NATIONAL ASSOCIATION OF Community Health Centers®

NACHC and Infant & Maternal Health

Improving the lives of patients served at health centers

Advisory Council on Infant and Maternal Mortality

June 14, 2023

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CMIO
National Association of Community Health Centers

The NACHC Mission

NACHC – National Association and Voice for Health Centers

- Research-based advocacy
- Education about the mission and value of health centers
- Training/TA to health center staff and boards
- Clinical Workforce, Innovation, Performance

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NACHC'S STRATEGIC PILLARS

1. Equity and Social Justice:

Center everything we can do in a renewed commitment to equity and social justice

2. Empowered Infrastructure

Strengthen and reinforce the infrastructure for leading and coordinating the Community Health Center movement, notably consumer boards and the NACHC itself

3. Skilled and Mission Driven Workforce

Develop a highly skilled, adaptive, and mission-driven workforce reflecting the community served

4. Reliable and Sustainable Funding

Secure reliable and sustainable funding to meet increasing demands for Community Health Center services

5. Improved Care Models

Update and improve care models to meet the evolving needs of the communities served

6. Supportive Partnerships

Cultivate new and strengthen existing mutually beneficial partnerships to advance the shared mission of improving community health

To learn more about NACHC's Strategic Pillars visit https://www.nachc.org/about/about-nachc/

The Community Health Center Movement: How Did It All Begin?

America's Health Centers owe their existence to a remarkable turn of events in U.S. history, and to a number of determined community health and civil rights activists who fought to improve the lives of Americans living in deep poverty and in desperate need of health care. Fifty-seven years ago in an urban, public housing project in Boston and in the rural Mississippi Delta, the first two Community Health Centers opened their doors.

Dr. H. Jack Geiger and Dr. John W. Hatch during construction of the Delta Health Center

Columbia Point Health Center in the Dorchester neighborhood of Boston

TODAY

Community Health Centers are the most comprehensive, wide-spread and effective primary care providers.
No patient is turned away.

14K Delivery Sites

1,400 Health Centers

30+M people served (1 in 11)

400K Veterans

1.3M Homeless People

8.6M Children

3.3M Elderly Patients

1 in 5 uninsured

1 in 5 rural residents

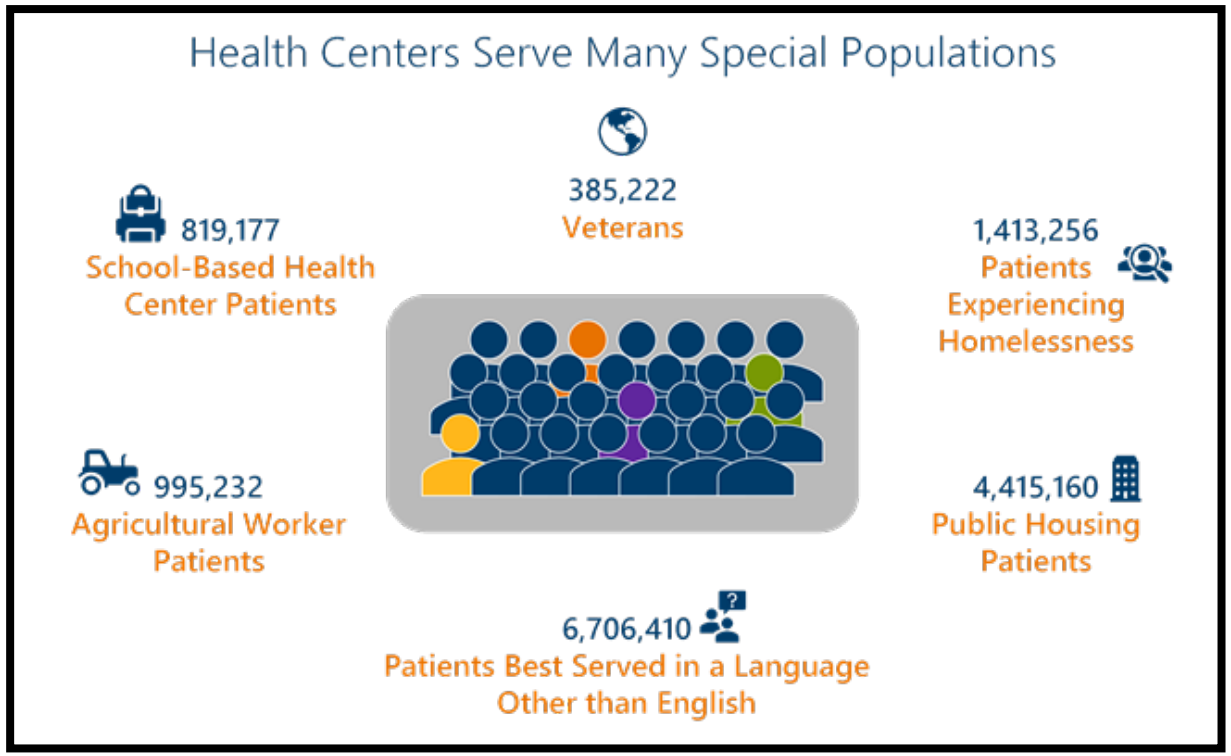
1 in 3 people living in poverty

HEALTH CENTERS

FIVE ESSENTIAL ELEMENTS

1. Located in **high-need areas.**
2. Provide **comprehensive** health and related services (especially “enabling services”).
3. **Open to all** residents, regardless of ability to pay, with sliding scale fee charges based on income.
4. Governed by **community boards**, to assure responsiveness to local needs.
5. **Follow performance and accountability requirements** regarding their administrative, clinical, and financial operations.

HEALTH CENTER PATIENT-CENTERED CARE



Health Services related to:

- Family Medicine
- Internal Medicine
- Pediatrics
- Obstetrics

Diagnostic Laboratory and Radiologic Services

Dental Screenings

Pharmaceutical Services

Referrals to Other Providers

Patient Case Management

Enabling Services: Translation, Transportation, Outreach, Health Education and Enrollment

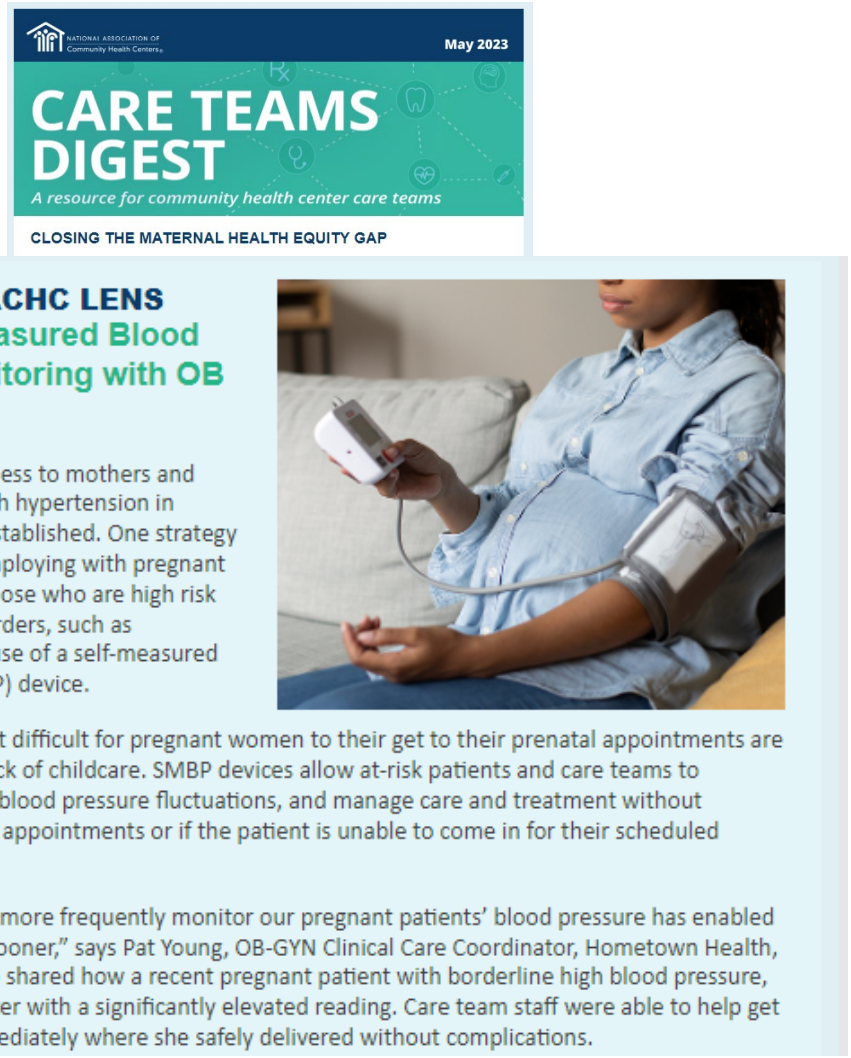
CHC PATIENT CHARACTERISTICS

Age Group	Male	Female	Total
Under 18	4,325,750	4,309,613	8,635,363
18-64	7,179,436	11,089,233	18,268,669
65 and Over	1,374,092	1,915,154	3,289,246
Total	12,879,278	17,314,000	30,193,278
Percent	42.7	57.3	100

Health Centers Serve 1 in 12 People in the U.S. including…

- 1 in 9 children
- 1 in 7 racial/ethnic minorities
- 1 in 5 Medicaid beneficiaries
- 1 in 5 uninsured persons
- 1 in 3 people in poverty

Health Centers' Focus on Mothers and Children



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May 2023

CARE TEAMS DIGEST

A resource for community health center care teams

CLOSING THE MATERNAL HEALTH EQUITY GAP

FROM THE NACHC LENS

Using Self-Measured Blood Pressure Monitoring with OB Patients

The risk of serious illness to mothers and babies associated with hypertension in pregnancy are well-established. One strategy health centers are employing with pregnant patients, especially those who are high risk for hypertensive disorders, such as preeclampsia, is the use of a self-measured blood pressure (SMBP) device.

Two barriers making it difficult for pregnant women to their get to their prenatal appointments are transportation and lack of childcare. SMBP devices allow at-risk patients and care teams to regularly monitor for blood pressure fluctuations, and manage care and treatment without scheduling additional appointments or if the patient is unable to come in for their scheduled appointments.

"Having the ability to more frequently monitor our pregnant patients' blood pressure has enabled us to identify issues sooner," says Pat Young, OB-GYN Clinical Care Coordinator, Hometown Health, Schenectady, NY, who shared how a recent pregnant patient with borderline high blood pressure, called the health center with a significantly elevated reading. Care team staff were able to help get her to a hospital immediately where she safely delivered without complications.

In 2020, health centers:

- Served over 16.8 million women
- Provided prenatal care to more than 566,000 patients
- Delivered just over 170,000 infants
- Roughly 1.55 million received contraceptive management services through an FQHC during the year

Health Centers' Focus on Mothers and Children 2

Maternal Health Takes Priority at This Detroit Health Center

May 12, 2023 | by Guest Post

Jessica Jackson, CNM, meets with a patient to talk about maternal health options at The Community Health And Social Services, Inc. in Detroit. (Photo by Olivia Lewis)

QIE helps AllianceChicago identify and reduce child lead exposure risk

Lead Safe Application Program Interface (Lead Safe API) is a first-of-its-kind clinical decision support tool that helps clinicians identify young children at risk of lead poisoning by leveraging multi-sector data

Women's Health Postpartum Quality Initiative

2018 - Current

Focused on using EHR and Pophealth tools for:

- Tracking quality of postpartum care
- Improving point of care workflows and tools
- Understanding gaps in care processes, coordination and technology support for postpartum women

NACHC projects

Postpartum Partner Organizations and Accomplishments

AllianceChicago
Innovating for better health

AllianceChicago implemented a centralized resource intervention across three health centers, in which a hired contractor provided case management services for identified high-risk patients, particularly ensuring they were connected to, scheduled for, and attended a primary care visit following routine postpartum care. At the end of implementation, they connected 83% (n=51) of identified high-risk patients to primary care.

AllianceChicago also disseminated trainings on the previously developed Pregnancy Episode EHR tool to increase uptake amongst health centers.

OCHIN 20 YEARS

Building on their success from the previous year, OCHIN released the postpartum express lane to the entire collaborative in April 2022 and allowed member organizations to request changes to the OCHIN model so that the express lane would better suit their needs.

The Express Lane gathers information from different locations within the EHR that would be relevant to the postpartum period.

REDWOOD HEALTH COMMUNITY COALITION

The Redwood Community Health Coalition (RCHC) Informatics Team conducted data test pulls and data collection using Relevant, their data analytics tool and population health platform. They identified the need for structured data for contraception counseling in the postpartum period. They engaged participating health centers and requested input on the current contraception practices in their health center.

New Year 4 Partner

CMQCC
California Maternal Quality Care Collaborative

NACHC engaged the California Maternal Quality Care Collaborative to refine the project measures.

New Year 4 Partner

Scope of Postpartum Quality Initiative

- High quality pregnancy status data – USCDIv3
- Support for pregnancy episode – requirement to close episodes
- More comprehensive documentation around pregnancy metadata and delivery dates and outcomes
- Identification of high-risk pregnancy categories and increased follow up
- Increase completion and documentation of post-partum visit
- Higher rates of peri- and post-partum contraception access and documentation
- More comprehensive management of hypertensive disorders of pregnancy
- Increased screening and follow up for postpartum mood disorders
- Increased substance use disorder screening, referral, and treatment
- Increased follow up for patients with gestational diabetes
- Improved workflow as perceived by the care team

104,712 Total Deliveries (Both Estimated and Actual Dates)

7,002 Total Deliveries had one of the HTN Dx. (6.6%)

- Hypertension - Primary, Secondary, and Combinations
- Preeclampsia
- HELLP Syndrome
- Eclampsia
- Gestational Hypertension
- Chronic Hypertension

97,428 Unique Patients had a Delivery (Estimated and Actual)

6,475 Unique Patients had one of the HTN Dx (6.6%)

(many fall into multiple categories)

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Chronic Hypertension – 3,691 (3.7%)

Hypertension - Primary, Secondary, and Combinations – 3,044 (3.1%)

Preeclampsia – 2,332 (2.4%)

Gestational Hypertension – 1,292 (1.3%)

HELLP Syndrome – 63 (less than 1%)

Eclampsia – 37 (less than 1%)

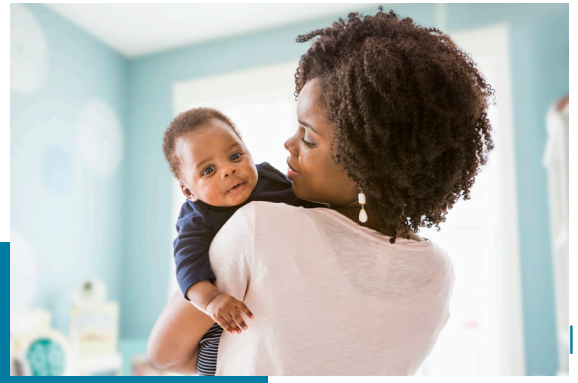
MMRC and PQC NACHC Collaborative

2022 - Current

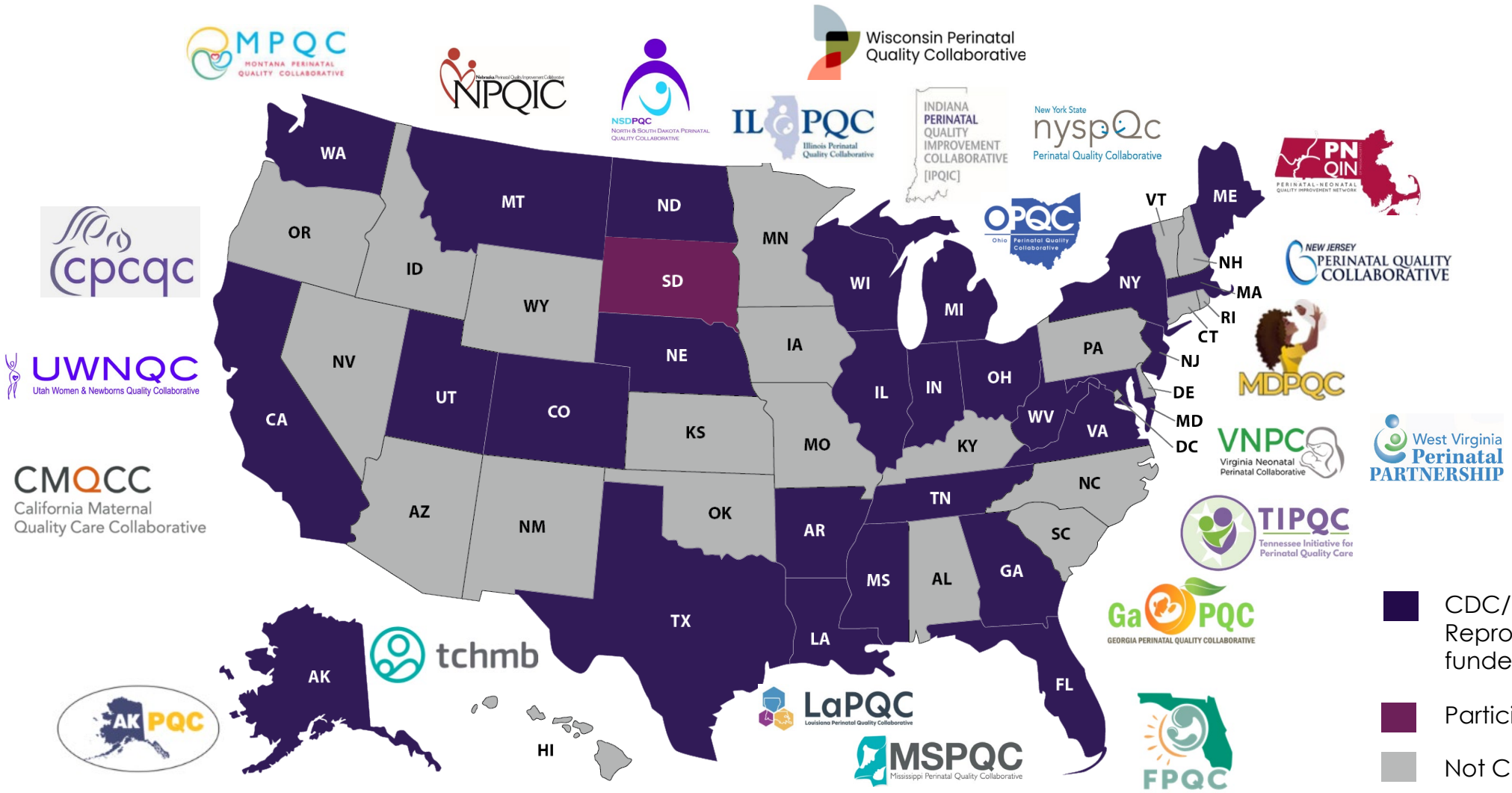
Goal to convene and establish a model for:

- State and national collaboration with health centers on perinatal quality and maternal mortality
- Using data-driven approaches from MMRC (Maternal Mortality Review Committee)
- Broadening focus of PQC (Perinatal Quality Collaboratives) to include:
  - Outpatient care
  - Care coordination across transitions of care
  - Health disparities across the care continuum

NACHC projects



2022 – 2027
Statewide Perinatal Quality Collaboratives



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MMRC and PQC NACHC Collaborative 2

ILLINOIS PERINATAL QUALITY COLLABORATIVE

IL PQC Illinois Perinatal Quality Collaborative

AllianceChicago
Innovating for better health

FLORIDA PERINATAL QUALITY COLLABORATIVE

FPQC

Health Choice Network
a Family of Health Centers

2022-2023:
In person and virtual meetings to identify priority areas for outpatient prenatal and postpartum quality improvement based on current state MMRC data and state challenges to access and equity.

THANK YOU!

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PLEASE VISIT US ONLINE nachc.org