Maternal Health Advisory Group

October 21st, 2025

September Maternal Health Advisory Group Meeting Recap

<u>September MHAG Meeting Recap</u>: *Patient safety and perinatal mental health*

- The DC Perinatal Quality Collaborative presented on how they implement AIM Patient Safety Bundles to improve care delivery and health outcomes, including the upcoming bundle around perinatal mental health.

- Children's National presented on programs they have implemented that help build infrastructure and support for perinatal mental health in the pediatric setting.

- *Breakout Room #1 Report-Out:* Participants identified barriers and key messages for a potential public awareness campaign to increase perinatal mental health screenings

- *Breakout Room #2 Report-Out:* Participants discussed the variety of screening tools used to identify perinatal mental health, as well as the timing and frequency of screening.

<u>Today's Meeting</u>: *Patient safety in managing high-risk pregnancies*

Today's Agenda

Welcome – 10 min

TMaH & Patient Safety in High-Risk Pregnancies – 5 minutes

Community of Hope Presentation – 20 minutes

MedStar Presentation – 15 minutes

Breakout Rooms – 15 minutes

Discussion and Next Steps – 10 minutes

TMaH Award Required Notice

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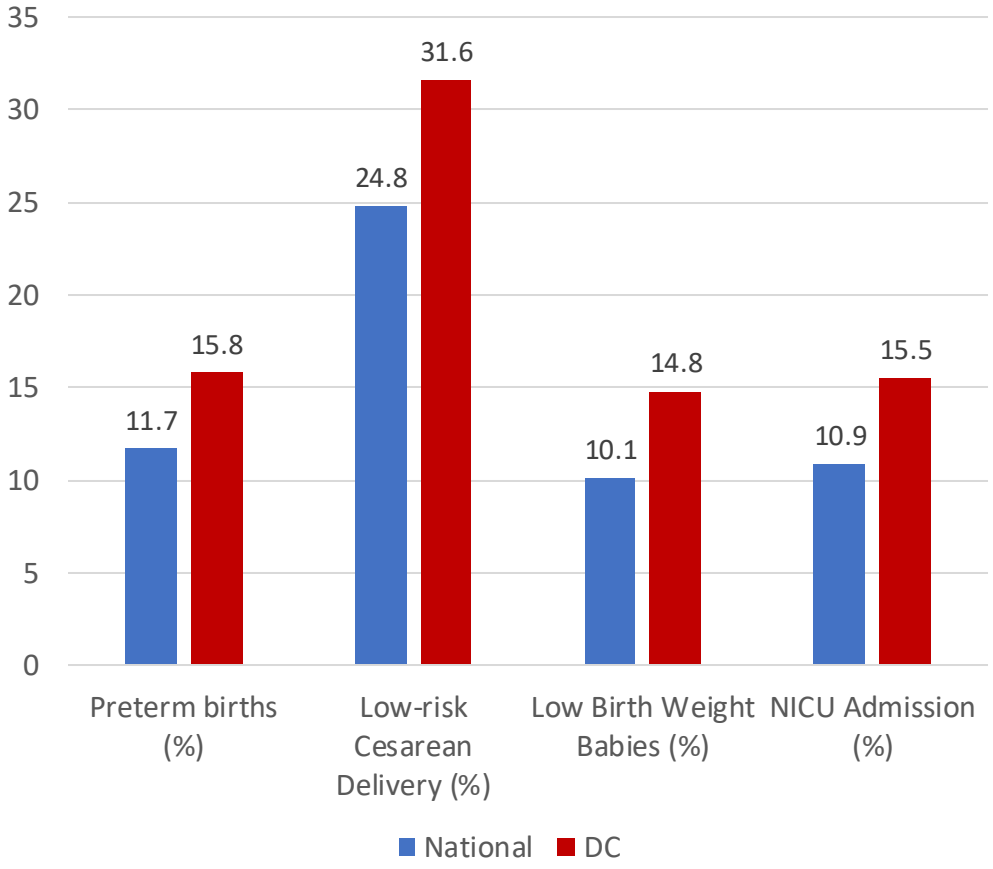
TMaH & Patient Safety in High-Risk Pregnancies

(5 minutes)

Key Maternal Health Outcomes for Medicaid Beneficiaries in the District Against National Averages

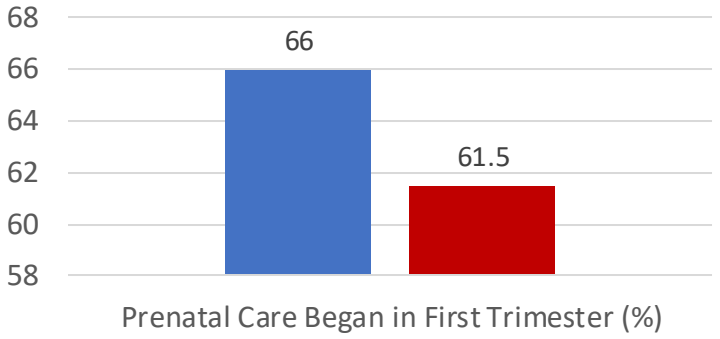
Key Maternal Health Delivery Outcomes:

DC Medicaid vs National Average (2024)



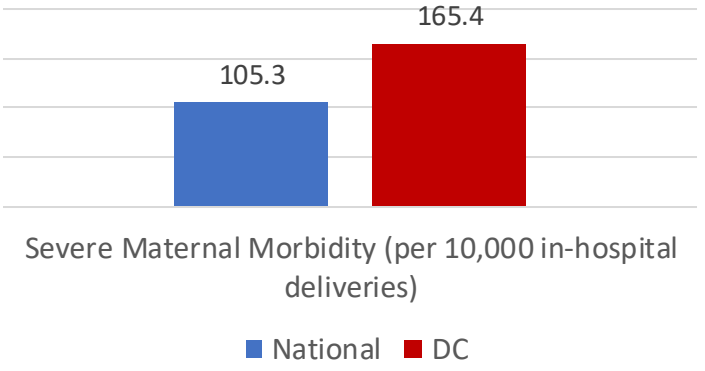
Early Prenatal Care:

DC Medicaid vs National Average (2024)



Severe Maternal Morbidity:

DC Medicaid vs. National Average (2022)



TMaH Aims To Enhance Patient Safety to Improve Maternal and Infant Health Outcomes

CMS-Identified Problem	Proposed TMaH Solutions
Lack of evidence-informed safety practices	• Implement evidence-based patient safety bundles • Effectively use medical and social risk assessments to drive care delivery • Achieve the "Birthing-Friendly" hospital designation
A "one size fits all" approach to care to manage medical complications that is not personalized to optimize overall health and wellness	• Institute evidence-based medical and social risk assessment to drive risk-appropriate care • Deliver care consistent with individual preferences • Incorporate home monitoring and telehealth technology for women with medical conditions like gestational diabetes and hypertension that complicate pregnancies

Community of Hope Presentation

(20 minutes)

Utilizing Care Coordination to Optimize Patient Safety

April Weeden, MPH
Director of Perinatal Services

Community OF HOPE

Agenda

- Overview of Community of Hope's Comprehensive Model of Maternal and Child Health
- Patient Outcomes Snapshot
- Review of 3 Program Strategies

Community of Hope

Mission

Community of Hope works to improve health and end family homelessness to make Washington, DC more equitable. Reaching over 16,000 patients and over 1,700 families and individuals experiencing homelessness.

Model of Maternal and Child Health provides a comprehensive model of care to eliminate health inequities for over 900 pregnant and postpartum people and their babies.

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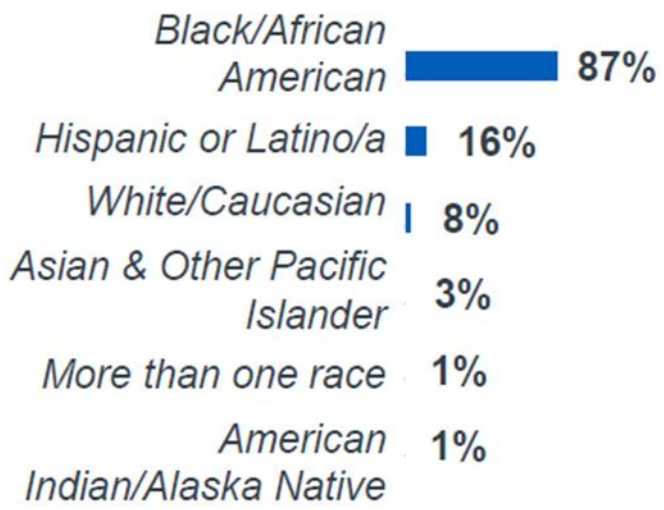
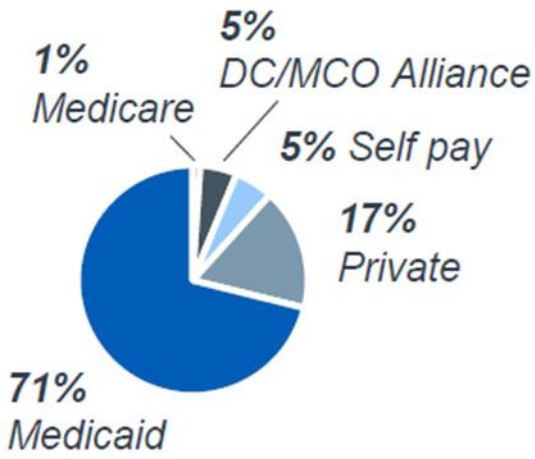
COH Patient Demographics

Underserved perinatal patients reached

By race and ethnicity*†



By health insurance coverage



* Hispanic is considered an ethnicity, not a race. The percentages do not add to 100 because Hispanics may be any race.
† Data does not include respondents who didn't report race.

700+

Perinatal patients served from 2023 to June 2024

339

Newborns delivered by COH midwives

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Great outcomes!

Program Impact Report by Optum

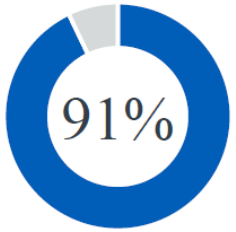
10%

From 2021 to June 2024, the percentage of COH babies born **preterm dropped** from 15% to 10%.

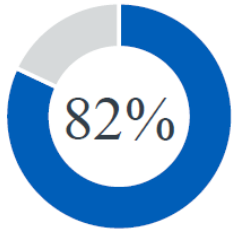
8%

From 2022 to June 2024, the percentage of COH babies born with **low birthweight dropped** from 11% to 8%.

Among postpartum patients...



Were **screened for postpartum depression**



Attended **timely postpartum visits‡**

79%

Of patients received **perinatal care coordination services**

‡Care visits occurred between 7 and 84 days after delivery.

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Program Strategy: Tiered Care Coordination and Navigation Services

Dedicated health workers trained to:

- Assesses patient risks, provides individualized health education, and referrals to social services and resources that mitigate the patient's risk factors.
- Supports perinatal patients who are clinically complex and/or at risk for preterm delivery through specialty care scheduling, ER follow ups, and transfer of care assistance.

Designed a staffing plan to maintain caseloads of 30-40 perinatal patients for Navigators and 50-65 perinatal patients for care coordinators

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Who can get Care Coordination or Navigation Services?

- All pregnant and parenting families with an infant 4 months old or younger
- Families are engaged for PCC services during their first prenatal, postpartum, or early pediatric appointment
- We take an opt-out approach: the services are available to all proactively unless they decline
- Services provided through 6 months postpartum or 8 weeks following a pregnancy loss

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MCH Tiered Services

The initial assessment completed during a prenatal or postpartum intake help a Navigator or Care Coordinator assign the appropriate Tier level.

The MCH Tier level is used to determine the level of support and engagement a patient needs based on their social needs, medical risk factors, and existing support system.

Risk Factors Used to Assign Tier Level

Lower Risk Factors

- Tobacco Use
- Marijuana Use
- Late to care
- Food insecurity

Higher Risk Factors

- Domestic Violence/ Interpersonal Violence*
- Substance Use Disorder *
- Mental Health Concerns*
- Housing instability*
- CFSA Involvement
- Social Isolation
- Previous preterm delivery
- Previous Low Birth Weight Baby
- Chronic medical conditions
- Teen pregnancy

* Indicates Risk Factors that may be considered Severe

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Tiered Service Provision

Baseline:

- Declines PCC Services

Tier 1

- Lower Risk
  - 1-2 Lower Risk Factors

Tier 2

- Medium Risk
  - 1 Higher Risk Factor or 3-4 Lower Risk Factors, Limited Care Engagement

Tier 3

- Higher Risk
  - 2 or more Higher Risk Factors or one Severe Higher Risk Factor

Patient Experience

Receive direct contact information for navigator or care coordinator	• Able to text and call directly • Working to increase their ability to communicate via patient portal • Care Coordinators and Navigators have direct access to the whole care team for the patient and their medical record– routing information and concerns as a liaison
Connection to care coordinator or navigator at every internal perinatal appointment	• Opportunity to review education, set goals, make referrals, support resource navigation
Follow up calls after emergency medical services use	• Patient reason for emergency room visit or hospitalization shared with perinatal provider team • Navigator provides support in scheduling follow up visit with perinatal care team
Access to digital or printed copy of our internally designed Perinatal Education Booklet	• 60+ pages of education, activities, timelines, warning signs • Reduce disinformation and reliance on non-reputable sources

Patient Experience

Qualitative focus group results. Overall, participants appreciated COH's care whole-person approach.[2] Parents felt:

- ***Supported*** by COH's care coordinators, who checked on them consistently and connected them to a range of pregnancy and postpartum services.
- ***Empowered*** by COH education to make informed care decisions on delivery options.
- ***Respected*** by the midwives and doulas with diverse backgrounds who cared for them. Multiple women noted the importance of receiving care from Black women who understood patient experiences.
- ***Listened to*** by doulas, midwives, and facilitated peer groups during pregnancy and postpartum. COH staff facilitated personal connections and spaces for participants to ask questions.

> My patient care coordinator has been helpful throughout my entire pregnancy and with my postpartum care. She'd always reach out to check on us, see how baby is doing, how I'm doing, let me know about resources that are available if I need them. I could tell she really cared.
>
> Angela
> *COH patient*

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Commitment to Workforce Development

- All care coordinators and navigators receive weekly reflective supervision
  - Supervisors trained in Facilitating Attuned Interactions (FAN) and Reflective Supervision
- Direct and consistent oversight that is strengths-based and risk-management focused
  - Supervision ratios of 1 supervisor for every 4-5 PCCs or PNs and 1 manager/director for every 3-4 managers
  - Director and Managers maintain high visibility in clinic and direct communication line with staff
  - Staff receive real-time consultation on patient interactions or concerns
- Routine professional development offered to increase capacity to support resource navigation, health education provision, safety planning

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Program Strategy: Rides for Moms

Transportation support to increase appointment adherence and aid in patient monitoring

For Birthing Parent

- Prenatal/postpartum appointments at COH
- Ultrasound appointments
- Nursing visit/labs
- **MFM appointments at COH or local hospital**
- **Rides to birth center or local hospital for: labor check, NSTs, c-section, induction, ECV**
- Emotional wellness appointments at COH
- Dental appointments

For Baby

- Well child check/**weight check**/sick visits until 6 weeks old
- **NICU visits**
  Limited to two rides a day for up to 2 weeks. If the infant is in NICU longer, set plan to continue ride provision until stable transportation in place or infant released.

Program Strategy: Case Conferencing

Coordinated plans of action that address complex clinical and/or social needs in a select group of high-risk patients by:

- Utilizing a standardized process for case conferencing and documentation of action and follow-up plans
- Identifying as a care team the patient's background, strengths, challenges, and priority clinical and social issues
- Collaboratively problem solving with the care team to identify opportunities for intervention to support desired patient outcomes
- Reduce duplication of efforts and improve follow up by aligning care team efforts

Facilitated by Director of Perinatal Services and Lead Emotional Wellness Clinician

Other strategies we don't have time to cover today:

Some other important elements of our program:

- Case Reviews for unfavorable outcomes, predelivery chart reviews
- Co-management for complex and high-risk patients with Maternal Fetal Medicine onsite in Ward 8
  - Onsite sonography
- Services brought close to home in Wards 5 and 8:
  - WIC/Farmers Market
  - Diapers, clothing closet, car seats, infant feeding supplies
- Emotional Wellness services (including psychiatry) readily available

Other strategies we don't have time to cover today:

Some other important elements of our program:

- Home visiting through Healthy Families America and Parents as Teachers focusing on child development, infant emotional wellbeing, and school readiness
- Group Care and Social support groups
  - CenteringPregancy, CenteringParenting
  - Parent Cafes (including one specifically for early postpartum families), Prenatal Yoga, Making Milk
- Quality improvement initiatives and platforms (ie Relevant)

Thank You!

Want to learn more,
read our Impact Report!

April Weeden, MPH
Director of Perinatal Services
aweeden@cohdc.org

MedStar Presentation

(15 minutes)

MedStar Family Choice

DISTRICT OF COLUMBIA

It's how we treat people.

MedStar Family Choice We Care: Growing Together Pregnancy Program

Erica McClaskey, MD, MS, FAAFP

Chief Medical Officer DC, Senior Medical Director

Agenda

- Safety Moment
- Provider Network
- Identification of Pregnant Enrollees
- Case Management and Coordination
- MFC DC Programs

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Safety Moment: Care Coordination Case

Enrollee: Single 28-year-old at 6 weeks pregnant with a history of depression and domestic violence without a support system.

Situation and Intervention:

MFC Case manager reached out to the Enrollee to establish care who disclosed that she was currently being treated for depression. An while she reported that while she was currently seeing a therapist, she was not satisfied with her progress and considering leaving the practice. Given the increased risk of complications that could develop without treatment or the use of her medications during her pregnancy, with the Enrollee's permission, the case manager referred her to MedStar Georgetown Women's Mental Health program for assistance with her behavioral health concerns. During that same outreach, the Enrollee also reported a history of domestic violence but declined encouragement to report this to law enforcement. In an effort to provide the Enrollee with a safe environment, the Case Manager collaborated with the MFC Social Worker and responded with trauma-informed care—offering emotional support and connected her to agencies that specialize in women's safety and legal advocacy.

Outcome:

The case manager has maintained close follow up with the Enrollee who has now reported improvement in her home situation. She also is seeing a therapist. She has expressed gratitude for the assistance because she does not have support from her family or friends and continues to appreciate the opportunity to have a listening ear.

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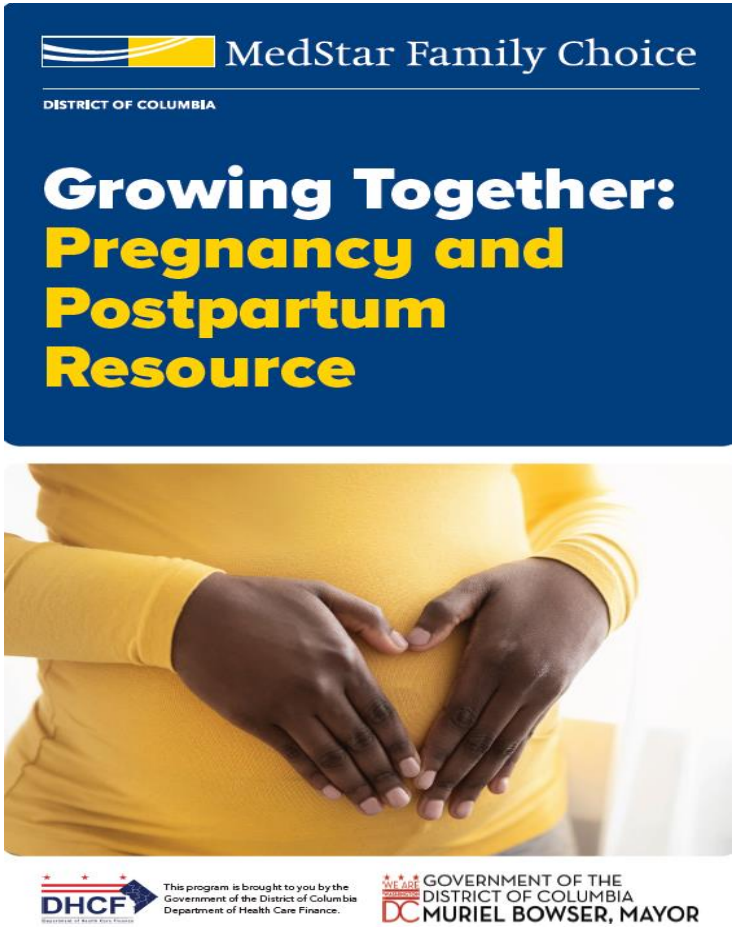
High-Reliability Organization Principles (HRO):

Reluctance to Simplify, Deference to Expertise

MedStar Family Choice Pregnancy Program



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MedStar Family Choice DC OB-GYN Provider Network

- Currently MFC-DC Provider Network has 275 unique OB-GYN providers.
- MFC-DC OB-GYN Provider Network meets network adequacy standards at 100%.
- Washington Hospital Center has the highest number of deliveries
  - Followed by HUH and GWU

TOP 10 Provider Groups	OB-GYN Providers
MedStar Medical Group	49
Medical Faculty Associates	40
Washington Hospital Center	32
MedStar Health & Georgetown University Hospital	30
HUFPP	28
Mary's Center for Maternal and Childcare Inc.	23
Planned Parenthood of Metropolitan Washington DC Inc.	20
Unity Health Care	14
JHU Physicians at Sibley and Johns Hopkins	14
Community of Hope	13

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Risk Factors for High-Risk Pregnancy

- Maternal age: Women over 35 years old
- Chronic health conditions: Diabetes, hypertension, heart disease, autoimmune disorders
- Infections: HIV
- Multiple pregnancies: Twins, triplets
- Placental problems: Placenta previa, placenta accreta
- Fetal abnormalities: Genetic disorders, birth defects
- Obesity
- Substance use: Smoking, alcohol, drugs

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Care Coordination & Case Management

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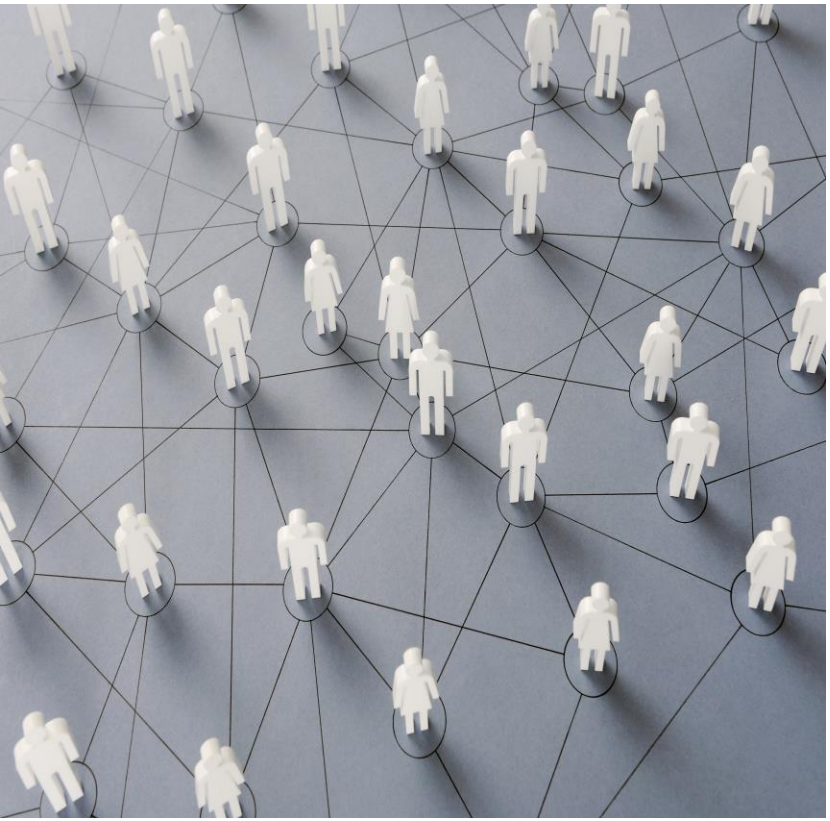
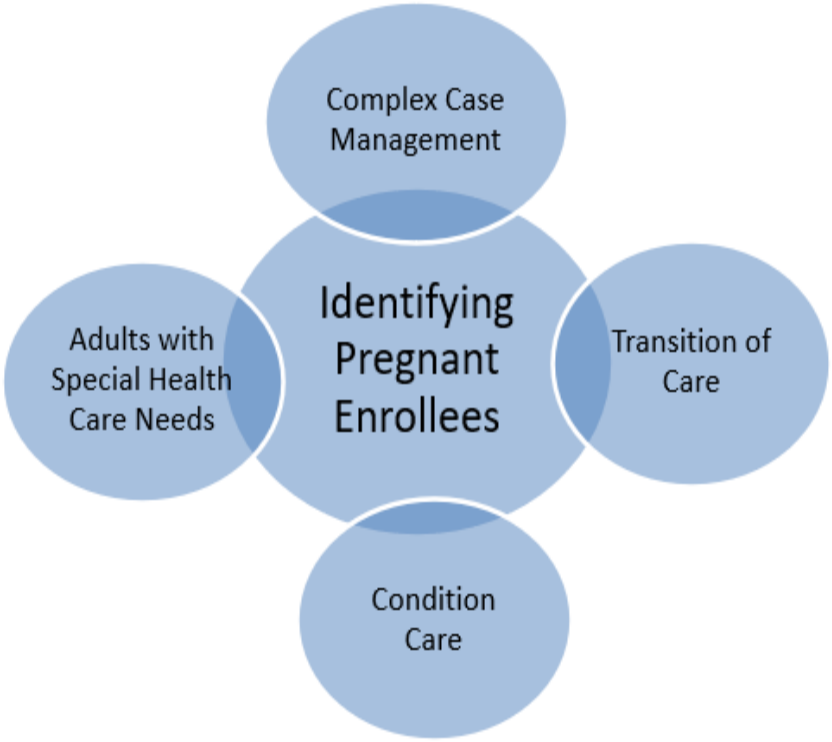
Identification



- ED visits (hospital utilization with symptoms suggestive of pregnancy)
- Chart reviews
- Pharmacy reviews
- Lab reviews
- Interdisciplinary referrals (CM's and SW)
- Utilization management
- Outreach department
- Provider offices as direct referrals or faxing in the Obstetrical Needs Assessment Form (ONAF)
- Self/family referrals
- Diabetic clinic
- Optum Home Services

Case Management



MFC DC provides case management for adults and children to support Enrollees with multiple healthcare needs and chronic conditions.

Case managers monitor individuals of childbearing age and discuss family planning, contraception and overall health education. If an individual is found to be pregnant, they are referred to the maternal program for close follow up.

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Maternal Health Programs

We Care Growing Together is a prenatal initiative designed for expectant individuals to offer support through case management, while offering incentives to promote prenatal and postnatal care.

- **We Care Growing Together: Prenatal Program-** Enrollees who participate receive incentives for prenatal visits, educational classes, and one dental visit. Goal is to increase awareness of prenatal health.

- **We Care Growing Together: Postpartum Program-** Works with postpartum Enrollees to monitor for ongoing needs, schedule postpartum visits, encourage visits for infants. Enrollees are eligible for gift certificates upon completion of postpartum exam.

- **We Care Growing Together : High-Risk Pregnancy and Maternal Care Program-** Care management targets Enrollees who are at risk of poor health outcomes. Individuals who meet the criteria are enrolled in the High-Risk program. They are followed at more frequent intervals. This could be weekly, every other week but no less than monthly. Frequency may also increase on a case-to-case basis. Enrollees receive care coordination from pre-delivery up to 365 days postpartum.

- **Maternity Mondays-** Monthly virtual education for expectant, new mothers and family/caregivers.
  - Safe Sleep- First Monday of each month is geared towards safe sleep education for newborns/infants. Enrollees receive a complementary pack n play after completion.

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Services offered

- Transportation
- Doula services
- Appointment scheduling
- Safe sleep training
- Community baby showers
- Health education and coaching
- Face-to-face classes/activities at the Wellness Center
- Address hypertension management
- Care coordination between specialists
- Chronic disease management
- Food and Friends
- Temporary Assistance to Needy Families (TANF)
- Special Supplemental Nutrition Program for Women, Infant, and Children (WIC)
- Diaper banks resources
- Legal resources
- Housing resources
- Behavioral health and substance abuse resources
- Home visits –NICU follow up
- Lactation support
- Postpartum follow up

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Growing Together: High-Risk Pregnancy Program

- Assigned a case manager
- Biweekly pregnancy follow ups or more frequently if warranted
- Encourages and schedules prenatal, dental and specialist appointments.
- Incentives offered for attending prenatal and dental appointments

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Growing Together: High-Risk Pregnancy Program

- Chronic disease management
- Support behavioral health concerns and SDOH needs
- Introduction to Cayaba Care for NICU families (Home visiting)
- Doula services offered
- Ongoing support for 12 months postpartum

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We Care: High Risk Pregnancy (Postpartum)

- Available to postpartum Enrollees
- Schedules postpartum clinic visits and offers transportation
- Resources for lactation assistance, breast pumps, cribs, bassinets, contraception planning
- Biweekly follow up 6 weeks (vaginal delivery) or 8 weeks (C-section).
- Ongoing support every 3 months at a minimum.

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Mental Health Collaboration

- MedStar Georgetown University Hospital Mood Disorders Clinic
  - Manages high-risk medications
- MedStar Georgetown University Hospital Women's Mental Health Program
  - Provides specialized mental health care
- Life Enhancement Services
  - Manages pregnant persons with behavioral health and SUD concerns.

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Maternity Mondays

- Safe Sleep education
- Self-care
- Baby showers
- Women, Infant and Children (WIC) benefits
- What to expect during prenatal visits
- The benefits of a Doula
- Financial planning

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Enrollee Community Wellness Center

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Resources

- **Enrollee portal -** allows Enrollees to change their doctor (primary care provider), request a new or replacement ID card, and view claims and authorizations http://mfcdcenrollee.healthtrioconnect.com
- **Healthy and Wellness Portal** To find more information on pregnancy health, visit our Health and Wellness Portal on our website . - https://medstarhealth.livehealthyignite.com/users/sign_in
- **Mamatoto Village -** prenatal and postpartum services, doula services, breast feeding support, child birthing and parenting classes
- (202) 248-3434 - 4315 Sheriff Rd NE, Washington, DC 20019 https://www.mamatotovillage.org/
- **Capitol Hill Pregnancy Center**- free resources including pregnancy tests, options education, parenting classes, free materials including baby clothes, diapers, wipes, children's books, baby equipment and more. (items may vary based on availability and you must make an appointment)
- 202-546-1018- 713 Maryland Ave NE, Washington, DC 20002
- https://www.capitolhillpregnancycenter.org/
- **MEDSTAR FAMILY CHOICE DC Wellness Center** - The Community Wellness Center is located at 3924 Minnesota Ave., NE in Ward 7. It is open Monday through Friday, 9:00 a.m. to 5:00 p.m. To plan your visit, see the Washington Metropolitan Area Transit Authority Trip Planner. Parking is available on the street and there are one-hour free parking lots nearby.
- **Birth Certificate Information -** Vital records -(202) 442-9303 - https://dchealth.dc.gov/vital-records
- **Help Me Grow DC –** resources for health and wellness for prenatal parents and families who have children through age 5. 1-800-666-2229 – helpmegrow.dc@dc.gov
- **Bread for the City -** Resources for food, clothing, medical care and legal and social services. 202-265-2400 - breadforthecity.org
- **Food & Friends-** prepared and delivered meals and groceries – 202-269-2277 info@foodandfriends.org
- **WIC** – support from pregnancy to age 5 - free healthy food, breastfeeding support, nutrition education and health resources www.fns.usda.gov/wic
- https://medstarhealth.livehealthyignite.com/users/sign_in

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Thank you!

MedStar Family Choice

Breakout Discussions

(15 minutes)

Breakout Group Discussion

Group #1: Public Awareness Campaign Building

- Participants will engage in a brainstorming activity with a given template to identify barriers, key themes/messages, and channels for a public awareness campaign to increase early engagement in prenatal care.

Group #2: Case Management and Care Coordination for High-Risk Pregnancies

- What are the common risk conditions you see among pregnant patients in your practice?
- What are the most effective practices your organization's case management team employs in managing high-risk pregnancies? Is there anything you are doing right now that isn't working?
- Are there other tools or technologies you are using to help manage your high-risk patients?

Next Steps

Next Meeting: November 18th, 11am-12:15pm

- Topic: Role of Doulas and Perinatal Community Health Workers in Patient Safety
- Subsequent Meetings: Every 3rd Tuesday from 11am-12:15pm (monthly)

Updates

- Perinatal Quality Collaborative Perinatal Mental Health Bundle Launches in January
  - Interested participants should contact Stephanie Ayala at sayala@dcha.org to express their interest and schedule an introductory call with the Perinatal Quality Collaborative (PQC)
  - Registration with the PQC this fall will be critical for participants in the TMaH Provider Incentive Program, as participation in this bundle will be a Year 2 Milestone

- Beneficiary Focus Groups
  - Community of Hope is conducting focus groups with prenatal and postpartum Medicaid beneficiaries in the District to gain insight on their experience of care.
  - Recruitment flyers will be emailed after this meeting; please share with eligible community members

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

Background Info

The District Must Meet Milestones for 10 Key Care Elements by End of Year 3

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Increase access to the midwifery workforce • Increase access to birth centers • Cover doula services • Improve data infrastructure • Develop payment model	• Support implementation of AIM patient safety bundles • Support "Birthing-Friendly" hospital designation	• Increase risk assessments, screenings, referrals, and follow-up for perinatal depression, anxiety, tobacco use, substance use disorder, and health-related social needs (HRSN) • Increase home monitoring of diabetes and hypertension • Develop health promotion and disease prevention plan

The District Can Elect Up To 8 Optional Care Elements; Milestones TBD

Pillar 1 Access, Infrastructure & Workforce	Pillar 2 Quality Improvement & Safety	Pillar 3 Whole Person Care Delivery
• Cover certified midwives (CMs) and certified professional midwives (CPMs) • Cover perinatal community health workers (CHWs) • Create regional partnerships in rural areas • Extend Medicaid eligibility to 12 months postpartum	• Promote shared decision-making	• Expand group perinatal care • Increase use of home visits, mobile clinics, and telehealth • Expand oral health care