Care Coordination at Our Healthy Start Program

Discuss these questions with your supervisor or ask to schedule some time at a staff meeting to discuss how your Healthy Start program works together to connect participants to health care, social services, and other supports. Use this worksheet to keep a record of what you discussed.

1. What are the different ways that our Healthy Start program identifies health risks and service needs of Healthy Start participants? *(For example, an intake visit, Healthy Start or other screening tools, interactions with participants during calls and visits, team meetings)*

2. Who on our Healthy Start team plays a role in connecting participants to health care and other services that they need? What role does each person play, and how does our team work together to connect participants to needed services?

3. What are our program's procedures for helping participants to get health insurance, including Medicaid and Children's Health Insurance Plan (CHIP)? Is there someone on our team who specializes in this?

4. What are the main agencies, programs, and service providers in our community that we have referral relationships with, that we can refer participants to for needed services and support?

    - Health care services:
    - Behavioral health services:
    - Food and nutrition programs:
    - Housing programs:
    - Education and employment programs:
    - Programs for young children:
    - Programs for families:

5. Who is responsible for keeping our referral directory up to date? Who should we tell if we have updates to information about a program in the community *(for example, changes in hours or eligibility)*?

6. What are our program's rules, procedures, and forms for sharing/release of participant information to other agencies, programs, or health care and social service providers?

7. What are some of the barriers and challenges our participants face in accessing health care and other services, or in following up on referrals we provide them? *(For example, transportation, child care, services not offered in their first language, prior negative experience with service providers, etc.)*

8. What are some effective ways we have found to help participants overcome these barriers and challenges?

9. What are our program's policies and procedures around helping participants with transportation and/or child care so that they can make it to appointments for health care and other services?

10. Do we have a form or process that we can use to talk with participants about their personal goals for their health, their lives, or their family? How do participants' goals fit into our care coordination work?

11. Does our program have meeting times when we discuss as a team the situation and needs of individual participants? How does this work in our program?

12. What are our program's procedures and forms for documenting participants' referrals and use of services?