Maternity Case Management

Satellite Conference and Live Webcast
Friday, July 8, 2016
9:00 – 11:00 a.m. Central Time

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

Meredith Adams, LCSW, PIP
Director of Social Work
Bureau of Family Health Services
Alabama Department of Public Health

Paige Mitchell, LBSW
Program Director
Family Coaching Program
Gift of Life Foundation

Objectives

- Understand the maternity case management process
- Understand the various educational items that will need to be explained to patients
- Understand the Gift of Life Family Programs
- Understand the documentation requirements for maternity referrals

Reasons ADPH Can Provide Maternity Case Management

- The Gift of Life did not renew their maternity waiver contract
- No case management services are being provided to pregnant women in an 8 county area: Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, and Pike counties

Why Can ADPH Now Bill for Maternity Services?

- Medicaid has eliminated SOBRA Medicaid
- This allows all pregnant women who once qualified for SOBRA to now be eligible for full Medicaid services during the pregnancy and through the post partum period
- The full Medicaid coverage allows ADPH to bill Patient First for case management

Coding

- Service Area 81: Patients under the age of 21
- Service Area 82: Patients 21 and older
- Activity Type: 4 for all services

Medicaid Status

- Verify the patient's Medicaid status
- If the patient does not have Medicaid assist with the Medicaid application
- Follow up with the patient to ensure that Medicaid has been obtained

Medicaid Status

- Track how long it takes for the patient to acquire Medicaid which will be documented in the progress note as well as on the Report to Referring Provider

Referral Sources

- Maternity case management will be performed in the Health Department
- Foresee obtaining referrals from the WIC clinic
- Marketing to private providers will be needed as time permits

Referral Form

- All Patient First referrals must have a referral form completed in ACORN
- Referring Provider Tab: Select Self / Family
- Reason for Referral Tab: Select Maternity Case Management

What if the Patient Does Not Want to Keep the Pregnancy?

- Refer the patient to the yellow pages or have a referral sheet with multiple referral sources that also includes abortion clinics
- NEVER give a patient the name and number to an abortion clinic on a piece of paper by itself
- This could be seen as coercion

Plan First Protocol – Title X Requirement

- Clients cannot be coerced to accept services or to use or not use any particular method of family planning
- Inform personnel working within the family planning project they may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure

Psychosocial Assessment

- A psychosocial assessment is required on all maternity referrals
- Please complete the assessment completely
- The Perinatal program nurse will be given access to ACORN in order to pull data from the psychosocial assessment

Case Plan

- A case plan is required on all maternity referrals
- The case plan has been pre-populated with multiple goals to try and limit the amount of typing required
- If a goal is listed that is not needed, do not put a date in the problem identified box

Goals on the Case Plan

- The goals are to assist patient in scheduling the first prenatal appointment, reminders for all prenatal and post partum appointements, acquiring Medicaid, refer to WIC, assess and refer for smoking cessation, refer for diabetic education classes as needed, educate on safe sleep, educate on Zika, arrange for post partum appointment, ensure patient has a car seat, refer to Gift of Life programs, encourage reliable birth control method

Establishing a Provider

- A list of providers for the eight Gift of Life counties can be found on the On Demand page for this broadcast and on the Document Library
- The list is updated and placed on the Medicaid Website under Programs, Medical Services, Maternity Care, Maternity Care Providers

Establishing a Provider

- The patient has the right to select any provider and the Care Coordinator will need to assist with establishing the first appointment

Initial Appointment

- Follow up with the provider to assess if patient kept initial appointment
- Track date and weeks gestation for first appointment
- Follow up with the patient to see how the initial appointment went and if she has any questions or needs arose during the initial appointment

Appointment Reminders

- Encourage the patient to keep all prenatal appointments
- Remind the patient of upcoming appointments
- Assist with the elimination of barriers in order for patient to keep all prenatal appointments
- Keep track of all prenatal appointment dates

Refer to WIC

- Refer patient to WIC
- Put the WIC 157 form up in your office for easy reference to WIC eligibility
- This can be found on the On Demand page for this broadcast and on the Document Library

Refer to WIC

- It was also sent statewide in an e-mail on 4/21/16
- Order WIC brochures to have available in your office as well

WIC Income Guidelines

For information contact your local county health department or

1-888-942-4673 or 1-888-WIC-HOPE

Income Guidelines: Household income (Based on 185% of Poverty.)

Family Size*	Annual	Month	Week
1	$21,978	$1,832	$423
2	$29,637	$2,470	$570
3	$37,296	$3,108	$718
4	$44,955	$3,747	$865
5	$52,614	$4,385	$1,012

* For a pregnant woman, count each unborn baby in the family size.

Smoking Cessation

- If patient uses tobacco, encourage the patient to quit
- Explain the health risks that are associated with smoking during pregnancy
- Smoking during pregnancy can increase the risk of a low birth weight baby
- Explain the monetary benefits of quitting

Smoking Cessation Forms

- Encourage a referral to the Quit Line
- The physician will have to complete paperwork in order for the Quit Line to provide smoking cessation medication to the pregnant individual
- Assist the patient in the completion of the paperwork if she agrees

Accessing the Forms

- ADPH home page
- A-Z Index
- Q for Quitline or T for Tobacco Quitline
- QuitlineAlabama.com
- At the top select Provider Referrals

Quitline Provider Referrals

Refer a Patient

To refer any patient to QuitNowAlabama, please follow the directions on the fax referral form and fax it to 1-800-261-6259 or submit an Provider Web Referral (see below).

Medicaid Patients

Effective Jan. 1, 2014, Medicaid patients are eligible for smoking cessation medications. If your patient is a full Medicaid recipient or a pregnant Medicaid client, please complete the Smoking Cessation Prior Authorization form AND Quitline fax referral form and **fax both** to HID at the number listed on the form. Fax the Quitline referral form to the Quitline at 1-800-261-6259. For more information, visit Medicaid's smoking cessation site.

Print and fax a referral. Fill out and submit a referral online.

Fax Referral | Provider Web Referral

Gestational Diabetes Test

- The Gestational Diabetes Test is conducted around 24 or so weeks
- Encourage the patient to complete this testing
- If positive for Gestational Diabetes refer the patient to diabetic classes conducted by a Certified Diabetes Educator (CDE)

Gestational Diabetes Test

- Through a Google search I found some at Baptist East-CC may want to do the same to find additional classes

Educational Classes

- Encourage a referral to childbirth classes, these can be found through Jackson & Baptist Hospitals
- Encourage a referral to breastfeeding classes which can be found through both hospitals as well

Breastfeeding

- Encourage the patient to breastfeed
- Check out the ADPH website under WIC and the perinatal program for more information
- Let the patient know that any amount of breastfeeding is a great start and to encourage it as much as possible

Breastfeeding

- Discuss concerns about breastfeeding and offer support and encouragement

Breastfeeding and WIC

- WIC offers supportive services for breastfeeding moms and a consultant is available in the central office for breastfeeding questions and resources:
  - Michell Grainger, 334-206-2921
- WIC can assist with acquiring a breast pump and other needed supplies

Breastfeeding resources

- Google Benefits of Breastfeeding:
  - WebMD link
  - Fit Pregnancy link
  - Women's Health link
  - Healthy Children link
  - Baby Center link
  - La Leche League

Early Elective Deliveries

- Educate the patient on the issues that come with early elective deliveries
- An early elective delivery is a delivery after 37 weeks but before 39 weeks that is not medically necessary
- www.acog.org

What Health Problems are Possible for Babies Born Too Early?

- The following health problems are possible in babies who are born too early:
  - Breathing problems, including respiratory distress syndrome
  - Temperature problems - Babies born early may not be able to stay warm

What Health Problems are Possible for Babies Born Too Early?

- Feeding difficulties
- High levels of bilirubin - Too much bilirubin can cause jaundice
  - In severe cases, brain damage can result if this condition is not treated
- Hearing and vision problems
- Learning and behavior problems

Why is it Not a Good Idea to Have an Elective Labor Induction or C-Section Before 39 Weeks?

- Health care professionals recommend that unless there is a valid health reason or labor starts on its own, delivery should not occur before at least 39 weeks

Why is it Not a Good Idea to Have an Elective Labor Induction or C-Section Before 39 Weeks?

- If the patient has a cesarean delivery or labor induction for a medical reason, it means that the benefits of having the baby early outweigh the potential risks

Why is it Not a Good Idea to Have an Elective Labor Induction or C-Section Before 39 Weeks?

- But when they are done for a nonmedical reason, the risks - both to the patient and to the baby - may outweigh the benefits
- When the pregnancy is normal and healthy, it should continue for at least 39 weeks, and it is preferable for labor to start on its own

How Does the Baby Grow and Develop During the Last Weeks of Pregnancy?

- The lungs, brain, and liver are among the last organs to fully develop during pregnancy
- The brain develops at its fastest rate at the end of pregnancy - it grows by one third just between week 35 and week 39

How Does the Baby Grow and Develop During the Last Weeks of Pregnancy?

- Also during these last weeks, layers of fat are added underneath the baby's skin
- This fat helps keep the baby warm after birth

Safe Sleep

- www.adph.org/perinatal on the left side click link for Safe Sleep
- You can order brochures and posters on safe sleep to have in your office and post around the health department
- There are also links on the website to a video about creating a safe sleep environment (3:18) and one on the latest crib safety (1:14)

ABCs of Safe Sleep

- Alone: Bed-sharing can be dangerous
- Back: It is always "Back to Sleep" unless instructed otherwise by a pediatrician
- Crib: Should be free of all objects (this includes bumper pads), just a firm mattress with a tight fitted sheet and slats that are close enough together so a soda can will not fit between them

Gift of Life Foundation

Healthy Mothers. Healthy Babies.
Healthy Communities.

Our Mission

- Since 1988, building a better Montgomery one mother, one baby, one family at a time

Who We Are

- Since 1988 GOL has worked to lower the county's infant mortality rate
  - Community leaders came together to coordinate the development of an organized obstetrical system, complete with high risk care

Who We Are

- Today, we operate three evidence-based family programs, including Growing Our Own Youth, a teenage empowerment and pregnancy prevention campaign

Family Programs

- Nurse Family Partnership
- Parents as Teachers
- Mobile Family Coaching

Montgomery County
Community Characteristics: 2015

Population Demographics for Montgomery City/County	
Population (city): 205,764 **Median Age:** 34 **Population Age Under 5 Years:** 7.18% (14,768) **Gender:** • M= 46.99% (96,687) • F= 53% (109,077) **Population by Race:** • **(B/O)= 63% (129,807)** • (W)= 37% (76,656)	**Primary Language:** English **Family Household Structure:** Children in Single-parent Homes: • **(B/O)= 64.8%** • (W)= 17.8% **Educational Attainment >25 Years of Age (2010):** • High School Graduation Rate= 63.8% Of the total Black population, > 25: 19% have no HSD; **Of BF >25 years old: 19% no HSD;** BM: 20% no HSD

Demographic / Socioeconomic Characteristics

- **Race / Ethnicity:**
  - **(B/O)= 63% (129,807)**
  - **(W) = 37% (76,656)**
- **Educational Attainment**
  - **Highest drop-out rate in 67 counties**

Demographic / Socioeconomic Characteristics

- **Income: Below $23,550 a year for a family of 4**
  - **Children in Poverty: 34%**
  - **National Average: 22%**

Family Structure

- **Family/Household Structure:**
  - **Female / unmarried: 21% (17,730)**
- **Children in Single-parent Homes:**
  - **(B/O)= 64.8%**
  - **(W) 17.8%**

Population Demographics for Montgomery City / County

- **Income:**
  - **Median Earnings Female /Full-time: $31,501**
  - **Receipt of Public Assistance:**
  - **Subsidized Lunches: 73.3%**
  - **Food Stamps/SNAP Benefits: 21.6%**

Population Demographics for Montgomery City / County

- **Housing (2010):**
  - **Renter-occupied units: 41.1%**
- **Mortality- Top 10 Causes of Death (2011):**
  - **Heart Disease, Cancer, Stroke, Accidents, Diabetes, Infection/pneumonia, Alzheimer's Disease, Suicide, Homicide, HIV**

Population Demographics for Montgomery City / County

- (Diabetes, homicide, and HIV higher among Blacks; all other causes higher among Whites)

- Health Insurance Status (2011):
  - No Health Insurance 14.1%

Socioeconomic Conditions

- Crime: Arrest Data (2010):
  - 57% of arrests: (B/O) Male
  - 23% of arrests: (B/O) Female
  - Domestic Violence was the #1 cause for arrest
- Public School Enrollment: 31,316
  - (B/O)= 84%
  - (W)= 16%

Selected MCH Population Outcomes 2010-2013 Montgomery County

- Live Births (2010-2012): 9,325
- Infant Mortality Rate (2007-2009) Montgomery County: 10.6
- (B/O 13.0) Of the 110 total infant deaths during those years, 80% (88) were to (B/O) mothers.
- Medicaid Deliveries (2012): 1,896
- (B/O)= 80.1% (1,519)

Selected MCH Population Outcomes 2010-2013 Montgomery County

- (W)= 19.8% (377)
- Total Low Weight Births (2012): 321
- (B/O)= 259
- (W)= 62

Family Programs

- Serve low-income Montgomery county residents
- Licensed and registered nurses and licensed social workers with specialized training form bonds with mothers, babies and (in some cases) their families

Family Programs

- Nurse Home Visitors and Family Coaches explore the health of mother and baby – physically, mentally, emotionally
- Nurse Home Visitors and Family Coaches work with clients to envision their futures and to develop plans to achieve those dreams

Nurse Family Partnership

- In Montgomery since 2008, Nurse-Family Partnership is nationally recognized as the gold-standard in family coaching programs
  - Nurse Home Visitors work with clients to set goals for their physical, emotional and economic well-being

Nurse Family Partnership

- The program accepts first-time mothers, who meet with their coach every two weeks in their home or another location
- Up to 25 clients for each full-time Nurse Home Visitor

Nurse-Family Partnership

- Nurse-Family Partnership®, a maternal and early childhood health program, fosters long-term success for first-time moms, their babies and society

Nurse-Family Partnership

- The evidence in Montgomery:
  - 32% of women enter employed; 77% are employed when they graduate from NFP
  - Over 40% of second births in Alabama are unplanned
    - Only 14% of our clients have an unplanned second pregnancy at 24 months postpartum

Nurse-Family Partnership

- The babies in NFP are developmentally assessed on a regular basis and, of over 300 babies, only 6 have had any type of developmental delay – and they were referred promptly

Nurse-Family Partnership Success: Marnechea

- Marnechea wanted to be the best mother she possibly could be.
- Marnechea enrolled in the program while pregnant and received visits every other week

Nurse-Family Partnership Success: Marnechea

- When Ky-mani was born, weekly visits began
  - Nurse Kathy came every Monday for six weeks to provide education, assistance with goal setting and lots of encouragement

Nurse-Family Partnership Success: Marnechea

- Visits continued for two years
  - The family moved into an apartment of their own
- Ky-mani met all of his milestones, both developmentally and emotionally
  - Marnechea learned to set life goals and take steps to meet them

In Marnechea’s Words

- As the relationship grew Nurse Kathy encouraged her to think about developing a plan for having another baby
- Marnechea decided to wait at least five years and focus on other life goals
- Marnechea came up with a plan that worked for her

In Marnechea’s Words

- She is now working full time and is enrolled is business school
- “I now have a plan and am sticking with it. I don’t think that would have happened if she had not encouraged me to think and plan for my family’s future.”

In Marnechea’s Words

- “The thing I like the best is that Nurse Kathy has helped me as a mother. She taught me that Ky-mani is a baby with his own personal space, and if I crowd him, it makes him anxious and fussy. She taught me to pay attention to his actions so that I can respond in the best way. I wanted Ky-mani to be smart…

In Marnechea’s Words

- … I have learned that reading and talking to him was very important for brain development. It must have worked because he was talking in sentences when he was 21 months old!
- “Even though I cancelled visits, Nurse Kathy always came back with a smile. “She never gave up on me.”

Parents as Teachers

- Parents as Teachers is a nationally-recognized program to encourage and support parents and families
  - Family Coaches work with parents to set goals, develop strategies for parenting, and encourage emotional, social and physical well-being for baby and family

Parents as Teachers

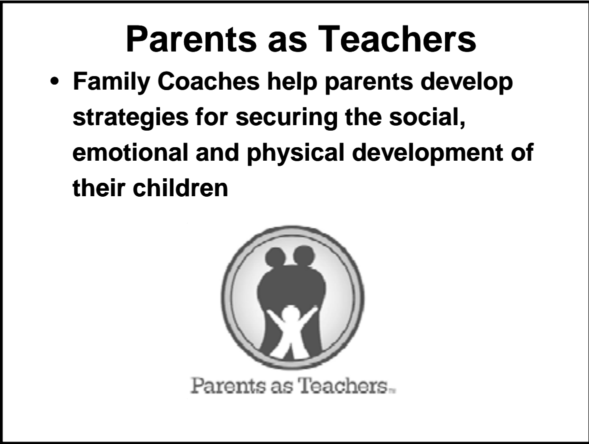
- Family Coaches meet with clients in their homes or another location of their choice every two weeks during the program
  - Clients may already have a child, and may enroll up until their child's first birthday
- Up to 25 clients for each full-time Family Coach

Parents as Teachers

- The concept for Parents as Teachers was developed in the 1970s when Missouri educators noted that children were beginning kindergarten with varying levels of school readiness
  - Research showed that greater parent involvement is a critical link in the child's development of learning skills, including reading and writing

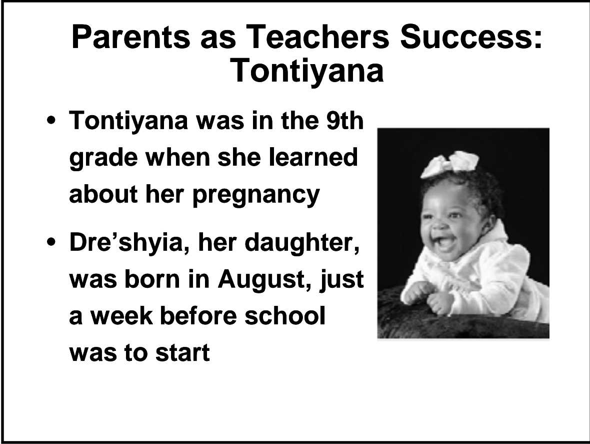
Parents as Teachers

- Family Coaches help parents develop strategies for securing the social, emotional and physical development of their children



Parents as Teachers Success: Tontiyana

- Tontiyana was in the 9th grade when she learned about her pregnancy
- Dre'shyia, her daughter, was born in August, just a week before school was to start



Parents as Teachers Success: Tontiyana

- At 16, Tontiyana was afraid of leaving her baby in commercial day care, so Tontiyana did not return to school
- In October, Tontiyana went to work. She decided that fast food service would not be her long-term career choice and began to think about going back to school

Parents as Teachers Success: Tontiyana

- Dre'shyia has exceeded all of her developmental milestones thus far!
- She is responsive, calm and smiles easily. She is a happy baby. Her parents have developed a relationship, so now, Dre'shyia gets to spend time with both her father and her paternal grandparents!

Mobile Family Coaching

- Mobile Family Coaching offers clients a flexible approach to Family Coaching
- Using a proven curriculum, Family Coaches work with clients using technology - from phone calls and text messages to Facetime chats and in-person meetings

Mobile Family Coaching

- Family Coaches work with clients to develop parenting strategies, set goals, and establish habits that encourage a healthy lifestyle for mother and baby
- Clients may enroll up until their child's first birthday, and may have more than one child

Mobile Family Coaching

- Family Coaches meet in-person with clients, at the location of their choice, every 10 weeks
- Additional visits take place remotely, by phone or other technology
- Up to 50 clients for each full-time Family Coach

Mobile Family Coaching Success: Camellia

- Camellia's family was excited to be welcoming a second baby
- Camellia was hospitalized at 18 weeks pregnant and spent her days cooperating in any way she could to stop the labor that would lead to a too-early birth

Mobile Family Coaching Success: Camellia

- Sharon, her Family Coach, kept in close contact with Camellia
  - Texts, phone calls, cards, anything to encourage her as the days grew long
  - As a coach, she helped Camellia keep focused on her goal
  - She wanted a healthy baby
- Adrian was born at 26 weeks gestation

Mobile Family Coaching Success: Camellia

- Seven months later, Adrian is still in the hospital
- Adrian is well loved. Whenever there is an off-day, his family visits, often rooming in so that he can hear his mother's familiar voice, feel the strength of his Dad's arms, and learn to recognize the giggles of his big sister.

Mobile Family Coaching Success: Camellia

- Christmas was celebrated in the hospital - together as a family
- From the day he was born, Adrian has received the gift of his mother's milk

In Adrian's Father's Words

- "You hardly knew us, yet you made sure we had food, when we were focused on just getting gas to make the trip (to UAB)"
  - –Adrian's Dad

Support and Enrichment Services

- Breastfeeding Support
- Counseling Services
- Group Connections
- Community Action Network
- Community Involvement
- Graduation

Breastfeeding Support

- Certified Lactation Counselor
- Available to Nurses and Family Coaches for consultation
- Provides visits to clients experiencing problems
- Referral to IBCLC

Counseling Services

- Screenings showed mental health services were needed and lacking in the community
- Counseling sessions are offered and provided at no cost to the client

Group Connections

- Bi-monthly meetings
- Families build social connections
- Engage in parent-child interaction
- Increase knowledge of ways to support child's development

Community Action Network

- Healthy Minds Network – Envision 2020
  - Quality Mental Healthcare for all
    - Recovery, Treatment, Prevention

Family Programs Graduation

- 2016 / 34 Graduates
  - Nurse-Family Partnership
  - 3 Mobile Family Coaches
  - 2 Parents as Teachers

Community Involvement and Affiliations

- Alabama Department of Public Health Perinatal Committee
- Alabama's MCHB Collaborative Innovation and Improvement Network (COINN) to Reduce Infant Mortality
- River Region Perinatal Committee Community Action Team
- Montgomery County District Attorney's Helping Montgomery Families Initiative

Community Involvement and Affiliations

- Montgomery North Precinct Service Providers Alliance
- Alabama Breastfeeding Council
- Junior League of Montgomery
- Children's Policy Council Early Care and Education Committee
- Centering Pregnancy Steering Committee
- Montgomery Catholic Social Services Board of Directors

Family Programs Graduation

- 34 Graduates
  - Nurse-Family Partnership
  - 3 Mobile Family Coaches
  - 2 Parents as Teachers

Referral Form

Gift of Life - Family Coaching
REFERRAL FORM

Date: ____________ Agency/Practice: ____________
Contact Name: ____________ Phone: ____________

- Mobile Family Coaching
- Home Visitation Family Coaching – A home visit based form of case management

Client's Name: ____________ DOB: ____________
Phone #1 ____________ Phone #2 ____________
Cell: ____________ Best time to call: ____________
Address: ____________
City: ____________ State: ____________ Zip: ____________

Preferred method of communication: ____Phone Call ___ Text____email
Email Address: ____________

Client Signature ____________ Date ____________

"Spread love wherever you go. Let no one ever come to you without leaving happier."

- Mother Teresa of Calcutta

www.golfound.org

Post Partum Appointment

- It is very important for the patient to keep the postpartum appointment
- The patient needs to be checked to ensure things are healing properly and to become established on a reliable birth control method

Birth Control

- Begin discussing birth control options as early as possible with the patient and encourage a reliable method
- Provide education on various birth control options
- Let the patient know that a Long Acting Reversible Contraceptive (LARC) is the most effective and can be placed while still in the hospital for delivery

Infant's Primary Medical Provider

- Ensure the patient has a PMP lined up for the infant upon delivery
- After delivery, follow-up with the patient to ensure the infant has been established with a PMP, meaning the infant has been taken to the PMP
- Encourage the patient to keep all appointments with the infant's PMP

Report to Referring Provider

- ACORN updates will be a lengthy process
- Until the updates are ready a Word document has been created with the data that will need to be captured
- The form is a point and click form so that hopefully it will not be too time consuming

Template Information

- Three and a half pages long
- Any place there is a "Click here to enter a date" click and a calendar box will appear to select a date
- If an answer is selected and it needs to be changed will need to click on the incorrect answer to de-select it after the correct answer is selected

Template Example

- When was the first prenatal appointment?
  Click here to enter a date.
- How many weeks was patient at first prenatal appointment?
  Choose an item.
- Did the patient have to wait to see a doctor because Medicaid was not yet active?
  ☐ Yes ☐ No
  If yes, how long did the patient have to wait to see a doctor because of the lack of Medicaid?
  Choose an item.
- What is the patient's due date?
  Click here to enter a date.
- Was the patient on WIC at first appointment with CC?
  ☐ Yes ☐ No
  If no, was the patient referred to WIC?
  ☐ Yes ☐ No
- Did patient keep all prenatal appointments?
  ☐ Yes ☐ No

Template Questions

- The majority of the questions are self explanatory
- If you are unsure of what a question means, please let me know
- The questions asked are for data purposes for multiple programs and the RCOs to provide evidence of how valuable our services are

Gravida

- Gravida refers to the number of times a patient has been pregnant
- This will include all pregnancies no matter the outcome
- All patients at a minimum will be Gravida 1 as they are pregnant currently

Para

- This is the number of births the patient has delivered that reached at least 20 weeks gestation
- Births/miscarriages prior to 20 weeks gestation are not included in the Para number

Examples

- A patient is currently pregnant and has a 2 year old child
- G2P1
- A patient is currently pregnant, has a 5 year old child, and had a miscarriage at 10 weeks gestation
- G3P1

Examples

- A patient is currently pregnant, and has a set of 3 year old twins
- G2P2

Template Information Continued

- It is a working document and should be completed throughout the pregnancy as information becomes available
- An intern will be responsible for entering the forms into ACORN once the updates are available

Sending in the Completed Template

- Once the case is closed the template can be submitted
- The templates can be sent in to the central office in which ever manner is easiest for you
- This can be hand mail (make yourself a copy first!), fax, or e-mail

Sending in the Completed Template

- All templates can be sent to Meredith Adams and I will get them distributed for data entry

ACORN Updates

- The Actual Report to Referring Provider will be similar to the template
- The questions are the same, but it will generate certain questions based on previous answers
- Similar to the Smoking Cessation tabs in Plan First

Contact Information

Meredith Adams
Meredith.adams@adph.state.al.us
(334) 206-3897

- Always let your supervisor know what your questions are so we can be on the same page!