REPORT OF THE
LEGISLATIVE TASK FORCE ON

Infant Mortality

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 26

COMMONWEALTH OF VIRGINIA
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STATEMENT OF THE CHAIRMAN

Over the past decade, one of the most serious health problems to plague our nation and our state has been infant mortality. The United States has ranked from sixteenth to eighteenth in infant mortality statistics published for the last four years by the United Nations -- lagging far behind other industrialized nations. In Virginia, and in the South as a whole, infant mortality rates are high. One thousand and fourteen infant deaths were reported in Virginia in 1984.

In recognition of the need to remediate this problem, former Governor Charles S. Robb, as president of the Southern Governor's Association, together with the Southern Legislative Council, established the Southern Regional Task Force on Infant Mortality to isolate the causes for the high rate of infant mortality in the South, to determine states' needs, and to propose strategies to reduce the rate of infant mortality. As a result of this initiative, the 1986 Virginia General Assembly established the Legislative Task Force on Infant Mortality to study the problem in the Commonwealth and to place the recommendations of the Southern Regional Task Force in the proper posture for legislative action.

The Legislative Task Force on Infant Mortality conducted hearings throughout the Commonwealth to solicit the views and suggestions of citizens regarding the problem. Throughout the conduct of the study, the Legislative Task Force received outstanding service from its staff, its legislative members and its citizen members whose particular expertise enabled the Task Force to understand the complex medical, social and economic issues related to infant mortality.

The report of this Task Force is a compilation of its work and the recommendations reflect its concensus. It is not the Task Force's intention that its recommendations be considered definitive solutions for the problem of infant mortality, but as minimum initiatives for its remediation.

Bobby Scott

Senator Robert C. Scott, Chairman
Legislative Task Force on Infant Mortality

Report of the
Legislative Task Force on
Infant Mortality
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1986

To: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

In 1984, the Virginia General Assembly passed Senate Joint Resolution No. 39, which requested the Departments of Health, Mental Health and Mental Retardation and Social Services to jointly conduct a study of the prevention of infant mortality with an emphasis on the minority population. In 1985, the Legislature continued this study via Senate Joint Resolution No. 106, changing what had been an agency study to a legislative study with the appointment of five legislators. The Legislative Task Force was asked to determine appropriate interventions which might be employed to reduce the high rate of infant mortality and to review the recommendations of the Southern Regional Task Force on Infant Mortality for potential implementation in Virginia.

HISTORY OF TASK FORCE ACTIVITIES

The Legislative Task Force began its study with a series of public hearings throughout the Commonwealth, one each in Tidewater, Southwest, and Central Virginia to solicit the public's perspectives of the nature of the problem and possible strategies for the intervention and remediation of the high rate of infant mortality in the State.

Testimony presented at the public hearings specified the following needs:

- Reducing the high rate of teenage pregnancy through such projects as sex education, school-based health clinics and outreach programs for teens.

- Establishing a mechanism to permit the follow-up of former neonatal intensive care infants.

- Educating consumers to obtain good prenatal care.

- Establishing better coordination between private and public perinatal services at the state level.

- Developing continuity of care in order to provide comparable care to both Medicaid and private-paying obstetrical patients.

- Marketing existing maternal and infant health programs and services and making such services accessible to the target populations.

- Reviewing the death certificate of each infant and conducting a medical records review of each of the mothers to isolate any factors which may have contributed to the death.

- Increasing the number of obstetricians in Southwest Virginia.

- Providing quality and accessible prenatal care services and other support services.

- Attracting obstetricians who can provide the necessary care for high-risk obstetrical patients.

- Providing a mechanism for follow-up care for high-risk mothers and infants.

• Increasing the Medicaid reimbursement level to obstetricians and pediatricians for the care of indigent and Medicaid patients.

• Emphasizing sex education to reduce the number of teen pregnancies and subsequent medical problems due to high-risk pregnancies.

• Improving prenatal care and it accessibility.

• Alleviating environmental factors which contribute to high risk pregnancies and infant mortality.

• Increasing the public subsidy to families with dependent children.

• Reviewing federal and state regulations which provide services to pregnant women and their children to clarify eligibility requirements and to determine the adequacy of services and financial benefits.

• Improving the timeliness of local services offered at the local level.

In addition, the Legislative Task Force requested its staff to conduct a fifty-state survey to determine other states' programs on infant mortality, to inventory the Commonwealth to determine the kinds of programs and services in operation and being developed to remediate the problem, and to identify exemplary programs which might be appropriately implemented in Virginia. The staff also was asked to develop a proposal which would approach resolution of the problem of infant mortality from three perspectives: the ideal, the feasible and the minimum. The staff's findings and proposal were presented to the Task Force for its consideration.

Throughout the course of its study, the Task Force followed the activities of both the Southern Regional Task Force on Infant Mortality and the Virginia Task Force on Infant Mortality. In reviewing "For the Children of Tomorrow," the final report of the Southern Regional Task Force, the Legislative Task Force found that many of the recommendations in the report paralleled its tentative conclusions. Consequently, the concensus of the Task Force was to adopt those recommendations which were appropriate to Virginia's needs.

THE PROBLEM OF INFANT MORTALITY

Infant mortality (death to a live born child prior to one year of age)[1] is one of the nation's most chronic, complex health problems and it continues to be of primary concern to both federal and state governments.

Testimony presented to the Subcommittees on Oversight and Investigations and on the Environment of the Committee on Energy and Commerce of the House of Representatives on March 16, 1986, indicates that although the infant mortality rate (IMR, or infant deaths per 1,000 live births) has declined steadily over the past decade, "the United States continues to lag behind other industrialized nations of the world, ranking from 16th to 18th on statistics published for the last four years by the United Nations. Some of the countries ahead of the United States include Japan, Spain, Canada, Australia, Singapore and Ireland."

Edward N. Brandt, Jr., M.D., Assistant Secretary for Health, U.S. Department of Health and Human Services, reported to this Subcommittee that babies born at the present time will live healthier and longer lives than ever before, yet just over one percent will not survive their first year. Among this one percent are infants born to school-age adolescents under 18 years of age; infants who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth; infants born to women who smoked during their pregnancy; and infants born to women who drank alcohol during their pregnancy. All infants belonging to these categories are considered "at risk."

"In Virginia, nearly 1,000 infants die each year. Over the last five years, Virginia's IMR lingered at over 12.0, worse than that for thirty-one other states, higher than the national average of around 11.8, but slightly lower than the 13.0 rate for the South. The IMR for minority babies more than doubles that for whites, and IMRs throughout the Commonwealth vary

considerably, some areas having rates twice as high as the state average.[2]

In Virginia, infant deaths attributable to congenital anomalies, disorders relating to short gestation and low birth weight, respiratory distress syndrome, sudden infant death syndrome, can frequently be traced to poverty and its accompaniments, poor nutritional status, low educational levels, inadequate health care and high rates of teenage pregnancy.[3]

A. Low Birth Weight

Of the leading causes of infant mortality, the "single greatest hazard is low birth weight, which is associated with increased occurrence of mental retardation, birth defects, growth and development problems, blindness, autism, cerebral palsy, epilepsy, and severe lung diseases such as respiratory distress syndrome. Other significant causes of death include congenital defects, birth injuries, crib death, infectious diseases, and child abuse and neglect." Five major factors have been identified as contributing to low birth weight:

- poverty, unemployment, and lack of health insurance
- inadequate nutrition
- unintended pregnancy
- lack of prenatal care
- substance abuse[4]

In addition to the physical and emotional problems experienced by and resulting from a low birthweight baby, economic considerations arise. The primary medical expense in caring for the low birthweight neonate is neonatal intensive care. The American Academy of Pediatrics defines neonatal intensive care as the constant and continuous care of the critically ill newborn. Such care includes individualized, specialized 24-hour nursing care, respirators, blood-gas and other diagnostic and therapeutic procedures to compensate for the lack of full development of the infant. Nationally, there are approximately 200,000 admissions of neonates to intensive care, and it is estimated that 100,000 of such admissions are due to complications associated with low birthweight. It has been estimated further that in 1983, the total annual costs for low birthweight-related neonatal intensive care, nationally, was $2.6 billion. Another major medical expense is associated with the rehospitalization of low birthweight infants during the first year of life for low birthweight-related conditions. The long-term costs of treatment for such neonates are apparent in the high incidence of severe impairment and developmental delay, such as blindness, deafness, major and minor birth defects. Studies indicate that low-birthweight infants tend to experience difficulty in school. It is the consensus of researchers in this area that the low birthweight, particularly the very low birthweight child, is at considerable disadvantage academically, even when no clinically detected handicap has been diagnosed. Other intangible adverse outcomes of low birthweight have been revealed in studies which demonstrate that low birthweight infants have the lowest interaction with mothers with a weak family support system, and a correlation of low birthweight to child abuse.[5]

B. Prenatal Care

For certain women and babies, childbirth remains hazardous, though the associated risks continue to decline. However, for these women and babies, there are effective interventions to improve pregnancy outcomes. One such intervention is prenatal care. Studies have demonstrated that prenatal care is effective in improving the health of the pregnant woman, detecting and managing possible problems and disorders which might complicate the pregnancy and labor, improving fetal health, reducing low birthweight, thereby reducing infant mortality and other adverse results from the lack of prenatal care.

Providing prenatal care is also cost effective. Given no prenatal care, a pregnant woman is three times as likely to have a low birthweight baby. The risk of a premature birth and the need for neonatal intensive care services are greatly increased. Estimates presented at the Select

Committee on Children, Youth and Families of the U.S. House of Representatives' 1983 hearing revealed a cost savings to the federal government of $361,081,220 by providing comprehensive prenatal care to all low-income women as opposed to $638,364,300 spent by the federal government for neonatal intensive care and rehospitalization of low-birthweight babies during the first year of life. The infant is also at greater risk of dying during the first month of life or suffering from severe handicapping conditions. Most often, as indicated in the 1983 hearing of the Congressional Committee, those women who do not receive prenatal care are those who are high-risk, that is, the indigent pregnant woman, black women and teenagers.

Current obstetrical standards recommend that prenatal care begin in the first trimester and, ideally, the patient should be seen at least once every four weeks for the first twenty-eight weeks, every two to three weeks until the thirty-sixth week, and weekly thereafter. Women who have health problems or who may be high-risk should be seen more often. To promote optimum physical and emotional well-being during pregnancy and to provide personalized care, it is recommended that prenatal programs be comprehensive. This would include clinical evaluation, laboratory tests, nutritional assessment and counseling, health education, childbirth preparation, psychological counseling, education in breast feeding, and family planning.

C. Teenage Pregnancy

Another determinant of infant health is maternal age. Teenage mothers are at a much greater risk of giving birth to a low birthweight baby than are other mothers. One reason given why teenage mothers bear more low birthweight and premature babies is that a girl's reproductive organs may not be sufficiently mature to sustain a pregnancy without undue stress. Also, the teenage mother is less likely to have a balanced diet, and once she becomes pregnant, the teenage mother is less likely than other pregnant women to get early, quality prenatal care which could avert many of the damaging health consequences of early childbirth.[6]

Data indicate that black mothers are more likely than white mothers to give birth before age eighteen and almost eight times more likely to do so under age fifteen, which means that black mothers have more births at an age which correlates with the highest percentage of low birthweight babies.

There is disparity between black and white teenage pregnancy rates. In 1979, the incidence of teenage pregnancy for blacks was eleven times higher than for whites; in 1980, the black rate decreased to four times the rate for whites, but increased in 1981 to six times the white rate. In 1981, thirteen cities were studied by the federal government to determine the dimensions of this problem. In this study, it was determined that while 122 white mothers under age fifteen bore babies, 1,021 black mothers in the same age group gave birth.

Regardless of race, there is a clear relationship between poverty and poor pregnancy outcomes. Consequently, the future for young mothers who have not completed their education and who are without a means of obtaining employment looks bleak, as families headed by young mothers are more likely to remain below the poverty level than other families.

D. Behavioral Determinants

Nutrition

The health of an infant at birth reflects the health of the mother before and during pregnancy. Health experts agree that the quality and quantity of food consumption during pregnancy is critical to infant health and the data confirms this. One-third of low birthweight babies are believed to result from retarded fetal growth during pregnancy and fifty-seven percent of low birthweight black neonates are the result of poor nutrition. Nutritional deficiencies are also linked to increased vulnerability to illness, anemia and mental retardation.

Introduced in 1972 to help remediate this problem, the Women, Infants and Children (WIC) Food Supplement Program provides food and nutrition education to low income, pregnant and nursing women, infants and children up to age five.

The Congressional report, Opportunities for Success: Cost-Effective Programs for Children, includes the WIC program as one of the cost-effective programs available for children. WIC participation, according to the report, has been associated with (i) earlier and more adequate prenatal care and improved birth outcomes, (ii) the largest improvements for populations at higher risk, and (iii) cost effectiveness. As much as three dollars are saved in short-term hospital costs for every one dollar invested in WIC's prenatal component.

Smoking

"Smoking is one of the most preventable determinants of low birthweight,"[7] and several studies link maternal smoking during pregnancy to a higher incidence of preterm births. The Surgeon General, summarizing extensive studies on smoking and pregnancy, has warned of the risks to infants of mothers who smoke. Recent studies suggest that smoking during pregnancy increases the risk of spontaneous abortion, perinatal death, low birth weight, prematurity, shortened body length, smaller head size, stillbirth, and potential long-term impairments in physical growth, mental development and deficiencies in behavioral development up to eleven years of age. Infants born to mothers who smoked during their pregnancy weigh 150 to 250 grams less than infants born to mothers who did not smoke. Twenty to forty percent of low birthweight infants born and an estimated fourteen percent of premature births in the nation are believed to be attributable to smoking. In addition, pregnant women who smoke are more likely than nonsmokers to deliver babies that:

Have a low Apar score

The Apar score is a combined numerical evaluation of a baby's heart rate, respiration, reflexes, muscle tone, and color, and can range from one to ten. Research conducted by the National Institute of Child Health and Development (NICHD) found that the proportion of low and depressed Apar scores measured in newborns at one and five minutes after birth is related to the extent of maternal cigarette usage during pregnancy.

Are born prematurely

Studies indicate that the risk of early delivery increases by at least thirty-six percent if the mother smoked; forty-one percent of mothers who smoked suffered miscarriages; mothers who smoke are at a higher risk for complications of pregnancy such as premature separation of the placenta from the uterine wall, premature rupture of the amniotic membranes, and uterine bleeding during pregnancy.

Are small or underweight

Research demonstrates that women who smoke during pregnancy deliver babies who are on the average 200 grams (7 ounces) lighter than those born to nonsmokers, regardless of the mother's weight gain during pregnancy. There is little evidence that such infants always "catch up" in their early years. The children who participated in this NICHD study were found to have persistent suppression of somatic growth at age five and will continue to be evaluated through their tenth birthday.

Have a health problem

Research findings indicate that respiratory and cardiovascular problems, including congenital heart disease, appear to be much more common among newborns whose mothers smoked during pregnancy. Likewise, an unrelated study found that babies who live in a home where one or both parents smoke have significantly more admissions to the hospital for pneumonia or bronchitis before the age of one year than do infants of nonsmoking parents.

Die within the first year

Research revealed that light smoking tended to increase the risk of perinatal death by twenty percent and heavy smoking by thirty-five percent. Maternal smoking has also been found to be strongly associated with sudden infant death syndrome (SIDS), which claims more than 6,000 lives yearly and is the leading cause of death in children between one and twelve months of age.

Other deleterious effects of maternal smoking include fetal hypoxia or oxygen deprivation. Carbon monoxide, a major ingredient in tobacco smoke, interferes with the delivery of oxygen to the tissues and deprives the developing infant of the oxygen necessary for full growth. Researchers have determined that another ingredient in tobacco smoke, nicotine, crosses the placenta and is passed onto the fetus and the amniotic fluid. Nicotine, a vasoconstrictor, has been linked to degenerative changes of the cells of blood vessels in the umbilical cord, suppression of muscle and nerve functions, increased blood pressure, bradycardia (slower heart beat), acidosis (accumulation of acid in the blood), and hypoxia (oxygen deficiency). Nutritional studies indicate that nicotine is secreted into breast milk and, in large doses, inhibits lactation.[8],

Alcohol

Alcohol is the most commonly used drug in the United States and alcohol-related health problems are among the nation's most serious health problems. Evidence is growing which indicates that intrauterine exposure to alcohol is a leading cause of birth defects, mental retardation, low birthweight, prematurity, spontaneous abortion, fetal distress and neonatal depression, developmental abnormalities, and behavioral and learning problems. There are no safe levels of alcohol consumption during pregnancy and the type of alcohol consumed does not appear to matter. Studies also indicate that alcohol is found in the breast milk of nursing mothers.

The effects of alcohol seen in infants of mothers who chronically drank prior to and during their pregnancy is termed "fetal alcohol syndrome," indicated by:

- prenatal and/or postnatal growth retardation, with weight, length and/or head circumference below the tenth percentile
- central nervous system involvement, e.g. neurologic abnormalities, developmental delay, intellectual impairment and mental retardation
- variety of birth defects, dysmorphology, microcephaly (small brain), microphthalmia (small eyes), and short palpebral fissures (smaller horizontal length of the eyes)
- poorly developed philtrum (distance from the base of the nose to the upper lip, thin upper lip, flattening of the maxillary area and poorly formed cheeks

These abnormalities are severe and irreversible. The incidence of fetal alcohol syndrome in the nation is estimated at 1,800 to 2,400 births a year, similar in prevalence to Down syndrome and spina bifida. Of all birth defects, fetal alcohol syndrome is uniquely preventable.

Drugs and Toxic Agents

It has been estimated that five billion dollars are spent yearly by Americans on over-the-counter drugs, the majority of which have not been tested for safety and effectiveness nor have the potential damaging effects of these drugs on maternal and fetal health been adequately determined. Additionally, billions are also spent by Americans on illegal drugs. The effects of drugs taken during pregnancy depend upon when they are taken, the quantity and type of drug used in combination and the time span when they were taken. As human growth follows a specific developmental pattern, every part of the body has a critical formation period in which any interference with that process results in arrested development. Certain drugs have been linked to damage of the kidneys, liver, central nervous system, brain, blood clotting abilities, and bone marrow; hemorrhaging; cleft palate; limb deformities; addiction; and death. Consequently, *no* safe levels of legal or illegal drug consumption during pregnancy exist.

Research also attests to the damaging effects of toxic agents on fetal health. Exposure of the fetus to infectious and toxic agents during pregnancy can cause congenital malformations, miscarriage, birth defects and stillbirth.[11], [12]

RECOMMENDATIONS

1. The Legislative Task Force recommends that a permanent statewide coordinating council be established to oversee the planning, delivery and financing of health services in family planning and maternal and infant health.

Discussion

The Task Force believes that the establishment of a coordinating council would facilitate the oversight of family planning and maternal and infant health programs and services throughout the State. It is recommended that this council consist of the Governor, the Lieutenant Governor, the Secretary of Human Resources, the Secretary of Finance, the Secretary of Education, the Commissioner of Health, the Commissioner of Mental Health and Mental Retardation, the Commissioner of Social Services, the Director of the Department of Medical Assistance Services, the Director of the Department for Children, the Superintendent of Public Instruction, the Speaker of the House of Delegates, the President Pro Tempore of the Senate, the majority and minority leaders of the House of Delegates and of the Senate, the chairmen of the House Committees on Finance, Appropriations, Education and Health, Welfare and Institutions, the Senate Committees on Education and Health, Finance and Rehabilitation and Social Services and two citizen members appointed by the Governor. The Council shall avail itself of the expertise of specialists in the fields of obstetrics, gynecology, pediatrics, perinatology, neonatalogy, health care financing and health administration. All agencies and instrumentalities of the Commonwealth would be required to assist the Council in its deliberations upon request as the Council deems appropriate. (Appendix A)

In Virginia, there are several programs which extend preventive and primary health care to women and children. However, there is no structure which is responsible for assuring the implementation of maternal and infant health programs and coordinating the delivery of services. Therefore, the inclusion of the foregoing individuals on the council, the Task Force believes, would provide the concentration of authority and expertise necessary for efficient delivery of state policy, programs and services in maternal and infant health care.

2. It is recommended that a study of the health needs of school age children be studied and that school-based health clinics be established in all public secondary schools in the Commonwealth.

Discussion

An emerging issue in recent years has been adolescent health. It has been assumed that because of their youth, teenagers are quite healthy when, in fact, they are subject to the same health problems and have the same need for health services as the general population.[13] Indeed, some of the health problems of teenagers are chronic. (See Appendix A.)

An approach which has emerged as a resource to address adolescent health problems is the school-based health clinic. School-based health clinics are "primary health care clinics that are located on the school grounds of public secondary schools or within the school building. The objectives of such facilities are to increase the adolescent's knowledge of preventive health care, reduce risk-taking behavior and assist adolescents in developing behaviors which promote health. The clinics are staffed by nurse practitioners and/or physicians. They vary in size, organizational structure, management and services offered. However, as a group, these clinics provide a variety of services, including athletic physicals, general health assessments, laboratory and diagnostic screenings, immunizations, first aid and hygiene, EPSDT testing, family planning counseling and services, prenatal and postpartum care, day care, drug and alcohol abuse counseling, nutrition and weight reduction programs, family counseling and referrals for special medical care."[14] School-based health clinics may also provide a vital service in medically underserved areas.

It is believed that one of the major unmet health needs of adolescents is family planning counseling and services. In 1982, there were more than 523,000 births to teens in the nation and nearly 10,000 were to girls under age 15. Data provided by the Division of Vital Records and Health Statistics of the State Health Department indicate that in Virginia there were 10,444 live births, 8,687 induced abortions and 741 natural fetal deaths atributed to women age nineteen and under in 1984. For women under age fifteen, there were 225 live births, 379 induced abortions

and 27 natural fetal deaths in Virginia in 1984. These figures indicate a severe problem and the need to confront teenage pregnancy on various levels. School-based health clinics, such as those located in Texas and in St. Paul/Minneapolis, which have included a family planning counseling component report that these programs have been successful in reducing the number of first and repeat pregnancies of teenagers. However, health experts and other professionals who are engaged in the care and counseling of youth and in research concerning their behavior, suggest that contraception and family planning counseling alone are not sufficient solutions to teenage pregnancy. "Much work needs to be done to motivate teens to delay sex and for those who choose to be sexually active, to be consistent users of contraception. Though contraception and sex education give teens the capacity to delay parenthood, teens also need sound reasons to believe that parenthood is inappropriate at this time of their lives. They need hope and a sense of positive options. In many ways, the best contraceptive is a real future."[15]

3. It is recommended that the State Health Department make effective use of its maternal and child health and family planning personnel in implementing programs focused on reducing infant mortality.

Discussion

Currently, Virginia ranks in the lower third in state infant mortality rates. Although the Legislature has directed the State Health Department to make programs which improve pregnancy outcome a high priority and it has appropriated funds for this purpose, there remains a need to aggressively seek solutions to the problem. In 1984, the Joint Subcommittee Studying the Operations and Services of the Department of Health stated that certain planning districts in the Commonwealth with the highest low birthweight rates have remained the same since 1975 and that these same areas are the ones with the highest incidences of infant mortality. The Task Force has found that though efforts to address this problem have been employed, many of these same areas continue to experience high low birthweight and infant mortality rates.

Testimony received by the Task Force at its Danville public hearing revealed that in a one-year study conducted by a local health department, 17 percent of the women who scheduled an appointment to obtain contraception during that year became pregnant before their appointment. Delay in the scheduling of appointments with local health departments was considered a problem in other areas of the State as well, some women having to wait as long as six weeks. This lag in scheduling appointments is attributed to understaffing.

To remedy this problem, the Task Force recommends that the Department conduct a thorough study of the personnel needs of local health departments to determine how full-time and part-time personnel can be utilized in programs for reducing infant mortality. The Task Force recommends further that the Department study the personnel needs in those areas of the Commonwealth having the highest incidences of low birthweight and infant mortality to determine the minimally optional staffing requirements of local health departments. The Department is requested to give special attention to these areas' possible need for additional personnel. A plan for the effective utilization of such personnel to provide outreach services and the adequate delivery of family planning and maternal and infant health services to the citizens of these areas should be developed.

According to the Southern Regional Task Force's Report on Infant Mortality, nurses, nurse midwives, nurse practitioners and other maternal and infant health personnel can be used to a greater degree to provide maternal and infant health care. Certified nurse midwives and nurse practitioners are trained to care for low risk obstetric and pediatric clients under the supervision of a qualified physician. Using them to provide these services can be more cost effective and result in a better match between health care providers and client needs.

Though the Commonwealth has a responsibility to employ an appropriate number of qualified staff to serve and protect the health and well-being of its citizens and while recognizing the right of its citizens to plan their families in accordance with their goals, values and beliefs, local health departments and health care providers are urged to provide pertinent information on human reproduction to their patients and to stress to the patient her responsibility to make use of available contraceptive devices which may be obtained without prescription (i.e., vaginal sponge, prophylactics, creams, jellies and suppositories) and can be safely and effectively used during the waiting period for an appointment. This information can be routinely provided to

patients when scheduling an appointment and to new mothers by the attending physicians or nurse during postpartum hospitalization.

4. It is recommended that family planning services be routinely provided by public and private health care facilities serving women of childbearing age.

Discussion

The Southern Regional Task Force on Infant Mortality stated in its report, "For the Children of Tomorrow," that unintended pregnancy occurs in over fifty percent of the entire childbearing population and that poorly timed or poorly spaced pregnancies contribute to the incidence of low birthweight and infant mortality. Consequently, the evidence indicates a need to encourage women of childbearing age to prudently plan and appropriately space their pregnancies.

5. The Task Force recommends that funds be appropriated and staffing levels be increased to supplement family planning services under P. L. 94-63, the Family Planning and Population Research Act of 1975 as amended, (42 USCS § 300 et seq.).

Discussion

Until the 1960s, family planning services were generally available only to those who could afford them. However, recognizing the relationship between birth spacing and the prevention of birth defects and maternal illness, Congress applied the broad authority of Title V of the Social Security Act to provide federal support for family planning services for the poor, and low income people received similar services via the Economic Opportunity Act of 1964. In 1967, the passage of the Social Security Amendments, which included the Child Health Act of 1967, gave special emphasis to family planning services. Expanded federal activities in this area have formed the basis for current federal involvement in the area of family planning services, population research and education. These services are provided only on a voluntary basis and with full and informed consent.

Currently, family planning services are provided through the Family Planning and Population Research Act of 1975, as amended (42 USCS § 300 et seq.). Funds authorized for such purposes by this Act are received by Virginia.

Though a part of the State's family planning services are funded through the Health Block Grant's component for preventive health services and maternal and child health services, augmentation of those funds with state funds targeted solely for family planning counseling and services would enable local health departments, such as in Danville, to increase their staffing levels in order that patients might be served without undue delay. Further, augmentation of these funds would improve delivery of family planning services and outreach programs.

6. It is recommended that the State appropriate funds necessary for the development of a statewide system of maternal transport.

7. It is recommended that a planned, coordinated system between local health department clinics and hospitals for the delivery of indigent and Medicaid obstetric patients be developed.

Discussion

Testimony presented at the Task Force's Norfolk and Richmond public hearings attested to the need to develop and fund a statewide system for transporting indigent pregnant women to regional perinatal centers for prenatal care and for coordination between local health department clinics and hospitals for the delivery of the baby. A system of maternal transport is needed most in the rural areas of Virginia where ready access to highly specialized obstetrical care is crucial to successful pregnancy outcomes.

It was stated by medical experts that many times indigent women who are not eligible for Medicaid find transportation a major obstacle to obtaining prenatal care. Often, such women are high-risk obstetric patients, and during their pregnancy need the consultation of perinatologists and tests such as the ultrasound, fetal heart rate monitoring, amniocentesis and other sophisticated testing. Because it is not feasible economically or logistically to provide obstetric

high technology at every patient's home site, efforts should be concentrated on bringing patients to the perinatal centers where the services are delivered. It is believed that a transport system for this purpose would contribute to the reduction of preterm birth and perinatal mortality in Virginia. Because local health departments conclude prenatal care services at thirty-six weeks' gestation, these patients are left on their own during the "gap" between the thirty-six weeks and delivery to find a hospital to deliver them. There are hospitals in this State that are reluctant to deliver indigent and Medicaid women. Therefore, the Task Force believes that a planned, coordinated system between the clinics and hospitals for the delivery of such patients should be developed.

8. It is recommended that a case management system be instituted for all patients seen in public health clinics.

9. It is recommended that the State Health Department develop a more expeditious mechanism to place prenatal and discharge summaries into records of patients served by the public health clinics.

Discussion

Often, obstetric patients who are served in public health clinics are eligible for or are in need of other health or social services. Usually, these patients are not aware of the availability of programs and services for which they may be eligible. Many times, once such patients have been made aware of such services, they are overwhelmed by the time-consuming task of going from one agency to another to contend with numerous forms. They also are hindered by a lack of transportation. When the obstetric patient delivers, she is attended by yet another physician whom she may not have seen prior to her delivery, making it highly possible for her to get lost in the system. Most obstetric patients return to the public health clinic for the postpartum examination.

The Task Force recommends that a staff person be designated to obstetric patients served by public health clinics to advise the patient of programs in which she may be eligible, to work with the staff of other agencies to provide coordination of services which may be needed throughout the pregnancy and delivery and to coordinate follow-up care of the patient and the infant after delivery with attending physicians.

Essential to providing appropriate medical care to all patients is access to the patient's medical records. In the case of high-risk pregnant women and infants, information concerning obstetric and pediatric care received or required is crucial. Other data concerning the mother's eligibility for health and social services allows for appropriate follow-up. The implementation of a case management system would provide coordination of health and social services and assure continuity of care to meet the obstetric patient's needs more effectively.

Essential to the health care of all children is an accessible and a consistent source of medical care. However, most public health clinics, while offering preventive health care (e.g. immunizations and well-baby check-ups), do not offer sick-child health care services. Consequently, the parents of these children frequently resort to emergency rooms for acute care services, which is a more expensive utilization of health care services due to the level of care and the setting of such services. Too, the emergency room setting does not promote the development of a physician-patient relationship or the continuity of care from one physician.

A more efficacious way of assuring that children will receive preventive and acute health care services from an identifiable place on an ongoing basis, is the program wherein the public health clinic in which the patient initiates care is designated as the "medical home" for that patient. The concept of the "medical home" thus becomes the primary care system to provide follow-up care for children as well as accessible and available comprehensive pediatric services.

10. It is recommended that the mobile health unit program be utilized to provide essential obstetric services in rural areas of the Commonwealth.

Discussion

The mobile dental health unit program has been used successfully by the State Health

Department to provide dental health care in rural areas of Virginia where access is a primary problem in providing health services. The program has been cost-effective and successful in providing dental health care among the citizens of the area and in educating them about the need for good dental health. It is suggested that a mobile health unit for obstetrical care be modeled, where appropriate, after the mobile dental health program to provide maternal health care to medically underserved areas.

11. The Task Force recommends that the State Health Department require as a condition of licensure that hospitals adopt a policy to admit all women in labor.

Discussion

Pursuant to the report, "For the Children of Tomorrow," labor is defined as a medical emergency requiring immediate attention. The practice of hospitals refusing to admit indigent and Medicaid women in labor is a problem in the South, though in Virginia the practice of refusing to admit women in labor who do not have proper health insurance or who have had little or no prenatal care may be marginal. Nevertheless, the refusal to admit just one woman in labor can have tragic consequences. This is especially true for high-risk pregnant women who are in labor. Lack of prompt medical care in such an urgent situation could result in the avoidable, needless death of yet another infant. Therefore, it is imperative that the Commonwealth guarantee that all women in labor receive prompt obstetric care.

12. It is recommended that the Departments of Education, Health and Social Services jointly develop an educational and public awareness program to inform men of their role and responsibility in the reproductive process and preventive maternal and infant health care.

Discussion

There has been a lack of attention to the male's role and responsibility in family planning and in maternal and infant health, especially adolescent pregnancies. Since it is the female who arrives at a health care facility, has the abortion or bears the child, more attention has been given to her.[16]

"Based on a national survey, it has been estimated that over fifty percent of 17 year old boys have had sexual intercourse and almost one in five 14 year old boys have had intercourse at least once. However, only two percent of fathers of teenage boys have discussed contraception with their sons, though over fifty-two percent of male teenagers indicated that they want to talk to their parents about sex. The study also revealed that a major factor in a woman's decision to use a contraceptive method is her partner's knowledge, beliefs and attitudes about sexuality and responsibility.[17]

Recognizing that the young male is often forgotten in addressing the problems of teenage pregnancy, many civic and private organizations have begun programs especially designed to reach the adolescent male. Such programs have begun to address the stereotype of the teenage male as "incorrigible and the characterization of the teenage father as one who victimizes his partner and abandons his family. Research has begun to document the significant impact fathers have on the development of their children, consequently, the teenage father presents an important challenge. These young men have a myriad of problems. Their youth, their psychological problems in becoming fathers so early, lack of job skills and employment opportunities, and their scant education all mitigate against easy solutions. However, multifaceted support programs which address the complex needs of adolescent fathers and their young families are required."[18] In addition to such programs, it must be recognized that a straightforward, hard-hitting message, such as that being employed by the National Urban League (i.e. "don't make a baby if you can't be a father") speaks frankly to young males and confronts the mythical association of fatherhood and manhood.

It must be stressed that both partners bear equal responsibility for family planning and the consequences of sexual intercourse. A program, jointly developed by the Department of Education, Health and Social Services, to reach sexually active males concerning their role and responsibility in family planning and maternal and child health is crucial to the remediation of the problems of unwed pregnant mothers and infant mortality.

13. The Task Force recommends that the Department of Education urge all school divisions to expand and coordinate the health education, home economics and biology curricula to include in-depth instruction on family life education which includes parenting skills.

Discussion

The family is in crisis today, beseiged by unrelenting adverse circumstances (i.e., economic problems, international turmoil, divorce, child abuse and neglect, teenage pregnancy, poverty, substance abuse, changing lifestyles, single parents) which undermine the foundation and purpose of the family.

Among these adverse circumstances, teenage pregnancy is one of the most complex and chronic. In Virginia, it has been estimated that "thirty-five percent of males and twenty percent of females under age sixteen are sexually active. There were 20,220 pregnancies in women under nineteen and twenty-nine percent of all abortions were to school-age children in the Commonwealth in 1983. An estimated eighty percent of pregnant teenagers drop out of school, with forty-one percent of them failing to receive adequate prenatal care.[19]

Solutions to this tragedy will have to be multifaceted. One viable component of the attack on the problem of teenage pregnancy is family life education. Family life education, as distinguished from sex education per se, is the total integration of educational concepts and experiences that would enable students to develop knowledge of and to understand the attitudes that influence family living, personal relationships, sexual development, and human sexuality. Family life education programs and sex education have existed in Virginia's public schools for many years, frequently existing as components of other programs. Currently, it is a component of the health education program, and it is also incorporated in the home economics and biology programs. Its goal, in part, is to help students to develop an understanding and appreciation for the roles of males and females in society and the roles of family members, to develop effective interpersonal skills and a wholesome attitude towards human sexuality, to understand the responsibilities that contribute to an effective family life and to prepare for responsible adulthood and parenthood. Local school divisions in Virginia are not required to offer family life education programs, but those that elect to do so utilize the curriculum guidelines developed for the program, though teaching methods vary among the programs.

Testimony before the Task Force indicates that there is disagreement as to whether family life education programs are a part of the public school curricula. It is perhaps safe to venture that those who have some concern regarding the thrust of some of the programs at the local level would state that the programs are in place, and that those who desire more in-depth instruction and the inclusion of family planning services would testify to the contrary. These arguments aside, it is apparent to the Task Force that more young people are becoming sexually active during the very early adolescent years and that too many young people have no comprehension of the very basic biological facts concerning human sexuality and reproduction. Most teenagers' realm of knowledge of human reproduction is composed of myths and misinformation obtained primarily from peers. To assist in remediating the problem of teenage pregnancy, teenagers must be provided factual information on human reproduction, instructed about the responsibilities and consequences of sexual involvement, and encouraged to postpone sexual activities. The Task Force urges that the Department work cooperatively with local school divisions, parents and the community in expanding and coordinating these programs in order to ensure academic excellence, to develop programs which address local needs and provide meaningful options for students, teachers and parents which are consistent with their religious beliefs or values.

14. It is recommended that pilot projects providing genetic screening as part of routine obstetrical care be implemented by the State Health Department.

15. The Task Force recommends that the Virginia Congenital Anomalies Reporting and Education System Act be amended to require the reporting of all congenital anomalies of children born in Virginia from birth to two years of age from hospital records.

16. The Task Force recommends that the State Health Department engage a reproductive epidemiologist to study the effects of environmental hazards on maternal and infant health.

17. It is recommended that the Department of Medical Assistance Services provide funding for apnea monitors for indigent and Medicaid eligible persons. It is recommended further that the Department assure that Medicaid funds are being maximized on behalf of pregnant women and children.

Discussion

Current research substantiates the relationship between the high risk for infant mortality and birth defects. It has been determined that prenatal care which includes genetic screening is effective in identifying potential problems and in isolating genetic disorders. The detection and treatment of these disorders can contribute to the reduction of infant mortality and morbidity. The State Health Department has begun five pilot projects in public health clinics to provide genetic screening as a part of routine obstetrical care. Primarily, such screening has been for sickle cell anemia. It is the opinion of the Task Force that such projects should be expanded to include private health care providers and screening for other genetic disorders.

In 1985, the General Assembly established the Virginia Congenital Anomalies Reporting and Education System to provide a centralized reporting system for all diagnosed congenital disorders in children at birth. Expansion of this system to include the diagnosis of such disorders from the medical records of children up to age two would provide needed information and identification of such disorders which were not detected at birth. This would help to facilitate appropriate planning, research and referral for these disorders.

It is envisioned that a review of the medical records for each infant death, the Perinatal Mortality Health Review, would enable the Department to determine whether some infant deaths could have been prevented and how the management and care provided the obstetric patient and infant may be improved.

Many high-risk pregnancies terminate with the birth of infants who are born prematurely or with genetic and other severe medical problems. To save and to sustain the lives of such infants, highly technical and intensive medical care must be administered. Although the miracle of medical technology has resulted in the saving of many infants' lives, the causes and course of the diseases and other health problems still remain unknown to physicians. Possible treatments for many diseases and disorders are in the developmental stage; consequently, these infants require constant monitoring.

One monitoring device, the apnea monitor, has proven effective in detecting crisis episodes in certain pulmonary diseases and neurological disorders, such as sleep apnea and SIDS. However, many indigent parents are unable to purchase or rent apnea monitors. Health professionals and specialists argue that the availability of apnea monitors to such parents would result in the early discharge of the child, thereby resulting in a significant savings in Medicaid funds and reducing infant mortality. It is the Task Force's understanding that some physicians have provided apnea monitors to their patients, but they have had to stop this practice due to questions of liability. To overcome this obstacle, the Task Force recommends that the Department of Medical Assistance Services provide funding for apnea monitors for indigent and Medicaid eligible persons through its customary procedure of facilitating the purchase, rental or contracting of apnea monitors for access statewide.

"Environmental health hazards can significantly affect maternal and infant health. Toxic substances in the air, land and water surrounding pregnant women and young children can all have a deleterious effect on their health. A specialist in reproductive epidemiology can study clusters of birth defects or note potential environmental hazards to assist state health planners in improving maternal and infant health outcomes."[20] It is believed that the Virginia Congenital Anomalies Reporting and Education System (VCARES) and the Perinatal Health Review can be instrumental in providing data for this study. Therefore, the Task Force recommends that the State Health Department include in its budget request for the 1986-1988 biennium funds for the implementation of VCARES and $200,000 for the Perinatal Mortality Health Review.

18. The Task Force recommends that a study be conducted to determine the feasibility of establishing a pool for malpractice insurance for obstetricians, neonatologists and perinatologists licensed to practice in the Commonwealth who have a significant indigent or Medicaid practice.

Discussion

The Intergovernmental Health Project states in its report, A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent, that during the mid-1970s, concerted action by many states was given to the malpractice insurance crisis due, in part, to the astronomical increases in malpractice insurance rates and the abandonment of this segment of the insurance market by several key insurers.

Malpractice claims, once virtually nonexistent, have risen because of the increase in the population and medical personnel, the expense and complexity of medical care, and the population's unwillingness to accept poor results. Rising malpractice insurance premiums and the fear of malpractice claims have caused many obstetricians, gynecologists, pediatricians and other associated specialists who provide maternal and infant health services to leave the practice. These physicians must also contend with a lengthy statute of limitations period for minors, which is the special tolling provisions for minors assuming injury at birth. Increasingly, these specialists are refusing to care for indigent and high-risk pregnant women. Nevertheless, an adequate supply of these physicians and the availability of and access to this specialized medical care are essential to the successful delivery of high-risk pregnant women and it is crucial to the reduction of infant mortality.

In the conduct of the study, the Task Force recommends the development of appropriate alternatives to the pool concept that would address the concerns of these physicians and assure the availability and access to such medical care.

19. The Task Force recommends that the reimbursement rate be increased for physicians licensed to practice in the Commonwealth who provide prenatal and neonatal health care and that those who make twenty or more indigent or Medicaid deliveries per year be reimbursed at a higher rate.

Discussion

Due to certain socioeconomic factors which influence the outcome of pregnancy, poor women are more likely to be among the high-risk population to experience an infant death. The care of high-risk pregnancies is expensive, entailing highly technical and sophisticated medical care and the expertise of certain specialists. Though a number of these women are Medicaid eligible, the Medicaid reimbursement rate for health care providers is too low, some physicians believe, to warrant their treating such patients in light of the pervasiveness of malpractice claims; however, the availability and accesss to quality care for high-risk obstetrical patients is vital to the reduction of the high rate of infant mortality in the Commonwealth.

20. The Task Force recommends that $50,000 be appropriated to permit the Commonwealth to participate in the Center for Disease Control's Nutrition Surveillance Program.

21. It is recommended that the State Health Department employ staff in nutrition services on a full-time basis in order to provide to such personnel appropriate benefits.

22. It is recommended that state funding for the WIC progam be increased to $500,000.

Discussion

It has been proven that good nutrition is critical to the development of a healthy baby and to the normal development of children. Proper nutrition during the prenatal peroid helps to lessen the incidence of low birthweight babies, birth defects and childhood morbidity. In Virginia, thousands of indigent pregnant women, infants and children are assisted by WIC, the Special Supplemental Food Programs for Women, Infants and Children, in obtaining nutritious foods. However, federal cutbacks in such programs affect a number of needy women and chilren in the Commonwealth. These cutbacks necessitate the purging of nearly 4,000 persons from the WIC program immediately. The Center for Disease Control has established a Nutrition Surveillance Program which is structured to provide states with an analysis of certain data regarding the state's population to determine that portion with the highest nutritional risk. It is imperative that only that portion of Virginia's population least at risk be dropped. Mindful of this priority, it is the Task Force's belief that this very difficult decision cannot be made without

timely and accurate information, and that the Center for Disease Control, having the expertise to provide such data, be requested to provide an analysis of Virginia's population to isolate those citizens who are nutritionally at risk.

Testimony presented at the Task Force's public hearing attest to the vital role of and the need for proper nutrition for pregnant women and infants. However, Virginia, as most "other Southern states, are understaffed in the number of nutritionists available for nutrition education and counseling. Information which was submitted to the Task Force indicates that nutritionists employed by the State Health Department are considered part-time personnel though indeed they actually have full-time work hours and responsibilities. Many of these employees have worked seven or eight years without benefit of health insurance, comparable compensation and other benefits and renumerations customarily provided full-time employees. The Task Force believes that the expectation that these employees work under this condition is unreasonable and that the insensitivity to the working conditions of these employees is unconscionable. The Task Force finds that it is especially ironic that these employees are responsible for "promoting the health of Virginians," yet they carry out this responsibility without benefit of "health insurance." It is the Task Force's recommendation that part-time nutritionists employed by the State be employed full-time and compensated accordingly.

Data supports the success of the WIC program in providing essential nutritional services to indigent mothers and infants. However, the manner in which these federal funds are allocated and guidelines on the utilization of WIC vouchers place both a planning and financial burden on states. Due to the structure of the program, it is possible for a state to receive cancelled WIC vouchers which exceed the total amount of the states' allocation. To compensate for this, states have set aside funds to "cushion" the difference between the total of cancelled WIC vouchers and the actual federal appropriation to the state for the WIC program. In Virginia, $100,000 has been set aside for this purpose. However, it is the Task Force's belief that this amount is insufficient to cover the difference and therefore recommends that an additional $400,000 be appropriated to provide a "cushion" for WIC expenditures.

23. The Task Force recommends that the Aid to Families with Dependent Children (AFDC) payment level be increased to 50 percent of the federal poverty level.

24. The Task Force recommends that the Department of Social Services establish an AFDC unemployed parent program.

Discussion

The aid to families with dependent children program is administered by the Department of Social Services. The current payment levels for aid to families with dependent children, as established by the Board of Social Services, are calculated on one hundred percent of the cost of living in Virginia based on the cost of housing across the Commonwealth. The Commonwealth pays ninety percent of this cost. The Board is contemplating revising the standards of need to increase the payment level to fifty percent of the federal poverty level. It is envisioned that there would be four payment groups based on various socioeconomic indicators such as the cost of housing, clothing and food. The increase in payment levels would enable poor families to secure needed medical care and other essentials necessary for survival. In the case of such families with high-risk pregant women and infants, the increased ability to obtain maternal and infant care is directly related to the reduction in infant mortality rates. The Task Force endorses the Board of Social Services' position on revising the standards of need and recommends that the payment levels for aid to families with dependent children be increased.

"The AFDC-UP program is an option under AFDC that allows states to extend eligibility for AFDC to families with children who (1) have two, able-bodied parents in the house, and (2) have the primary wage earner unemployed for at least 30 days. This option would make such families eligible for Medicaid coverage, thus removing the current bias against providing health care for poor, two-parent families."[21]

25. The Task Force recommends that a study be conducted to determine the feasibility of establishing a special indigent care program to fund health care for indigent mothers and infants.

Discussion

"State governments have long been concerned about the need to finance and deliver necessary health services to persons without resources to pay for care. States have been forced to make very difficult policy choices because the cost of medical care has constantly increased at a rate exceeding that of the increase in state revenues. States are reassessing their indigent care programs because of the convergence of a number of forces: cutbacks in federal and state programs, cost containment initiatives and the increasing financial difficulty of health care institutions serving large indigent populations. These forces have decreased the number of persons eligible for Medicaid, the major source of funding for medical services for the poor, and these forces have induced price competition among providers, reducing their ability to cross-subsidize health services for the poor. The recent economic recession and higher rates of unemployment have left greater numbers of people without health insurance coverage. Also, as a result of employers' efforts to contain their own burgeoning health costs, more people may be underinsured and at a risk of greater medical expenses. In addition, a number of court decisions have enforced the principle that state and local governments have a legal responsibility to provide medical services to the indigent.

In response to heightened awareness of the indigent care issue, a number of states have established special deliberative bodies to identify the scope of the problem, issue findings and recommendations and suggest state policy in this area."[22] Some others have responded by establishing mechanisms to fund indigent health care.

The Task Force is aware that the 1985 General Assembly authorized a study of indigent health care. However, the Joint Subcommittee Studying Indigent Care has not considered the arrangement for funding indigent health care that is being recommended for investigation here. Therefore, it is unlikely that the Joint Subcommittee Studying Indigent Care will make such a recommendation. In view of this fact, the Task Force believes that it is imperative that state policy be developed to address the health needs of indigent Virginians.

26. The Task Force recommends that the 21-day limitation under Medicaid be eliminated.

Discussion

Presently, the Virginia Medicaid Program does not reimburse for more than twenty-one days of acute care per episode. However, there are some maternal situations in which the mother may have to be hospitalized for more than twenty-one days to prevent a preterm birth. In addition, there are instances in which high-risk infants and children (e.g. premature, low birthweight) may have to be hospitalized beyond the current authorized stay. In many instances, the care provided in these situations may be the critical determinant of the health and life or death of the mother and child. The elimination of the twenty-one day limit is necessary to assure that the health needs of this population are met and needless complicating conditions and death are avoided.

27. It is recommended that business and industry in the Commonwealth examine their employee benefits to assure that policies are not discriminatory in regard to pregnant women.

Discussion

The involvement of the private business sector is crucial to the solution to the problem of infant mortality. "Because preventive care has such widespread fiscal implications and because a corporation's strength and economic security is dependent upon a strong, healthy and secure community," [23] business and industry in Virginia are encouraged to examine company policies to assure that they are neither punitive nor discrimnatory in regard to women of childbearing age.

Education of employees concerning the effect of health and lifestyle habits on their lives and the future of their families can contribute to reduced costs in medical care and insurance to the company and minimize loss of productive work hours due to excessive employee absences.

28. It is recommended that the State Health Department compile and disseminate data on the cost benefits of preventive maternal and pediatric care and make such data available to the Governor, the General Assembly and other elected state officials.

Discussion

The Task Force was informed that data substantiating the cost effectiveness of preventive maternal and pediatric health care has been ascertained by the State Health Department, but it has not been assembled for ready use or distribution. Compilation of the data would enable health care providers, legislators, health planners and other officials to gauge the effectiveness of programs and services and to determine which should be phased out, revised, augmented or continued. Given economic realities, it is prudent and fiscally responsible to evaluate and assess the progress obtained in preventing and remediating maternal and pediatric health problems.

29. It is recommended that the State Health Department provide timely health statistics to local public health departments and other states. It is recommended further that contiguous states be requested to promptly release health statistics.

Discussion

The State Health Department, among its many duties, is responsible for maintaining the vital records and health statistics of the Commonwealth. In this capacity, the Department also cooperates with other states and the federal government in the compilation, analysis and exchange of such data for national statistical and planning purposes. The Department then disseminates this information to local health departments. The Commonwealth also has reciprocity agreements with contiguous states for the exchange of health statistics, particularly data on the live births, abortions, deaths, etc., of Virginians which occur in these states. These figures are incorporated into the Department's records for such events to obtain as accurate totals as possible. The comparative data on infant deaths, teenage pregnancies and other related matters are essential to effective health planning and decision making.

There is an urgent need to address the problems of infant mortality, teenage pregnancies and other maternal and infant health issues relative to pregnancy outcomes. Though the timely compilation and release of such data is an integral part in estimating the severity of the problems and in developing appropriate interventions, currently, the data received may be too old to provide valid information. The State Health Department is requested to compile and disseminate data on infant mortality, teenage pregnancy and related matters in a timely manner. Likewise, it is recommended that legislative action be taken to request contiguous states to reciprocate.

30. It is recommended that local coalitions to address the need for providing optimal maternal and infant health care be established.

Discussion

During the course of the Task Force's study and its public hearings across the Commonwealth, it became apparent that the problems of infant mortality and teenage pregnancy are severe, and that social, cultural and economic factors which contribute to these problems are pervasive, though they are not prevalent to the same degree throughout the Commonwealth. Consequently, the intensity of the problems varies from region to region. For example, the factors which appear to most influence the high infant mortality rate in the more rural, less populated areas of the Commonwealth are poverty, inadequate supply of health care providers and specialists in obstetrics and pediatrics, lack of health facilities that provide neonatal intensive care, inadequate staffing of local health departments, lack of access to health care and the environment. In the urban areas of the Commonwealth, the problems appear to be exacerbated by poverty, lack of access to health care, inadequately staffed local health departments, reluctance of private health care providers and facilities to treat indigent and Medicaid patients, and teenage pregnancy. Consistent throughout the Commonwealth is a lack of knowledge on the part of citizens of the need for and the appreciation of family planning and prenatal care. Few citizens realize the health consequences for both mother and child when there is insufficient spacing of births and the determinants which increase the risk of birth defects, infant mortality and childhood morbidity.

Recognizing that there are problems and needs unique to localities throughout Virginia, the Task Force recommends the establishment of local coalitions to address the problem of infant mortality and to provide optimal maternal and child health care. It is strongly urged that local

coalitions include representation from all socioeconomic stratas of the community, civic, professional and educational associations, business and industry, parents, the clergy and lay religious community, public and private schools, youth, health care providers and elected officials. It is believed that local coalitions in which the community is encouraged to participate are more likely, through compromise, to develop solutions specifically designed to meet the community's needs, while reflective of its interests, standards and values.

31. The Task Force recommends that the Better Beginnings for Virginia's Children Program be continued.

Discussion

Begun in 1982, the Better Beginnings for Virginia's Children Program is Virginia's response to the chronic problems and needs of children. Because of the many intricate factors which influence the healthy development of children, the program has focused on adolescent pregnancy during its first phase. Initially funded by a $65,550 grant from the State Health Department's Bureau of Maternal and Child Health, as well as monetary and in-kind contributions and subsidized components of the program by the Department of Corrections, the program is coordinated and implemented at the local level. Since its implementation, there have been established thirty-seven local coalitions. The program has been successful in promoting interagency cooperation and in encouraging local coalitions to learn more about the problem and to develop effective community solutions. Therefore, it is recommended that funds be appropriated for the continuation of this program.

32. The Task Force recommends that funds be appropriated for the Resource Mothers Program.

Discussion

The Resource Mothers Program is the outcome of the Virginia Task Force on Infant Mortality, which is chaired by Mrs. Lynda J. Robb. The program, based on the model in South Carolina, recruits, trains and supervises women to serve as resource mothers for pregnant teenagers who have limited support systems. Resource Mothers provide basic health advice, help teenagers cope with their problems and follow their clients through the duration of pregnancy. The programs are operative in Richmond, Norfolk and Newport News and six Southwest localities. The limited experience of these programs suggests the potential for improved health and competence of adolescent mothers and their children. (Appendix E)

CONCLUSION

The staggering rate of infant mortality in Virginia is a reproach to the Commonwealth's tradition of excellence. Many of the causes of infant mortality are preventable, but the problem is multifaceted and not amenable to small, stop-gap solutions. Remediation of the problem must be comprehensive and requires the deliberate effort of federal, state and local government. Most important to the resolution of the problem is the interest and support of all Virginians. The future of Virginia is not only dependent upon economic progress and educational achievements; it is also dependent upon the healthy development of its children. Any expenditure to eradicate the causes of infant mortality and childhood morbidity will be less costly than treating birth defects and attempting to rehabilitate the lives of those who are among the population most at risk.

The Task Force appreciates the contributions of all persons who provided assistance throughout the course of its study.

Respectfully submitted,

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FOOTNOTES

[1] Priscilla A. Guild, "Infant Mortality and Teenage Pregnancy Profile of Children in the South," Research Report 12, 1980 Commission on the Future of the South, 1980.

[2] "Infant Mortality Briefing Paper," 1985 and Fact Sheet, "Virginia Vital Statistics Data Related to Maternal and Infant Health," 1983.

[3] "1984 Virginia Vital Statistics Annual Report," p. 23.

[4] Infant Mortality Rates: Failure to Close the Black-White Gap, Hearing Before the Subcommittee on Oversight and Investigations and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, 98th Congress, 2nd Session, March 16, 1984.

[5] Prevention Strategies for Healthy Babies and Healthy Children, Hearing Before the Select Committee on Children, Youth, and Families, U.S. House of Representatives, 98th Congress, 1st Session, June 30, 1983, pp. 224-242.

[6] Infant Mortality: A Report Prepared by the Congressional Research Service for the use of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, U.S. House of Representatives, March, 1984.

[7] Committee to Study the Prevention of Low Birthweight, Preventing Low Birthweight, Division of Health Promotion and Disease Prevention, Institute of Medicine, Washington, D.C.: National Academy Press, 1985, p. 67.

[8] "Facts About Pregnancy and Smoking," Pamphlet, U.S. Department of Health and Human Services, 1984.

[9] Preventing Low Birthweight, p. 68.

[10] Prevention Strategies for Healthy Babies and Healthy Children, p. 176.

[11] Ibid., pp. 180-182.

[12] Infant Mortality, pp. 4-8.

[13] Douglas Kirby, School-Based Health Clinics: An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy, Washington, D.C.: Center for Population Options, 1985, p. 3.

[14] Ibid., p. 4.

[15] "Preventing Children Having Children," Washington, D.C.: Children's Defense Fund, 1985.

[16] "Adolescent Pregnancy and Childbearing: Growing Concerns for Americans," undated.

[17] Andre Watson and Debra W. Haffner, Implementing a Young Man's Sexuality Education Program: A How to Guide, Washington, D.C.: Planned Parenthood of Metropolitan Washington.

[18] "Teen Father Collaboration: A Pioneering Research and Demonstration Project," 1985.

[19] Bureau of Maternal and Child Health, State Health Department, January 3, 1986.

[20] Southern Regional Task Force on Infant Mortality, For the Children of Tomorrow, November, 1985, p. 16.

[21] Ibid., p. 22.

[22] John Luehrs and Randy Desonia, A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent, Washington, D.C.: George Washington

University Intergovernmental Health Policy Project, 1984, p. 1.

[23] For the Children of Tomorrow, p. 28.

APPENDICES

A. Legislation

B. The Effect of the Task Force's Work

C. Conditions Detected by Prenatal Care

Clinical Features of Fetal Alcohol Syndrome: Table of Abnormalities

D. Resource Mothers Program

APPENDIX A

LD2084134

SENATE BILL NO. 205

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health on

January 30, 1986)

(Patron Prior to Substitute–Senator Scott)

A BILL to amend and reenact § 32.1-127 of the Code of Virginia, relating to licensure of hospitals.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127. Regulations.–A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety and to the provisions of Article 2 (§ 32.1-138 et seq.) of this chapter.

B. Such regulations shall include minimum standards for (i) the construction and maintenance of hospitals and nursing homes to assure the environmental protection and the life safety of its patients and employees and the public; (ii) the operation, staffing and equipping of hospitals and nursing homes; (iii) training of nursing home staff; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence.

C. Such regulations shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each licensed hospital which operates or holds itself out as operating an emergency room.

D. In its regulations, the Board may classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity.

E. Further, such regulations shall also require that each licensed hospital establish an organ procurement for transplant protocol which encourages organ and tissue donation.

F. Such regulations shall require that each licensed hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor.

LD1213134

SENATE BILL NO. 288

Offered January 21, 1986

A BILL to amend and reenact § 32.1-69.1 of the Code of Virginia, relating to reporting of

hospital data to the Congenital Anomalies Reporting and Education System.

Patrons–Scott, Holland, C. A., and Holland, E. M.; Delegates: Maxwell, Cohen, and Marshall

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Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-69.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-69.1. Virginia Congenital Anomalies Reporting and Education System.–A. In order to collect data to evaluate the possible causes of birth defects, improve the diagnosis and treatment of birth defects and establish a mechanism for informing the parents of children identified as having birth defects and their physicians about the health resources available to aid such children, the Commissioner shall establish and maintain a Virginia Congenital Anomalies Reporting and Education System using data from birth certificates filed with the State Registrar of Vital Records *and data obtained from hospital medical records* . *The chief administrative officer of every hospital, as defined in § 32.1-123, shall make or cause to be made a report to the Commissioner of any person under two years of age diagnosed as having a congenital anomaly.* The Commissioner may appoint an advisory committee to assist in the design and implementation of this reporting and education system with representation from relevant groups including, but not limited to, physicians, geneticists, personnel of appropriate state agencies, handicapped persons and the parents of handicapped children.

B. With the assistance of the advisory committee, the Board shall promulgate such rules and regulations as may be necessary to implement this reporting and education system. These rules and regulations may include determinations of specific genetic disorders to be monitored, the scope of the information to be collected, appropriate mechanisms for follow-up, relationships between the reporting and education system and other agencies and mechanisms for review and evaluation of the activities of the system. The reporting and education system may collect the name, address, sex, race, and any other information, determined to be pertinent by the Board, regarding persons reported to have birth defects.

LD1214134

SENATE BILL NO. 289

Offered January 21, 1986

A BILL to amend the Code of Virginia by adding in Title 2.1 a chapter numbered 10.3, consisting of sections numbered 2.1-116.15 through 2.1-116.19, creating the Statewide Council on Maternal and Child Health.

Patrons–Scott and Holland, E. M.; Delegates: Maxwell, Cohen, and Marshall

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Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 2.1 a chapter numbered 10.3, consisting of sections numbered 2.1-116.15 through 2.1-116.19 as follows:

CHAPTER 10.3.

STATEWIDE COUNCIL ON MATERNAL AND CHILD HEALTH.

§ 2.1-116.15. Statewide Council on Maternal and Child Health created.–There is hereby created the Statewide Council on Maternal and Child Health for the purpose of improving Virginia's infant mortality rate and improving the availability of medical services to children and pregnant women.

§ 2.1-116.16. Membership.–The Council shall be chaired by the Governor and shall be composed of twenty-three members as follows: the Lieutenant Governor, the President Pro Tempore of the Senate, the Speaker of the House of Delegates, the majority leader of the Senate, the majority leader of the House of Delegates, the minority leader of the Senate, the minority leader of the House of Delegates, the chairman of the Senate Committee on Finance, the chairman of the House Committee on Appropriations, the chairman of the House Committee on Finance, the chairman of the Senate Committee on Education and Health, the chairman of the House Committee on Health, Welfare and Institutions, the Secretary of Finance, the Secretary of Human Resources, the Commissioner of the Department of Health, the Commissioner of the Department of Mental Health and Mental Retardation, the Commissioner of the Department of Social Services, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Director of the Department for Children and two citizen members to be appointed by the Governor.

§ 2.1-116.17. Meetings; duties and responsibilities.–The Council shall meet twice in every fiscal year to review plans and programs, including, but not limited to, budget requests and expenditures focused on improving the outcomes of pregnancies and reducing infant mortality. The Council shall receive such reports on the progress in reducing infant mortality in the Commonwealth and make such recommendations on the implementation and revision of such programs or new directions for such activities as it deems appropriate. All state agencies shall cooperate in developing and implementing any requested programs and plans, developing and presenting any requested data or reports and in implementing any new directions for the purpose of improving the outcomes of pregnancies and reducing infant mortality.

§ 2.1-116.18. Duty to oversee state programs.–The Council shall oversee all state programs which affect the outcomes of pregnancies and have the potential to reduce infant mortality including, but not limited to, the following activities:

1. Establishing health clinics caring for adolescents;

2. Expanding family planning services and the coordination of such services with other systems of routine public and private health care;

3. Determining the adequacy of regional perinatal health care and methods for more effectively structuring a system of regionalized perinatal health care;

4. Determining the adequacy of transportation services for high-risk women and children to perinatal health centers;

5. Developing of a case-management system for all intermediate risk and high-risk women and children seen in the public or private health care systems;

6. Determining the need for mobile health care units, particularly in rural areas;

7. Developing a primary care system for following all children discharged from a health care facility;

8. Assuring that hospitals do not turn away any woman in labor without assuring that such woman will receive immediate care from another institution;

9. Developing special education campaigns targeted at men as well as women to improve the understanding and appreciation of the role they play in preventive maternal and infant health care;

10. Establishing a Healthy Mothers, Healthy Babies Coalition to coordinate public awareness by providing ongoing education to the general public;

11. Developing and implementing expanded health education curricula in the public schools to promote adequate family life, life skills and self-esteem;

12. Developing of an expanded program of genetic screening and counseling as a part of routine maternity care;

13. Evaluating environmental hazards on maternal and infant health and the remediating of these hazards where possible;

14. Studying professional liablity for maternal health care providers to ascertain any disincentives to practitioners electing to pursue specialties in this area;

15. Continuing to examine Medicaid reimbursement rates to ascertain any disincentive for practitioners accepting Medicaid patients;

16. Developing ways to make better use of state maternal and child health personnel in providing care for pregnant women and infants;

17. Developing a timely and comprehensive method of collecting the necessary data to plan effectively and properly for future perinatal health care needs;

18. Developing a training incentive program for nutritionists so that an increased number of qualified nutrition experts will enter and remain in the public health system;

19. Establishing a Virginia Maternal and Infant Health Clearinghouse to consist of information gathered from the public and private sectors on available services in order to avoid duplication of efforts;

20. Evaluating AFDC Standards of Need to assure that such Standards are realistic and humane;

21. Seeking the assistance of the private sector in solving the problem of infant mortality in Virginia; and

22. Developing such other programs, plans or activities as it deems relevant and necessary in order to reduce the rate of infant mortality in Virginia.

§ 2.1-116.19. Assistance.–The Council shall seek the expert advice of representatives of state medical, allied health, nursing and health industry organizations as appropriate.

LD1212134

SENATE BILL NO. 290

Offered January 21, 1986

A BILL to amend and reenact § 32.1-325 of the Code of Virginia, relating to medical assistance plans.

Patrons—Scott and Holland, E. M.; Delegates: Maxwell, Cohen, and Marshall

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Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.—A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

(1) A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services;

(2) A provision for determining eligibility for benefits which disregards any transfer of assets into an irrevocable trust where such transfer has been designated solely for burial of the transferor or his spouse. The amount transferred into the irrevocable trust together with the face value of life insurance and any other irrevocable funeral arrangements shall not exceed $1,500; and

(3) A requirement that, in determining eligibility, a home shall be disregarded. A home means the house and lot used as the principal residence and all contiguous property as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

(4) A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission.

In preparing the plan, the Board shall work cooperatively with the State Board of Health to ensure that quality patient care is provided. The Board may make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

B. The Director of Medical Assistance Services is authorized to administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations.

C. The Director of Medical Assistance Services is authorized to enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new contract.

When the services provided for by such plan are services which a clinical psychologist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan.

D. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

LD4083134

SENATE JOINT RESOLUTION NO. 35

Offered January 20, 1986

Establishing a joint subcommittee to study malpractice insurance for certain primary care providers of obstetric and pediatric care.

Patrons--Scott and Holland, E. M.; Delegates: Maxwell, Marshall, and Cohen

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Referred to Committee on Rules

WHEREAS, the Intergovernmental Health Policy Project states in its report, A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent, that "during the mid-1970s, concerted action by many states was given to the malpractice insurance crisis due, in part, to the astronomical increases in malpractice insurance rates and the abandonment of this segment of the insurance market by several key insurers"; and

WHEREAS, once virtually nonexistent, malpractice claims have risen because of the increase in the population and medical personnel, the expense and complexity of medical care, high insurance premiums, and the population's unwillingness to accept a poor outcome; and

WHEREAS, these factors present significant problems for obstetricians, gynecologists and pediatricians and associated specialists; and

WHEREAS, these specialists provide medical care to high-risk women and children and it has been determined that such patients are more likely to have a poor health outcome, increasing the specialists' risk for malpractice claims; and

WHEREAS, the increasing insurance premiums and "the pervasive atmosphere of fear of malpractice claims" are evidenced in the number of such physicians leaving practice and the increasing tendency of these physicians to refuse to care for indigent and high-risk women; and

WHEREAS, these physicians also must contend with a lengthy statute of limitations period for minors, the special tolling provision for minors assuming injury at birth; and

WHEREAS, an adequate supply of these physicians is essential to the delivery of highly specialized and sophisticated medical care required in high-risk pregnancies and in perinatal and

neonatal care; and

WHEREAS, the availability and access to this specialized care is crucial to the reduction of the high rate of infant mortality; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study the feasibility of estabishing a pool for malpractice insurance for obstetricians, neonatalogists and perinatalogists licensed to practice in the Commonwealth who have a significant indigent or Medicaid patient practice.

The joint subcommittee shall consist of eleven members as follows: two members of the Senate Committee on Education and Health, one member each of the Senate Committees on Finance, on Commerce and Labor, and on Courts of Justice, to be appointed by the Senate Committee on Privileges and Elections, and three members of the House Committee on Health, Welfare and Institutions, one member each of the House Committees on Appropriations, on Corporations, Insurance and Banking and on Courts of Justice, to be appointed by the Speaker of the House. The joint subcommittee shall also determine appropriate alternatives to the pool concept that would address the concerns of these physicians and assure the availability and access to such medical care.

The joint subcommittee shall submit its recommendations to the 1987 Session of the General Assembly.

The direct and indirect costs of this study are estimated to be $18,570.

LD4086134

SENATE JOINT RESOLUTION NO. 38

Offered January 20, 1986

Requesting the Senate Committees on Education and Health and on Finance and the House Committees on Health, Welfare and Institutions and on Appropriations to study the feasiblity of establishing a special indigent health care program for indigent mothers and children.

Patrons--Scott and Holland, E. M.; Delegates: Maxwell, Marshall, and Cohen

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Referred to Committee on Rules

WHEREAS, "state governments have long been concerned about the need to finance and deliver necessary health services to indigent persons," and

WHEREAS, "states have been forced to make very difficult policy decisions because of the increasing cost of medical care, shortages in state revenues, federal cutbacks and the increasing financial difficulty of health care institutions serving large indigent populations," and

WHEREAS, many indigent Virginians may be uninsured, underinsured or are not eligible for Medicaid and would likely be unable to afford necessary medical care; and

WHEREAS, the Legislative Task Force on Infant Mortality concluded that a number of

indigent mothers in Virginia are more prone to have a poor pregnancy outcome; and

WHEREAS, a study of indigent health care issues was conducted by the Joint Subcommittee Studying Indigent Health Care during the 1985 interim, but it did not consider the concept of a special indigent health care program to fund the necessary medical care for indigent mothers and children; and

WHEREAS, it has been suggested that a special program to fund the health care of these mothers and children could assist in reducing the rate of infant mortality and uncompensated hospital costs for indigent patients; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study the feasibililty of establishing a special indigent health care program to fund the necessary medical care of indigent mothers and children.

The joint subcommittee shall be composed of six members, two members each from the Senate Committees on Education and Health and on Finance to be appointed by the Senate Committee on Privileges and Elections, and one member each of the House Committees on Health, Welfare and Institutions and on Appropriations to be appointed by the Speaker of the House of Delegates.

In studying the feasibility of such a program, the joint subcommittee is requested to consider appropriate eligibility criteria and funding alternatives.

The joint subcommittee shall submit its recommendations to the 1987 Session of the General Assembly.

The direct and indirect costs of this study are estimated to be $14,970.

LD2185134

SENATE JOINT RESOLUTION NO. 39

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Rules on

February 10, 1986)

(Patron Prior to Substitute--Senator Scott)

Relating to infant mortality.

WHEREAS, in 1982, Virginia ranked forty-third in state infant mortality rates in the nation with a rate of 12.9 per 1,000 births, higher than the rate for the nation and some third-world countries; and

WHEREAS, although the State Department of Health has been directed by the General Assembly in the 1984-1986 biennium budget to make "programs which improve pregnancy outcome ... a high priority," there still appears to be a need to aggressively seek solutions to this problem; and

WHEREAS, the Legislative Task Force on Infant Mortality through its study during the 1985 interim found the following:

1. A one year study conducted by a local health department in one area of the Commonwealth, revealed that seventeen percent of the women who scheduled an appointment to

obtain contraception during that year became pregnant before their appointment; and

2. Delays in scheduling an appointment with local health departments is also a problem in other areas of the Commonwealth, some women having to wait as long as six weeks; and

3. There is a need to compile and disseminate data on infant mortality, teenage pregnancies and other data related to pregnancy outcomes in a timely manner; and

4. Economic constraints and federal cutbacks necessitate the immediate purging of nearly 4,000 needy women and children in Virginia from the WIC program, the Special Supplemental Food Program for Women, Infants and Children; and

5. The Center for Disease Control's Nutrition Surveillance Program is structured to provide states with an analysis of certain data regarding the state's population to determine that portion with the highest nutritional risk. This analysis would assist the Commonwealth in dropping from the WIC program only those Virginians who are nutritionally least at risk; and

6. The establishment of the case management system for all obstetric patients served by local health departments would provide a coordinated system for the delivery of health and social services and assure continuity of care for such patients throughout their pregnancy, delivery and postpartum period; and

7. The case management system would provide: interagency communication and coordination with community organizations for the delivery of needed services, coordination between the clinic and hospitals for the delivery of indigent and Medicaid patients, a primary care system to facilitate maternal and infant follow-up care, and a maternal transport system for indigent obstetric patients, who are ineligible for Medicaid, to receive prenatal care and for delivery; and

8. Apnea monitors have been proven effective in monitoring and saving the lives of high-risk infants, such as those with certain pulmonary diseases and neurological disorders in which the respiratory system is affected, now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services is encouraged to provide funding for apnea monitors in order that these life-savng monitors may be available for indigent and Medicaid eligible persons. The Department is requested to utilize its customary procedure in facilitating the purchase, rental or contracting of apnea monitors for access Statewide; and, be it

RESOLVED FURTHER, That the State Department of Health is hereby requested to:

1. Study the personnel needs in those areas of the Commonwealth having the highest incidences of low birth weight and infant mortality to determine the minimally optimal staffing requirements of local health departments and to develop a plan for the effective utilization of its full-time and part-time personnel to provide outreach services and the adequate delivery of family planning and prenatal, perinatal and neonatal medical services to the citizens of these areas;

2. Establish the case management system for all obstetric patients served by local health departments;

3. Initiate the necessary process by which the Commonwealth of Virginia may participate fully in the Center for Disease Control's Nutrition Surveillance Program;

4. Compile and disseminate data on infant mortality, teenage pregnancies and other matters related to pregnancy outcomes in a timely manner; and, be it

RESOLVED FURTHER, That the Clerk of the Senate shall prepare and send a suitable copy of this resolution to the Governors of the States of Tennessee, North Carolina, Maryland and West Virginia, the Commonwealth of Kentucky and the Mayor of the District of Columbia that they may be apprised of the sense of this body that such states reciprocate in the compilation and dissemination of timely data on infant mortality, teenage pregnancies and related pregnancy outcomes; and, be it

RESOLVED FINALLY, That the Departments of Medical Assistance Services and Health submit their findings and proposals for the implementation of the interventive strategies recommended to each Department to the Governor and the 1987 Session of the General Assembly.

LD4085134

SENATE JOINT RESOLUTION NO. 76

Senate Amendments in [ ] - February 12, 1986

Requesting the [~~Senate Committee on Education and Health and the House Committees on Education and on Health, Welfare and Institutions~~ Secretary of Human Resources] to study the health needs of school-age children.

Patrons--Scott and Holland, E. M.; Delegates: Maxwell, Cohen, and Marshall

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Referred to Committee on Rules

WHEREAS, there are 1,248,574 children and adolescents five to nineteen years of age in Virginia, constituting twenty-two percent of the State's population; and

WHEREAS, the Legislative Task Force on Infant Mortality found that health services to school-age children are provided by a wide variety of professionals and paraprofessionals in both public and private settings; and

WHEREAS, these services vary in range, scope and quality across the Commonwealth and often, the access to, and the availability, utilization and effectiveness of health services are limited; and

WHEREAS, testimony to the Legislative Task Force on Infant Mortality revealed the following facts:

1. Of Virginia's 1,248,574 children and adolescents five to nineteen years of age, nearly fifteen percent have a chronic health impairment limiting their school attendance and performance.

2. It is estimated that thirty-five percent of males and twenty percent of females under sixteen are sexually active and in 1983, there were 20,220 pregnancies in women under nineteen, with sixty-four percent in white and thirty-six percent in nonwhite women.

3. In 1983, twenty-nine percent of all abortions in the Commonwealth were to school-age women, forty-one percent of school-age pregnant women did not receive adequate prenatal care and eighty percent of pregnant teenagers dropped out of school.

4. In 1984, twenty-seven percent of reported cases of gonorrhea were in school-age children and there were 345 cases in children under fourteen.

5. In 1984, fifty-six percent of 12,072 reports of abuse and neglect were in school-age children and ninety-seven percent of missing children in Virginia are runaways.

6. Approximately five percent of children drop out from high school every year in the Commonwealth, averaging 17,000 dropouts a year for the last four years.

7. It is estimated that seventy-two percent of high school seniors have used alcohol, thirty-five percent have smoked cigarettes within a thirty-day period, five and one-half percent use alcohol on a daily basis, twenty percent use cigarettes daily, five percent use marijuana on a daily basis, ten percent of school-age children are obese and the rates of bulemia and anorexia nervosa are increasing.

8. Approximately fourteen percent of children six to eleven years and seven percent of children twelve to seventeen years have never received dental care and fifty percent are in need of dental care.

9. Less than thirty percent of children are covered by health insurance for physician services and only ten percent of physician visits by school age-children are for preventive health care; and

WHEREAS, children and adolescents require comprehensive health care including mental health, dental, nutrition, special education and rehabilitation services; and

WHEREAS, there is a need to determine whether the current system of school health services promotes and maintains the health of children, whether it provides for the early identification of high risk children and adolescents, and whether there is a need for a coordinated, comprehensive school health service system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the [~~Senate Committee on Education and Health and the House Committees on Education and on Health, Welfare and Institutions are requested to establish a joint subcommittee to study the health needs of school-age children.~~

~~The joint subcommittee shall be composed of seven members, three members of the Senate Committee on Education and Health to be appointed by the Senate Committee on Privileges and Elections, and two members each of the House Committee on Education and the House Committee on Health, Welfare and Institutions to be appointed by the Speaker of the House. The Commissioners of the Departments of Health, Mental Health and Mental Retardation, and Social Services, the Directors of the Department of Medical Assistance Services and the Department for Children and the Superintendent of Public Education shall serve as ex officio members.~~

~~The joint subcommittee is also~~ Secretary of Human Resources is requested to study the health needs of school-age children.

The study is] requested to determine the status, quality and effectiveness of the current school health service system to identify gaps in the delivery of services and to determine the feasibility of establishing a statewide coordinated, comprehensive school health service system. All agencies of the Commonwealth shall assist the joint subcommittee as it deems appropriate, upon request.

The [~~joint subcommittee shall submit its~~ Secretary shall submit her] findings and recommendations to the 1987 Session of the General Assembly.

[~~The direct and indirect costs of this study are estimated to be $15,690.~~]

APPENDIX B

COMMONWEALTH *of* VIRGINIA

Office of the Governor
Richmond 23219

Gerald L. Baliles
Governor

February 14, 1986

The Honorable Richard W. Riley
Governor
P. O. Box 11450
Columbia, South Carolina 29211

Dear Governor Riley:

It is my pleasure to enclose a status report on Virginia's response to the recommendations set forth in the Final Report of the Southern Regional Task Force on Infant Mortality.

Many of the report's proposals are already under consideration in Virginia's General Assembly. Many others will become part of a comprehensive plan which I have asked my Secretary of Human Resources, Eva Teig, to develop in conjunction with Virginia's Regional Task Force members.

In addition to pursuing legislative and administrative initiatives, both former Governor Robb and I highlighted Virginia's infant death problem in our State of the Commonwealth speeches last month. It is also featured as a critical issue in the "Perspectives" section of th 1986-1988 Executive Budget (copies enclosed).

I am pleased with the initiatives Virginia has generated in the two months since the final report was released. They represent my strong commitment to addressing Virginia's unacceptably high infant death rate.

Thank you for your leadership and good work. I look forward to working with you and the other Southern Governors to diminish this problem that plagues our region.

With kindest regards, I am

Sincerely,

Gerald L. Baliles

GB/mcb

Enclosure

SUMMARY OF VIRGINIA'S RESPONSES
TO RECOMMENDATIONS OF
THE SOUTHERN REGIONAL
TASK FORCE ON INFANT MORTALITY

February 14, 1986

In the three months since the Final Report of the Southern Regional Task Force on Infant Mortality was issued, the Commonwealth of Virginia has bade a fond farewell to Governor and Mrs. Charles S. Robb, and welcomed the new administration of Governor Gerald L. Baliles.

Typically, the period of transition inherent in a change of leadership can diminish the momentum of new initiatives. Fortunately, this has not been the case with Virginia's attempts to resolve its infant death problem.

Governor Baliles has endorsed the programs suggested by former Governor Robb and has enhanced Virginia's efforts to address infant mortality by proposing several additional initiatives.

This summary of Virginia's responses to the recommendations contained in the Final Report consists primarily of legislative initiatives currently under consideration in Virginia's General Assembly. After the 1986 legislative session is over, Virginia's Secretary of Human Resources will assess the status of these proposals, and develop a comprehensive plan to address the Commonwealth's infant mortality problem.

For the convenience of any reader who is reviewing this document in conjunction with the Task Force's Final Report, this document follows the format of that report.

I. Service Delivery

A. A bill to create a Statewide Council on Maternal and Child Health to oversee all state programs which affect the outcomes of pregnancies and have the potential to reduce infant mortality. To be chaired by the Governor with key legislators, agency heads, providers and consumers as members. (SB 289 - Scott)

B. A budget item continuing the "Resource Mothers" projects where women from high risk communities are trained to go back into the community to identify and assist pregnant teenagers who need medical help and social support. (Governor's Budget)

C. A bill requiring each licensed hospital that provides obstetrical services to establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor. (SB 205 - Scott)

D. A budget item continuing the "Better Beginings Program" which provides funds to local prevention coalitions who sponsor outreach activities dealing with teenage pregnancy, infant mortality and other related issues. (Item 401 - Governor's Budget; Scott; Maxwell)

E. A bill restricting professional liability for physicians rendering free obstetrical care unless the act or omission was the result of gross negligence or willful misconduct. (HB 851 - Cranwell)

F. A resolution to study the feasability of establishing a pool for malpractice issurance for obstetricians, neonatologists and perinatologists licensed in Virginia who have a significant indigent or Medicaid practice. (SJR 35 - Scott)

G. A budget item to increase Medicaid reimbursement rates to obstetricians. (Item 398 - Governor Baliles)

H. A bill and budget item to expand the time period for which congenital anomalies are to be reported to the Virginia Congenital Anomalies Reporting and Education System (CARES), to include any person under two years of age. (SB 288 - Scott; Item 388 - Scott; Maxwell)

I. A resolution requesting the Virginia Department of Health to compile and disseminate in a timely manner, data on infant mortality, teenage pregnancies and other matters related to pregnancy outcomes. (SJR 75 - Scott)

J. A budget item to fund a perinatal death review study to gather information that can be used in program planning. (Governor's Budget)

K. A budget item creating the Infant Mortality Prevention Action (IMPACT) Program to fund innovative local programs aimed at reducing infant mortality. (Item 388 - Governor's Budget; Scott; Maxwell)

L. A bill establishing the Virginia Hearing Impairment Identification and Monitoring System to identify hearing loss and to intervene at the earliest possible age (SB 284 - Scott)

M. A resolution requesting the Department of Health to study and report on personnel needs in areas of high infant mortality, and to develop a plan for the effective utilization of personnel in providing family planning services. (SJR 39 - Scott)

O. A resolution establishing the Commission on Coordinating Preventive Health, Education and Social Programs in the Commonwealth. (SJR 36 - Scott)

II. Financing

A. A budget item to increase the ADC Standard of Need to approximately 90 percent of the federal poverty level, and to pay 55 percent of the revised standard. (Item 470 - Governor Baliles)

B. A bill and budget item permitting Medicaid patients up to the age of twenty-one to remain in acute care for medically necessary treatment in excess of twenty-one days. (SB 290 - Scott; SB 121 - Mickie; Governor's Budget)

C. A bill and budget item to establish a Health Start Program to provide comprehensive prenatal and obstetrical care to targeted low income women. (SB 206 - Scott; Item 388 - Scott)

D. A resolution to study the feasability of establishing a special indigent health care program to fund necessary medical care of indigent mothers and children. (SJR 38 - Scott)

E. A resolution establishing A Governor's Task Force on Indigent Health Care. (SJR 32 - Emick)

F. A bill to detect and control inborn errors of metabolism which lead to mental retardation. (HB 411 - Plum)

G. A resolution and budget item encouraging Medicaid to provide funding for apnea monitors so more premature or severely impaired infants can be saved. (SJR 37 - Scott; Item 388 - Maxwell)

H. A budget amendment appropriating two million state dollars to the WIC Program to prevent current participants from being cut from the program. (Item 389 - Scott; Maxwell)

I. A budget item ($8.5 million) to continue funding Perinatal Centers. (Governor's Budget)

J. A budget item increasing Family Planning Funding. (Governor's Budget)

K. A budget item increasing Medicaid fees for care of high risk infants and developing a procedure code specific for neonatal care. (Item 398 - Scott; Maxwell)

L. A bill removing the 4 percent state sales tax from WIC and Food Stamp purchases. (SB 192 - Scott; HB 765 Van Yahres)

III. Education/Awareness of State and Community Leaders

A. Both Governor Baliles and former Governor Robb highlighted Virginia's infant mortality problem in their State of the Commonwealth speeches in January, 1986.

B. Infant death is listed as a critical issue and described in detail in the "Perspectives" section of the Executive Budget 1986-1988.

C. A resolution establishing February 13, 1986 as Motherhood and Apple Pie Day in Virginia. On that day, the Virginia Perinatal Association distributes apple pie to legislators to remind them of the importance of maternal and child health issues. (SJR 78 - Scott)

IV. Research

A. A resolution requesting the Department of Health to participate in the Center for Disease Control's Nutrition Surveillance Program (SJR 34 - Scott)

B. A resolution requesting the legislature to study the health needs of school age children. (SJR 76 - Scott)

C. Three bills creating a joint legislative committee to study the problem of teenage pregnancy in Virginia, and to develop recommendations to reduce its incidence (HJR 17 - Maxwell; HJR 61 - Munford; HJR 100 - Christian)

LD1936134

SENATE BILL NO. 206

Offered January 20, 1986

A BILL to amend the Code of Virginia by adding in Chapter 3 of Title 32.1 an article numbered 2.1, consisting of sections numbered 32.1-78.1 through 32.1-78.5, to establish a Healthy Start Program.

Patrons—Scott and Holland, E. M.; Delegates: Maxwell, Cohen, and Marshall

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Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 3 of Title 32.1 an article numbered 2.1, consisting of sections numbered 32.1-78.1 through 32.1-78.5 as follows:

Article 2.1.

Healthy Start Program.

§ 32.1-78.1. Citation.—This article shall be cited as the Healthy Start Program.

§ 32.1-78.2. Creation of program by Board.—The Board shall establish the Healthy Start Program which shall make available to certain women throughout the Commonwealth, without cost, prenatal care and obstretical services. The comprehensive care services to each participant shall include medical care, case management, education, nutrition and social services.

§ 32.1-78.3. Organization and management.—The services shall be organized and managed on a regional basis. The Commissioner of Health shall designate a Regional Healthy Start Coordinator in each of the twenty-two planning districts of the Commonwealth who will be responsible for overseeing the registration, financial screening, enrollment and referral for each woman. Case management of the recipient following acceptance into the program shall be the responsibility of the appropriate local health department.

§ 32.1-78.4. Eligibility.—In order to be eligible for services through the Healthy Start Program, each participant shall:

1. Reside in the Commonwealth of Virginia;

2. Be ineligible for Medicaid;

3. Be uninsured for prenatal costs, hospital costs related to pregnancy, and delivery;

4. Be willing to receive care from an approved provider of the participant's selection; and

5. Provide evidence that the family of the participant is at or below 185 percent of the

poverty guidelines as established annually by the federal government.

§ 32.1-78.5. Funding.—Funding for the program shall be as provided in the current general biennium appropriation act which may provide for a percentage match by the counties and cities.

LD0374305

SENATE BILL NO. 284

Senate Amendments in [ ] - February 3, 1986

A BILL to amend the Code of Virginia by adding in Chapter 2 of Title 32.1 an article numbered 6.1, consisting of sections numbered 32.1-64.1 and 32.1-64.2, establishing the Virginia Hearing Impairment Identification and Monitoring System.

Patron—Scott

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 2 of Title 32.1 an article numbered 6.1, consisting of sections numbered 32.1-64.1 and 32.1-64.2, as follows:

Article 6.1.

Virginia Hearing Impairment
Identification and Monitoring System.

§ 32.1-64.1. Virginia Hearing Impairment Identification and Monitoring System.—In order to identify hearing loss at the earliest possible age and to provide early intervention for such infants, the Commissioner shall establish and maintain the Virginia Hearing Impairment Identification and Monitoring System. This system will be for the purpose of identifying and monitoring infants who are at risk for hearing impairment to assure that such infants receive appropriate early intervention through treatment, therapy, training and education.

The Virginia Hearing Impairment Identification and Monitoring System shall be implemented in two phases as follows:

1. In the 1986-1988 biennium, the system shall be initiated in all hospitals with neonatal intensive care services; and

2. In 1988, the system shall be initiated in all hospitals in the Commonwealth having newborn nurseries.

[~~The~~ *In all hospitals with neonatal intensive care services, the*] *chief medical officer of*

such hospitals or his designee shall identify infants at risk of hearing impairment using criteria established by the Board. All such infants shall then be screened for hearing loss by the chief medical officer or his designee. The chief administrative officer [or his designee] of the hospital shall report to the Commissioner all infants identified as at risk of hearing impairment and all infants who are identified through screening as having hearing loss.

[*In all other hospitals, the chief medical officer or his designee shall identify infants at risk of hearing impairment using criteria established by the Board. The chief administrative officer or his designee shall report to the Commissioner all infants identified as at risk of hearing impairment.*]

The Commissioner may appoint an advisory committee to assist in the design and implementation of this identification and monitoring system with representation from relevant groups including, but not limited to, physicians, hospital administrators and personnel of appropriate state agencies. The Department of Education and the Department of the Deaf and Hard of Hearing shall cooperate with the Commissioner and the Board in implementing this system.

With the assistance of the advisory committee, the Board shall promulgate such rules and regulations as may be necessary to implement this identification and monitoring system. These rules and regulations shall include criteria for the identification of infants at risk of hearing impairment and may include the scope of the information to be reported, reporting forms, screening protocols, appropriate mechanisms for follow-up, relationships between the identification and monitoring system and other state agency programs or activities and mechanisms for review and evaluation of the activities of the system. The identification and monitoring system may collect the name, address, sex, race, and any other information determined to be pertinent by the Board, regarding infants determined to be at risk of hearing impairment or to have hearing loss.

§ 32.1-64.2. Confidentiality of records; publication; authority of Commissioner to contact parents and physicians.–The Commissioner and all other persons to whom data is submitted pursuant to § 32.1-64.1 shall keep such information confidential. No publication of information shall be made except in the form of statistical or other studies which do not identify individuals. However, the Commissioner may contact the parents of children identified as at risk of hearing impairment or having hearing loss and their physicians to collect relevant data and to provide them with information about available public and private health care and educational resources including hearing impairment clinics.

LD4198506

SENATE JOINT RESOLUTION NO. 36

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Rules on

February 26, 1986)

(Patron Prior to Substitute–Senator Scott)

Establishing the Task Force on Coordinating Preventive Health, Education, and Social Programs in the Commonwealth.

WHEREAS, the problems of infant mortality, child abuse, elder abuse, spouse abuse, emotional and mental disorders, premature deaths from complications of smoking and diet, and substance abuse and delinquency are serious ones in the Commonwealth; and

WHEREAS, these problems are related because they are predictable consequences of modern life, including isolation, violence, and the destruction of families and other social support systems; and

WHEREAS, recent research and tested programs strongly suggest that a new method of countering these modern dangers by teaching life skills and stress management, building positive self images, changing environments, and strengthening family and other support systems, can reduce the incidence of these problems and in many cases reduce state expenditures both in the short run and long run; and

WHEREAS, many programs focused on "prevention" are currently funded, operated or supported by the Departments of Health, Mental Health and Mental Retardation, Education, Social Services, Corrections, Children, Criminal Justice Services, Aging, and others across the Commonwealth; and

WHEREAS, these programs could be of greater benefit to the citizens of the Commonwealth with better coordination, organized information exchange, combined skills and resources, and greater support from a citizenry aware of the nature and benefits of such programs; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Honorable Gerald L. Baliles, Governor of Virginia, is hereby requested to establish a Task Force on Coordinating Preventive Health, Education and Social Programs. The Task Force shall review such preventive programs and legislation of other states and inventory all of those in the Commonwealth to determine effective prevention programs in different functional areas, and recommend how best to coordinate prevention efforts and maximize the benefits to be obtained from these programs throughout the Commonwealth.

The Task Force shall consist of the Commissioners of the Departments of Health, Mental Health and Mental Retardation, and Social Services, and the Directors of the Departments of Corrections, Children, Criminal Justice Services, Aging, and Medical Assistance Services, the Superintendent of Public Instruction, and the Superintendent of Correctional Education or their respective designees.

The Task Force shall complete its work prior to November 15, 1986, and report its findings soon thereafter.

LD1890134

SENATE JOINT RESOLUTION NO. 78

Offered January 21, 1986

Designating February 13, 1986, as Motherhood and Apple Pie Day in the Commonwealth.

Patron–Scott

Referred to Committee on Rules

WHEREAS, the Virginia Perinatal Association is dedicated to the promotion of perinatal health through fostering the delivery of optimal care, education, research and the establishing of priorities within the Commonwealth; and

WHEREAS, the future generations of this great Commonwealth depend upon the health of the expectant mother; and

WHEREAS, the infant death rate in the Commonwealth has steadily declined and in 1983 reached an all time low of 11.9 infant deaths per 1,000 live births for the lowest rate to date but higher than the national objective of 9.0 per 1,000 live births by 1990 which has been adopted as the goal for the Commonwealth; and

WHEREAS, the greatest preventive impact on the health care of this future generation can be made through the provision of adequate prenatal care; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That February 13, 1986, be recognized as Motherhood and Apple Pie Day in the Commonwealth.

LD1474548

HOUSE BILL NO. 411

Offered January 20, 1986

A BILL to amend and reenact §§ 32.1-65, 32.1-66 and 32.1-67 of the Code of Virginia, relating to testing of infants for inborn errors of metabolism.

Patrons--Plum, Almand, Stambaugh, McDiarmid, Byrne, Van Yahres, Munford, Jennings, Cranwell, Marshall, Slayton, Giesen, Diamonstein, Van Landingham, Keating, and Brickley

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Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-65, 32.1-66 and 32.1-67 of the Code of Virginia are amended and reenacted as follows:

Article 7.

Detection and Control of Phenylketonuria

and Other Inborn Errors of Metabolism.

§ 32.1-65. Infants to be subjected to tests.–In order to prevent mental retardation, every infant who is born in this Commonwealth shall be subjected to a test for *biotinidase deficiency,* phenylketonuria, hypothyroidism, homocystinuria, galactosemia and Maple Syrup Urine Disease, except any infant whose parent or guardian objects thereto on the grounds that such test

conflicts with his religious practices or tenets. The physician, nurse or midwife in charge of the delivery of a baby or, if none, the first attending physician shall cause such test to be performed.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.–Whenever a test result indicates suspicion of ~~phenylketonuria~~ *biotinidase deficiency, phenylketonia, hypothyroidism, homocystinuria, galactosemia and Maple Syrup Urine Disease,* the Commissioner shall notify forthwith the attending physician and shall perform or provide for any additional testing required to confirm or disprove the diagnosis of *biotinidase deficiency,* phenylketonuria , *hypothyroidism, homocystinuria, galactosemia and Maple Syrup Urine Disease* . All physicians, public health nurses and administrators of hospitals in this Commonwealth shall report the discovery of all cases of *biotinidase deficiency* phenylketonuria , *hypothyroidism, homocystinuria, galactosemia and Maple Syrup Urine Disease* to the Commissioner.

§ 32.1-67. Duty of Board with respect to treatment.–The Board shall recommend procedures for the treatment of *biotinidase deficiency,* phenylketonuria , *hypothroidism, homocystinuria, galactosemia and Maple Syrup Urine Disease,* and shall provide such treatment for infants in medically indigent families. The Board shall provide the parents or guardian of any child, who is a legal resident of the Commonwealth and who is diagnosed as requiring treatment for phenylketonuria, the special food products required in the management of phenylketonuria. The parents or guardian of any such child shall, in the discretion of the Department, reimburse to the local health department the cost of such special food products in an amount not to exceed two percent of their gross income. The reimbursement required by this section shall be payable quarterly by the first day of January, April, July, and October.

LD4010509

HOUSE JOINT RESOLUTION NO. 17

Offered January 14, 1986

Requesting the House Committees on Education and on Health, Welfare and Institutions and the Senate Committees on Education and Health and Rehabilitation and Social Services to study the feasibility of establishing a statewide program for the prevention of teenage pregnancy.

Patrons–Maxwell, Morrison, Stieffen, Miller, Y. B., Grayson, Cranwell, and Diamonstein; Senators: Scott and Andrews, H. B.

Referred to Committee on Education

WHEREAS, teenage pregnancy is a chronic problem of national magnitude, threatening the social fabric and burdening the health care industry and financial structure of society; and

WHEREAS, 35 percent of males and 20 percent of females under age 16 in the nation are sexually active and in 1984 there were 10,444 live births, 8,687 induced abortions and 741 natural fetal deaths attributed to women age 17 and under in Virginia; and

WHEREAS, the rate of teenage pregnancy in Virginia places the Commonwealth among states with the highest rates of teenage pregnancy and infant mortality in the nation; and

WHEREAS, teenage pregnancy is one of the leading causes of infant mortality because very young mothers are more likely to have a poor pregnancy outcome, such as premature birth, preterm birth or a low birth weight baby; and

WHEREAS, teenagers who have their education interrupted by a pregnancy usually never complete their education and often become financially dependent upon public social and health programs; and

WHEREAS, there is some question as to who is financially responsible for the care of the baby; and

WHEREAS, many public agencies and community, religious and private associations have launched efforts to address this problem, but presently there is no coordinated effort statewide focused on the prevention of teenage pregnancy; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committees on Education and on Health, Welfare and Institutions and the Senate Committees on Education and Health and on Rehabilitation and Social Services are requested to establish a joint subcommittee to study the problem of teenage pregnancy in the Commonwealth and to determine the feasibility of establishing a statewide coordinated program for the prevention of teenage pregnancy.

The joint subcommittee shall consist of six members, two members each from the House Committees on Education and on Health, Welfare and Institutions to be appointed by the Speaker of the House and one member each from the Senate Committees on Education and Health and on Rehabilitation and Social Services to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall submit its findings and recommendations to the 1987 General Assembly.

The direct and indirect costs of this study are estimated to be $14,970.

LD4118530

HOUSE JOINT RESOLUTION NO. 61

House Amendments in [ ] - February 10, 1986

Requesting the House Committees on Education and on Health, Welfare and Institutions and the Senate Committees on Education and Health and on Rehabilitation and Social Services to study the problem of teenage pregnancy in the Commonwealth.

Patrons--Munford, Glasscock, Lacy, Cranwell, Van Landingham, Stambaugh, Murphy, Hargrove, Van Yahres, Cohen, Grayson, Cooper, Plum, Jennings, Keating, Dobyns, Woodrum, Robinson, W. P., Miller, Y. B., Dicks, McDiarmid, Almand, and Slayton; Senator: Michie

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Referred to Committee on Rules

WHEREAS, teenage pregnancy is a chronic problem of national magnitude, threatening the

social fabric and burdening the health care industry and financial structure of society; and

WHEREAS, one-half of the $170,728,946 expended by the Aid to Dependent Children program in Virginia during the last fiscal year went to families headed by mothers who had their first children as unmarried teenagers; and

WHEREAS, teenage pregnancy rates in the United States were determined to be seven times higher than those found in European countries with comparable rates of teenage sexual activity; and

WHEREAS, it is estimated that four out of every ten fourteen-year-old girls in the United States will become pregnant before the age of twenty; and

WHEREAS, in 1984 there were 10,444 live births, 8,687 induced abortions and 741 natural fetal deaths attributed to women age seventeen and under in Virginia; and

WHEREAS, the rate of teenage pregnancy in Virginia places the state among states with the highest rates of teenage pregnancy; and

WHEREAS, less than half the school divisions in Virginia offer programs of family life education; and

WHEREAS, teenage pregnancy is one of the leading causes of infant mortality because very young mothers are more likely to have a poor pregnancy outcome such as premature birth, preterm birth or a low birth weight baby; and

WHEREAS, Virginia's rate of infant mortality ranks among the highest in the country; and

WHEREAS, teenagers who have their education interrupted by a pregnancy usually never complete their education, frequently lack job skills and employment opportunities and often become financially dependent upon public social and health programs; and

WHEREAS, many states are studying this issue, including a new Wisconsin statute which places financial responsibility for the children of teenage parents upon the grandparents until the teenage parents reach the age of majority; and

WHEREAS, urgent steps are necessary to prevent teenage pregnancies in order to provide our young people with futures full of opportunities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committees on Education and on Health, Welfare and Institutions and the Senate Committees on Education and Health and on Rehabilitation and Social Services are requested to establish a joint subcommittee to study the problem of teenage pregnancy in the Commonwealth and to develop recommendations to reduce the incidence of teenage pregnancy through means such as, but not limited to, education, service delivery and financial responsibility.

The joint subcommittee shall consist of six members, two members each of the House Committees on Education and on Health, Welfare and Institutions to be appointed by the Speaker of the House and one member each of the Senate Committees on Education and Health and on Rehabilitation and Social Services to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall [~~submit its findings and recommendations to the 1987 Session of the General Assembly~~ complete its work prior to November 15, 1986].

The direct and indirect costs of this study are estimated to be $14,970.

LD4112434

HOUSE JOINT RESOLUTION NO. 100

Offered January 21, 1986

Creating a joint subcommittee to study possible solutions to problems with teen-age pregnancies.

Patrons–Christian, Purkey, Cunningham, J. W., Grayson, Putney, Byrne, Copeland, Andrews, R. T., Cohen, and Giesen; Senator: Andrews, H. B.

Referred to Committee on Rules

WHEREAS, an ever-increasing number of pregnancies are occuring among junior high and high school students in spite of information provided to educate young people on the social and moral advantages of abstinence from sex as well as ways for sexually active individuals to prevent pregnancy; and

WHEREAS, these teenage pregnancies constitute an abundance of problems for so many segments of our society; the education and the preparation for the lives of the parents are emasculated, the prospects of the unborn child are extremely poor, the grandparents are often made to suffer social, emotional and financial hardships, and in many cases public agencies must strain their limited budgets to provide services for the pregnant teenager and her unborn child both now and in the future, thus imposing substantial costs upon the public; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee, consisting of four members of the House Committee on Health, Welfare and Institutions appointed by the Speaker and three members from the Senate Committee on Education and Health appointed by the Senate Committee on Privileges and Elections, is created. The subcommittee shall study matters concerning the education, family planning, health care and personal options available to the pregnant student.

The subcommittee shall complete its study and report its recommendations to the General Assembly prior to November 15, 1986.

The direct and indirect costs of the study are estimated to be $18,857.

APPENDIX C

Conditions Detected By Prenatal Care

Hypertension, toxemia
Anemia - see list for many kinds
Rh negative - ± sensitization
Syphilis - with serology
Rubella - with titres
Gonorrhea - with cultures
Cervical cancer - with Pap smear
Sickle cell diseases
Obesity
Diabetes mellitus - detected with urinalysis or history, confirmed
  with appropriate blood tests
Virus diseases detected with virus screen
Heart diseases
Lung diseases - tuberculosis with Tine test
Cancer by thorough history and physical examination
Urinary tract infection (asymptomatic bacteruria)
Vaginitis (that can predispose to premature rupture of membranes)
Abnormalities of placenta - location, growth and size with ultrasound
Fetal death in utero - no movement, no fetal heart tones, ultrasound,
  x-ray, decreased measured fundal height
Thrombophlebitis
Incompetent cervix - requiring suture of cervix at appropriate time
  to prevent premature labor or abortion
Infections - acute and chronic
Ultrasound can detect fetal anomalies, inadequate amniotic fluid too

Source: Infant Mortality Rates: Failure to Close the Black-White Gap. Hearing Before the Subcommittee on Oversight and Investigations and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce. U.S. House of Representatives, 98th Congress, 2d. Session, March 16, 1984.

TABLE I.—CLINICAL FEATURES OF FAS: TABLE OF ABNORMALITIES

Growth abnormalities; Prematurity; Intrauterine growth retardation; Postnatal growth retardation, short stature, diminished weight.

Craniofacial anomalies: Microcephaly; eye abnormalities, epicanthal folds, ielecanthus, short palpebral fissures, corneal opacity, ptosis, high myopia, strabismus tortuosity of retinal vessels; flattened nasal bridge; abnormally formed ears; maxillary hypoplasia; narrow vermilion border of upper lip; small mandible; cleft palate.

Joint and limb malformations: Limitation of elbow extension; phalangeal anomalies, small nails, clinodactyly; abnormal palmar creases; dislocated hips.

Cardiac abnormalities: atrial septal defects; ventricular septal defects; tetralogy of fallot; patent ductus arteriosus; aortic arch interruption type A; peripheral pulmonic stenosis.

Renal anomalies: hydronephrosis; single kidney; hypoplastic kidneys.

Functional abnormalities; neonatal, poor suck, hypotonia, tremulousness.

Postnatal: developmental delay, mental retardation, poor gross motor coordination, poor fine motor coordination, learning disabilities, hyperactivity, decreased attention span.

Other findings: Hydrocephalus: neural tube defects; single umbilical artery; Noonan syndrome; Klippel-Feil anomaly; capillary hemangiomata; abnormal external genitalia; accessory nipples; adrenal cortical carcinoma; spastic diplegia.

Source: Prevention Strategies for Healthy Babies and Healthy Children. Hearing Before the Select Committee on Children, Youth and Families, U.S. House of Representatives, 98th Congress, 2d. Session, June 30, 1983.

APPENDIX D

Resource Mothers Program

As an outgrowth of the Southern Regional Task Force on Infant Mortality, the Virginia Task Force on Infant Mortality was established in 1985 to promote preventive strategies to reduce the incidence of infant mortality in the Commonwealth. Members of the Task Force, which is chaired by Mrs. Lynda J. Robb, are represented on the Southern Regional Task Force. To facilitate improved teenage pregnancy outcomes, the Task Force has funded Resource Mothers Programs serving nine Virginia localities. These grant awards were intended to provide seed funds to stimulate local interest and responsibility for improving infant mortality; the expectation was that upon expenditure of these funds programs would actively seek continued funding from the local community.

Based primarily on the model developed in South Carolina, the funded Resource Mothers Programs recruit, train, and supervise women to serve as "resource mothers" for pregnant teenagers having limited support systems. Serving as support persons, resource mothers help those teenagers deal with their problems, provide them basic health advice, and ensure they start prenatal care early, keep appointments, and follow through with medical recommendations. Targeted pregnant teenagers are assisted by resource mothers from their own communities and receive program services starting early in pregnancy and continuing until the infant is one year of age. Teenagers being served by a Resource Mothers Program include those who need information and other assistance in adequately meeting health care needs during pregnancy, postpartum, and the first year or parenting or those who are fearful or confused about their pregnancy.

The primary goal of the Resource Mothers Program is to promote improved coping among teenagers delivering for the first time who lack knowledgeable support persons (family or close friends) with whom to discuss their pregnancy. A supplemental preventive goal of the program is to lower the rate of teenage pregnancies in targeted communities through outreach, advice, and support.

The South Carolina Program, which began operation in 1980, has experienced dramatic success. An evaluation of the program published in 1985 revealed that the percentage of low birth weight infants for teens participating in the program was 8.6% versus 14.8% for a comparison group of non-participating teens. Similar success has also been experienced by the Louisiana Resource Mothers Program.

In July, 1985, the Virginia Task Force on Infant Mortality awarded grants of $30,000 each to Norfolk State University, Newport News Office of Human Affairs, and Richmond City Health Department to develop and implement year-long Resource Mothers Programs. Funding was provided through the Virginia Department of Health's Maternal and Child Health Services Block Grant. In October, each of these programs was awarded an additional $5,000.

The limited experience of the Richmond, Norfolk, and Newport News Resource Mothers Programs suggests the potential for improved health and competence of teen mothers and their infants. In addition to the anticipated benefits to the teens, the programs have elevated the self-esteem and capabilities of the resource

mothers. The newly acquired skills and experiences of the resource mothers should transfer well to the labor market, allowing them to be competitive in seeking future employment. A summary of the Norfolk, Newport News, and Richmond Resource Mothers Programs is included in the attached appendix (Pages 3 - 6).

In addition to the programs in Tidewater and Richmond, Resource Mothers programs have been funded serving six Southwest localities. In August, 1985, at the request of the Task Force, the Department of Health applied for a grant from the Applachian Regional Commission (ARC) to fund additional Resource Mothers Programs. In October, 1985 the Department of Health received approval of a $60,000 grant from the Department of Health and Human Services (sponsored by the ARC) to supplement the required $60,000 match provided by the Department of Health. The $120,000 will be awarded to the health departments in the counties of Lee, Wise, and Giles to develop and implement Resource Mothers Programs in these localities. Funding will be provided through April, 1987. These programs are in the developmental phase and have not yet begun operation.

Finally, in November, 1985, the Task Force provided a grant award of $25,000 to People, Incorporated to develop and implement a Resource Mothers Program serving the city of Bristol, and the counties of Washington and Russell. State funding will be provided through June, 1986. This program has just recently begun operation. A list of the contact persons for this program as well as the others being implemented in Southwest Virginia is included in the attached Appendix (Page 7).

Richmond City Resource Mothers Program

Project WARMTH (Willing and Able Resource Mothers Team Up for Health) is the community name for the Richmond City Resource Mothers Program which began operation in August, 1985. It is a joint program of the Medical College of Virginia Department of Preventive Medicine and Richmond City Health Department. Program responsibility is roughly divided into: 1) training/team building which is directed by the Department of Preventive Medicine and 2) service which is directed by the health department. Program staff includes two Program Co-Directors, a public health nurse supervisor, six outreach workers, and a secretary.

Two other organizations are linked to the program: J. Sargeant Reynolds Community College and another similar pilot program for teens called Proud Parents. The college has provided faculty for training of resource mothers. In addition, the college has deemed the resource mothers program staff to be faculty so that the resource mothers will receive 21 hours of quarter college credits and a career studies certificate in Community Health Service upon completion of the training program. The Proud Parents program, having "family friends" serving metropolitan Richmond area pregnant teens one-on-one, has a goal of preventing child abuse. The Proud Parents program has participated in Project WARMTH by contributing training and offering a peer support group to the teens.

Project WARMTH employs eleven resource mothers who serve Richmond teens delivering for the first time who sign an agreement to participate after being informed about the program by outreach workers. Priority consideration is given to young teens, teens with absent or difficult mothers, and teens from certain high-risk census tracts. The resource mothers collectively are currently following 30 teens, most of which are 17 years or younger; these 30 teens are considered "active" cases, meaning there has been one or more meetings, frequent phone contacts, and meaningful accomplishments.

Resource mothers provide guidance and friendship throughout pregnancy and until the infant is one year of age. The thrust of the program is to ensure that teens obtain early prenatal care. Once they are at a clinic the resource mother will reinforce health advice given by the nurse or nutritionist, but the resource mothers are not responsible for giving primary health information. Rather, their time is spent in recreation, (such as shopping or cooking with the teen) social support, and "keeping an eye out" for a crisis or emergency. The resource mothers work on a part-time basis to accomplish specific tasks with the teens and are available for day, night, and week-end work. In addition to receiving the college certificate in Community Health Service, the resource mothers also receive a minimal stipend for their work.

Resource mothers received two weeks of intensive training (55 hours) of didactic, field, seminar, observation, and workshop experience. Information pertaining to a range of relevant topics was provided, including material on maternal/child health, behavioral science and community resources.

Additional information concerning the Richmond City Resource Mothers Program

may be obtained by contacting the following individuals:

Mrs. Ida Chambers, R.N.
Family Planning Nursing Supervisor
Richmond City Health Department
600 East Broad Street
Richmond, VA 23219
(804) 780-4765

Edward H. Peeples, Jr., Ph.D. (Program Co-Director)
Associate Professor
Department of Preventive Medicine
Medical College of Virginia
Box 212, MCV Station
Richmond, VA 23298
(804) 786-9786

Norfolk Resource Mothers Program

Norfolk State University Department of Nursing operates the Norfolk Resource Mothers Program. Specific goals of the program, which began operation in August, 1985, include: engage the adolescent in her own care and of her child to foster healthy lifestyle patterns, improve nutritional practices and encourage school attendance with satisfactory academic performance. Program staff include the Project Director, Project Coordinator, a faculty consultation team, seven resource mothers, and a secretary.

The uniqueness of the Norfolk design lies in the cooperation among university faculty, established neighborhood mothers' associations, and other community groups in planning and implementing the project, thus giving the community joint ownership in the project. The Presidents' Council of the Neighborhood Tenants Organization, an action/advocacy association for residents of the targeted neighborhoods, participated in the early planning process and the selection of Resource Mother applicants. This group continues to be supportive by promoting the project, providing referrals, and giving feedback regarding program acceptance and effectiveness.

The Steering Committee of the project is responsible for interagency coordination, community liaison, and future funding of the program. It is composed of representatives from the Neighborhood Tenants Organization, maternal and child health providers, university representatives, as well as public school, civic, church, and business leaders.

One resource mother was recruited from each of seven public housing parks in Norfolk. These public housing parks were selected as project sites because they experience many of the risk factors contributing to adolescent pregnancy and infant mortality. In addition, the residents were organized and willing to assist in planning and implementing the program.

Resource mothers received 50 hours of training in basic concepts related to prenatal care, adolescence, child care and development, parenting, and the skills of communication, interviewing and assessment. Graduation and induction ceremonies highlighted the transition from training to community service.

Each resource mother works fifteen hours per week and will attain a caseload of fifteen to twenty teens, following them from initial identification through the first year of parenthood. Each teen will be visited once or twice a month and may call her resource mother with questions or requests for help. The resource mothers also recruit teen mothers into prenatal care and the Resource Mothers Program. Additionally, they promote community awareness of the program and educate neighbors about the prevention of adolescent pregnancy and infant mortality. Each resource mother receives a specified stipend for expenses incurred during her work with the program. Eighteen teens have been referred to the program.

Additional information concerning the Norfolk Resource Mothers Program may be obtained by contacting:

Ms. Margaret M. Konefal, M.S.N., R.N. (Project Coordinator)
Assistant Professor
Department of Nursing
Norfolk State University
2401 Corprew Avenue
Norfolk, VA 23504
(804) 623-8228

Newport News Resource Mothers Program

The Newport News Office of Human Affairs (OHA) operates a Resource Mothers Program designed to reduce a high infant mortality rate centered in the city's Southeast community. The program, which began operation in August, 1985, seeks to improve the use of perinatal services by expectant teenagers (eighteen years of age or younger) and the use of postnatal/medical services for at least one year after delivery. Additionally, it supports each teen's positive self-concept.

The program employs four resource mothers each of whom works 25 paid hours per week. Direct supervision is provided by a program coordinator from the OHA staff who works 20 paid hours per week. Supervision of the program is provided by two other OHA staff members on an in-kind basis.

The human services agencies/organizations which support the program and provide membership to its advisory council include: Health Department, Department of Social Services, Youth Services Commission, Newport News Public Schools, Peninsula Institute of Community health, Area Health Education Center, YWCA, and Planned Parenthood of the Virginia Peninsula.

There are twelve clients currently enrolled in the program. Services provided include information on pregnancy and postnatal care in the form of films, pamphlets, brochures and individual and group "chat" sessions with the resource mothers. Discussions and demonstrations covering basic health education, the advantages of delaying additional pregnancies, the importance of staying in school, and development of good parenting skills are offered continuously. Additionally, counseling, transportation for pre and postnatal care, information on budgeting, and referrals to other community resources are provided. Since OHA operates multifaceted programs, other support is available from agency components such as child care, employability training and emergency services for housing, food and clothing. This assistance is available on an in-kind basis, as required.

The resource mothers received approximately 88 hours of extensive training in pregnancy and postnatal care. This training, along with the interaction with clients, enables the resource mothers to develop leadership and counseling skills, to serve as positive role models and to enhance their own self-esteem.

Additional information concerning the Newport News Resource Mothers Program may be obtained by contacting the following individuals:

Angela Peoples (Program Coordinator)
Newport News Office of Human Affairs
P. O. Box 37
Newport News, VA 23607
(804)247-9045

Carolyn Hutcheson (Program Coordinator)
Newport News Office of Human Affairs
P. O. Box 37
Newport News, VA 23607
(804) 247-0071