Treatment of the Rural Substance Abusing Gravida

A Model for Collaboration

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Abstract

Treatment of pregnant women abusing illicit substances and alcohol during pregnancy remains challenging—especially in rural areas. Limited resources and large geographic service delivery areas hinder even the most idealistic program to effectively care for these women. With increasing budget constraints, the likelihood of funding for new, highly integrated programming is unlikely. A more realistic approach, based upon the collaboration of existing service providers may show greater promise. Such a model is presented here utilizing existing providers in North Carolina.
Substance abuse among pregnant women in North Carolina continues to be an ethical, social and medical quagmire of great significance. Equally alarming is the variability of treatment options and availability throughout the state. Despite notable improvement in service delivery since 1993, the gap between the substance-abusing gravida and treatment resources remains large—especially in rural areas. The lack of service integration between medical, mental, and social providers likely plays a major role in the disparity. A more integrated approach focusing on collaboration between existing services may better serve pregnant substance abusers. Many standard treatment models are primarily developed in and for substance abuse populations in large cities. A more consolidated approach, utilizing current providers, may be more adaptable to rural, socioeconomically disadvantaged areas.

In 1994, Ira Chasnoff performed a needs assessment of North Carolina's public health approach to substance abuse services in pregnancy. This study proved to be a comprehensive assessment of service delivery provided through the state's public health model. Prevention, education, and assistance are the hallmarks of the public health model. Reed (1999) states that “public health approaches seek to define perinatal substance abuse as a health problem—a chronic and relapsing disease that can be prevented and managed once it has developed” (p. 496). This approach differs from primarily punitive strategies that
tend to criminalize substance abuse in pregnancy through the courts or through social service agencies (Schroder 2001). Using this public health model, North Carolina policy emphasizes prevention and denounces criminalizing drug abuse. The hope of this strategy is to decrease the number of addicts with prevention strategies and to increase the number of current pregnant substance abusers in treatment. The needs assessment showed that the state’s efforts fell quite short of delivering these services.

Overall, Chasnoff noted three major inadequacies in North Carolina’s approach to substance abuse in pregnancy:

- The one-dimensional approach to alcohol and drug treatment focused primarily on abstinence, but failed to address “the multiple needs of substance abusing women such as shelter, child care, mental health treatment, death counseling, parenting skills, development, and preventative intervention for children” (executive summary).
- Cultural sensitivity and cultural appropriateness were lacking in the treatment systems.
- The children of substance abusing women lacked prevention and early intervention services.

Since this landmark study, North Carolina has invested significant funds to improve treatment services offered to pregnant women and their families. On the state level, the Department of Health and Human Services has two divisions that
collaborate to provide these initiatives: the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services – Substance Abuse Section and the Division of Public Health. This perinatal/maternal substance abuse initiative coordinates services on the state level, the regional level, and the local level. On the state level, the initiative supports a statewide toll free line, the North Carolina Family Health Resource Line, for pregnant substance abusing women to inquire about services available throughout the state. (S. Scott-Robbins, personal communication, March 18, 2003). The Substance Abuse Specialist staffs the resource line and maintains census level of the perinatal/maternal residential substance abuse treatment sites (J. Sutter, personal communication, June 18, 2002). Also on the state level, a training module, “Responding to Prenatal Substance Use—A Guide for Local Health Departments”, is distributed to each health department for use in their clinics.

The substance abuse treatment services offered are outpatient therapy through the local mental agencies, acute regional detoxification centers, and residential services for both treatment and recovery. If detoxification services and/or long-term residential facilities are not available locally, these women may be admitted to any appropriate facility throughout the state. Using this regional process, the state complies with Public Law 102-321(1993), which requires states "to ensure that pregnant women have first priority for treatment, are not put on waiting lists, have timely access to health care, and are provided with childcare and transportation assistance" (Reed, 1999). Case management services are available on every level.
Specifically, there are twenty-one perinatal treatment sites in North Carolina to which pregnant and postpartum women may be referred for substance abuse treatment and medical care. In addition, there are eight residential treatment facilities sponsored by the North Carolina CASAWORKS for Families Initiative—a collaboration effort between the Division of Mental Health, Disabilities, and Substance Abuse and the Department of Social Services Work First Program. Most of these facilities serve the children of these women as well, thus providing true comprehensive gender-specific therapy. This type of care includes substance abuse counseling/treatment, mental health counseling, parenting skills, and prenatal care. Also, case management is provided to aid with linkages to other services such as employment training programs and children's programs.

Despite the ideally comprehensive nature of these programs, the reality of poor delivery of these services in a rural setting (Wagenfeld, Murray, Mohatt & DeBruyn, 1997) is unsettling. In rural areas, initial substance abuse treatment is primarily through the community mental health center. “These centers are characterized as [serving] a large geographic area [having] decentralized service delivery and [requiring] its professionals to function as generalists [coordinating] closely with other agencies” (Wagenfeld et al. 1997). In the last 10-15 years, these agencies have become further strained due to more stringent requirements to narrow its service provider role to treat only the seriously impaired or those able to pay (Conger, 1997). In addition, the professional staff in these agencies is limited in number. Robertson and Donnermeyer (1997) as cited in Clark, J. J.
et al. (2002) describe the obstacles to rural substance abuse and treatment as the following: "extreme difficulty in recruiting and retaining professional; lack of sophisticated treatment technologies; professional and client isolation from social support; geographic barriers; low clinician salaries; and heavy case loads" (p.397). These factors result in many persons needing mental health services — including substance abusers — to remain unserved or underserved.

In addition to internal agency concerns, the "coordination among substance abuse, mental health, and primary care delivery is often poor in rural areas" (Wagenfeld et al., 1997). "Shortages of professional resources, inadequate distribution of services, and orientation to seek service provider agents limit the cooperation and collaboration between providers of care" (Wagenfeld et al., p. 419). This lack of collaboration is where the public health model falls short -- especially in rural areas.

Very little has been written regarding collaboration efforts between agencies and primary care treating substance abuse. The body of knowledge lessens when considering women or rural areas. Most models of substance abuse treatment therapy in pregnancy are based upon inner city experiences. The special needs of rural areas have been poorly studied—despite the pertinent yet frequently overlooked fact that approximately 25% of all United States citizens live in rural areas. (Rand,1997). The ability to study and apply models in these areas is worsened by the unique nature of these communities.

A recent study funded by the Health Care Financing Administration (now the Center for Medicare & Medicaid Services) suggests that collaboration is
instrumental to the success of a drug treatment program. Howell and Chasnoff (1999) conducted 33 focus groups of pregnant substance abusers and those providing their care. They found that successful programs tend to develop collaboration measures with governmental agencies, prenatal care providers, and substance abuse treatment providers. The effective programs also educate providers in the screening of pregnant women and utilize intensive case management. The findings in the study are encouraging for the possibility of widespread application of service linkage.

The literature on collaboration in drug use treatment in general is limited; however, discussion of therapy integration in the United Kingdom is easier to find than that in the United States. This disparity suggests a more generalized appreciation for service linkage. Gerada and Farrell (1998) present a model of “shared care” linking substance abuse treatment and primary care. The role of the primary care community provider in this model is paramount, whereas in the American literature, this role seems to be de-emphasized except as it relates to medical care in primary residential facilities. In this model primary care providers coordinate medical care between other providers including specialists, pharmacists, drug agency, social worker, and a practice (home health) nurse. Methods of sharing information in this model include the following: the community/mini clinic where specialists come to primary care setting to train primary care provider and staff; liaison and consultancy where the general practitioner and the other providers meet face-to-face; shared record cards where information is exchanged via a booklet or card carried by the patient (commonly
used with prenatal patients); computer assisted shared care; and electronic mail
where the generalist and the specialists have access to the same information.
This approach differs greatly from what actually happens in rural communities.
Not infrequently, health care providers are not even aware of participation in drug
treatment.

Anecdotal reports of collaboration are available in the US. The Treatment
Improvement Exchange, an organization dedicated to information sharing
between substance abuse treatment agencies and providers maintains a website
to which agencies may choose to post their community experiences. These
reports allow US communities to share their experiences. Many of them are
rural. An example is the Addiction Service Consortium of Upper Michigan which
is comprised of six treatment providers of substance abuse care: a regional
medical center, 2 district health departments, a freestanding residential facility,
and a Native American tribe. Once organization was achieved, the group
focused on continuum development to provide seamless care to serve its clients
as they move from one phase to the next. The long-term results are pending.
The group felt that some of the factors associated with successful development
were the following: the members had some level of a previous relationship; there
was minimal competition between members; and the members were innovative
in the rural communities served (Tikkatan, 2002 [available]).

A model of the delivery based upon the collaborations between providers
who are present in all areas of the state would likely be the quickest and easiest
method to improve the quality of care for these gravida during their pregnancy
and postpartum. Implementing such an approach also potentially gives insight to the unique nature of the community based upon the utilization of all services available.

Such a model would involve four providers of care: substance abuse/mental health counselors, obstetricians/midwives, maternity care coordinators (MCC), and social services social workers. The services provided by these 4 entities are available to all women of the state. Currently, a substance abusing gravida has most of her care coordinated by the substance abuse counselor. Unfortunately, because the worker frequently has to wear many “hats”, the substance abuse/mental health counselor may also provide case management services. Wordarsk (1983) likens a rural mental health worker to the “proverbial jack-of-all trades” (p. 178). Alternatively, one of the staff social workers may be given responsibility for case management for these specialized clients in addition to an already burdened caseload. The mental health case manager is ultimately responsible for service coordination.

Many medical providers are not aware of compliance with outpatient substance abuse therapy. Equally as disturbing is the lack of knowledge regarding the perinatal mental health system. This concern is further suggested by a small survey of 5 rural, northeastern North Carolina obstetricians and midwives (Appendix A). In this small survey, all of the providers stated that they would refer a substance abusing gravida to mental health agency; however, only one was aware of any residential facility (including detoxification) in the state that
would accept pregnant woman. This lack of collaboration may prevent opportunities for potentially beneficial advocacy.

In the current initiative, the MCC has no role in the case management for these patients because mental health personnel assume that role completely. Throughout the state, the Maternity Care Coordinator offers case management and coordinates outreach services to pregnant women through the Baby Love program, a joint venture between the Division of Medical Assistance and the Division of Public Health, Women and Children’s Health Section which provides Medicaid for pregnant women. These specially trained nurses and social workers assist gravidas in obtaining medical care and support services such as transportation, housing, job training, and day care (NC DMA, 2002) As per the DMA Baby Love website, evaluation of the Baby Love program reveals that women receiving MCC services have more prenatal visits, have higher participation in the Women, Infants, and Children’s (WIC) and more frequently receive family planning postpartum. On the local level, the MCC services are administered through the local health departments.

Finally, the representative from social services assigned to the substance-abusing gravida ensures eligibility for the receipt of medical care and nutritional assistance. If the applicant is eligible for the Work First 104B program (Substance Abuse/ Mental Health Initiative), the social worker is responsible for ensuring that the gravida maintains eligibility required to remain in the program. If the client does not comply with substance abuse treatment she will receive less cash assistance and will only receive the limited funds through a protected payee
designated by the social worker (NCDHHS [online]). Also, through social
services, child protection services may be helpful in assessing the needs the
gravida’s other children if applicable. Resources in many rural areas are limited
and earliest that knowledge of need is important.

In the proposed model, the sharing of the patient-controlled,
treatment/service specific information is the cornerstone. The substance
abuse/mental health counselor ensures partnering of all entities. The
agencies/providers share treatment information specific to the needs of the
service providers. For example, the social worker may only require information
regarding compliance with mental health visits, whereas the physician may
benefit from knowledge of compliance with visits and continued substance use.
Likewise, the mental health case manager and the MCC require awareness of
compliance with prenatal visits. This information enables them to identify barriers
that may inhibit them obtaining the needed care.

The model is further characterized as supported on the state level,
adaptable to each community’s unique characteristics, and realistic. The
common goals are detoxification, stabilization, and recovery for substance
abusing gravidas and their families and delivery of a healthy infant. Although
initial collaborative efforts may require significant effort on the state and local
levels, the final product must not increase workloads of individuals who are
already overburdened. In fact, the flow of goal-oriented information should
increase the efficiency of individual entity participants.
The model must clearly maintain North Carolina’s public health approach to substance abuse in pregnancy as any studies have shown that fear of punitive measures deters gravidas from seeking treatment for substance abuse (Schrodel and Fiber, 2001). Finally, in addition to the long-term goals of healthy mother family and baby, the shorter goals of collaboration should be lengthen stay in substance abuse treatment and strengthening the family ties and support as these two variables have consistently been shown to improve long-term outcomes (Howell, Heiser, and Harrington, 1999; Kelly, Blacksin, and Mason, 2001).

The benefits of the collaborative model for substance abusing gravidas are many. An important benefit is that patient need will be better matched with services. The one size fits all approach of applying urban models to rural areas and providing the exact same services for each client’s situation will hinder treatment goals as a well as the process goal of delivering strength based care. Matched services do better. Klein, diMenza, Arfken, and Schuster (2002) demonstrated that retention in and completion of treatment was improved when patient characteristics such as demographics and substance-related problems were matched to treatment setting (outpatient, intensive outpatient, residential) based on prior theory and investigation. More services may improve outcome. Smith and March (2002) showed a strong relationship with the number of services offered to positive treatment outcomes in women with children. Culturally competent treatment practices may influence utilization of some treatment services Campbell and Alexander (2002).
Secondly, collaboration will allow for more intensive case management services. A collaborative effort with the Maternity Care Coordinator and the mental health case manager (MHCM) will better meet the needs of the pregnant gravida that of the MHCM alone. The MCC’s more extensive knowledge base of services available to pregnant women and their children enhances the likelihood of positive treatment outcomes. In addition, refining of obligations would enable the mental health case manager to plan for long-term case management for all phases of substance abuse treatment and recovery.

Case management services have been repeatedly shown to be beneficial. Laneheart, Clark, Rollings, Haradon, and Scrivner (1996) showed that intensive case management intervention on substance-using pregnant and postpartum women was beneficial. In the 152 women exposed to the services, significant improvements were demonstrated in all variables studied including substance use, employment, arrests, incarceration, birth weight and social support. Case management improves retention in treatment programs. Laken and Ager (1996) showed that prenatal attendance was improved in this population with intensive case management –especially when combined with transportation. Neonatal outcomes are improved when substance abuse therapy and prenatal care are provided (Sweeney, Schwartz, Mattis and Vohr, 2000). Substance abuse therapy with case management is associated with increased employment and improvement of their areas of life including psychiatric, social and family relationships and drug/ alcohol use. (Siegal et al., 1996). Case management
may decrease chances of short-term relapse. (Schwartz, Baker, Mulvey, and Plough, 1997).

Collaboration may facilitate access to medical care or substance abuse therapy if the patient enters care in either of these service delivery areas. In this setting, a streamlined referral process will only benefit the patient and promote timely referral. In addition to the referral pathways involving the medical provider, the mental health counselor, and possibly the MCC in the clinic setting, the MCC in the outreach role may have a profound effect on a patient’s entrance into drug treatment. Corrarino et al. (2000) conducted a pilot study providing home visits by a public health nurse to develop care plans matched for each patient's needs. All services were delivered in the home, including substance abuse counseling. Nine out of ten of the participated entered drug treatment and showed improvement while there. This finding further demonstrates the usefulness of collaboration in the referral process.

There are many potential barriers to these collaborative efforts. Physician attitudes toward addiction in pregnancy and treatment of these gravidas may frequently be a barrier to collaborative in these gravidas. Although the American College of Obstetrics and Gynecology has issued specific recommendations on the need for screening of prenatal patients (ACOG, 1999), some physicians still do not perform general screening. Duszyniski, Nieto, and Valente (1995) as cited in McPherson and Hersch (2000) found that only 41% physicians screen routinely for alcohol and 20% screened for other substance abuse. They also reported that 50-90% of physicians failed to recognize substance abuse in their
patients. Friedmann, McCullough, and Saitz (2001) surveyed a national sample of family physicians, internists, obstetricians and gynecologist, and psychiatrists. Although 68% of the physicians responding reported that they usually or always question new outpatient about illicit drug abuse, obstetricians and gynecologists were least likely to intervene. In 1995, Gehshan showed that although a majority (65%) of women may be screened very few (5%) are referred for treatment. In 2000, Salmon, Joseph, Saylor, and Mann showed 67% of pregnant and parenting substance-abusing women felt that the support received from their medical providers was inadequate and that most of these women restudied received no information on risks of substance abuse during pregnancy from their providers. In the general substance abuse population, stigma is thought to be a major factor affecting the failure of physicians to address substance abuse (Lewis, 1997). Although outcome data regarding brief intervention has been positive (Flemming, Mundt, and French, 2000; Friedmann, Saitz & Samet, 1998), attitude studies show that physicians tend to be pessimistic about the potential benefits of their clinical involvement and the actual ability of their patients to recover (Lewis).

Secondly, for the physicians who are screening, many of them are likely using less effective tools. Likely, many of them are merely inquiring about the use of alcohol, tobacco and illicit drugs without a formal measuring tool. Many such tools exist. The CAGE questionnaire proved to be an effective instrument for evaluating alcohol use. In 1995, Escobar, Espi, and Canteras showed that the CAGE questionnaire was indeed efficacious and discriminative in a primary
care setting. In a review, Fiellin, Reid and O'Connor (2000) found that the CAGE was superior for detecting alcohol abuse and addiction in the primary care setting. The CAGE is a 4-item questionnaire:

Have you ever:

1. attempted to Cut back on your alcohol?
2. been Annoyed by questions about your drinking?
3. felt Guilty about drinking?
4. had an Eye-opener first thing in the morning to steady your nerves? (Schottenfeld and Pantalon, 1999)

Concerns regarding length of time added to the visit in order to perform these screenings may deter many providers from performing such tests. How

Both of these physician-related concerns can be addressed with education. Providers need to be educated regarding the benefits of diagnosis and treatment. Keyser-Smith, Dampeer, and Sambrano (2000) evaluated nine community-based drug prevention, education, and treatment programs for pregnant and postpartum women. All programs provided case management services. This study clearly showed at least short-term benefits of alcohol and illicit drug therapy. Friedmann et al. (1998) report of studies showing that physician counseling for five to ten minutes on multiple visits is “more effective than no counseling and may be as effective as more intensive approaches”.
Fleming et al. demonstrated that monthly 15-minute physician visits for problem drinkers resulted in less consumption of alcohol after two visits.

In addition, with education, the provider can select a screening tool or tools that can be easily integrated into his/her practice. McPherson and Hersch (2000), in their review of substance abuse screening tools, deduced that despite the existence of several screening tools for use, most of them are not appropriate for screening in the primary care setting, and they acknowledged a need for the development of a valid and reliable screening instrument that could be incorporated easily into a primary care setting. In 1999, Clark, Dawson, and Martin compared 200 randomly selected pregnant patients who were screened using their old protocol and compared them to a randomly selected group of 400 gravidas screened with their new protocol. The old screening approach consisted of three check boxes for the following categories: "smoking/alcohol", "drug use (any)", "drug addiction/ alcoholism." The new protocol added more detailed questions about the frequency of cigarette, alcohol, and illicit drug use during pregnancy. The new protocol increased reporting of smoking/ alcohol from 21%-72%, reporting of any drug use from 12%-18%, and the reporting of alcoholism and drug addiction from 0%-6% thus suggesting that using direct screening questions requesting amount and frequency of substance use increases reporting when compared to the "yes/no" format. This method could be easily integrated into a busy obstetric practice as opposed to the Substance Abuse Subtle Screening Inventory (SASSI). This tool is a one page self report
tool that requires 10-15 minutes of time and is administered by support staff (SASSI Institute [online]).

To be considered, these tools must be presented in a format that providers can appreciate. For example, if a screening instrument can be demonstrated in a regularly scheduled staff meeting and its use modeled, providers are more likely to utilize it.

All entities in the collaborative effort may be concerned about time spent with potentially increased paperwork. Mental health counselors may see providing follow-up as an additional unpleasant chore in their already paper-burdened workdays. Physicians, too, may be reluctant because of fear of increased staff time with making referrals and providing follow-up. The MCC may be concerned about increased time with the specialized patient group. The social services worker may have concerns about more paper work as well.

These barriers may be overcome by creating user-friendly, succinct, refined methods and documents for sharing of information. All parties involved—including support staff—should be adequately trained with the process. If these steps are taken carefully, the process will likely be less time consuming with more consistent knowledge of the patient’s situation. For physicians it is likely that stuff will do less case management, following missed appointments and missed testing. The MCC may likely have a few extra patients; however, case management for these high-risk patients will be less intense because of the non-obstetric case management performed by the mental health social worker or counselor. The current communication between mental health and Social
Services can merely be widened to the audience of the four entities. Overall, with careful planning, concise documents and adequate communication, the fear of increased workload can be abated.

Probably the most significant barrier to the integrated model would be reluctance to disclose patient information. All participating entities are bound to protect patient privacy. The awareness of the need to this protection has heightened with the implementation of the Health Information Privacy and Portability Act (HIPPA) in April 2003. The mental health counselor may be even more reluctant because of laws requiring specific consent for release of mental health and substance abuse records. The purpose of these laws is to protect the patient from stigmatization and possible alienation in society. Because of this training, the MCC may not embrace the concept of sharing information even with the patient/client's consent.

This barrier may be overcome with reassurance and specialization of the consent processing. Confidentiality laws bind all health care providers, maternity care coordinators, social workers and mental health counselors. All entities should be reminded of this fact as well as the conditions for which laws mandate the need to report certain confidential information. A uniform consent form (Appendix B) designed especially for this patient group, will also help overcome the barriers of reluctance. The form allows for each entity to request only information that will aid them in performing their duties of patient/client care. Adherence to this request will allow for less sensitive information to released thus encouraging participation in collaborative efforts.
In addition to barriers, there are limitations to collaborative efforts. Linkage of services cannot improve if the patient will not consent. Treatment outcomes may still vary significantly because of the resource limitations to the four entities providing services. Rural areas with large geographic areas that are supported by one multi-county agency suffer from major time constraints.

Integration of service delivery to rural substance abusing gravidas is beneficial to pregnant women and to providers alike. Collaborative efforts have shown great promise in many of area of health care. The much-desired, highly integrated programs with the “one stop shopping” are not reasonable for rural communities with large geographic service delivery areas. Linkage of existing services such as the mental health counselor, the physician, the maternity care coordinator, and the social worker is a more reasonable approach. Collaborative efforts with these providers will allow each specialist to concentrate on his/her profession with the assurance that services which have been clearly linked to improved outcome are provided. Two such services are intensive case management and consistent prenatal care.

Barriers to these linkages do exist. Concerns regarding patient confidentiality and increased work demands on service providers can be alleviated, however. Careful planning and commitment to and patience for the implementation process will allow for the efficient and protected flow of information. Thus, all partners are enabled to visualize the common goal of a healthy gravida and healthy infant for every pregnancy complicated by substance abuse.
References


Institute on Drug Abuse Monograph, 168, Rural Substance Abuse: State of knowledge and issues, 418-437.


Appendix A

Survey of Rural Providers Obstetric Providers

<table>
<thead>
<tr>
<th>Total n = 5</th>
<th>n</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screens all patients for alcohol abuse</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Screens all patients for substance abuse</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Aware of specific outpatient drug abuse treatment</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of specific outpatient alcohol abuse treatment</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of regional inpatient drug abuse treatment</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Aware of regional inpatient alcohol abuse treatment</td>
<td>1</td>
<td>20%</td>
</tr>
</tbody>
</table>

Subjective question: If a patient has a positive verbal screen for alcohol or illicit drugs, what would be your next step?

All (5) responded, “Refer to Mental Health [Agency]”.
Appendix B

Collaborative Consent For Release of Medical/Social Information
N.C. Agency/Provider Uniform Consent

Entity obtaining my consent:

___ Department of Mental Health (Agency) _______________________________________

___ Social Services (County) ___________________________________________________

___ Obstetrician/Health Care Provider (Name) _____________________________________

(Address) ___________________________________________________________________

___ Maternity Care Coordinator

Health Department ____________________________________________________________

MCC _______________________________________________________________________

I, ____________________________, hereby authorize the above named individual
entity to release or exchange any medical/social records in the manner as I have
indicated below:

___ To Social Services ___ Appointments made and kept

(Compliance/Mental Health)

___ To Health Care Provider ___ Appointments made and kept

(Compliance/Mental Health)

___ Overall progress with drug/alcohol treatment

including any drug use/alcohol

___ Laboratory reports

___ Application/approval for social services

programs

___ Maternity Care Coordination utilization (MCC)
To MCC

- Nutritional counseling.
- Psychiatric evaluation.

- To Mental Health

- Compliance with mental health appointments (appointments made and kept).
- Compliance with doctor’s appointments (appointments made and kept).

- Approval/application Baby Love/Medicaid.

The purpose of releasing this information shall be:

- Continuity of Care

I understand that release of this information may include information in regard to drug abuse and alcohol abuse. I also understand that my record may contain information regarding AIDS and tests of human immunodeficiency virus (HIV).

I certify that the authorization is made freely, voluntarily, and without coercion. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire after 180 days from the date it is signed.

This authorization and request is fully understood and is made voluntarily on my part.

Signed _______________________________ / _______________________________ (Patient) (Legal Guardian)

Witness: _______________________________ Date _______________________________

Witness: _______________________________