

Speakers

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&

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CLSSGB

Health Choice Network



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a Family of Health Centers



Reducing Maternal Morbidity in Community Health Centers

Role of HCCN & FQHCs

April 9, 2026



Disclosures

- Neither speaker has any financial conflicts.



Agenda



Introductions & Set the Stage



Role of HCCN



Role of FQHCs



**Resources and Closing
Remarks**



Learning Objectives

- Describe how HCCNs support maternal health outcomes through EHR optimization, quality improvement initiatives, and peer learning across community health centers.
- Explain the role of FQHCs in reducing maternal morbidity, including delivery of prenatal and postpartum care, risk monitoring, and behavioral health screening.
- Identify promising practices and collaborative strategies, such as Nurse-Family Partnership programs, that enhance support for mothers and babies—especially during times of emergency or heightened risk.



Sandy Calle, MD
Clinical Champion



Fred Aira, RN
NFP Nurse Supervisor

20

States and Territories

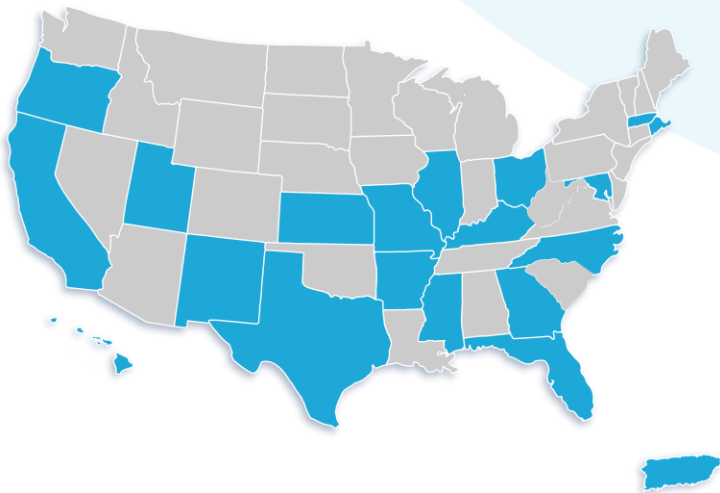
Health Choice Network, Inc. (HCN) is the first funded health center-controlled network, a successful nation-wide collaboration among health centers and partners.

94

Safety-net Provider Organizations

12M

Total Patient Visits



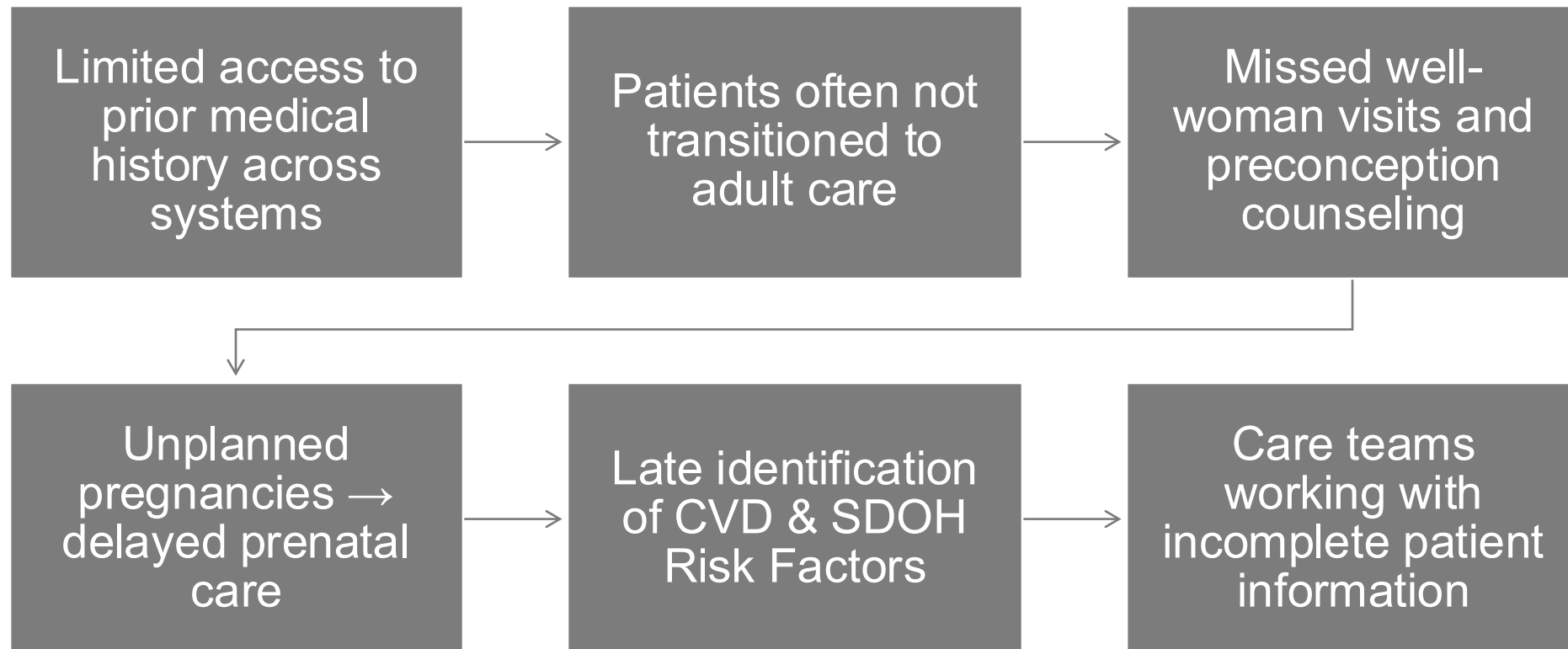
Providing key business services in:

- Finance
- Manage Care
- Billing Support
- Strategic Initiatives
- Health Information Technologies
- Clinical Quality
- Clinician Training and Development

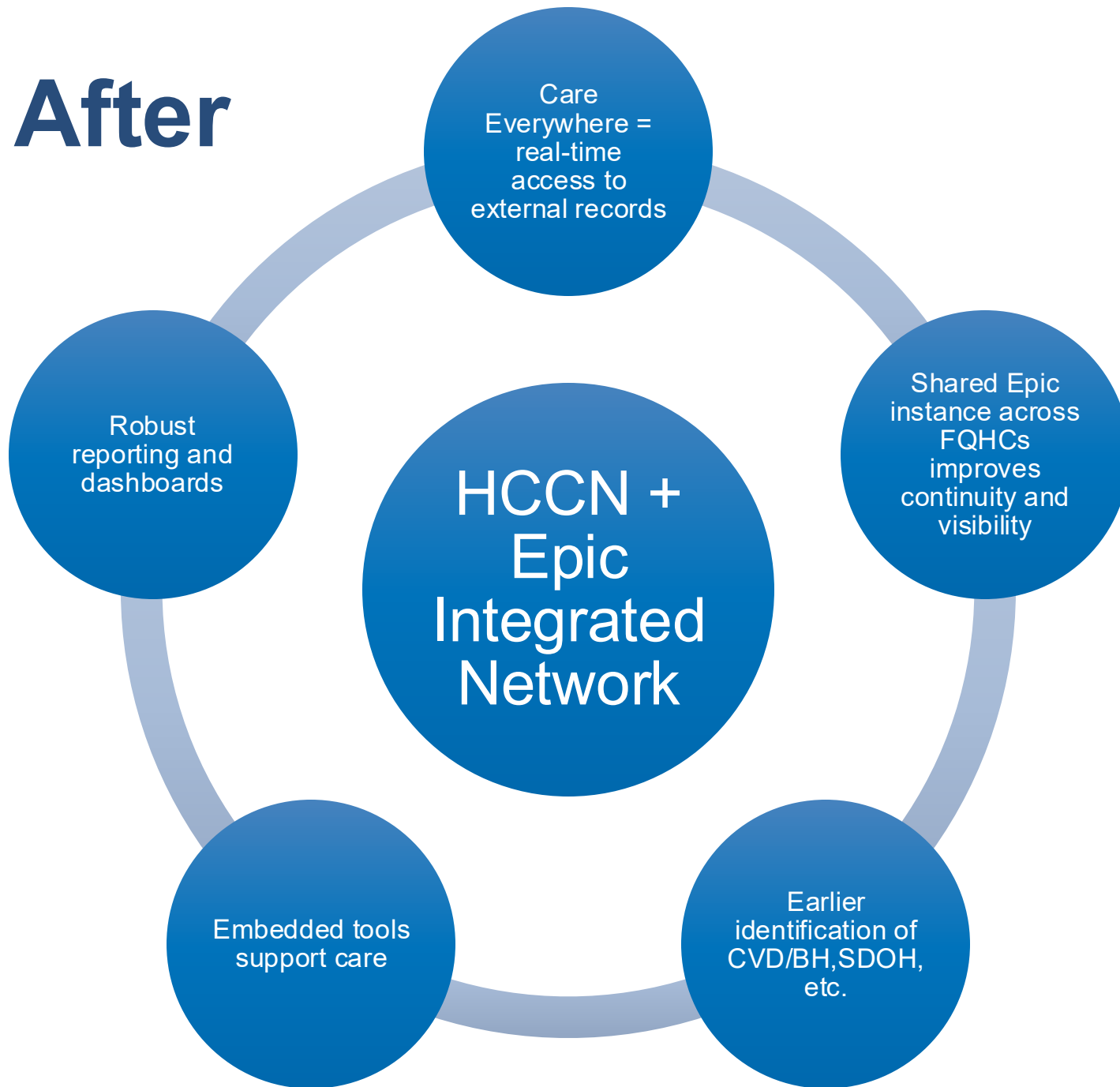
Role of HCCN

- Optimize EHR to streamline workflows in clinical practice
- Engage health centers in Quality Improvement activities
- Facilitate the exchange of effective practices across peer organizations
- Support collaborative partnerships and strategies

Before (Fragmented Care)



After



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Impact on Maternal Care

- ✓ Earlier identification of high-risk pregnancies
- ✓ Improved care coordination and timely intervention
- ✓ Data-driven ability to proactively manage patient populations
- ✓ Supports improved maternal outcomes and quality performance
- ✓ A shift from reactive care to proactive, population-based maternal health management

Epic Optimizations Highlights

All HCN Epic-hosted health centers benefit from the below optimizations:

Live

- **OB trimester & Hypertension Express Lanes** streamlines management & documentation
- **Storyboard Icon** alerts providers and care teams of postpartum status 365 days after pregnancy outcome is documented.
- **OPA** to recommend aspirin to reduce pre-eclampsia risk
- **Pregnancy Checklist** that guides providers through care tasks for each trimester
- **Risk of HTN predictive model** predicts whether an adult patient will be diagnosed with hypertension in the next two years
- **OB CVD Risk Assessment tool** to identify pregnant and postpartum patients at elevated risk earlier

In progress

- **PREVENT Risk Calculator** (pending Epic release)
- **Remote Patient Monitoring Solution** is a new program where patients can document their BP through MyChart for participating centers



CENTRAL ILLUSTRATION: Universal Cardiovascular Disease Risk Assessment in Pregnancy and Postpartum

Goal: Integrate cardiovascular disease risk assessment tool into routine obstetric care to identify pregnant and postpartum patients at risk for cardiovascular disease (CVD)

Involve various healthcare providers, including obstetricians, primary care physicians, and emergency healthcare providers in conducting CVD risk assessment screening in the electronic medical record (EMR)



Physical Exam

Abnormal findings:



Loud murmur

OR



Basilar crackles

Vital Signs

- Resting HR ≥ 110 beats/min
- Systolic BP ≥ 140 mm Hg
- Respiratory rate ≥ 24
- Oxygen saturation $\leq 96\%$

Self-Reported Symptoms

- Dyspnea
- Mild orthopnea
- Tachypnea
- Asthma unresponsive to therapy
- Palpitations
- Dizziness/syncope
- Chest pain

Risk Factors

- Age ≥ 40 years
- African American
- Pre-pregnancy obesity (BMI ≥ 35 kg/m²)
- Pre-existing diabetes
- Hypertensive disorder
- Substance use (nicotine, cocaine, alcohol, methamphetamines)
- History of chemotherapy

Recommended diagnostic tests:



EKG



ECHO



BNP/NT-proBNP and other laboratory tests

Referral pathways for patients identified as at risk for CVD

Improved identification of previously unknown CVD, including monitoring of high-risk patients throughout pregnancy and postpartum period

Patient education and counseling about modifiable CVD risk behaviors



Hameed AB, et al. JACC Adv. 2024;3(8):101055.



OB CVD Risk Assessment

Screenings - 3/30/2026 visit with Sandy Calle, MD for Treatment

Standard tools Adult Med Peds Tools **OB/GYN** BH Tools Substance Use HIV Tools Dental Tools

OB CVD Risk

Pull Data from Chart Pull Data from the chart for 1st assessment of cardiovascular risk. To reassess risk, data items must first be cleared before this button is used to recheck data

Self Reported Symptoms (*NYHA Class >= II)	Vital Signs	Risk Factors
Suggestive of Heart Failure	Resting HR >=110 bpm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Age 40+ <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Shortness of breath <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Systolic BP >=140 mmHg <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	African American <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Short of breath lying flat <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Respiratory Rate >=24 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pre-pregnancy obesity (BMI >=35) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Rapid heart rate <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Oxygen Sat <=96% <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pre-existing diabetes <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Asthma unresponsive to therapy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hypertension <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Suggestive of Arrhythmia		Cancer Diagnosis or History <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Palpitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Physical Exam <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	History of chemotherapy or chest radiation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fainting or loss of consciousness <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Heart: Loud murmur <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Substance Use <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Suggestive of Coronary Artery	Lungs: Basilar crackles <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Nicotine use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Chest pain <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Alcohol use: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="button" value="Mark All Symptoms Negative"/>		Use of risky drugs: Cocaine, Depressants (Alcohol, Barbituates, Benzodiazepines), MDMA, Ecstasy, Methamphetamines, or Opiates <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Screenings - 3/30/2026 visit with Sandy Calle, MD for Treatment

Standard tools Adult Med Peds Tools **OB/GYN** BH Tools Substance Use HIV Tools Dental Tools

SCREENINGS

Edinburgh

Family Planning

GAD-7

PHQ-2/9

Sexual Health Qnr

OB CVD Risk as...

SBIRT

Shortness of breath <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Systolic BP >=140 mmHg <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	African American <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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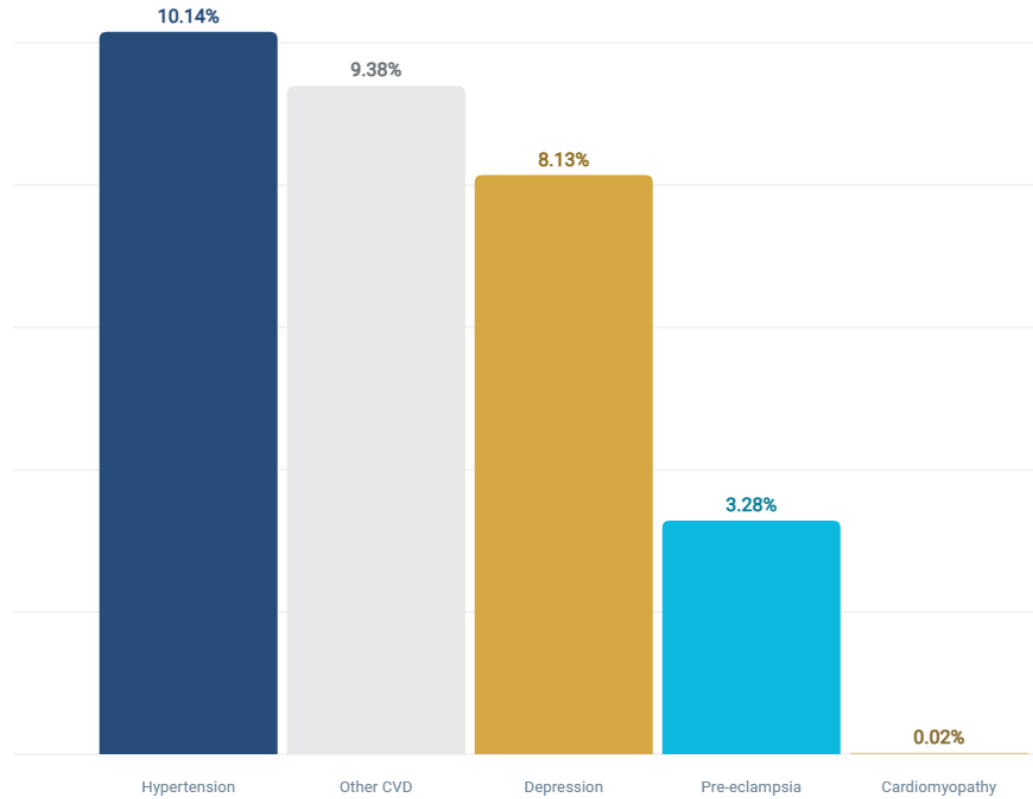
Calculated Risk

Fill form before clicking Calculate

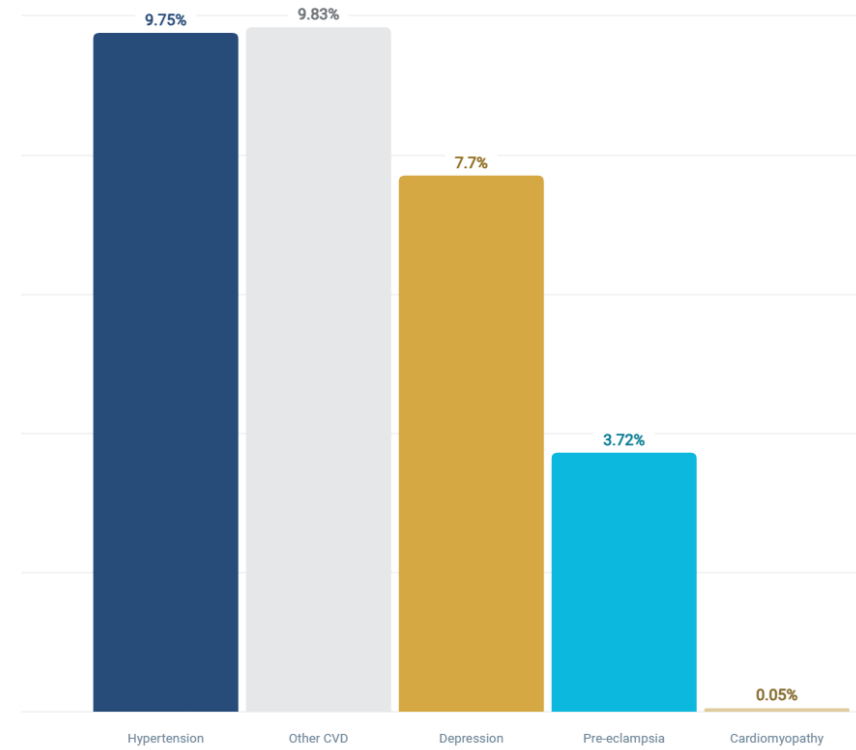
If this form loaded with an existing positive screen, please do not re-screen patient

Signed by:

National



Florida



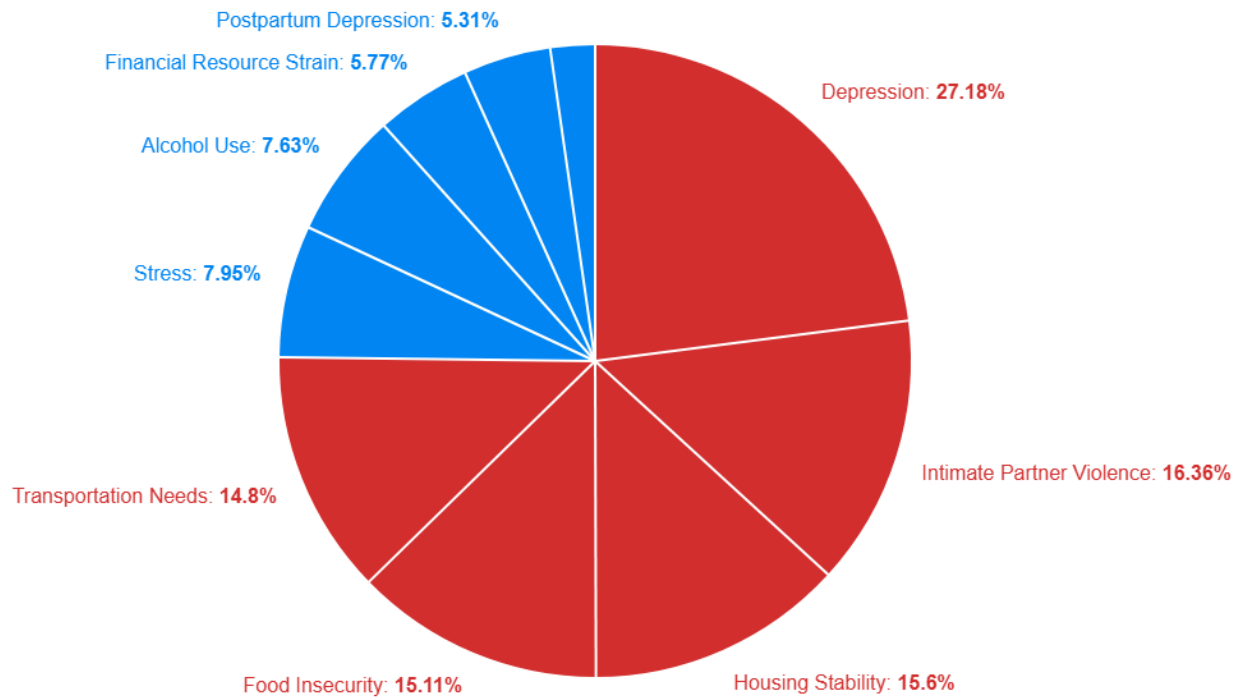
♥ Social Drivers of Health ↗



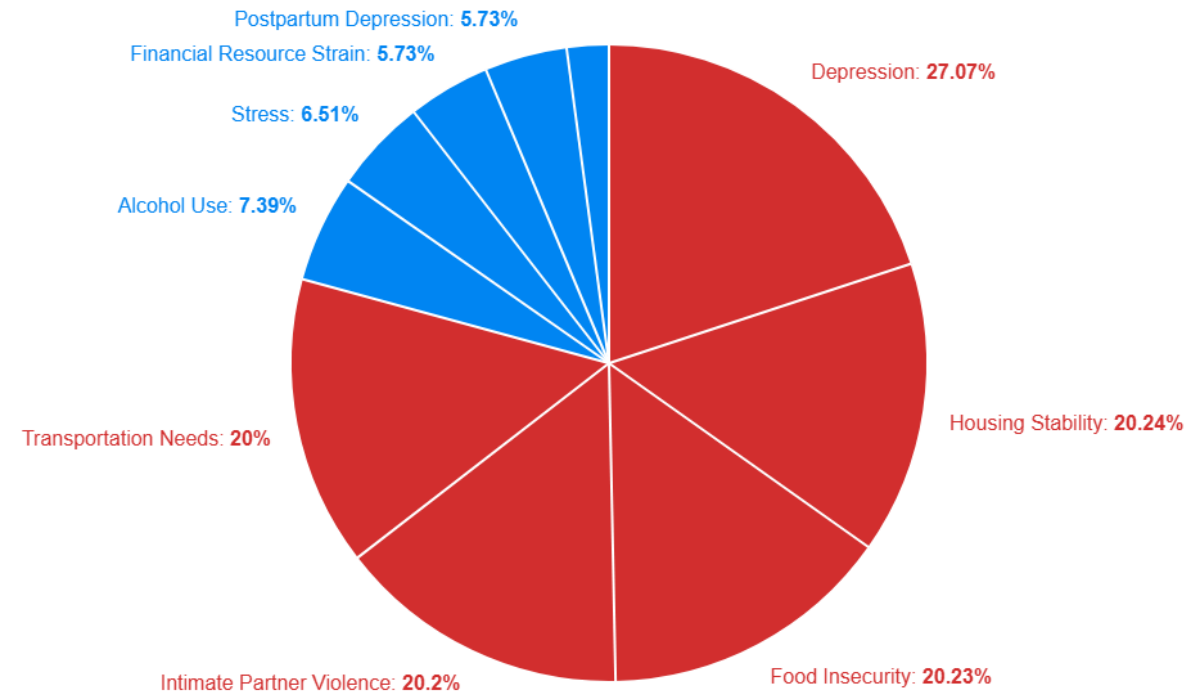
♥ Social Drivers of Health ↗



Black/AA Patients

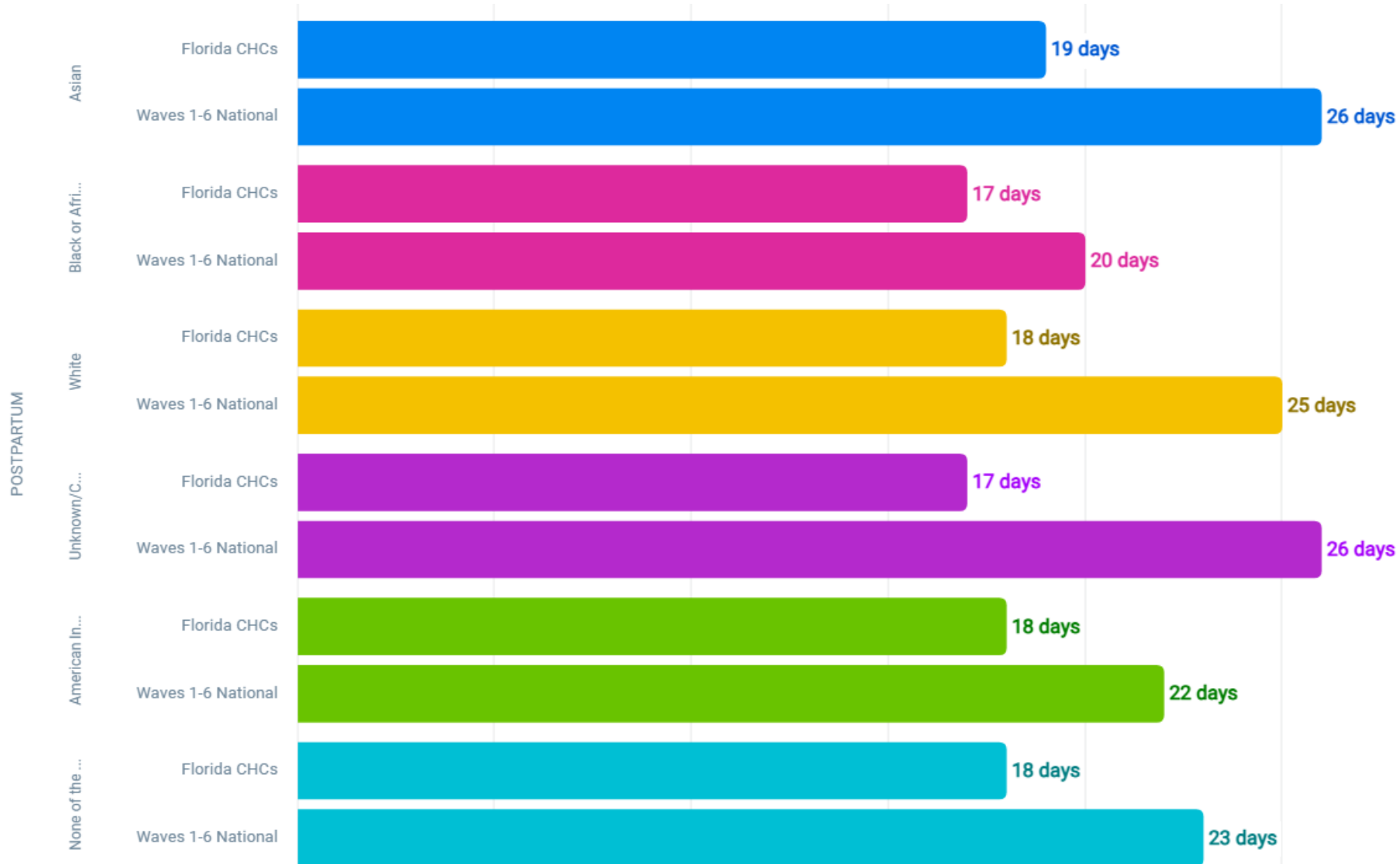


All Patients



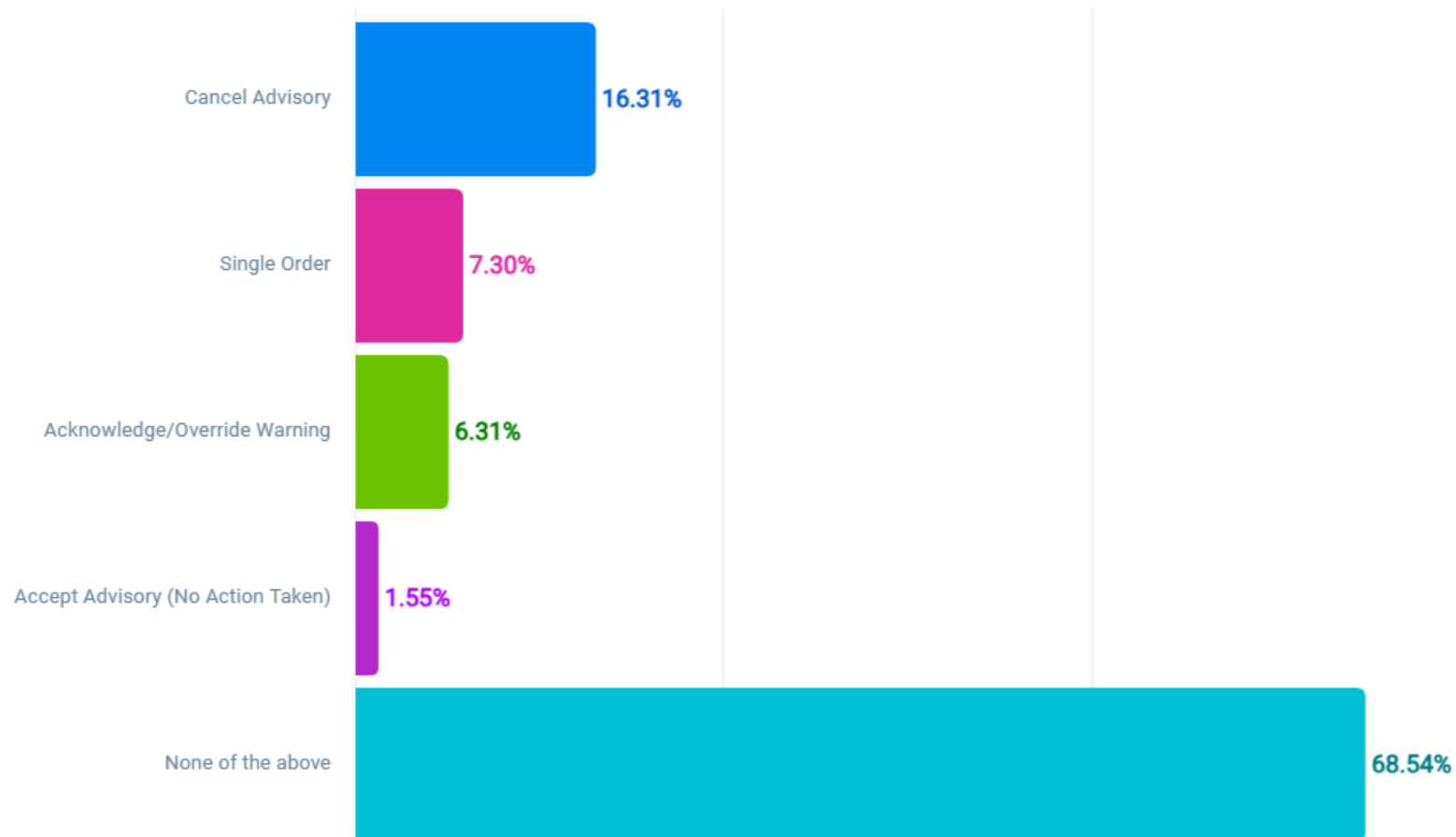


Average Post Partum Lead Time – Last 6 Months





Aspirin OPA – Action Taken



The OurPractice Advisory for aspirin prescription resulted in an order for aspirin via the OPA in only 7.3% of patients over the last 6 months.

This data point propels us to consider:

- Is the OPA useful?
- Are the right patients being prescribed aspirin?
- Is there a documentation gap to consider?

Continuous Quality Improvement



NACHC Maternal Health: Leading Change

- SMBP At Home with Patient Care Kits



Patient Centered Medical Home

- Support NCQA PCMH accreditation
- Emphasize care management



Facilitate Peer Learning

HEALTH CENTER SPOTLIGHTS

Tampa Family Health Center's Best Practices for Hypertension Control

At Tampa Family Health Center (TFHC), blood pressure control is a team effort built on strong clinical practices, consistent training, and proactive patient support. Hypertension is reviewed regularly during daily huddles and biweekly medical provider meetings, keeping quality goals consistently in focus. This combination of training, data transparency, and patient-centered support turns everyday workflows into long-term improvements in blood pressure control.

On February 6th, TFHC went RED and celebrated National Wear Red Day.

Strong Foundations

Every year begins with hands-on Medical Provider and Medical Assistant training focused on achieving quality goals. For blood pressure control, TFHC reinforces proper technique, correct cuff sizing, and repeated measurements to obtain blood pressure readings under **140/90**.



Data-Driven Care

The clinical team uses customized schedule views in Epic to quickly identify patients with uncontrolled hypertension in preparation for their day. Additionally, the Medical Providers utilize their provided education in lifestyle medicine and medication management to help patients achieve their healthy blood pressure and weight goals. The quality team performs quarterly chart audits and quarterly peer reviews aligned with UDS metrics and clinical best practices and the leadership teams use Epic dashboards to measure progress.

Built-In Follow-Up

Consistency is key. All uncontrolled blood pressure readings trigger a follow-up scheduled by the clinical or front office team within two weeks. The patient must leave the health center with an appointment. Our teams utilize Epic reports to identify patients overdue for follow-up and initiate appointments both virtual and in-person. Patients utilize assigned blood pressure flowsheets in MyChart to communicate home blood pressure readings with their medical provider.

Whole-Person Support

TFHC extends heart-health resources beyond the exam room. They have onsite pharmacies for medication counseling and easy access. Their food pantries and community garden provide nutritious options for patients and they conduct nutrition classes providing education on cooking techniques.



PRescription
FOR HEALTHY HEARTS

To: You
From: Your Provider

INSTRUCTIONS

Join the movement!

1. Log-in to Your MyChart
2. Report Your Blood Pressure Twice a Day
3. Follow up with your PCP

Your proactive actions can be a game-changer in your hypertension management.



HEART EQUITY SYMPOSIUM: Advancing Cultural Competence to Achieve Hypertension Control



Jointly hosted by



with facilitation from
Urban Health Partnerships



Nurse-Family Partnership of Miami-Dade

Fred Aira, RN

Nurse-Family Partnership, Nursing Supervisor





Nurse Family Partnership: Program Goals

1. Improve pregnancy outcomes by partnering with moms to engage in **good preventive health practices**, including thorough prenatal care from their healthcare providers, improving their diets and reducing any use of habit-forming substances;
2. Improve **child health and development** by assisting families to provide responsible and competent care; and
3. Improve the **economic self-sufficiency** of the family by supporting parents to develop a vision for their own future, additional pregnancies, continue their education and find work.

Nurse-Family Partnership and Health Choice Network

How NFP Serves Miami-Dade County

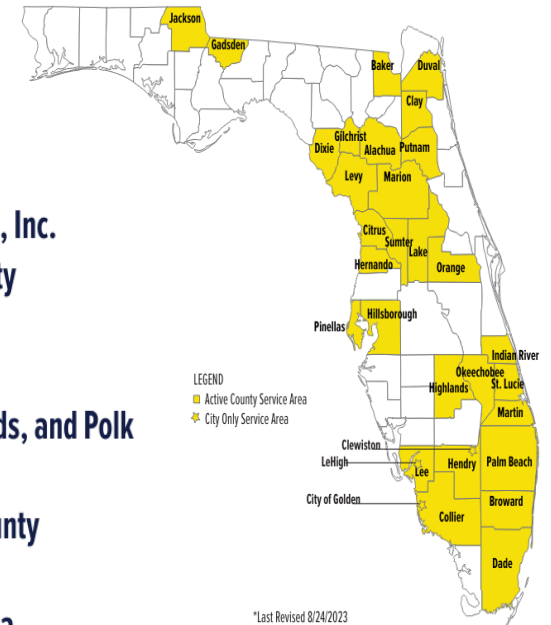
- 1 Nurse Supervisor, 1 Program Administrator, and 6 Home Visit Nurses
 - Each nurse has a maximum caseload of 25 families = 150 total program family capacity

Program Information

- Serving Miami-Dade County, primarily to English, Spanish & Creole speaking families.
- Housed within local FQHCs: Community Health of South Florida (CHI), Center for Family and Child Enrichment (CFCE) & Jessie Trice Community Health System (JTCHS).

NETWORK PARTNERS

- Broward Regional Health Planning Council, Inc.
- Department of Health of Palm Beach County
- Gadsden County Healthy Start Coalition
- **Health Choice Network of Miami Dade**
- Healthy Start Coalition of Hardee, Highlands, and Polk Counties
- Healthy Start Coalition of Hillsborough County
- Healthy Start Coalition of Orange County
- Healthy Start Coalition of Southwest Florida
- Northeast Florida Healthy Start Coalition
- Healthy Start Coalition of St. Lucie County





NFP Network & Referrals



NFP's national network allows clients who relocate—whether within Florida or to another state—to be reassigned and continue uninterrupted services, as long as an active NFP site operates in the new area.

Enrollment Assessments

- **Household Profile**
 - Tracks education, employment, income, housing, tobacco use.
- **Participant Record**
 - Tracks demographics, race/ethnicity & language, general health/mental health history, marital status.
- **Interpersonal Violence Assessment**
 - Mom is screened for domestic violence at home within 6 months of enrollment.

Nurse-Family Partnership - Prenatal Enrollment			
Participant Name	Mama Jones		
Enrollment Date	01/15/23		
ENROLLMENT			<i>Completed</i>
Form/Assessment	Start	Deadline	
Participant Record	01/15/23	01/15/23	
Household Profile	01/15/23	02/15/23	

Form/Assessment	Start	Deadline
IPV Assessment	01/15/23	07/13/23

Postpartum Assessments (Mom & Baby)

- **Delivery Information**
- **Infancy Questionnaires**
 - Tracks Safe Sleep Practices, Postpartum Visits, Early Literacy & Breastfeeding.
- **Edinburgh Depression**
 - Depression screening for mom (routine & as needed).
- **ASQ Assessments**
 - Tracking developmental milestones (communication, gross/fine motor skills)

Child Name	Baby Jones	
Child DOB	12/03/22	
<i>If child was born preterm, enter # weeks gestation</i>	38	
ONCE CHILD IS BORN		
Form/Assessment	Start	Deadline
Target Child Record	12/03/22	1st visit with child
Delivery Information	12/03/22	ASAP
Child Wellness Update	12/03/22	1st visit with child
Infancy Questionnaire: 0-1 mo old	12/03/22	02/01/23
Infancy Questionnaire: 2-3 mo old	02/05/23	04/01/23
Infancy Questionnaire: 6-7 mo old	06/05/23	08/01/23
Infancy Questionnaire: 10-11 mo old	10/05/23	12/01/23
Edinburgh (EPDS)	12/03/22	03/01/23
PCI HOME Inventory/Dance: 1-3 mo	01/05/23	04/01/23
PCI HOME Inventory/Dance: 8-10 mo	07/05/23	11/01/23
PCI HOME Inventory/Dance: 15-17 mo	02/05/24	06/01/24
PCI HOME Inventory/Dance: 21-23 mo	08/05/24	12/01/24
ASQ-3 (10 mo Q)*	09/05/23	11/01/23
ASQ-3 (18 mo Q)*	05/05/24	07/01/24
ASQ-3 (30 mo Q)	05/05/25	07/01/25



Routine, Ad-Hoc or One-Time Assessments

- Updated Household Profiles & Child Wellness Updates (2x a year)
- Home Visit Form to be completed for every visit.
- Delivery Information – captured at delivery.
- MIECHV Referrals – if mom screens positive for depression, domestic violence, tobacco use and/or the child is experiencing developmental delays, they can be referred to for services within an FQHC or to external resources/partners.

HOUSEHOLD PROFILE/CHILD WELLNESS UPDATES		
Form/Assessment	Start	Deadline
Winter 2025	11/01/25	01/31/26
Summer 2026	06/01/26	08/31/26
Winter 2026	11/01/26	01/31/27
Summer 2027	06/01/27	08/31/27
Winter 2027	11/01/27	01/31/28
At Every Visit or As Needed		
Form/Assessment	When is it completed?	
Home Visit Form	At every visit	
MIECHV Referral Form	As needed for IPV, tobacco, EPDS, ASQ-3	
Delivery Information Form	At birth of any child to enrolled mother	
Household Profile/Child Wellness Update	At closure/dismissal, when possible	
Dismissal Form	At closure/dismissal	
*ASQ-3 timeframes for 10-mo and 18-mo ASQ-3 are adjusted for prematurity if # weeks gestation are entered above and are less than 37 weeks.		



Role of FQHCs

- Expand access to care
- Identify risk early (HTN, CVD, DM, Mental Health)
- Address SDOH
- Provide integrated team-based care
- Ensure care coordination and continuity
- Use data and population health tools to track risk and close care gaps
- Strengthen postpartum follow-up and monitoring

Reducing Maternal Morbidity FQHC & HCCN Action

FQHCs (Care Delivery)

- Standardize risk screening
- Strengthen care coordination and referrals
- Improve postpartum follow up and engagement
- Deliver integrated, team-based care

HCCNs (Infrastructure & Scale)

- Use dashboards and registries to identify high-risk patients
- Enable data sharing and interoperability
- Implement clinician decision support tools
- Drive quality improvement & benchmarking

Thank You

Questions?





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