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[Improving Pregnancy Outcome in the District of Columbia].
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Report to Albert P. Russo, Director, District of Columbia: Dept. of Human Resources; by Robert V. Parabaugh, Assistant Director, Human Resources Div.

Contact: Human Resources Div.

Organization Concerned: District of Columbia.

Authority: Social Security Act, as amended. P.I. 93-641.

A review was conducted of the District of Columbia's (D.C.'s) progress in improving pregnancy outcome. The District's infant mortality rate declined from 35.3 per 1,000 live births in 1966 to 24.9 per 1,000 live births in 1976. However, the District's 1976 infant mortality rate is substantially higher than the U.S. rate (15.2 per 1,000 live births) and ranks among the highest of all the States and large cities. Substantial differences also exist in the infant mortality rate among the District's nine health service areas. No organization has effectively assumed overall responsibility for seeing that the District has a concerted, systematic approach for improving pregnancy outcome. Planning responsibility is fragmented; better collection and use of data are needed; service delivery and financing need to be coordinated; resources are unevenly distributed; and many physicians are reluctant to accept medicaid patients. More concerted and coordinated efforts are needed to deal with adolescent pregnancy, and more concerted community outreach efforts are needed. The Director of the D.C. Department of Human Resources should: exert more leadership and concerted action to address adverse pregnancy outcome in the District by seeing that responsibilities among agencies for planning, financing, delivering, coordinating, and evaluating services for mothers and infants are clearly defined, understood, and carried out. He should also hasten the development and implementation of a District-wide plan for attacking this problem, work more closely with the Board of Education to pinpoint responsibilities and coordinate efforts to prevent adolescent pregnancy, assess the feasibility of increasing medicaid reimbursement rates, take other action to encourage private physicians to accept medicaid patients, and expand the use of nurse-midwifery services. (RBS)



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HUMAN RESOURCES
DIVISION

Mr. Albert P. Russo, Director
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OCT 31 1978

restricted

Dear Mr. Russo:

We have completed our review of progress made and problems encountered in the District of Columbia to improve pregnancy outcome. As you know, our work in the District was part of our national review of Federal efforts to reduce or prevent infant mortality and morbidity and other adverse pregnancy outcomes. Our work in other States is still underway, and we expect to report the results of our national review to the Congress in the Spring of 1979. As agreed when we began our work in the District, we are providing this summary of our findings to you.

Although pregnancy outcome has generally improved in the District in the last several years, many problems persist. Infant and fetal death rates and the incidence of low birthweight infants, teenage pregnancy, and abortion in the District are high relative to other areas in the United States. Many District women do not receive prenatal care at all or do not begin receiving such care until late in their pregnancies.

Many factors contribute to these problems. The Department of Human Resources (DHR) can help alleviate several of these factors. To do this, we recommend that you:

- Exert more leadership and concerted action to address adverse pregnancy outcome in the District, by seeing that responsibilities among agencies for planning, financing, delivering, coordinating, and evaluating services for mothers and infants are clearly defined, understood, and carried out; and by working more closely with private organizations and providers in the District with interests in this area.

- Hasten the development and implementation of a comprehensive and cohesive District-wide plan and approach for attacking this problem, and collect, report, and effectively use more comprehensive data to identify needs and problems and to evaluate progress.
- Work more closely with the District's Board of Education to pinpoint responsibilities and coordinate efforts for preventing unwanted adolescent pregnancy.
- Assess the feasibility of (1) increasing the District's Medicaid reimbursement rates for obstetric care, (2) taking other action to encourage more private practice physicians to accept Medicaid patients, and/or (3) expanding the use of nurse-midwifery services to areas with limited resources and with significant pregnancy outcome problems.
- Assess the need for a full-time neonatologist at D.C. General Hospital and see that the District has an Infant Intensive Care project that fully meets the Department of Health, Education, and Welfare (HEW) requirements.
- Take appropriate action to improve community outreach efforts by DHR agencies and coordinate such efforts with private providers.

DHR has initiated efforts to improve management of its maternal and child health program as part of an HEW grant it received in September 1977 to improve pregnancy outcome and is proposing additional activities under an Improved Child Health plan it is preparing. These efforts should help, but more is needed.

We recognize that some factors contributing to poor pregnancy outcome may be beyond the influence and control of the District Government. For example, even with intensive public health education efforts, it may be difficult to change negative attitudes of people toward pregnancy, health care, and parenting. We also recognize that actions taken by other agencies, such as the District's Board of Education and by HEW, can affect efforts to improve pregnancy outcome. We expect to report actions needed to be taken by HEW in our overall report to the Congress.

ADVERSE PREGNANCY OUTCOME
IS A PROBLEM IN THE DISTRICT

The District's infant mortality rate^{1/} has declined from 35.3 in 1966 to 24.9 in 1976. However, the District's 1976 infant mortality rate is substantially higher than the U.S. rate--15.2--and ranks among the highest of all the States and large cities in the country. Furthermore, substantial differences in the infant mortality rate exist among the District's nine health service areas, ranging from 5.6 in area eight to 30.1 in area four. Over the last 10 years, two areas have shown virtually no improvement and one area experienced an increase in its infant mortality rate.

Other data for 1976 illustrate the adverse pregnancy outcome problem for District residents.

--The District's fetal death rate^{2/} --17.1--was about twice the U.S. rate and has increased since 1973.

--12.6 percent of the infants born to District residents were low birthweight--less than 2500 grams.

--Nearly one of four births in the District was to an adolescent mother, including about 1100, or 11.5 percent, to women 17 or younger.

--Over half the births were out-of-wedlock, and there were more abortions than births.

--Many District women received no prenatal care or received such care late in their pregnancies.

1/ Infant Mortality Rate is based on the number of deaths under one year of age per 1,000 live births.

2/ Fetal Death Rate is based on the number of fetal deaths (gestation 20 weeks or over) per 1,000 live births.

RESPONSIBILITY FOR PLANNING
DELIVERING, AND FINANCING MATERNAL
AND INFANT CARE SERVICES IS DIFFUSED,
FRAGMENTED, AND NOT WELL-COORDINATED

Several organizational components in DHR, other District agencies, and federally-supported private health care providers plan, deliver, or finance maternal and infant care services in the District. However, no organization has effectively assumed overall responsibility for seeing that the District has a concerted, systematic approach for improving pregnancy outcome. Consequently, the District lacks a comprehensive plan and coordinated approach for delivering and financing maternal and infant care services.

Planning responsibility is
fragmented

The District lacks a current, comprehensive plan for improving pregnancy outcome which identifies problems, sets objectives, specifies actions to be taken, pinpoints responsibilities, and provides for interagency coordination. Furthermore, DHR is either not collecting, or not effectively using, data needed to develop such a plan and monitor problems and progress.

DHR has given at least three of its component agencies some responsibilities for planning for maternal and infant care services in the District. These agencies are the (1) Office of State Agency Affairs, which houses the District's State Health Planning and Development Agency established under P.L. 93-641 and is responsible for developing health service plans to meet Federal requirements, (2) Office of Planning and Evaluation which is responsible for overall health service planning in the District, and (3) Division of Maternal and Child Health, which administers the District's Maternal and Child Health program authorized by title V of the Social Security Act. Responsibilities and relationships among these agencies are not clearly defined or understood and none has developed a current or comprehensive plan for improving pregnancy outcome District-wide.

The Division of Maternal and Child Health has developed a maternal and child health plan to qualify for Federal funds under title V of the Social Security Act.

This plan, however, is not comprehensive, does not sufficiently identify specific problems, measurable objectives, priorities, or responsibilities District-wide and has not been updated for several years. Furthermore, it does not sufficiently consider the District's relationship with the neighboring jurisdictions. Such consideration is particularly important because more infants are born in the District to non-District residents than to District residents. For example, in 1976, only about 9,200 of about 19,900 deliveries in the District were to District residents. Both HEW and DHR officials agree that the plan is outdated and is not adequate to meet the current health care needs of mothers and infants in the District.

The need for a good plan for improving pregnancy outcome has been recognized by such groups in the District as the District of Columbia chapter of the American Academy of Pediatrics and the March of Dimes. In addition, representatives from the D.C. Medical Society told us that they believe they can offer assistance to DHR but have usually not been brought into the planning process early enough. The need for a comprehensive, coordinated planning effort in the District for improving pregnancy outcome will become even more important as the District's Health Planning and Development Agency shifts from its conditional status to an operational mode.

DHR officials believe that planning responsibilities among DHR component agencies are conceptually clear. However, in practice, the Offices of Planning and Evaluation and State Agency Affairs and the Division of Maternal and Child Health have overlapping responsibilities for improved pregnancy outcome planning. The specific planning activities they are to undertake and the operational interrelationships among these organizations are not clear or well understood. One DHR official told us that DHR recognizes this operational problem and plans to clarify planning responsibilities among its component agencies.

Better collection and use
of data are needed

DHR needs better data to develop and monitor implementation of a comprehensive plan for improving pregnancy outcome and for evaluating the effectiveness of its on-going programs which affect pregnancy outcome. Such evaluations are lacking. To pinpoint specific problems,

DHR needs current data on such matters as infant morbidity, causes of fetal deaths, adolescent pregnancies, and inadequate prenatal care. DHR did not either collect or compile complete or current data of this nature. For example, DHR does not collect complete data on causes of fetal deaths or the incidence of adolescent pregnancy for District residents. According to the Chairman, Fetus and Newborne Committee, D. C. Chapter of the American Academy of Pediatrics, the lack of sufficient pregnancy outcome data is a significant problem in the District.

DHR officials agreed that they need better data to plan and evaluate efforts to improve pregnancy outcome. They indicated that efforts to obtain and use such data have been hampered by a number of factors, including lack of resources and the failure of many physicians to provide all the data called for on birth certificates. However, they said that they are taking several actions to obtain and use better data.

Service delivery and financing need to be coordinated

The delivery or funding of maternal and infant care services in the District is divided among several Federal, District, and private organizations and providers. DHR needs to clearly designate one organization responsible for orchestrating and overseeing the District's efforts for improving pregnancy outcome and seeing that efforts within DHR, the District's Board of Education, HEW, D.C. General Hospital, and other private organizations and providers are integrated.

Within the District, maternal or infant care services are provided by (1) a total of 15 clinics operated by three divisions in DHR's Bureau of Clinical Services, (2) 4 independent, federally-funded community health centers, (3) D.C. General Hospital--the only non-Federal, acute care public hospital in the District--and 9 other hospitals, (4) 3 private organizations which receive Federal funds to provide family planning services, (5) the District's Board of Education, which mandates health and family life education for school students, and (6) numerous other private health care providers.

Funding for maternal and infant health services comes from a variety of sources, including several organizational components within DHR. These include the Bureau of Clinical Services, the Social Rehabilitation Administration, which administers the District's social services program, and the Office of State Agency Affairs and the Payments Assistance Administration, which administer the District's Medicaid and medical charities programs.

HEW also provides resources for maternal and infant services in the District. Some of these resources, such as funds for maternal and child health, Medicaid, and social services go to DHR. However, HEW provides other resources directly to other providers, such as project grants for community health centers and family planning services, and National Health Service Corps personnel. Private organizations such as the National Foundation-March of Dimes, also provide funding.

No organizational unit in DHR has effectively taken a leadership role for directing, coordinating, or overseeing service delivery efforts in the District to improve pregnancy outcome. According to DHR functional statements, the Division of Maternal and Child Health has the responsibility for overseeing the level of maternal and child health in the District, proposing remedial measures when necessary, and coordinating services provided by other community agencies. However, the Division has not been able to effectively carry out these responsibilities. Organizationally, it is not in a position of influence even within DHR; it directly controls only 3 of DHR's 15 clinics that provide maternal and infant care services. According to DHR officials, the Division's oversight responsibilities have generally been limited to those involving the administration of federally-funded maternal and child health activities.

During our review, we noted a number of problems which illustrate the need for DHR to take a strong leadership role to improve pregnancy outcome in the District. Many of these problems have also been identified by others. They are summarized below.

Uneven distribution of resources

Maternal and infant care resources are not evenly distributed throughout the District. For example, five DHR clinics and one independent community health center are located in service areas (3 and 4) east of the Anacostia River. Three of the DHR clinics and the center are clustered in one section of area 3. Two DHR clinics providing maternal or infant care are located in area 4, which lies east of the Anacostia and south of Pennsylvania Avenue, and one of these clinics provides obstetric services only one-half day Monday through Friday. The infant mortality rate for area 4 is the highest in the District and was higher in 1975-1976 than in 1965-1966. In 1976, this area accounted for more births, infant deaths, births to teenage mothers, low birthweight infants, and births to unwed mothers than any other health service area in the District.

The limited hours obstetric services are available are not limited to DHR clinics. For example, one of the four independent community health centers in the District offers obstetric services for only 3 hours a week. Until recently, the community health center in the area east of the Anacostia offered obstetric services only four hours weekly. The addition of full-time National Health Service Corps obstetricians to the center staff in August 1978 will enable the center to expand this service.

Reluctance of physicians to accept Medicaid patients

Many obstetricians in the District reportedly will not accept Medicaid-eligible patients because of the District's relatively low Medicaid payment rate for obstetric care. For example, in April 1978, the District increased the Medicaid payment rate for a normal delivery from \$85 to \$150. Despite this increase, the Medicaid payment to an obstetrician in the District for a normal delivery is about one-fourth the maximum rate allowed by Washington Blue Shield for this service. According to the Chairman of the D.C. Medical Society's Committee on Maternal and Child Health, low Medicaid payment rates coupled with the high risk nature of the pregnancies of many Medicaid-eligible women discourage many obstetricians from accepting Medicaid patients. He said that although the District's Medicaid program provides for additional payments for some complicated deliveries, paperwork requirements and lengthy delays in payment for such services further discourage acceptance of Medicaid patients.

More concerted and coordinated
efforts needed to deal with
adolescent pregnancy

Although adolescent pregnancy is a significant problem in the District, no one has assumed overall responsibility for seeing that this issue is addressed District-wide. Some schools, health clinics, and hospitals have established programs to deal with adolescent pregnancy, but these are not part of an organized, District-wide effort. Services provided by the School Health Branch of Maternal and Child Health include student health appraisals, screening and referral, and health services for handicapped children. This branch also serves as the coordination point for DHR and other agency programs providing health services to students.

The Director of the School Health Services Branch told us, however, she does not get involved in school programs designed to deal with the problem of unwanted adolescent pregnancy. Although a health and family life curriculum is mandated in the District's school system, it has not been fully implemented. Two reasons cited were the reluctance of instructors to teach such subjects and the lack of training for instructors on how to teach these subjects.

A report recently issued by a task force which studied adolescent pregnancy in the District identified the lack of coordination and communication among the District's school system, health care providers, and DHR, as the most significant barrier to alleviating the problem. The report cited the need to make adolescents aware of the services available to them and where they were located.

DHR's Director of Maternal and Child Health told us that her staff has been working with staff at several schools in the District to assist in providing health education and other related services. However, the lack of a clear policy in this area by the Board of Education hampers expansion of these efforts District-wide. She said that her staff has met with public school officials to discuss the adolescent pregnancy problem, but no definitive action plan was adopted. She agreed that better linkages between health providers and the schools are needed.

No focal point exists for overseeing
family planning services

Family planning services are provided by many organizations in the District, including DHR clinics, hospitals, and federally-funded community health centers and title X family planning grantees. No organization, however, appears to have responsibility for seeing that the need for and availability of family planning services District-wide are assessed and that the delivery of such services is coordinated and evaluated.

The need for such efforts is evidenced by the high number of abortions and adolescent and out-of-wedlock births in the District. A family planning project in Northwest, partially funded by the Division of Maternal and Child Health, operates an underutilized clinic, serving relatively few persons, while another clinic east of the Anacostia reportedly has a 2-week waiting period for new family planning patients. In addition, relatively little funding had been allocated in 1978 for family planning services under the District's social services program, although DHR's 1979 budget provides for a substantial increase.

Infant intensive
care services need assessment

According to a preliminary report by the American Academy of Pediatrics, D.C. General Hospital had the highest neonatal death rate (deaths to infants within the first 28 days of life) in 1974-75 of the nine non-Federal hospitals in the District which provide obstetrical services. D. C. General's role as the traditional provider of inpatient care for low income (high risk) persons could at least partially account for its relatively high neonatal death rate. In April 1977, the Academy reported that a neonatology position at the hospital was vacant for 2 years and that the addition of such a specialist to D.C. General would improve the situation considerably. Also, the District's Maternal and Child Health plan provided for such a specialist at D.C. General.

The Director, Division of Maternal and Child Health, said that she would assess the need for a full-time neonatologist at D.C. General Hospital. She said that although such a position was established as part of the District's Infant Intensive Care Project, it was never filled.

Although D.C. General Hospital serves as the District's Infant Intensive Care project, no formal agreement or other document clarifies the administrative relationship between DHR and the Hospital in terms of the Infant Intensive Care project under the Maternal and Child Health Program. According to an HEW region III Maternal and Child Health program representative, such a written agreement is needed to comply with HEW requirements.

In September 1978, the National Capital Medical Foundation, Inc., initiated a review of the hospital services provided to premature infants in all the District hospitals providing such services, including D. C. General. The Foundation expects the study to be completed in about 3 months.

More concerted community
outreach efforts needed

The large number of women who receive no or late prenatal care and the high rate of broken appointments for pre- and post-natal care, family planning, and pediatric care at clinics serving low income persons illustrate the need for better outreach efforts to encourage people to initiate or continue visits to health care providers. For example, the broken appointment ratios at the Division of Maternal and Child Health's maternity clinics vary from 30 to 40 percent. The title X family planning grantee and the community health center we visited have similar broken appointment ratios for family planning and pediatric care.

Many DHR units, including those responsible for maternity and infant care, family planning, supplemental foods, and public health nursing, appear unable to provide sufficient community outreach efforts to meet the needs of District residents. According to DHR representatives, resource limitations have restricted the maternal and child health outreach activities of public health nurses, and outreach efforts for family planning services under the social services program have been minimal.

To illustrate, many women, infants, and children in the District needing supplemental foods apparently are not receiving them in spite of the availability of such such foods. According to DHR data, only about one-third of those eligible for supplemental foods are receiving them.

In July 1978, the District of Columbia Auditor reported that the location of distribution points, poor outreach, and insufficient community information and education efforts significantly contributed to this problem. According to DHR, 23 new positions have been established to increase public participation in the District's Supplemental Food Program.

In as much as the outreach problem affects private as well as DHR providers, coordinated efforts to inform and educate District residents may be advantageous.

RECENT HEW INITIATIVES IN THE DISTRICT

HEW has recently given additional resources to organizations in the District to improve and expand health care delivery. Some of these resources are targeted at improving pregnancy outcome.

In September 1977, HEW awarded a \$382,000 project grant to improve pregnancy outcome in two health service areas (5 and 6) in the District and to establish a regional perinatal coordinating body. The grant is being administered by DHR's Division of Maternal and Child Health. This award was part of a 5-year Improved Pregnancy Outcome project grant program under which the District can receive up to \$400,000 annually for the next 4 years. Although DHR was slow in getting started, project activities have been initiated and are underway.

In fiscal year 1978, HEW provided additional resources to several private organizations in the District as part of its Urban or Adolescent Health Initiatives. Some of these resources are aimed at improving pregnancy outcome. Three of the District's four federally-funded community health centers received funds to expand services, including those that are pregnancy related, to adolescents. One of these centers also received two National Health Service Corps personnel--an obstetrician and a pediatrician. In addition, HEW added another title X grantee in the District to provide additional family planning services, including services to teenagers and to males.

DHR is preparing an application for an HEW Improved Child Health grant. This is a project grant for improving health services for high-risk mothers and infants in areas with excessive mortality and morbidity. Resources are available under this program from up to four HEW programs--Maternal and Child Health, Community Health Centers, Family Planning, and National Health Service Corps. According to DHR, its plan for this grant will provide for establishing a health center for mothers and children in service area 4 as well as several other activities to improve pregnancy outcome.

CONCLUSION

Although pregnancy outcome in the District has generally improved, significant problems persist. Several organizations in the District, including DHR, are acting to help resolve or alleviate many of these problems. However, most of these efforts are being initiated by HEW and private organizations without benefit of a comprehensive, District-wide plan or managerial or programmatic leadership. More cohesive and aggressive DHR efforts to plan, organize, promote, implement, coordinate, and evaluate District-wide efforts to improve pregnancy outcome are needed to see that resources are effectively marshalled, used, and coordinated.

HEW and DHR have recently initiated and planned several actions to improve management and expand resources for improving pregnancy outcome in the District. Although these steps should help improve access to health care for District residents, it is too early to determine their impact on improving pregnancy outcome.

DHR COMMENTS

In September 1978, we discussed the results of our review with DHR officials. They generally agreed with our findings and recommendations and made the following comments.

--Although DHR does need to take a greater leadership role for improving pregnancy outcome in the District, other District organizations such as the Board of Education, the City Council, and the private health care providers will have to cooperate if efforts are to succeed. Furthermore, DHR's efforts have been impeded by the categorical and diverse nature of the HEW programs.

--They believe that their ability to manage a comprehensive, concerted effort to improve pregnancy outcome would be enhanced if they had more influence over HEW funds which are given directly to private community health centers and family planning grantees in the District.

--District efforts under HEW's Improved Pregnancy Outcome project are a step in the right direction. However, HEW has several initiatives relating to improving pregnancy outcome. Each initiative requires a separate application, staff, and effort. The initiatives are short-term. DHR officials believe HEW needs to consolidate its efforts in this area. For example, they suggested that the Improved Pregnancy Outcome and Improved Child Health projects be consolidated and be made a part of the on-going Maternal and Child Health formula grant program. This would give the District greater assurance that funds would be available to continue project activities and would make it easier to hire and retain competent staff because they would not have to worry about a short-term employment status.

In October 1978, DHR provided comments on a draft of this report. It recognized the need for more cohesive efforts to improve pregnancy outcome in the District and outlined several actions it was taking or planned to take in response to our recommendations. DHR said that:

--It was, as part of its Improved Pregnancy Outcome project, inviting the private sector in developing a Perinatal Council to effect coordination among all agencies dealing with infant mortality in the District.

--It has initiated several steps to collect and use more and better data to improve its service delivery systems for improving pregnancy outcomes and, as part of its Improved Child Health plan being developed, is proposing to study pregnancy outcome problems in service areas 3 and 4.

--The Office of State Agency Affairs will function as the District's coordinating unit for federally funded family planning services and community health centers. Also, DHR is addressing the coordination of family planning efforts in its Improved Child Health plan being developed.

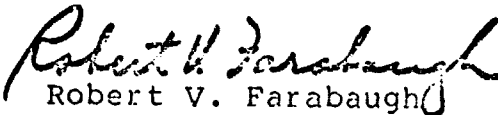
- It will continue to pursue efforts with the District's Board of Education to develop and implement a city-wide program of family life and sex education in the school system. Also, it has placed high emphasis on outreach and education relating to adolescent pregnancy under its Improved Pregnancy Outcome Project and its Improved Child Health plan being developed.
- It has a commitment to continuously review Medicaid rates and make adjustments where appropriate within available resources.
- It is assessing the need for a full-time neonatologist at D.C. General Hospital and will take appropriate action if the need is validated.
- It is proposing, as part of its Improved Child Health Plan being developed, to establish a health center for mothers and children in service area 4 which would include outreach and education activities and has initiated action to expand outreach activities in its Supplemental Food program.

We believe that the actions taken or planned by DHR are generally responsive to our recommendations. However, DHR's comments did not specifically discuss the issue of pinpointing overall responsibility for improving pregnancy outcome in the District, nor did they specify what actions would be taken to clarify planning responsibilities among DHR agencies. We believe that DHR can help ensure more cohesive efforts to improve pregnancy outcome by clarifying responsibilities among the Offices of Planning and Evaluation and State Agency Affairs and the Division of Maternal and Child Health for planning, promoting, coordinating, and evaluating activities in the District for improving pregnancy outcome.

The Director of DHR, in transmitting his comments to us on a draft of this report, stated that he shared our concern about improving pregnancy outcome in the District. The recently initiated efforts are illustrative of DHR's concern and are steps in the right direction. Because of the severity of the District's pregnancy outcome situation--according to 1976 National Center for Health Statistics data, having the highest infant mortality rate of all States and large U.S. cities--we strongly recommend that the Office of the Director monitor and support DHR's efforts to ensure that they are consistent with the commitment of improving pregnancy outcome in the District and are effective.

We appreciate the cooperation provided by your staff during our review.

Sincerely yours,


Robert V. Farabaugh
Assistant Director