

## CARE COORDINATION TEAM

The Care Coordination Team consists of:

- *NASW Certified Care Coordinators who are responsible for needs assessment of, development and implementation of an action plan, monitoring and evaluation of the effectiveness of the plan, and facilitating the receipt of needed services in accordance with the Medicaid guidelines.*
- *Certified Community Health Workers serve as health advocates providing service coordination assistance that aids in assurance that participants receive the services for which they are entitled.*
- *Outreach workers, familiar with the communities, promote community awareness of the MCH Network Care Coordination programs.*



**Changing Lives With  
Love, Support & Education**

## MCH NETWORK ORGANIZATIONS

FUNDED BY THE INDIANA  
STATE DEPARTMENT OF  
HEALTH

**NWI Healthy Start**  
6939 Grand blvd.  
Hammond, Indiana  
(219)989-3939

**Maternal Child Health Clinic**  
Gary Health and Human Services.  
2200 Grant Street, Suite 204  
Gary, Indiana 46404  
(219)887-5146

**HEALTHVISIONS MIDWEST**  
Sponsors the following sites:

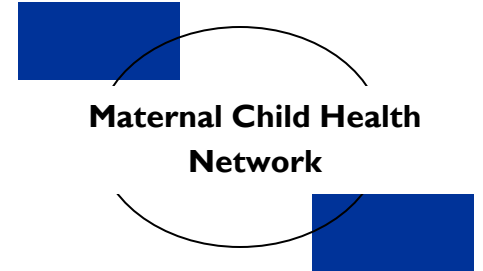
**Great Beginnings**  
150 West 15th Avenue  
Inside Gary YWCA  
Gary, Indiana 46407  
(219)886-9388

**NATALE**  
1021 West 5th Avenue  
2nd Fl. Gary Community Health Ctr.  
Gary, Indiana 46402  
(219)886-0585 phone  
(219)886-5105 Fax

**Promotores de Salud Maternal e  
Infants**  
524 W. Chicago Ave.  
East Chicago, IN 46312  
(219)397-2477  
(219)391-4042



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***WE ASSIST WITH  
MEDICAID  
APPLICATIONS***

## WHO WE ARE



### What does Care Coordination Mean?

The care coordination services of the Maternal Child Health Network agencies are State and Federally funded projects with the goal of reducing the infant mortality in Lake County, Indiana. Our Missions are to assist women in having healthy babies, reduce infant deaths, reduce low birth weight, and establish ongoing preventive health services for children. These services will be administered professionally and with respect, dignity, courtesy and compassion, regardless of sex, age, creed, religion or culture.

In Lake County, many newborns have low or very low birth weights. Often, pregnant women do not seek prenatal care early in the pregnancy. Some may feel that giving birth is a “natural” thing and ongoing care is not needed. For others, barriers such as a lack of transportation and adequate child care or inadequate financial resources may delay access to health care. Others may need assistance provided by community resource agencies, but do not know how to access services for which they could be eligible to receive.

The role of the case management and care coordination staff is to minimize existing barriers and facilitate access to needed medical and social services. The medical care of the physician, and the care coordination process, aid in the assurance of a more positive outcome for pregnancy for those participants most at risk.

## WHAT WE DO

Our Social Workers, Community Health Workers and Nurses are available to provide personal assistance for the woman and her family during her pregnancy

We specialize in facilitating health care and social services for pregnant women in an effort to reduce infant mortality and low birth weight rates.

We collaborate with physicians and community agencies to locate high risk pregnant women and facilitate their early entry into prenatal care.

An individualized action plan is developed to address the identified needs of the participant..

The pregnant woman is visited in her home to determine her environmental needs and to gain insight into her circumstances.

Information and referral services are provided to link the participant with available services to meet her needs.

Services are coordinated with the physician to provide re-enforcement of the health, nutritional, and other teachings given during the client’s visits to the physician’s office or clinic.

Transportation and child care service can be provided for prenatal and pregnancy related appointments.

The participant is encouraged to decrease health risk behavior through education, counseling and referral services.

## WHO TO REFER

Any one can be referred for services no insurance, Medicaid eligible pregnant women all can be referred to the Care Coordination Programs. The program will do an initial assessment to determine if the individual is at risk for a poor pregnancy outcome due to existing medical and/or psychosocial factors. The client is enrolled in the appropriate program for which she is eligible only after the **initial assessment**.

The following situations qualify for care coordination services;

Clients who experience the following:

- Have a previous history of a poor pregnancy outcome,
- Missed physician appointments,
- Are under 18 years of age or over age 34,
- Need emotional or mental health services,
- Have inadequate family support,
- Abuse alcohol, drugs or tobacco,
- Have nutrition related problems or need assistance with purchasing food, or
- Have been identified with behaviors that pose a risk.