COMMUNITY HEALTH CARE ASSOCIATION of New York State

Data Driven Strategies to Keep Expecting Patients Engaged

Speakers:
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June 27, 2025

Housekeeping

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- **Please add your Health Center/Organization Name next to your name!**
- **Please drop all questions in the chat.**
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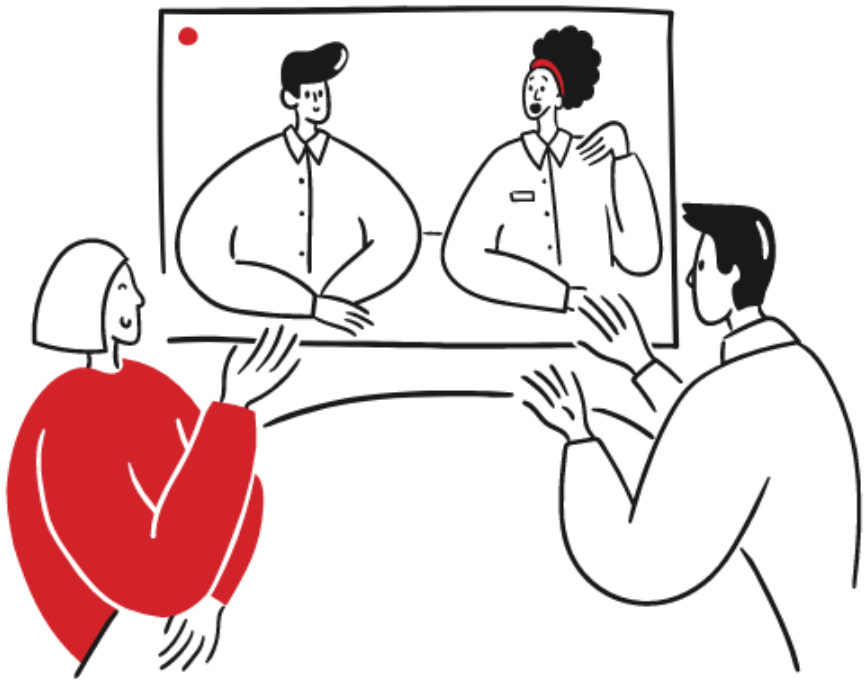


Advancing Maternal Health

Unlocking Insights: Data for Maternal Health Progress

JSI Presenters Today

Emma Ansara

Jillian Maccini

Priorities

A couple of big goals

Moving past relying on calling the patient for information

Having a standardized plan for the data, which will be used for care and reporting

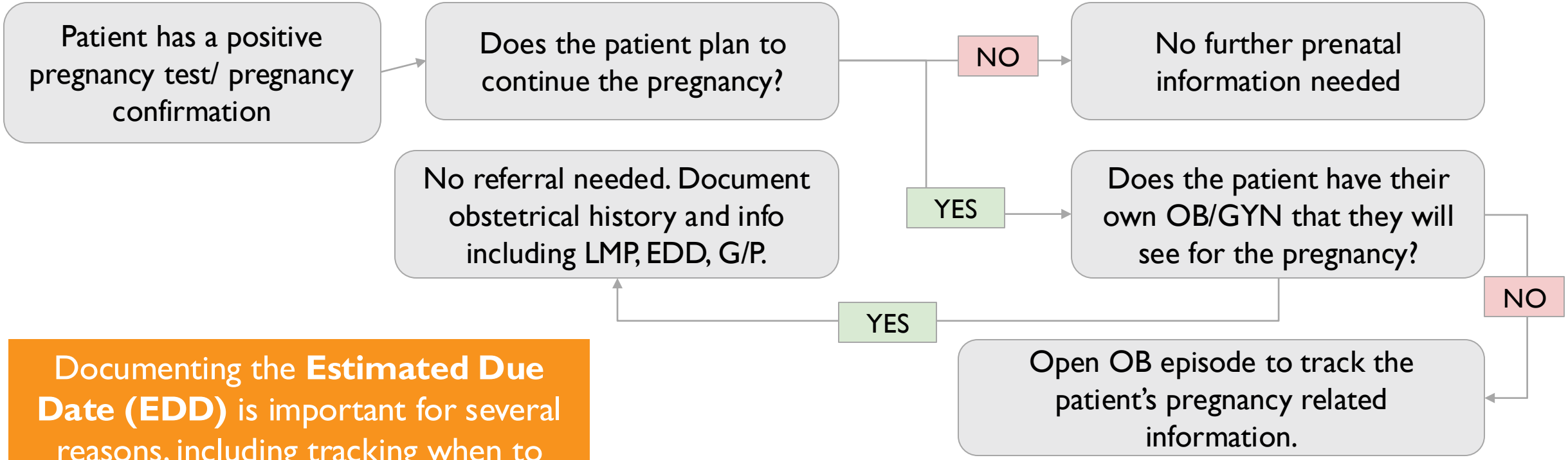
Data is an Outcome of Care

- Caring for patients is the goal, and data collection that can be used to for analysis, planning, and improvement is an outcome of that care!

- The resulting data allows health centers to meet reporting requirements and use data for wraparound care and care planning.

Process

Brief Initial Documentation Workflow



Documenting the **Estimated Due Date (EDD)** is important for several reasons, including tracking when to look for records regarding prenatal visits, birth records, etc. and when to follow up with the patient to bring them back into primary care and perhaps baby into peds.

Opening the **OB episode** is important because it loads up templates and flowsheets that are important for prenatal care, and ensure that information is reportable.

Is the person the Health Center's Prenatal Patient?

Patient is not going to continue the pregnancy	Patient has an OB/GYN who they will see for this pregnancy	Patient needs prenatal care, and will receive that from the health center	Patient needs prenatal care, and will receive that through a referral partner
			

* Relies on UDS

EHR Functionality Important in Prenatal Care

Template Utilization ensures that standard information is captured for efficiency and completeness. Includes key screenings!

Problem List Management including activating and deactivating pregnancy-related problems.

Medication Reconciliation that identifies any contraindications specific to pregnancy or drug interactions.

Order Management including placing labs, imaging, referrals -- and closing them when complete!

Patient Portal/ mHealth integration to allow patients to engage in their own care outside the four walls and have more access and information.

Sticky notes or global alerts that flag important information like high-risk pregnancy, upcoming delivery

Labor, Delivery, and Birth information
Needed for Continuity of Care

Confirmation of delivery, date, time.

Mode of delivery (vaginal, C-section).

Birth weight, APGAR scores, infant sex and other demographics.

Complications during labor/delivery for mother (e.g., hemorrhage, infection, lacerations).

Complications for infant (e.g., NICU stay, birth defects).

Orders/ medications from hospital -- transitioning care, follow up, etc.

what is required for UDS! Other information improtantfor

Options for Getting Pregnancy/L&D Records

Calling the patient or bringing the patient back in, in order to get the labor, delivery and birth information.

Pros:

- Opportunity to re-engage the patient in care

Cons:

- Very hard to reach and engage a busy postpartum patient!

Access information from HIE or RHIO. This may be available directly in the EHR at the point of care or may require logging into a portal.

Pros:

- Does not require reaching the patient.
- Accesses multiple sources at once.

Cons:

- Not all organizations participate in HIE/ RHIO.

Get information from the hospital or delivering provider such as through access to their system (like read-only access to your patient's information in their EHR) or fax.

Pros:

- Full information might be accessed outside the point of care.

Cons:

- Need agreements/ access for each system.
- Can be time consuming to read through notes that don't succinctly summarize necessary data

Practical Considerations

While there is lots of potential upside, **calling patients often has the lowest chance of success** and requires more manual work and comprehensive workflows.

- Having a comprehensive, up-to-date list of patients to call
- Following up with those who aren't reached
- Entering verbal information into the chart in the right place so that information can be used.

Receiving documents that **need to be scanned in or uploaded and attached to the patient's record are higher success** (at least you have the information!) but still require manual work unless other tools/ functionalities are in place.

- Attaching to the appropriate patient/ encounter.
- Still need to enter the information into the appropriate fields in the EHR in order for that information to be reportable.

Accessing data that can then be "pulled" into the patient's chart, such as through APIs, C-CDA documents may take more upfront effort, but may take less overall effort in the end by ideally **pulling that structured data directly** into the patient's chart.

- This level of integration lessens some of the workforce and training needs as well (as staff don't have to enter information into the chart)
- Allows information to be reported.

Outcomes

Better Follow Up

You're able to use the information available to identify the need for follow-up appointments

- Ongoing scheduling or coordination for high risk
- Bringing mom (and baby!) in for ongoing care post-delivery, including postpartum screening, birth control, etc.
- Following up on hospital discharge or transitions of care
- Continuing management of conditions identified in pregnancy

Better Reporting

UDS is one example of where prenatal and birth outcome information is reported, as a clinical quality indicator.

- Early entry into prenatal care
- Low and Very Low Birth Weights

This information from the UDS is also used for funding opportunities like the Quality Improvement Fund Maternal Health Awards in 2023.

There are also metrics for other programs, like Healthy Start or the Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set).

Thank you!

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Harnessing Data to Improve Maternal Health Outcomes

Frank Smith, Senior Director of Quality

Neighborhood Health Center of WNY

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About Neighborhood Health Center

NEIGHBORHOOD HEALTH CENTER

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- 6 brick and mortar locations, plus a mobile unit, located throughout Western New York
- Providing services to over 32,000 patients
  - Internal Medicine
  - Pediatric Medicine
  - OBGYN
  - Behavioral Health
  - Wellness and Nutrition
  - Dental
  - Podiatry
  - Optometry
  - Maternal Fetal Medicine
  - Pharmacy
  - Psychiatry
- Over 350 employees
- 85 providers across all services
- 455 Deliveries in 2024
- 903 pregnant patients cared for

Why Engagement Matters

Goal: Share practical, data-informed strategies to improve maternal engagement across the care journey.

- Regular prenatal care improves birth outcomes and reduces maternal risk.
- Engaged patients are more likely to follow care plans and attend follow-ups.
- Early engagement helps identify and address social and behavioral health needs.
- FQHCs have a unique opportunity to support patients holistically across the maternal health journey.

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Challenges to Overcome

- Social & Environmental Factors
  - Transportation issues
  - Difficulty scheduling around work, childcare, or school
  - Housing instability or homelessness
  - Food insecurity and financial stress
- Health System Navigation
  - Confusion about care plans or visit schedules
  - Delays in care coordination or follow-up
  - Limited trust in healthcare system due to past experiences or uncertainty
- High Clinical Complication
  - Patients with chronic conditions (e.g., diabetes, hypertension)
  - Complex pregnancies needing more frequent monitoring
  - May feel overwhelmed or discouraged from engaging

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Social & Environmental Factors

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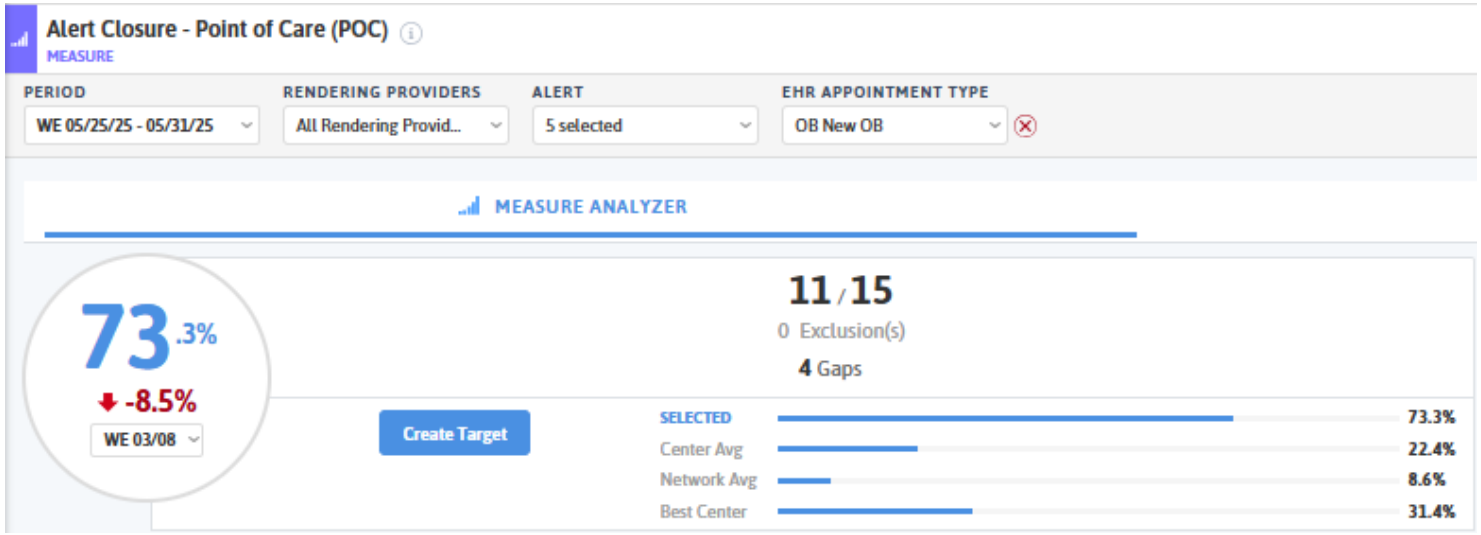
- Standardized, universal screening at all new OB appointments for medical and non-medical needs
  - NYS AHC HRSN Screener
  - Administered and scored by the MA at rooming
  - Reviewed by the provider in the exam room
  - All alerts are included on the Pre-Visit planning document used by front line staff
- Monitor performance
  - Routinely review completion using Alert Closure report in Azara
  - Present individualized results to care teams



Social & Environmental Factors

- How the data is utilized
  - Order sets to update the problem list
    - Standardized order sets to connect positive screenings to ICD 10 codes and automatically generate referrals
    - Each positive indicator on a screener generates its own referral to be followed up on
    - Committee meets monthly to review order set utilization as well as referral volume and follow up

Social Support Referrals (# of Related Referrals - Monthly)	September	October	November	December	YTD
% of Completed referrals (YTD)	20.7%	20.15%	20.3%	21.0%	20.4%
Total # of social support-related referrals	289	466	325	299	2,833
Community Health Worker Referral	89	132	120	83	1,223
Education Assistance	3	14	7	6	58
Employment & Job Training	25	43	24	20	175
Financial Counseling	0	0	0	0	0
Food Assistance Program Referral*	28	40	33	24	271
Housing Support Program Referral*	45	76	42	44	375
Literacy Program Referral	0	0	0	0	0
Patient Transportation*	46	76	35	49	456
Maternity Services	53	85	64	73	275

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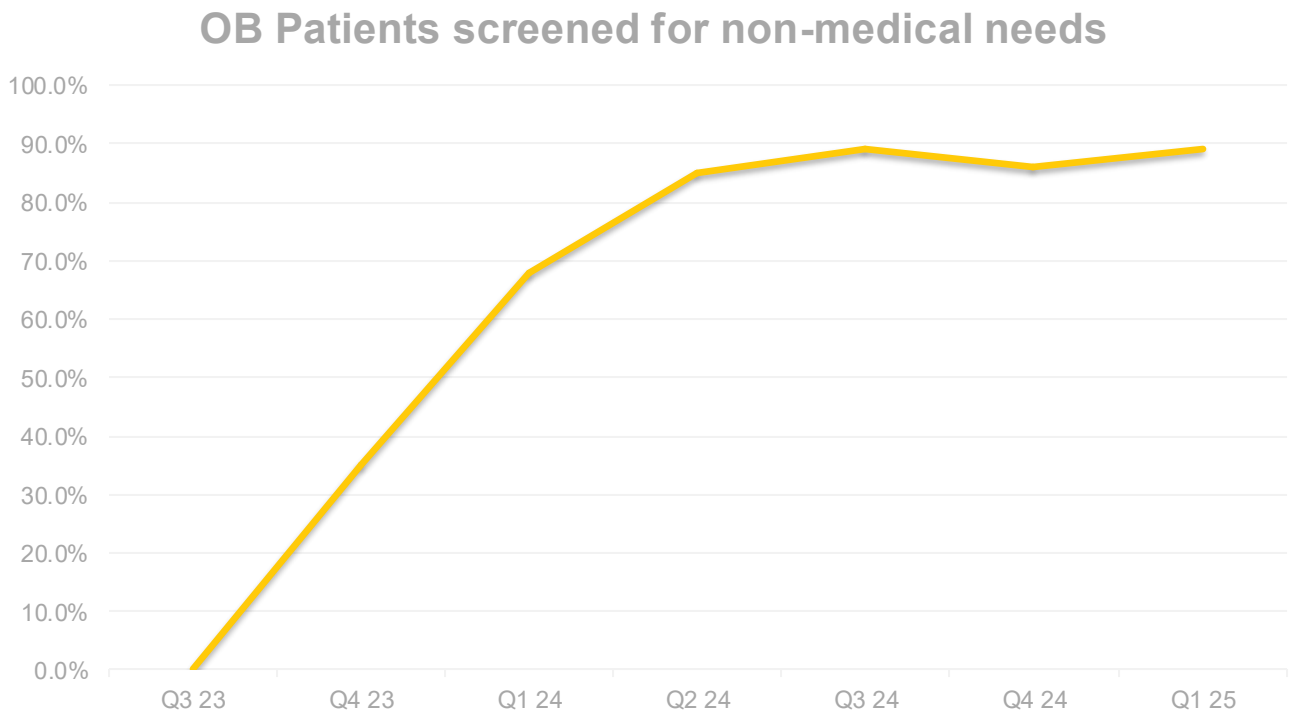
Social & Environmental Factors

Key Outcome: 90% of all pregnant patients have been screened for non-medical needs using a standardized screening tool



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Health System Navigation

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- Care Coordination and Visit Scheduling
  - Maternity Services Referral
    - Internal referral to a Care Coordinator who works exclusively with OBGYN patients
    - Directly or indirectly connects patients to resources such as baby supplies or home monitoring equipment
    - Supports scheduling and transportation as needed, especially for outside visits (labs, ultrasounds etc.) as well as facilitate a warm handoff to nursing for any clinical questions
    - Referral stays open for the duration of the pregnancy and all supports are documented in the EHR
  - Appointment Adherence Support
    - Automated EHR report is sent to nursing each week with any patients who had a no show in the week prior and have no appointment scheduled
    - Nursing contacts patients directly to discuss clinical importance of maintaining engagement and attending each appointment
    - Nursing weekly reviews a registry of currently pregnant patients to contact any patients with no scheduled appointment

Health System Navigation

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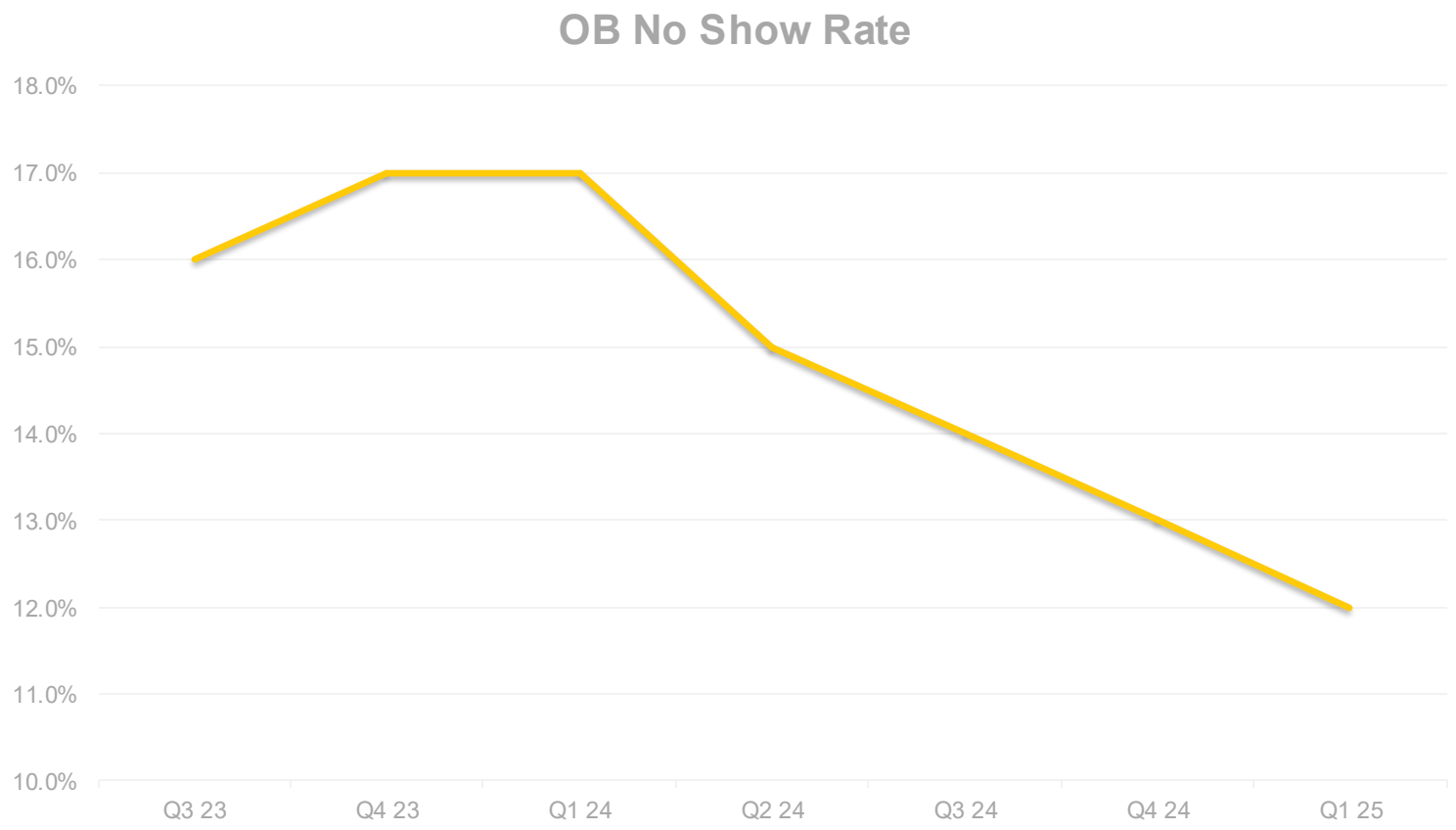
Key Outcome: No show rate for pregnant patients across all Neighborhood services is 12%



High Clinical Complication

- Risk Stratification and Patient Registry
  - An ongoing registry of all pregnant patients includes key data points such as EDC, first OB, demographic data, risk score, no show count, last appointment and next appointment among others
  - All pregnant patients receive a Pregnancy Risk Assessment (PRA) which assigns them a risk score
  - That score is used to stratify patients into a low or high risk category
  - High risk patients are part of a monthly review

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OB Dashboard 2024

MONTH	EXPECTED	MONTH	DELIVERED
JANUARY	44	JANUARY	47
FEBRUARY	39	FEBRUARY	33
MARCH	39	MARCH	42
APRIL	38	APRIL	37
MAY	57	MAY	47
JUNE	47	JUNE	35
JULY	49	JULY	37
AUGUST	49	AUGUST	41
SEPTEMBER	43	SEPTEMBER	33
OCTOBER	32	OCTOBER	26
NOVEMBER	54	NOVEMBER	46
DECEMBER	56	DECEMBER	32

Years based on EDC	2024	2025	TOTAL
Currently Pregnant Patients	3	317	**320**
Currently Pregnant Patients - High Risk	2	288	**290**
Currently Pregnant Patients w/ No Next Appointments	1	15	**16**
Currently Pregnant Patients w/ No Next Appointments - High Risk	1	14	**15**

Total Deliveries	**456**	**7.7%**
Underweight Deliveries	**35**	

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High Clinical Complication

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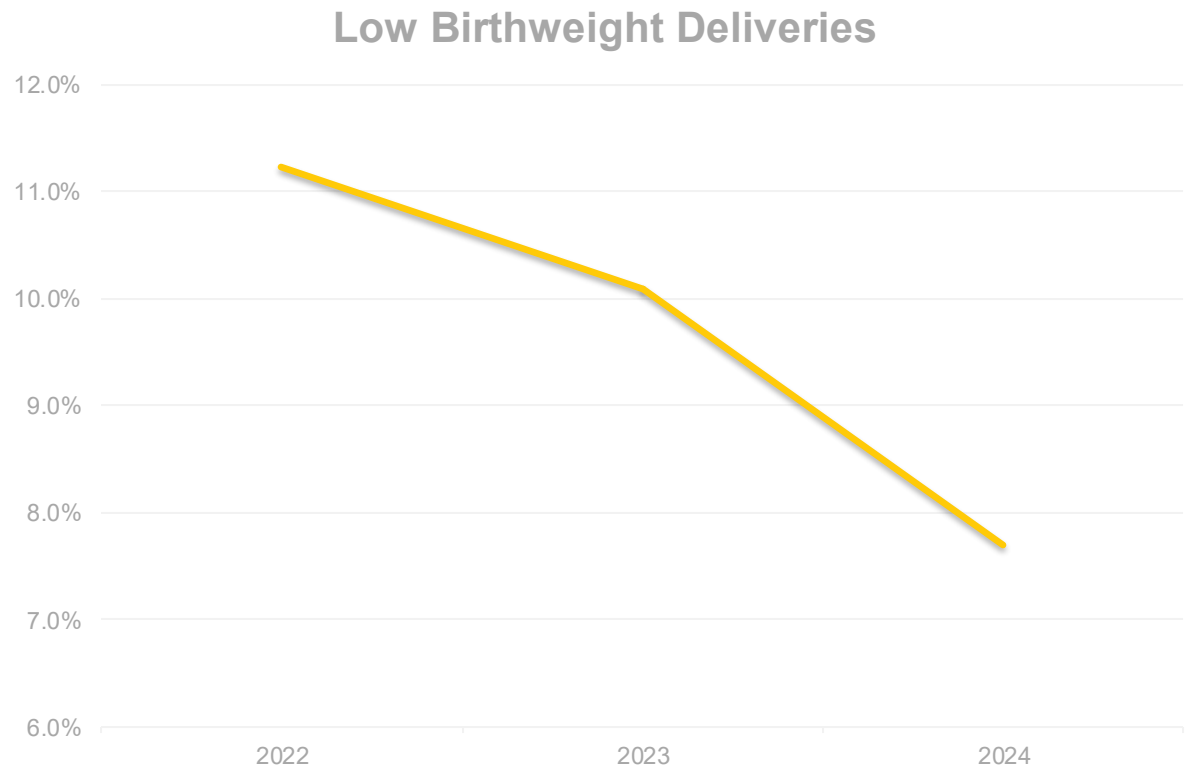
- Monthly High Risk Meeting
  - Monthly meeting that includes all OB clinicians, nursing staff and care coordination staff led by department physicians
  - A provider assigned to each office (typically a Nurse Practitioner or Nurse-Midwife) is responsible for reviewing a registry of high risk patients from their office and presenting to the group any updates or concerns on their care
  - The group collaboratively provides input or addresses any gaps (scheduling needs, outstanding social supports etc.) in the meeting to support continuity
  - This collaborative approach ensures that while a patient may see multiple providers throughout their pregnancy, the care team is up to date on their story and their plan of care

- Integrated Services
  - Neighborhood offers a wide range of services including key services for pregnant patients such as nutrition and behavioral health
  - An automated tickler system is used in the EHR so these appointments can be schedule at check-out
  - Reports are routinely generated and followed up on for patients with open ticklers and no appointments

High Clinical Complication

- **Key Outcome: Low birthweight deliveries have decreased each of the last 3 years**



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Summary

- We use data from multiple Data Sources
  - EHR System
  - Azara
  - Manual Tracking
- Key data points to track support
  - Non-medical needs
  - No show rates
  - Referral closure
  - No next appointment
  - Expected deliveries
  - High risk pregnancies
  - Low birthweight percentage
- Using common data points we were able to improve multiple process measures that ultimately drove improvement on our main goal, improved birthweight outcomes

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Takeaways

- Creating standardized workflows and documentation is what makes data collection and reporting possible
- Clinical buy in and support is critical to meaningful data collection and utilization
- Use data to drive change and innovation, not just for reporting
- Engagement across the entire care team is crucial. All departments who work with pregnant patients have data their accountable to
- Engagement by the care team facilitates engagement from the patients.

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