



Maternal Health Advancement in Community Health Centers

Featuring:

- Moderator: Kelly McGowan (Health Resources & Services Administration Department of Health & Human Services)
- Dr. Gracie-Ann Roberts (Community Health Center of Richmond)
- Dr. Meleen Chuang (NYU Family Health Centers)

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COMMUNITY HEALTH
CENTER OF RICHMOND

Gracie-Ann Roberts, DMSc, MPH, PA-C, CPHQ
Chief Quality Officer

June 27th, 2025



Community Health Center of Richmond Inc

Federally Qualified Health
Center founded in 2006

Four locations

NCQA NYS Patient-Centered
Medical Home recognized

Joint Commission accredited

NCQA Behavioral Health
Distinction

Serving ~11,000 unique
patients annually with
~40,000 total patient visits

Internal Medicine
Pediatrics
Obstetrics
Gynecology
Dentistry

Behavioral Health
Nutrition
Maternal & Child health
services

Maternal and Child Health Division

Healthy Start

Perinatal and Infant
Community Health
Collaborative (PICHC)

MIH Breastfeeding &
Infant Safety Initiative

Direct Doula Services

Cribs for Kids

Staten Island Perinatal
Network

Comprehensive Family
Planning Program

Special Supplemental
Nutrition Program for
Women Infants and
Children (WIC)

Coordinated Intake
Process

QIF-MH EPCP

Centering Pregnancy

Maternal Child Health Team

2017 (Total=8)

- Manager, MICHC
- Manager, Community Partnerships
- Case Manager (3)
- Community Health Worker (3)

2025 (Total=19)

- Manager, Healthy Start
- Manager, Maternal & Child Health Operations
- Director, WIC
- Doula Coordinator
- Case Manager (6)
- Clinical Case Manager
- Community Health Worker (5)
- Fatherhood Coordinator
- Breastfeeding Educator
- Family Planning Coordinator

Enhanced Postpartum Care Project (EPCP)

Enhanced Postpartum Follow-up
schedule

Postpartum Care Plan

Transportation Support

Postpartum Doula

Remote Patient Monitoring

Enhanced Postpartum Follow-up Schedule

- 3 weeks postpartum (Medical & CHW visit)
- 6 weeks postpartum (Medical & CHW visit)
- 12 weeks postpartum (CHW visit)
- 6 months postpartum (Medical & CHW visit)



Postpartum care plan

Postpartum Care Team

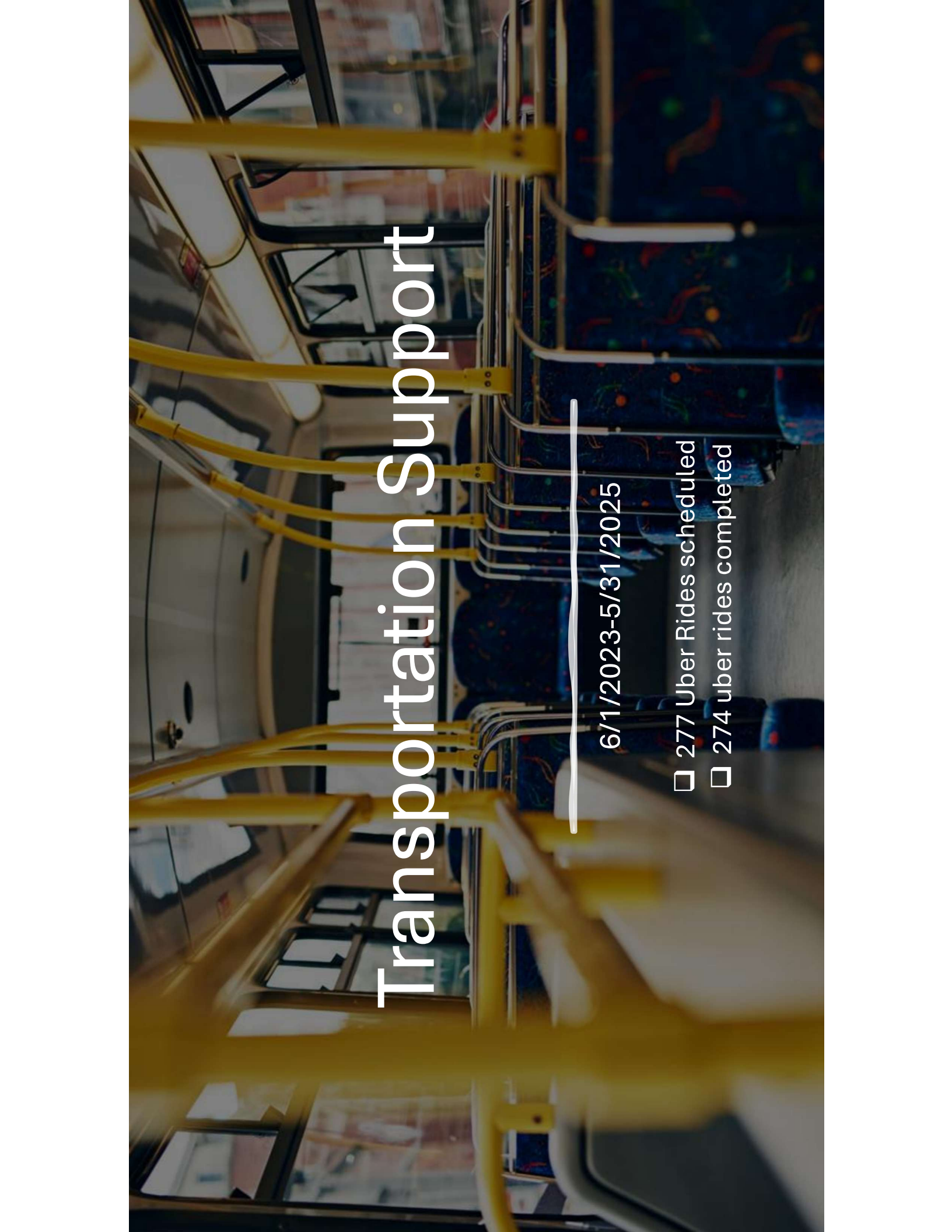
Infant feeding plan

Medical Visits

Maternal Health plan

Support team

Wellness activities

The background of the slide is a photograph of the interior of a bus. It features yellow handrails and blue seats with a colorful, abstract pattern. The text is overlaid on this image.

Transportation Support

6/1/2023-5/31/2025

- ☐ 277 Uber Rides scheduled
- ☐ 274 uber rides completed



Postpartum Doulas

6/1/2023-5/31/2025

- 134 patients requested postpartum doula
- 131 patients matched with postpartum doula

Postpartum Care Plan and Follow Up Rates

243 postpartum care
plans completed
(6/1/2023-5/31/2025)

Postpartum follow
up rate 87.5%
(10/1/2023-3/31/2025)

Client Feedback

- “When I first got the call to come up with a postpartum care plan, I was like ‘I don't need a care plan.’ You know? But actually, going through it and talking through it, helped and really set a perspective for me. It helped in a big way, and it made everything much easier.”
- “It's necessary because there might be a couple things going on... so, having someone call you and spend time with you, actually listening and paying attention to you and following through, following up on your questions and concerns, that's something the majority of us, mothers, parents have never had.”



Quality Improvement Fund: Maternal Health

Perinatal Dashboard
Doula Service
Community Health Worker

June 27th, 2025

Presented by

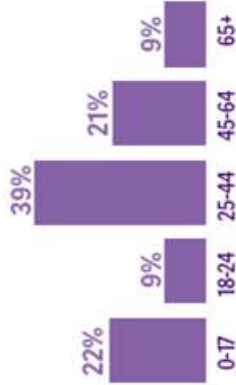
Meleen Chuang MD MBA

Women Health Medical Director NYU Langone Health Family Health Center
Chief of Service OB/GYN

Sunset Park

Population
132,721

Age
Distribution



% Born
Outside U.S.



% Limited
English Proficiency



	Sunset Park	Brooklyn	NYC
Adults without Health Insurance	22%	12%	12%
Adults without Needed Medical Care	4%	10%	10%



Data and graphics from NYC Health's Community Health Profiles 2018

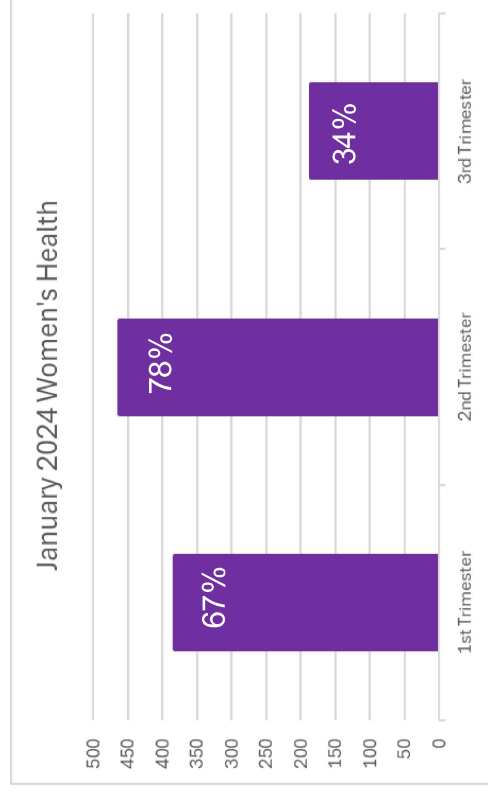
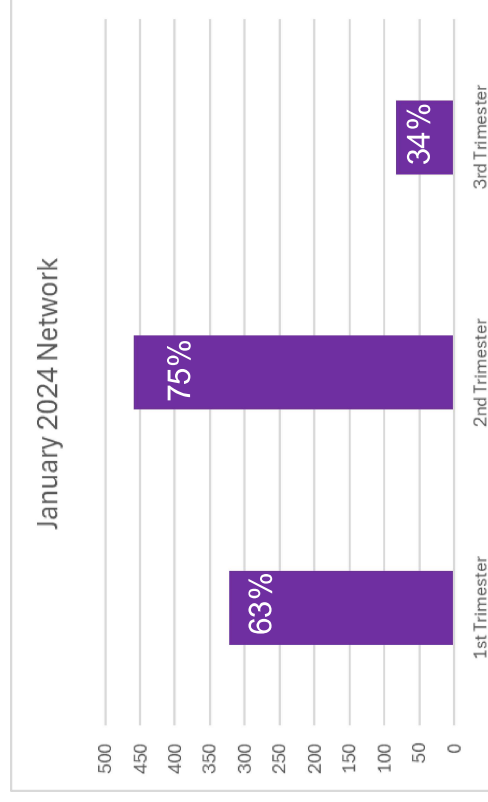
HRSA Quality Improvement Fund in Maternal Health 2023-25 \$2 Million Grant Recipient

Addressed gaps in maternal health outcomes through the development and implementation of perinatal dashboards, and by funding community health workers and doula services.

- **Community Health Workers and Patient Navigators** will reduce missed visits by addressing barriers to care.
- A **Pregnancy Registry Dashboard** will identify opportunities for community health workers to conduct outreach, focusing on patients facing obstacles to care.
- A **Clinical Dashboard** will help identify patients who have missed lab studies, imaging, or prenatal visits, allowing targeted interventions.
- **Travel Funding Opportunities** may allow community health workers to assist patients by picking up essential items, such as strollers, car seats, and infant clothing, from charitable programs for those lacking resources.

OUR SITUATION:

- Prior to 2024, there was no structured mechanism to identify prenatal patients who did not complete pertinent OB lab work



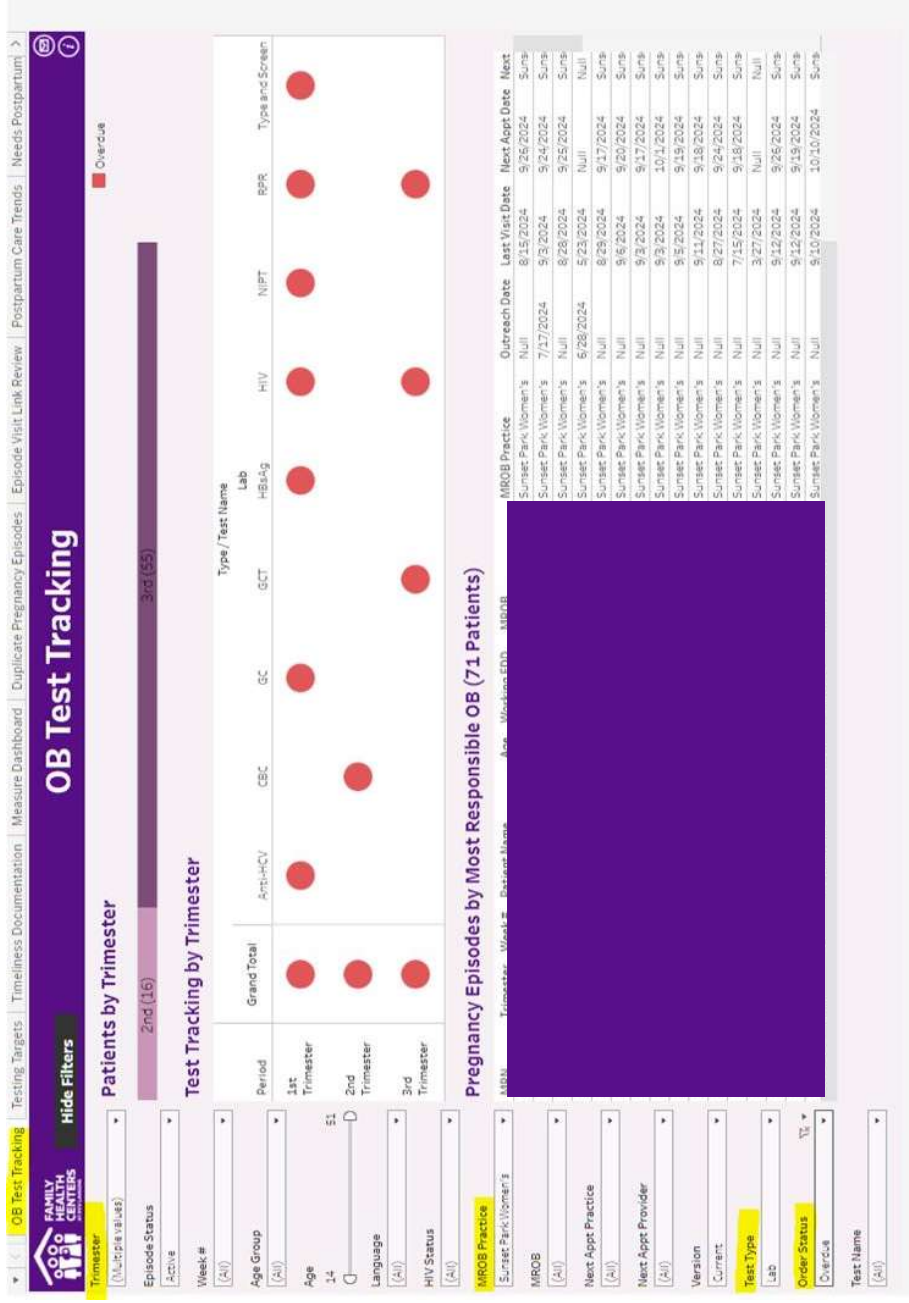
- Percentage Rate of Completed Prenatal Labs for each trimester in January 2024

BACKGROUND: Importance of timeliness for prenatal labs

- Timing of tests can be essential for providing safe and quality prenatal care.
- Timely prenatal labs provide key information to guide the appropriate plan of care for each patient, as well as preparing patients for unfavorable outcomes.
- Certain prenatal testing can only be done, or be most useful within a particular timeframe, such as genetic testing or glucose testing.
- Creating a means to identify prenatal patient gaps in care is pivotal to ensure timely results

BACKGROUND: Utilization of the Prenatal Registry by RNs

- The RN will review the registry on a weekly basis
- To identify the patients with overdue labs the nurse utilizes these filters:
 - ❖ FHC SITE,
 - ❖ TEST TYPE: Labs
 - ❖ ORDER STATUS: Ordered and Overdue

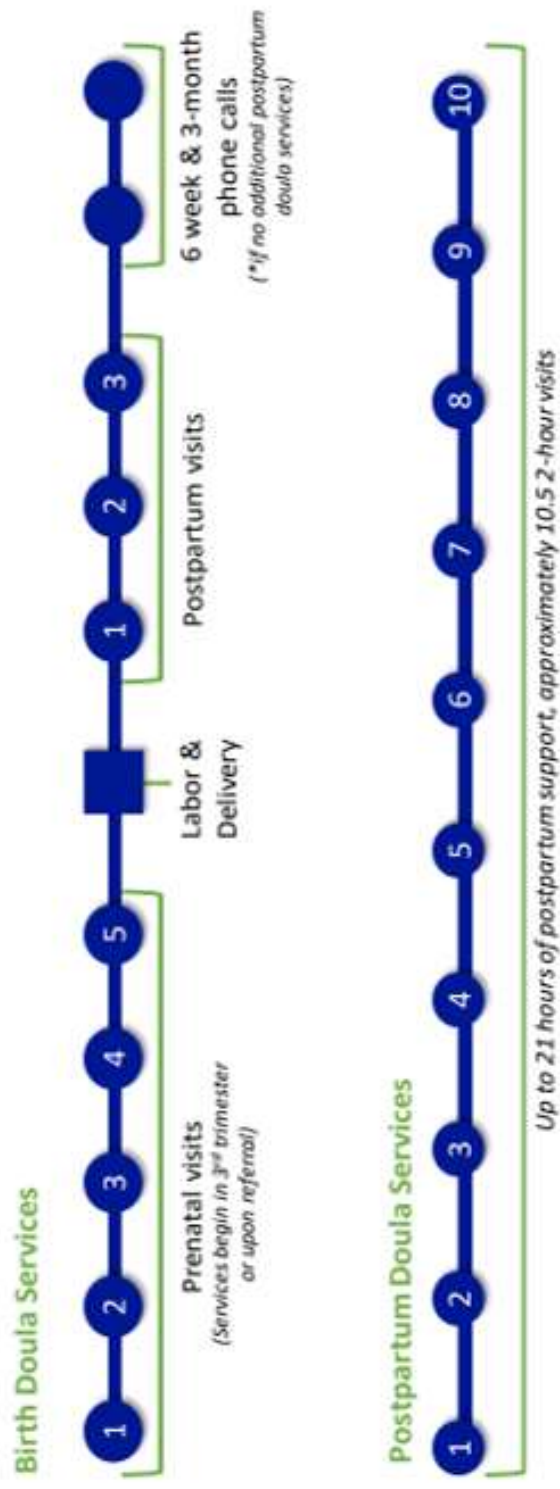


Achieved Goals QIF-MH

Accomplishment	Responsible Parties	Status
Creation of our Tableau Dashboards (QIF-MH and OB Prenatal)	Data/Quality	- Dashboards were created to track, flag and follow up on trimester testing throughout the evaluation period to better service our patient population. - Incorporated the Outreach Details linking the OB smartphrase in EPIC to the dashboard.
Visio Workflows	Quality	- Pathway of the Prenatal Patient - Doula Workflow
Partnership with CWHH	FHC	Partnered with community doula agencies to service 40 women from our Flatbush site and connected these women with Doula services to help service the community.
Non-Medical Needs	CHW	- Expanded prenatal patients' assessments for non- medical needs at other sites by utilizing our community health workers - Through this project we increased our family support services referral service from 77% in Nov 2023 to 96% in April of 2025.

Doula Workflow

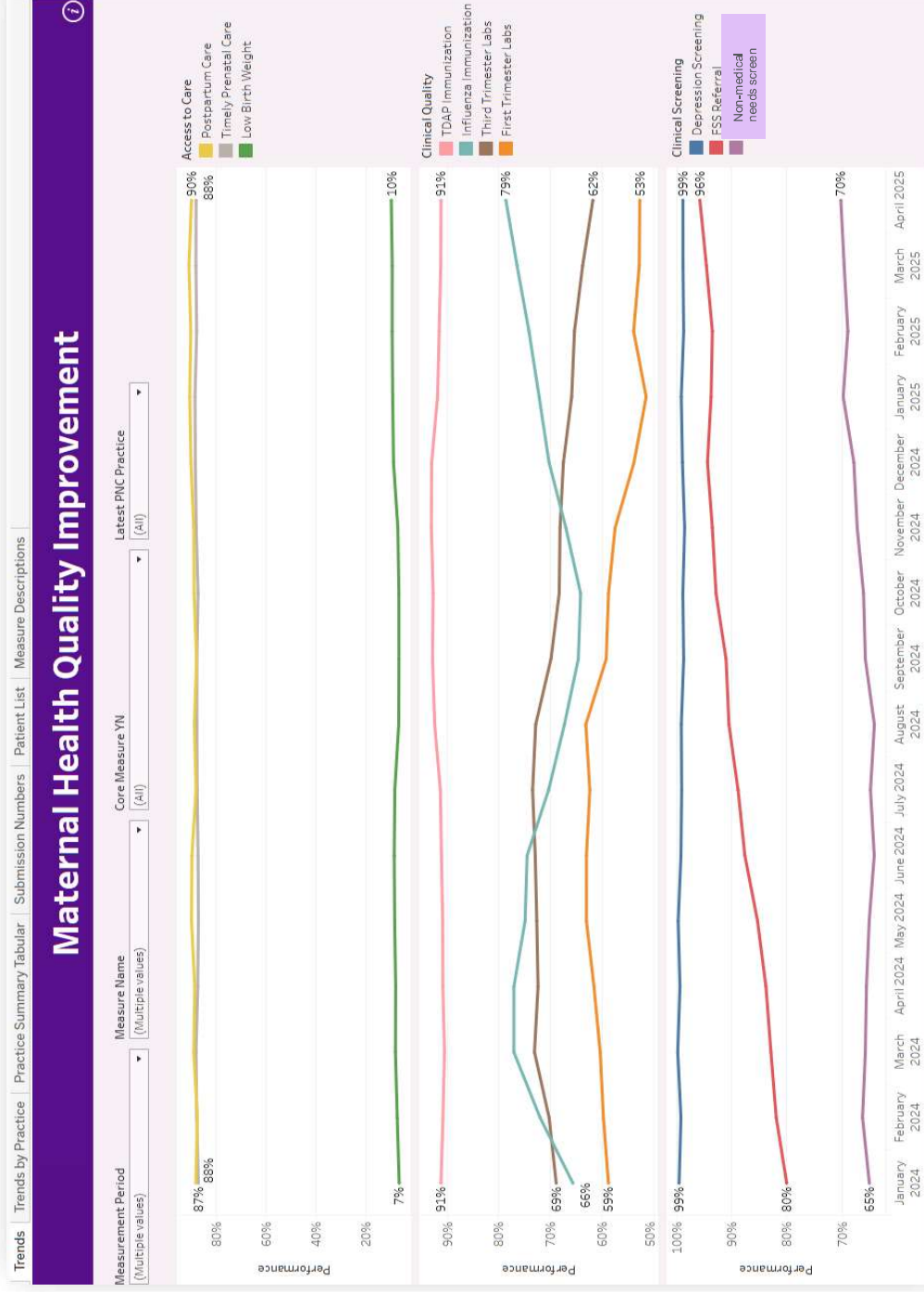
Scope of Services



**FAMILY
HEALTH
CENTERS**
AT NYU LANGONE



QIF-MH QI Dashboard – Back End Users (Quality)



Sustainability Future Projects

Area of Opportunity	Responsible Parties	Next Steps
1 st and 3 rd Trimester Lab Capture	Data/Quality	Continue refinement of the OB Dashboard and monitoring and identifying discrepancies.
Evaluation Report 4	Quality	Collect Final round of data for Evaluation Report 4 (December 24 – May 25) and report out to HRSA by July 5th, 2025.
Final Progress Report to HRSA	FHC	Submission of our Final Progress Report to HRSA.
Labs Due Now	Nursing/Quality	Proactive outreach to Patient List “Due Now” and not just targeting patients that are “Ordered and Overdue”.
Robinhood Grant	FHC	Continued Doula services will be picked up under the new grant.

Thank you!





Thank you!

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