

# *How Do We Capture Pregnant Women?*

Create easy access for pregnant women by:

- Centralized Intake and Appointment Scheduling  
1 “800” Phone Number for any service
- Cross-training Staff to allow for the integration of the Women, Infants & Children (WIC) Nutrition Program and the Maternal Infant Health Program (MIHP)
- On-going Appointment Coordination  
WIC/MIHP/Immunizations

*“Every Door is a Right Door”*

## **WIC/MIHP Integration Program Model**

Pregnant Woman Appointment Includes:

WIC Enrollment    MA Application    MIHP Screen



# *Benefits of WIC & MIHP Integration*

- ↓ Infant Mortality
- ↑ MIHP Participation
- ↑ Breastfeeding Initiation
- ↑ Immunizations
- ↑ WIC Enrollment 1st Trimester
- ↑ Prenatal Care 1st Trimester
- ↑ Adequacy of Prenatal Care

# *How do we capture infants?*

- High Percentage of eligible pregnant women are on MIHP
- Newborn home visits available to any family
- Service integration with other programs, such as Children's Special Health Care Services (CSHCS)
- WIC clinic encounters~nurses identify families who need more services

# *Medical Home Care Coordination*

- Create an understanding of WIC/MIHP services through long term relationship with providers and consistently providing a high quality service
- Meet with large OB practices every 1-2 years
- Communicate concerns/issues with medical providers on a regular basis

# *Medical Home Care Coordination*

- Meet with hospital staff yearly
- Expand some services to the general population, such as newborn home visits
- Work with community medical providers on initiatives such as a “Community Breastfeeding Standard” or WIC Breastfeeding Peer Support Counselors

# *Community Resource Connections*

- Meet with local DHS yearly to review programs
- Participate in community initiatives such as the Human Services Coordinating Bodies, Early On Local Councils, Local Child Abuse Prevention Councils, Preschool Advisory Committees....
- Participate in community initiatives such as Health Fairs, Baby Showers, Information Summits
- Partner with other community agencies to maximize community resources thereby increasing services and decreasing duplication



# Priority Health Services Inc. (PHS)

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Effective Use of Outreach for the Maternal Infant Health Program To Promote Healthy Pregnancy and Infant Outcomes

Susan Gough, RN, BSN  
President



# Maternal Infant Health Program

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- We have collaborated with hospital discharge planners to identify and refer mothers and babies to the MIHP.
- We have integrated with Managed Care Plans and work in close collaboration with OB and Peds case managers in identifying high risk cases. We work with plans to identify members in need of MIHP.
- We collaborate with County WIC programs where MIHP is not offered by the health department. WIC has a requirement to collaborate with and offer clients other services that may be beneficial. CDE produced by WIC can be used for demographic data to initially contact clients and a HIPAA Business Associates Agreement can be put in place so that the release of this data is compliant. In addition, a signed consent agreeing to release of information is also in place.

# Maternal Infant Health Program

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- We collaborate with PS and DHS. DHS has outreach workers whose sole responsibility is to seek out community resources. Working with the DHS outreach workers, in four DHS offices in Wayne County, we are able to do direct outreach in the waiting room to pregnant women and mothers of infants. PS in several Wayne County offices contact us with referrals but many attempts were made to market to them regarding MIHP.



# Maternal Infant Health Program

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- We participate on the Child Death Review Team in Macomb County, FIMR teams in Detroit and Macomb County, and Community Action Teams from FIMR that are working on infant mortality reduction in Detroit/Wayne County/Macomb County. These teams offer exposure to a cross section of people that touch the target population of MIHP thus increasing the visibility of the program. It also allows the MIHP provider to point out when an opportunity for the MIHP has been missed and could have made a difference in the outcome of a particular case.

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# Maternal Infant Health Program

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- We developed a website that allows for direct referrals for either the maternal or infant portions of the program.
- We did a mass mailing of a brochure developed for our agency to past physicians that had clients enrolled in the MIHP.
- We have had multiple opportunities to speak at community symposiums regarding the MIHP that have arose from the contacts gleaned in infant mortality reduction/FIMR community action teams. We have a standard MIHP power point presentation that explains the program to community audiences.
- We have attended Health Fairs in a variety of venues to promote the MIHP.

# Maternal Infant Health Program

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- We have a good “word of mouth” reputation within the community and receive a fair amount of referrals from this.
- We have formed a Foundation that is collaborating with General Motors Womens Club. This partnership has allowed us to do a small car seat give away program for our neediest clients as well as to provide a small pack and play program that requires a safe sleep class. Through this partnership, we have also linked with women’s shelters who are in need of the MIHP due to the promotion of the GM Womens Club.
- We have teamed with the Wayne County Health Department in a safe sleep project where pack and plays are given to clients after an educational program is completed.



# Maternal Infant Health Program

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- Questions?
- Thank you for the opportunity to come and speak with all of you today!
- Website: [www.priorityhealthservices.com](http://www.priorityhealthservices.com)