Healthy Start FAQ: Care Coordination & the Healthy Start Community

On April 14, 2015, Kimberly Sherman from the Maternal Child Health Bureau (MCHB) and Dr. Kimberlee Wyche, an expert in the perinatal health field, presented a webinar on the value of incorporating care coordination into Healthy Start programs. In addition to defining care coordination, discussing the differences between care coordination and case management, and recognizing the role that care coordination can play in Healthy Start communities, presenters also highlighted tools and models relevant to working with Healthy Start participants.

In case you or a colleague missed the webinar, a recording can be found here.

During the presentation, participants asked some great questions, all of which have been answered below.

Which care coordination case management model did Dr. Wyche implement when she ran the Healthy Start program in Nashville, TN?

During Dr. Wyche's involvement in Nashville's Healthy Start program, the mayor orchestrated a central referral system to which all referrals for maternal child health services were sent. Then, based on needs of individual, the referrals were distributed to specific home visiting organizations. Once this process was established, Healthy Start began facilitating more of the coordination piece, and was better able to address the wrap-around services not already part of home visiting process, such as mental health, housing issues, fitness, obesity, etc. This division of work fostered a community-centered approach, providing an overarching vision of what it means to have a community of healthy women and healthy babies.

How long did it take Dr. Wyche, her team, and the community partners to achieve such an established level of harmony?

Much of the work that took place began prior to the implementation of the Healthy Start program. The central shift that had to take place was getting all of the partners to agree that the focus needed to move away from the competition of who received the referral and towards who was able to provide the services most needed by the particular client. Partnership became oriented around meeting client needs instead of the organizations' egos. The focal shift required a lot of time, but Dr. Wyche felt that if the partners had addressed the issues of competition and barriers earlier in the process instead of assuming such issues would naturally dissolve, the process would have been much shorter.

What can Healthy Start program staff do to better understand the various contexts of their clients and how these backgrounds shape clients' values and choices?

Dr. Wyche recommends encouraging staff to complete the Bridges out of Poverty program as a method of socioeconomic competency building and to ensure that program staff recognizes a client's unique context and background before offering assistance. The Bridges out of Poverty program offers opportunities to learn about different ways of looking at situations that may be unfamiliar to the Healthy Start employee.

When working with a client, especially around encouraging behavior change, try approaching the situation with an outcomes vs. relationships mindset. Look at where a client is on the spectrum of what's most important to her and build the dialogue around what she seems to value. Issues tend to frequently be approached with an outcome-based mentality while the more effective approach would be relationship-based. For example, instead of telling a teen that she must stop having unprotected sex

because she will get pregnant and/or contract an STI, encourage her to think about if she loves herself enough to not get pregnant and/or if she loves her partner enough to not get pregnant. Establishing this approach to client issues helps employees better understand their female clients and makes team work stronger and more effective.