LOGISTICS

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- Phone lines are **muted** upon entry.
- To **submit comments or questions**, click the Chat icon at the bottom of your screen.
- To enable **closed captioning**, click the closed caption icon on the bottom of your screen or press Ctrl, Shift, A.
- For help with **technical issues**, send a message through the Chat feature.
- The **slides and a recording** of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.
- Right-click on your name in Zoom, select “Rename,” and **add your organization to your name**.

From Shared Understanding to Action:

Application of Best Practices for Seamless Maternal Health Care

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
Zipatly Mendoza, MPH
Olivia Reding, MPH, PMP
Michele Bosworth, MD
Kelli Stannard, BSN, RN
Julie Rabinovitz, MPH

Tuesday, June 9, 2026
11:30 AM–12:30 PM ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF). This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS). A total of $1,527,057.67, or 57 percent, of the project is financed with federal funds, and $1,147,478.36, or 43 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS or the U.S. Government.

DHCF
Department of Health Care Finance

HMA

TODAY'S AGENDA

INTEGRATED CARE DC
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- Welcome and Session Orientation
- Themes From Initial Engagements
- Evidence-Based and Best Practices
- Breakout Sessions: Applying Evidence-Based Practices
- Full Group Debrief: Emerging Themes and Opportunities
- Conclusion and Next Steps

Image Source: Microsoft 365 Stock Photos

LEARNING OBJECTIVES

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- Summarize cross-provider themes and coordination challenges identified through engagement with Transforming Maternal Health (TMaH) Model providers.
- Recognize real-world and evidence-based approaches to address identified challenges in providing seamless perinatal and postpartum health care.
- Describe practical opportunities to strengthen coordination and closed-loop referrals within existing roles and systems.
- Identify priority areas for continued technical assistance and Learning Collaborative support.

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Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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CONTINUING MEDICAL EDUCATION/CONTINUING EDUCATION (CME/CE) CREDIT PROCESS

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2025–09/22/2028. Social workers completing this course receive 1 continuing education credit.
  - *To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.*
- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 05/12/2026 to 05/11/2027. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1 Online Only, Live AAFP Prescribed credit.
  - **If you would like to receive CME credit, the online evaluation will need to be completed.**
  - You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 12 business days of course completion.

THEMES FROM INITIAL ENGAGEMENTS AND BEST/EVIDENCE-BASED PRACTICES

KEY THEMES

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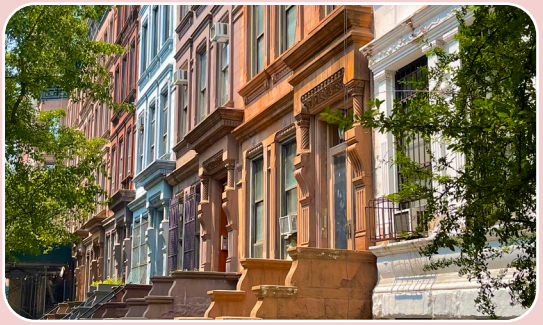
From our initial engagements with you, we have identified the following key themes.

Building trust and offering support to patients who use marijuana in a way that encourages engagement in care.

Strengthening gaps in screening and referrals in the postpartum period, particularly regarding domestic violence.



Identifying resources and establishing partnerships to address health-related social needs (HRSN) and ensure provision of needed perinatal and postpartum care.

Ensuring that patients have the support systems in place to meet physical, mental, and emotional health needs throughout their perinatal and postpartum journey.

Images Source: Microsoft 365 Stock Photos

EVIDENCE-BASED PRACTICES: MARIJUANA USE

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Image Source: Microsoft 365 Stock Photos

- **Recovery Doulas and Peer Support Models:** Maternal health programs are encouraging doulas to pursue specialized “recovery doulas” training (as pioneered by the Recovery Doula Alliance), and physician groups and federally qualified health centers (FQHCs) to partner with recovery doulas and peer mentors to strengthen support for pregnant and postpartum women with substance use disorders, including cannabis use.
- **Universal Screening and Brief Intervention:** Universal screening for cannabis use during the pre-pregnancy, pregnancy, and postpartum periods is now recommended.
- **Patient/Client Education on Risks and Abstinence:** Provide clear, evidence-based education about cannabis risks and advise abstinence during pregnancy and the postpartum period.
- **Harm Reduction Strategies for Cannabis**: Consider an emerging framework in perinatal substance use care that meets women “where they are” to reduce negative consequences of use.
- **Collaboration with Specialized Services:** Build linkages to substance use treatment, mental health services (like the DC Mother-Baby Wellness program), and other specialized services that understand perinatal needs.

EVIDENCE-BASED PRACTICES: MARIJUANA USE (CONT'D.)

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Image Source: Microsoft 365 Stock Photos

Tell Us!

In the chat or come on video and off mute!

How are you using the approaches discussed today to support pregnant and postpartum individuals with cannabis or other substance use?

BEST PRACTICES: DOMESTIC VIOLENCE

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Image Source: Microsoft 365 Stock Photos

- **Partnerships with Domestic Violence Organizations:** Collaborate with local DV groups, such as DC Coalition Against Domestic Violence or DC SAFE, to facilitate trainings and identify resources and referrals.

- **Establishing Domestic Violence-Specific Safety Protocols**

  - Establish clear protocols and assign specific team roles for domestic violence screening, brief intervention, and follow-up care.
  - Follow strict privacy and safety protocols when addressing domestic violence, such as ensuring that the patient is alone during interviews, using neutral language, and protecting documentation.
  - Leverage secure communication, electronic health record (EHR) settings, materials, and posted information

Chat with Us!

With which other organizations are you partnering?

EVIDENCE-BASED PRACTICES: DOMESTIC VIOLENCE

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Domestic Violence Enhanced Home Visiting (DOVE) Model

- This model involves home nurses providing structured abuse screening and six empowerment sessions during pregnancy and through 2 years postpartum.
- A randomized clinical trial of DOVE (239 women) demonstrated significant reductions in DV frequency through 24 months postpartum in the intervention group compared to usual care.

» **Ongoing Training for Screening and Referrals**

- Conduct universal periodic screening, provide ongoing support, and conduct reviews of available prevention/referral options.
- Promote long-term client/patient engagement to support better outcomes.
- Implement trauma-informed care principles across maternal health services, such as training providers to recognize trauma and deliver care emphasizing safety, trustworthiness, choice, and empowerment.

» **Home Visiting Integration:** Integrate intimate partner violence prevention into evidence-based home visiting models.

EVIDENCE-BASED AND BEST PRACTICES: HEALTH-RELATED SOCIAL NEEDS

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HRSN Screening and Assessment

Conduct universal HRSN screening that is low-burden for patients, delivered in a setting offering respectful care and privacy.

Build trust, focus on social needs and explain why screening questions are being asked and how information may be used.

Partnerships with Community-Based Organizations (CBOs)

Foster robust relationships with organizations that can meet the social needs of clients are critical.

Stay in close touch with contacts at referral partners to keep up-to-date on services offered and availability.

Provide warm handoffs, ensuring connection to services.

Closed-Loop Referrals to Programs that Address HRSN

Employ high-performing models that move beyond identify and refer to care coordination, connecting clinical and community partners.

Perform real-time tracking to confirm service receipt.

Track closed-loop referrals from start to finish to ensure service receipt and shared accountability for positive patient outcomes.

Data Sharing and Confidentiality

Explore opportunities for low-burden data sharing with CBOs, while protecting patient confidentiality, to improve access to services and outcomes.

Deidentify as much data as possible to respect patient confidentiality while enabling targeted, equitable, and efficient community interventions.

Sources: American College of Physicians. Transforming Clinical Practice Initiative: Closing-the-Loop. https://www.cms.gov/priorities/innovation/files/x/tcpi-san-pp-loop.pdf
Anoosha Han, Addressing Social Determinants of Health for Pregnant and Postpartum Medicaid Beneficiaries, NASHP, June 24, 2024. https://nashp.org/addressing-social-determinants-of-health-for-pregnant-and-postpartum-medicaid-beneficiaries/

Images Source: Microsoft 365 Stock Photos

HEALTH-RELATED SOCIAL NEEDS RESOURCES IN THE DISTRICT

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DC in Action

- **LinkU Platform**
  - Centralized tool for screening, referral, and tracking outcomes.
- **CRISP DC (Health Information Exchange)**
  - Integrates screening and referral data into clinical workflows
  - Enables shared visibility and coordination across providers
  - For CRISP DC-related inquiries, let your coach know and we'll connect you to the correct resources.

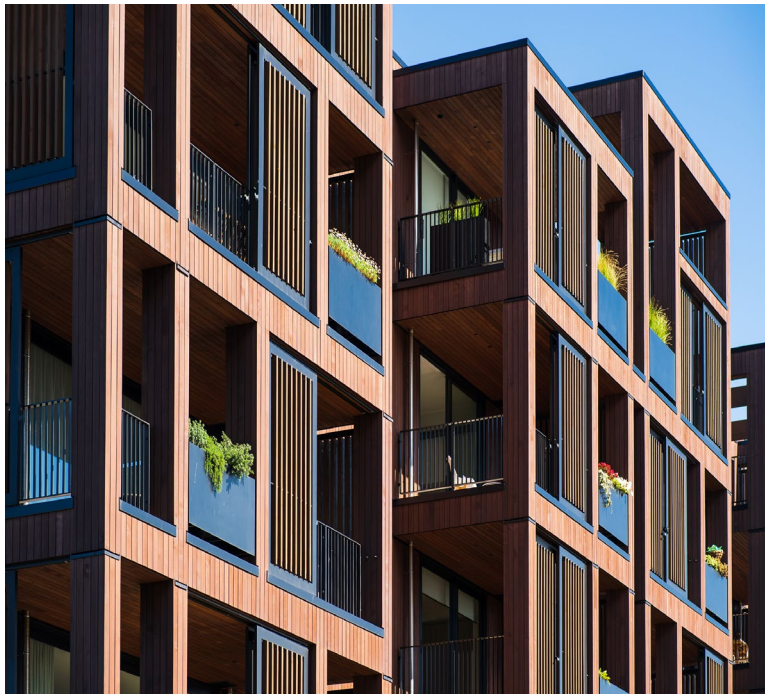

Image Source: Microsoft 365 Stock Photos

CROSS-PROVIDER BREAKOUTS: APPLYING EVIDENCE-BASED PRACTICES

BREAKOUT ROOM LOGISTICS

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Breakout Group Composition

- Participants will be placed into three to four mixed-provider groups with facilitator:
  - Physician groups, FQHCs, doulas, and PCHWs
  - Up to eight participants to support meaningful discussion

Breakout Group Activities

- Introduce yourself; join on video and come off mute!
- Facilitator to briefly summarize one of the three personas created with The Lab @ DC
- Discuss barriers identified by each assigned persona
- Select one participant to report back key themes

Breakout Discussion

- Discuss your experiences applying evidence-based practices and opportunities to address barriers, using personas to guide the discussion
- Not intended to refine, edit, or finalize journey maps during this session

BREAKOUT SESSION: LISA

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- Discuss Lisa and her current pain points:
  - Lack of a support system
  - Stable housing uncertainty and unreliable transportation.
  - Marijuana use to address anxiety.
  - *Others?*
- Apply Evidence-Based Practices
  - Screening opportunities
  - Referral improvements
  - Postpartum care
  - Role definition
  - Integrated care
  - Client privacy

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

Image Source: The Lab @ DC

BREAKOUT SESSION: LISA

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Perinatal

First Prental visit

Mental Health Screenings- PASS/PHQ9

ONAF form - helps identify HRSN needs early

Outpt screens - referrals go to the GW social worker, so that they have it at delivery and they can meet before they leave the hospital

Barrier: client doesn't share their needs / situation

Housing referrals: barrier (the process itself, as well as interpersonal interactions)

Labor and Delivery

Have SW meet with postpartum client before leaving the hospital

Postpartum

postpartum visit

BREAKOUT SESSION: SASHA

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- Discuss Sasha and her current pain points:
  - Unreliable transportation and unstable housing.
  - Unemployed.
  - Lack of a support system to balance parenting and wellbeing needs.
  - *Others?*
- Apply Evidence-Based Practices
  - Screening opportunities
  - Referral improvements
  - Postpartum care
  - Role definition
  - Integrated care
  - Client privacy

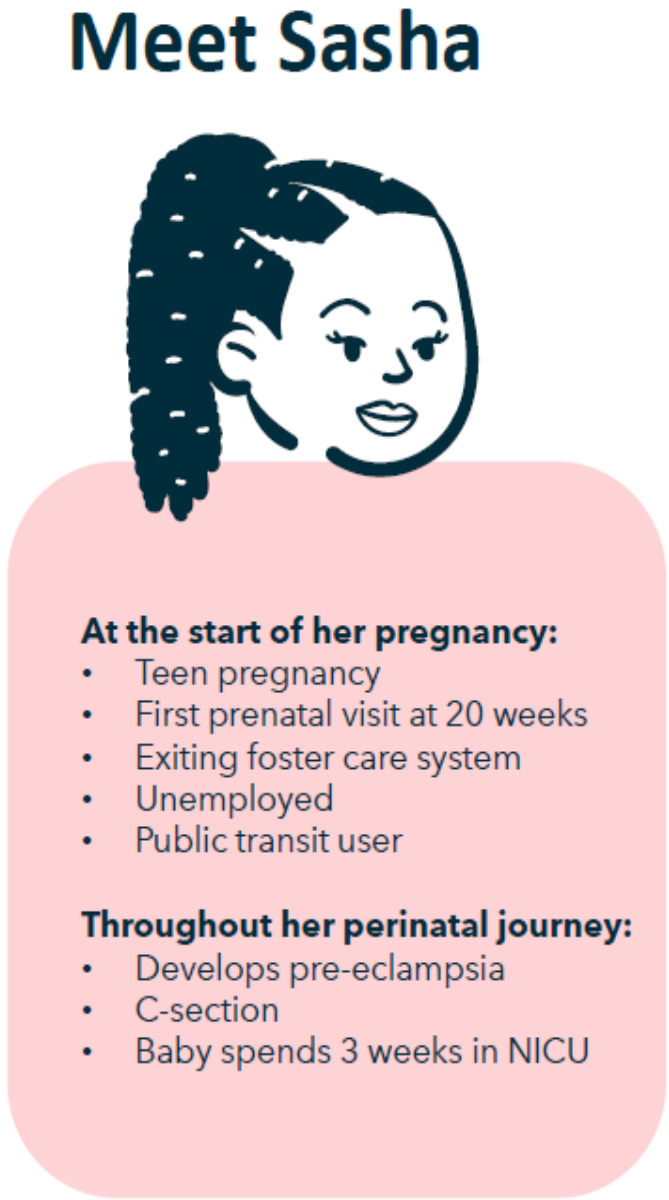

Image Source: The Lab @ DC

BREAKOUT SESSION: SASHA

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Perinatal

- tools for screening that patient feel comfortable completing in a safe space
- What their mental health is at the time and past mental health.
- understanding health insurance and all benefits associated with.
- Communication, making sure Sahsa is included in conversations around her care in a way she can digest it. CJ
- Educate yourself about the housing process, policies and resources in clients area
- provide ride vouchers to appointments
- Columbia risk scale to assess safety. Assessment of her supports and help build that list.
- Connect patient to case manager on-site to address SDOH concerns
- Build relationships between providers and doulas
- monthly or routine meetings among various care team members to discuss HR paiteints
- direct lines of communication between team, collaborative team environment
- EPDS (BH clinician or OB) & PRAPARE, at Unity all patients are screened with PHQ2 at all visits
- Screen for behavioral health and SDOH (at least) each trimester in attempt to stabilize before delivery.

Labor and Delivery

- Full support during L&D as a doula, advocating for her needs.
- Helping the patient understand the process of labor and delievey.
- Helping the patient understand they have a say in their care in the hospital.

Postpartum

- transition from the hospital home, having resources to care for baby and coordination of PP appointmetn and care
- As a Doula, understanding where to refer for housing.
- Also referring someone to a place thats really gonna help.,

BREAKOUT SESSION: MIRANDA

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» Discuss Miranda and her current pain points:

- Unreliable transportation and unstable housing.
- At risk for domestic violence.
- Lack of a support system to manage parenting a child with special health care needs and an infant, along with domestic violence risk with spousal arguments.
- *Others?*

» Apply Evidence-Based Practices

- Screening opportunities
- Referral improvements
- Postpartum care
- Role definition
- Integrated care
- Client privacy

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

Image Source: The Lab @ DC

BREAKOUT SESSION: MIRANDA

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Perinatal

Family Support Worker ❤️

Social Worker, OB/Midwife ❤️

Perinatal Community Health Worker, OB

Labor and Delivery

Doula
PCHW
OB

DV and substance use screening occurs in L&D, but not all social needs are covered

Housing is not asked during L&D more in postpartum period but if screening questions are asked guests are asked to leave the room

Doula, Nurse

Difficulty ensuring privacy for domestic violence screening during labor & delivery

Postpartum

PP Doula
PCHW
Social Worker
Pediatrician

Sharing postpartum discharge notes with doulas and care team can improve continuity

Care coordination across providers (doulas, physicians, FQHCs) is needed

Postpartum doula
Pediatrician
OB

Across all Stages of Preganancy

People may have complex needs often missed by screening tools that are singular and straightforward on the kind of needs people may have.

Screening tools are too simplistic and do not capture complex needs

Confidentiality challenges can prevent disclosure needed for referrals

Demand exceeds resource capacity "need outweighs capacity"

WHITEBOARD INSTRUCTIONS

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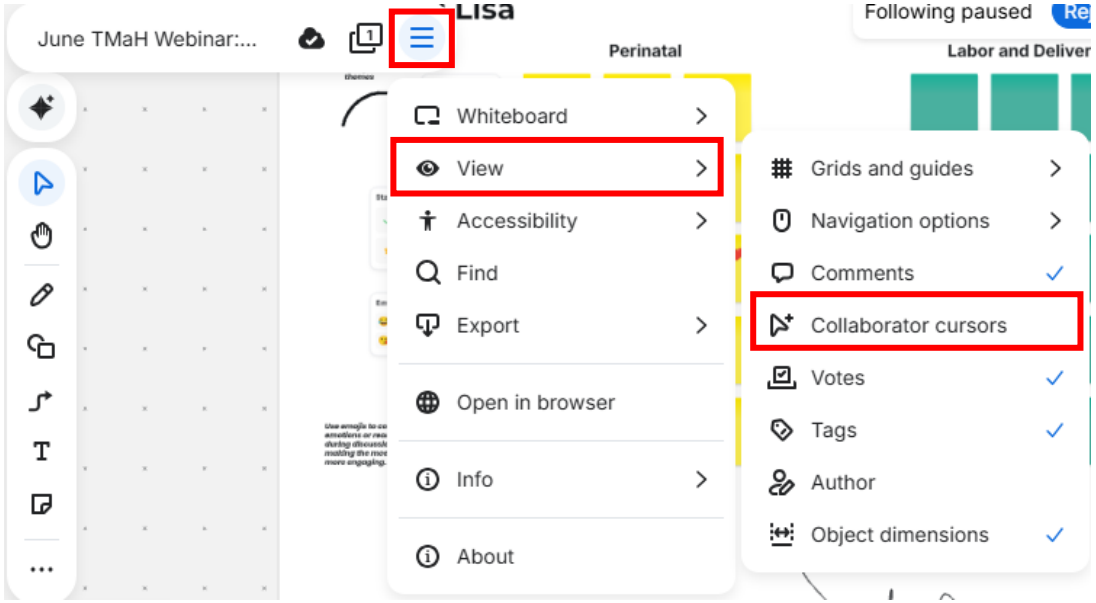
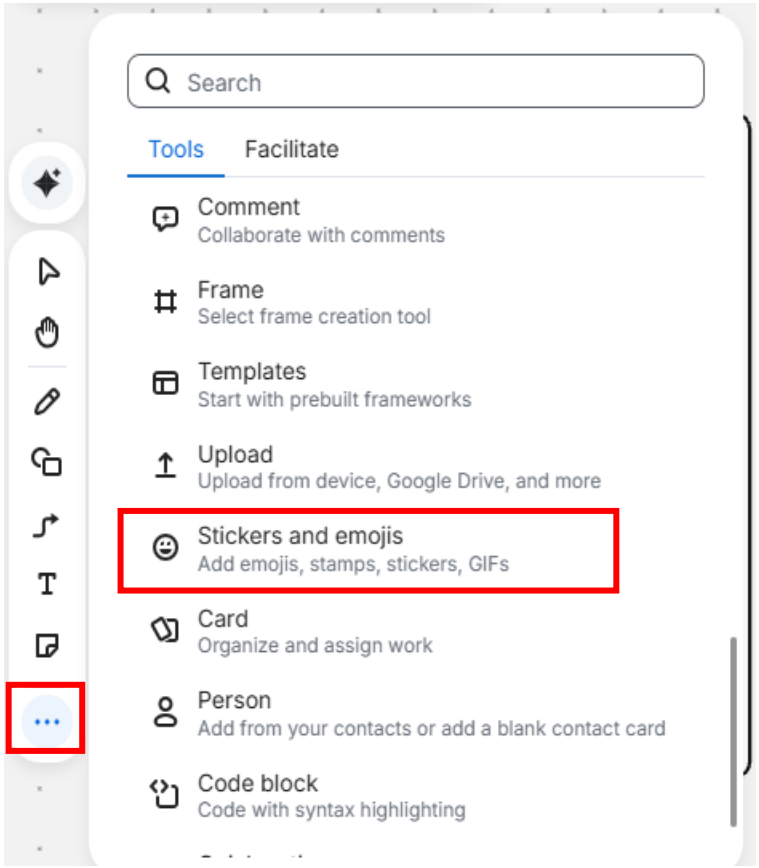
When the **Whiteboard** is shared, you should see **sticky notes** on the screen under each category.

To add content to one, click on a **Sticky Note** and this toolbar will appear. Then use the T button to enter text (outlined in the **red box**).



If you do not want to see everyone's mouse moving along the screen (as it can be distracting), follow the path laid out in this screenshot and **Uncheck** the **Collaborator cursors**.



If you like something added by one of your colleagues and would like to react to that note, you can add stamps, stickers, or emojis.

To do this, go to the **button of 3 dots** at the bottom of this **toolbar** on the left of your screen (outlined in **small red box**).

Then scroll down until you fins the **Stickers and emojis** option (outlined in **red rectangle**).

Image Source: Zoom screen capture.

FULL GROUP DEBRIEF: KEY AREAS OF REFLECTION

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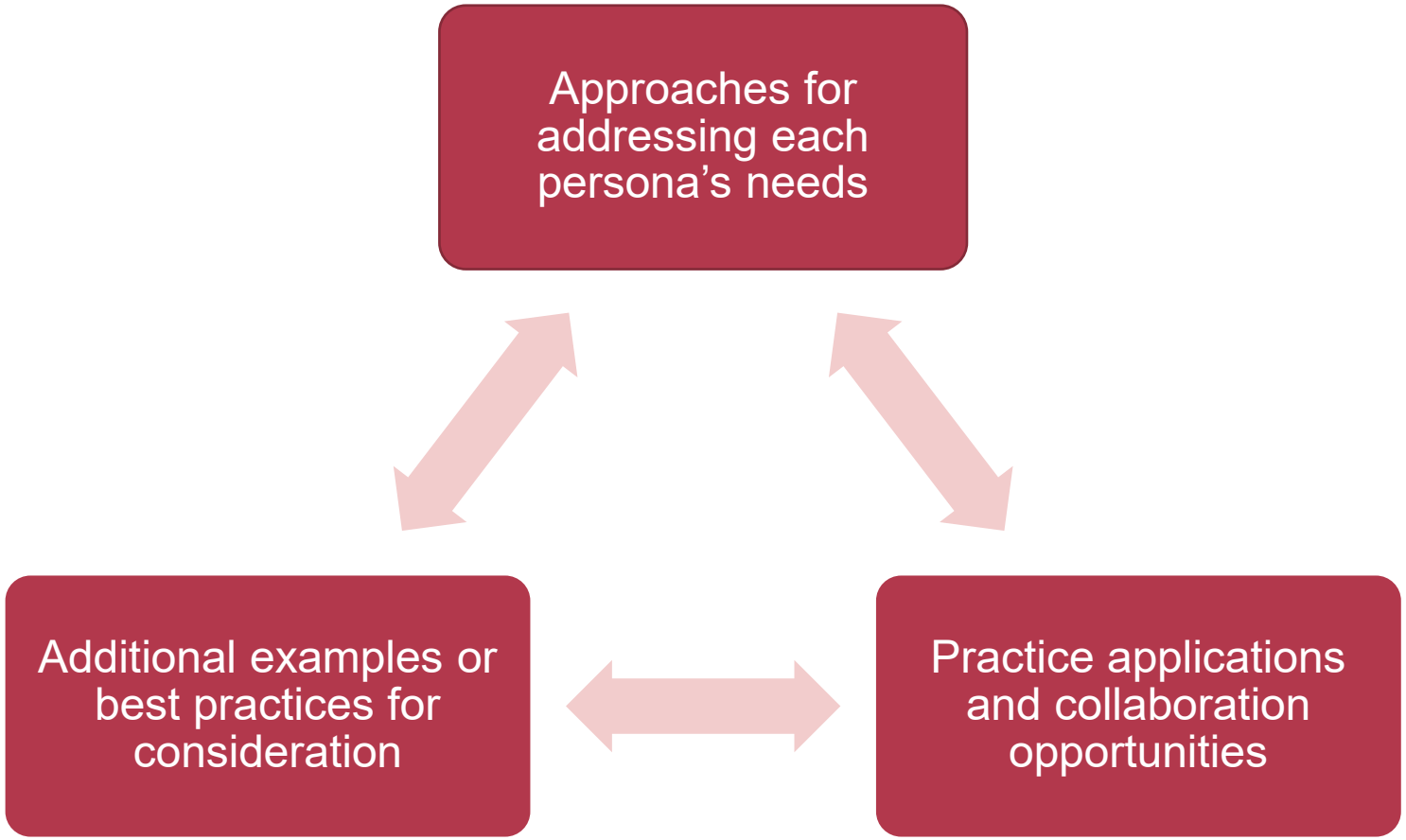

Image Source: Microsoft 365 Stock Photos

FULL GROUP DEBRIEF: OUTPUT

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- Strive to **standardize screening** across the perinatal and postpartum period.
  - Once a patient brings a concern what is available in the District for a referral, and who handles it? How are language and literacy barriers considered and addressed? Someone able to walk the person through the process is most helpful/impactful.
  - Best practice: Outpatient referrals that are built into the hospital to address post-delivery.
- Use screening to identify SDOH supports, understand current/past mental health history, and ensure that the patient understands recommendations in their terms and that providers educate themselves on the practices/policies.
  - During labor and delivery, help patients understand the delivery process and that they have a say in their care so they can advocate and coordinate for themselves.
  - In the postpartum period, support patients with determining transportation for care and available resources.
- **Integrate care teams** (PCHWs, OB/GYNs, doulas, midwives)
  - Determine what questions are asked, when, and by whom to identify, document, and address needs.
  - Share postpartum discharge notes with broader care teams and assess referral capacity.

Image Source: Microsoft 365 Stock Photos

Connecting Insights to What's Next

- Themes identified will help shape:
  - Upcoming group learning topics
  - Areas for deeper peer discussion
  - Priority focus for practice-specific TA

REMINDERS AND NEXT STEPS

TIMELINE FOR 2026

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May
Cross-Provider Journey Mapping (5/12/26)
1:1 TA

June
Improving Coordination Across Screening and Referral Workflows (6/9/26)
1:1 TA

July
Group Learning (7/14/26)
1:1 TA

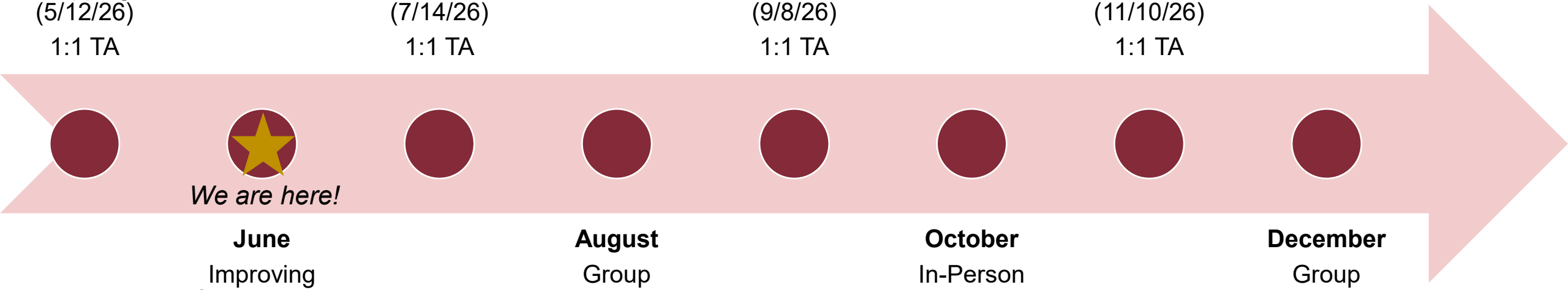
August
Group Learning (8/11/26)
1:1 TA

September
Group Learning (9/8/26)
1:1 TA

October
In-Person Workshop (10/20/26)
1:1 TA

November
Group Learning (11/10/26)
1:1 TA

December
Group Learning (12/8/26)
1:1 TA



MILESTONE 7 ACTIVITIES DUE DATE

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All Milestone 7 activities (Learning Collaborative participation) and required documentation must be completed and uploaded in D-TIPs by **December 15, 2026**, to receive the incentive payment of $15,000.

Image Source: Microsoft 365 Stock Photos

LOOKING AHEAD: NEXT STEPS

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Homework

- Consider which themes and pain points most resonate with you and your patients.
- Identify one or two evidence-based practices discussed today that you would like to consider advancing in your practice for your individual coaching sessions.

Collaboration and Support

- **Individual Coaching**: All participants should have individual coaching sessions scheduled with their assigned coaches!
- **Goal**: Complete all sessions before **December 15, 2026**.

Coming Next!

- **Session 3**: Tuesday, July 14, 2026, 11:30 AM–12:30 PM
  - **Focus**: Strengthening operational sustainability for maternal health providers through Medicaid payment and revenue strategies, including breakout sessions on value-based payment and Medicaid billing and revenue optimization.
- **In-Person Workshop**: Tuesday, October 20, 2026 (***SAVE THE DATE!***)

WRAP UP AND NEXT STEPS

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- Please complete the online **evaluation by <u>June 18</u>!**
  - **<u>If you would like to receive CME and CE credit, the evaluation will need to be completed</u>.** You may use the link in the chat box or scan the QR code to access the evaluation.

- The slides and a recording of the webinar will be emailed to registered participants and available soon on the Integrated Care DC website.

- For more information about Integrated Care DC, please visit: www.integratedcare.dc.gov

CONTACT US

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All content was created and delivered by HMA.

For the Amazing Work You Do!

APPENDIX

DC HOMELESS CONTINUUM OF CARE

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"Front Porch" Services	Short-term Placement / Interim Housing	Permanent Housing
Daytime Services Center	Outreach Beds	Rapid Re-Housing (RRH)
Central point of access for households seeking homeless assistance services.	Very small, specialized shelter for hard-to-reach individuals, often with severe and persistent mental illness.	Short- to medium- term supportive services and housing subsidy.
Street Outreach	Emergency Shelter	Permanent Supportive Housing (PSH)
Engagement services for hard-to-reach, chronically homeless individuals sleeping on the street.	Short-term emergency housing for the majority of households entering the homeless services system.	Intensive, wrap-around supportive services and long-term housing subsidy or affordable unit
Prevention/Diversion	Transitional Housing	
Assistance at front door of shelter system to prevent housing loss and stabilize households outside of shelter.	Therapeutic, communal environment for special populations (e.g., victims of domestic violence and individuals with substance abuse issues)	

SERVICE LANDSCAPE

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Prevention	Transitional/ Short-Term	Permanent Housing
• **Emergency Rental Assistance Program (ERAP)-** DC residents earning less than 40% of AMI facing housing emergencies. Provides funds for overdue rent to prevent eviction; security deposit for new apartments • **Homelessness Prevention Program (HPP)** – for families; provides emergency housing outside of shelter; low level of CM • **DC Flex**: 5yr rental subsidy program for low-income working families, where families get $8,400 per year to supplement income gaps needed for rent	• Low Barrier Shelter (10) • Short Term Family Housing (7) • Bridge Housing (3) • Transitional Housing (57) • Non-congregate Shelter (2)	• Rapid Rehousing • Permanent Supportive Housing

EMERGING PRACTICES: DOMESTIC VIOLENCE

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Emerging practices:

- **Digital Safety Planning Tools:** Leverage technology to support survivors. Smartphone apps and online tools (e.g., the myPlan research-based mobile app created by survivors and Johns Hopkins researchers that guides users through decision-making) enable women to privately assess their risk and develop individualized safety plans.
- **Integrated Housing & Legal Support Initiatives:** Some communities are pioneering programs that integrate maternal healthcare with social services to address root causes of postpartum IPV. For example, initiatives are emerging that co-locate OB/GYN with DV services, housing supports, and other resources. (like the District Alliance for Safe Housing in DC).
- **Peer Support and Survivor Mentorship:** Peer-led support groups or survivor mentorship programs for pregnant/postpartum women are emerging as an innovative method to reduce isolation and enhance coping for DV survivors. In such programs, individuals with lived experience of overcoming perinatal IPV (or trained doulas with special DV expertise) provide mentorship, accompany survivors to appointments, or co-facilitate support circles.

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INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

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