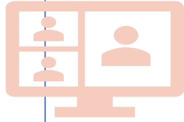
DHCF
Department of Health Care Finance

Perinatal Mental Health Task Force

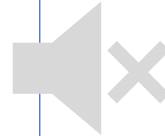
June Meeting

Tuesday, July 25, 2023

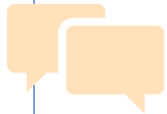
Virtual Meeting Processes



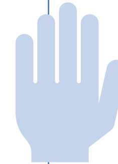
To increase engagement, turn on your video



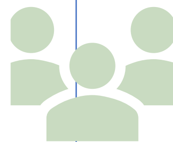
Mute your microphone upon entry, and until you are ready to speak



Use the chat function to introduce yourself: ***Name, Title, Organization*** *(if any)*



If you have comments or questions, please use the '***Raise Hand***' feature and speak clearly



If you are not a member of the Task Force, kindly hold your questions till the end of the meeting or add your questions to the chat!

Overview

- **Welcome and Overview – Melisa Byrd**
- **Observations of Individuals with Lived Experiences – Melisa Byrd**
- **Safe Babies Safe Moms – Angela Thomas**
- **Mary's Center Home Visiting Program – Keila Olughu**
- **Mamatoto Village – Sydney Willson-Hunter**
- **Help Me Grow – DC Health**
- **Deep Dive**
    - **Recommendation Update – DaShawn Groves**
    - **Discussion – Melisa Byrd**
- **Public Comments**

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Observation of Individuals with Lived Experiences

Any Task Force or Member of the Public may share their lived experience with Task Force and raise issues that Task Force should consider in their conversations.

Safe Babies Safe Moms

MedStar Health

It's how we treat people.

July 25, 2023

Safe Babies Safe Moms

Perinatal Mental Health Task Force Meeting Series

MedStar Health Research Institute

About Safe Babies Safe Moms

- $30M Initiative
- April 2020 – March 2025
- Overarching Objectives:
  - Improve maternal & infant health outcomes in DC
  - Reduce maternal & infant health disparities in DC

D.C. Safe Babies Safe Moms.

A. JAMES & ALICE B. CLARK FOUNDATION

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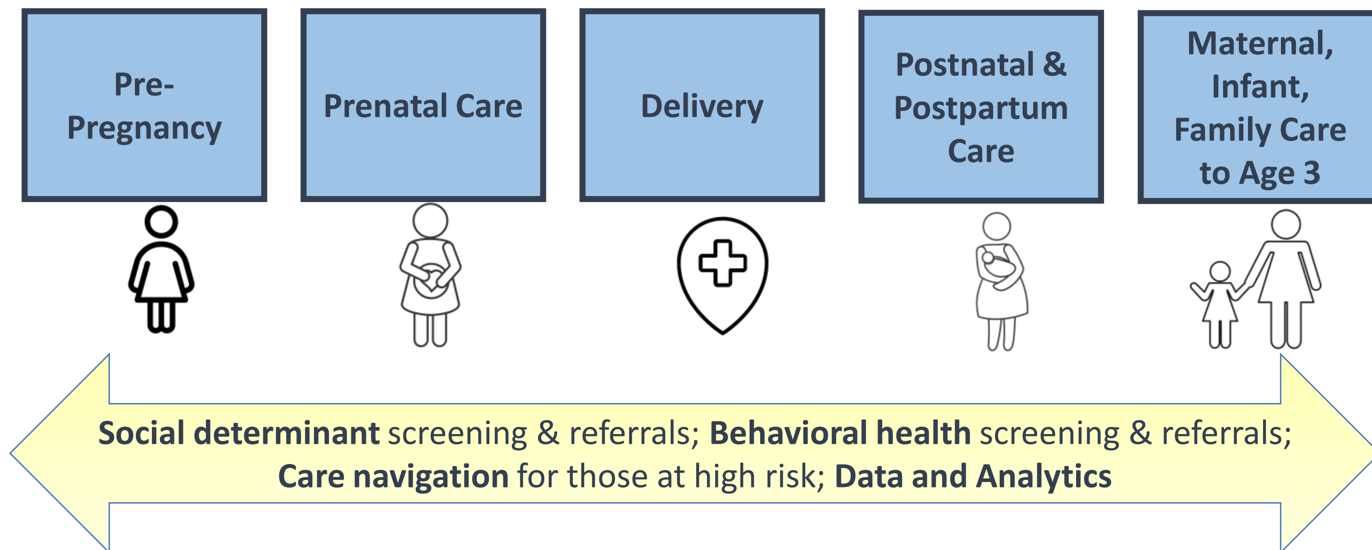
Integrated, Multigenerational Care

- Integration of four MedStar service assets:
  - Women and Infants Services (MWHC)
  - Department of Family Medicine (MGUH)
  - Department of Community Pediatrics (M
  - Department Child and Adolescent Psych

- Strong Community Partnerships
  - Community of Hope
  - Mamatoto Village

Five Key Stages of Care Delivery



SBSM Outcomes

- Long-term
  - To reduce maternal and infant mortality rates among those who deliver babies in Washington, D.C.
- Short-term to reduce (overall & disparities):
  - Low birthweight rates
  - Pre-term birth rates
  - Severe Maternal Morbidity rates
  - Nulliparous cesarean birth rates
  - Postpartum readmissions

D.C. Safe Babies Safe Moms.

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Process Metrics

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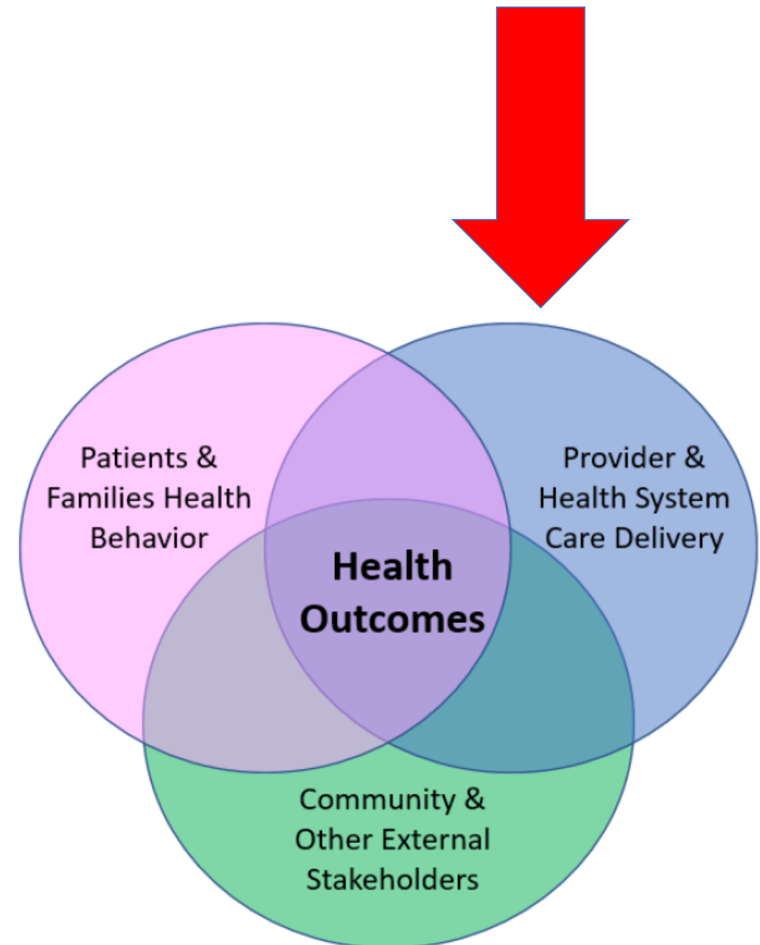
- >20% by the end of Year 2
- >50% by the end of Year 3
- >80% by the end of Year 4
- >90% by the end of Year 5



Examples

METRICS
PRECONCEPTION METRICS
GOAL: % high-risk women receiving tobacco cessation counseling
PRENATAL METRICS
GOAL: % pregnant women who screened positive for use of alcohol, cigarettes, and illicit drugs, and was referred
GOAL: % pregnant women receiving breastfeeding education
POSTPARTUM METRICS
GOAL: % eligible women delivering a live birth at MWHC who receive depression and anxiety referrals
GOAL: % of COH patients screened for depression using the Edinburg Postpartum Depression Screener (EPDS)
GOAL: % women screened for SDoH
GOAL: % women screened positive for SDoH who receive a referral
ZERO TO THREE METRICS
GOAL: % infants and toddlers with at least one outreach attempt after a missed well child check visit
GOAL: % infants and toddlers behind on developmental milestones who get referral to Strong Start
GOAL: % infants and toddlers without health insurance referred to services to get insurance

SBSM Highlights

Making a Difference!

Refugee 16-weeks Pregnant with Twins

- Same day appointment with MFM
- Behavioral health counseling
- Addressed food insecurity
- Transportation support
- Dental Care
- Baby Supplies

D.C. Safe Babies Safe Moms.

10-month-old Failing to Thrive

- Mother distrusting of providers
- Father unsure how to become more actively involved
- Daughter now hitting developmental milestones
- Parents received health and mental health support
- Housing assistance through MLP

D.C. Safe Babies Safe Moms.

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D.C. Safe Babies Safe Moms Initiative Brings High-risk Obstetrics Services to Birthing Individuals in Ward 8

Mamatoto Village

MedStar Health high-risk obstetrics specialist Melissa H. Fries, MD to begin seeing patients with high-risk or complicated pregnancies at Community of Hope's Conway Health and Resource Center in Bellevue starting February 22, 2022

Process Metrics Performing >90%

METRICS	EOY 2 4/21-3/22
PRECONCEPTION METRICS	
GOAL: % high-risk women receiving tobacco cessation counseling	98%
PRENATAL METRICS	
GOAL: % pregnant women who screened positive for use of alcohol, cigarettes, and illicit drugs, and was referred	94%
GOAL: % pregnant women receiving breastfeeding education	100%
GOAL: % pregnant women who are eligible for the diabetes care bundle receiving one or more services as intended	90%
GOAL: % pregnant women who are eligible for the depression and anxiety care bundle receiving one or more services as intended	95%
GOAL: % pregnant women who are eligible for the hypertensive disorders care bundle receiving one or more services as intended	95%
GOAL: % pregnant women without established pediatrician receiving pediatric care options	96%
GOAL: % women screened for SDoH	93%
GOAL: % women screened positive for SDoH who receive a referral	94%

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Process Metrics Performing >90%

POSTPARTUM METRICS	
GOAL: % eligible women delivering a live birth at MWHC who receive depression and anxiety referrals	93%
GOAL: % of COH patients screened for depression using the Edinburg Postpartum Depression Screener (EPDS)	100%
GOAL: % women screened for SDoH	96%
GOAL: % women screened positive for SDoH who receive a referral	98%
ZERO TO THREE METRICS	
GOAL: % infants and toddlers with at least one outreach attempt after a missed well child check visit	98%
GOAL: % infants and toddlers behind on developmental milestones who get referral to Strong Start	100%
GOAL: % infants and toddlers without health insurance referred to services to get insurance	90%

METRICS
AS OF SEP 2022

Patients Served

23,895 patients

3,000+ visits/mo

You saved me. You showed me that there are still good people who want to help.

-- single mother of two, assisted by PLAW, who was at risk of being unhoused

PROCESS METRICS

>95%

of birthing persons screened for SDOH during the prenatal and postpartum periods at Women's and Infants Services

>90%

of birthing persons received referrals to address a positive screen at Women's and Infants Services

100+

pregnant patients without an established pediatrician receiving pediatric care options

85%

of infants and toddlers screened for developmental milestones

>95%

pre-pregnancy patients receiving tobacco cessation counseling

>95%

prenatal patients receiving breastfeeding education

DHCF Department of Health Care Finance

OUTCOMES
MID-YEAR 3 (APR – SEP 2022)

METRIC	TREND	SIGNIFICANT DISPARITY GAP
Postpartum Readmission	✓ Rate is lower compared to like hospitals	✓ None Consistently
Severe Maternal Morbidity Among Preeclampsia Cases	✓ Rate is lower compared to like hospitals	✓ None
Low Birthweight Babies < 2500g	✓ Patients seen prenatally at a SBSM location have lower rates compared to like hospitals	✓ None
Low Birthweight Babies < 1500g	✓ Patients seen prenatally at a SBSM location have lower rates compared to like hospitals	✓ None Consistently
Preterm Birth	✓ Patients seen prenatally at a SBSM location have lower rates compared to like hospitals	✓ None

Thank you

It's how we treat people.

Mary's Center Home Visiting Program

Kelia Olughu

MARY’S CENTER HOME VISITING PROGRAM: SUPPORT FOR PERINATAL MENTAL HEALTH

Established in 1988 to care for Latin American immigrants, Mary's Center now serves the broader community.

- Over 60,000 participants from 50+ countries
- 5 full-service community health centers
- 19 School-based mental health programs
- 2 Senior Wellness Centers
- Public Charter School co-located at 3 health centers
- Social services supporting families outside of clinic setting

OUR SOCIAL CHANGE MODEL

Treating health problems alone is insufficient

- Comprehensive health care
- Two-generation education
- Social services

Striving to address all aspects of wellbeing that can impact quality of life and advancement

Mary's Center

HOME VISITING: DEFINITION

Home visiting is a service delivery strategy that serves as a prevention and early intervention support for expecting parents and families of young children from before birth until kindergarten entry.

- Voluntary programs
- Trained home visitors and participants regularly meet in the home or other comfortable setting designated by the family
- Implements a model for addressing specific maternal, family, and child outcomes through education, counseling, coaching, and other services.
- Home visitors provide families with connections to community-based services and resources relevant to their goals.

HOME VISITING DEPT: OVERVIEW

- Five individual programs

- Mix of evidence-based and mission-driven models
  - Healthy Families America
  - Parents As Teachers
  - Father Child Attachment
  - Healthy Start
  - Nurse Family Partnership

HOME VISITING DEPT: AN OVERVIEW

	FATHER CHILD ATTACHMENT	NURSE FAMILY PARTNERSHIP	HEALTHY START	HEALTHY FAMILIES AMERICA	PARENTS AS TEACHERS
FOCUS	Promoting positive father involvement and strengthen father-child relationship	Improving pregnancy outcomes, child health and development, and economic self-sufficiency	Improving birth outcomes & decreasing disparities in health outcomes for moms and babies	Improving parent-child attachment and supporting parents at risk of child abuse and neglect	Child development, ensuring young children are healthy, safe and ready to learn
PARTICIPATION	• Fathers & male partners enroll prenatally. • Can participate until child turns 5 years old.	• First-time parents enroll before 28 weeks gestation. • Can participate until child turns 2 years old.	• Enrolls women in all stages of reproductive life cycle, and families in Wards 5, 7, and 8. • Can participate until child turns 18 months old.	• Families enroll prenatally through three (3) months postpartum. • Can participate until y oungest child is 5 years old	• Families can enroll prenatally through child turning 36 months. • Can participate until y oungest child is 5 years old

Mary's Center

MULTI-DISCIPLINARY APPROACH

- Large team of professionals
  - Direct service providers (PRWs and FSWs)
  - Registered Nurses
  - Project Managers and Supervisors
- Home visitor is assigned to each family according to program specifics and provides:
  - Case coordination
  - Health education
  - Connection to healthcare and community resources
  - Services tailored to family's interests and development stage
- Partnerships and collaboration to meet families where they are

CARE COORDINATION

- Regularly scheduled home-based visits
- Strength-based approach
- Participant-led support
- Family goal planning
- Linkages with community resources
- Consistent reliable support

Mary's Center

HEALTH EDUCATION

- Prenatal and postpartum health
- Reproductive Life Plan
- Medical and social screenings
- Linkages to health services, insurance, and primary care
- Breastfeeding and newborn care
- Infant and well-child care education including immunizations

Mary's Center

HOME VISITING PROGRAMS: PMH SUPPORT

Our Home Visiting Programs at Mary's Center support perinatal mental health through:

- Formal mental health assessment
- Informal mental health assessment
- Staff capacity building
- PMH Collaboration

FORMAL MENTAL HEALTH ASSESSMENT

HEALTHY START	- **PHQ-2** at Enrollment – to assess depression - **EPDS Screening** at enrollment (baseline), 6 weeks postpartum & 6 months postpartum – to assess postnatal depression
NURSE FAMILY PARTNERSHIP	- **PHQ-9** within first month of enrollment, 6 weeks postpartum, 6 months postpartum – to assess for postnatal depression - **GAD-7** to assess for anxiety
HEALTHY FAMILIES AMERICA	**- PHQ-9** within first month of enrollment, 6 weeks postpartum and annually – to assess for postnatal depression
PARENTS AS TEACHERS	- **PHQ-9** within 3 months of enrollment or 3 months postpartum (if not enrolled prenatally)

Mary's Center

INFORMAL MENTAL HEALTH ASSESSMENT

- Regular visits allow home visitors to assess participants mental health
- Home visitors build trusting relationship with participants
- Relationship serves as good foundation to initiate mental health conversation & connect to support as needed
- Clients resistant to initiating care, home visitors support clients during home visits in a participant-led approach, until client is ready
- When participants are not ready to be connected to PMH services, home visitors continue to support them
- Refer clients at the point they are ready, reducing huge lag between referral and initiation of care

Mary's Center

CAPACITY BUILDING

- Our Home Visitors undergo training to prepare them to recognize symptoms, support participants, crisis management, and support referrals.

- Mothers and Babies Curriculum
- Promoting Maternal Mental Health During Pregnancy Curriculum
- NFP Maternal Mental Health Intervention (MHI) Course
- Motivational Interviewing training

Mary's Center

PERINATAL MENTAL HEALTH COLLABORATION

The Perinatal Mental Health (PMH) Program at Mary's Center collaborates with our Home Visiting Programs to:

- Offer training to Home Visitors. Training have included: engaging the PMH program, recognition of symptoms, crisis management, referrals
- Offer HVs with CBT minded tools and activities to support participants (e.g., Mothers and Babies Curriculum)
  - Participants have reported application of these tools and positive impact
- Opportunity for direct referral to the PMH program following a positive mental health assessment/screen
- PMH program provides consultation to Home Visitors regarding participants
- Opportunity for warm handoffs, which promotes timeliness to supporting PMH issues

Mary's Center

PERINATAL MENTAL HEALTH COLLABORATION

- The PMH Program developed PMH Acuity Scale that serves as a guide for Home Visitors
- The PMH Acuity Scale grades symptoms based on identified Risk Factors and Indicators and offers Action Steps.

A : IMMINENT RISK AND EMERGENCY
B: HIGH URGENCY
C: MODERATE URGENCY
D: ROUTINE

Mary's Center

GAPS/OPPORTUNITIES FOR IMPROVEMENT IN THE DISTRICT

Language access barriers to PMH services

- Limited number of bilingual PMH professionals
- In absence of bilingual PMH professionals, services are offered with an interpreter, participants find this uncomfortable especially with 1:1 services
- When there are bilingual PMH professionals, they must document the sessions they complete in another language (say Spanish) into English
  - So, they are made to serve as translators
  - Additional workload should be taken into consideration with opportunity for incentivization of these professionals

Mary's Center

GAPS/OPPORTUNITIES FOR IMPROVEMENT IN THE DISTRICT

- Sustainability of service provision

- Home Visiting Services Reimbursement Act of 2023 B25-0321
  - Introduced June 9, 2023
  - Would extend health insurance coverage through Medicaid, the DC Healthcare Alliance Program, and the Immigrant Children's Program
  - Reimburse eligible Home Visiting services
  - Utilizing Medicaid leverages federal resources and creates more sustainable funding. Many jurisdictions are already doing so.
  - Additionally, using Medicaid dollars can free up local dollars to increase access to evidence-based Home Visiting (EBHV) that would not be eligible for Medicaid funding.
  - Allows EBHV to become part of more comprehensive managed care strategy to improve maternal and child health outcomes since most Medicaid and Alliance births are paid by Medicaid MCOS.
  - Cost-effectiveness

Mary's Center

HOW TO REFER TO HOME VISITING

Online Referral Form:
https://www.maryscenter.org/social-services/family-support-programs/home-visiting/

Email for Referrals/Inquiries
HomeVisitingManagement@maryscenter.org

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Perinatal and Family Health Program Manager
kolughu@maryscenter.org

Magali Ceballos
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Mary's Center

Mamatoto Village

Sydney Wilson-Hunter

MAMATOTO VILLAGE

Mamatoto Village is a D.C. based Black led for impact organization devoted to serving Black women through the creation of career pathways in maternal health; and providing accessible perinatal support services designed to equip women with the necessary tools to make the most informed decisions in their maternity care, parenting, and lives.

Mamatoto's guiding principles are set to "**I. CARE. SIS**"

Inclusion. Collaboration. Advocacy. Respectful Care. Equity. Support. Integrity and Accountability. Service.

Mothers Rising Home Visiting Program

The Mothers Rising Home Visitation Program provides womxn with expansive ancillary services during the prenatal and postpartum periods. Working with a care team, program participants receive health education, support with social service needs, care coordination, advocacy, and parenting support during their pregnancy and throughout the infant's first three months of life.

CARE MODEL

MOTHERS RISING
MODEL OF CARE

Enrollment, risk stratification & assessment

Evaluate & co-create individualized care plan with client

Client & family receive targeted services, education, care coordination, perinatal support, resource navigation, & advocacy

Enhanced autonomy, behavior change, increased health literacy, & improved family stability

Improved perinatal & psychosocial outcomes

CARE MODEL

PERINATAL CARE COORDINATOR
Team Management & Family Support

PERINATAL COMMUNITY HEALTH WORKER
Care Coordination

COMMUNITY BIRTH WORKER
Labor Support

CARE SPECIALIST
Perinatal Support

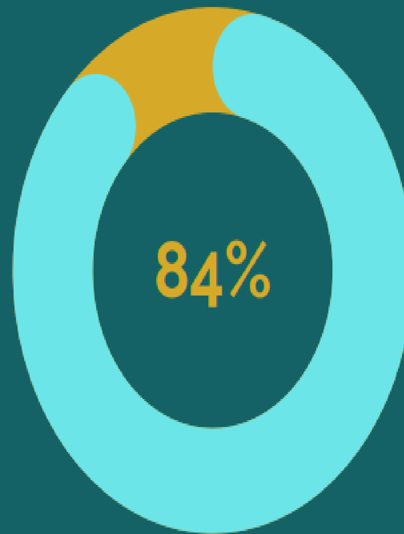
LACTATION SPECIALIST
Breastfeeding Support

WELLNESS SPECIALIST
Wellness Coaching

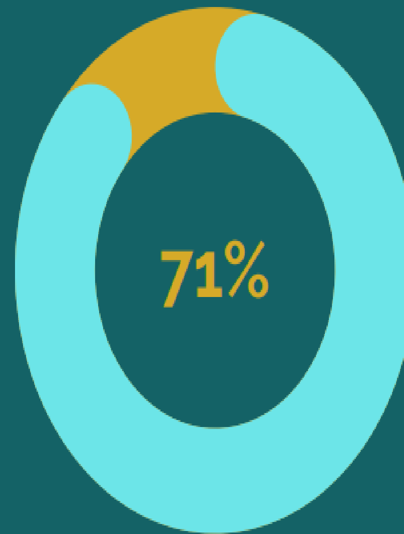
FY21 MOTHERS RISING SOCIAL IMPACT

During 2021, we served 313 mamas, babies, and families in DC, and Prince George's County, Maryland through 3,703 visits. In 2021, we had a total of 144 births.

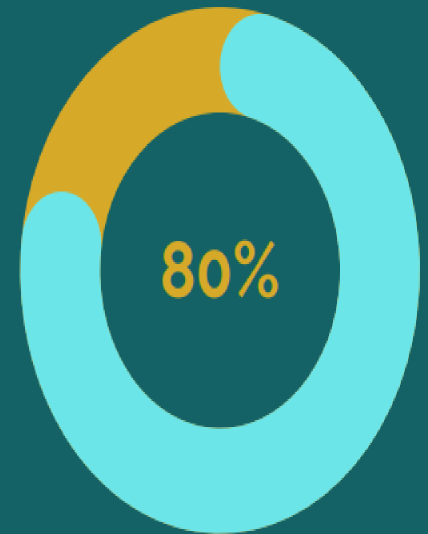
MATERNAL DEMISE



FULL-TERM DELIVERY



BREASTFEEDING INITIATION



HEALTHY BIRTH WEIGHT

NEW HOME IN WARD 7

Help Me Grow

DC Health

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Help Me Grow DC

Program Overview

7/25/2023

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AGENDA

- Program overview
  - Services
- Data

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DC Health Overview

Mission statement

- The District of Columbia Department of Health promotes health, wellness and equity across the District, and protects the safety of residents, visitors, and those doing business in our nation’s capital.

STRATEGIC PRIORITIES

- Promote a culture of health and wellness
- Address the social determinants of health
- Strengthen public-private partnerships
- Close the chasm between clinical medicine and public health
- Implement data driven and outcome-oriented approaches to program and policy development

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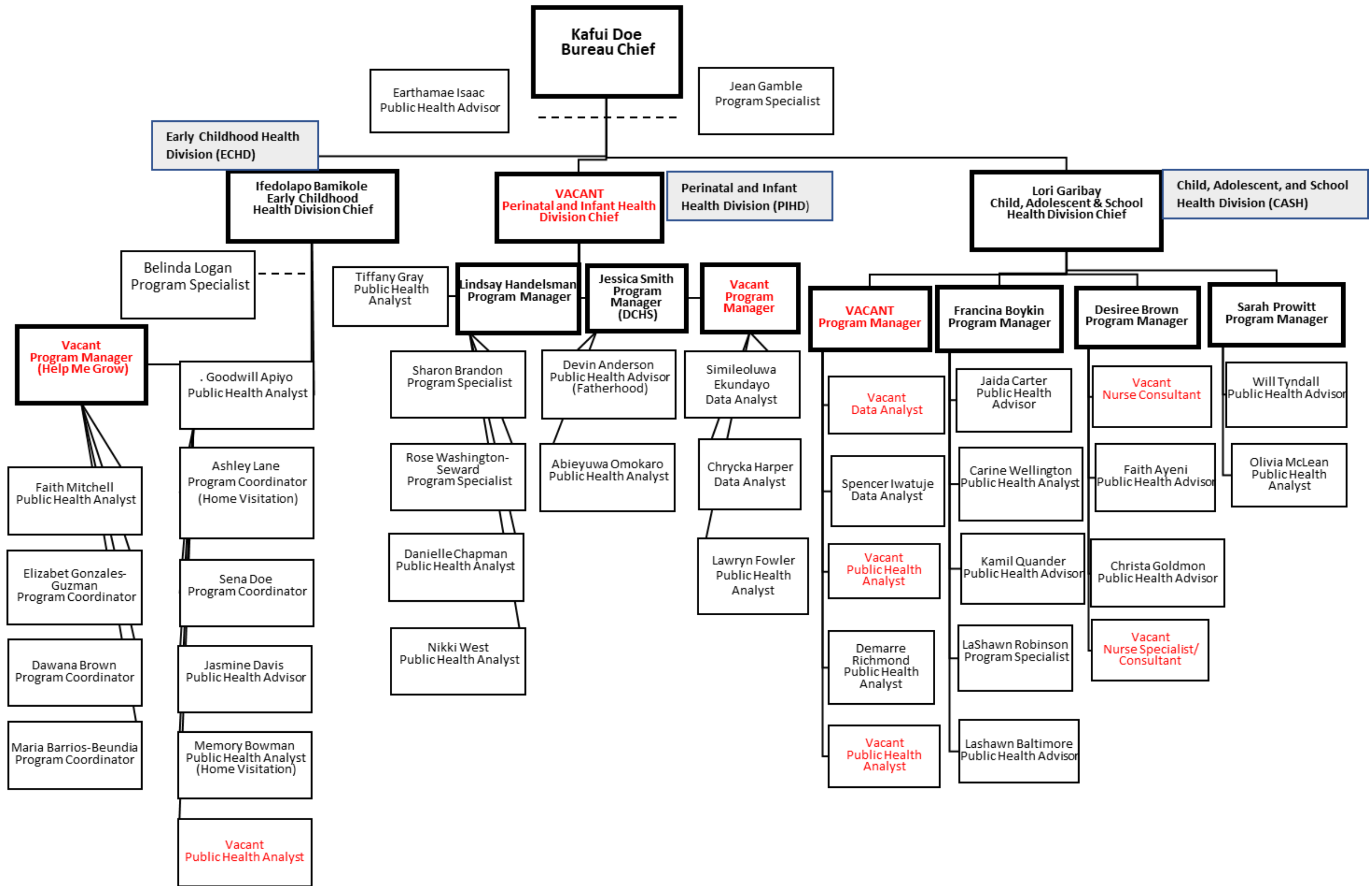
DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

COMMUNITY HEALTH ADMINISTRATION
Family Health Bureau – 8506



HMG Services and Updates

- Centralized Access Point
- ASQ Screenings
- Safe Sleep Training
- Breastfeeding Education
- Vital Records Support
- Parent Cafes

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THE FOUR COMPONENTS OF HELP ME GROW

- Centralized Telephone Access Point
- Family Outreach
- Provider and Community Outreach
- Ongoing Data Collection and Analysis

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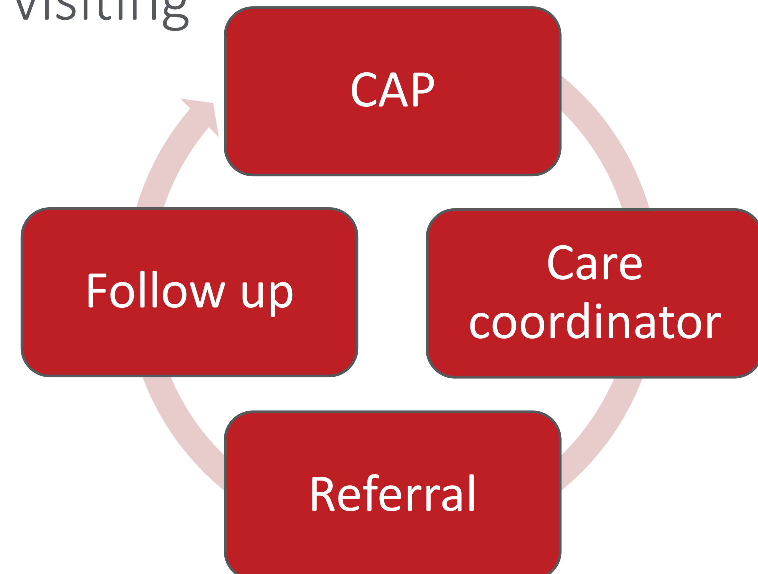
Centralized Access Point (CAP)

Help Me Grow DC call center

- 1-800-MOM-BABY
- 4 Care coordinators (2 Bilingual – Spanish)
- Referrals to over 1,000 resources
- C-Intake: special focus on home visiting
- ASQ screenings (online)



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How To Access HMG DC Services?

If you are interested in referring a family to Help Me Grow DC, you can:

> Call 1-800-Mom-Baby/1-800-666-2229

> Email helpmegrow.dc@dc.gov

> Fax a Referral Form to 202-447-4947

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HMG DC Team

Maria Barrios-Buendia (CC)

Faith Mitchell - Outreach

Denia Hale (CC)

DaWana Brown (CC)

Elizabet Gonzales (CC)

Belinda Logan – Program Support

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Safe Sleep Education

Supports decreasing infant sleep deaths

- Trainings to parents and caregivers that increase knowledge of safe sleep practices
- Care coordinators host 8 trainings virtually in English and Spanish each month
- After the training, caregivers receive a portable crib
- Over 50 safe sleep trainings FY23 to date

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Breastfeeding Education

Strategic Objective: Increase the precent of mothers breastfeeding infants at 8 Weeks of age from 63% to 75%

- 3 Care coordinators have received lactation training
- Clients receive immediate support and education
- Can schedule a 30-minute individual session with our lactation consultant
- Clients who need additional support are referred to various programs in the District

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Vital Records

HMG Bilingual Care Coordinators have assisted over 100 families during Vital Records outreach

- Provide education about EC development, prenatal care, Lactation support, Safe Sleep, Women Infant Children (WIC) etc.
- Assist caregivers who need to obtain their child's birth certificate
- Advocating for cultural competence training and education on working with international families
- Advocating for bilingual staff and/or consistent translators
- Supporting efforts for legal counsel

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Parent Cafes

March 2023-September 2023

To better understand the needs of families in the District, HMG DC provides funding for Parent Cafes as a means for a strengths-based approach to eliciting parents' goals for their child's well-being.

- Delivered by parents for parents with staff playing supportive and supporting roles
- 8 cafes since March
- Work with collaboratives to host Cafes

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Program Data

- On track to meet or exceed families served in 2022
  - 382 served in FY22
  - 182 families midyear FY23
- 80% of clients are perinatal women
- 47% of perinatal women served are age 25-34
- 47% of clients live in wards 4, 7, and 8
- Increase in ASQ screenings from 8 in FY22 to 21 in FY23
  - Strategic Objective: Increase the percentage of children under age 3 who are screened for development using standardized tools from 32% to 45% by 2026.
- Top 3 referrals provided are baby items/basic needs, WIC, insurance navigation

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Key Performance Indicators (ECHD)

- More than 75% of families with one or more completed referrals through Help Me Grow within three months of referral

- We have exceeded expectations for children screened for developmental and socio-emotional challenges:
  - Target: 85%
  - Achieved 87.7%

- Our target for women screened for depression is 90% in FY23. We are currently at 79.19% (in Q3) for completed depression screenings.

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Program Data (Mid-year 2023)

Families Served

Unique Families Intake & Inquiries					
	FY 2019	FY 2020	FY 2021	FY2022	FY23 Midyear
Inquiry	92	123	138	159	79
Intake	81	69	75	223	96
Total	173	192	213	382	182

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Program Data (Mid-year 2023)

Perinatal Women Served

Number of Perinatal Women Served			
Fiscal Year	**Perinatal (pregnant)**	**Perinatal (0-31 days after delivery)**	**Total**
FY19	69	15	84
FY20	90	34	124
FY21	107	27	134
FY22	187	39	226
FY23 Midyear	105	41	146

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Program Data (Mid-year 2023)

Perinatal Women served by Race

Race	FY19	FY20	FY21	FY22	FY23 YTD
African American	61	75	57	126	87
White	13	3	0	8	3
Two or More Races	0	2	1	2	5
Other	3	32	70	75	29
Missing data	7	12	6	15	21
Don't know/ declined	0	0	0	0	1
Total	84	124	134	226	146

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Program Data (Mid-year 2023)

Perinatal women served by Ethnicity

Ethnicity	FY19	FY20	FY21	FY22	FY23 YTD
Hispanic or Latino	59	75	65	89	47
Not Hispanic or Latino	15	33	63	135	91
Don't know/ declined	0	2	3	1	0
Missing data	10	14	3	1	8
Total	**84**	**124**	**134**	**226**	**146**

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Program Data (Mid-year 2023)

Resident Ward: Majority of perinatal women live in Wards 4, 7, and 8

Ward	FY19	FY20	FY21	FY22	FY23 YTD
Ward 1	4	1	15	10	7
Ward 2	2	5	4	7	4
Ward 3	0	2	2	3	3
Ward 4	15	1	44	70	32
Ward 5	17	30	21	21	12
Ward 6	8	12	6	12	11
Ward 7	13	4	22	35	24
Ward 8	21	25	18	51	29
Homeless *	0	30	1	1	0
Missing data	4	14	1	16	24
Total	84	124	134	226	146

*some clients have unstable housing. This is not captured in our database

DC HEALTH
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Budget/Funding

- Help Me Grow Receives Funding from the following Sources:
  - DC Health Care Finance (Local dollars): $409,114.91
  - Title V (Federal dollars): $500,029.34

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Questions?

Call » 1-800-MOM-BABY

THE NUMBER EVERY PARENT IN DC SHOULD KNOW

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899 North Capitol Street NE, 5th Fl, Washington, DC 20002

Deep Dive

Recommendations Update

- Only 10 recommendations have been submitted.
- Only 3 out of 20+ Taskforce members submitted at least one recommendation.
- New Deadline:
  - **This Friday - July 28th**

•https://app.smartsheet.com/b/form/9b03ee31f3a74e3faa620093a93fd9c4

Discussion Question

What program funding, reimbursement strategies and policy development must be implemented for perinatal mental health initiatives?

Public Comments

DHCF Department of Health Care Finance

Questions?

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