the Resources Mothers' 25 sites and an additional $50,000 per year for evaluation for a total request of $350,000 additional funding for this home visiting program.

Trisha Hunsaker –

Ms. Hunsaker is the Volunteer and Education Coordinator with Avalon, a shelter for abused and sexually assaulted women and children, located in Williamsburg. She asked that healthcare providers be trained on how to screen for victims of domestic violence and sexual assault and provide proper referrals for those clients. Currently healthcare providers are not trained in this area. She also mentioned a need for more forensic nurse examiners across the state, there is currently a lack of these people and they are necessary for support of victims, in addition to victim advocates. She pointed out that pregnant women are at a higher risk for being abused or battered and healthcare providers need to be able to identify and access resources for these women. Ms. Hunsaker also stated that there is a need for more funding to develop more resources in this area.

Northern Virginia

The public hearing for Northern Virginia was held on Friday, April 22, 2005 in Annadale, Virginia. Those in attendance included the following:

Fred Mecklenburg, M.D., INOVA Fairfax Hospital
Betty Connal, SIDS Mid Atlantic
Debby Byrne INOVA Fairfax Hospital
Jennifer Sedlmeyer, Northern Virginia Perinatal Council
Shelby Gonzales, INOVA Community Health
Brenda Mohile, RN, Fairfax Neonatal Associates
Anne Terrell, Prince William Health District
Julie Huff, Arlington Health Department
Mayra Granados, DMAS
Peggy Cressy, INOVA
Dean Montgomery, Northern Virginia Health Systems Agency
Evy Duff, Fairfax County Health Department
Nancy Owens, Miscarriage, Infant Death, and Stillbirth (M.I.S.)
Doreen Love, Marymount University

Karen Cameron, Executive Director of the CVHPA, introduced the process being used to assess the needs of women and children in Virginia. She introduced David E. Suttle, M.D., Director of OFHS, who gave an overview of the services provided by OFHS and additional information about Title V funding and this needs assessment for the state's five-year grant. Dr Suttle then proceeded to facilitate an informal question and answer session with the attendees. He noted that the New Parent Kit should be given to women during the prenatal period and that OFHS found that women most liked (in order): the box (for holding information), the book (Good Night Moon), and the calendar. Ms. Cameron then proceeded to conduct the public hearing.

The following is a summary of those who spoke and their comments:

Fred Mecklenburg –

Dr. Mecklenburg spoke in support of the MCH block grant. He is the Chairman of the Department of OB/GYN at Fairfax Hospital, which is the busiest obstetrical unit in the state. Currently one-fourth of their patients are underserved. Most Medicaid patients are cared for by private physicians, the majority of patients who deliver are uninsured. They currently work with the Fairfax County Health Department. He went on record as favoring no decreases in prenatal funds. He feels unmet needs include cancer screening programs. Typical cervical cancer patients at FFH have not had a pap smear in seven years. He feels that the problem with the current funding stream from the federal government for breast and cervical cancer patients is that the individual must be a citizen. Later, Dr. Mecklenburg asked if there ever is an opportunity to shift money from one program to another. It was noted that generally local health departments can only do genetic testing if the first prenatal care is done at the health department.

Betty Connal –

Ms. Connal is the Director of SIDS, Mid-Atlantic. Issues and questions she brought up included: a need to get FIMR reports, which are not available statewide. Question: Why is the same amount that goes for FIMR the same, regardless of the number of births for an area? There are a large number of immigrants using health department services. These individuals are not Medicaid-eligible and therefore there is no reimbursement for the health department. She noted that the Access to Care program is doing a good job of getting children enrolled in FAMIS but that there are a huge number of kids needing services (therefore, while enrollment targets are exceeded, the estimate of those eligible were underestimated). There is also a need for funds for genetic testing and amniocentesis, as well as follow-up counseling to make sure there are local resources available. Later on, Ms. Connal expressed support for Resource Mothers and the development of grassroots support to meet the needs of families. Resource Mothers visits mothers in their homes. She would like to see greater collaboration between Health Department and the March of Dimes (it was noted that the National Chapter covers northern Virginia and the Virginia Chapter covers the rest of the State).

Ann Terrell –

Ms. Terrell works at the Prince William Health District and noted that there was a need for usable data. Currently, the data is either not current when received or it costs every time you need a different query of the database.

Shelby Gonzalez –

Ms. Gonzalez is the Director of Partnership for Healthy Kids with INOVA, a not-for-profit healthcare system. She noted that the area's growing population has diverse needs. They often have lower life expectancies, higher rates of pre-maturity and teenage births, and high rates of infant mortality. INOVA coordinates the Care Connection for Children in Northern Virginia, which is funded by VDH for special needs children. They would like to continue to see this funding but are concerned because they are not connected to a medical university that is state-subsidized to provide the care that is needed. They are dependent upon the generosity of community resources for care for these children. Sometimes they have to send patients as far as the University of Virginia Hospital for care. There is also a need for funding for violence/gang prevention and childhood obesity.

Brenda Mohile –

Ms. Mobile is a former NICU nurse. She currently works with Fairfax Neonatal Associates which provides neonatal services for three hospitals, including Fairfax and Fair Oaks. She spoke on record in support of the FIMR program and the perinatal council in Northern Virginia. The FIMR data collected has been extremely helpful in providing feedback to help the physicians fine-tune policies and procedures.

Nancy Owens –

Ms. Owens is a representative from M.I.S., the Miscarriage, Infant Death and Stillbirth organization. Ms. Owens strongly supports FIMR and the perinatal council. She recently saw a family that was going to be referred for genetic testing due to multiple deaths. She also commented how well the various resources work together to meet the needs of these communities. Ms. Owens noted that Resources Mothers and other organizations in the area work very well together to meet the needs of these communities.

Northwestern Region

The public hearing for the Northwestern Region was held on Wednesday, April 27, 2005 in Charlottesville, Virginia. Those in attendance included the following:

Katy Pitcock, Winchester Medical Center
Sara Long, March of Dimes
Sharon Veith, Skyline Region Perinatal Coordinating Council
Terri Smoot, RN, Skyline Regional Perinatal Coordinating Council
Terry Lucas, UVA Medical Center

Elizabeth Farrell, Assistant Director of the CVHPA, described the process being used to assess the needs of women and children in Virginia. She introduced Janice Hicks, PhD, Director of Policy and Assessment at OFHS, who gave an overview of the services provided by OFHS. Additional information about Title V funding and the needs assessment for the five year grant currently underway was provided during her presentation. Ms. Farrell then proceeded to conduct the public hearing.

The following is a summary of those who spoke and their comments:

Sara Long –

Ms. Long is the Director of Program Services for the Virginia Chapter of the March of Dimes Birth Defects Foundation. Her prior position was program consultant for the Resource Mothers Program at the VDH. She advocated for the budget increase from the General Assembly that allowed expansion from the original ten to the twenty five Resource Mothers programs currently supported. She attributed this success to the cost effectiveness of the program but noted that no new money has been budgeted since then. A recent prematurity task force of 18 public and private organizations, including the VDH, supports expansion of home visiting programs. Ms. Long continued with the specifics of the March of Dimes support for additional funding to Resource Mothers, as outlined in the presentation by Elisabeth Hutton during the Central area public hearing (detailed previously in this summary).

Terry Lucas –

Ms. Lucas, a member of the University of Virginia's (UVA) administration department, stated that she had sent the link to the online survey to several UVA staff members. In addition, she asked these members what they thought the top concerns were for women's and children's health care needs. The prioritized needs are: 1) dental health; 2) rising number of long-term chronic children who cannot find resources to support them in the home or the subacute care setting (a RN shortage, especially for home health and vent dependent children, contributes to this); 3) increasing number of sexually transmitted diseases in the middle school population; and 4) lack of, as well as ability to, access mental health resources for the under 16 population, especially the under 12 population.

Although no other speakers presented, those present discussed some issues and concerns. These are listed below.

1. *What percentage of the health departments provide prenatal services?* Dr. Hicks stated that health departments provide different levels of services. Some provide pregnancy testing and referral for care while others actually provide prenatal care for some portion of the pregnancy and then refer to physicians for delivery. So it varies from one health department to another.

2. Several people noted that some health departments which do not provide prenatal services give a copy of the yellow pages to the pregnant women. *Currently prenatal services at the health departments are not a mandated service. The audience believed that they need to be mandated.* An example was given from the Rappahannock/Rapidan Health Department about prenatal services. 98% of the pregnant women receive prenatal care in the first trimester from the health department's nurse practitioner. These women deliver at Fauquier Hospital.

3. *A question was asked about how priority needs were measured.* Dr. Hicks stated that the Title V grant includes national and state performance measures and that the OFHS is currently working on creating additional on-going data measures that are reviewed annually.

4. *One person noted that some health departments had previously provided dental care to pregnant women as a part of their prenatal care.* A link exists between dental health and preterm babies. This concern of dental care for pregnant women has been stated at several public hearings.

5. *A question was asked about how health departments use funding if they do not provide prenatal care.* Dr. Hicks said that $3.7 million is provided to 35 health departments. Some health departments do not use prenatal funding and some use money for outreach. Also some health departments use funding to support child health related activities and to address issues such as childhood obesity and injury prevention.

6. *One person noted that WIC enrollment has declined over the past several years.* She suggested that WIC and prenatal clinics could be held at the same time to increase the number of

pregnant women who receive WIC. Dr. Hicks said that the WIC program is specifically targeting pregnant women this year.

7. *One person stated that some private providers do not know what is available at local health departments.*