BATTLING DRUG USE IN PREGNANCY

A Maternal Assistance Program Coordinates Community Medical, Substance Abuse, and Social Services

BY JOYCE A. ZANDIEH, RN

Summary Holy Spirit Hospital, Camp Hill, PA, established the Capital Region Maternal Assistance Program (MAP) to reduce the incidence of substance abuse in pregnant women and new mothers by creating a bridge between perinatal and substance abuse services in the community.

Two nurses at Holy Spirit developed the idea of setting up a program in the community and obtained permission from the hospital administrators to pursue the project. They drew in staff from an inner-city obstetrical clinic in nearby Harrisburg, PA, and formed a work group to plan and build a consortium of agencies. Another hospital joined the consortium within a year. With several grants, the team hired an MAP coordinator, who in turn hired care managers, leased vans, and started the MAP in an office on the campus of Holy Spirit Hospital.

The program focuses on case management (facilitating access to available community resources) as opposed to direct service delivery. Referrals come from a variety of healthcare providers, county courts, probation and parole offices, and Children and Youth Services. Care managers visit clients weekly in their homes; coordinate services provided by multiple hospitals, clinics, and agencies; help clients set goals and become self-reliant; and address problems with transportation and babysitting.

The unhealthy life-style of a typical substance-abusing woman and the harmful effects of substance abuse itself result in medical and obstetrical complications for both the mother and child. To offer these women both help and hope, Holy Spirit Hospital, Camp Hill, PA, established the Capital Region Maternal Assistance Program (MAP).

The MAP's overall goal is to reduce the incidence of substance abuse in pregnant women and new mothers by creating a bridge between perinatal and substance abuse services in the community. That bridge is provided by care managers who coordinate access to outreach, education, intervention, referral, and follow-up services, as well as child development services, methadone conversion, inpatient and outpatient substance abuse treatment, mental health services, and other social and legal services.

Recognition of addiction as a disease and the nonjudgmental treatment of addicted people have been traditions at Holy Spirit for more than 20 years. The hospital operates a detoxification unit, outpatient services, and family education programs. MAP is Holy Spirit's most recent endeavor to take the spirit of caring out into the community.

A Leap of Faith

Since its inception in 1991, MAP has been a project driven by mission and vision. In that year, two nurses—an addiction specialist and a perinatal specialist—received from the Pennsylvania Department of Health's Office of Drug and Alcohol Programs a request for proposals for services for pregnant substance abusers. The nurses decided "We can do this!" and presented their concept to the hospital's administrators.

Holy Spirit's administrators gave the nurses permission to explore the feasibility of setting up

Ms. Zandieh is program director, Maternal Assistance Program, and nurse manager, Detox, Holy Spirit Hospital, Camp Hill, PA; and chair, Human Relations Commission, Harrisburg, PA.

a program in the community. In a traditional business environment, the project would have never progressed beyond the concept stage, because of all the obstacles to success, most notably nay-sayers in prominent positions. At some point, however, the administrators decided to take a leap of faith.

Holy Spirit's obstetrical staff all maintain private practices, so the hospital's team approached an inner-city hospital in nearby Harrisburg, PA, which operates an obstetrical clinic. This facility, Polyclinic Medical Center, expressed an interest in working with Holy Spirit. Soon a work group of 8 to 10 people was meeting regularly to plan and build a consortium of agencies.

Harrisburg Hospital became involved in the project a year later, when the perinatal clinical nurse practitioner at Polyclinic Medical Center accepted a similar position at the hospital. A member of the original work group, the nurse practitioner was able to draw her new hospital into the project, eliminating what could have become a competitive situation.

Technical assistance came from St. Francis Health System in Pittsburgh, which operates a successful MAP. Members of the work group visited St. Francis during the initial planning stages and obtained copies of its policies, procedures, and protocols; advice on avoiding pitfalls; and other valuable information to assist in program development. The Pennsylvania Department of Health contracts with St. Francis to provide such assistance to agencies seeking to initiate similar services.

The original proposal was submitted to a Masonic organization, which provided a seed grant of $24,000. With these dollars, the team researched and developed the program's framework and hired a part-time coordinator and secretary. Since Holy Spirit was the local institution with the expertise in substance abuse treatment, those persons hired were considered Holy Spirit Hospital employees. The two nurses and the drug and alcohol outpatient services coordinator conducted the interviews and made the hiring decisions, with help from the hospital's Human Resources Department.

The group wrote a second grant proposal to the Department of Health, which awarded $257,790 to implement the program. The MAP coordinator, in conjunction with the work group, hired care managers, purchased office equipment, wrote policies, leased vans, and started the MAP in an office suite on the campus of Holy Spirit Hospital.

Care managers help clients set goals and encourage them to become self-reliant.

Holy Spirit's Department of Nursing supervises the MAP, and MAP personnel are included in all hospital in-services. Ongoing funding comes from the Pennsylvania Department of Health, Office of Drug and Alcohol Programs. The cost to operate the program is usually more than the $257,790 grant allocation, so the hospital absorbs the remainder.

Getting Off the Ground

The first year of the MAP was difficult. Too much seemed to be happening too soon, and program development sometimes lacked focus. The clients were economically disadvantaged and had more extensive needs than the project leaders had anticipated. Ranging in age from 14 to 38 years, most clients receive medical assistance, with only a few being covered by private insurance. Issues to address included food, housing, and domestic violence. At one point the care managers were spending four to five hours a week delivering food to clients' homes.

In October 1994 a reorganization and change of direction got the program back on track. The MAP refocused on case management (facilitating access to available community resources) as opposed to direct service delivery. Instead of delivering food, for example, care managers refer clients to local food banks and provide education on budgeting and meal planning.

Women learn of the program through the prenatal clinics at Polyclinic Medical Center, Harrisburg Hospital, and other area healthcare providers. Many are referred by the Dauphin and Cumberland county courts, the probation and parole offices, and Children and Youth Services. Referrals from Holy Spirit Hospital have come from the maternity care unit, the detox unit, and the Medical Outreach Service, which offers health screenings at a local downtown soup kitchen.

Using an intensive case management model, care managers visit clients weekly in their homes. Care managers help break down barriers to care by coordinating services provided by multiple hospitals, clinics, and agencies. Care managers help clients set goals and encourage them to become self-reliant. A typical treatment plan might include such goals as abstaining from the use of alcohol and drugs (including nicotine), entering treatment for substance abuse, keeping all prenatal appointments, and following care givers' recommendations.

To overcome common barriers to care, care managers address problems with transportation

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COMMUNITY BENEFITS

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Some organizations separate benefits for the poor from those for other groups.

Defining Benefit Services to the Poor

The community benefit services identified in the **Table** might be further broken down according to the intended recipient. Some not-for-profit healthcare organizations, including religiously sponsored facilities and programs established to serve the poor, separate community benefit services for the poor from services for the broader community. It is not always possible or appropriate to formally means test each service recipient (i.e., to ask for participant income and asset data). Instead, the following criteria can be used to identify services for the poor:

- Most program users are poor (i.e., at 150 percent or less of the federally defined poverty level).
- Most program users are beneficiaries of Medicaid or of state and/or local programs for the medically indigent.
- The program is directed at reducing high morbidity or mortality rates (e.g., low birthweight) caused by poverty.
- The program is physically located in and apparently draws most of its users from a site shown to be populated by low-income or medically underserved residents, as demonstrated by:

—Demographic data (e.g., from the census) demonstrating a higher poverty rate than the average for the state as a whole

—Designation as a "medically underserved area" or a "health manpower shortage area"

Applying the Criteria

To apply the benefits categorization criteria, consider the examples presented earlier. Do these services qualify as community benefits?

- Medicaid workers in emergency room. This is definitely a community benefit because it helps uninsured persons access more appropriate primary care. However, this would probably not appear in a quantified, cumulative community benefit inventory because it is likely a cost-saving, and not a cost-generating, activity.
- Dietary staff volunteering their time. This is a wonderful community service, one for which both the organization that encouraged the service and the individuals involved deserve recognition. However, it should not appear in a cumulative report because it does not involve budgeted funds.
- Marketing at the county fair. This is a nice thing to do, but the for-profit in town was probably in the booth next door. It is not a community benefit.
- Pastoral care. Because pastoral care is integral to overall good care, the staffing and basic services should not be regarded as community benefits; however, all outreach services sponsored by pastoral care may be considered community services.
- CEO leadership. Executive and staff collaboration with community service organizations should always be counted as community benefits, at least in the narrative report. CEO membership on the symphony board, an example of nonhealth-related civic participation, does not qualify for inclusion in the community benefit inventory. □

For more information, call Julie Trocchio at 202-296-3993.

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and babysitting. They provide bus passes to women who are able to use them. In other cases, care managers drive women to their appointments in vans leased by the hospitals, accompanying their clients during the visit to assist with other children.

The Program's Success

In the second fiscal year of operation (1994-95), 4 care managers worked with 91 clients. In 1995-96 MAP served 102 women (excluding 12 who either did not meet the admission criteria or were referred but refused services). The majority of clients are residents of Harrisburg. Twenty-one women were evaluated at the Dauphin County Prison and referred for treatment before their babies were born. This represents a 100 percent increase in this service area compared with the previous year. Of the 55 babies born to MAP clients, 20 were healthy and drug free; 10 were healthy but tested positive for drug exposure.

During 1995-96, seven clients successfully completed involvement with MAP and received certificates acknowledging this accomplishment.

Comments received in surveys conducted by telephone and in person with mothers who have been helped by the program indicate that MAP is achieving its goals. The vast majority reported home visits, transportation, and referrals to be the most helpful services, along with education and moral support. For example, one mother stated, "I was tired of running from justice, and prison life was hard. Thank God it's over. I'm proud I made the decision to contact MAP. I've gained a lot." Another client commented, "MAP made me think of life in a different way—the right way." □

For more information, call Joyce Zandieh at 717-763-2575.