REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF ACCESS TO OBSTETRICAL CARE FOR THE WOMEN OF RURAL VIRGINIA PURSUANT TO SJR 331 OF 1995

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 13

COMMONWEALTH OF VIRGINIA
RICHMOND
1996

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Preface

Senate Joint Resolution 331 from the 1995 General Assembly directed the Joint Commission on Health Care to study access to obstetrical care for the women of rural Virginia. This report presents the findings of the study along with policy options for improving access to obstetrical care in rural areas.

Quality obstetrical care is obviously important for good maternal and infant health. Early prenatal care can help to reduce infant mortality and low weight births. Specialty obstetrical care is critical for high-risk pregnancies and difficult births. However, the availability of medical care, by itself, is not enough to assure good maternal and infant health. Experience shows that providers and local communities must work together to provide outreach, education, counseling, transportation, and other services to make sure that women receive the right services at the appropriate time.

Conventional measures such as infant mortality rates and low weight births indicate that although Virginia has made significant progress, there is more work to be done to improve maternal and infant health status in the Commonwealth. While the infant mortality rate is declining, it is still unacceptably high, particularly for minority infants. At the same time, the rate of low-weight births is rising, causing both human suffering and economic stress within the health care system. These are statewide problems which are particularly acute in rural areas of Eastern, Southside, and Southwestern Virginia.

There are several barriers to obstetrical care in rural areas which must be addressed if Virginia is to make continued progress toward improved maternal and infant health. Many pregnant women still lack health coverage and thus the ability to pay for needed health care services. At the same time, the supply of obstetrical providers -- including obstetricians, family physicians, and nurse midwives -- is dwindling in rural areas, at least partly due to economic disincentives and a lack of adequate collaboration between different provider groups. These issues, combined with educational and social problems, result in complex challenges which defy simple solutions.

This report includes five policy options for improving access to obstetrical care in rural areas:

* To improve access to health coverage for pregnant women and infants, the General Assembly could consider expanding eligibility for the Virginia Medicaid program as one option for removing financial barriers to obstetrical care.

* To contain malpractice insurance costs for rural obstetrical providers, the General Assembly could consider requesting the Secretary of Health and Human Resources, the Bureau of Insurance, and the Worker's Compensation Commission to conduct a study of the effectiveness of the Virginia Birth-Related Neurological Injury Compensation (VBRNIC) Program in rural areas.

* To improve collaboration among obstetrical care providers: (i) the Virginia Academy of Family Practice and the Virginia Obstetrical and Gynecological Society could form a joint task force for the purpose of developing guidelines for effective collaboration; (ii) Virginia's academic health centers could evaluate their programs for obstetrical training of family practice residents to ensure that their graduates are fully prepared to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians; and (iii) the General Assembly could consider funding a nurse midwifery training program at Virginia Commonwealth University-Medical College of Virginia.

Public comments on this report were received from fifteen individuals and organizations. These comments, which are summarized in the back of the report, provide thoughtful insights on the issues and options raised in the report.

Jane N. Kusiak
Executive Director

December 7, 1995

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Authority for Study

Senate Joint Resolution (SJR) 331 from the 1995 General Assembly directed the Joint Commission on Health Care to study access to obstetrical care for the women of rural Virginia. SJR 331 specifically directed the Joint Commission to consider:

(i) third-party payer reimbursement policies and the effects of such policies on the maldistribution of obstetrical services in Virginia;

(ii) obstetrical practice barriers for family practitioners and other practitioners, including nurse midwives, in rural areas of the Commonwealth; and

(iii) ways to encourage more practitioners in rural practice sights to provide obstetrical services, including, but not limited to, the feasibility of initiating a program similar to the North Carolina Rural Obstetrical Incentive Program for the reduction of malpractice costs in underserved areas.

The Joint Commission was further requested, upon completion of its study, to report its findings and recommendations to the joint subcommittee established to study women's access to obstetrical and gynecological services, pursuant to House Joint Resolution 560 (1995). This subcommittee is charged with studying women's access to obstetrical and gynecological services in managed care plans in particular. Finally, the Joint Commission was requested to complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly.

I. Indicators of Maternal and Infant Health

Obstetrical care is concerned with the care of women during pregnancy, childbirth, and the recuperative period following delivery. Quality obstetrical care is obviously important not only for the health of the mother, but also for the health of the infant. Two of the most common indicators of maternal and child health are infant mortality and low birth weight infants. Statistics indicate that while Virginia's infant mortality rate is improving, the percentage of low weight birth weights is increasing. Also, there are remarkable differences in these rates depending on race, age, education, and geographic region. The indication is that while Virginia has made significant progress, there is more work to be done for the state as a whole, including many rural areas.

Pregnancies in Virginia

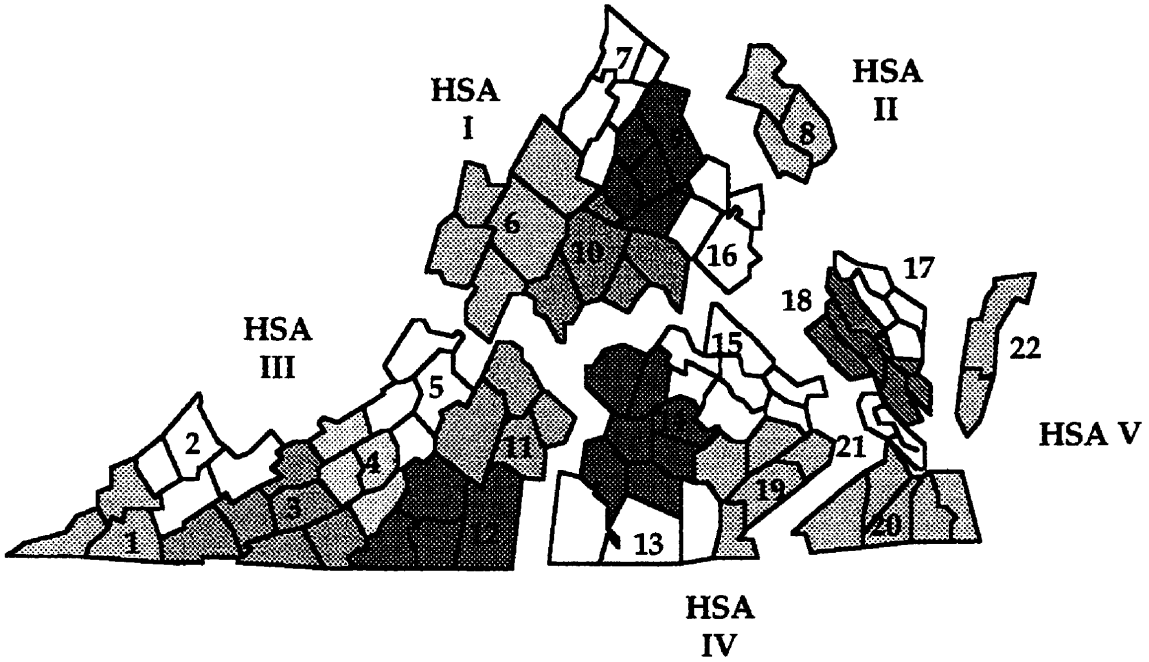
According to Virginia Health Department data, in 1993 there were 129,822 reported pregnancies among Virginia women (Figure 1). These pregnancies resulted in 93,881 live births, 27,965 induced abortions, and 7,979 natural fetal deaths. Teens and women over 45 years of age were more likely to terminate by induced abortion. Women aged 35 and older experienced the largest number of fetal deaths. Figure 2 shows Virginia's five Health Planning Regions and 22 Health Planning Districts. Figure 3 shows the number of live births by planning district in 1992.

Figure 1
Total Virginia Pregnancies
1993

	Number	Percent
Total Reported Pregnancies	129,822	100%
Total Live Births	93,881	72%
Total Induced Abortions	27,965	22%
Natural Fetal Deaths	7,976	6%

Source: Virginia Health Department data

Figure 2
Virginia Health Service Areas and Health Planning Districts



Note: Shading is used to indicate geographic boundaries of each of the 22 Planning Districts.

Figure 3
Virginia Resident Live Births
1992

Health Planning Region	Planning District	Live Births
I. Northwest	6	2,824
	7	2,278
	9	1,735
	10	2,311
	16	3,096
II. Northern	8	24,339
III. Southwest	1	1,149
	2	1,426
	3	2,039
	4	1,641
	5	3,295
	11	2,730
	12	2,838
IV. Southern	13	1,031
	14	1,078
	15	11,704
	19	2,509
V. Eastern	17	518
	18	992
	20	19,346
	21	7,215
	22	625
Unknown		6
Total		96,725

Source: Virginia Health Department data

Infant mortality is declining while low weight births are rising

As shown in Figure 4, Virginia's infant mortality rate has shown a steady decline from 10.4 deaths per thousand live births in 1988 to 8.6 deaths per thousand live births (810 total infant deaths) in 1993. Virginia's 1993 infant mortality rate was slightly higher than the national rate of 8.3.

Figure 4
Virginia Infant Mortality Rate
(Infant Deaths per 1,000 Live Births)
1988-1993

Year	Total Number	Total Rate	White Rate	Black Rate	Other Rate
1988	965	10.4	8.0	18.5	4.4
1989	963	10.0	7.3	18.7	4.4
1990	1005	10.2	7.4	19.3	3.9
1991	963	10.0	7.4	18.3	4.4
1992	903	9.3	6.9	17.2	4.1
1993	810	8.6	NA	NA	NA

Source: Virginia Health Department data

The leading causes of infant death were congenital anomalies (20%), disorders related to short gestation and low birth weight (17%), and Sudden Infant Death Syndrome (12%). Within Virginia, there are remarkable differences in infant mortality rates among populations. In 1992, the infant mortality rate among black citizens was more than twice that for white citizens. The mortality rate for infants born to teenage mothers (13.0) also was significantly higher than the statewide average.

Low birth weight is also an important concern in Virginia. As shown in Figure 5, the percentage of low weight births rose from 7.1% in 1988 to 7.5% in 1992. The national rate of low rate births for 1992 was 7.1%. Again, the low-birth-weight rate for black citizens was more than twice that for white citizens.

Figure 5
Virginia Low Birth Weight Rate
(Percent of Live Births Under 2500 Grams)
1988-1992

Year	Total Number	Total Percent	White Percent	Other than White Percent
1988	6,628	7.1	5.5	11.7
1989	6,941	7.2	5.5	11.8
1990	7,241	7.3	5.7	12.5
1991	7,098	7.3	5.7	12.5
1992	7,224	7.5	5.7	12.8

Note: "Other than White Percent" includes blacks only for 1990-1992.
Source: Virginia Health Department data

National studies show that health care costs can be significantly higher for lower birth weight infants. According to a summary of national studies developed by the Virginia Health Department, in 1990 the average excess hospital and physician fee costs were more than $4,400 for each low birth weight infant and more than $32,000 for each very low birth weight infant. Also, rehospitalization costs during the first year of life were more than $3,900 higher for each low birth weight infant and more than $14,000 higher for each very low birth weight infant.

Figure 6 on the following page shows infant mortality rates and low birth weight rates by health planning district. The bold-print figures identify those planning districts with infant mortality rates and low weight birth weights above the statewide average. Rural areas in Eastern Virginia, Southside Virginia, and parts of Southwest Virginia tend to have high infant mortality rates and low-weight-birth rates compared to the rest of the state. This is not to say that problems are isolated in rural areas.

Figure 6
Infant Mortality, Low Birth Weight, and Prenatal Care
By Health Planning District
1992

Health Planning Region	Planning District	Infant Deaths Per 100 Live Births	Low Weight Births as Percent of Total	Percent Beginning Prenatal Care in First Trimester
I. Northwest	6	5.0	**8.3%**	85.3%
	7	7.9	5.3%	84.5%
	9	5.2	6.2%	84.3%
	10	7.8	6.4%	84.0%
	16	**9.7**	5.9%	87.0%
II. Northern	8	6.6	5.5%	82.6%
III. Southwest	1	7.8	5.9%	**73.4%**
	2	**9.8**	7.1%	**74.5%**
	3	7.4	6.9%	84.0%
	4	7.9	6.3%	83.3%
	5	8.5	8.3%	87.5%
	11	8.4	6.6%	84.3%
	12	**14.8**	**9.7%**	**78.7%**
IV. Southern	13	**10.7**	**10.7%**	**66.4%**
	14	**13.0**	**10.6%**	**79.2%**
	15	**10.7**	**9.3%**	87.0%
	19	**10.4**	**9.1%**	**74.8%**
V. Eastern	17	**13.0**	**8.9%**	**73.4%**
	18	3.0	**7.6%**	82.4%
	20	**12.5**	**8.6%**	**76.4%**
	21	**10.1**	**7.7%**	**76.2%**
	22	**14.4**	7.5%	**66.2%**
State		9.3	7.5%	81.1%

Source: Virginia Health Department data

Urban areas such as Richmond City also have serious maternal and infant health problems.

Prenatal care is critical for good maternal and infant health

It is widely recognized that early and ongoing prenatal care is important for decreasing infant mortality and low weight births. This principle is generally illustrated in the infant mortality and low birth weight statistics shown in Figure 6. While there are some exceptions, those regions with higher infant mortality and low-birth-weight rates also tend to have a lower percentage of mothers who began prenatal care in the first trimester of pregnancy. (Planning districts below the statewide average for first trimester prenatal care are identified in bold-print). Statistics also indicate that teenage mothers are much more likely than older mothers to either avoid prenatal care or delay it until the second or third trimester of pregnancy. Education also plays a role, as women with a high school education or greater are much more likely to seek early prenatal care compared to those who do not complete high school.

II. Barriers to Obstetrical Care in Rural Areas

There are several barriers to obstetrical care in rural areas which must be addressed if Virginia is to make continued progress in improving maternal and infant health. First, despite recent Medicaid expansions, many pregnant women continue to lack health insurance coverage. Second, the supply of obstetrical providers -- including obstetricians, family physicians, and certified nurse midwives -- is dwindling in rural areas. Third, specialized hospital services are concentrated in urban areas, making transportation a difficult problem for some rural women. These issues, combined with educational and social problems, result in complex access problems for many rural communities.

Many pregnant women lack health coverage

The ability to pay for obstetrical services is an important factor in individual decisions to seek care. Research shows that people without health coverage are more susceptible to preventable health problems, less likely to obtain appropriate primary care services, and more likely to use hospital emergency rooms for primary care. Focusing on obstetrical care in particular, a 1989 study by the Virginia Statewide Health Coordinating Council found that among local health department patients, women without health coverage had fewer prenatal visits, and were less likely to seek prenatal care, less likely to start care early, more likely to need Caesarean sections, and more likely to have infants who needed neonatal intensive care units.

Although there are no comprehensive figures available on the number of uninsured women in Virginia in need of obstetrical care, a Virginia Health Department analysis of Virginia Commonwealth University Survey Research Laboratory data indicated that 17 percent of Virginia women of childbearing age lacked health coverage in 1993. Also, during FY 1994, 25,876 women received maternal health services at local health departments. In addition, Virginia's 41 Community and Migrant Health Center sites also play an important role in providing prenatal care services for poor women. However, Community and Migrant Health Centers and local health departments are at best a partial safety net for low income and uninsured pregnant women.

Obstetricians are concentrated in urban areas

According to the best available data from the American Medical Association (AMA), Virginia had approximately 894 active obstetricians in 1993. The vast majority of these physicians were located in urban areas, as only 127 (17%) practiced in rural areas. Also, as of 1993 at least 40 rural localities did not have a resident obstetrician.

The most widely cited factor discouraging obstetrical practice in urban and rural areas is the high cost of medical malpractice. In a 1989 study conducted by the Medical Society of Virginia, obstetricians cited medical liability concerns as a major reason why they or their peers were leaving the practice of obstetrics. The study also identified additional reasons why obstetricians may be reluctant to practice in rural areas, for example:

* The birth rate in sparsely populated areas may not be sufficient to support one or even two obstetricians.

* Obstetricians generally prefer to practice within close proximity to a medical center or hospital, in part due to liability concerns.

* Larger population areas are more likely to have larger numbers of obstetricians to provide back-up.

* Stronger urban economies offer a more stable source of revenue due to a higher percentage of patients with health coverage.

Few family physicians provide obstetrical services

Family physicians are more widely distributed across urban and rural areas than obstetricians. AMA data indicates that in 1993 there were a total of 1,708 active family physicians in Virginia, including 533 practicing in rural areas. Within rural areas, family physicians outnumbered obstetricians by more than a 4-to-1 margin. However, very few family physicians practice obstetrics. According to regional and local surveys, only about 10 percent of Virginia family physicians actually practice obstetrics, and only about 6 percent actually assist in deliveries. These are among the lowest rates in the country.

In evaluating the obstetrical practice patterns of family physicians, it is important to recognize that not all family doctors want to practice obstetrics. For example, a recent national survey indicated that about 49%

of family physicians in the South Atlantic region have no desire to practice obstetric care in their hospital practices. Among those who are interested in practicing obstetrics but do not, a variety of reasons are cited. A 1993 study by the Virginia Academy of Family Practice noted the following difficulties in providing obstetrics in rural Virginia:

> **High medical malpractice costs**. Family physicians who provide obstetrical care report that they pay between $5,000 and $7,000 per year for obstetrical medical malpractice coverage in addition to their normal medical malpractice coverage of $5,000 per year.
>
> **Adverse reimbursement policies.** Commercial insurers tend to reimburse rural areas less than urban areas of Virginia for the same services, even though rural practitioners claim that rural practice overhead is substantially higher than urban practice overhead. Also, Medicaid reimbursement, which pays the same rate throughout Virginia, has been historically low compared to commercial payers. This is a particular concern for rural providers who carry large Medicaid caseloads.
>
> **Demanding call schedules.** Because of the relative lack of obstetric providers in rural areas, family physicians who practice obstetrics face demanding call schedules with little backup.
>
> **Difficulty securing backup from obstetricians.** According to the VAFP study, more family practitioners are having difficulty in obtaining consultative help from obstetricians, including caesarean-section back-up.

Nurse midwives are few in number and concentrated in urban areas

Research has demonstrated that certified nurse midwives (CNMs) are capable of providing high quality, cost-effective care within their scope of practice. Within Virginia, the use of CNMs is not widespread. According to a 1992 study by Virginia Health Planning Board and the Department of Health Professions, Virginia had 76 licensed nurse midwives. However, at least one third of these nurse midwives were not actively practicing. Those who were practicing were strongly concentrated in urban areas.

Barriers to the practice of nurse midwifery have been evaluated in several studies requested by the legislature since 1990. In these studies and in recent interviews, nurse midwives have identified the following as barriers to practice:

* Lack of direct third-party reimbursement by private insurers;
* Difficulty in finding a collaborating physician;
* Difficulty in obtaining hospital privileges;
* Lack of prescriptive authority;
* Substantial increases in malpractice insurance rates; and
* Lack of an education program in Virginia.

Specialty obstetrical services are concentrated in urban hospitals

Of 92 Virginia acute care hospitals (other than children's', rehabilitation, and other specialty care hospitals), seventy-two are licensed to provide obstetrical services (Figure 7). Most rural areas have at least one local hospital providing basic obstetrical services, although there are areas such as the Northern Neck and parts of Southwest Virginia where patients have to travel significant distances to obtain basic services. Specialty obstetrical services are concentrated in large urban centers, and transportation of mothers before they deliver and high-risk infants after birth can be a major challenge in rural areas. Also, it can be difficult to maintain small obstetrical units in rural hospitals. In a recent survey of its rural hospitals, the Virginia Hospital Association identified several rural institutions which were experiencing problems recruiting obstetrical care providers.

Multiple factors combine to create complex local problems

The problems outlined in the preceding pages -- lack of health coverage, inadequate supply of providers, and distant hospital services -- combine with social problems to create complex barriers to obstetrical care, particularly in rural areas. Virginia local health departments and Regional Perinatal Coordinating Councils report that many rural women lack adequate access to prenatal care, and that lack of health coverage and transportation are major factors in the problem. Also, problems with teen pregnancy, drug abusing mothers, and HIV/AIDS are posing difficult challenges.

Figure 7
Availability of Hospital Obstetrical Services in Virginia Health Planning Districts, 1993

Health Service Area	Planning District	Acute Care Hospitals	Obstetric Units	Obstetric Beds
I. Northwest	6	5	4	56
	7	4	3	37
	9	2	2	19
	10	2	2	57
	16	1	1	25
II. Northern	8	11	8	281
III. Southwest	1	5	5	33
	2	5	1	9
	3	5	5	72
	4	4	3	39
	5	5	3	111
	11	2	2	48
	12	4	4	65
IV. Southern	13	2	2	26
	14	1	1	20
	15	11	6	240
	19	3	3	50
V. Eastern	17	1	1	8
	18	2	0	0
	20	11	11	289
	21	5	4	95
	22	1	1	10
	Total	92	72	1,590

Source: JCHC staff analysis of Virginia Health Department data

II. Policies for Improving Access to Obstetrical Care in Rural Areas

There are a number of strategies which should be considered in the effort to address obstetrical care access problems in rural areas. The remainder of this report provides a discussion of current and potential policies for improving access to obstetrical care in rural areas. Specific policy issues to be considered include the status of health coverage for pregnant women, medical malpractice concerns, provider collaboration in the delivery of rural obstetrical care, and financial and educational incentives for rural providers. To stimulate and guide the development of effective maternal and infant health policies, the Commonwealth has established the Virginia Maternal and Child Health Council and obtained federal funds to support seven Regional Perinatal Coordinating Councils.

State Policy Development and Regional Coordination

In 1992 the General Assembly established the Maternal and Child Health Council to improve the health of the Commonwealth's mothers and children by promoting and improving programs and service delivery systems related to maternal and child health. The Council is chaired by the Secretary of Health and Human Resources. Members of the Council include the Commissioners of the Department of Health and the Department of Mental Health/Mental Retardation and Substance Abuse Services; the Director of the Department of Medical Assistance Services; and the Superintendent of Public Instruction. In addition, representatives of business, local governments, the health professions, private non-profit organizations and hospitals are appointed by the Governor. Two legislative members may be appointed by the Speaker of the House and the Senate Privileges and Elections Committee, respectively.

The Council is required to meet at least four times in every fiscal year and is authorized to:

1. Examine trends and causes of maternal and child morbidity and mortality;

2. Review and evaluate the Commonwealth's maternal and child health programs and services;

3. Identify maternal and child health problems and issues including fragmentation and gaps in services and programs;

4. Develop policies, principles, and priorities with which to guide programs and services for mothers and children in the Commonwealth;

5. Advise and report to the Governor and the General Assembly annually regarding potential policy and program initiatives in maternal and child health;

6. Promote public/private partnerships or systems of care and coordination of agency efforts in the area of maternal and child health;

7. Review and disseminate information on maternal and child health issues and developments;

8. Select and guide ad hoc professional and technical advisors or committees to address particular issues and prepare periodic reports for the Council.

The Council may also appoint subcommittees to assist it in its work, including a subcommittee on infant mortality and a subcommittee on perinatal services. To date, Council subcommittees have been established to study the issues of prenatal care, school health, and teenage pregnancy. The prenatal care subcommittee participated in a study of health services for pregnant women in crisis which resulted in Senate Document No. 45 (1994). The work of the school health subcommittee has been subsumed by a Governor's task force on school health. The teen pregnancy prevention subcommittee continues with active meetings.

Regional Perinatal Coordinating Councils

In an effort to improve the system by which perinatal health care is provided within the state, the Virginia Health Department established seven Regional Perinatal Coordinating Councils (RPCCs) in 1992. The goal of these federally-funded councils is to create collaborative networks among providers of perinatal services to ensure the availability of appropriate care to all perinatal patients. Each of the RPCCs is comprised of representatives from hospital perinatal services, local health departments, private physicians, and other health-related agencies and consumers within their regions. The issues and problems they address include: access to care, transportation, consumer and professional perinatal education, teenage pregnancy, perinatal data collection and

analysis, substance abuse, infant mortality, and standards of care. According to Department of Health staff, thus far each RPCC has completed regional perinatal needs assessments, identified priority perinatal issues, and planned or implemented related community-based projects. Examples of ongoing programs include infant mortality reviews, perinatal continuing education programs for health professionals, development of regional standards of care, and consumer awareness campaigns.

Health Coverage

Virginia has enacted several Medicaid changes which have resulted in expanded health coverage for a significant number of poor women and children. In 1989 coverage was extended to pregnant women and infants with income up to 100% of poverty. In 1991 coverage was extended to pregnant women and infants with income up to 133% of poverty. As a result, between 1990 and 1994 there was an 81 percent increase in the number of unduplicated pregnant women enrolled in the Medicaid program (12,330 in 1990 compared to 22,455 in 1994).

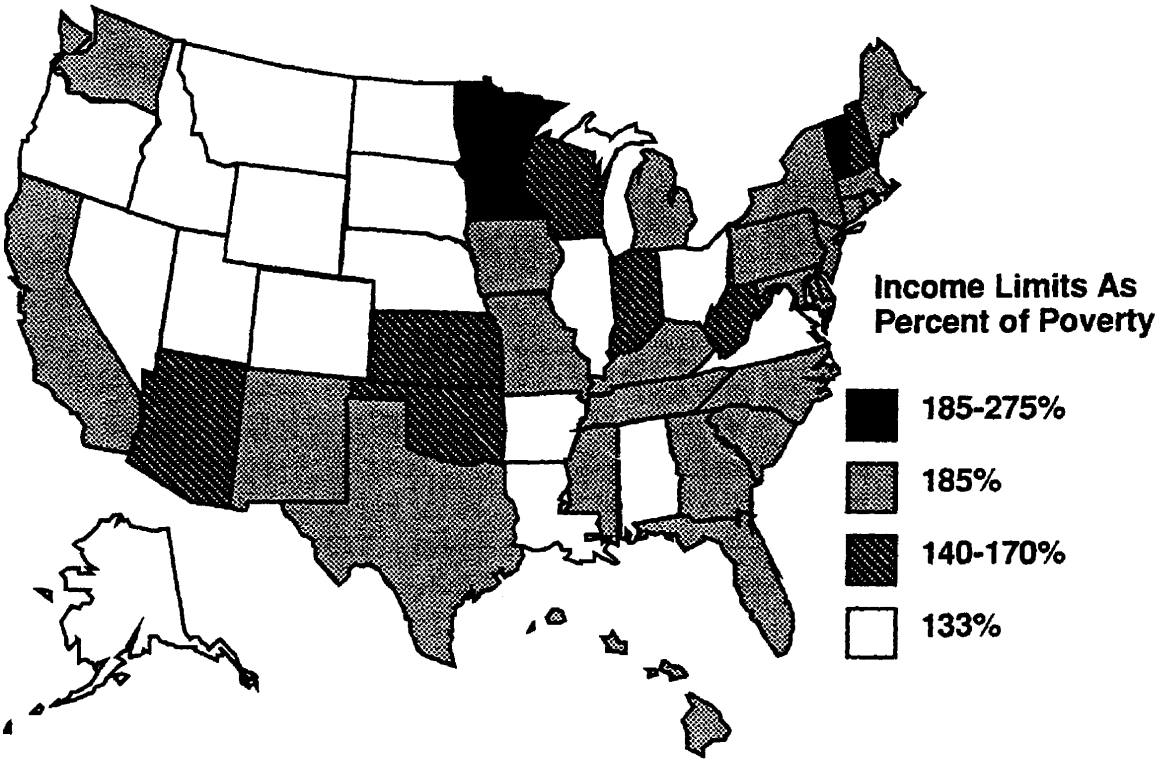
Virginia is also attempting to expand health coverage through the private sector. Recent legislative reforms in the small group insurance market are aimed at increasing the availability and affordability of private health insurance for small firms. In addition, Virginia is in the midst of designing pilot projects to make a subsidized, essential benefits insurance policy available to the working uninsured. These pilot projects will be funded through private donations to the Indigent Health Care Trust Fund, and possibly through federal Medicaid dollars for catastrophic coverage. The pilot projects are being initiated with an eye toward eventually converting the Indigent Health Care Trust Fund into a public/private partnership to make private insurance available to the working uninsured.

Looking to the future, the prospects for expanded access to health coverage for pregnant women and children will be shaped by Medicaid policy, welfare policy, and the private insurance market. If the Congress adopts a "block grant" approach to Medicaid, the structure of that block grant in terms of dollars and federal mandates will frame Virginia's options for expanding Medicaid coverage either on its own or through public/private partnerships. From a health care perspective, the success of Virginia's welfare reform efforts will depend on whether welfare recipients transitioning out of the system are able to find employment which offers affordable health insurance for individuals and families. In this environment, careful planning and analysis will be required to ensure that

existing levels of health coverage are not eroded, and that all reasonable opportunities for expanding coverage are explored.

Given this context, Virginia could explore the option of further expanding Medicaid coverage for pregnant women and infants. Federal law allows the states to increase the income level for pregnant women and infants from the mandated level of 133% of poverty to an optional level of up to 185% of poverty. Virginia is among 17 states that has not exercised this option (Figure 8). In addition, a number of states have either implemented or are planning comprehensive Medicaid program expansions under Medicaid 1115 waivers.

Figure 8
Medicaid Coverage Options for Pregnant Women and Infants



Source: National Governor's Association, 1994

In considering a Medicaid expansion it is important to recognize that enhanced coverage by itself will not necessarily bring about a significant increase in access to prenatal care. The experience of states which have implemented Medicaid expansions indicates that aggressive local outreach

and coordination of programs are vital for making sure that pregnant women take advantage of available services. According to a recent study of Medicaid expansions conducted by the Alpha Center in Washington, D.C., states have the most success when Medicaid expansions are accompanied by programs that provide comprehensive prenatal care services, including nutritional supplements, counseling, transportation, and case management.

The feasibility of Medicaid expansion options would have to be evaluated in the context of federal Medicaid policy as well as welfare reform policy. Thus there would be a need for a comprehensive study involving the Secretary of Health and Human Resources as well as the Department of Medical Assistance Services and the Department of Social Services.

Option (1). The General Assembly may wish to consider requesting the Secretary of Health and Human Resources to study available options for expanding Virginia Medicaid coverage for pregnant women and infants.

Malpractice Concerns

Obstetricians, family physicians, and certified nurse midwives alike consistently identify medical malpractice concerns as a serious barrier to obstetrical practice. Virginia's major response to this problem has been the Virginia Birth-Related Neurological Injury Compensation Act, which was passed in 1987 and became effective in 1988. Another potential option, as outlined in SJR 331, would be a program along the lines of North Carolina's Rural Obstetric Practice Program. These two approaches are compared below.

The Virginia Birth-Related Neurological Injury Compensation Program

This Act was passed when several malpractice insurers stopped issuing new obstetrics policies in Virginia due to the number and size of obstetric malpractice awards. The Act established the Virginia Birth-Related Neurological Injury Compensation (VBRNIC) Program as an alternative dispute mechanism to resolve the most serious and costly birth-related injury cases. The VBRNIC Program includes a fund, supported with provider fees, which is used to compensate patients for injuries which qualify under the terms of the Act. Malpractice insurance carriers are required to provide a credit against the cost of malpractice insurance for Virginia health care providers who participate in the VBRNIC Program,

thereby making malpractice insurance more widely available and affordable. Participating providers are required by law to make an agreement with the Health Commissioner to participate in the development of a program to provide obstetrical care to indigent patients, including those eligible for Medicaid. Providers who do not participate in the VBRNIC Program are subject to normal tort liability and are not protected by the program.

As of November 1995, 29 claims had been filed against the fund, with 24 of those filed in the last two years. Of the 29 claims that have been filed, 18 have been approved, with payments to date exceeding $1.5 million. Four claims have been denied, and seven are pending. Given the spurt of claims in the last two years, it appears that the fund is becoming more widely known.

Current participants in the Program include 427 physicians, 4 nurse midwives, and 27 of 72 Virginia hospitals with obstetric units. Historically, participating physicians and nurse midwives have paid an annual fee of $5,000 to be covered under the program, and hospitals have paid $50 per live birth up to a total of $150,000 annually. Due to the fund's large balance ($61 million) and actuarial soundness, the fees were reduced for most providers in 1995. The 1995 fees range from $500 to $5,000 for physicians and nurse midwives depending on the number of years the provider has participated in the program. Similarly, hospital fees ranged from $5 to $50 per live birth depending on the number of years the hospital had participated in the program.

It is difficult to render a definitive conclusion about the impact of the VBRNIC Program on malpractice insurance costs. In 1993, in House Document 22, the State Corporation Commission's Bureau of Insurance reported that due to the immaturity of the fund at that time, it was impossible to estimate the impact of the fund will ultimately have on OB/GYN medical malpractice rates in Virginia. It is worth noting, however, that the same report indicated a general decline in medical malpractice premiums for OB/GYNs between 1988 and 1992 (Figure 9).

Figure 9
OB/GYN Physician Rates for Medical Malpractice Insurance
1988-1992

(Rates for $1 million worth of coverage)

Territory/ Company	1988 $	1989 $	1990 $	1991 $	1992 $
Northern VA					
St. Paul	43,738	33,524	33,524	33,524	35,468
TVIR	41,488	41,488	30,723	30,723	30,723
PHICO	37,055	37,055	31,130	31,130	31,130
Tidewater					
St. Paul	40,519	31,059	31,059	31,059	31,059
TVIR	38,546	38,546	28,446	28,446	28,446
PHICO	34,269	34,269	31,130	31,130	31,130
Richmond Area					
St. Paul	27,545	21,115	21,115	21,115	22,336
TVIR	31,185	31,185	22,759	22,759	22,759
PHICO	23,682	23,682	31,130	31,130	31,130
Remainder of State					
St. Paul	32,423	24,854	24,854	24,854	26,293
TVIR	31,185	31,185	22,759	22,759	22,759
PHICO	27,860	27,860	31,130	31,130	31,130

Source: State Corporation Commission Bureau of Insurance, House Document 22, 1993.

For two of the three major medical malpractice firms operating in Virginia, rates varied significantly by region, with the highest rates in Northern Virginia.

The Virginia Academy of Family Practice reports that the VBRNIC Program has had a limited impact on rural family physicians due to adverse economic incentives. As noted earlier, family physicians who

provide obstetrical care report that their malpractice coverage for obstetrical care costs an additional $5,000 to $7,000 per year. These same providers report that participation in the VBRNIC Program would reduce their malpractice premiums by $2,500 at most. With program fees historically set at $5,000 per year, it has not made short-term economic sense for rural family physicians to participate in the fund. However, with current fees set as low as $500 per year depending on length of participation in the program, the benefits of participating in the program could begin to outweigh the costs over time.

The North Carolina Rural Obstetrical Care Incentive Program

During the late 1980s, North Carolina was experiencing problems similar to Virginia and other states in terms of rapidly rising obstetrical malpractice costs and a diminishing supply of obstetrical providers relative to need. North Carolina's problems were particularly acute in rural areas. In response, the North Carolina legislature established the Rural Obstetric Care Incentive (ROCI) Program as an attempt to offset some of the malpractice insurance costs of rural providers.

The ROCI Program provides a state subsidy to physicians and certified nurse midwives who agree to provide obstetrical care to rural women according to the terms of a maternity care coverage plan developed in conjunction with the local health department. Subsidies for physicians are equal to the extra insurance costs incurred by delivering infants or $6,500, whichever is less. CNMs are eligible to receive up to $3,000 in subsidy. The subsidy is distributed through local health departments.

As of 1993, annual state funding for this program was $840,000 per year. A total of 196 providers (186 physicians and 10 midwives) participated in the program during that year, resulting in an average subsidy of more than $4700 per participant. Published evaluations of the program indicate that it has contributed to better access to obstetrical care in rural areas by increasing physician participation in Medicaid and by improving early access to prenatal care.

Comparison of the two approaches

The VBRNIC Program and the ROCI Program are two largely different approaches to the same problem. For example:

* Virginia's approach reflects a statewide focus, whereas the North Carolina program is targeted to rural areas.

* Virginia's program is a no-fault compensation pool which actually compensates injured patients, while the North Carolina program is a direct subsidy to offset the cost of malpractice insurance.

* Virginia's program is financed with provider fees, while North Carolina's program is state funded.

It is important to recognize that both programs are primarily intended to keep current providers from leaving the system as opposed to attracting former providers back into the system. This is consistent with research from California and elsewhere indicating that reductions in malpractice costs do not have the effect of luring former providers back into the practice of obstetrics. This means that under either program, new providers will come primarily from the ranks of new graduates or new recruits to rural areas rather than those who have left the field due to malpractice concerns.

This being said, the primary appeal of the North Carolina program lies in its rural focus and definite impact on the affordability of malpractice insurance for rural providers including obstetricians, family physicians, and CNMs. As noted earlier, the VBRNIC Program, at least until this point, has not been viewed as a cost-effective option for rural family physicians. Thus it appears that a more targeted approach may be warranted for rural areas in Virginia. Given that the VBRNIC Program has been in place for a number of years, it would be prudent to more fully evaluate the effectiveness of this program in rural areas before experimenting with an entirely new program along the lines of the North Carolina model.

Option (2). The General Assembly may wish to consider requesting the Secretary of Health and Human Resources, in cooperation with the State Corporation Commission's Bureau of Insurance and the Worker's Compensation Commission, to evaluate the impact of the Virginia Birth-Related Neurological Injury Program in rural areas and recommend policies for improving the utility of the program for rural providers.

Provider Incentives

Obstetrical care providers must have adequate financial incentives to practice in rural areas. Recent reports indicate that third party reimbursement rates are a continuing source of concern for physicians. Also, nurse midwives believe that mandatory direct reimbursement for nurse midwifery services is critical if nurse midwives are to play a more significant role in Virginia's rural areas. Looking beyond reimbursement issues, the Commonwealth has established several scholarship and loan repayment programs which could be of benefit to obstetrical providers interested in practicing in rural underserved areas.

Third-party reimbursement rates

Rural providers point to low Medicaid reimbursement rates as a continuing disincentive against obstetrical practice. As of 1989-90, most Medicaid physician fees were set at the 15th percentile of prevailing charges. Beginning in 1991, fees for obstetrical services and certain other services for children were increased to the 25th percentile. These rates largely remained in effect through the end of FY 1995.

Beginning in FY 1996, the Department of Medical Assistance Services (DMAS) is phasing in a new physician fee structure based on a Resource-Based Relative Value Scale (RBRVS). According to DMAS staff, under this system the global fee for obstetric services will be increased slightly from $1200 in FY 1995 to $1210 in FY 1996, and eventually will reach $1240 in FY 1998. At the same time, the rate for Caesarean section deliveries will decrease from $1441 in FY 1995 to $1423 in FY 1996 to $1388 in FY 1998. It will be important for DMAS to evaluate the impact of these rate changes on access to obstetrical care for rural Medicaid recipients. By the same token, it will be important to evaluate the impact of Medicaid managed care and capitation on rural obstetrical practice.

Another concern identified by family physicians is regional differentials in reimbursement from insurance companies. Insurance companies often reimburse less in rural areas than in urban areas. This policy is based on differences in cost of living as well as differences in charge rates. However, rural physicians contend that their overhead per obstetrical case is significantly higher than in many urban practices due to a lower volume of cases. Virginia's largest insurer, Trigon BlueCross BlueShield, has recently implemented a policy in which only Northern Virginia providers receive a payment differential based on geographic

location alone. Also, DMAS uses a uniform statewide fee structure which does not vary by geographic region.

Third-party reimbursement for certified nurse midwives

Virginia certified nurse midwives point to a lack of direct reimbursement by third-party payers as an obstacle to nurse midwife practice throughout Virginia and in rural areas in particular. According to a 1992 report by the Advisory Commission on Mandated Health Benefits (House Document 38), at least 23 states, including Maryland, have enacted statutes which mandate direct reimbursement by insurers for nurse midwives. Twenty of these states enacted their statutes during the 1980s. Within Virginia, direct reimbursement is available to CNMs from Medicaid, Medicare, the Federal Employee Health Benefit Plan, and CHAMPUS. Direct reimbursement is not available from Trigon BlueCross BlueShield, and by extension, the State Employee Health Benefit Program. As of 1992, several other health insurers within Virginia were providing direct reimbursement to CNMs.

In 1992, House Bill 1089 was introduced for the purpose of adding "nurse practitioners who render nurse midwife services" to the list of mandated providers for third party reimbursement. This bill was referred to the Advisory Commission on Mandated Health Benefits, which responded through House Document 38. The Advisory Commission recommended against enactment of the legislation, concluding that:

> "...coverage for maternity care is generally available in the absence of a mandate of direct reimbursement to certified nurse midwives," (and that) "mandating direct reimbursement has not been determined to be an effective or necessarily appropriate means of encouraging expansion of the practice of certified nurse midwives."

Scholarship and Loan Repayment programs

Virginia has established several scholarship and loan repayment programs for the purpose of creating incentives for health care providers to practice in medically underserved areas of Virginia. These programs could be an important resource for attracting family physicians and obstetricians to rural underserved areas. The programs include:

The Virginia Medical Scholarship Program. This program provides medical scholarships for students who intend to enter designated specialties of family practice medicine, general internal medicine, pediatrics, and OB/GYN. Students agree to practice for one year in a medically underserved area of Virginia in return for each year of scholarship. The General Assembly appropriated $445,000 for this program in FY 1996.

State/Federal Physician Loan Repayment Program. This program provides loan repayment assistance for physicians who agree to practice in medically underserved areas of Virginia, including OB/GYN physicians. State funding for this program in FY 1996 is $50,000, which is matched with $50,000 in federal funding.

The Virginia Nurse Practitioner Scholarship Program. This program provides scholarships for nurse practitioners and nurse midwives who agree to practice in medically underserved areas of Virginia. Nurse midwives are allowed to attend school out-of-state because Virginia does not currently have a nurse midwife education program. State funding for this program is $25,000 in FY 1996.

Provider Collaboration

Collaborative arrangements are crucial for effective obstetrical care in rural areas because neither the rural communities nor the urban centers can meet all rural obstetrical needs on their own. Family physicians and obstetricians must work together to establish working standards for prenatal care and detection of high risk pregnancies. The role of nurse midwives must be clearly understood by CNMs, family physicians, and obstetricians alike. Rural hospitals and urban medical centers must have collaborative relationships based on clear understanding of their respective capacities and referral protocols. In addition, providers must cooperate with local health departments and other local service agencies to reach out to women and make sure they have access to transportation and other resources needed to receive care in the most appropriate setting.

Rural family physicians and obstetricians

Rural family physicians who provide obstetrical care report increasing difficulty in obtaining consultative help from obstetricians, including caesarean section back-up. Family physicians also report that there have been several cases in which family physicians have stopped

providing obstetrical care because they could not secure adequate back-up from obstetricians. On the other hand, obstetricians are sometimes reluctant to provide emergency backup to family physicians for fear of liability given the malpractice environment. This concern could be eased if the obstetrician could be assured of the family physician's ability to provide state of the art prenatal care and detect high risk pregnancies.

At the same time, family physicians are concerned about the obstetrics component of family medicine residency training. Family medicine residents typically train for three years, of which three to six months is spent in obstetrical training. Based upon a survey of family medicine residency program directors and interviews with family physicians, there is a concern that this obstetrical component -- which is typically taught by obstetricians -- does not always prepare family medicine residents to practice technical or interventional obstetrics on their own. On the other hand, obstetric medicine faculty have expressed concern about exposing family medicine residents to the most sophisticated obstetrical procedures during their three-to-six month obstetrical training period when OB-GYN residents typically are not allowed to do high-intervention procedures until the second year of their four-year program. Also, in some cases there are only "so many obstetric cases to go around," meaning that family medicine residents do not always have the opportunity to assist in high intervention deliveries.

Family physicians and obstetricians must have a clear and mutually supportive relationship if Virginia is to make progress in assuring adequate access to obstetrical care in rural areas. In many ways, this relationship begins to take shape during the education of obstetricians and family physicians. Given advances in obstetrical practice, it may be time to re-examine traditional obstetrical education programs for family physicians and explore more innovative possibilities such as advanced obstetrical training for family physicians (some obstetricians and family physicians are already in the early stages of this research). This can best be accomplished in an environment of committed cooperation between the family physician and obstetrician communities.

Option (3). The Virginia Academy of Family Practice and the Virginia Obstetrical and Gynecological Society should consider establishing a joint task force to establish standards and protocols for prenatal care, detection of high risk cases, obstetrical referral, and backup.

Option (4). Virginia's academic health centers should evaluate their programs for obstetrical training of family medicine residents to ensure that they produce graduates who are adequately trained to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians.

Nurse midwives, family physicians, and obstetricians

Virginia nurse midwives have pointed to legal restrictions on their scope of practice as one barrier to more extensive practice of nurse midwifery. Of particular concern are statutory and regulatory codes which require nurse practitioners to practice under the supervision of a physician. Section 54.1 - 2901 of the Code of Virginia states that:

> The provision of this chapter shall not prevent or prohibit...any licensed nurse practitioner from rendering care under the supervision of a duly licensed physician when such services are authorized by regulations promulgated jointly by the Board of Medicine and the Board of Nursing.

Nurse midwives site this requirement as a major disincentive for physicians to collaboratively practice with them and for insurance companies to reimburse them.

The Joint Commission on Health Care reviewed statutory and regulatory barriers to the use of nurse practitioners in 1994 in response to Senate Joint Resolution 164 from the 1994 Session. In an effort to clarify the scope of practice of nurse practitioners, SJR 164 also requested the Joint Boards of Nursing and Medicine to promulgate proposed appropriate definitions of the term "collaboration" and other terms affecting interdependent health care practices between physicians and nurse practitioners. The Joint Boards of Medicine and Nursing are about to release final regulations which define the term "collaboration" as follows:

> "Collaboration means the process by which a nurse practitioner, in association with a physician, delivers health care services within the scope of practice of the nurse practitioner's professional expertise and with medical direction and supervision, consistent with these regulations."

Furthermore:

> "A licensed nurse practitioner shall be authorized to engage in the practices constituting the practice of medicine in collaboration with and under the medical direction and supervision of a licensed physician."

It should also be noted that the General Assembly has taken several steps to enhance the practice of nurse practitioners (including nurse midwives) in recent years. In 1991 the General Assembly authorized limited prescriptive authority for nurse practitioners including nurse midwives, and in 1995 the legislature authorized physicians to supervise up to four nurse practitioners with prescriptive authority (as opposed to two) in private practice. In 1992 the General Assembly passed legislation to prevent hospitals from excluding nurse midwives from hospital practice without cause.

Legal requirements alone cannot guarantee that nurse midwives will find suitable practice environments. As has been the case with nurse practitioners generally, one of the barriers to more extensive use of nurse midwives may be the lack of a collaborative training environment for nurse midwives and physicians.

Virginia does not presently have a nurse midwife training program. In 1992 House Bill 992 would have directed the State Council of Higher Education to request feasibility studies and program proposals for the establishment of a nurse midwifery educational program within a school of nursing at a Virginia health science center. The bill would have implemented a recommendation of the Department of Health Professions and the Virginia Health Planning Board pursuant to a study of access to obstetrical care and the role of nurse midwives requested by House Joint Resolution 431 (1991).

The Senate Committee on Education and Health did not recommend the bill, but did request the State Council to study the issue. The State Council solicited responses from the University of Virginia (UVA) and the Virginia Commonwealth University Medical College of Virginia (VCU-MCV). UVA expressed no interest in developing a program, but VCU-MCV did commit to conducting a full feasibility study. VCU-MCV concluded that it would be operationally feasible to develop a nurse midwifery training program, but significant state resources would be required (as of 1992 the total estimated budget would have ranged from $126,000 in year one to $358,000 in year three).

Option (5). The General Assembly may wish to consider appropriating state funds to establish a nurse midwifery program at Virginia Commonwealth University - Medical College of Virginia.

Hospital collaboration

Few rural hospitals are able to provide the complete range of services which may be required for high-risk obstetrical cases and neonatal care. Consequently, systems of care are necessary to assure that mothers and infants are treated in the most appropriate setting. The need for collaboration is recognized by Virginia's rural hospital community. In a recent survey of rural hospitals, more than half of those responding indicated that they are currently interested in working cooperatively with other hospitals to provide obstetrical services within their service area.

Systems of obstetrical and newborn care must be based on clearly defined levels of care which each hospital can provide, as well as clear protocols for transferring the mother prior to delivery or the newborn after delivery to a facility that can provide the appropriate level of care. In response to this concern, Section 32.-127 of the Code of Virginia requires the Board of Health to promulgate licensing regulations requiring that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself in labor. Also, as a result of 1992 legislation, the Board is required to establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national- or state-developed evaluation system.

After a prolonged period of study and debate, the Board of Health approved the required regulations for neonatal care on August 10, 1995. The regulations will take effect with the next round of hospital licensure renewals, the applications for which will be distributed in the fall of 1995. The initial round of site surveys for hospital licensure will begin in 1996. The regulations prescribe a comprehensive set of standards, policies, and procedures for newborn care in Virginia. The regulations include four designated levels of newborn service levels: General, Intermediate, Specialty, and Subspecialty. At each level of service there are certain requirements for:

Medical direction

Physician consultation and coverage

Nursing direction, staff, and coverage

Protocols for management of all neonatal medical conditions at each service level

Requirements for the operation of a 24-hour neonatal transport system

Written collaboration agreements with hospitals that provide higher levels of newborn services not available at the referring hospital

Establishment and ongoing, documented quality assurance systems

Physical design criteria for newborn services

Equipment requirements

Support service requirements.

The new regulations for neonatal levels of care will help to provide a framework for collaborative arrangements among Virginia's hospitals with obstetrical services. In practice, effective collaboration will require a commitment on the part of rural hospitals and urban centers to work together with a clear understanding of the full capabilities and limitations of rural hospitals.

Collaboration on educational, social, and medical interventions

As pointed out earlier, there are educational and social as well as medical factors which affect access to obstetrical care in rural areas. Consequently, Virginia has established a number of programs designed to link high-risk women and infants to medical care through outreach and education. The key to success for these programs is ongoing cooperation between medical care providers, local public health professionals, and local social service organizations. Examples of these programs include:

The Infant Care Program. This program, funded through Virginia Medicaid, provides prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two. Physicians, nurse practitioners and certified nurse midwives

are a critical link between the high-risk pregnant woman or infant and the services available through the Infant Care program.

The Resource Mothers Program. This program targets teenagers pregnant with their first child, and provides counseling and other services designed to reduce infant mortality and low birth weights, prevent school drop-outs and repeat pregnancies, and facilitate good health practices and utilization of health care services. It is funded with Medicaid and federal maternal and child health block grant funds, and serves 25 localities across the state.

The NIP Program -- Nutrition Intervention Project for Underweight Pregnant Women and Women with Inadequate Weight Gain. This federally-funded program targets underweight pregnant women and women with inadequate weight gain for intensive nutrition counseling and follow-up in an effort to reduce the number of low birth weight infants.

Project Link. This is a federally-funded, community-based program designed to provide coordinated services to substance-abusing pregnant and post-partum women and their infants. The program was designed by the Virginia Departments of Health, Mental Health, Mental Retardation, and Substance Abuse Services, and Social Services, as well as the Virginia Cooperative Extension Services. The major components of Project Link are cross-agency referral and case management, prevention and outreach, and health education services. Trained paraprofessionals from the community serve as specialized "resource mothers" to assist the women in obtaining and complying with needed services. The program is operational in five regions across the state (both urban and rural).

The Healthy Families Program. This program provides home visiting services in five communities: Alexandria, Eastern Shore, Fairfax, Hampton, and Martinsville/Henry County. The program provides comprehensive services including family planning, prenatal care, child abuse prevention, well child care, and immunizations.

IV. Summary

Access to obstetrical care has been a long-standing concern in Virginia. The major findings of this study are that lack of health coverage, provider shortages, transportation problems, and social problems are combining to create significant barriers to obstetrical care in many rural communities. This report identifies a series of options to address these problems, including expanded health coverage, reviewing the Virginia Birth-Related Neurological Injury Program, developing better collaborative relationships among providers, and establishment of a nurse midwifery training program in Virginia. Ultimately, the key to progress will be the strong and ongoing commitment of health care providers and local communities to develop effective systems for comprehensive obstetrical care.

APPENDIX A

SENATE JOINT RESOLUTION NO. 331

Directing the Joint Commission on Health Care to study access to obstetrical care for the women of rural Virginia.

Agreed to by the Senate, February 23, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, many women in rural Virginia must travel up to 75 miles to obtain obstetrical care because of the maldistribution of obstetricians in the Commonwealth; and

WHEREAS, obstetrical services are reimbursed by commercial insurance carriers as much as 30 percent more in urban areas than in rural areas; and

WHEREAS, although 85 percent of rural Virginia physicians are family physicians, only 10 percent provide obstetrical services—one of the lowest rates in the United States; and

WHEREAS, in rural Virginia localities where family physicians offer obstetrical services, the infant mortality rate is generally lower than in those where family physicians do not provide obstetrical services; and

WHEREAS, there are many barriers to family physicians providing obstetrical care in rural Virginia; for example, family physicians who perform obstetrical services do not benefit from lower malpractice costs through participation in the Birth-Related Neurological Injury Act, and the only obstetrical fellowship program in the Commonwealth provides advanced obstetrical training to just two family physicians per year; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study access to obstetrical care for the women of rural Virginia. In its deliberations, the joint commission is requested to consider: (i) third-party payer reimbursement policies and the effects of such policies on the maldistribution of obstetrical services in Virginia, (ii) obstetrical practice barriers for family physicians and other practitioners, including nurse-midwives, in rural areas of the Commonwealth, and (iii) ways to encourage more practitioners in rural practice sites to provide obstetrical services, including, but not limited to, the feasibility of initiating a Virginia program similar to the North Carolina Rural Obstetrical Incentive Program for the reduction of malpractice insurance costs in underserved areas.

The joint commission is further requested, upon completion of its study, to report its findings and recommendations to the joint subcommittee established to study women's access to obstetrical and gynecological services, pursuant to HJR 560 (1995), and to complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care
Summary of Public Comments on Draft Issue Brief 5:
Access to Obstetrical Care in Rural Areas

Comments on this issue brief were received from the following 15 interested parties:

Virginia Obstetrical and Gynecological Society
Virginia Academy of Family Physicians
The Medical Society of Virginia
League of Virginia Health Systems
Virginia Hospital Association Rural Health Task Force
Director, Blackstone Family Practice Residency Program
Director, Riverside Regional Medical Center OB/GYN Residency Program
Director, Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Virginia Health Sciences Center
Faculty Member, Roanoke Memorial Hospital Family Practice Residency Program
Dean, VCU-MCV School of Nursing
Obstetrical Staff, Fairfax Hospital
Member, Maternal Health Committee, Medical Society of Virginia
Coordinator, Region IV Perinatal Coordinating Council
Private OB/GYN Physician
Private Family Practice Physician

Policy Options Presented in Issue Brief

Five policy options were presented in the issue brief for consideration by the Joint Commission on Health Care.

Option (1). The General Assembly may wish to consider requesting the Secretary of Health and Human Resources to study available options for expanding Virginia Medicaid coverage of pregnant women and infants.

Option (2). The General Assembly may wish to consider requesting the Secretary of Health and Human Resources, in cooperation with the State Corporation Commission's Bureau of Insurance and the Worker's Compensation Commission, to evaluate the impact of the Virginia Birth-Related Neurological Injury Compensation (VBRNIC) Program in rural areas and recommend policies for improving the utility of the program for rural providers.

Option (3). The Virginia Academy of Family Practice and the Virginia Obstetrical and Gynecological Society should consider establishing a joint task force to establish standards and protocols for prenatal care, detection of high risk cases, obstetrical referral, and backup.

Option (4). Virginia's academic health centers should evaluate their programs for obstetrical training of family medicine residents to ensure that they produce graduates who are adequately trained to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians.

Option (5). The General Assembly may wish to consider appropriating state funds to establish a nurse midwifery program at Virginia Commonwealth University - Medical College of Virginia.

Summary of Comments

Commenters either expressed support or did not comment on Options 1, 3, and 4. Several of the comments on Options 3 and 4 included innovative ideas for improving the training environment and collaboration for family physicians and OB/GYN physicians.

In response to Option (2), the Virginia Academy of Family Physicians and the Director of the Blackstone Family Practice expressed support for reevaluating the VBRNIC Program. Also, the VHA Rural Health Task Force did not take a position on Option (2), but did recommend that the Commonwealth continue to study North Carolina's Rural Obstetrical Care Incentive Program. Writing to express concern about changing the fund as currently structured were the Medical Society of Virginia, the Virginia OB-GYN Society, two OB/GYN physicians, one group of OB/GYN physicians, and one family practice physician.

The Virginia Hospital Association Rural Health Task Force expressed support for Option (5). The Virginia OB-GYN Society, the Director of the Blackstone Family Medicine Program, and the Virginia Academy of Family Physicians wrote in opposition to Option (5).

Summary of Individual Comments

Virginia Obstetrical and Gynecological Society

Robert B. Bowden, M.D., commented on behalf of the Virginia Obstetrical and Gynecological Society. The Virginia OB/GYN Society expressed support for Option (1) to expand Medicaid coverage to 185% of poverty, but noted that a federal Medicaid block grant could make this option problematic.

In response to Option (2) to reevaluate the VBRNIC Program, the Society commented that it would strongly oppose any attempt to re-direct any program funds for purposes other than compensation to the injured infants. The Society also commented that the fund should work equally well for rural and urban practitioners under the assumption that malpractice insurance credits should be the same for rural and urban practitioners. Also, fees have become more affordable for participants depending on how long they have participated.

In response to Option (3), the Society is supportive of forming a joint task force with the Virginia Academy of Family Physicians to discuss ways in which collaborative relationships between the two specialties may be improved.

In response to Options (4) and (5), the Society stated that academic health centers play an important role in the training of family practice residents. Historically, the Society has also supported the establishment of a nurse midwifery program. However, the Society feels that an increase in the number of nurse midwives is not a substitute for medical care providers, and Virginia must be careful not to create a second level of medical care.

Finally, the Society believes that one of the most important factors in improving access and outcome is the ability to educate those in both the rural and urban areas concerning the importance of seeking prenatal care.

Virginia Academy of Family Physicians

Roger Hofford, M.D., commented on behalf of the Virginia Academy of Family Physicians. The Academy supports Option (1) to expand Medicaid coverage for pregnant women and infants. The Academy also pointed out that there have been instances in which teenagers who have commercial insurance and are dependents of their parents are not covered for obstetrical care. The Academy asks that the General Assembly consider requiring all commercial carriers who sell health insurance in Virginia be required to provide obstetrical insurance coverage for teenage female dependents. Academy members have also pointed out that current Medicaid policies are perceived as discouraging teenage mothers from staying with their parents. The Academy suggests that such policies should be changed if they do in fact exist.

In response to Option (2), the Academy supports setting up a program to help subsidize obstetrical malpractice premiums in underserved areas of Virginia. The Academy would support using the VBRNIC Program as a source of this funding. Under this approach, medically underserved areas and standards for maternity care would be established by the Virginia Department of Health.

The Academy supports Option (3) regarding the establishment of a joint task force to establish standards and protocols for obstetrical care. The Academy further stated that it is important to keep both parties "feet to the fire" by requiring a progress report to the General Assembly and the Secretary of Health and Human Resources within one year. The Academy also recommends that the Virginia Department of Health be asked to be a part of the process for several reasons: 1) VDH can help target new collaborative practices in areas of need in the state; 2) through state involvement, liability concerns could be improved by state endorsed practices and protocols, and 3) this may allow a chance for VDH to collaborate with family physicians in areas where OB backup cannot be obtained.

The Academy supports Option (4) which asks Virginia's academic health centers to evaluate their programs for the obstetrical training of family practice residents. However, one concern is that the number of obstetrical patients available for teaching purposes at the academic health centers is declining, meaning that more teaching will have to be done at community hospitals which are not under the complete influence of the AHCs. The Academy recommends that the state and the academic health centers consider setting up a postgraduate six month cesarean section Family

Practice Fellowship in Virginia to provide the surgical skills to practice obstetrics without relying on surgical obstetrical backup where it may be available.

The Academy believes that Option (5) regarding the establishment of a nurse midwifery program at VCU-MCV is not a viable option for solving problems in rural areas. The major reasons are the declining number of obstetrical patients for teaching purposes and the historical concentration of nurse midwives in urban areas.

Finally, the Academy emphasized the importance of monitoring the effectiveness of rural obstetrical care on an ongoing basis. The Academy suggested that Virginia may want to reevaluate the effectiveness of its Regional Perinatal Coordinating Councils and see if there are better ways to empower these Councils to address the needs of Virginia.

Medical Society of Virginia

Ms. Madeline I. Wade commented on behalf of the Medical Society of Virginia. The Medical Society supports Option (1) regarding expansion of Medicaid coverage for pregnant women and children, and noted the need to continue efforts to encourage private insurance coverage through the various strategies currently under review by the Joint Commission.

In response to Option (2), the Medical Society is opposed to any change to the use of the VBRNIC Program fund or regulations of the fund. The Medical Society also noted that statute requires providers to participate in agreements with the Health Commissioner to participate in a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and it does not appear that these plans have been fully implemented.

The Medical Society does not support Option (5) regarding establishment of a nurse midwifery training program at VCU-MCV as a means of enhancing the supply of rural providers, primarily because nurse midwives tend to concentrate in urban and suburban areas.

Finally, the Medical Society commented that incentive programs such as the Virginia Medical Scholarship Program, the State/Federal Physician Loan Repayment Program, and the Virginia Nurse Practitioner Scholarship Program are the most likely vehicles for attracting more providers to underserved areas, as opposed to efforts to change the VBRNIC Program.

League of Virginia Health Systems

Robert B. Manetta, Associate General Counsel, commented on behalf of the League of Virginia Health Systems. The League would be in favor of Option (1) to expand Medicaid coverage because it would in turn increase access for the working poor.

The League would favor Option (3) to establish a joint task force between the VAFP and the Virginia OB/GYN Society, and points out that it would be best if the obstetricians and family practitioners developed a collaborative practice model which includes standards for referral of patients.

The League would support Option (4) to evaluate residency training programs, and points out that Carilion's Community Hospital of the Roanoke Valley has already bolstered training for family practitioners by, among other measures, the addition of family practice faculty who have provided obstetrical care in private practice.

The League did not explicitly comment for or against Option (5) to establish a nurse midwifery training program at VCU-MCV, but did note that such a program should include a focus on rural health.

The League also made several additional comments about the study. First, it is important to assess the impact of state government restructuring/downsizing on the availability of prenatal care for the 26,000 women who receive prenatal care from local health departments. Also, the Maternal and Child Health Council could and should be a strong advocate for the needs of women and children, although the Council could benefit from more rural representation. The state's Office of Rural Health could also play an important role in improving access to obstetrical care.

The Virginia Hospital Association Rural Health Task Force

Rayburn A. Thompson, Chairman, commented on behalf of the Virginia Hospital Association Task Force on Rural Hospitals and Health Care. As a general comment, the Task Force emphasized its support for the idea of provider collaboration in the provision of obstetrical care in rural areas. In addition:

The Task Force supports Option (1) to expand Medicaid, but points out that this is not a likely option under a Medicaid block grant.

The Task Force does not have a position on Option (2), but would be interested in further review of North Carolina's Rural Obstetrical Care Incentive Program.

The Task Force supports Option (3) to establish a task force on standards and protocols for OB care, and views this Option as a critical step toward enhancing the delivery of OB care in rural areas.

The Task Force supports Option (4) to evaluate residency training programs at Virginia academic health centers, and suggests that establishing a fellowship in family practice OB training would be an appropriate step toward encouraging interest in delivery OB services.

The Task Force supports Option (5) to establish a nurse midwifery training program as an excellent first step toward increasing the availability of nurse midwives in rural areas.

Director, Blackstone Family Practice Residency

Benjamin H. McIlwaine, M.D., commented on Options (2) through (5). With regard to Option (2), Dr. McIlwaine echoed the Virginia Academy of Family Practice's concern that the malpractice premium reductions resulting from participation in the VBRNIC Program do not offset the increased costs of malpractice coverage for rural family physicians who practice obstetrics. Dr. McIlwaine suggests that the North Carolina Rural Obstetrical Care Incentive program may be a more effective solution.

Dr. McIlwaine supports Option (3) regarding establishment of a joint task force on obstetrical standards and protocols. Dr. McIlwaine urged that the Virginia Department of Health be included in the task force process to provide guidance on underserved areas, facilitate collaboration with local health departments, and provide a "liability calming effect" through state-sanctioned practice standards and protocols.

Dr. McIlwaine supports Option (4) regarding evaluation of residency training programs. Dr. McIlwaine does not support Option (5) regarding the establishment of a nurse midwifery program at VCU-MCV as a solution to rural access problems.

Faculty Member, Roanoke Memorial Hospital Family Practice Residency Program

James W. Banks, III, M.D., a faculty member with the Roanoke Memorial Hospital Family Residency Program, commented on the changing environment of rural obstetrical care. Dr. Banks stated that family physicians are an excellent resource for high quality obstetrical care in rural areas, and that there is strong evidence for this assertion. In recent years, the Roanoke Family Practice Residency Program has added family physician faculty with particular expertise in obstetrics so that the program now has four faculty who are actively delivering babies and teaching residents. Nearly half of the program's current group of 36 residents are interested in practicing obstetrics, but, unfortunately, the job market for these physicians is bleak because so few family physicians in private practice provide OB care. Dr. Banks recommends that steps be taken to increase opportunities for these physicians to practice the full scope of family medicine, perhaps including incentives from the state and from local hospitals.

Dr. Banks also described a declined in the number of obstetrical patients available to both the family practice residency at Roanoke Memorial and the OB-GYN residency at Community Hospitals of Roanoke Valley. Ironically, the major reason for the decline is the increasing interest in Medicaid patients by private practitioners resulting from Medicaid payment increases. Dr. Banks stated that while increased reimbursement has resulted in a shift of patients to private physicians, it remains unclear whether there has been an actual increase in the number of Medicaid women seeking prenatal care during the first trimester. It is also unclear whether there is a need for the current number of OB-GYN residency positions. Given the broad scope of practice of family physicians and their prevalence in rural areas relative to other specialties, Dr. Banks believes that the Commonwealth would do well to promote the training of family physicians and their practices as part of the solution to inadequate access to obstetrical care in rural areas.

Director, Riverside Regional Medical Center OB/GYN Residency Program

William J. Mann, Jr., M.D., Director of the Riverside Regional Medical Center OB/GYN Residency Program, commented on several aspects of the study. In response to Option (4) regarding residency training, Dr. Mann recommended the establishment of a combined residency training program of five years duration which would allow the physician to

become eligible for board certification in both family practice and OB-GYN. Dr. Mann believes that this approach would be superior to attempts at educating family practice residents in obstetrics through 6-12 month fellowships or simply intensifying their experience during the traditional 2-4 month obstetrical rotations. In his opinion, neither of these approaches would produce physicians capable of delivering the full scope of high quality obstetric care rural patients deserve. Dr. Mann has constructed such a curriculum and believes that it is feasible, practical, and can be done with a modest investment of time and faculty.

Dr. Mann also said there is a need to challenge the conventional wisdom which holds that improvements in prenatal care would necessarily reduce infant mortality to more acceptable levels. He points out that congenital anomalies and Sudden Infant Death Syndrome (SIDS) are two of the leading causes of infant death, and in his view neither of these would be influenced by early prenatal care. Dr. Mann suggests that it may be worth examining whether congenital anomalies and SIDS fetal losses are random throughout the state of Virginia, or not random but rather occurring in specific geographic areas. He further suggests an examination of whether these two causes of death are associated with low income, drug abuse, or perhaps the lack of adequate rural pediatric care. Dr. Mann also suggested further research to confirm whether low weight births are in fact occurring in patients who do not have access to early prenatal care.

Finally, Dr. Mann described a viable approach for extending obstetrical care into rural areas. Riverside Regional Medical Center identified a significant number of patients living in the Gloucester area who were presenting for delivery without prenatal care. Riverside established a satellite obstetric service in Gloucester where patients could see not only obstetricians but also maternal fetal medicine specialists who could assist in the management of high risk pregnancies. This was accomplished with residents, staff, and faculty, but Dr. Mann points out that satellites such as this could also be staffed with some other combination of nurse midwives, nurse practitioners, and physicians. Dr. Mann pointed out that satellite approaches could be more cost effective than establishing new centers in rural areas which may not have adequate numbers of patients to support a practice.

Director, Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Virginia Health Sciences Center

J.E. Ferguson, M.D., commented in opposition to making changes to the VBRNIC Program. He further commented that efforts should be focused

on recruiting OB-GYN physicians to rural areas because of their more advanced training relative to family physicians and nurse midwives. He also noted that in many urban and suburban areas in Virginia, it is getting more difficult to establish a reasonably active practice, and more practitioners are looking to rural areas.

Dean, VCU School of Nursing

Nancy Langston, Ph.D., R.N., Dean of the VCU School of Nursing, commented on Option (5) regarding the establishment of a nurse midwifery program at VCU-MCV. She stated that VCU remains committed to working with the State in any way deemed appropriate to provide access to nurse midwifery education, and noted that she sees no reason why it would not be feasible to establish a nurse midwifery program at VCU-MCV. However, Dr. Langston, expressed reservation about the representation of nurse midwives as a potential solution to access problems faced by women residing in rural areas. In Dr. Langston's view, nurse midwives would encounter the same barriers to practice in rural areas as physicians. Therefore, the primary focus of legislative intervention should be on creation of an appropriate rural practice environment for non specialists in obstetrics, regardless of whether the provider is a generalist physician or a nurse midwife.

Private Family Practice Physician

John R. Partridge, M.D., a private physician and Associate Clinical Professor of Family Practice at VCU-MCV, commented on Option (2) regarding the Virginia Birth Related Neurological Injury Fund. Dr. Partridge cautioned against using the resources in the Fund for any purposes other than compensating injured infants. Dr. Partridge pointed out that the Fund has been effective for both injured infants and participating providers. He also noted that while the Fund currently has substantial assets, those assets may be needed as claims against the Fund increase.

Private OB/GYN Physician

Jeffrey M. Schulman, M.D., wrote to add his voice to "...those who are protesting any attempts to redistribute (funds from the VBRNIC Program) in any fashion which would not directly impact upon patient care or reduction of malpractice premiums for physicians in the Commonwealth of Virginia." Dr. Schulman also commented that it would seem

appropriate, if the VBRNIC Program is felt to be overfunded, that a portion be returned to the physicians who have paid into it.

Obstetrical Staff from Fairfax Hospital

Twenty-three members of the Obstetrical staff at Fairfax Hospital signed a letter expressing their great concern "...regarding reports that efforts have been made to funnel (VBRNIC Program funds) into other uses." These respondents further stated that "Elimination of (the VBRNIC program fund) would be a grave error and would return us to the litigious adversarial relationship between doctors and their patients which existed prior to its institution."

Member of Medical Society of Virginia Maternal Health Committee

Herbert G. Hopwood Jr., M.D., commented that the VBRNIC Program should be kept intact. Dr. Hopwood commented further that the program "has been a great source of help in the provision of obstetrical and gynecological care in Virginia.

Coordinator, Region IV Perinatal Coordinating Council

Ms. Carey Bailey, Coordinator of the Region IV Perinatal Coordinating Council, commented on the impact of managed care upon obstetrical services in Virginia. According to Ms. Bailey, one effect of managed care has been an increasing trend in which pregnant women must travel outside their city or even district to receive prenatal care or deliver their infants, despite the existence of risk-appropriate services nearer their residence. This practice affects both the pregnant women and rural providers who may not be part of the managed care provider panel. Another concern is the trend toward early postpartum discharge of mothers and babies after delivery. Insurance-mandated very early postpartum discharge should be discouraged in instances where either the mother or the practitioner feels it is premature, or there does not exist sufficient community or home health services to replace the hospital care.

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