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# Washington and Lee University

## Women's Reproductive Health in Rockbridge County

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A Community-Based Research Project

## Introduction

Throughout the past four years, I have studied the relationship between health and poverty and worked firsthand with organizations that provide health care specifically to the very poor and extend access beyond the non-poor to indigent populations. Over the past summer, I interned in the medical clinic at So Others Might Eat in Washington, DC, where I worked largely with the homeless population in the area. At SOME, I learned about the particular challenges of providing care to the very poor, including empowering patients to actively participate in their health and healthcare. As a future physician, access to care and providing healthcare to the poor is especially important to me.

Rural areas are subject to characteristic problems with access, which I have seen firsthand working with organizations in my hometown and in Lexington. The poor in rural areas are especially vulnerable because they are often far from providers, may lack transportation, and may be less likely to know about available services. For my capstone, I wanted to focus on a personally relevant rural healthcare issue. I grew up in a rural community, much like Rockbridge County, where unplanned teenage pregnancy is unusually prevalent and the nearest physicians' office and pharmacy are over twenty minutes away.

In Lexington, women's reproductive health issues have reached prominence of late, especially those of obstetric and prenatal care, because of the birthing center at Stonewall Jackson Carilion Hospital in April 2010. When the opportunity arose to assist a local alliance of healthcare providers in assessing community health by conducting a community-based research study, I chose to focus my project within the study on access to women's reproductive health services in the area. This paper outlines my research methods and draws on this research in

order to identify areas of proficient and deficient access to reproductive services within the community. I explore access to contraception, family planning services, teenage and unplanned pregnancy, prenatal care and support, obstetric care, and abortion services in and around the area. I then make recommendations for the different entities within this local coalition of health care providers, in order to address gaps in access and to extend care in Lexington and the greater Rockbridge area.

## **Community Based Research Methods**

### *Community Health Assessment*

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic planning process for improving overall community health developed by the National Association of County & City Health Officials (NACCHO).<sup>1</sup> The framework allows community health leaders to address public health issues in order to improve efficiency, effectiveness, and the overall performance of local public health systems. A partnership of the Rockbridge Area Free Clinic, Carilion Stonewall Jackson Hospital, and the Rockbridge-Lexington and Buena Vista Health Departments supported my project as part of a larger community health assessment. Information was collected using the MAPP Community Health Needs Assessment (CHNA), a discussion-group based framework designed by NACCHO for use with the MAPP program to determine the health needs of the community.<sup>2</sup> The members of the coalition, particularly the Rockbridge Area Free Clinic (RAFC), were interested in the health needs of the poor, uninsured, and underinsured in the area. The CHNA targeted specific groups, selected to capture the

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<sup>1</sup> National Association of County & City Health Officials. "Mobilizing for Action through Planning and Partnership." 2012. < <http://www.naccho.org/topics/infrastructure/mapp/index.cfm>>.

<sup>2</sup> "Mobilizing for Action through Planning and Partnership."

health needs of the poor or near poor of Rockbridge County.<sup>3</sup> The study utilized four focus group populations: (1) parents of young and school-aged children, (2) women of childbearing years, (3) adults, and (4) the elderly. These groups were selected to provide a representative sample of those groups least likely to have adequate access to health care services.

My project focuses on women during the childbearing years, although I draw on information collected in focus groups targeting the other three population groups.<sup>4</sup> Although study participation did not require financial information, it is reasonable to suspect that all or most of participants are low-income because of the nature of eligibility for the services we targeted. All pregnant women with income below 133% of the federal poverty line are eligible for Medicaid; therefore, unlike the other groups, most of the women involved in my project have or are eligible for health insurance coverage through Medicaid. Participants were also asked about insurance coverage and where they receive other services such as dental care.

This question confirmed that participants were low income and whether or not they have Medicaid.

### *Focus Groups*

Focus groups were conducted by student researchers and/or trained facilitators at a variety of locations throughout the community. In order to reach low-income community members, focus groups were conducted in conjunction with organizations and services that provide care to poor or uninsured persons. Focus groups targeting women of childbearing years were held at either the Lexington or Buena Vista Health Departments and targeted

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<sup>3</sup> "Mobilizing for Action Through Planning and Partnership."

<sup>4</sup> Childbearing years are considered 15-44.

Guttmacher Institute. "Facts on Contraceptive Use in the United States." 2010. In Brief: Fact Sheet June 2010. < [http://www.guttmacher.org/pubs/fb\\_contr\\_use.html#5a](http://www.guttmacher.org/pubs/fb_contr_use.html#5a)>.

recipients of three services, including: (1) the maternity clinic; (2) family planning services; and (3) Women, Infants, & Children (WIC) clinic. The MAPP CHNA format, which leaves room for interpretation and modification to suit the nature of the conversation, provided the basic framework for the focus group interviews (See Appendix I for format).<sup>5</sup> Several modifications were made to the interview format to facilitate data collection at the Health Department. To accommodate the Health Department and the patients, interviews were conducted one-on-one, rather than in larger groups. The one-on-one format also offers a more comfortable environment for patients and may encourage women to share sensitive information. Unfortunately, in order to accommodate appointment schedules and because of limited space at the Health Department, interviews were conducted in the waiting room before, after, or between appointments. Although most women were comfortable in this setting, this may have prevented full disclosure, increased participant discomfort, or biased some participants' responses.

Patients were asked about general access to healthcare and about positive and negative experiences with area providers. Additionally, participants were asked specifically about reproductive health services, including access to prenatal care and maternity support services, obstetric care, genetic testing, family planning, and contraception. Patients and facilitators discussed overarching themes in reproductive and general health and discussed healthy behaviors, such as nutrition and exercise. Interviews were recorded and transcribed by student researchers for use by RAFC in the CHNA. Participants signed consent forms and were entered to win a \$25 gift certificate in return for participation (See Appendix II for consent form).

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<sup>5</sup> National Association for County & City Health Officials. "Rockbridge Area MAPP format." 2012.

## Women's Reproductive Health in Rockbridge County

In order to discuss reproductive health, it is first necessary to define what the term encompasses. The World Health Organization defines "reproductive health" as follows:

...reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.<sup>6</sup>

The WHO goes on to qualify what constitutes exercising the right to reproductive health and alludes to which services are included in full access to reproductive health.

Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.<sup>7</sup>

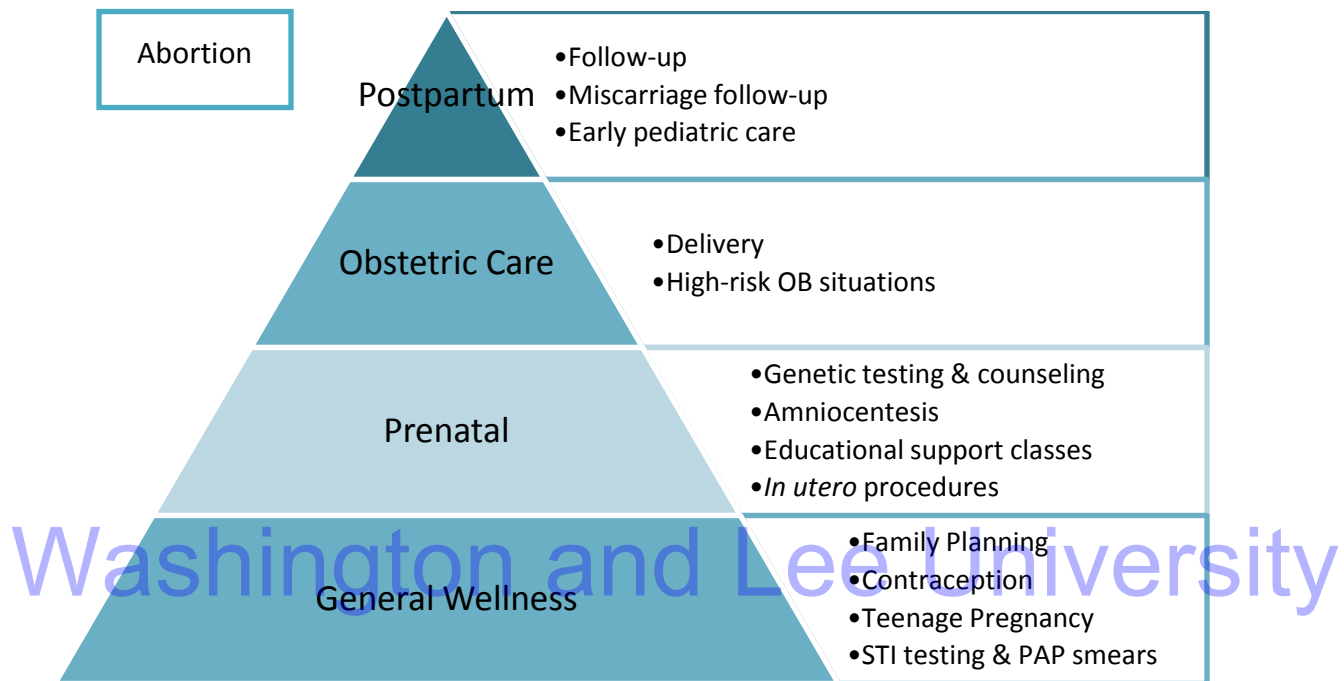
Inherent in this definition is the right of all women to have full access to a broad range of reproductive health services for the sake of the mother as well as the child.

Figure 1 offers a schematic representation of these services, beginning with the broadest category of general reproductive wellness at the base of the pyramid. This category encompasses all women of reproductive age and some services, such as STI testing, extend beyond this category. Moving up the pyramid from the base follows the progression of pregnancy from conception to prenatal care through postpartum follow-up care. Abortion, while an important reproduction health service, does not fit neatly into the pyramid schematic and is represented as a box at the side of the figure. STI testing and cervical cancer screening, while important reproductive health services, are not included in this paper because their reach

<sup>6</sup> World Health Organization. "Reproductive Health." 2012. Accessed 9 April 2012 < [http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)>.

<sup>7</sup> WHO. "Reproductive Health."

extends beyond women of reproductive age, i.e. women continue to have regular PAP smears after they go through menopause. Similarly, early pediatric care, while an important aspect of reproductive health care, shifts the focus of care from the mother to the child. Therefore, these services are beyond the scope of this paper and will not be included.



**Figure 1 – Reproductive Health Services.**

Before exploring these services individually, it is important to gauge the need of the community. One of the themes developed throughout this paper is that many women may not take advantage of existing services because they either do not know about the services or do not know they are eligible for services. There are approximately 5,966 women aged 18-44 in Rockbridge County, including Lexington and Buena Vista cities.<sup>8</sup> Utilizing data from the Rockbridge Area Free Clinic, I estimated approximately 1,895 poor or near poor adult women in

<sup>8</sup> United States Census data. 2010. (Provided by Laura Simpson, RAFC).

the area.<sup>9</sup> Medicaid eligibility for pregnant mothers includes women with income up to 133% of the federal poverty line (FPL). I used this data to generate a conservative estimate of adult women eligible for Medicaid in the area. I multiplied the number of adult women per area by the matched poverty rates for less than 100% FPL to estimate approximately 740 Medicaid-eligible women. The poverty rates for between 100% and 199% percent are higher; therefore, this is probably a very conservative estimate. This estimate also does not include teens who may be even less likely to know or understand they are eligible for coverage.

If one-third of these women do not know they are eligible, there are approximately 250 women who may become pregnant who do not know they are eligible for Medicaid coverage. One-third of the poor or near poor in the area is well over 600 women, who may have more complicated eligibility requirements for reduced fees or other services. While it is unlikely that all of these women will become pregnant at once, it is reasonable to estimate that there may be a significant portion of women in the area that are or may become pregnant that do not know they are eligible for coverage.

**Dr. Beckley,**

**I asked the health department if they could help me gauge how many patients take advantage of their maternity, family planning, and WIC services. Gloria said they would have to do a chart count so I told her not to worry about it. The nurses may be better able to estimate this number. I also used one-third as an arbitrary benchmark. I don't really have any evidence to suggest that this is a reasonable number, but my mother suggested this benchmark based on the methods they use to estimate numbers for free and reduced lunch at her school. One-third seemed a reasonable place to start for the purposes of this paper. I think the personnel at the Health Department are as good as anyone to help you with these estimates. They know much more than we do.**

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<sup>9</sup> United States Census data. 2010. Poverty rates from: United States Census Summary File 3. 2000. (Both provided by Laura Simpson, RAFC).



## *Services Offered at the Health Department*

The state of Virginia is divided into 35 health districts, all of which fall under the Virginia Department of Health. Lexington and Rockbridge County belong to the Central Shenandoah Health District, which is comprised of the counties of Augusta, Bath, Highland, Rockbridge, and Rockingham, and the cities of Buena Vista, Harrisonburg, Lexington, Staunton and Waynesboro. Within the Central Shenandoah district, seven health departments serve approximately 285,000 residents.<sup>10</sup> The Health Department offers a variety of reproductive health services, some of which are free, some have a flat fee, and some are billed on a sliding scale based on income. STD and AIDS testing are offered free of charge. Women, Infants, & Children (WIC), a federally funded supplemental food program available free of charge to eligible participants, is also administered at the Health Department. The rest of the Health Department's reproductive health services are billed on a sliding scale, determined by gross family income and family size.

### **Sliding Scale Guidelines:**

Based on client income, payment will be full fee, 95% (of full fee), 75%, 50%, 25%, 10% or free.<sup>11</sup>

<b>Family Size</b>	<b>Free if less than:</b>	<b>Full Fee if above:</b>
1	\$10,890	\$27,226
2	\$14,710	\$36,776
3	\$18,530	\$46,326
4	\$22,350	\$55,876
5	\$26,170	\$65,426
6	\$29,990	\$74,976
7	\$33,810	\$84,526
8	\$37,630	\$94,076
9	\$41,450	\$103,626
10	\$45,270	\$113,176

<sup>10</sup> Virginia Department of Health. "Central Shenandoah Health District." 2012. Accessed 19 April 2012. < <http://www.vdh.state.va.us/lhd/CentralShenandoah/>>.

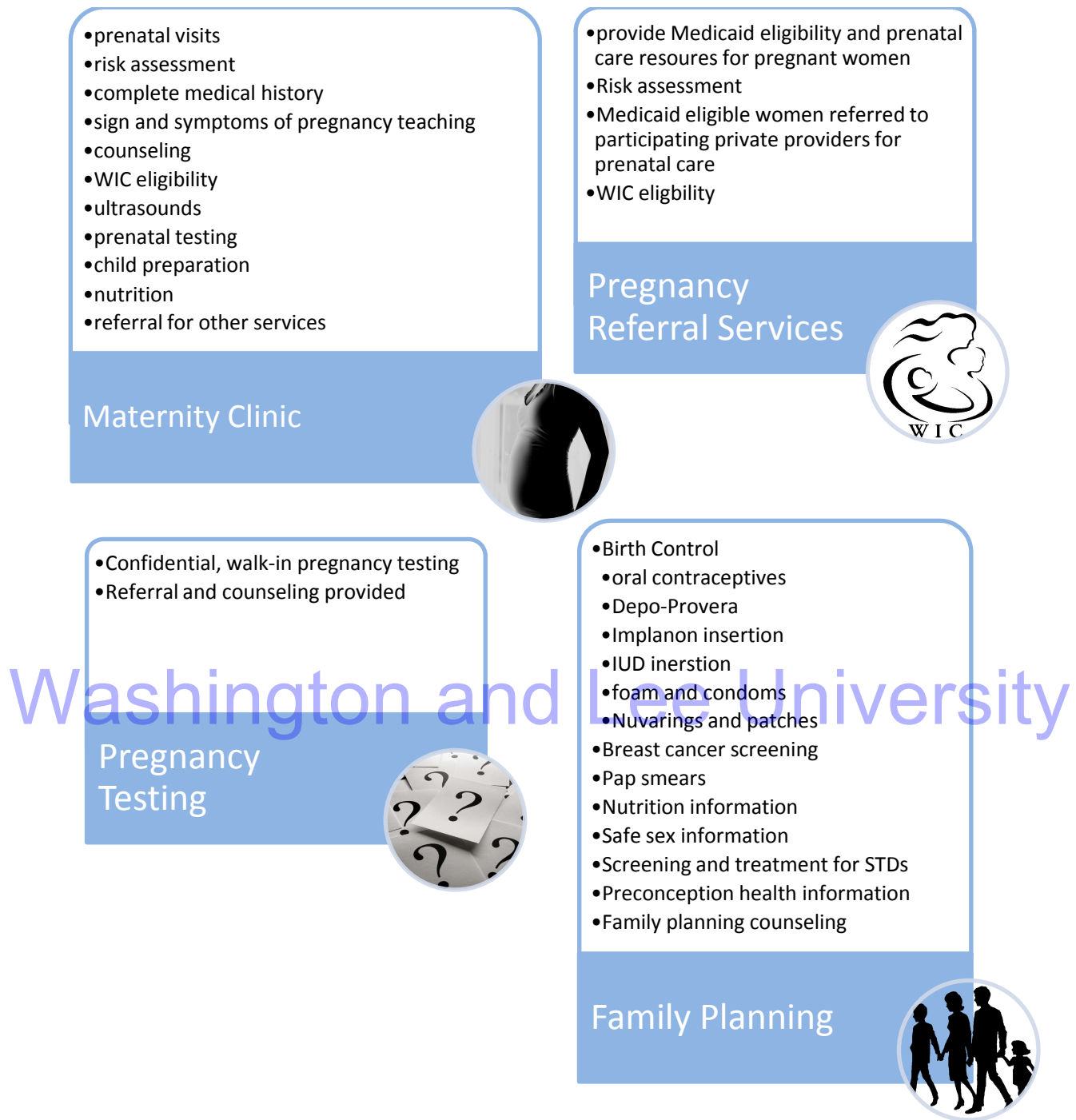
<sup>11</sup> Virginia Department of Health. "Virginia Beach Health Department: Clinic." 2012. Accessed 14 March 2012 < <http://www.vdh.virginia.gov/LHD/vabeach/Clinic.htm>>.

Scaled-fee services include: the maternity clinic, which offers comprehensive prenatal care to women who are not eligible for Medicaid or are uninsured as well as to women who are covered by Medicaid; family planning and birth control services; and pregnancy testing and referral services. A comprehensive list of services is given in Figure 2.<sup>12</sup>

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<sup>12</sup> The Health Department also offers early pediatric well childcare; however, I will not be including early pediatric care in this paper. While it is not included here, early pediatric care is a very important part of women's reproductive health services and as such deserves adequate attention.  
"Virginia Beach Health Department: Clinic."



- prenatal visits
- risk assessment
- complete medical history
- sign and symptoms of pregnancy teaching
- counseling
- WIC eligibility
- ultrasounds
- prenatal testing
- child preparation
- nutrition
- referral for other services

Maternity Clinic

- provide Medicaid eligibility and prenatal care resources for pregnant women
- Risk assessment
- Medicaid eligible women referred to participating private providers for prenatal care
- WIC eligibility

Pregnancy Referral Services



- Confidential, walk-in pregnancy testing
- Referral and counseling provided

Pregnancy Testing

- Birth Control
  - oral contraceptives
  - Depo-Provera
  - Implanon insertion
  - IUD insertion
  - foam and condoms
  - Nuvarings and patches
- Breast cancer screening
- Pap smears
- Nutrition information
- Safe sex information
- Screening and treatment for STDs
- Preconception health information
- Family planning counseling

Family Planning



Figure 2. Comprehensive list of Reproductive Services offered by the Health Department.<sup>13</sup>

<sup>13</sup> “Virginia Beach Health Department: Clinic.”

Image sources from top left:

- 1) Maternity: <http://msmagazine.com/blog/blog/2011/11/18/another-barrier-to-maternity-leave-for-those-most-in-need-knowing-about-it/>
- 2) WIC logo: <http://co.crook.or.us/Departments/Health/WIC/tabid/152/Default.aspx>

## Contraception

The Affordable Care Act brought insurance coverage of prescriptions for birth control to the forefront of the political climate.<sup>14</sup> Beginning in August 2012, insurance companies must offer policies that cover all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling without cost sharing via co-pays or deductibles.<sup>15</sup> There are currently 62 million women of childbearing years in the United States; some 43 million of these women (seven out of ten) are sexually active but do not wish to become pregnant. Virtually all women (over 99%) who are sexually experienced have at some point used contraception other than natural family planning methods.<sup>16</sup>

Despite the political uproar caused by the ACA mandate, the recent trend has been toward rather than away from coverage of prescription contraceptives. There are currently 28 states with laws in place that mandate that insurance policies that cover prescription drugs in general must provide the full range of contraceptive drugs and devices approved by the Food

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3) Question: <http://rickischultz.wordpress.com/category/the-recovering-english-teacher/writing-the-recovering-english-teacher/you-have-a-question-i-have-an-answer/>

4) Family: <http://erikbrewer.wordpress.com/2011/05/09/faith-in-jesus-and-the-family/>

<sup>14</sup> The issue was hotly debated at W&L's own Mock Convention by Mary Matalin and James Carville. Perhaps not surprisingly, the most notable aspects of the discussion were the one-liners, including the likening of coverage of prescription contraception to providing free M&Ms.

<sup>15</sup> "Beginning in August, many health plans will cover additional preventive services with no cost-sharing, including well-woman visits, screening for gestational diabetes, domestic violence screening, breastfeeding supplies and contraceptive services." This coverage does not include abortifacient drugs. HealthCare.gov. "The Affordable Care Act and Women." 2012. Accessed 20 March 2012. <<http://www.healthcare.gov/news/factsheets/2012/03/women03202012a.html>>

<sup>16</sup> This includes women of "childbearing age", ages 15-44. This is also true of Catholic women, 98% of whom have used a contraceptive method other than natural family planning.

Jones, Rachel K., and Joerg Dreweke. "Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use." 2011. Available online: <<http://www.guttmacher.org/media/nr/2011/04/13/index.html>>.

and Drug Administration (FDA).<sup>17</sup> Federal employees are guaranteed coverage and nine in ten employer-based insurance plans cover the full range of contraceptives.<sup>18</sup> One-quarter of the more than 20 million American women who obtain contraceptive services from a medical provider receive care from a publicly funded family planning clinic.<sup>19</sup> In 2008, 7.2 million women, including 1.8 million teenagers, received contraceptive services from publicly funded family planning clinics in the United States.<sup>20</sup>

In 2006, there were 4,110 women of reproductive age, about half of which or 2,050 women, were in need of contraceptive services in Rockbridge County.<sup>21</sup> Of these, 1,160 women in Rockbridge County needed public funding to afford contraceptive services. Three-quarters of those in need of publicly funded contraceptive services were below 250% of the federal poverty line. This and additional data are summarized in Tables 1 and 2.

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<sup>17</sup> Jones RK, *Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills*, New York: Guttmacher Institute, 2011.

<sup>18</sup> This is three times the number that did so just a decade ago.

Dailard C, Contraceptive coverage: a 10-year retrospective, Guttmacher Report on Public Policy, 2004, 7(2):6–9.

Sonfield A et al., U.S. insurance coverage of contraceptives and the impact of contraceptive coverage mandates, 2002, *Perspectives on Sexual and Reproductive Health*, 2004, 36(2):72–79.

<sup>19</sup> Jennifer J. Frost. "Trends in US Women's Use of Sexual and Reproductive Health Care Services, 1995–2002." *American Journal of Public Health*: October 2008, Vol. 98, No. 10, pp. 1814-1817.

<sup>20</sup> Frost, 2008.

<sup>21</sup> This study considered 13-44 reproductive age, as opposed to other studies, which consider women 15-44 to be in their childbearing years.

Guttmacher Institute. "Contraceptive Needs and Services." 2008. Accessed 14 March 2012. <<http://www.guttmacher.org/pubs/win/index.html>>.

Women in Need of Prescription Contraceptives				
		Rockbridge County	Virginia	National
	All Women (13-44)	4,110	1,726,080	66,380,710
	Total	2,050	921,450	36,214,680
Age	<18	150	57,240	2,233,560
	18-19	130	71,060	2,822,470
	20-29	910	388,710	15,582,000
	30-44	860	404,420	15,576,910
By Poverty Status (20-44)	<100%	300	84,750	4,478,170
	100 – 132%	90	30,440	1,582,030
	133 – 184%	220	58,910	2,792,530
	185 – 249%	270	85,680	3,576,520
	250+%	890	533,430	18,729,520
Race/ Ethnicity	Non-Hispanic, White	1,920	590,810	22,523,500
	Non-Hispanic, Black	80	197,610	5,094,380
	Hispanic	30	64,130	5,857,390

**Table 1. Women in Need of Prescription Contraceptives. Rockbridge County is compared to Virginia and the numbers for the United States. Women who would be eligible for coverage by Medicaid are highlighted in yellow, i.e. those who fall below 132% of the Federal Poverty Line (FPL). The actual cut-off is 133%. Those between the eligibility benchmark for Medicaid and 250% of the FPL, or those who would be considered “near poor” are highlighted in orange.<sup>22</sup>**

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<sup>22</sup> “Contraceptive Needs and Services.”

Women in need of Publicly Funded Contraceptives				
		Rockbridge County	Virginia	National
Total	Total	1,160	388,030	17,485,330
	<20	280	128,270	5,055,790
	20 – 44 and <250% pov	880	259,630	12,429,570
Non-Hispanic, White	Total	1,080	225,120	9,560,250
	<20	270	78,270	3,057,690
	20 – 44 and <250% pov	810	146,900	6,502,530
Non-Hispanic, Black	Total	60	107,020	3,068,450
	<20	10	35,220	903,730
	20 – 44 and <250% pov	50	71,840	2,163,990
Hispanic	Total	10	31,210	3,646,100
	<20	0	6,970	748,660
	20 – 44 and <250% pov	10	24,120	2,895,970

Table 2. Women in Need of Publicly Funded Contraceptives. Rockbridge County is compared to Virginia and the total for the United States. Highlighted in yellow are the numbers for women are over 20 and either poor or near poor (below 250% FPL). Highlighted in orange are numbers for teenagers who are in need of public funding in order to have access to contraceptive services.<sup>23</sup>

### *Kathy\**

Kathy\* first came to the Lexington Health Department as a young girl to get birth control.

“I don’t remember how old I was. Thirteen or fourteen. I remember we walked.”

“We” included Kathy and her mother; as a young girl, Kathy needed birth control to regulate her periods and alleviate her pre-menstrual symptoms. Without prompting, she commented that she started using birth control well before she began having sex. Kathy chuckled as she recalled her first visit to the health department, including her discomfort at having a male physician.

<sup>23</sup> “Contraceptive Needs and Services.”

\*All names have been changed to protect study participants.

“He sung a song or something that was...like...to...to know what to check,” she recalled, referring to her first breast exam and the physician trying to teach her to perform a breast self-examination. She laughed as the facilitator quipped, “Yeah, it’s like why are you singing and touching me.” Despite her discomfort, Kathy spoke very highly of the Health Department staff.

Kathy is a lifelong Lexington resident and mother of two girls, aged two and five. Hers was a family planning interview conducted when she came in for her regular Pap smear. Ironically it was the same services that initially brought her to the Health Department that landed Kathy in this study. Kathy has not always received care at the health department:

“Um, I had a job where I actually had insurance, so I was going to Dr. S----’s office. But then when I stepped down...single mom, separated from my husband, and all that good jazz. Um, I’ve actually been coming here for a year.”

One of the more poignant moments of the interviews was Kathy’s response to how it felt to come back to the Health Department as an adult. She chuckled warmly as she said, “The same...the same people are still here.”

#### ***Lottie***\*

Contrast Kathy’s story with that of Lottie\*. At fifteen, Lottie’s aunt encouraged her to go to the Health Department to get birth control. She wrote in her diary that she planned to do so and on the day she arrived for her appointment, to her surprise, her parents “intercepted” her at the Health Department and prevented her from obtaining contraceptives. “I was so pissed,” she remembers, “I was like ‘Do you think this will stop me from having sex?’”

#### ***Virginia***\*

Virginia, a Glasgow resident, has lived in the area for about twenty years. She was a



member of the maternity clinic focus group, but she has also received WIC and family planning services at the Health Department. Unlike Kathy, Virginia has insurance; she and her children have Medicaid coverage. Virginia is the mother of a fifteen-year-old girl, a four-year-old boy, and is pregnant with her third child.<sup>24</sup> When asked about her pregnancy, she replied, “This one’s been miserable. I’m glad it’s the last one.”

“Are you going to get your tubes tied or something?” the facilitator queried.

“I don't know. I guess it's just like...I wouldn't mind doing that but I don't know how much it would cost compared to if I did just some kind of birth control.”

What Virginia did not know is that Medicaid covers tubal ligations up to twenty-four months after delivery.<sup>25</sup> However, there are claims regulations about when the service must be requested and performed. Fortunately for Virginia, the facilitator was a former labor and delivery nurse and was aware that Medicaid would pay for the tubal ligation after delivery. The facilitator was able to explain to Virginia that, because she has Medicaid, she is eligible and also to warn her about the time constraints and claim restrictions.

Once a woman eligible for Medicaid-covered family planning services has had a sterilization procedure, she is no longer eligible for coverage, including for complications resulting from the sterilization procedure that require care beyond an office or clinic setting.<sup>26</sup> Medicaid coverage of contraceptive services, including tubal ligation and other sterilization

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<sup>24</sup> At the date of her interview, Virginia’s due date was rapidly approaching. She actually delivered her baby between her interview and the writing of this paper. She is also participating in RAFC’s photovoice program, a community nutrition assessment in which participants are asked to photograph their family’s food.

<sup>25</sup> Virginia Department of Medical Assistance Services. “Medicaid Memo: New Codes Approved, Billing Guidance for Plan First Family Planning Services Program as well as the Essure Sterilization Procedure.” 2010. Accessed online at < <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/>>.

<sup>26</sup> “Medicaid memo: New Codes Approved, Billing Guidance for Plan First Family Planning Services Program as well as the Essure Sterilization Procedure.”

procedures, provides an effective and cost-saving means to reduce unwanted and unplanned pregnancies. However, this coverage cannot help women that do not know it is available or that they are eligible for coverage. Although this is only one of a few anecdotes related in the focus group interviews, many Rockbridge County women may not know they are eligible for services or coverage.

### *Teenage Pregnancy*

The teen birth rate in Rockbridge County is currently 48 per 1,000 female teenage women. This is more than double the national benchmark (22 per 1,000) and much higher than the teen birth rate for the state of Virginia, which is 35 per 1,000 live births.<sup>27</sup> In 2005, there were 15,560 pregnancies among Virginia teens aged 15–19, a rate of 61 pregnancies per 1,000 teen women, compared with 70 per 1,000 nationally.<sup>28</sup> Teenagers (aged 15–19) who do not use a contraceptive the sexual upon initiation are twice as likely to become teen mothers as teenagers who use some method of contraception.<sup>29</sup> Title X, enacted in 1970 as Title X of the Public Health Service Act, provides federal funding for family planning and contraceptive services.<sup>30</sup> The following is taken from a description of Title X on the Department of Health and Human Services website:

Title X is the only Federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Title X

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<sup>27</sup> Teenage population includes females age 15 – 19.

County Health Rankings & Roadmaps. "Rockbridge County." 2012. Accessed 4 April 2012. <<http://www.countyhealthrankings.org/app/virginia/2012/rockbridge/county/1/overall>>.

<sup>28</sup> Guttmacher Institute. "State Facts About Title X And Family Planning: Virginia." 2011.

<sup>29</sup> Center for Disease Control. "Use of Contraception in the United States: 1982–2008." Vital and Health Statistics: Series 23 (29): August 2010.

<sup>30</sup> ["Population Research and Voluntary Family Planning Programs" (Public Law 91-572)] Office of Population Affairs. "Title X Family Planning: History of Title X." Accessed 17 April 2012 <<http://www.hhs.gov/opa/title-x-family-planning/>>.

program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families.

In 2006, contraceptive services provided at Title X–supported centers in Virginia helped women younger than age twenty avoid an estimated 4,571 unintended pregnancies. In the absence of Title X services, the number of teen pregnancies would be an estimated 29% higher in Virginia.<sup>31</sup>

The Health Department currently offers a weekly “teen clinic” at Rockbridge County High School. During this “clinic,” a nurse from the health department speaks with teens about family planning, STI testing, and cervical cancer screenings and provides general information about sex, pregnancy, and STIs. The nurse also hands out informational pamphlets and refers students to the health department as needed.

Dr. Beckley,

**I am waiting for the nurses from the Health Department to call me back and give me more information about what they actually do at the teen clinic, if it’s offered to all students or just students who want to come, etc. etc. I will update this paragraph when I get that information. Good.**

*Effie\**

Effie’s story is not the stuff of shows like MTV’s *Teen Mom* and MTV’s *Sixteen and Pregnant*. Effie is nineteen years old and when I spoke with her, was twelve weeks pregnant; however, age is one of few things Effie has in common with what you might consider the “typical” unplanned teenage pregnancy. Therefore, her interview will set the stage for the discussion of genetic testing and prenatal care as well or better than it would for teenage pregnancy. Her experience is also very different from the account of Lottie, whose parents

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<sup>31</sup> “State Facts About Title X And Family Planning: Virginia.”

prevented her from accessing contraception when she began having sex as a teenager.

Effie, formerly of Pleasant Grove, UT, in addition to being nineteen and pregnant, has been happily married to her husband Fred\* for eight months. Fred is a twenty-six year old student from Branson, MS; he and Effie met at a local university, where they are both seniors this year. Although the couple did not plan the pregnancy, both were very happy and excited for the baby to come. I had the opportunity to talk with Fred before the interview while we waited for Effie to finish her appointment. The baby disrupted his plans to apply to law school, but since he was unsure about law school, he claimed the switch to sports management was not difficult. At the time of the interview, he was applying for jobs and hoping to end up back in Missouri, working for one of the sports team in St. Louis.

Effie unfailingly described her experiences at the Health Department as positive.

“It was nice to just to be able to go where people were excited for you. And where our families live so far away that was really awesome. I was a little surprised, it was sort of an assumption about my age that I wouldn’t want to keep the baby. And women were a little bit shocked that I was like, ‘No, I’m happy that I’m pregnant.’ I’m not...It was a shock but it wasn’t ‘I had a crazy night and I’m pregnant’ it’s ‘I have a husband and we’re married and we’re ok. We’re having a baby.’

“...When we found out I was pregnant, the first question was – insurance. Because you have to have insurance to have a baby. It costs between \$10,000 and \$15,000 and luckily the free clinic was there and we were able to utilize it and use what they offered for us,” Effie responded when I asked her about a time when she had gone to seek care in the area. When

Effie got married, she was no longer eligible to be covered under her parents insurance.<sup>32</sup>

“Well, I knew that I could apply for Medicaid as a pregnant person. So we went to apply for Medicaid before we even knew where the free clinic was located.”

Effie and Fred are residents of Buena Vista. Both claim they are generally healthy people and had not, before Effie became pregnant, had occasion to seek health care in the area, especially because both go home frequently enough to receive regular care from their physicians at home. Neither knew about the health department or free clinic in Buena Vista until they were directed to the free clinic in order to obtain proof of pregnancy in order to qualify for Medicaid. Although there is a health department in Buena Vista, Effie and Fred must travel to Lexington because the maternity clinic is only offered at the Lexington Health Department.

*Genetic Testing*

Effie, Fred, and I talked extensively about information sharing between the health department, free clinic, and other providers. Effie described the health department as very open and helpful in their interactions. I was left with the impression that information was made readily available to Effie and Fred.

“They’re very open about the information. There’s no...I don’t have to sit there and dig

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<sup>32</sup> Effie and Fred, as stated above, are students at a local university. Because most institutions require their students to present proof of health insurance before or upon matriculation, I was surprised to learn that Effie did not have insurance. Upon further investigation, I learned that only athletes and students studying abroad with this particular university are required to carry health insurance. Other students may sign a waiver stating that they understand they are encourage to carry health insurance but do not hold the institution responsible for medical bills and will not participate in athletics of any kind.

Southern Virginia University. *Insurance Waiver*. Accessed 18 March 2012 < [svu.edu/pdf/sfs/health-insurance-waiver.pdf](http://svu.edu/pdf/sfs/health-insurance-waiver.pdf)>.

for information. They just say, ‘This is what it is.’” Effie provided a particularly helpful example: “Just like just now, there’s a genetic test I can do for the baby to find genetic problems right now and I didn’t have to ask for it.”

Virginia Medicaid covers both genetic testing and genetic counseling to help patients cope with the results of these tests.<sup>33</sup> These services are offered through the Health Department’s maternity clinic. When I spoke with one of the family planning coordinators at the Health Department, she explained that the health department is able to offer amniocentesis and other genetic testing through a partnership with the University of Virginia Health System in Charlottesville. They practice what is known as telemedicine: patients undergo genetic testing and amniocentesis in Charlottesville at UVA and receive the results and counseling from via teleconference under nurse or nurse practitioner supervision at the health department. Women receiving this service through the Health Department also receive prenatal care and deliver at UVA.<sup>34</sup> Amniocentesis is also offered at the other local medical centers, although the health department partners specifically with the University of Virginia.<sup>35</sup>

Effie and her husband are firmly opposed to abortion, as she mentioned several times throughout our interview. She admitted that she was initially hesitant to even have the genetic test done. Because she would never have an abortion, she thought there was little point in knowing ahead of time if the baby would have genetic defects. However, as Effie would realize, genetic testing and counseling allow parents, if they choose to carry to term, the opportunity to prepare for life with a child with a genetic condition and open the possibility of *in utero*

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<sup>33</sup> StateHealthFacts.org. “Virginia.” Accessed 3 April 2012. <<http://www.statehealthfacts.org/profileglance.jsp?rgn=48>>.

<sup>34</sup> Phone Interview with Gloria at the Lexington-Rockbridge Public Health Department. 18 April 2012.

<sup>35</sup> Simpson, Laura email message to author. 11 April 2012.

therapies before delivery.

“And I asked her, do I really want to know this? Because you could find out and be worried. And she was like, it just depends on if you find out that you’re baby has a genetic problem, what’s going to happen? And I’m like, well, we’re not into abortion, so I would still have the baby. It would still be my baby. And that was just beneficial to know that they have this information and that it’s offered to us, even though we’re on Medicaid. There’s another [test] between 16 and 18 weeks for Down’s Syndrome. And it’s just good to know that that’s there. And where we don’t want to have an abortion, even if our baby is mentally retarded, it’s our baby. Then it’s good to know so you can prepare for it.”

### *Prenatal Care*

This paper further develops Kara Karcher, 2011, a community-based research project in conjunction with RAFC.<sup>36</sup> This project examined access to prenatal care in the Rockbridge Area and the effects of the closing of the birthing center at Stonewall Jackson in April 2010 on the women of the area. I draw on her work and contribute new examples from the focus groups in order to provide up-to-date insight into the current situation.

It is helpful to think of prenatal care as having two components – clinical care and educational support care. Traditionally, general and family physicians have served as providers of prenatal care; however, in recent years, there has been a significant trend away from using family physicians toward obstetrician-provided prenatal care. Lexington suffers not only from the closing of the birthing center at Stonewall Jackson but also from a lack of general physicians in general. In Virginia, twelve obstetrics programs, the majority in rural areas, have closed in

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<sup>36</sup> Karcher, Kara. “Access to Prenatal Care in Rockbridge County: A Community-Based Research Project.” 2011.

the past eight years.<sup>37</sup> We spoke with several women in the focus groups about their prenatal care.

Virginia delivered both of her children at Augusta Medical Center in Fishersville, VA. She received her prenatal care in Augusta as well. Her thoughts on the travel distance and inconvenience: “It’s not been too bad. You know for the prenatal care. At first, it’s once a month and then it gets shorter. Like I said, I’ve had all my children up there and so it really hasn’t been that big of a deal. And I use it to also do other things, like to go to Sharp Shopper when I go up there.”

***Polly***\*

Polly, a 28-year-old mother of two – Norman\*, four-years-old, and Sasha\*, six months – moved from Pennsylvania to Natural Bridge about nine years ago. She received her prenatal care for her son, Norman, in Lexington, and delivered him at Stonewall Jackson before the closing of the birthing center. During her second pregnancy, with her daughter Sasha, she received her prenatal care and delivered at Augusta. She provided telling commentary on the difference between the care received at both facilities. Polly remembered feeling “rushed” during her prenatal care appointments at Stonewall and as if her doctors were not really listening to her, particularly when “the fluid began packing on,” as Polly described it. She felt as if this fluid packing was abnormal and when she tried to voice her fears to the physicians, she was dismissed. This fluid resulted in a complication, necessitating an emergency C-section. Polly’s sentiments, despite nearly an hour of travel time, echo the feelings of many women in the community: it is worth the drive to feel supported and to receive quality care. Although it

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<sup>37</sup> Karcher, 2011.



may be worth it for women with means to travel the distance to Fisherville, this begs a question about the quality of care and access for women with no easily accessible means of transportation. It is difficult to estimate how many women in the community are prevented from accessing care because of transportation because all of the women interviewed had some means of transportation; however, there are surely some women for whom this is the case.

Another important aspect of prenatal care is the educational and support component. Both of Kathy's children were born in Augusta and both were difficult pregnancies. She had toxemia both times, the first at 26 weeks and the second at 34 weeks.<sup>38</sup> Fortunately both were successful deliveries. It is likely that toxemia, or eclampsia, as it is now called, is the "fluid packing" that Polly referred to in her interview. Eclampsia provides an illustrative example of a preventable complication that could be alleviated with proper prenatal education. Potential causes, especially diet, and risk factors, including obesity, history of diabetes and high blood pressure, are often products of or coincident with an impoverished lifestyle. An interview with a Dr. Tom Brewer, MD, an obstetrician-gynecologist, highlights the prevalence of eclampsia among women in poverty and cites malnutrition as a major contributor to the condition's progression.<sup>39</sup> A former labor and delivery nurse also indicated that the condition is more prominent in African American women and that having eclampsia in the first pregnancy increases the likelihood that it will occur in the second pregnancy.<sup>40</sup> Dr. Brewer provides anecdotal evidence to support the success of nutrition education in alleviating toxemic

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<sup>38</sup> 26 weeks is VERY early in the pregnancy to develop toxemia; the most common treatment is to deliver the baby immediately.

<sup>39</sup> Puotinen, CJ. "Preventing eclampsia (metabolic toxemia of late pregnancy): an interview with Tom Brewer, MD." *Townsend Letter for Doctors and Patients*. November 1, 2004. Accessed 17 April 2012 <<http://www.highbeam.com/doc/1G1-123709104.html>>

<sup>40</sup> Simpson, Laura email message to author.

pregnancy, even among poor women. Prenatal nutritional education may have prevented Kathy's and Polly's complications and could have even saved money by allowing them to carry to term and deliver naturally, rather than having more difficult, dangerous, and expensive emergency caesarian section.

Prenatal support groups and classes are offered at Stonewall Jackson.<sup>41</sup> Effie and Fred were full of praise for these support classes, explaining how they made them feel as if they had a "home away from home" and provided a much-appreciated support network.<sup>42</sup> However, the Carilion website lists only one of more than fifty of the upcoming classes that is located at Stonewall Jackson in Lexington.<sup>43</sup> After hearing how helpful these classes were for Effie and Fred, I called the coordinator for prenatal classes at Stonewall Jackson, to investigate these classes further and to see how regularly they are offered. There are two upcoming sessions on the first and third Saturdays in May; these sessions are held in a conference room at Stonewall and last from 8 am to 4 pm.<sup>44</sup> Topics covered include: baby care basics, breastfeeding options, car seat safety, childbirth education and more.<sup>45</sup> The first session includes all of the topics listed above, while the second session includes infant CPR in addition to the other topics. Classes are open to participating mothers and whomever they chose to bring with them. The class costs \$50, which is covered by Medicaid and most private insurers and the coordinator

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<sup>41</sup> Carilion Clinic. "Pregnancy and Parenting." Accessed 4 April 2012 <<http://www.carilionclinic.org/Carilion/Pregnancy+and+Parenting>>.

<sup>42</sup> Effie and Fred were decidedly positive and very happy people. Their positive testimony may overestimate the effectiveness of these classes.

<sup>43</sup> The information on the website may not accurately reflect the services offered at the hospital and they may utilize some other form of advertising in order to reach women to let them know about the classes and their availability.

"Pregnancy and Parenting."

<sup>44</sup> This class is offered on either May 5 or May 19.

Phone Interview with Sandy Fitzgerald, Stonewall Jackson Carilion Hospital. 18 April 2012.

<sup>45</sup> "Pregnancy and Parenting."

assured me that no woman would be turned away because of inability to pay. The coordinator estimated that there are usually six to eight mothers per session.

At the beginning of our phone call, the coordinator (mistakenly) thought that I was planning to register for the class. I learned that registration is fairly straightforward and that women are required to provide the hospital at which they are receiving their prenatal care and where they plan to deliver. Not only did I learn that the staff at Stonewall is friendly and accommodating, but the coordinator was also able to confirm that women participating in the class represent prenatal and obstetric care at each of the four nearest medical centers. Although this does not confirm that the group is socioeconomically diverse, it may indicate socioeconomic and geographic diversity.

### *Obstetric Care*

The closing of the birthing center at Stonewall Jackson means that Lexington and Rockbridge County women must drive at least an hour to give birth. The closest care facility offering obstetrics services is the Augusta Medical Center in Fishersville, VA, an hour away from Lexington and farther from other outlying areas in the county. The next closest option is the University of Virginia Health Care System in Charlottesville.<sup>46</sup> Having to travel long distances in order to give birth is associated with an increase in potentially avoidable maternal complications.<sup>47</sup> Emergency room deliveries are also potentially risky in the event that something goes wrong.<sup>48</sup> Therefore, all Rockbridge County women are subject to elevated

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<sup>46</sup> Karcher, 2011.

<sup>47</sup> Laditka, Sarah B., Laditka, James N., Bennett, Kevin J., and Janice C. Probst. "Delivery Complications Associated With Prenatal Care Access for Medicaid-Insured Mothers in Rural and Urban Hospitals." 2005. *The Journal of Rural Health* 21 (2): 158-166.

<sup>48</sup> Karcher, 2011.

delivery risk; poverty exacerbates this risk.

Polly provided even more helpful insight into the obstetric care available in Lexington in comparison to Augusta. Although a birthing center at Stonewall Jackson seems preferable, Polly claims that she had similar feelings during her hospital stay for Norman's birth than she did during her prenatal care. She was better attended in Augusta, she claimed. At Stonewall, if she needed to rest and wanted Norman to go to the nursery, she would have to get up and take him herself, whereas at Augusta, a nurse would check on her and take Norman back to the nursery. She also discussed the openness of the providers in Augusta: "I know with [Sasha] when I had went [for care and delivery], they were really sure on taking time to explain everything to me. Why they were doing it, explaining any reason for blood work." Polly's experience with Augusta was so positive that she now prefers to make the drive for her children's doctors appointments, despite difficulties coordinating her transportation, in order to feel assured that her children are receiving quality care and that she is not being ignored or dismissed.

Although Polly had positive experiences, in a focus group of older women at the Free Clinic, one participant told the story of her niece. The niece was pregnant for a second time, after losing her first child due to a complication with the placenta during delivery. She was driven to Augusta for delivery, but arrived too late to undergo a caesarian section and lost the baby. Her aunt, the focus group participant, summarized the feelings of many when she said that it is "too dangerous to travel that far," and "that is endangering their life and the baby's life."

*Abortion*

I would be remiss not to mention access to abortion services. In 2006 – 2009, Rockbridge County had the 124<sup>th</sup> highest rate of aborted pregnancies in the state of Virginia. The countywide rate for 2006 – 2009 was 49 per every 1,000 live births or 4.6%. Interestingly, the Buena Vista city rate was more than double the countywide rate, at 162 per 1,000 live births or 14.0%, making it the 76<sup>th</sup> highest rate of aborted pregnancies in Virginia. Lexington city was more than double the Buena Vista rate (356 per 1,000 live births) and came in at the 24<sup>th</sup> highest rate in the state of Virginia.<sup>49</sup> This data indicates that more than a quarter of all pregnancies in Lexington city are ending in abortion. Although these rates, especially the Buena Vista and Lexington rates, may seem rather high, the actual figures for 2009 were eight abortions for Rockbridge County, and eleven each for Buena Vista and Lexington cities.

Therefore, although abortion services are an important aspect of reproductive health for Rockbridge County women, the population of the area is simply not large enough to justify providing abortion services in the area, regardless of whether it would be economically, socially, or culturally feasible to do so.

Currently, Medicaid does not cover abortion services and/or abortifacient drugs. Challenging this policy and attempting to justify coverage for abortion services is beyond the scope of this paper; therefore, it is more relevant to examine barriers to utilizing existing abortion services. Abortion services are not available in Rockbridge County. The closest Planned Parenthood is in Roanoke (50 miles or 58 minutes away) and the next closest is in

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<sup>49</sup> Percentages are equivalent to abortions as a percentage of pregnancies, excluding fetal deaths and miscarriages.

Johnston, Wm Robert. "Virginia abortion percentages by county/city." Last updated 6 November 2011 <<http://www.johnstonsarchive.net/policy/abortion/usac/ab-usac2-VA.html>>.

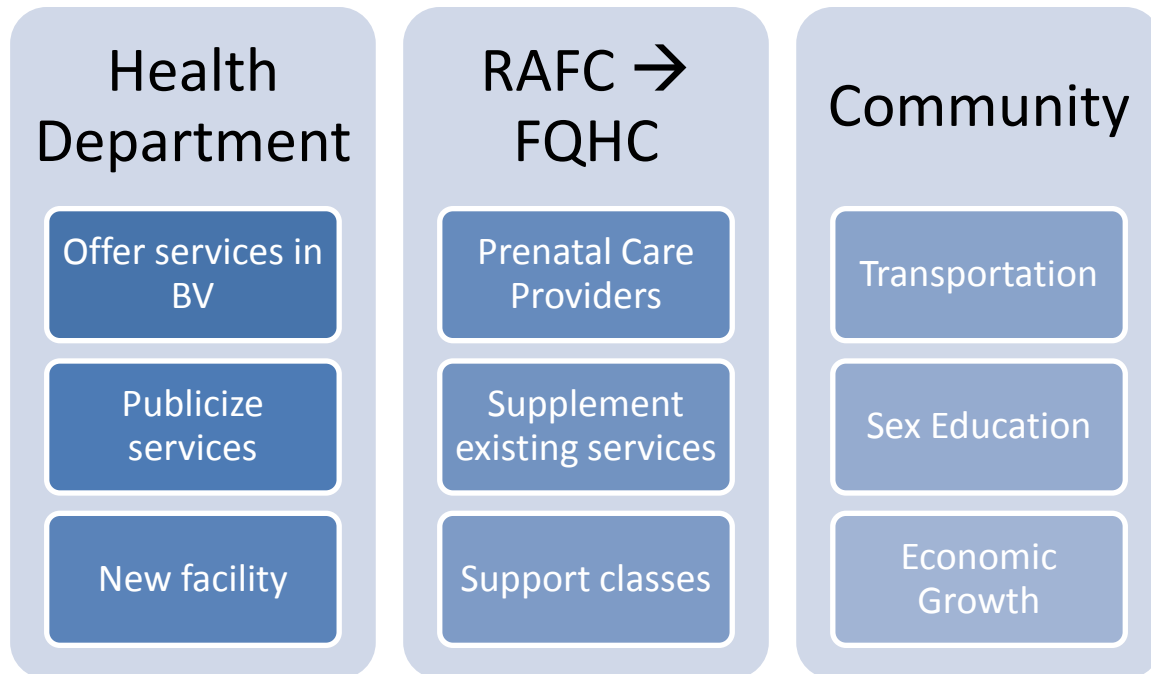
Charlottesville (70 miles or 1 hour and 16 minutes away).<sup>50</sup> The most significant barrier to a poor woman seeking an abortion is transportation to Planned Parenthood in either Charlottesville or Roanoke. Other barriers may include social or cultural stigmatization of abortion or lack of information about what services are available and where they are provided. Follow-up care for women after an abortion may not be readily available in the area for women who experience complications.

### **Policy Recommendations**

The purpose of this study is to identify deficits in access to women's reproductive health services in the community and to make recommendations for the entities within the study in order to address these deficits. I start with the Lexington-Rockbridge Public Health Department because it is the primary provider of reproductive services to poor women in the area. I then expand to the Rockbridge Area Free Clinic (RAFC) as it changes to a federally qualified community health center (FQHC). I include both services an FQHC can provide and ways it could supplement existing services. I then provide recommendations for the third entity, the community, and address ways in which the first two entities can work synergistically with the community in order to improve or expand access to poor and near poor women in the community.

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<sup>50</sup> Distances calculated from Randolph Street in Lexington, VA, using Google Maps, <maps.google.com>.



### *For the Health Department*

First, the Health Department must be commended for several areas of proficiency.

Every participant cited positive experiences with the staff and services offered at the health

department. All felt welcome and well informed and claimed that the staff members were easy

to work with and helpful. Services and distribution of information among providers and other

organizations – the free clinics, Medicaid office, and health departments – seem to be well

coordinated. Both Effie and Polly described information as very easy to access and Effie’s

experiences especially demonstrated how area organizations are working together to promote

patient well-being. Also, patients, like Kathy, feel comfortable returning to the health

department to receive care when they lose insurance coverage or cannot afford to go

elsewhere for care.

### ***Offer Services at the Buena Vista Health Department***

Based on my observations, the most significant barrier to access care at the Health

Department is travel distance and lack of reliable transportation. Some of the services are offered only at the Lexington Health Department and/or in Lexington at Stonewall Jackson. Offering some of the services, especially maternity clinic and/or birthing classes, at the Buena Vista Health Department would expand access to these important services to a broader geographic range of patients and more fully incorporate the entire county, rather than concentrating the services in Lexington. Although increasing funding and staffing and the availability and cost of equipment present significant barriers to offering some of the services at the Buena Vista Health Department, many of the services offered at the Lexington Health Department are offered through telemedicine. These services may be offered in Buena Vista without significant financial and equipment-related barriers. Another reasonable solution would be to improve transportation; this goal is addressed in the community recommendations.

## Washington and Lee University

*Publicize Services*

The Health Department currently utilizes the newspaper and other health care providers in the area to publicize its services. Occasionally, the Health department will advertise services and special programs in the local newspapers. Other than these methods, the health department relies on word of mouth within the community to advertise its services.<sup>51</sup> Although an aggressive advertising campaign is neither feasible nor necessary, increasing advertising in strategic locations and organizations within the community may serve to make community members, especially those most in need, aware of available services and/or their eligibility for such services. Advertising special programs or community events in locations that do not specifically cater to health and/or provision of care, such as local grocery stores or churches,

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<sup>51</sup> Phone interview with Gloria.



may increase the target populations. Another way to expand access to information is leaving informational pamphlets about the health department and its services, including contact information and hours of operation, with organizations that target poor and indigent populations, at the high school, and with other health care providers like Stonewall Jackson and the free clinic. Finally, an advertising campaign utilizing small items that people use regularly, such as pens or magnets that include the contact information for the Lexington and Buena Vista Health Departments may serve to remind community members of the services offered at the health department.

### ***New Health Department Building in Lexington***

While the staff at the Lexington Health Department was invariably friendly and readily accommodated our research as much as possible, space at the current facility is limited. These space constraints forced us to conduct patient interviews in the waiting area of the health department. In speaking with nurses and other employees at the health department, it was my sense that the current facility, while functional, leaves much to be desired. Not only is space limited, but much of the layout is not conducive to make patients feel comfortable or to allow providers to readily provide care. One room is connected to another through a bathroom stall and doors are necessarily blocked with chairs. The waiting room is sterile and unwelcoming, although this is often the case with public health departments. The health department needs either a complete overhaul of the current facility or a new building entirely. This is the most expensive and least feasible option and would require a significant increase in funding, most probably from federal or state funds.

*For the Free Clinic*

One of the goals of the assessment is to gauge whether or not the Rockbridge Area Free Clinic could better meet community health needs by transitioning to a federal qualified community health center (FQHC). An FQHC is able to treat patients with insurance, bill Medicaid and other private insurers for procedures, and eventually generate profits in order to create a sustainable practice. Because a free clinic by nature does not see patients with insurance, RAFC does not see pregnant women or teenagers under the age of eighteen. It also does not provide pregnancy testing, prenatal or obstetric care, or other reproductive health services. Therefore, these recommendations identify ways in which an FQHC could better meet community needs than the free clinic is currently able to do.

#### ***Family Practice Physicians & Midlevel Obstetric Care Providers***

Cohen and Coco, 2009, investigated the rates of family practitioner-provided prenatal care. This study identified younger women, those on Medicaid, and those in rural areas as more likely to seek prenatal care from a family practice physician than from an obstetrician.<sup>52</sup> Lexington is at a disadvantage because of the overall lack of general practitioners; increasing the availability of family physician-provided obstetric and prenatal care is a cost-efficient solution. Mid-level providers of obstetric care, like nurse midwives, also provide an alternative to obstetrician-provided care. A federally qualified community health center could not only support an additional general practitioner and/or certified prenatal care provider, it is required by law to provide reproductive health services either on-site or by contract. OB/GYN care

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<sup>52</sup> "Rural areas" are defined as non-metropolitan statistical areas. "A metropolitan statistical area (MSA) is defined as a county or group of contiguous counties that contains at least 1 city with a population of 50,000 or more or an urbanized area with a metropolitan population greater than 100,000." Cohen, Donna and Andrew Coco. "Declining Trends in the Provision of Pre natal Care Visits by Family Physicians." 2009. *Annals of Family Medicine* 7 (2): 128-133.

offered at an FQHC must include prenatal and perinatal care, well-checks, and cancer screenings.<sup>53</sup> Free Clinic coordinator, Laura Simpson, has already spoken with Augusta Medical Center in order to discuss contracting a nurse midwife to provide prenatal and obstetric care part-time if the free clinic becomes a community health center.<sup>54</sup>

An FQHC may even have an advantage over a private or group practice or the hospital in supporting prenatal care providers, especially midlevel care providers like nurse midwives. Because nurse midwives services are more specialized, supporting a practice may be more difficult than for general practitioners and family physicians. Stonewall Jackson may lack resources to employ nurse midwives and the justification to allocate scarce resources to providing this service, in light of other community health needs. An FQHC could fill this important gap in local access to reproductive services by providing local access to prenatal care.

## Washington and Lee University

### *Supplementing Existing Services*

A community health center could augment existing services in the area. It could offer family planning services to supplement the family planning clinics at the health department. A community health center offers some advantages in providing family planning services in that, in general, a community health center is a more integrated, family- and community-targeted form of providing care than the health department. Many people seek specific, targeted services, such as vaccinations, at the health department, whereas a community health center strives to meet health needs on a broader scale. Women may feel more comfortable engaging in discussions about reproductive health decision-making with providers from whom they receive regular care and with whom they have established relationships.

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<sup>53</sup> Simpson, Laura email message to author.

<sup>54</sup> Simpson, Laura email message to author.

Additionally, a community health center could supplement pregnancy and STI testing services offered at the free clinic. Because proof of pregnancy is required for Medicaid, increasing the availability of testing services and the geographic reach of providers may increase the number of women who are able to take advantage of these services. Because testing services are often relatively quick and inexpensive, these could be easily implemented and would supplement the services offered at the health department by making them more available, rather than having a deleterious through competition with the services.

Another important function the community health center could serve is coordinating and referring services. My internship over the summer highlighted the importance of well-coordinated and integrated care for the poor. A community health center may be better able to transition women into and out of pregnancy because of the broader range of care offered. They may also be better equipped to offer additional services, such as dental care, to expectant and new mothers. An FQHC may also improve the quality of care for mothers who lose Medicaid postpartum and then opt to forego care. A community health center may provide a stronger link in the referral chain than the free clinic is currently able to do.

### ***Support & Educational Classes***

A community health center could play a similar role in supplementing educational and support classes within the community. Education is a crucial component of the community health center model and an FQHC may have an advantage over other entities in providing educational services to the community. The FQHC may also be able to better gauge the community's needs because of the integrated nature of services. Patients may feel more comfortable attending classes at the community health center and may be more receptive to

information provided by the organization from which they receive the majority of their care.

The community health center could extend access to prenatal educational classes and support groups. It could coordinate with Stonewall Jackson to make more sessions of existing classes available at different times, perhaps on different days of the week, and in a variety of locations. An FQHC could also support classes that have shorter, perhaps one to two hour sessions, and meet regularly to discuss topics similar to those currently offered in the sessions at Stonewall. The groups could focus on providing support rather than specifically information and the goal would be to develop a regular schedule and support system for expectant mothers. Perhaps some hybrid of these two models would be most effective. Some women may prefer, because of work schedule or transportation, to receive as much information as possible in one long session. Others may prefer the shorter sessions in order to extend the education and support throughout the duration of their pregnancy. An FQHC may be better able than other community entities to develop pilot programs and find a model or models that work best for the women of Rockbridge County.

Sex education is a crucial part of preventing teenage pregnancy and fostering informed decision-making regarding sexual initiation and practices. Disconnect between outdated or outmoded sex education and teenagers, coupled with lack of communication between adults and teens often contribute to misinformation, embarrassment, and confusion about sex. A community health center may be better equipped to engage both teens and their parents in healthy and honest discourse about sex within the social and religious contexts of the community. I deal with this topic more fully in the next section; however, sex education represents an area in which the community and providers could work together to improve

access and quality.

### *For the Community*

#### ***Transportation***

In the words of one study participant, the lack of transportation is “endangering their [the mother’s] life and the baby’s life.” Although many of the women interviewed cited transportation as merely an inconvenience, all of the women interviewed owned or had access to a vehicle. One of the biggest barriers to accessing prenatal and obstetric care in rural areas is transportation and Rockbridge County is no exception. Many of the most basic and necessary reproductive services are offered by and in conjunction with hospitals that are an hour away.

Table 3 lists the distance to travel a central location in Lexington, to the four nearest hospitals.

Hospital	Location	Travel Distance (mi)	Travel Time
Augusta Medical Center	Fishersville, VA	38.3	0:43
Lewis Gale Medical Center	Salem, VA	56.2	1:06
Carilion Roanoke Memorial Hospital	Roanoke, VA	57.3	1:06
UVA Hospital Medical Center	Charlottesville, VA	66.6	1:11

**Table 3. Distance and Travel Time to Four Hospitals Nearest Rockbridge County. Hospital names and locations are given with the travel distances in miles and travel time in hours and minutes (H:MM). Distances and times calculated from Randolph Street, Lexington, VA, using Google Maps.<sup>55</sup> Travel times from other locations within Rockbridge County vary with location, i.e. Glasgow, VA, is over an hour (1:11, 51.4 miles) from AMC in Fishersville, VA. Lexington is used to provide a baseline in order to demonstrate the significance of transportation as a barrier to accessing reproductive health care services.**

Rockbridge County is fortunate enough to have Rockbridge Area Transportation System (RATS), which works in conjunction with LogistiCare to provide transportation to members of the community. LogistiCare is the largest non-emergency medical transportation broker in the country. LogistiCare was the first to implement and has the most experience managing a

<sup>55</sup> [www.maps.google.com](http://www.maps.google.com)

statewide Medicaid non-emergency transportation brokerage system.<sup>56</sup> Last year, RATS provided 17,652 rides, a quarter of which were to Medicaid patients, and logged 390,847 miles providing these rides.<sup>57</sup> Although RATS destinations include local area medical centers, rides must be scheduled forty-eight hours in advance (five days in advance for Medicaid riders); therefore, RATS does not provide adequate support for women in labor.<sup>58</sup> RATS services are offered on a sliding scale fee-for-services basis. Although most women in this study meet the Medicaid income eligibility, near-poor expectant mothers would be subjected to fees. Even though the fees are offered on a sliding scale, the nearest medical centers that offer obstetric care are in the highest and next-highest mileage brackets, costing \$48-\$56 for a 40% fare rate.<sup>59</sup> Therefore, transportation, especially in a difficult pregnancy, could easily become an exorbitant expense for near-poor expectant mothers.

The most immediate transportation need is that of emergency transportation for women in labor, in order to prevent situations in which the mother and child are endangered by the lengthy commute to the nearest hospital. RATS could foreseeably provide this service during its operating hours if it was able to offer transportation with shorter notice. Emergency transportation provided by local ambulance services or the fire department may provide emergency transportation outside of RATS operating hours. Another foreseeable issue is that of short turn-around appointments, such as to come back to receive test results. This could also be improved by decreasing the amount of time needed between requesting and receiving

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<sup>56</sup> LogistiCare. "Government Transportation Solutions." 2012. Accessed 18 April 2012 < <http://www.logisticare.com/government-transportation-solutions.html>>.

<sup>57</sup> Rockbridge Area Transportation System. "Service Report." Provided by Laura Simpson.

<sup>58</sup> RATS. "Service Report."

<sup>59</sup> Rockbridge Area Transportation System. "Fares: Taxi (no van required)." Accessed 17 April 2012 < <http://rats.rockbridgearea.info/fares.htm>>.

a RATS ride. This could be supplemented by expanding access to telemedicine services in the area, previously discussed in the recommendations for the Health Department. Both of these might be achieved with supplemental funding in order to increase the RATS staff and fleet.

### ***Improving Sex Education***

Improving both sex education and education in the area may decrease the incidence of unwanted and/or unplanned pregnancy. Sex education, as described above, often functions only to make teens embarrassed or confused and can be more divisive and isolating if teens do not feel comfortable talking to their parents or teachers about what they are learning. In rural areas especially, there is often strong religious and social opposition to sex education that is not abstinence only. Therefore, misinformed teens are initiating sexual relationships; because this behavior is stigmatized, they are doing so without discussing this decision with their parents and/or physicians. Ideally, sex education should promote honest and open discourse and should lead to informed-decision making. It is therefore important to tailor educational programs to the target audience and to design programs that are appropriate for their social context. There is no reason that an educational program cannot promote responsible sexual decision-making, emphasizing both contraceptive services and abstinence-only prevention of pregnancy. This integrated approach may also serve to encourage discussion between teens and their parents in order to prevent situations like Lottie's.

Improving sex education in the area will work best if all three entities work together to foster effective programming for Rockbridge County teens. It may be difficult to implement this programming through the local schools; therefore, this may require developing after school programs for teens in the area. The Health Department already provides a weekly nurse visit to



the high school. The nurse spends about an hour talking with the students about STI and pregnancy testing and advocating the Health Departments services. She also brings pamphlets and other literature to the school with her when she goes to the school.<sup>60</sup> Although the health department is already seeking to meet this need, the Rockbridge Area Free Clinic, if it becomes an FQHC, could supplement these efforts. Education is a required component of the FQHC care model. Teens who are receiving the majority of their primary and dental care at an FQHC may be more comfortable speaking with their providers about these sensitive issues. An FQHC may also be better equipped to engineer community outreach programs and integrate the community as a whole in order to foster healthy and active lives for Rockbridge County teens.

### ***Economic Development***

As discussed above, Cohen and Coco, 2009, identified the study's target population as more likely to utilize family physicians for prenatal care. While an FQHC would significantly improve access to midlevel providers, economic development is necessary to attract new general providers and specialists to the area. The economic and social climates of Lexington may make it difficult to "break in" as a new physician and to support a practice after it has been established. Providers cannot be expected to practice where they cannot make a living. Improving the economic climate of the area may allow more providers to open practices in the area. This goal offers a long-term approach to improving the overall health of the community and extending access to indigent populations. Although it is not an easily achievable goal and may not be readily achievable in the near future, it may offer a means through which to improve the overall economic prospects of the area poor as well.

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<sup>60</sup> Phone Interview with Gloria.

## Conclusions

Access to reproductive health is an issue of particular importance for women, especially poor women, in rural areas. This community health assessment identified the following areas of proficiency for local providers, chiefly the Lexington-Rockbridge Public Health Department, the primary provider of reproductive health services for poor women in the area:

- Health department staff are friendly, helpful, and well-liked by patients
- Coordination of services and referral to other providers
- Information sharing between patients and providers
- Patients return to the health department for services

The study also identified barriers for women to access reproductive health services. The most significant barrier for women in the area is that many services, most importantly prenatal and obstetric care, are only offered by providers that are an hour or more away. Another significant barrier is that many women may not know about or know they are eligible for coverage or for particular services. The paper offers the following recommendations for the community and local providers in order to address these deficiencies:

- Increasing access to services that are offered far away:
  - **Health Department:** offer services at both the Lexington and Buena Vista health departments
  - **RAFC:** Transitioning to an FQHC would provide nurse midwife-provided prenatal and obstetric care in the community. An FQHC could also provide educational and support classes to expectant mothers and their partners.
  - **Community:** improve access to reliable transportation by expanding RATS and using community emergency transportation resources to supplement RATS
- Decreasing the number of women who do not know about or know they are eligible

for coverage/services

- **Health Department:** expend advertising for existing services
- **RAFC:** an FQHC may provide a stronger link in the referral chain and may be better able to transition women into and out of care for pregnancy

The paper makes additional recommendations in order to target other reproductive health issues in the area; for example, improving sex education in order to target teenage pregnancy.

While many of these recommendations may require significant time investments and funding to implement, they may extend access to important reproductive health services to the poor and near poor women of the community.

Grade A Kelli, this is a very thoughtful and helpful paper, particularly its recommendations.

Because it is so important and helpful, I encourage you to continue work on it this spring as you

have time. I know that you will learn more when you present it. I have a few suggestions to think about. First, does the FQHC need to find ways to publicize its services, especially as they

expand, in ways similar to those you suggest for the PHD? Second, will the FQHC be able to

take private insurance that is subsidized? Women above 133% of the poverty line will probably

not have Medicaid, but they will have subsidized insurance. Will they be able to seek services

from the FQHC? Third, you mention support classes, but I am not clear whether the classes

offered to pregnant persons are for mates and more than information classes. My judgment is

that young women and their mates—even older women and their mates—need support classes

and not just information. (I know from experience that everything is frightening the first time

through. Fourth, do you need to give dates for e-mail correspondence and interviews? You do

in the bib., but not in the notes. Maybe it is not necessary in the notes. Check your guide on

that one. Fifth, I have made a few changes in the tracking mode. Most of them are simple

proofreading changes. Please incorporate them, as you see fit, when you add a few items and make some changes for the posted draft. We may also want to print some copies, but I hope you will continue to make a few minor changes as you have time and learn more, even after the public presentations. I have learned a lot from your work thanks.

Kelli you earned an A/A- for the seminar portion of this course, so you will earn another A from me. I will miss your intellect and concern for these matters. Thanks.

# Washington and Lee University

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## Pledge

*On my honor, I have neither given nor received any unacknowledged aid on this project. Reviewed and edited by Harlan Beckley, Charles Lowney, Greg Jarrell, and Penny Jarrell.*

*Helli Lee Jarrell*

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Washington and Lee University



## Rockbridge Area MAPP Project

### Focus Group Guidelines

#### **Background**

The main purpose of the focus group is to provide an opportunity for community members to share their experiences with the health care system. The objective is to learn what about the current system works and what doesn't work. Furthermore, the Rockbridge Area MAPP Project team aims to hear first hand how the Rockbridge community could better work together to meet the needs of the underserved.

#### **Selection of Focus Groups**

The Rockbridge Area MAPP Project team selected four target populations representative of the life span.

- Parents of young children
- **Women of child-bearing age**
- Adults (ages 19-64)
- Elderly (aged 65+)

In the selection of focus group sites, effort was made to have representation from different geographic areas within Rockbridge County and also to hear from minority populations. (see *Focus Group Locations for specific sites*)

Maximum of 8 participants selected per site.

#### **Minimum Staff**

- Facilitator (Rockbridge Area MAPP Project team member)
- A person responsible for taping and making notes on how well the focus group is running (Washington and Lee student)
- Someone responsible for general organizational issues (staff member of agency). This person should leave the room after the team is oriented to the space.

### The Focus Group Agenda

1) Facilitator introduces him/herself

2) Brief explanation of why the focus group has been gathered and how the focus group will be run. The explanation should read as follows:

**We are meeting to discuss your experiences when seeking health care. We are part of a team looking to improve health care services in the Rockbridge area. We want to hear from you about what works, what doesn't work, and how we can all work together as a community to make things better.**

**I will start by asking you to briefly describe an experience you have had seeking health care in our county. Then we will go on to discuss some of your experiences in more detail. The entire session will probably take about one and a half hours. During this time we will provide you with something to eat and drink.**

**What we discuss here will remain confidential. We will tape this session, but all the information will remain anonymous and names will not be used in any reports. *(If participants are clients of an agency, reiterate (as stated in consent) that no staff members will see the original transcripts or hear the tapes.)***

**We are taping the sessions because we need to have an accurate record of the discussions. The work we are doing is part of a countywide assessment project.**

3) The facilitator introduces the team and encourages everyone to make themselves comfortable

4) The facilitator invites members of the focus group to introduce themselves and say a short word on.

- who they are
- the area of the county/ city they are from

5) The facilitator then starts the discussion with the following opening sentence:

**Before we get started, we would like to do a quick brainstorming session about what health means to you? Let's just throw out some words that you would use to define health.** (The scribe will need to write the words on a flip chart so that everyone can see.)

**Now, very briefly, would each of you please describe a situation when you went to seek health care in Rockbridge County. Think about a time you were sick, needed help with stress, or needed a dentist. Who would like to start? (expected time: about 20 minutes)**

The facilitator and/or scribe will need to make short notes on each story as they go through, to

help him/her decide who will be selected for more detailed story-telling.

6) After everyone has completed their stories, indicate that you would like to focus on a few stories in more detail. The facilitator will need to select about 5 stories to focus on. The stories should be diverse and representative of experiences with primary care, mental health, dental and wellness/prevention, as well as positive and negative experiences. (expected time: about 1 hour)

**The stories that you have told are very interesting. I would now like us to focus on the details of a few of these stories. I would like to start with X's story. X, could you please describe your experience again in a little more detail. While X is describing the experience, I would like everyone else in the group to think about what happened to X and how they would have felt in X's situation. After X has retold the story, I will ask some questions for clarification. I would then like to open up the discussion for the whole group to ask questions and make any comments on their reaction to X's story. Once we have finished discussing X's experience, we will go on to discuss another story. I would like us to cover four or five stories told here today in a similar way, so I will keep an eye on the time so that we have a chance to hear a variety of stories. Now, X, would you please start.**

7) After completion of the first story, the facilitator should prompt the respondent for more information using the following questions, if necessary and not covered by the respondent:

- **Please tell me more about the place where you saw the health care provider? For example was it the ER, the Free Clinic, a local doctor, dentist or counselor, the Community Services Board?**
- **Was this your usual place of care?**
- **How long ago was the incident you are describing?**
- **How were you treated by the doctors/nurses/staff?**
- **What did you think of the place where you received care?"**
- **Was it easy to go there and get the help you needed?**
- **If you could change anything about the experience, apart from whether or not you got better, what would you change?**

**Now, please would the rest of the group like to discuss their reaction to X's story?**

The facilitator should move on to the next story, once no more comments are forthcoming from the group, or as time allows.

8) This is the final section of the focus group.

**This is the final part of our focus group. Many of you have told stories about health care experiences, but we were wondering whether any of you here have been sick but then chose not to seek any health care. If any of you have had that experience, would you**

**please spend a little time telling us about it? If you have not had that experience, then think about things that you do or people who help you stay healthy so that you don't need to seek health care.**

- Make sure their description answers the questions: why did you not seek health care? or what do you do to stay healthy? or where do you go for information about how to stay healthy or take care of yourself?

9) The facilitator should close the session by thanking everyone for his or her participation:

- **Your stories have been very insightful and interesting. I would like to thank you all for your participation.**

The 1 and a half hour time limit should not be followed strictly. If the facilitator sees that participants are enjoying the discussion, she/he should let it run longer. In closing, the facilitator should also ask if the group was satisfied with the way the discussion ran and if everyone felt that they were able to say what they had wanted, bearing in mind that they could not keep going for much longer than an hour and a half.

### **Reporting on the Focus Group**

An electronic copy of the following should be sent to Laura Simpson. Please save the documents in MS Word and name them as listed at bottom of page.

- The transcript of the focus group session (please number participants 1 to 8 and refer to them as such in the transcript)
- Any notes made during the meeting
- Answers to the following evaluation questions:
  - a) How could we have improved the instructions to the participants?
  - b) How could we have improved the instructions to the facilitators?
  - c) How well did all the members of the group participate in the discussion?
  - d) If you could have improved any aspect of the focus group, what would that have been and how would you have improved it?

Also return the actual session recordings to Laura Simpson.

### **Due Date**

We would like to have the transcripts by March 15, 2012

*Naming instructions omitted*

These Focus Group Guidelines are based on the WHO guidelines:

[www.who.int/entity/.../surveys/Focus-Group-Mod-Guide-final.pdf](http://www.who.int/entity/.../surveys/Focus-Group-Mod-Guide-final.pdf) and modified with input from the Rockbridge Area MAPP Project Focus Group Work Group received on January 23, 2012.

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## APPENDIX II

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### Rockbridge Area MAPP Project Focus Group Consent Form

➤ **PURPOSE**

The purpose of this study is to discuss your experiences of the health care system in the Rockbridge area. We are part of a team looking to improve health care services in the Rockbridge area. We are meeting with nine groups of people to hear about what works, what doesn't work, and how we can all work together as a community to make things better. A member of the research team will help guide the discussion and we will audiotape the discussion to make sure that it is recorded accurately. We ask that you do not repeat what is discussed in the focus group with anyone else. The focus group will last about one and a half hours.

➤ **RISKS**

Some of the questions asked may make you uncomfortable or upset. You are always free to decline to answer any question or to stop your participation at any time.

➤ **BENEFITS**

There will be no direct benefit to you from participating in this study. However, the information that you provide may help the community better understand how we can improve the health care services for everyone living in the Rockbridge area.

➤ **EXTENT OF CONFIDENTIALITY**

Participation in this research may involve a loss of privacy; however, your records will be handled as confidentially as possible. After the audiotapes of the interview have been transcribed, the recording will be destroyed. Your name will not be used in any written reports or publications which result from this research. Only the Project Manager, the student researcher, and I, the facilitator, will have access to the research data. Data will be kept for three years (per federal regulations) after the study is complete and then destroyed.

➤ **PAYMENT**

Your name will be placed in a drawing for a \$25 gift card. When will it be drawn?

➤ **QUESTIONS**

If you have any questions or concerns about your participation in this study, you should first contact the Project Manager, Laura Simpson at [laurajudithsimpson@gmail.com](mailto:laurajudithsimpson@gmail.com) or 540-460-3522.

If you have questions about your rights as a research participant, you may contact the Washington and Lee Institutional Review Board (IRB), which is concerned with the protection of volunteers in research projects. You may reach the board chair, Claudette Artwick, at [artwick@wlu.edu](mailto:artwick@wlu.edu) or 540-459-8865.

**PARTICIPATION IS VOLUNTARY**

You do not have to be in this study if you do not want to. If you volunteer to be in this study, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

**DOCUMENTATION OF CONSENT**

I have read this form and/or it has been read to me and I decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks have been explained to my satisfaction. I understand I can withdraw at any time. I have received a copy of this form.

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Printed Name of Study Participant

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Signature of Study Participant

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Date

---

Signature of Person Obtaining Consent

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Date