



Maternal Health Advisory Group

May 19th, 2026



Today's Agenda



1. **Welcome – 5 minutes**
2. **MedStar Safe Babies Safe Moms Program – 20 minutes**
3. **The Lab @ DC: Maternal Health Journey Mapping Project – 20 minutes**
4. **Maternal Health Journey Mapping Discussion – 25 minutes**



TMaH Award Required Notice

This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$17,000,000 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.



MedStar Safe Babies Safe Moms

(20 minutes)



MedStar Health

It's how we **treat people.**

May 19, 2026

Safe Babies Safe Moms

Maternal Health Advisory Group

Angela D. Thomas, DrPH, MPH, MBA
Vice President, Healthcare Delivery Research
Executive Lead, Safe Babies Safe Moms

Agenda

1. Describe the Safe Babies Safe Moms model overall, including outcomes
2. Maternal mental health care coordination highlights
3. Current state and next steps for Safe Babies Safe Moms



The SBSM Model



About Safe Babies Safe Moms

- April 2020 – March 2025
- \$30M Initiative
- Long-term Goal



**D.C. Safe Babies
Safe Moms.**



A. JAMES & ALICE B.
CLARK FOUNDATION

– Reduce maternal & infant mortality in Washington, D.C.



SBSM 5 Year Outcomes

- Reduce:
 - Low birthweight rates
 - Pre-term birth rates
 - Severe Maternal Morbidity rates
 - Nulliparous cesarean birth rates
 - Postpartum readmissions

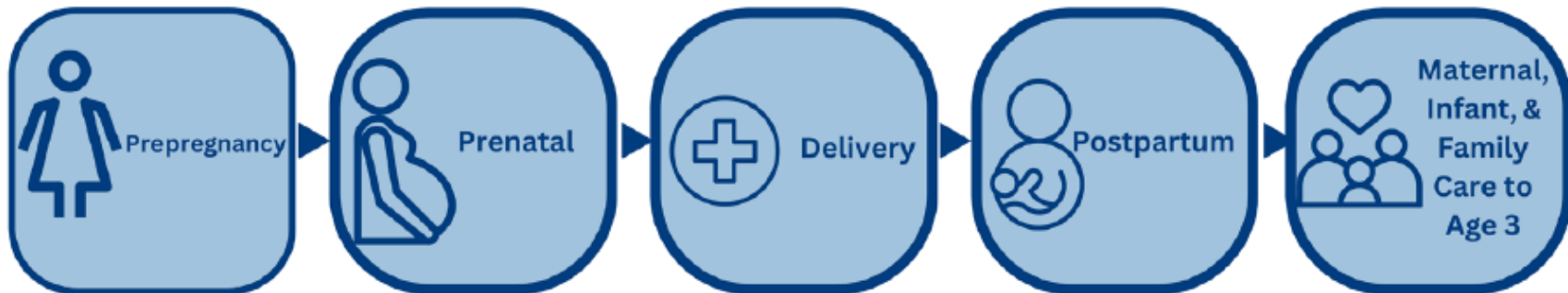


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Safe Moms.**



CLINICAL & COMMUNITY PARTNERS

Womens & Infants' Services, Family Medicine,
Community Pediatrics, Child & Adolescent Psychiatry,
Community of Hope, and Mamatoto Village

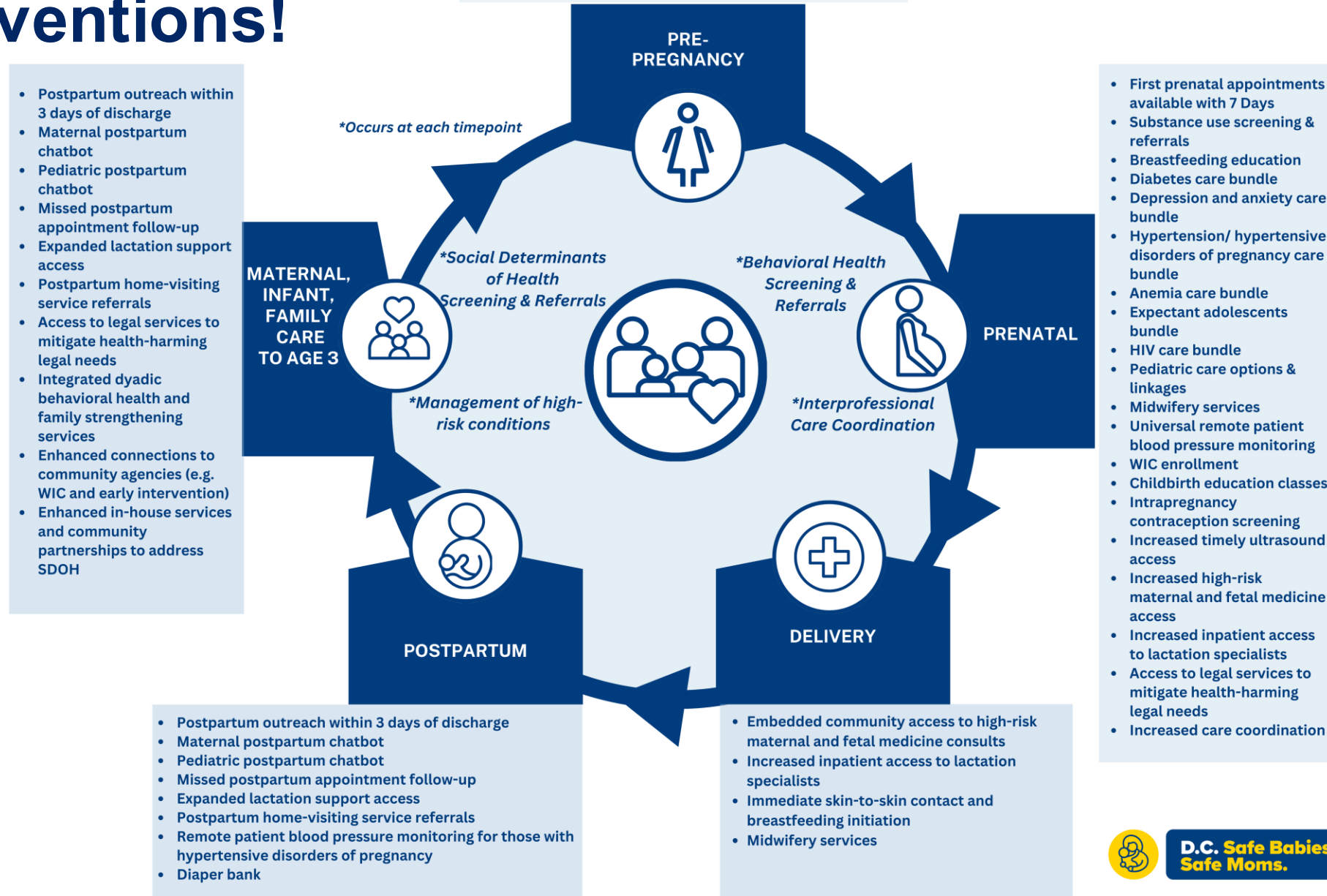


Biostatistics, Informatics, Data Science
Health Equity, Health Economics,
Implementation Science

RESEARCH



More than 70 Interventions!



Patients served



53,600+

patients' lives touched
(Nov. 2020 - Mar. 2025)

16,700+

babies born under our care

Services provided

Patients received more than **\$630K** in financial benefits

to address health harming legal needs
(benefits includes SNAP & TANF benefits, backpay, rental & utility assistance benefits, and more)

2,100+ pregnant people and children received care **in the community** who otherwise would have limited access or delay in care



1,750+ pregnant people experiencing **complex medical conditions** receiving wraparound support




97% of those who screened positive for social risk factors received a referral in the last year

97% receiving mental health support for moms and families with high-risk conditions in the last year

Patients who receive prenatal care under SBSM have...

- 66%* *lower odds of* **Very Low Birthweight Babies** (<1500g)
- 47%* *of* **Low Birthweight Babies** (<2500g)
- 47%* **Preterm Babies** (<37 weeks gestational age)
- 10% **Severe Maternal Morbidity**
- 8% **Nulliparous Cesarean Birth**
- 2% **Severe Maternal Morbidity** among hemorrhage cases

...compared to non-SBSM prenatal patients.

OPPORTUNITY	177*
Non-SBSM patients who could have experienced better outcomes over 5 years	Very Low Birthweight Babies
	509*
	Low Birthweight Babies
	554*
	Preterm Babies

Closing the disparity gap



Black patients who receive prenatal care under SBSM have...

- 66%* *lower odds of* **Very Low Birthweight Babies** (<1500g)
 - 61%* *of* **Preterm Babies** (<37 weeks gestational age)
 - 50%* **Low Birthweight Babies** (<2500g)
 - 29% **Severe Maternal Morbidity**
- ...compared to non-SBSM prenatal White patients.

Patients with Medicaid insurance have...

- 33%* *lower odds of* **Very Low Birthweight Babies**
 - 27%* *of* **Low Birthweight Babies**
 - 26%* **Preterm Babies**
- ...compared to patients with commercial insurance.

Statistical models include data from Apr. 2020 - Mar. 2025. Statistically significant numbers are marked with a "*".

This program is made possible by the generous support of the A. James and Alice B. Clark Foundation. Source: MedStar Health patient data from 2020-2025.



Catalyst

Innovations in Care Delivery

CASE STUDY

D.C. Safe Babies Safe Moms: A Novel, Multigenerational Model to Reduce Maternal and Infant Health Disparities

Angela D. Thomas, DrPH, MPH, MBA, Matthew Biel, MD, MSc, Janine Rethy, MD, MPH, FAAP, Michelle Roett, MD, MPH, FAAFP, CPE, Kelly Sweeney McShane, MBA, Aza Nedhari, DHS, MSc, CPM, LGPC, Loral Patchen, PhD, MSN, MA, CNM

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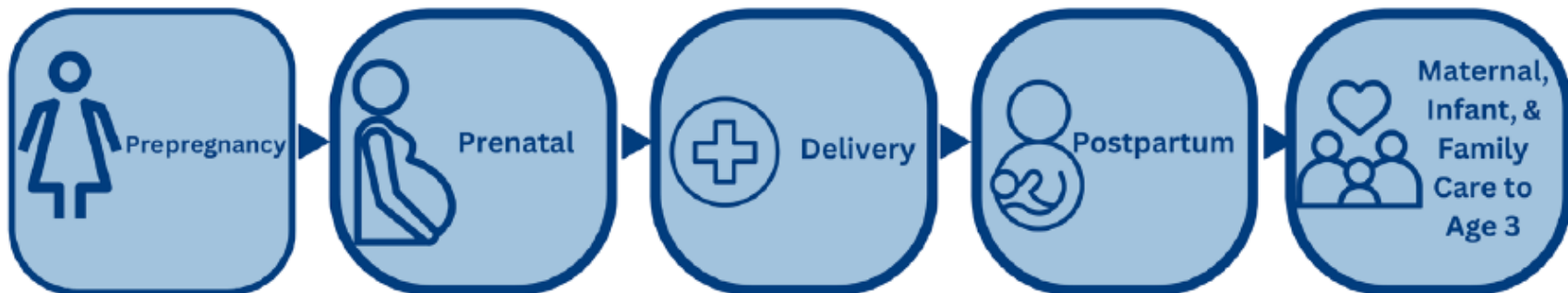
DOI: 10.1056/CAT.24.0161

Maternal mental health care coordination highlights



CLINICAL & COMMUNITY PARTNERS

Womens & Infants' Services, Family Medicine,
Community Pediatrics, **Child & Adolescent Psychiatry,**
Community of Hope, and Mamatoto Village



Screening & Referrals for Behavioral Health & Social Determinants of Health
Multi-disciplinary Care Coordination
Management of High-Risk Conditions

Biostatistics, Informatics, Data Science
Health Equity, Health Economics,
Implementation Science

RESEARCH



Safe Babies Safe Moms Women's and Infants' Services Perinatal Mental Health and Wellness Program: A Comprehensive Integrated Model for Prevention and Treatment

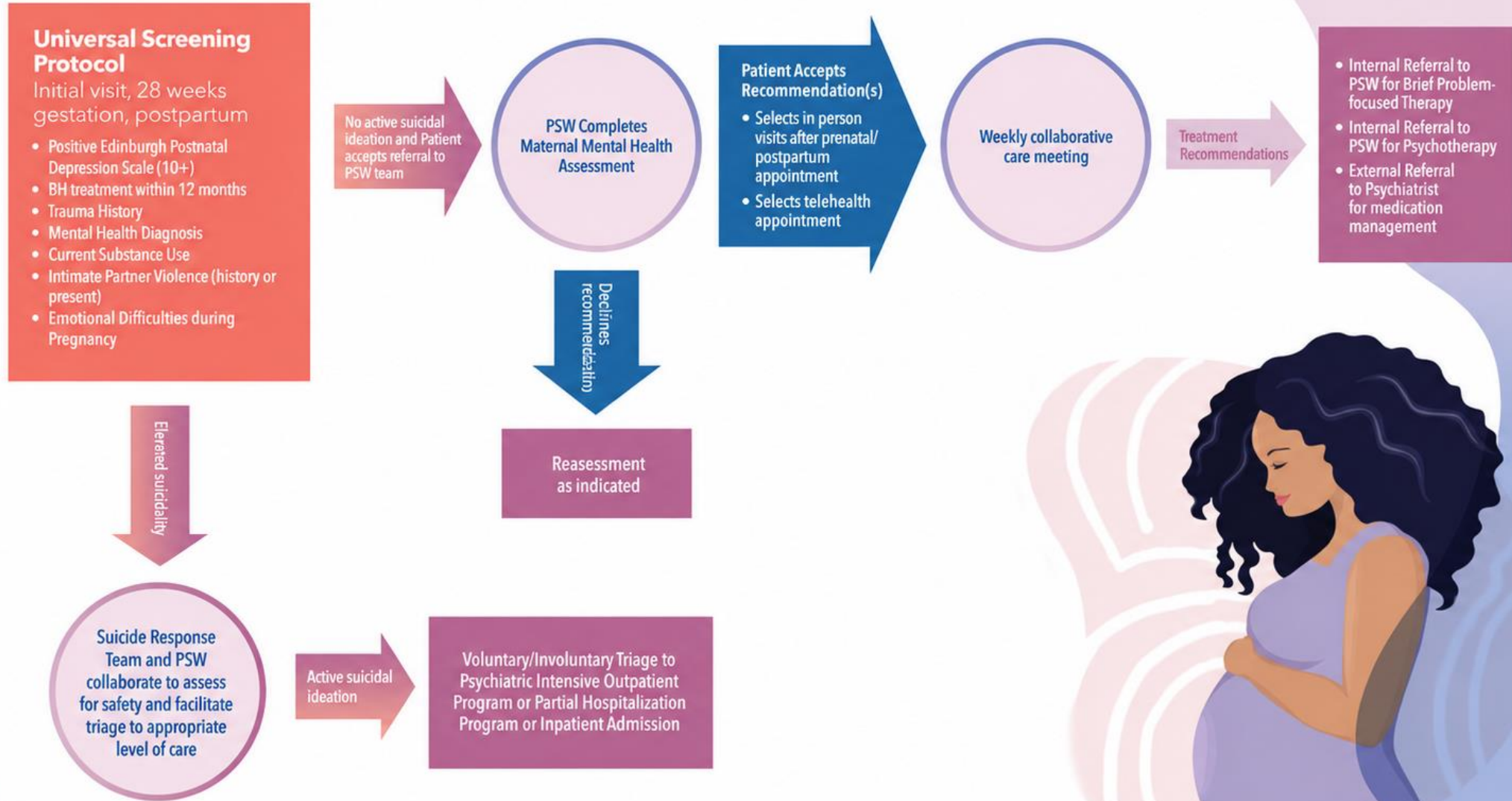
Evelyn E. Asegieme¹, MSW, LICSW, LCSW-C, PMH-C, Aimee L. Danielson^{1,2}, PhD, Amalia Londoño Tobón², MD, Elisabeth S. Rindner³, BS, Yanbao Xiong⁴, MS, Patricia B. Tanjutco⁴, MD, Matthew G. Biel^{2,3}, MD, Loral Patchen^{1,3,4}, CNM, PhD

Quick Points

- ◆ Screening to identify perinatal mental health needs and adverse social drivers of health occurs multiple times during the perinatal period to engage patients in communicating their lived experience and centers their social identity(ies), culture, context of their lives, support systems, and goals connected to their care experience.
- ◆ Led by perinatal social workers, program clinicians develop a plan with the patient based on identified strengths, goals, and needs using a dynamic team approach including nurses, referral specialists, therapists, psychologist, psychiatrist, midwives, and physicians.
- ◆ The perinatal mental health team offers recommendations and treatment options including prevention services, individual brief, targeted therapy, intensive therapy, group therapy, and medication management. Both in-person and telehealth options are available.



WIS SBSM Perinatal Screening, Assessment, Treatment, Referral Workflow



PSW: perinatal social worker

Role	Primary Function
Perinatal Mental Health Program Coordinator	Licensed independent clinical social worker with postpartum support and international perinatal mental health training/certification
Perinatal Social Worker	Licensed graduate social worker or licensed independent clinical social worker with postpartum support and international perinatal mental health training/certification
Integrated Perinatal Therapist	Licensed independent clinical social worker with postpartum support and international perinatal mental health training/certification
Perinatal Psychiatrist	Psychiatrist with fellowship in perinatal psychiatry or specialized reproductive/perinatal psychiatry training
Nurse Navigator	Bachelor of Science in Nursing with maternal-child health experience and certifications in IBCLC, CBE, or C-EFM
Referral Specialist	High school diploma or GED with 1–2 years of healthcare office experience
Perinatal Behavioral Health Care Coordinator	Behavioral health care coordination experience supporting pregnant and postpartum patients requiring higher levels of psychiatric care
Perinatal Behavioral Health Therapist	Specialized training in psychotherapeutic treatment for pregnant and postpartum individuals requiring higher-acuity behavioral health support



WIS SBSM Perinatal Mental Health Care Continuum

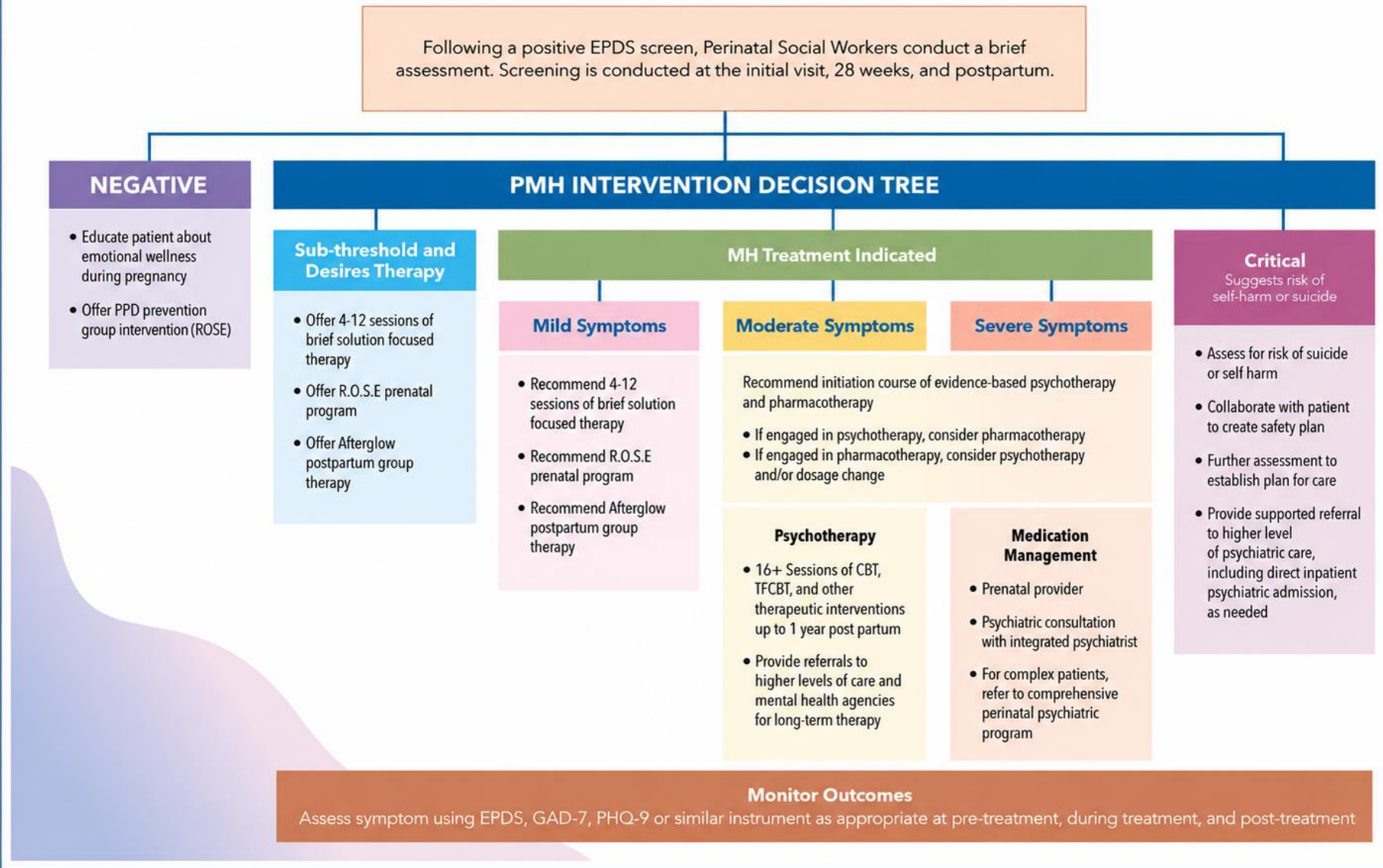


Figure 2. The Women’s and Infants’ Services Safe Babies Safe Moms Protocol to Guide Team Recommendations Reflects Screening, Assessment, Treatment, and Referral Pathways and Includes Ongoing Monitoring for Symptom Improvement.



Table 3. Recommendations to Facilitate Adoption of Similar Approach in Other Settings

RECOMMENDATIONS



1 Anticipate multiple revisions and compromises to develop an instrument and workflow that is both efficient and effective.



2 Consider establishing distinct pathways to provide social services interventions and behavioral health treatment.



3 Build in processes and multiple intervention options to be responsive to patient’s goals and readiness for therapy.



4 Leverage existing perinatal mental health care resources to be able to offer services across the perinatal mental health continuum of care.



5 Recognize telehealth mental health appointments may offer a highly desired option to receive mental health services and increased engagement.



6 Invest in team training and coaching to build cohesion, expand specialty skills, and strengthen resilience.



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Safe Moms.**

Journal of Midwifery & Women’s Health

www.jmwh.org

Innovations from the Field

Safe Babies Safe Moms Women’s and Infants’ Services Perinatal Mental Health and Wellness Program: A Comprehensive Integrated Model for Prevention and Treatment

Evelyn E. Asegieme¹, MSW, LICSW, LCSW-C, PMH-C, Aimee L. Danielson^{1,2}, PhD, Amalia Londoño Tobón², MD, Elisabeth S. Rindner³, BS, Yanbao Xiong⁴, MS, Patricia B. Tanjutco⁴, MD, Matthew G. Biel^{2,3}, MD, Loral Patchen^{1,3,4}, CNM, PhD

MedStar Georgetown University Hospital Mother-Baby Intensive Outpatient Program



The program supports mothers and pregnant people in crisis by providing holistic and personalized treatment for perinatal mood and anxiety disorders while centering the mother-baby relationship.



Current state and next steps for Safe Babies Safe Moms



Most Impactful Interventions

- Social determinants of health screening & referrals
 - Including Medical Legal Partnership
- Clinical care bundles for high-risk populations
- Behavioral health screening, referrals, and integration
- Care navigation and coordination
- Co-location of high-risk obstetrics services in the community
- Pediatric delivery
- Ongoing research and innovation



DC | HEALTH



When scaling...
The Local Context MATTERS!

Across our health system...and beyond



MedStar Georgetown University
Hospital



MedStar Southern Maryland
Hospital Center



MedStar Franklin Square Medical Center



MedStar St. Mary's Hospital



MedStar Harbor Hospital



MedStar Montgomery Medical Center



**D.C. Safe Babies
Safe Moms.**

Sustainability

- Positioning**
Position SBSM as a “best in class” model of integrated maternal-child health care delivery that improves outcomes and reduces disparities, and as a national center for convening partners and delivering technical assistance to scale this work across systems.
- Partnerships**
Continue to collaborate with new and existing internal and external partners to deepen expertise, expand reach, and broaden influence.
- Presence**
Tell the “SBSM story” locally and nationally, including successes and lessons learned, to ensure SBSM contributes to nationwide efforts to improve maternal and child health outcomes.
- Predictive Analytics**
Leverage the power of predictive analytics produced by informaticists, statisticians, and economists to determine which SBSM services are most effective, who benefits most from those services, and the costs associated with delivering those services
- Payors, Policy, and Philanthropy**
Drive long-term sustainability by maximizing reimbursement opportunities, influencing policy to strengthen access and funding, and continuing philanthropic fundraising efforts to sustain and scale SBSM initiatives.



Questions & Discussion



It's how we **treat people.**



MedStar Health



The Lab @ DC: Maternal Health Journey Mapping Project

(20 minutes)



Maternal health for DC Medicaid patients

Observations on screening for needs and
referral to services



THE **LAB** @ DC



We must:

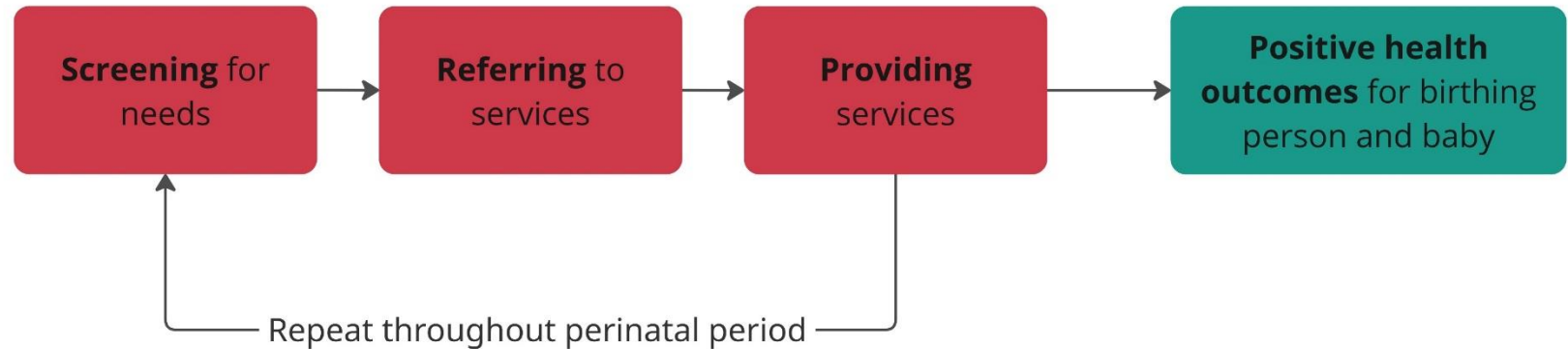
Care for the birthing person's **mental health**

Meet the birthing person's **health-related social needs**

Treat the birthing person's **substance use disorder**

...and others, but we focused on these three

We do this by:



Which leads to:

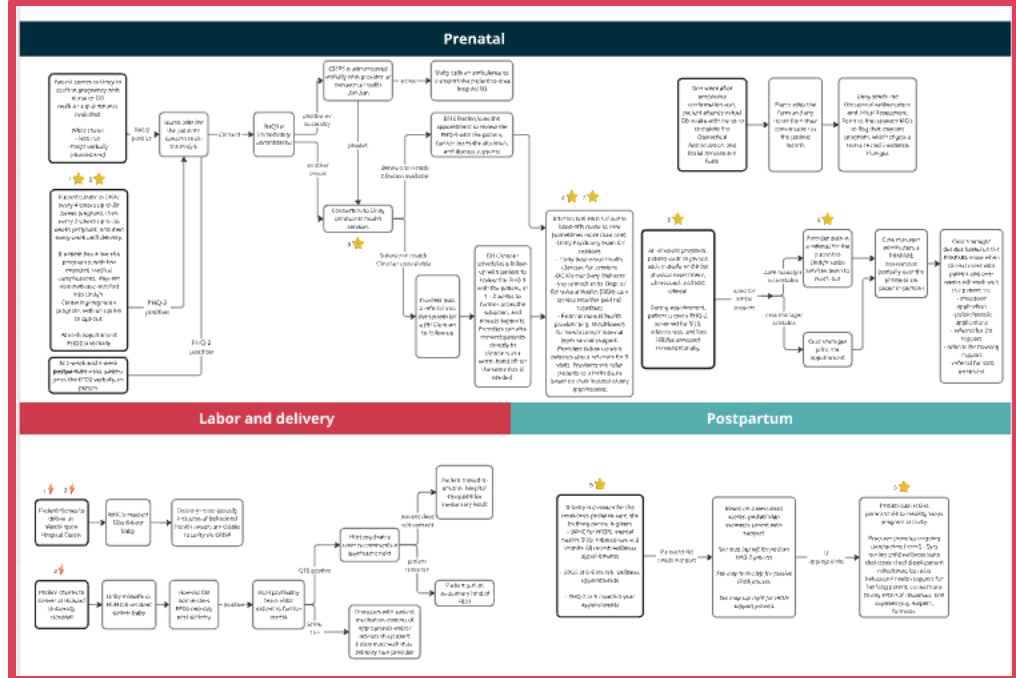
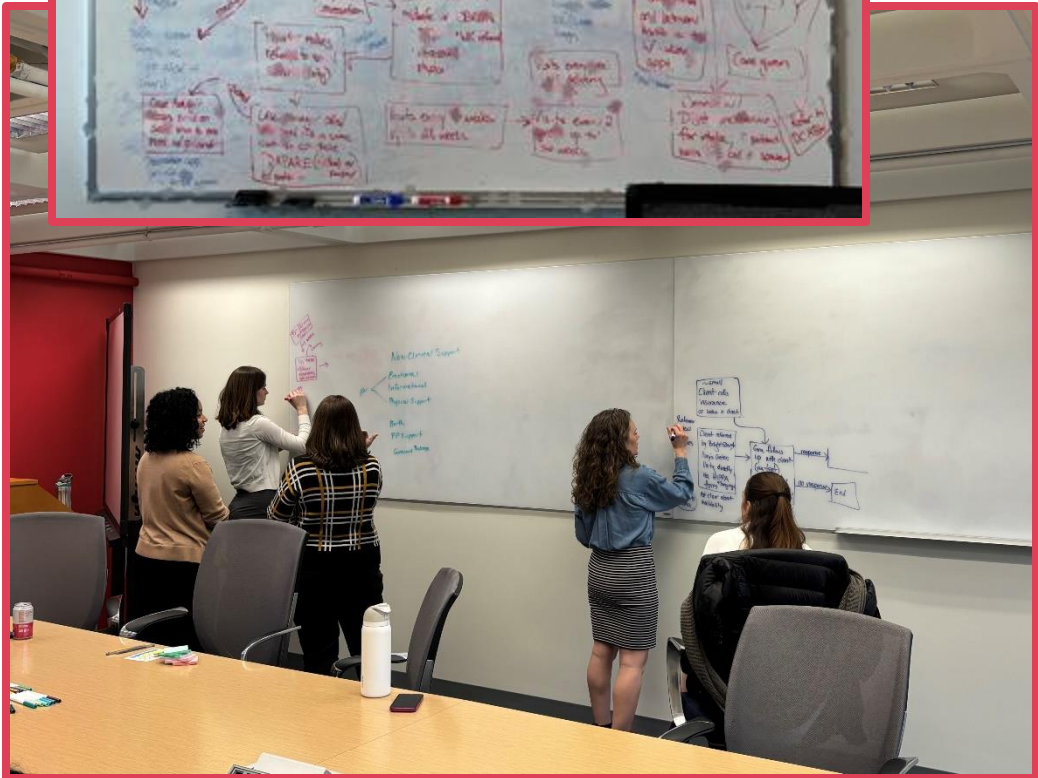
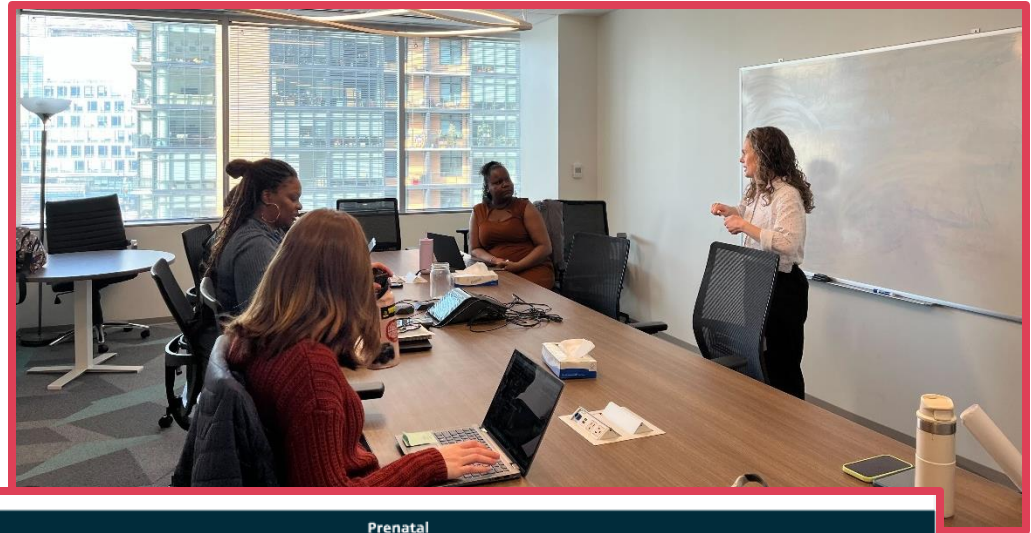
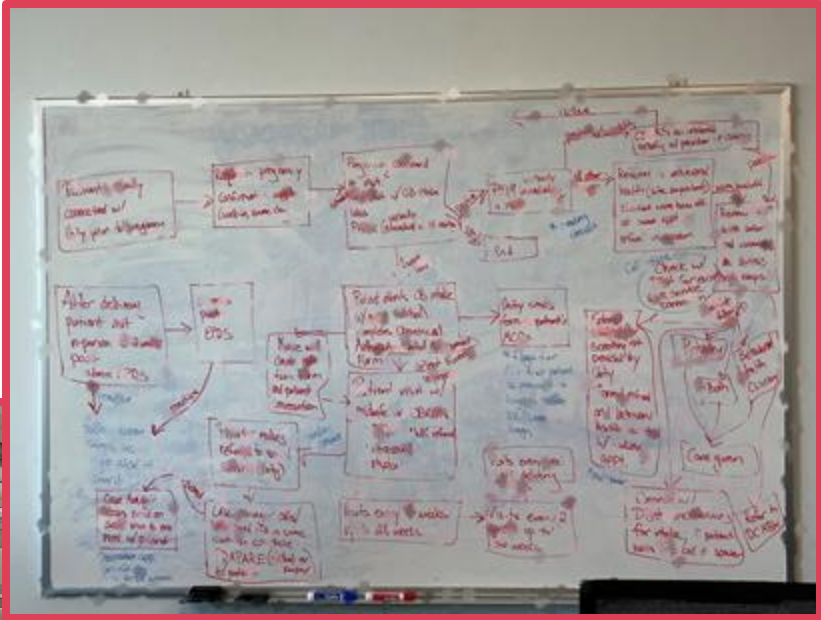


What we did

We spoke with the majority of perinatal providers in DC who see Medicaid patients and created patient **journey maps**.

- 5** Physician Groups & Federally Qualified Health Centers
- 3** Hospitals
- 10** Doulas and community health workers







A note about terms

For consistency in this presentation, we use the following terms:

- **Perinatal period**
- **Providers**
- **Patient**



1

Screen

- 1** Screening is happening. Frequency varies.
- 2** Very little screening happens in the postpartum period.
- 3** Not all providers use formal assessment tools, and that's ok.
- 4** Doulas are struggling to participate in the Medicaid environment.

Screen



Screen

- 1 Screening is happening. Frequency varies.



Why this matters?

Patient needs change, trust takes time to build. Infrequent screening means needs can go undetected.

Screen

1

Screening is happening. Frequency varies.

2

Very little screening happens in the postpartum period.



Why this matters?

Homicide and suicide are the leading causes of postpartum death. Patients are particularly vulnerable postpartum.

Screen

- 1 Screening is happening. Frequency varies.
- 2 Very little screening happens in the postpartum period.
- 3 Not all providers use formal assessment tools, and that's ok.



Why this matters?

Identifying patient needs must be compatible with the provider's model to be sustainable.

Screen

- 1 Screening is happening. Frequency varies.
- 2 Very little screening happens in the postpartum period.
- 3 Not all providers use formal assessment tools, and that's ok.
- 4 Doulas are struggling to participate in the Medicaid environment.



Why this matters?

Even once a patient has successfully connected to support, there are real barriers that prevent them from receiving that care.

2

Refer

- 1** The amount of referral support offered, depends on the provider staffing model.
- 2** The strength of cross-provider relationships and referral systems vary.
- 3** Housing, transportation, and childcare are key barriers to accessing care and support services.

Refer



Refer

1

The amount of referral support offered, depends on the provider staffing model.



Why this matters?

Screening without the time to refer patients becomes a dead end.

When the onus is on patients to follow through the odds of connection to help go down.

Refer

1

The amount of referral support offered, depends on the provider staffing model.

2

The strength of cross-provider relationships and referral systems vary.



Why this matters?

When providers know who to call on to support their patient, and have a clear path to make a referral, the odds of their patient getting support go up.

Refer

- 1 The amount of referral support offered, depends on the provider staffing model.
- 2 The strength of cross-provider relationships and referral systems vary.
- 3 Housing, transportation, and childcare are key barriers to accessing care and support services.



Why this matters?

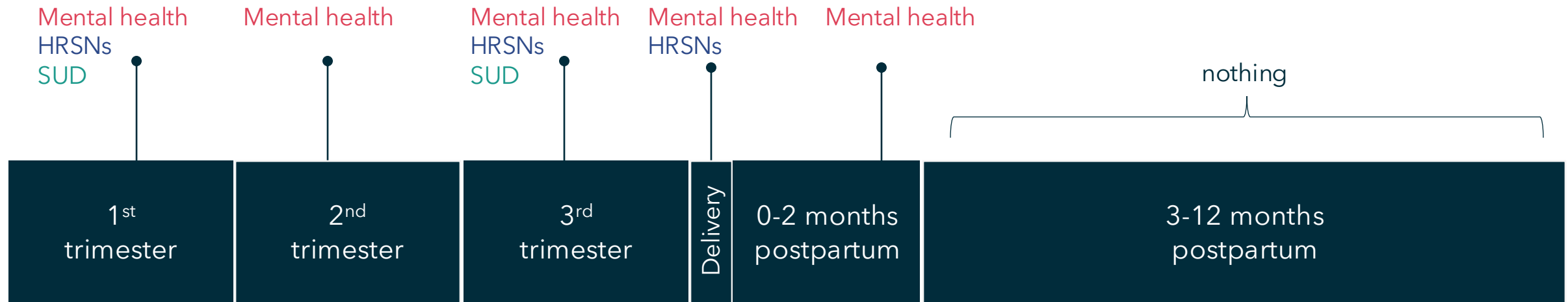
Even once a patient has successfully connected to support, there are real barriers that prevent them from receiving that care.

4

Pulling it all together

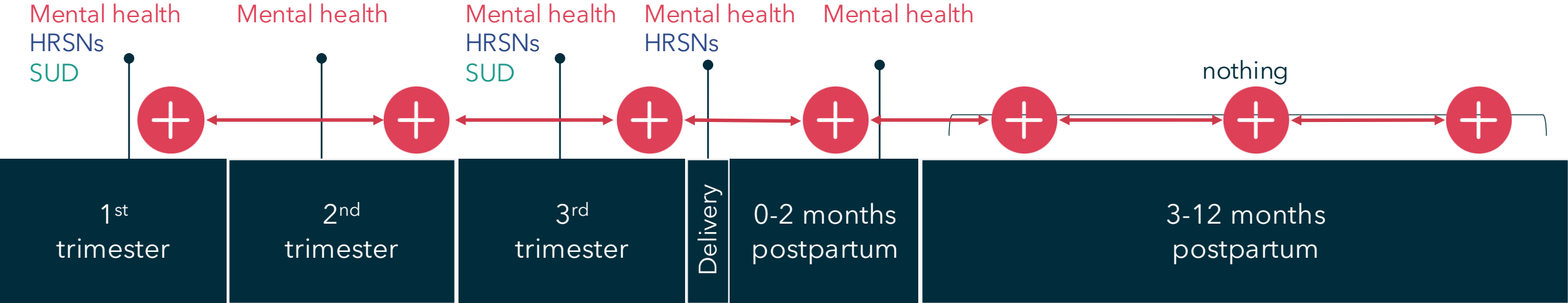


Clinical care



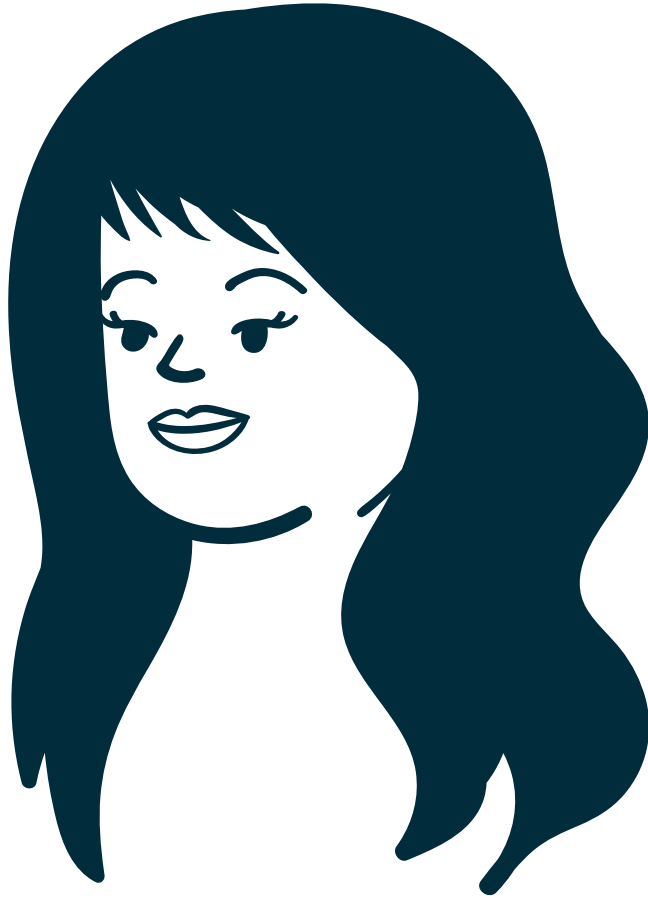


Networked care





Meet Lisa



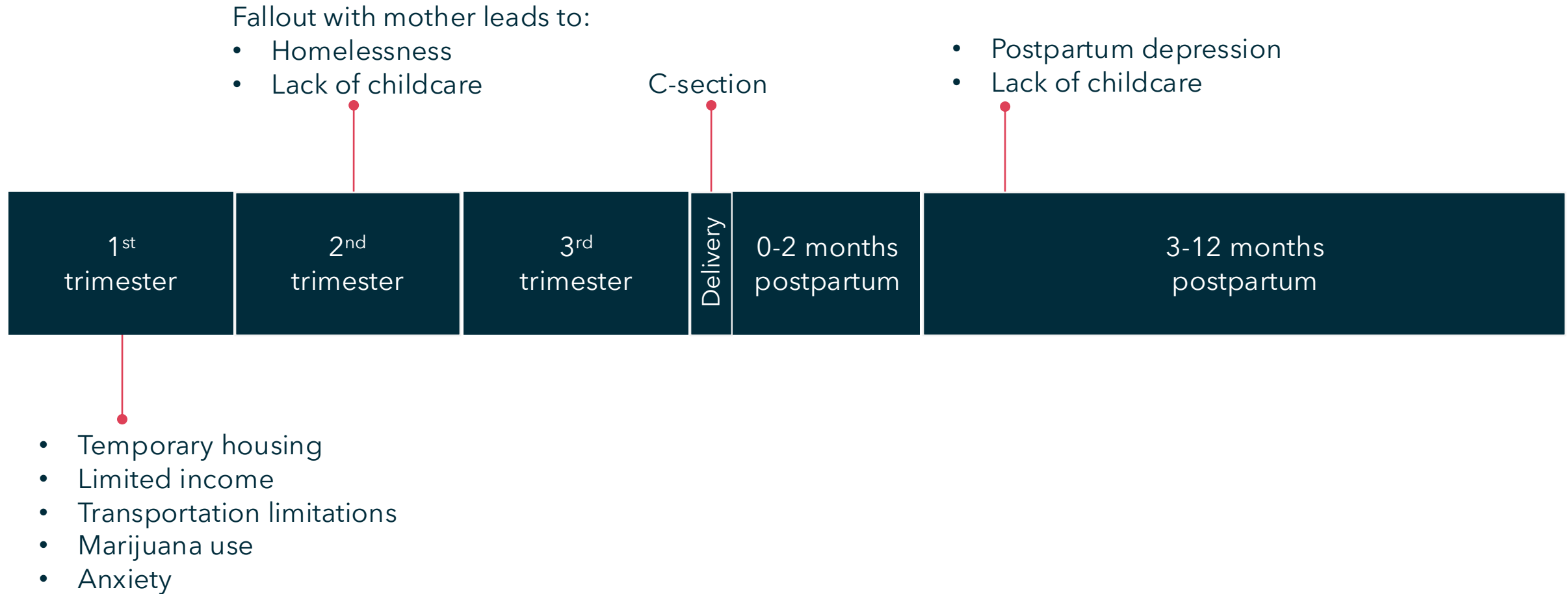
At the start of her pregnancy:

- Single parent
- Living with mother
- Employed part-time
- Public transit user
- Occasional marijuana use
- Generally good health

Throughout her perinatal journey:

- Homelessness
- C-section
- Postpartum depression

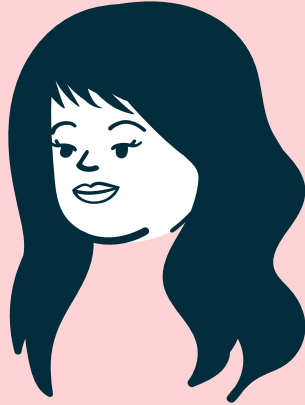
Lisa's story





Try out some user stories

Lisa



At the start of her pregnancy:

- Single parent
- Living with mother
- Employed part-time
- Public transit user
- Occasional marijuana use
- Generally good health
- Undiagnosed anxiety

Throughout her perinatal journey:

- Homelessness
- C-section
- Postpartum depression

Sasha



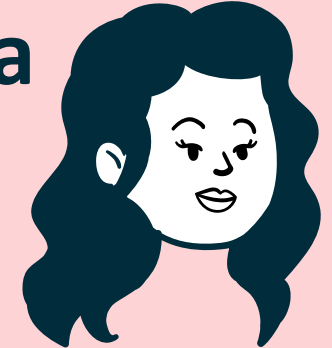
At the start of her pregnancy:

- Teen pregnancy
- First prenatal visit at 20 weeks
- Exiting foster care system
- Unemployed
- Public transit user
- Unstable housing

Throughout her perinatal journey:

- Develops pre-eclampsia
- C-section
- Baby spends 3 weeks in NICU

Miranda



At the start of her pregnancy:

- Spanish speaker/limited English
- Married; spouse undocumented
- 5 year-old daughter
- Previous postpartum depression with daughter
- Renter

Throughout her perinatal journey:

- Job loss
- Frequent spousal arguments
- Development disability diagnosed for daughter

Questions & Discussion

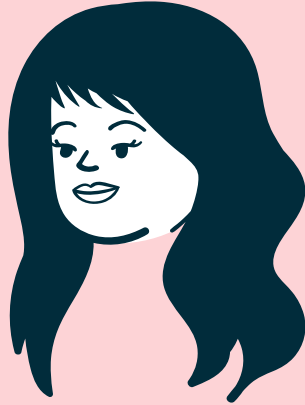


THE **LAB** @ DC



Try a user story thinking about your own model of care

Lisa



At the start of her pregnancy:

- Single parent
- Living with mother
- Employed part-time
- Public transit user
- Occasional marijuana use
- Generally good health
- Undiagnosed anxiety

Throughout her perinatal journey:

- Homelessness
- C-section
- Postpartum depression

- What does referral for marijuana use and anxiety look like in your care model?
- Where do you see patients like Lisa hit roadblocks in receiving support for marijuana use and/or anxiety? How have you helped patients navigate that?



TMaH Journey Mapping: Validated Assessment Tools

Combined (used in programs focused on parent and baby, e.g. Healthy Starts)

- Survey of Well-being of Young Children (SWYC)

Mental health

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire (PHQ-2/4/9)
- Ask Suicide-Screening Questions (ASQ)
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Generalized Anxiety Disorder (GAD-2)
- Panic Disorder Severity Scale (PDSS)

Substance Use Disorder (SUD)

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Health Related Social Needs (HRSNs)

- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
- Hurt, Insult, Threaten, Scream (HITS)



How can we support patients 3-12 months postpartum?

- What opportunities for this period do you see?
- Who is missing from the conversation to help connect patients to care in this period?



Appendix



THE **LAB** @ DC



Understanding and leveraging user personas

Why use personas?

User personas are a tool from Human-Centered Design (HCD) that help organizations understand the experiences, needs, and behaviors of the people they serve. Personas are created using qualitative and quantitative research and represent common patterns across a group. Although fictional, they provide a realistic snapshot of user motivations, barriers, and contexts. Personas help teams build empathy at scale and make more informed decisions when designing services, products, or workflows.

DC Medicaid personas for TMaH

The personas included in this packet are based on insights shared by physicians, midwives, doulas, and other perinatal service providers The Lab @ DC met with while journey mapping in February 2026. They reflect common characteristics and challenges experienced by Medicaid patients in the District. These personas are a starting point—you can adapt or refine them based on behaviors, needs, or motivations you see in the populations you serve.

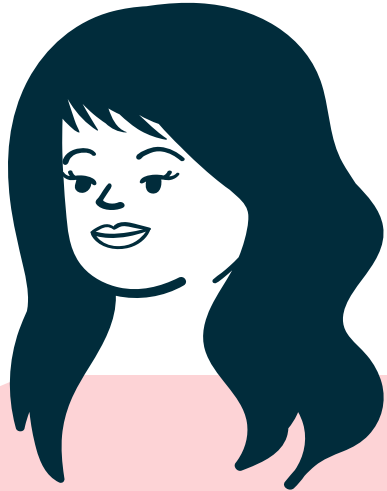
How these personas can support service design

These personas were created to help DC perinatal providers refine screening, referral, and care-coordination workflows related to mental health, substance or tobacco use, and health-related social needs. They can help teams build alignment across departments by providing a shared reference point when identifying opportunities to improve service delivery.

Personas should be revisited and updated over time, as user characteristics and contexts change.



Meet Lisa



At the start of her pregnancy:

- Teen pregnancy
- First prenatal visit at 20 weeks
- Exiting foster care system
- Unemployed
- Public transit user
- Undiagnosed anxiety

Throughout her perinatal journey:

- Develops pre-eclampsia
- C-section
- Baby spends 3 weeks in NICU

Lisa is a recently single mother of her 2-year old son. At the start of her pregnancy she and her son are temporarily living with Lisa's mother in the Manor Park neighborhood of DC following her separation from her partner. Lisa often relies on her mom to help care for her toddler. Lisa is working part-time and hoping to get housing support in the future to be able to move into her own place. She doesn't have a car and uses public transportation. She occasionally uses marijuana recreationally to help when she's feeling anxious. That's been more frequently lately since her partner left. Lisa is in generally good health as she enters this pregnancy.

A few key things happen during her perinatal journey:

- In her second trimester, she and her mom have a falling out and she needs to find a new place to live rather abruptly.
- Around 38 weeks, she goes into labor and has an emergency C-section and delivers a baby girl.
- Because she is supporting herself with no family engagement, it's around 10 weeks postpartum that she finds herself struggling emotionally. She's still healing from the c-section, not getting enough sleep, and is acting as the sole caretaker for both her 2-year-old and newborn.



Meet Sasha



At the start of her pregnancy:

- Teen pregnancy
- First prenatal visit at 20 weeks
- Exiting foster care system
- Unemployed
- Public transit user

Throughout her perinatal journey:

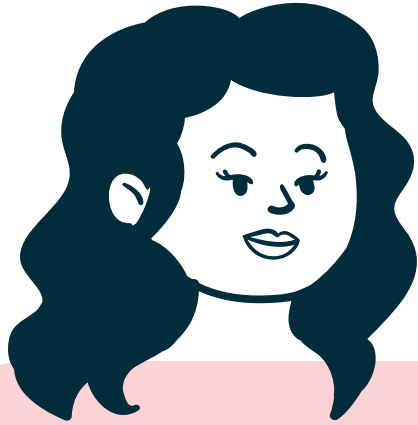
- Develops pre-eclampsia
- C-section
- Baby spends 3 weeks in NICU

Sasha currently lives with her aunt who has been her guardian for the last 5 years. They live in Southwest, near the waterfront. Sasha doesn't yet have a driver's license and relies on public transportation and bike share to get around. She is 18 and pregnant for the first time. She realizes she is pregnant around 14 weeks, it takes her some time to schedule an appointment, so she doesn't see a provider until around 18 weeks. While she starts her prenatal care a bit late, she is generally healthy at the start of her pregnancy.

Over the course of her pregnancy, there are a few key events:

- In her second trimester, her aunt who recently lost her job gets evicted and they move to transitional housing.
- In her third trimester, she is diagnosed with pre-eclampsia and must start medication to manage the condition.
- She goes into labor at 35 weeks early and delivers via C-section. Her baby girl spends 3 weeks in the NICU.
- Around week 2 PP, she starts to feel overwhelmed navigating parenthood while going back and forth between the NICU and trying to find stable housing.

Meet Miranda



At the start of her pregnancy:

- Spanish speaker/limited English
- Married; spouse undocumented
- 5-year-old daughter
- Previous postpartum depression with daughter
- Renter
- Risk for gestational diabetes

Throughout her perinatal journey:

- Job loss
- Frequent spousal arguments
- Development disability diagnosed for daughter

Miranda has lived in DC for about 7 years. She speaks English with limited proficiency and is more comfortable in her native language—Spanish. She is married. Her husband is a dreamer and his ability to remain in the U.S. is uncertain. She has a 5-year-old daughter. Miranda lives with her family in an apartment in Columbia Heights and mostly uses metro and buses for transportation since her husband uses their vehicle for work. She struggled with post-partum depression after her daughter was born and is nervous she will struggle again after her second.

Through her pregnancy, she navigates a few bumps, including:

- In her second trimester, she loses her part time job, and the financial strain on the family provokes frequent arguments with her husband.
- In her third trimester, her daughter is diagnosed as on the autism spectrum.
- At 39 weeks, She delivers a baby boy naturally.
- Around week 8, Miranda starts to struggle emotionally, as caring for a newborn and identifying the appropriate supports and programs for her older daughter's recent diagnosis become overwhelming.

Creating more robust personas

- What behaviors have you observed in patients whose access to care is limited by a lack of transportation or childcare?
- What other barriers do you see in patients when they first come to you?
- What common challenges arise in the 3rd trimester?
- What common challenges do patients experience postpartum, and how do you support them?

Rene



At the start of her pregnancy:

Throughout her perinatal journey:



Next Steps and Announcements



Next Meeting:

- June 16th, 2026, 11am-12:15pm
 - Topic: TMaH Updates; Perinatal Behavioral Health & SUD

Meeting Cadence: We will transition to bi-monthly meetings starting in July

- Subsequent Meetings: June, July, September, November
- Calendar invite will be updated to reflect this new cadence

Stay in Touch

- Questions: Send questions or requests to dhcf.maternalhealth@dc.gov
- Meeting Materials: Available at <https://dhcf.dc.gov/page/transforming-maternal-health>