



## Maternal Health Advisory Group

Virtual Meeting via WebEx

Tuesday, May 19th, 2026

Meeting Summary

<p><b>MedStar Safe Babies Safe Moms</b></p> <p><i>See slides 5-27</i></p>	<ul style="list-style-type: none"><li>• The <a href="#">MedStar Safe Babies Safe Moms</a> program improves maternal and infant health outcomes by engaging clinical and community partners to provide more than 70 interventions from pre-pregnancy through postpartum and family care through age 3 (<i>see slides 10-11</i>).</li><li>• Participants receiving prenatal care through the program showed better outcomes across multiple metrics, including reduced disparities for Black birthing parents and Medicaid beneficiaries.</li><li>• The model uses a team-based mental health screening approach supported by in-person and telehealth options. Care coordination connects the patient with the level of care needed to meet their individual needs.</li><li>• For organizations interested in adopting similar practices, recommendations include refining the model over time, building clear pathways for social and behavioral health needs, offering multiple intervention options (including telehealth), leveraging existing resources, and investing in team training.</li><li>• Key impactful interventions include addressing social determinants of health (such as through a medical-legal partnership), implementing hypertension and diabetes remote monitoring, and working with community leaders to co-locate high-risk obstetric services to address the needs of the community.</li><li>• Participation barriers often relate to work and family demands, making telehealth a critical engagement tool. The program also addressed late entry to prenatal care by adjusting workflows to reduce wait times for prenatal appointments to under five days.</li><li>• For more information on the Safe Babies Safe Moms program, please see the following publications:<ul style="list-style-type: none"><li>○ <a href="#">D.C. Safe Babies Safe Moms: A Novel, Multigenerational Model to Reduce Maternal and Infant Health Disparities</a></li><li>○ <a href="#">Safe Babies Safe Moms Women's and Infants' Services Perinatal Mental Health and Wellness Program: A Comprehensive Integrated Model for Prevention and Treatment</a></li></ul></li></ul>
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<p><b>The Lab @ DC: Maternal Health Journey Mapping Project</b></p> <p><i>See slides 29-50</i></p> <p><i>Appendix: Slides 55-60</i></p>	<ul style="list-style-type: none"> <li>The Lab @ DC interviewed physicians, FQHCs, hospitals, doulas, and perinatal community health workers to map behavioral health and social needs screening and referral workflows. 18 maps were created and analyzed.</li> </ul> <p><u>Screening:</u></p> <ul style="list-style-type: none"> <li>Screening frequency varies widely. Some patients decline, answer inaccurately, or experience changing needs, leading to missed opportunities to identify patient needs when screening is inconsistent.</li> <li>Homicide and suicide are often tied to mental health and social needs, highlighting the vulnerability of the postpartum period.</li> <li>Providers with brief visits with patients consistently rely on validated screening tools; longer-visit providers (e.g., care coordinators) can identify needs through conversation. Please see <i>Slide 53</i> for a list of validated assessment tools that are commonly used by providers.</li> <li>Doulas report facing barriers to Medicaid participation (e.g., contracting, billing, reimbursement). However, they are well positioned to identify patient needs due to their sustained contact and trusted relationships.</li> </ul> <p><u>Referrals:</u></p> <ul style="list-style-type: none"> <li>Referral support depends on staffing model. Providers with care coordinators can connect patients directly; those without care coordinators often shift follow-up responsibilities to patients, making screening less effective.</li> <li>Knowing available resources and having formal referral pathways increases the likelihood that patients receive services.</li> <li>Housing, transportation, and childcare barriers limit access even after referral; providers address these barriers through arranging rides, offering telehealth appointments, and conducting home visits.</li> </ul> <p><u>Clinical Care Model vs. Networked Care Model:</u></p> <ul style="list-style-type: none"> <li><b>Clinical Care Model:</b> A common model, where a physician or midwife provides prenatal care and the hospital handles labor and delivery.</li> <li><b>Networked Care Model:</b> A model that adds screening and referral support from doulas, community health workers, care coordinators, FQHCs, MCPs, nonprofits, and therapists, creating helpful redundancy and closing gaps.</li> </ul>
<p><b>Discussion</b></p> <p><i>See slides 52-54</i></p>	<p><u>Referral Pathways and Care Models:</u></p> <ul style="list-style-type: none"> <li>Providers with more time with the patient can explore emotional needs and connect patients to therapy; Non-clinical providers (e.g., yoga therapists) were also identified as essential early risk accessors.</li> <li>Integrated emotional wellness models foster immediate linkage to specialists.</li> </ul> <p><u>Disclosure, Trust &amp; Stigma:</u></p> <ul style="list-style-type: none"> <li>Patients are often hesitant to share concerns and connect with services due to fear of CPS, punitive responses, or excessive interventions;</li> </ul>

	<p><u>Access &amp; System Barriers:</u></p> <ul style="list-style-type: none"> <li>• Roadblocks to receiving support include long wait times for mental health appointments, limited higher-level substance use treatment options for pregnant individuals in the District, and delays in insurance coverage.</li> </ul> <p><u>Need for Provider Training:</u></p> <ul style="list-style-type: none"> <li>• Training gaps exist in areas like domestic violence/interpersonal violence screening and substance use related conversations.</li> <li>• Urine drug screens need to be used to guide treatment decisions and inform care, not to intimidate patients.</li> </ul> <p><u>Screening Tools:</u></p> <ul style="list-style-type: none"> <li>• Many providers are testing new screening and referral workflows as part of this year’s <a href="#">Perinatal Quality Collaborative Perinatal Mental Health</a> bundle.</li> <li>• Across systems, providers use multi-time-point depression screening, typically combining EPDS and PHQ-2/9 during pregnancy and postpartum, with some adding tools like the C-SSRS for safety.</li> <li>• Participants identified specialized assessments: BARC-10 for assessing recovery supports for patients with SUD; MDQ for identifying bipolar disorder.</li> </ul> <p><u>Resources:</u></p> <ul style="list-style-type: none"> <li>• <a href="#">First Shift Justice Project</a> was identified as an advocacy organization that helps patients understand their workplace rights.</li> <li>• The <a href="#">Community of Hope HONEY Program</a> focuses on providing support for pregnant individuals experiencing homelessness.</li> </ul>
<p><b>Next Steps</b></p> <p><i>See slide 61</i></p>	<ul style="list-style-type: none"> <li>• Next meeting is on <b>June 16th, 2026, 11am-12:15pm</b> <ul style="list-style-type: none"> <li>○ <u>Topic:</u> TMaH Updates; Perinatal Behavioral Health &amp; SUD</li> <li>○ <u>Meeting Cadence:</u> We will transition to meetings every other month starting in July</li> </ul> </li> <li>• Contact <a href="mailto:dhcf.maternalhealth@dc.gov">dhcf.maternalhealth@dc.gov</a> with questions; meeting materials are posted on <a href="https://dhcf.dc.gov/page/transforming-maternal-health">https://dhcf.dc.gov/page/transforming-maternal-health</a></li> </ul>