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Naomi: Hello, everyone, and welcome to the Healthy Start Community Webinar on Care Coordination. My name is Naomi Clemmons and I'm with the Healthy Start EPIC Center. I will be moderating today's webinar. We have about 90 minutes set aside for the webinar and it's being recorded. You'll be able to find it along with the transcript and the slides posted to the EPIC Center website.

So Care Coordination has been the topic of high interest among our Healthy Start grantees. It seems really timely to have Care Coordination webinar early on in our webinar series. This webinar is really intended for the Healthy Start Community with a particular focus on the project managers, care coordinators, supervisors, and case managers. Our webinar objectives: recognize the role of care coordination in the Healthy Start program, define care coordination and case management, define the key components of care coordination and case management, and apply the key components of care coordination and case management to Healthy Start case examples.

Before I introduce our guests speakers for today, I have a couple of announcements. We want your participation. So at any point in time, if you have questions or comments, please feel free to type them in at the bottom left corner of your screen. We will only be taking questions via chat, and will be breaking at the end of the webinar to answer them. If we don't get to all of your questions, we'll include them in a Frequently Asked Questions document that we'll post along with the webinar materials on the EPIC website. At the end of the webinar, you'll be asked to complete an evaluation. We really appreciate your feedback, so please take a moment to complete that survey.

Also, following the webinar, we will be hosting a series of discussion groups for you to continue the conversation about Care Coordination where you can share experiences, best practices, learn from your peers, and inform the Healthy Start model. You'll be able to sign up for these discussion groups following this presentation. So now let me introduce your speakers for today. First, will be Kimberly Sherman. Kimberly is a Project Officer with the HRSA MCHB Division of Healthy Start in Perinatal Services. She assists with the grantees Alabama, Arkansas, Mississippi, and Louisiana. Kimberly has been fantastic to work with on the training and technical assistance activities. She really has her finger on the

pulse of the Healthy Start Community, is a wealth of knowledge, and always comes to the table with great ideas.

Our other presenter and main presenter today is Dr. Kimberly White Etheridge, fondly known as Dr. Kim, and for her commitment toward improving prenatal and perinatal health outcomes and addressing disparities in health equity. Dr. Kim is a pediatrician, a clinical instructor, an MCH subject expert, MCH program director and innovator, as well as a community advocate. And truly the list goes on in terms of what she has done, what she has contributed, what she is doing, and what she plans to do. I've not known Dr. Kim as long or as well as many of you, but I really have enjoyed getting to know her. It's been a really treat.

Before I hand the controls over to our presenters, I would like to take this opportunity and ask all of you in the audience a question. How satisfied are you with your grant projects, current case management care coordination model? Are you very satisfied? Satisfied? Or unsatisfied? I'm going to give you a minute to answer, and then I'll share the results. They're coming in. Anyone else want to answer the poll before I close it? They're still coming in. I'll give it 20 more seconds. Okay, so it looks like the majority of you are satisfied with your current case management care coordination model. I think that's fantastic. And on that note, I'm going to hand it over to Kimberly Sherman.

Kimberly: Thank you very much, Naomi, and good afternoon, Healthy Start. My name is Kimberly Sherman, and as you know, I work here on the Division of Healthy Start in Perinatal Services. Thank you for your time today to learn a little bit more about what the Healthy Start Community [inaudible 00:06:00] case management case coordination, but also to hear from the leaders in the field. Lastly, we really want to take some time, this is just the initial phase as we begin to talk about care coordination and case management in Healthy Start. We are in year one implementation for this, as we stated earlier. It's the best time to assess the care coordination models that you're currently using, and to figure out other ways that we can enhance this model.

And from those of you who filled the phone questionnaire and found that you're unsatisfied with the mechanisms that you're currently using, this is the time to hear from your peers and see what's working, what's working in other Healthy Start

communities. Is it an evidence-based model? Is it a hybrid model? But we are going to begin that conversation today. As many of you know, Care Coordination is the major tenet of the Healthy Start program. Healthy Start exists for the communities where we have poor perinatal outcomes, and the central tenet is coordination and facilitation of access to care and needed services. So as a Healthy Start grantee, you are required to serve the participant and making sure that they have a documented medical home, and that they have access to that medical home. And not only that, but they have access to wraparound services. Many clients come in and they need additional medical or behavioral health services. They may need assistance with housing, finding childcare, increasing their education.

They may also have individual health targets, and that's why we use tools such as the Reproductive Life Plan, or assist moms during their intercession phase to meet their health goals so that as subsequent pregnancies, they have enhanced perinatal outcomes and improved health for themselves. So when we say service delivery, we mean that service delivery is really centered around the needs of our program participants. What does that mean? How do you assess what are their needs? You may begin definitely by completing a comprehensive needs assessment. During that time, you want to figure out what the success means for your program participants, but what does it also mean for the organization. As you all know, you have targets, benchmarks, and performance measures that you must submit information to HRSA and show improvement along that spectrum. But again, these needs are really centered around the program participant.

Some of the components of service delivery in the realistic Care Coordination and case management include a comprehensive needs assessment, the development of a care plan, the identification of appropriate services and additional services that your program participant may ask for, facilitation to services that may be outside of your scope. For instance, if a mom is scoring high on our depression screen but you don't currently provide in-house counseling services, you may have a partner in the community that will readily see your client. So facilitating those linkages is key, and making sure that she receives those needed services.

Through the course of her enrollment in the Healthy Start program, you want to continue to monitor her progress as her needs change and grow, the needs of her family change and grow. That care plan may change as well. So again, to be

responsive to the needs of the client, but also responsive to the needs of your requirements as a Healthy Start grantee. So case management in Healthy Start, again, is the provision of services through a coordinated, culturally competent approach, which includes the client who's central to the creation of the care plan, referral, monitoring, facilitation, and then follow-ups on the utilization of needed services. For pregnant women, these services might include access to care and utilization of timely and quality prenatal care, delivery of those services, especially around labor and delivery. And then follow-up with postpartum care and subsequent care during the interconception phase.

For infants up to the age of two, these services would include access and utilization of quality services and primary care services. So within the Healthy Start Community case management, is also known as care coordination. You'll hear more about that today from Dr. Kim. This is central to the goal of Healthy Start. We want to make sure that our clients achieve success by meeting their needs as it relates to a medical home and creating outcomes, but again, those wraparound services. At this time, I will turn the presentation over to Dr. Kim who is going to provide a little bit more background and some case examples of care coordination in the Healthy Start communities. Dr. Kim?

Dr. Kim: Well, good afternoon. It's a pleasure to be here. Thank you for the opportunity to be able to speak and also to share some of this information. First and foremost, I just want to say for all of you who have taken on the Healthy Start project with the dedication to really change the perinatal outcomes of the women that you're working with, kudos to you. It's hard work. It's a lot of work, but it's so rewarding. It's just an honor to be in the presence of people that care so much about moms and babies that they're willing to do this kind of work. So with that, keep up the good work. The community needs you.

I want to take this opportunity to introduce you to your next four referrals, to the women that you are helping, as a way to frame some of the information that we're going to be talking about. Your first referral, and usually if you're like our project was, it's usually about 4:30 on a Friday when these types of referrals come in. Ledonne [SP] is a 38-year old. She was just recently released from prison last year after serving a drug and prostitution sentence. She's back together with her "bad news boyfriend/pimp," four months pregnant with twins. Her other eight children

are living with relatives or are in foster care, and the question of whether or not she's actually using again or not. She developed gestational diabetes and has a history of preeclampsia from her last pregnancy, and has missed her last three prenatal care appointments.

And these are all actual women that names have been changed to protect the innocent, but these are clients that have been referred, or have come for services. So that is Ms. Ledonne. Next is Ms. Britney. Britney is a 17-year old high school honor student, three months pregnant with her first child. Britney's mom was a single parent. She was also young as a teen, and she is just highly disappointed that her daughter didn't "learn from her mistakes" and ended up getting pregnant herself. She practices tough love and does not plan to help Britney, so she seems to learn the hard way. She wants her to realize how hard it is to be a young mom so that, hopefully, it won't happen again. Her boyfriend was recently deported after a traffic stop, but he promised to sneak back into the country and take care of her and their baby.

Our next one is Heather. Heather is a 26-year old stay-at-home mom. She's five months pregnant with a small for gestational age fetus. She has been living in generational poverty. She failed out of high school in ninth grade and is currently in an abusive relationship with the father of her other two children. She wants help from you to become an LPN. She met an LPN and thought that this would be a really cool career to have. If she can support herself, she's convinced that maybe it'll give her the opportunity to flee from her current situation and start a new life someplace else.

And then, lastly is Mimi. Mimi is 19-year old married student working on her cosmetology certificate. She's eight weeks postpartum after delivering her third infant in the last four years. After quitting smoking while pregnant, she has started smoking again cigarettes and occasional marijuana. She has difficulty breastfeeding and her 27-year old husband is encouraging her to give it up, but she really wants to breastfeed. She missed her follow-up OB appointment and is not currently using any kind of family planning methods. She recently moved into [inaudible 00:14:48] apartment, and her oldest child who was premature has been seen in the ER twice for asthma exacerbations.

So these are the women that has come into your program. So you ask yourself, "Is your current Healthy Start model structured to be able to provide all of the services to these four very different women that they need to fill those gaps? And do you have access to the expertise needed to address these issues? And how will you measure your success? How would your client measure success?" It's not just whether or not we think our programs are successful, but do the clients, or the women, that we have the pleasure to work with finding success also? And what does it mean to successfully coordinate the interventions and services needed in each of these individual cases? So I like this quote, it says, "Many have tried, but few have conquered the call." And what is that referring to, is it's referring to defining care coordination. Everyone says that you needs a good elevator speech, but if you went from floor one to the top of the Empire State Building, most people still can't verbalize what it is when they talk about care coordination.

So a couple of years back, the National Center for Biotechnology Information took on the challenge of looking at care coordination. They completed an analysis to really look at what was in the literature around care coordination. They identified over 40 different definitions of care. They looked at the similarities in services and the characteristics, the words that were used when you search or to describe it, and several other domains to try to come up with a definition of care coordination. Some of what they found, and you can look at these and see if this fits into any of the definitions that you see. The American Academy of Pediatrics call care coordination a process that facilitates the linkage of patients and their families with appropriate services and resources and coordinated efforts to achieve good health.

And something in those, on several cases, the word patient. In 1995, under the [inaudible 00:17:04] of Alfred, said that coordination refers to the regulation of activities between the nurse and the case managers, so that the necessary patient activities do not go unperformed. In 2004, the term care coordination has no well-established definition - so there it goes right there - rather generally understood to mean the process of improving communication among the various medical professionals with whom patients come in contact, and between those and the patient themselves and their families. So right in the definition, they say, "Well, we don't really know what this is, but this is kind of what it looks like."

And there are several other examples all describing the incorporation of information about independent actors coming together. The term that encompasses a variety of care management methods from case to disease management aiming to improve the quality of care for patients. Coordination has been defined as the conscious activity of assembling and synchronizing differentiated work efforts. Whew! So if you try to get all of that in an elevator and you wonder if at the end, do you still really know what exactly care coordination is by definition. So what they did is they came up with a working definition, which was the deliberate organization of patient care activities between two or more participants, including the patient involved in the patient care to facilitate the appropriate delivery of healthcare services. A little bit of a run-on sentence, but it grabs the essence of what all the definitions before that were saying when it came to care coordination.

So when you look at this definition and a lot of the other ones that have come about, some of the things that you notice when you talk about care coordination is that it's still modeled around the medical model in nature. Medical care is still the central process, the epicenter of the whole coordination. Every one of those definitions refer to working with patients. And by definition of patient, is someone who is under medical treatment. If you're under medical treatment, then there's an assumption that there's something wrong that must be corrected. Usually, when it comes to medical protocols, how it should be corrected is pretty much prescribed, and the only question is how do you get all the pieces together to get that done? So when you look at medical, when you say medical, it's the science of it. It's not necessarily the art of what needs to be done.

And then we say, "Well, that doesn't really sound like what I'm doing. So maybe I'm doing more case management than care coordination." So we looked at case management, and this is the "collaborative process of assessment planning, facilitation, advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes." Whew! And that's from the Case Management Society of America. It says that case management "enhances care coordination through the designation of a case manager whose specific responsibilities to oversee and coordinate delivery for high-risk patients with a diverse combination of health, functional, and social problems." So it goes a little bit beyond the care coordinator, because it is taking into considerations things that aren't necessarily medical in nature.

So these models really depend on the type of management, whether it's homeless, whether it's behavioral health, or several others. The services are essential to the process. So unlike the care coordination, it's not the medical component or the services that are in the epicenter. And unlike the other one where you're working with patients, this is more so when you're working with clients. A client is then defined as "the person utilizing services of a professional or organization," and it assumes that there is an unmet need that needs to be filled. It is health needed in filling that need. So if you think about your clients, the people you're working with, and you think about what it is you're doing, you say, "Well, it's a little bit of care coordination and there's some case management in there. So if we take care coordination and add case management to it, then what do we end up with?" And what we did is kind of a care coordinated case management, which means that it's hard to differentiate one from the other when you think about Healthy Start. Because the women that we work with have so many different layers of issues or concerns that needs to be addressed that it's difficult to put it one box by itself.

So we talk about this care coordinated case management as the moving definition. And so when you look at this, you say whether a new participant that are participants or people coming around the table. There's numerous participants involved when we talk about care coordination. Usually, you've got the patients, the family caregivers, docs, nurses, pharmacists, social workers, support staff, all involved in, again, figuring out what is the best way to deliver this prescribed healthcare services. But when you add the case management part, then you add additional participants that may exemplify what's happening in the housing community, grassroots community organizations that can provide services that might be legal aid or it might be educational systems or schools. Another part is based on what the actual issues are that are identified, and medical is no longer the central piece of this type of care coordinated case management.

So this coordination is really necessary when your participants are dependent upon each other to carry out this sort of activity related to that patient care. So when you have multiple people with multiple disciplines and multiple agendas coming to the table, they've got to coordinate to make sure that everybody is bringing what needs to be brought, but that is done in a way that maximizes. When you take it and you multiply it, instead of creating additional silos when you're working with your client. And when these potential contacts' health needs are augmented by these

complex social needs and management needs, it's essential to make sure that all these issues are being addressed in a way where somebody can see the big picture, is in charge, and making sure that there is adequate follow-up for all of the moving pieces.

So in order to carry out the needed, requested, recommended activities of care coordinated case management, each participant that comes needs to have adequate knowledge about their own and the role of others, as well as available resources. So it's not enough just to know your role, but what else is available, what else might other people be bringing to the table. They have to understand the pieces as well as the whole. Decisions cannot be made in a vacuum. In public health, we have so many examples of silos, whether it's because of the way that we're funded, or categorical funding of those, that we get tunnel vision often and say, "Well, my job is to A, B and C." We don't take into consideration D, E and F that would work much better if we actually were working together or we're talking, because we're getting what we need to get done. This is a disservice when we think about care coordinated case management.

Whatever is done as far as planning and moving forward, strongly incorporate the ideas and the desires of the client that you're working with. It must be clear about the scope of services each participant is involved in, and can realistically offer us. If we don't know what everybody does and we often come up with some false expectations about what people can bring to the table or what problems they can solve. I remember sitting with a client in a team like this, and she was homeless. A comment came up, "Well, the social worker should be able to find housing for her," and not realizing that the waiting list is several hundred people long for public housing and just all of the issues that went along with that because it wasn't well-verbalized what the limitations were of each part that came to the table. And as we mentioned, someone has to be in charge as the main advocate for the client, and that person has to be empowered to make the final decision when disagreements may occur among the participants.

So in order to manage all these required client care activities, participants must rely on the exchange of information. Plans have to be shared, they have to be integrated. Again, it cannot be done in a vacuum or in a silo. But also, not just what is the plan, but why is the plan, the rationale behind why decisions or steps are put

in place. Because if everyone understands not just the plan but the steps of the plan, then it's much easier to get it done. And with this, of course, documentation is key. We always say in medicine, "If it's not documented, it didn't happen." So keeping it documented and also making sure that the accountability is well-established and everyone understands what they're responsible for.

So when we think of this integration of activities and services with the goal of facilitating the delivery of not just the mix, but the right mix of appropriate social and health interventions, then there's the opportunity for success and being able to move our clients forward to a place where have better birth outcomes. But not just better birth outcomes, but are more to have a healthier life across their lifespan. So ingredients for then care coordinated case management successes. One is keeping the client in the center. The needs of the client, the person that we're working with, should be the driving factor, not the needs of the organizations and partners. We can all probably think of examples where partners came to the table and they had specific requirements for their goals, for their funding, for their logic model that had to be completed for them to remain at the table. It wasn't necessarily whether or not it was the best thing for the client, but it was a requirement that they had to write down for either their particular file or for their report. As a result, the coordinated care was never quite as good as it could've been, because the patient or the client was not the centerpiece of the discussions.

This gets into the importance of collaboration, shared power and authority, that no one participant or partner coming to the table is going to be any more important than this person. So housing may be more of an immediate issue, but the housing folks are not going to be any more important partners than maybe the food advocacy folks. And with that, that little sense of humility and acceptance of others, then there's a different atmosphere that comes when you're talking about a successful care coordinated case management system. [inaudible 00:29:19] to other teamwork, as I said, everybody brings specialized knowledge, expertise, and this non-hierarchical relationship. With that, there's opportunity to respond to situational demands and not traditional roles. So if your nurse case manager traditionally does A, B and C, and comes and says, "Well, I'm going to do A, B and C," but that's not what is necessarily needed, then there's a disservice because she or he is looking at traditional roles instead of at the situation. And as you follow the four women that I introduced you to, it's all very, very different cases.

Continuity. There should be some account that ties everything together, should read like a story. You have to see where you came from in order to see where you're going, and what changes and successes have been made. Sometimes our women and our families, their lives are so chaotic that you don't really see the difference you're making because there are so many, so many needs. But if your continuity is there, and your documentation is there, then you can start seeing the small parts of progress that are moving forward that keeps everybody motivated, including the client, in the sense that things are changing for the better. Checks and balances, as far as success, is dependent on all of the pieces of the puzzle being completed. And, of course, this issue of mutual respect that no partner at the table knows everything about everything, and that humility is a learned skill. Usually, we get in positions because of our competence and our ability to portray what we know, but at some point, you have to sit down and realize that you don't know everything. But what you have to offer is important in a bigger picture.

So when we talk about steps and conventions, a lot of these earlier, one is this issue of how do we assess the client, identify the life challenges to successful outcomes. We talk about developing a plan and the important part of this is a plan with the client. I've seen so many plans that have been done in isolation. Then the plan is brought to the client, and if you're like some of our clients that we've had, you get a shake of the head and the, "Yes, because I'm going to please you while you're here and then I'm not going to do anything that you said, because I don't have the buy-in. Because I wasn't part of creating that plan that works best for me." We identify the necessary participants and specify their roles. Every partner or every participant isn't required for every case. You're going to have to know what the needs are. If you know what the needs are, then you're able to see who needs to be at the table. If you have opportunities where different women have totally different teams, then that tells you that you're being responsive to the specific needs.

Communication to the client and all other participants ensures information exchange across all entities. Transparency is key. I met a woman that when she met - or I guess when she was talking about at that point - she had a case manager. She said abruptly, "I am not a case and I do not need to be managed." So that just shows a little bit of her frustration about having something done to her instead of done with her. And with her it would've been much more successful in that situation. And then, of course, executing the plan, implementing the managed

coordinated interventions that have been discussed, realistically put down, and then moved on. It makes no sense to do anything if you're not going to monitor and adjust in a continuous cycle, or looking at what works, what doesn't work, what do we need to do differently, and what are our failures. Failures are opportunities for improvements, not defeat.

Naomi: So Dr. Kim, we have another poll. The question for the audience is, "Which case management care coordination model is your organization currently using?" Some of the examples that we put out here include Nurse-Family Partnership, Parents as Teachers, Healthy Families America, Partners for a Healthy Baby, and other. We'll give you a few minutes to complete the poll. All right, shall we take a look at results?

Dr. Kim: Yes.

Naomi: So Dr. Kim, quite a few are doing Parent as Teachers. Partners for a Healthy Baby is high as well. And the other, I'm curious about the other category, but I'm going to hand it over to you now.

Dr. Kim: And that's wonderful. All of these, every single program that is designated as a best practice or a promising practice are that way because they are excellent programs. They all have a lot to offer. It's just sometimes what they have to offer may not be what is needed. You'll find that a lot of programs are using a little bit of a hybrid model, and that may be some of what the other is. Hopefully, we'll have some opportunities a little bit later when we do more questions and answers to hear what some of these others are that people are using. Because once you see, there's not a one size fits all. Almost half of the programs in the call are using Parents as Teachers. If you add in, as you said, the Partners for a Healthy Baby, then we have a pretty good understanding of where people are with their programs.

And as we saw earlier, 88% are satisfied or very satisfied with the case management system that are in place. So it sounds like people have programs that are working for them in the way that they need it to be working. This slide just shows when we talk about care coordination case management practices, what we were saying about the role of the risk assessment, the linkages to services, the establishing of management services, the following of participants once they've

been linked to those services. Some of the practices that may have not started yet but are in the process of getting moving. And, of course, home visiting has the highest percentage there with the case management approaches, with supportive and strength-based coming in very close, and also comprehensive. I think that that's very telling of Healthy Start 3.0, when you say that we're leaning towards using many more strength-based programs instead of the deficit-based programs, which were much more common before.

So again, when you look at the whole Healthy Start group, the Parents as Teachers was the number one, with about 26% of the Healthy Start programs, with a large population of Nurse-Family Partnership also, and then Partners for Healthy Baby at 21% along with Healthy Families of America. When we were talking and planning for this webinar, and seeing what would be the most useful for you all that are signing in, we realized that it may be that the programs that are using some of the more well-established or well-known programs like Nurse-Family Partnership or so, that have such tightly prescribed programs, may not be the ones that were on the call. But some of the ones that are doing others, some hybrids, and just needing a little bit of help, or looking for some information about how other people might be marrying their efforts would be here.

It looks like with 33% of the participants doing something a little bit different, that may be a little bit true. But as we said, we left time at the end because we wanted to make sure that we have the opportunity here from everyone regarding what some of those others are, or some of the hybrid ways that you've managed to coordinate your programs.

So again, just with the more popular models that have come up with the Healthy Start programs, Parents as Teacher was 26%. In case you may not be as familiar with some of the programs that you're not using, we listed here the goals of the specific programs. So with Parents as Teachers, it's really looking at increasing parent knowledge, providing early detection, and increasing school readiness. Versus the Nurse-Family Partnership, which is really about improving pregnancy outcomes, improving child health, and improving parental life course by helping parents develop a vision for the future. With the Parents for a Healthy Baby, which is improving birth outcomes, reducing rates of child abuse, strengthening families, enhancing child health, and promoting family stability. And then Healthy Families

America, which wasn't represented on the call today as well, building and sustaining community partnerships to systemically engage overburdened families and home visiting services, prenatal and at birth, cultivating and strengthening, nurturing parent-child relationships, promoting health and enhancing families.

So down below on the horizontal, are our four women that we talked about earlier. So what I want you to think about is in the context of the program that you've chosen to use in your Healthy Start program, what would you be able to offer the four women with those four different scenarios? And are you satisfied with the care plans or the coordinated plan that would come out of your model for the women? And if there's something missing, what is it? And how do you identify it and how do you then fill it to make sure that, again, you are being client-central or centered in your decisions?

So we're going to talk a little bit about Ledonne as one individual. So which model would serve her best? We mentioned that she was a 38-year old who had just gotten out of prison. She has this history of drugs and prostitution. One of her big strengths is she has a really, really good relationship with her parole officer, someone who she trusts. She's very diligent as far as keeping her appointments and opening up to some of the issues that she might be facing. We mentioned that she was back together with her bad news boyfriend, her pimp. One of the major concerns I listed here is that for her, he's arranged a furnished apartment for her. She now has access. She's got a cellphone. She can talk to her other children. She's not hungry as she was in the past, where she's provided money for food and also for transportation.

So when we talk about how do we best help her in the situation that she is in, we have to make sure that we understand the whole situation in the context of the individual. As far as her pregnancy, she was also a twin. She believes that being pregnant with twins is a sign of God's forgiveness for the choices she has made. So she is very, very, very dedicated to this pregnancy and really wants to see good birth outcomes for these two babies as another chance for her to do right. Is she using again? For her, the drugs help her nerves and helps her keep from gaining too much weight, especially being pregnant with twins. So she's not going to admit that she is or isn't, but there's a good chance that she might be.

And as far as her medical, she's afraid of bad news. As mentioned, the pregnancy is so important to her that she's afraid that if she goes into her prenatal care appointment, one, she's going to be judged. She knows that all of her information is in her medical record, and everybody is going to look at her and know her history and know that she's missed appointments. That's not a comfortable feeling for her, so the choice has been not to go, instead of going. But it's not that she doesn't care about the babies, it's just that she's uncomfortable going to the appointments. So then, when we talk again about the model, you see Ledonne. What are her immediate needs that need to be addressed? What is the plan that you put together for her? Do you have all of the people and can you identify the people to bring to the table to address issues that she has that have been identified? How do you communicate with it? How do you involve the parole officer? How do you involve the medical community, the judgers, the non-judgers, everyone who needs to be involved in making sure that we do everything we can for her twins? And then executing the plan, and then, again, monitoring and evaluating it.

So just as a way of showing a little example of coordination in the purest form, I'm going to show you this quick little video. It's real short, and then we'll talk about it and why I made you watch it. You'll see. Now, one thing you'll notice is that you have to have the sound through your computer. There are subtitles, but they're not in English because I don't want you reading them. Okay? I want you to watch, and then we'll talk about it. I think it's going to take a quick second to load up, or maybe three or four seconds once we get our technology going. Just tell me if I need to push any of the buttons or if it'll go on its own. All right.

[Video Plays]

So I hope that you enjoyed that, that it made you smile a little bit. But when you think about what you saw, you saw a group of kids, in a sense, coming together, each one with learned expertise in one area, whether it's one instrument or one thing. That's what they were focused on, but they also realized that they were part of a whole. If you were banging on the keyboard, you needed to know when to stop banging on the keyboard by listening to the other instruments or the other kids, in this situation. And then, of course, the maestro was in charge. So if you think of this in a sense of care coordination, here you have someone who is in charge, all the different participants being experts in their own way, but also being

part of a whole, and only when all of those partners are working together, did you get the concert, or the sound, and the enjoyment of it.

So when you think of it in that sense, we have another poll question for you which is just based on this video that you just watched, and thinking about your programs, your partners, your coordination, and how you all work together. Are you working together without harmony? Do you guys get the music in moderate harmony? Or in beautiful harmony? So think about how are you guys working together. Most people said they're pretty satisfied or very satisfied with their model. We know which models you're using. So is it harmony, no harmony, a little bit of harmony? We'll let you guys just take a couple of seconds to answer that poll question also.

So you'll see from the results, moderate harmony. We're doing a pretty good job, but there's still a lot of work to be done to get better at what we're doing. Almost 17% in beautiful harmony, we've got the orchestra going there, and 12.5% still trying to figure out how do we get everybody working together. Again, because it's just a simple little video, but it is a nice "aha" moment to remind us that some of the things that we were much better at when we're in kindergarten, with working together, being mutually respectful, identifying what our role is in the bigger picture, and everything else like that. So with this many people in moderate harmony, but only a few in beautiful, we know that this is something that can continue to be worked to figure out how can we do what we're doing better.

So that was your little diversion. So back to our care coordinated case management. We're talking about Ledonne, and when we talked about her assessment, we talk about what are the immediate needs that she has. We know that for her, safety is a big one. The risky pregnancy, of course, being pregnant with twins and having complications in her last pregnancy. This issue that prostitution and drug use are all part of needs that should be addressed if we're going to see Ledonne deliver two healthy babies. When looking at the plan that's going to be best for her, and prioritizing the issues at triage, what do you do if Ledonne is not ready to get off the streets? The first thing we need to do is get her off the streets and quit the prostitution. Well, if that's not her priorities, then how do you work with her on a plan when you have different perceived outcomes? That's important because a lot of times what we want for our client and what a

client wants, may be different. That doesn't mean that you don't advocate for the things that you think are important, but you have to do it within the context of where the clients are.

Who needs to be at the table to help make this plan with Ledonne? The social worker, can we get her knowledgeable about domestic violence and her parole officer with law enforcement, the mental health issues in there, the medical component, etcetera? So who all needs to be at the table? Again, depending on what kind of music you want to make, the instruments and the people are going to be different. How will this group communicate, setting ground rules and expectations, and identifying the barriers up front, executing the plan, including a timeline as realistic and as important and agreed upon by all for each aspect of the plan that are going to be addressed in order and how? Again, that order and how is going to be very dependent on the client, not just on the organizations. And then, determining what success looks like for Ledonne, not necessarily simply for the individual organizations at the table. We know that's important, but what does it look like for her? If we're successful and for her, then we've done a major service in the community.

So that's the beginning of the conversation. It's in no way the end of the conversation. There are a couple of references that'll be there, if you want more information on some of the studies and the analysis about care coordination that we talked about. That is there for you. But more important, this is to start the conversations about what are you doing in your programs that you'd like to share as far as being successful. How have you hybrid your programs when you have a patient like Ledonne, and maybe Nurse-Family Partnership doesn't provide all of the different aspects of care that she needs for the partners? For Healthy Families doesn't quite give you everything you need, but you have these women, the clients, that are in desperate need of others.

So that's just a start to hopefully get you guys thinking, talking, and working together. There is, again, no one sizes fits all. Ledonne was just one woman. There are three more that we talked about, but there are thousands that are out there, each one with a little bit of a different history or what's bringing them to the table, to the Healthy Start table. And, for me, I think as long as we realize, as providers, as advocates, that our goal is to help our women and our families get to where they

want to be, then it just takes a different stand point than getting them to necessarily where we want them to be. Hopefully, the two visions are similar, but sometimes we've got to keep ourselves in check and make sure we're meeting women where they are. So on that, I am going to turn this back over, to talk about some of the next steps in coordination. So thank you. I hope that was helpful as a start. I look forward to continuing the conversation in some of the small groups and during the time that we have remaining on this call.

Naomi: Dr. Kim, thank you so much for a fantastic presentation. But before we jump in to the next steps around care coordination, I have one question for you. When you ran your Healthy Start program, and I forgot to mention that when I introduced you, that you have run a Healthy Start program. That's one of the reasons why we tapped you here for From Your Peer webinar. Can you tell us a little bit about the care coordination case management model that you used?

Dr. Kim: Yes. We had an interesting opportunity because here in Nashville, we had a former Healthy Start program that was through our local health department. I was at the health department for about 12 years, and recently left. I left before the new guidance came out, so unfortunately, our department did not have the capacity to compete for a Healthy Start. We entered the health department after I left. But what we did is we had what was called our central referral, which was something that was actually orchestrated by our mayor - probably about 15 years ago - where all referrals for maternal-child health services went in through a central referral, to one place. Then, based on the needs of the individual, they were dallied out to the specific organizations that were doing the home visiting.

So what Healthy Start had the opportunity to do was to do more of the coordination and to fill the gaps in. Because the case management home-visiting part was already taken cared of, based on the needs of the individual client. So we were providing the wraparound services that we weren't part of that. We were the mental health. We were the housing. We were the fitness and obesity gurus. We were doing all of those other parts that made it much more into a community, and gave it a sense of the overarching vision of what it means to have a community of healthy women and healthy babies, while our individual partners were doing the actual management.

Naomi: Okay. Then I have a follow-up question. How long do you think it took you, your team, and your community partners to achieve that beautiful harmony?

Dr. Kim: Well, I can say that because we were building on a model that took a very long time to orchestrate, and probably the reason that I harp so much on this issue of working together and breaking down the silos, is because it really affected us in Nashville when we had our different programs. If you got one referral and they got two, there was a sense of competition where you took that woman that we needed. It took a long time to get to the point where all of our partners and everyone we were working together was saying that it's not about who gets the referral, it's about who is able to provide the services that this particular woman needs most. Once we were able to flip that switch and see it as part of a whole instead of a "mine, mine, mine," then we were able to work together a lot better in the services that we were providing.

So I'm going to say a long time, but a lot of that time was spent prior to Healthy Start. So by the time that we got going, a lot of this had already been worked out. But I think that if we had actually addressed the issues sooner, instead of assuming they would go away, then it would've been even faster.

Naomi: Great. One thing that you and I had talked about in preparation for this webinar and looking at the case studies, was just the various contacts that these young women, the case studies that you shared, were in, and how values can enter into the work with the women.

Dr. Kim: Definitely.

Naomi: I wonder if you could share some of the things that you shared with me earlier.

Dr. Kim: Oh, yes. I'd like to say that we are very well-trained in what can be considered a middle-class view of success and what life should be. Because that's the way that our educational system is and many of our degrees are based on that, that value system, when we worked with clients that may not have been through that, sometimes it's a little bit different. We made all of our Healthy Start employees go through Bridges Out of Poverty as one example of a socioeconomic competency building. There are others. Some people don't like Bridges. But for us,

it was very, very useful just to get the different ways of looking at things. When you function in a world of, I'm going to call it middle-class privilege, then you sometimes forget that everybody doesn't think that way.

So for us, when we looked at the difference between outcomes versus relationships and where people are on that spectrum of what's most important to them, we don't realize that if we tell a teenager - an example I always use - "If you continue to have unprotected sex, you will get pregnant or you will HIV," which is very much of an outcome mentality. If you're working with someone who's not as in tuned to outcomes but more on relationships, then we have to flip that switch and say, "Do you love yourself enough not to get pregnant right now? Do you love your boyfriend enough not to make him a father right now?" How do you change the dynamics of the relationship into a competency that a lot of us don't even know that we're missing?

Once we were able to do some of that, it really helped us to understand the women that we were working with in a little bit of a different light. Then, we were able to learn from each other. That, I think, was a major "aha" moment for a lot of our case managers and home visitors because they hadn't thought about that. They just spent their time banging their head against the wall about why won't A, B and C do D, E, and F like we talked about, but not realizing that it was a different mentality of whether or not you're really focused on the outcomes, or with the relationships that may be interfering with those outcomes is going to be more important.

Naomi: Thank you so much, Kim. I really wanted to take the time to have that little bit of a conversation to give the audience insight to upcoming discussion groups around care coordination. Because what we've learned today is that there are many layers to care coordination and many nuances. Kim is this wealth of information, knowledge, and experience as is the entire Healthy Start community. We're hoping, the EPIC Center is hoping that Healthy Start programs out there are interested in carrying on this conversation a bit more.

So as we mentioned, we'll be convening a discussion group on care coordination to give folks a chance to share and discuss via conference call, best practices, successes, challenges and lessons learned in a smaller group intimate setting. The results of these conversations will feed up to inform the Healthy Start model. So I

really hope folks sign up for the discussion groups because I think there's a lot that we can share with each other and learn. So in order to sign up, you'll get an email following this webinar, with a link to register for the discussion groups. The email will ask you about your availability. We'll allow for one week for folks to sign up. Then, after that week, we're going to look at the date that works best for everyone. Then, we'll send out a confirmation email. So please, do sign up.

Again, there's some great webinars coming up in April, and then into May. The Using Doulas as a Resource for Case Management, April 21; Reproductive Life Planning, April 28; Centering Pregnancy and Centering Parenting, April 30; and Quality Family Planning Recommendations and Healthy Start, May 5. These webinars are also listed on our Healthy Start EPIC website. We hope you can visit the website frequently because, again, there's a lot of resources there. You can register for any of these webinars on the website, and I think you'll also be getting an email notice.

So thank you all for your participation this afternoon. Thank you, Kimberly Sherman. Thank you, Dr. Kim, for a great presentation. We look forward to the next webinar.