Making Maternal Care Primary

Improving Long Term Outcomes for Mothers

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Today's Presenters

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Agenda

The Maternal Care Mandate
Maternal health and value-based care

Alabama Primary Care Association
Alabama’s approach to promoting healthy maternal and baby outcomes

Massachusetts League of Community Health Centers
Closing data gaps and building solutions for maternal care

Edward M. Kennedy Health Center
Applying analytics tools at the point of care and beyond

The Problem

Women in the United States often experience **fragmented and incomplete** prenatal + postpartum care

41%

of pregnancies are **unplanned**

80%

Of maternal deaths are likely **preventable**

Over 50%

of maternal deaths occur postpartum

A substantial portion

of women do not attend any postpartum care visits

Sources:

https://www.cdc.gov/reproductive-health/hcp/unintended-pregnancy/index.html#:~:text=Rates%20of%20unintended%20pregnancies%20declined,to%20achieve%20a%20healthy%20pregnancy.
https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html
https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html
https://pmc.ncbi.nlm.nih.gov/articles/PMC9283204/

In Recent News…

First trimester prenatal care decreased, while second trimester prenatal care and late or no care increased, for nearly all race and Hispanic-origin groups from 2021 to 2024.

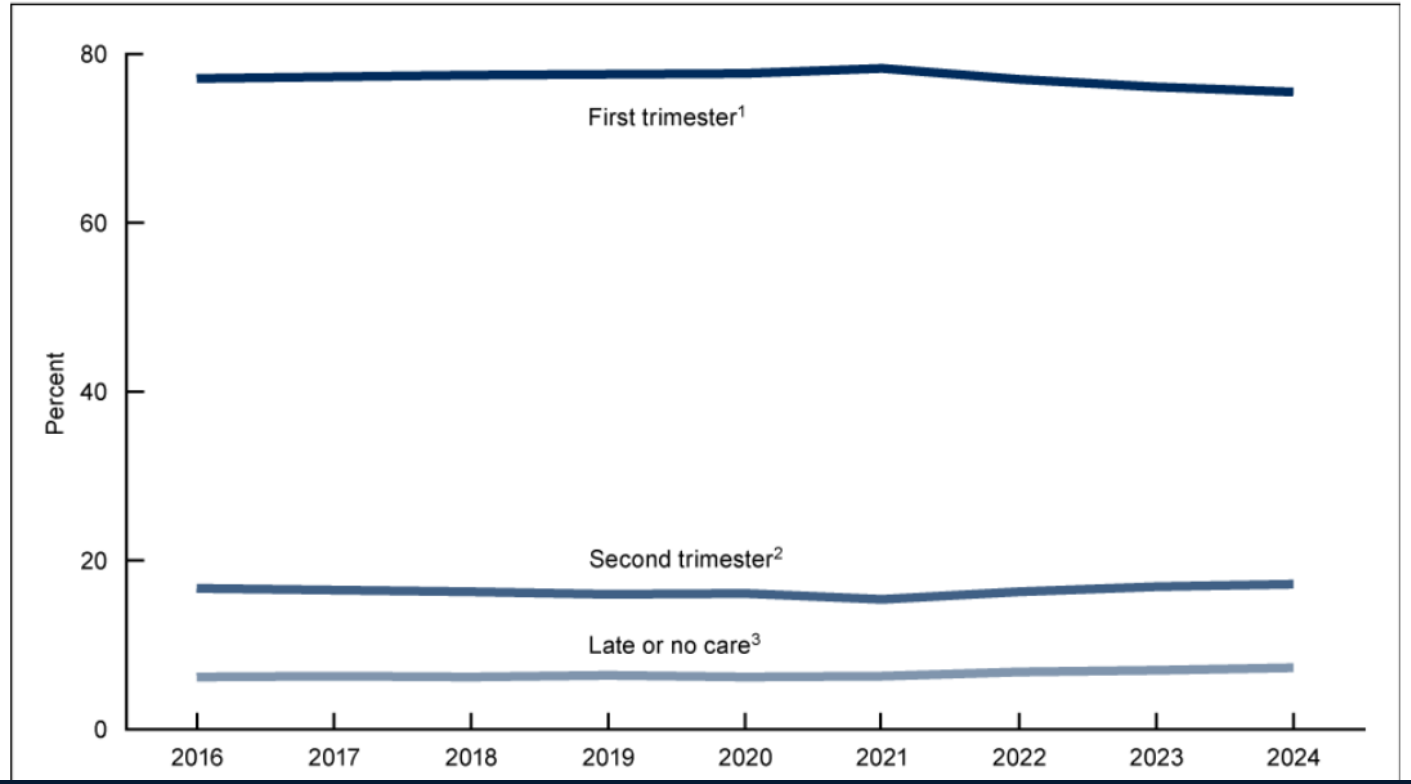
From 2021 to 2024, late or no care increased in 36 states and the District of Columbia.

Meanwhile for Azara customers, the **Early Entry Intro Prenatal Care UDS measure rate has risen from 46% to 52% between 2022 and 2025**

https://www.cdc.gov/nchs/products/databriefs/db550.htm#Key_finding

- From 2016 to 2021, prenatal care beginning in the first trimester increased 2% from 77.1% to 78.3%; care beginning in the second trimester decreased 8% from 16.7% to 15.4%; and late or no prenatal care fluctuated, ranging from 6.2% to 6.4% (Figure 1, Table 1).
- From 2021 to 2024, first trimester prenatal care declined 4%, from 78.3% to 75.5%.
- Prenatal care beginning in the second trimester increased 12% from 2021 to 2024, from 15.4% to 17.3%.
- Late or no care increased 16% from 2021 (6.3%) to 2024 (7.3%).

Figure 1. Timing of prenatal care initiation: United States, 2016–2024



Maternal Health and Value-Based Care

38% of the female population in the US is age 15-44 (~66 million)

25% of this population (~17 million) is on Medicaid

Pregnancy complications are expensive in the perinatal and postpartum period and in future pregnancies, and often increase the risk for cardiovascular and metabolic conditions later in life (NIH)

Pregnancies impact primary care

Support + Funding Sources for Maternal Care

- CMS Transforming Maternal Health Model
- HRSA local Healthy Start programs
- HRSA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program
- HRSA State Awards for Maternal Health
- HRSA RMOMS Program (Rural Maternity and Obstetrics Management Strategies)

How Azara Maternal Care Tools Can Help

Identify pregnant patients

Manage prenatal & postpartum patient populations

Evaluate program efficacy

Support Primary Care and OB

Monitor patients at risk

Report to external stakeholders

Alabama Primary Health Care Association

Alabama's Approach to Promoting Health Maternal and Baby Outcomes

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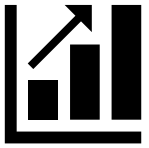
We Are APHCA

A **catalyst** for high performance and improved outcomes across its health care network of over 224 locations

Enhancing clinical and operational performance of health centers statewide

Providing professional services, training, health IT, and technical assistance rooted in APHCA's Values in Action.

Recognized by members, state and federal stakeholders, and partners for a strong culture and "elbow-to-elbow" services that result in performance improvement



>95% member Satisfaction ratings

Demonstrating strong financial performance and growth with highly reliable internal controls and compliance

Key Patient Characteristics

95%
At or below 200% FPL

25%
Children

7,108
Served in school-based clinic

74.4%
Uninsured, Medicaid, and Medicare

8,949
Experiencing homelessness

28,715
Best served in a language other than English

6,401
Veterans

6,921
Agricultural workers

APHCA | Quality Connect Network

20 Health Center Organizations across 2 states

- 224 care delivery sites
- Representing over 414,000 patient lives

Began partnering with Azara in 2021/2022

- Currently have 19 out of 20 organizations live

HCCN staff (4 primary members) built relationships through:

- Quality Connect monthly meetings
- User Groups – EHR and Azara
- CLIMB - quarterly in person, quality work group

A Look at the Data

From 2016-2021, the Maternal Mortality Rate (MMR) in Alabama **increased significantly**[1]

- Alabama Pregnancy related deaths increased by almost 35 deaths/100,000 live births
- Pregnancy associated deaths increased over by almost 55 deaths/100,000 live births
- The rates in rural areas were statistically higher (154.4 vs 110.9)

Leading causes of pregnancy related deaths were infection, hemorrhage, and cardiomyopathy – all of which have **increased incidences in patients with major uncontrolled chronic health conditions (such as hypertension and diabetes)**[1]

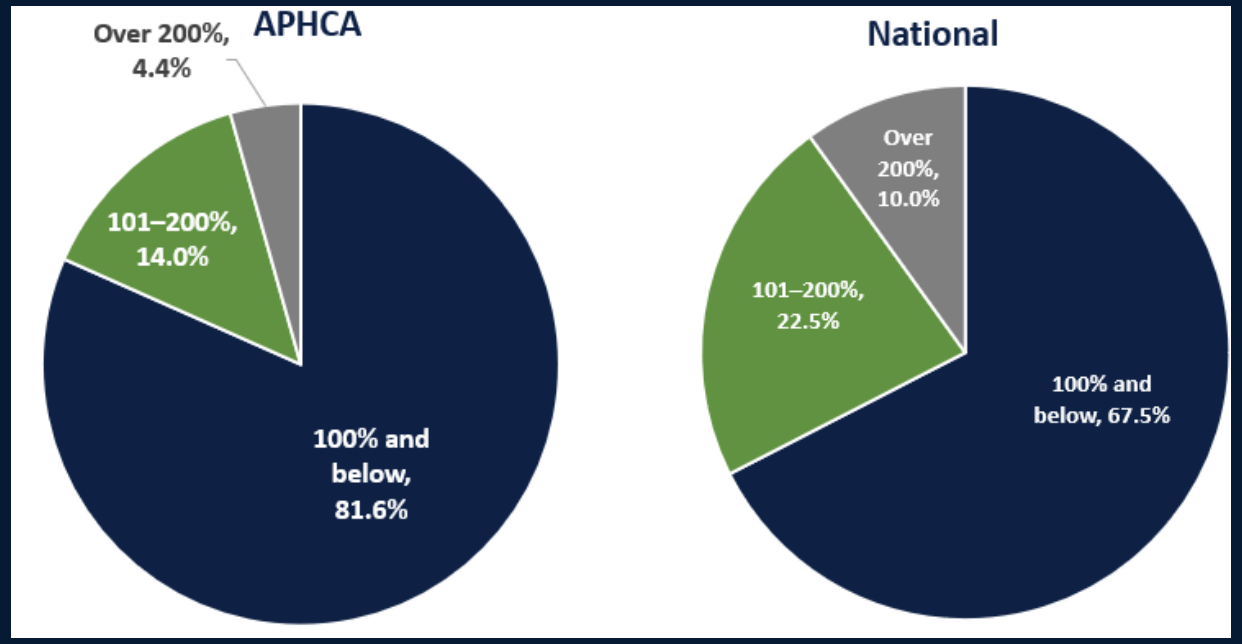
Over 54% of preventable pregnancy associated deaths occurred 43-365 days post delivery[1]

According to research and a nation-wide study, **perinatal patients who died were more likely to have experienced intimate partner violence (IPV), depressed mood, & substance use disorder which contributed to their death**[2]

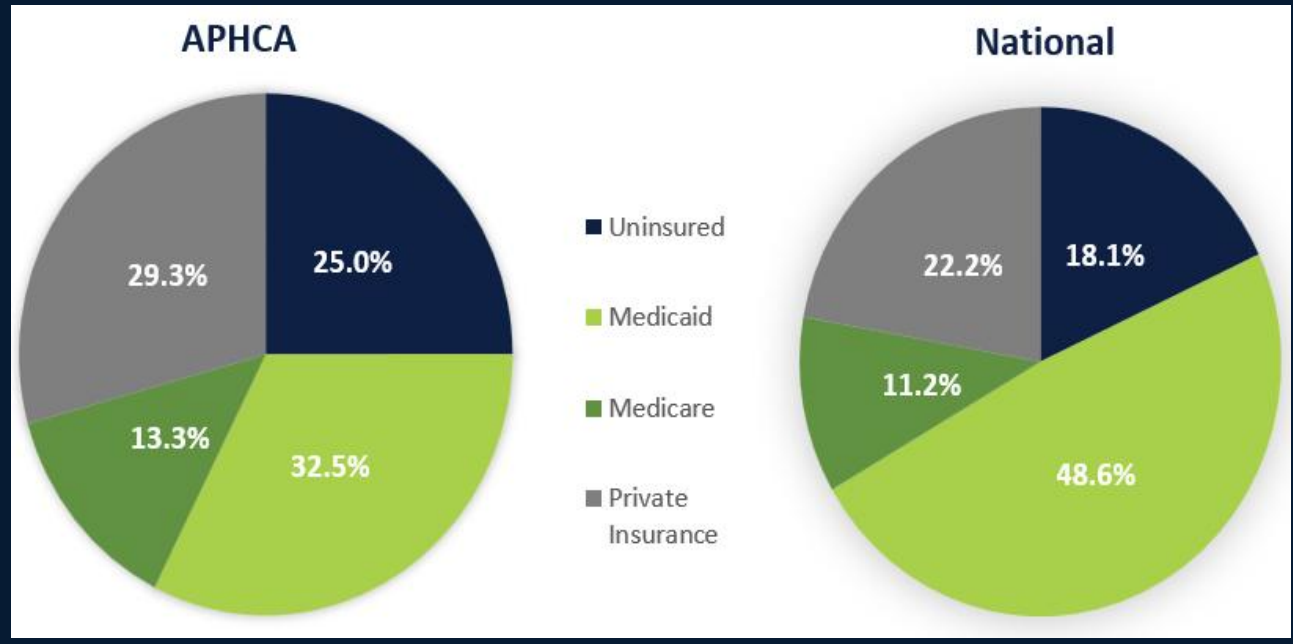
1. 2020-2021-annual-mmr.pdf
2. Suicide Mortality During the Perinatal Period | Public Health | JAMA Network Open | JAMA Network

Unique Challenges in Alabama

Alabama FQHC patients at 100% and below of FPL is over 17% higher than national data



Uninsured rates for Alabama FQHC are 7% higher than national data



Medicaid and Hospital Impact

Alabama is one of only 10 states without an expanded Medicaid program

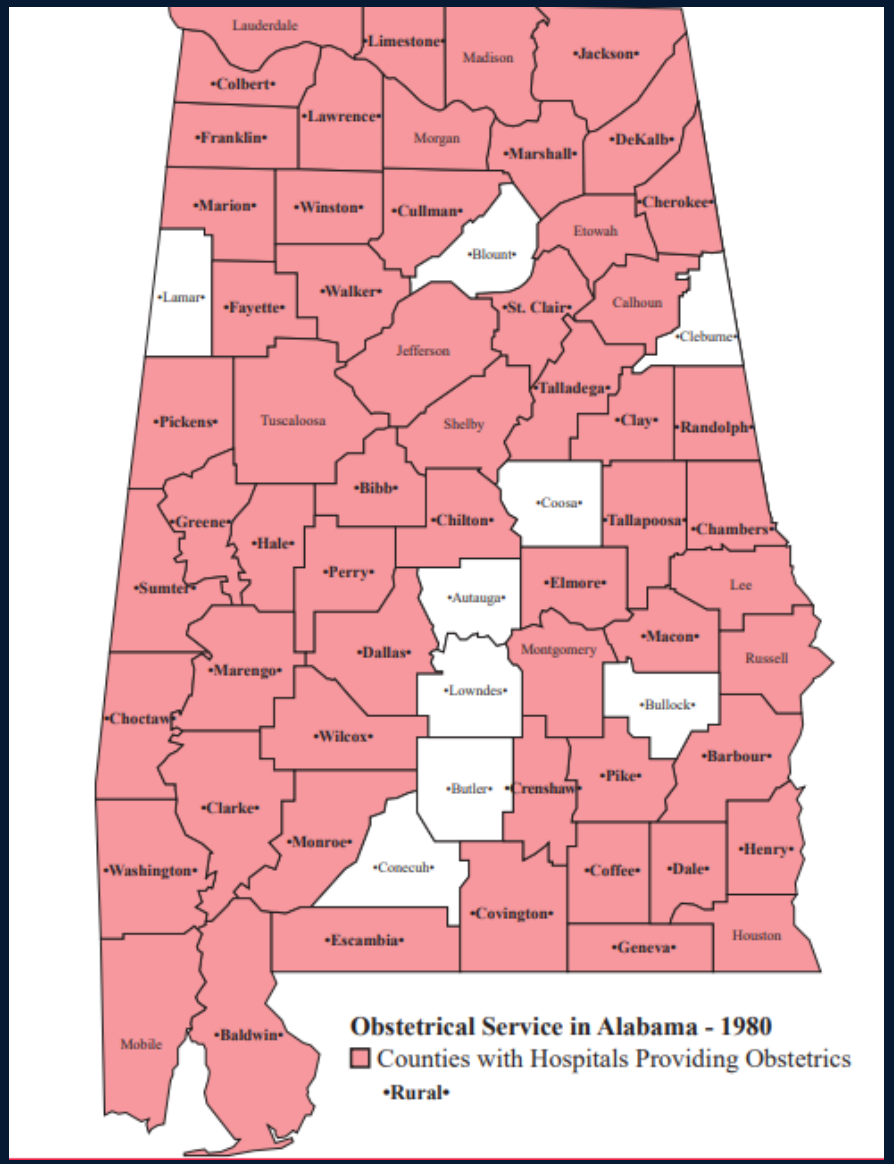
Uninsured women who are legally in the US are immediately eligible for Medicaid while they are pregnant and for 12 months post birth → Because some women are not eligible for Medicaid before pregnancy, many return to uninsured status once coverage stops

Since the end of 2020, more than 120 rural labor and delivery units nationwide have closed[1]

Less than 33% of rural hospitals provide maternity care leading to longer travel for OB care – often 50 minutes or more – and 20% of still existing units are at significant risk of closing[1]. South Alabama has been particularly hard hit with two rural hospitals fully closing since 2020.

Distance to Obstetrical care is a barrier FQHCs are addressing by increasing focus on mental health and safety, as well as chronic condition management post delivery

1. Rural_Maternity_Care_Crisis.pdf



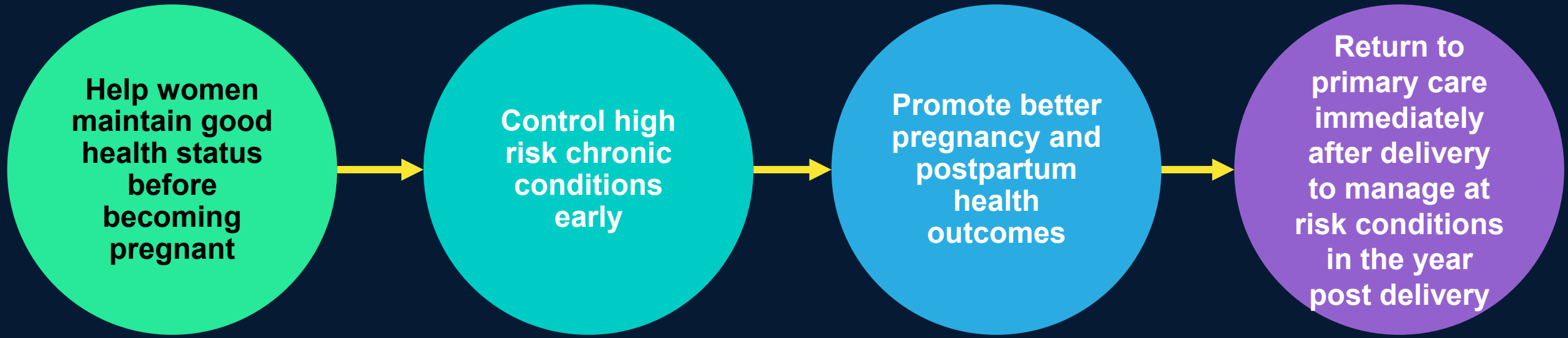
45 of the 55 counties currently considered **RURAL** had hospitals providing obstetrical service in **1980**

15 of the 55 counties currently considered **RURAL** have hospitals providing obstetrical service **TODAY**

PICTURE OF THE LOSS OF RURAL OBSTETRIC AL SERVICE 1980-2025

Produced by the Alabama Department of Public Health, Office of Primary Care and Rural Health, September 3, 2025. The defining of countries as rural or urban is based upon a definition that is used by the Alabama Rural Health Association. ADPH Rural Health Service Map - OB_service_map_2025

Strategic Approach



Approach improving Maternal Health as a continuum from child-bearing age throughout the first-year post delivery

Prevalence of Disease and Related Needs

Women of Child Bearing Age Disease Prevalence

DASHBOARD

FILTER

PERIOD: TY February 2026 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

Diagnosis Prevalence - CBA Females

PATIENT DIAGNOSES	NUM	% TOTAL
Anxiety	28,075	11.8%
Depression	22,458	9.5%
Morbid (Severe) Obesity	16,692	7.0%
Hypertension (all types)	16,521	7.0%
Hypertension - Essential	16,443	6.9%
Severe Mental Illness and Psychosis	15,008	6.3%
Hyperlipidemia	14,606	6.2%
Asthma	8,853	3.7%
Chronic Non-malignant Pain	7,953	3.4%
Prediabetes First Dx	7,745	3.3%
Diabetes Type I or Type II	6,993	2.9%
Severe Emotional Disturbance (SED)	6,412	2.7%
Attention-deficit hyperactivity disorders	6,206	2.6%
Prediabetes	5,999	2.5%
Pregnancy Past Year	4,614	1.9%
Diabetes (Any Type) With Complications	4,248	1.8%
Bipolar Disorder First Dx	4,113	1.7%
Bipolar Diagnosis	3,642	1.5%
Hypothyroidism	3,325	1.4%
Post-Partum Patient 12 Months	3,030	1.3%
Post-traumatic stress disorder (PTSD)	2,553	1.1%
Cirrhosis or other liver disease	2,407	1.0%
Alcohol/Substance Dependency	2,399	1.0%

Chronic Condition Comorbidity Prevalence - CBA Females

PATIENT DIAGNOSES	NUM	% TOTAL
Actively Pregnant Patient	320	0%
Acute Myocardial Infarction	25	0%
Alcohol Disorder	300	0%
Alcohol/Substance Dependency	989	1%
Anxiety	9,820	8%
Arteriosclerosis/Cardiovascular Disease (ASCVD)	327	0%
Asthma	8,853	7%
Atrial Fibrillation/Flutter (ICD-9 codes)	78	0%
Attention-deficit hyperactivity disorders	1,800	1%
Autism Spectrum Disorders	137	0%
Bipolar Diagnosis	1,442	1%
Bipolar Disorder First Dx	1,606	1%
Cancer or Malignancy Active Diagnosis	312	0%
Cataract Age-Related	60	0%
Cerebral Palsy	101	0%
Chronic Hepatitis C	153	0%
Chronic Kidney Disease Stages 3 and 4	249	0%
Chronic Kidney Disease, Stage 5	55	0%
Chronic Non-malignant Pain	3,861	3%
Chronic Obstructive Pulmonary Disease (COPD)	267	0%
Cirrhosis	45	0%
Cirrhosis or other liver disease	1,232	1%
Congestive Heart Failure	371	0%

Non-Medical Needs Identified Prevalence Females 13+

SDOH	NUM	% TOTAL
ISOLATION	7,185	14%
SAFETY	5,323	11%
INSURANCE	4,993	10%
MED/CARE	4,291	9%
STRESS	4,063	8%
EMPLOYMENT	3,546	7%
FOOD	2,926	6%
UTILITY	2,512	5%
CLOTHING	1,979	4%
EDU	1,872	4%
TRANSPORT-MED	1,830	4%
PHONE	1,773	4%
HOUSING	1,458	3%
TRANSPORT-NONMED	1,447	3%
MIGRANT	1,006	2%
CHILDCARE	820	2%
HOMELESS	813	2%
VIOLENCE	683	1%
VETERAN	519	1%
INCARC	430	1%
RENT/MORTGAGE	318	1%
MATERIAL SECURITY	121	0%
REFUGEE	117	0%

Use Cases for Azara Builds

Assessment of needs at population level, center level, and even location level.

Ongoing trend data to improve performance, target challenge areas and provide resource management.

Actionable point of care alerts to allow providers and staff to address needs while patient in office.

Utilize populations in care effectiveness reports to improve outcomes across all post partum patients in primary care – not just in immediate post partum follow up visit.

Azara Built to Capture Data

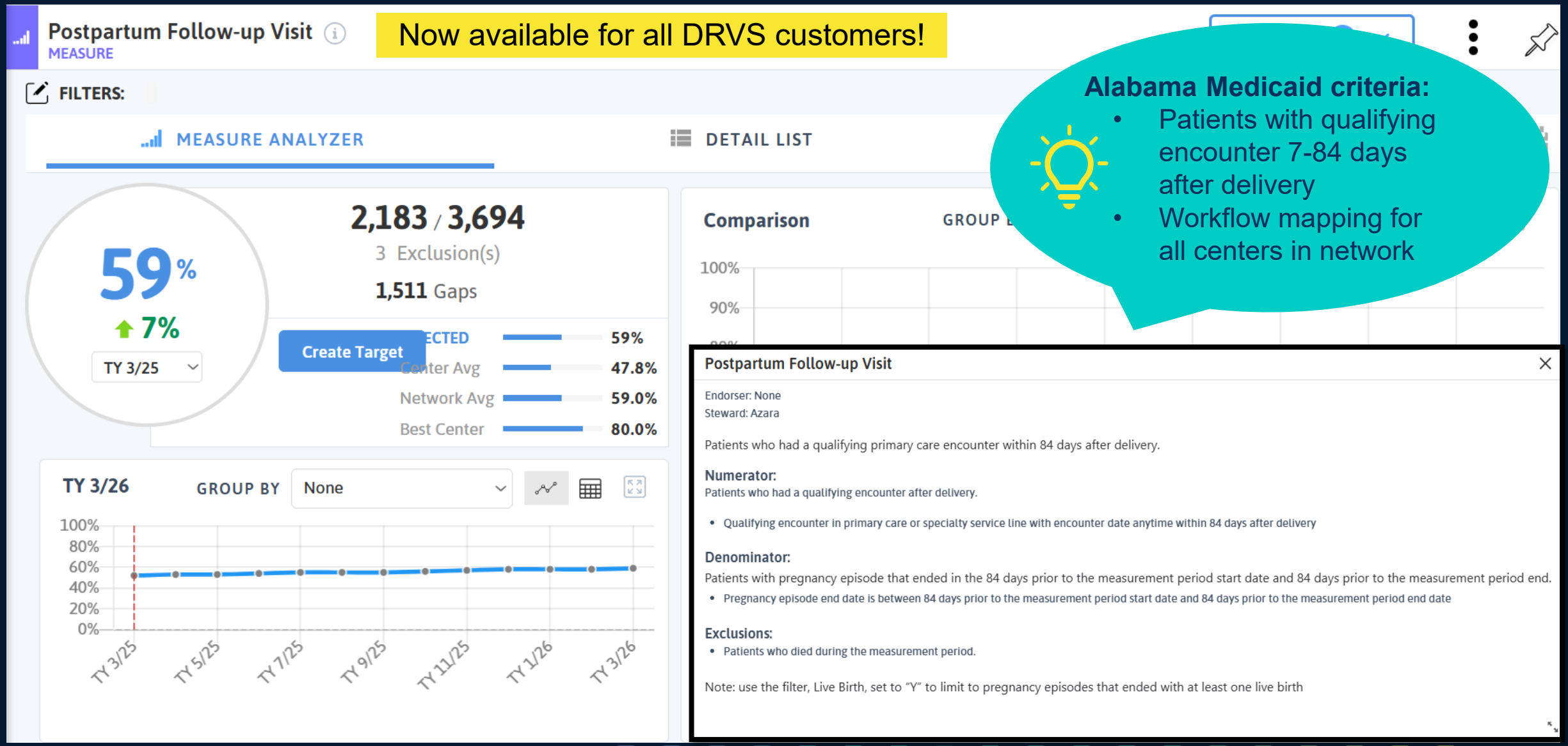
Filters across Azara for any quality measure to show patients both Actively pregnant as well as up to 1 year post partum:

- Compares overall chronic conditions for Post partum patients
- Facilitates outreach and management of non-medical health related needs
- Provides targeted, actionable dashboard builds

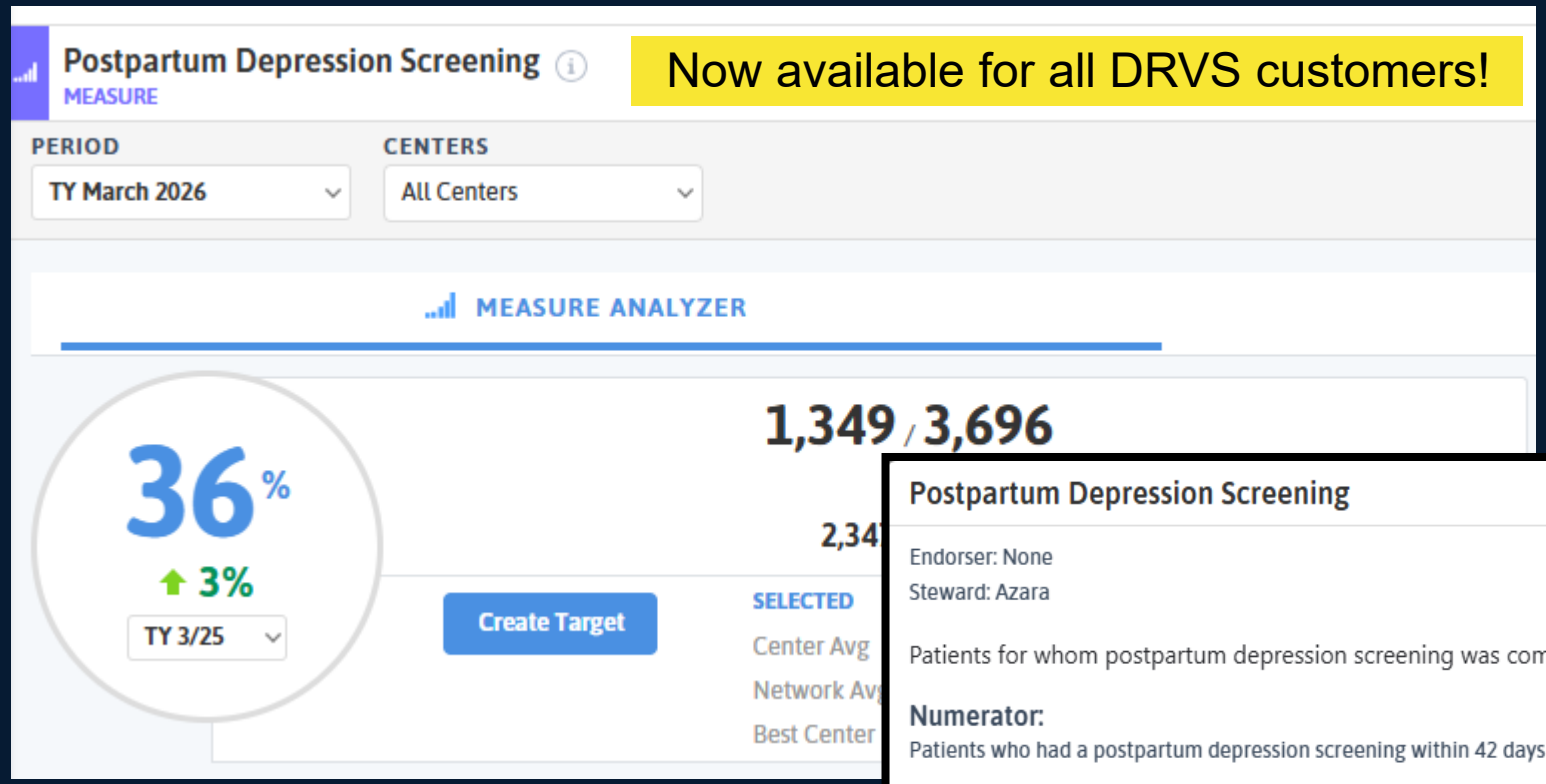
Vitamin D and STI screening

Identifies if women of child-bearing age are being screened for appropriate Vitamin D levels (directly impacts overall pregnancy health) and STIs prior to conception

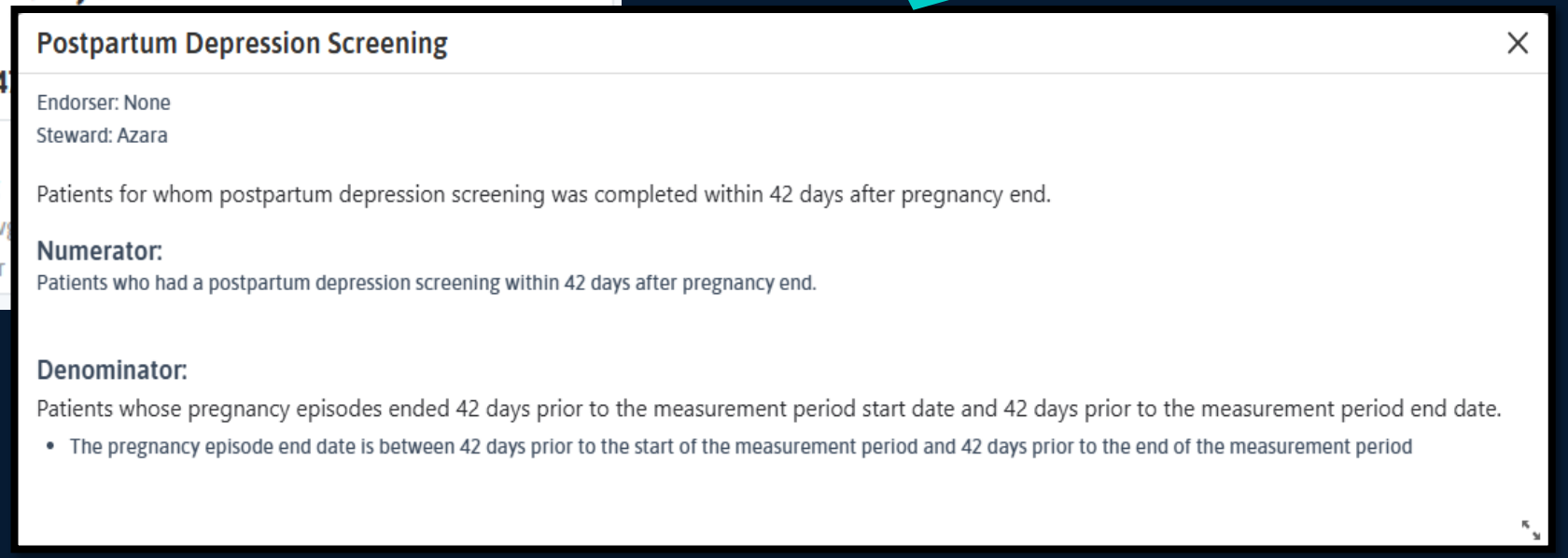
Post Partum Follow Up Visit Tracking



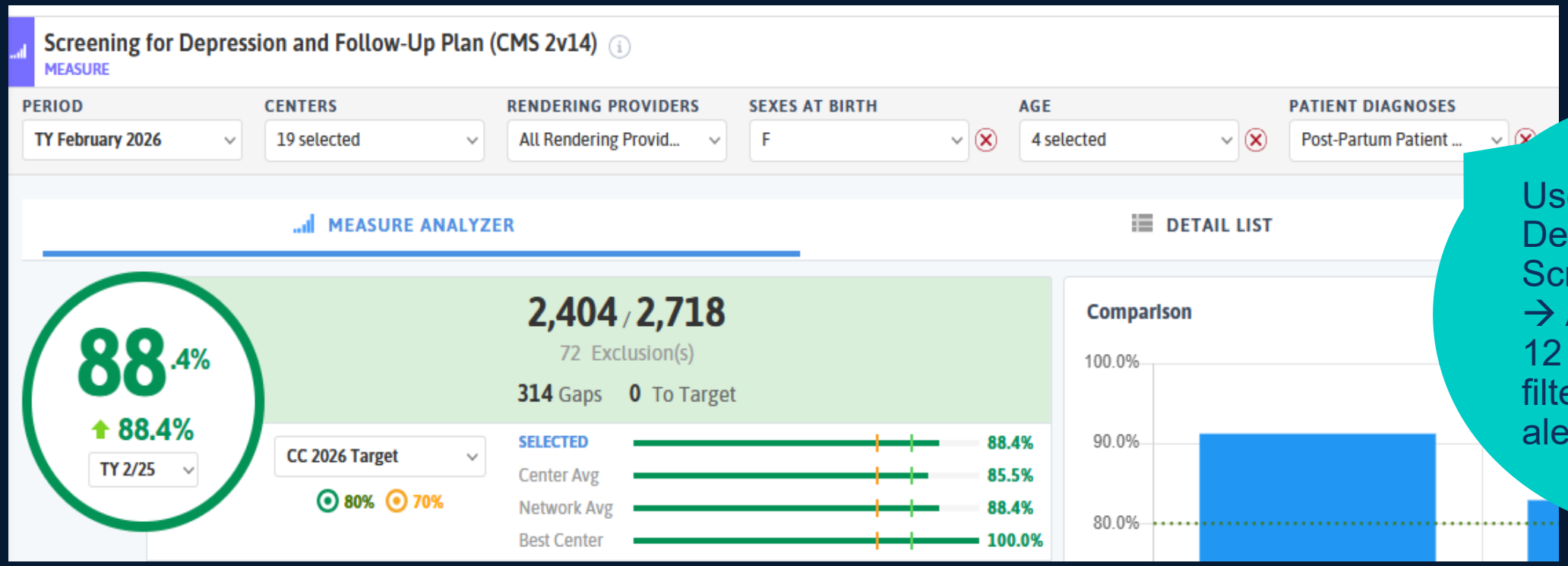
Post Partum Depression Screening Initial



Post Partum Depression Screening first 42 days: Screening rate for all patients in first 42 days after pregnancy end – no intervention portion



Post Partum Depression Screening 12 months

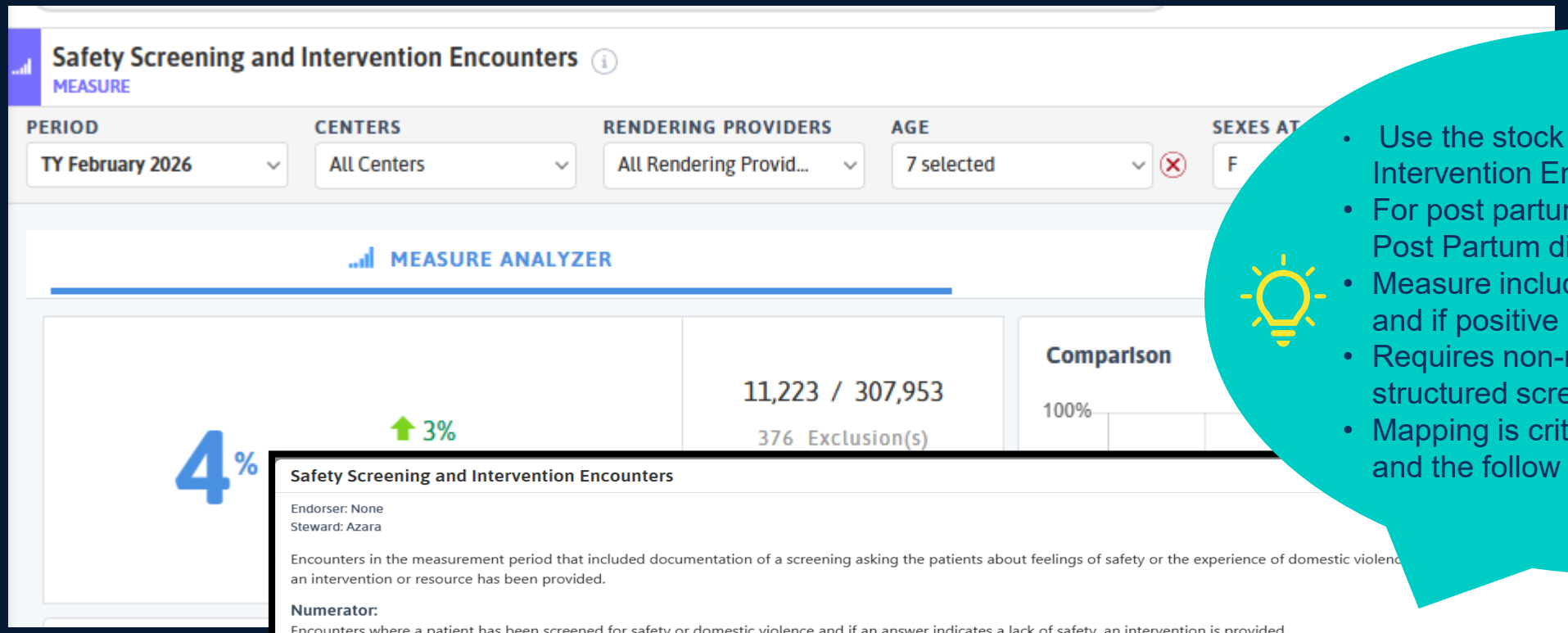


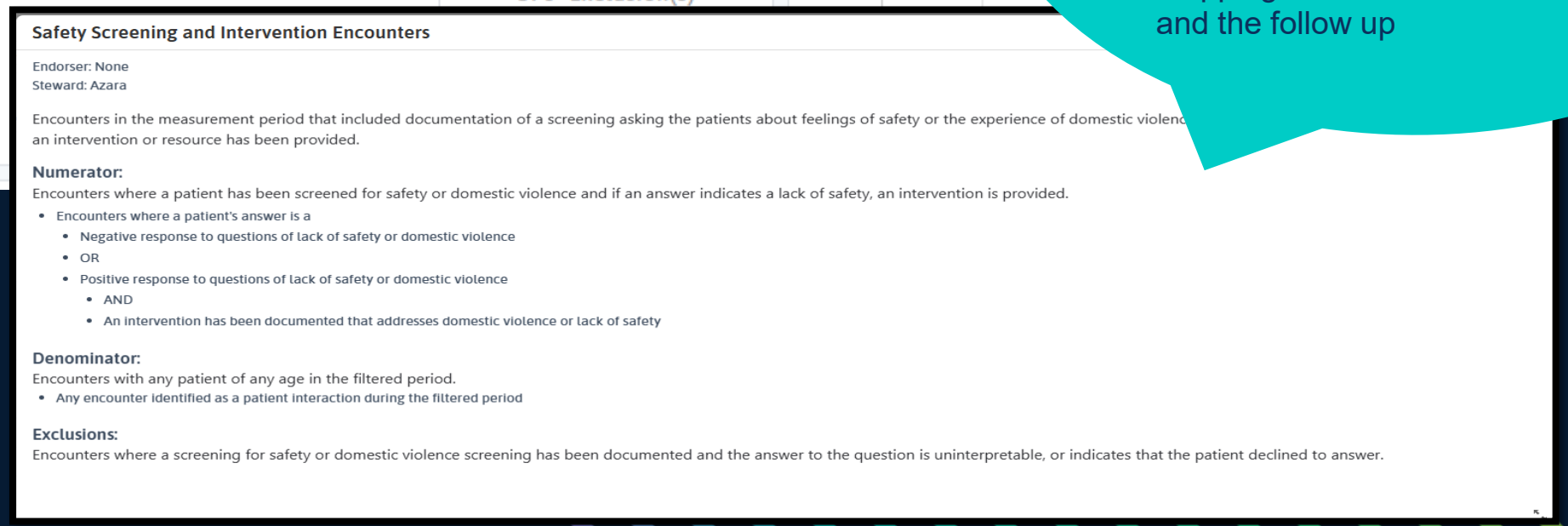
Use standard Depression Screening measure → Apply PP Patient 12 Mo Diagnosis filter → Enable PVP alert

NAME	PVP NAME	ENABLED	CONFIGURABLE	DESCRIPTION
Postpartum Depression Screen 12mos	Post Partum Depression	N	N	Alert will trigger for patients which had a pregnancy episodes that ended in the past 12 months, but no depression screening has been completed since the end of the pregnancy. This alert is not configurable

Now available for all DRVS customers!

Intimate Partner Violence Screening





Safety Screening and Intervention Encounters

Endorser: None
Steward: Azara

Encounters in the measurement period that included documentation of a screening asking the patients about feelings of safety or the experience of domestic violenc
an intervention or resource has been provided.

Numerator:
Encounters where a patient has been screened for safety or domestic violence and if an answer indicates a lack of safety, an intervention is provided.

- Encounters where a patient's answer is a
  - Negative response to questions of lack of safety or domestic violence
  - OR
  - Positive response to questions of lack of safety or domestic violence
    - AND
    - An intervention has been documented that addresses domestic violence or lack of safety

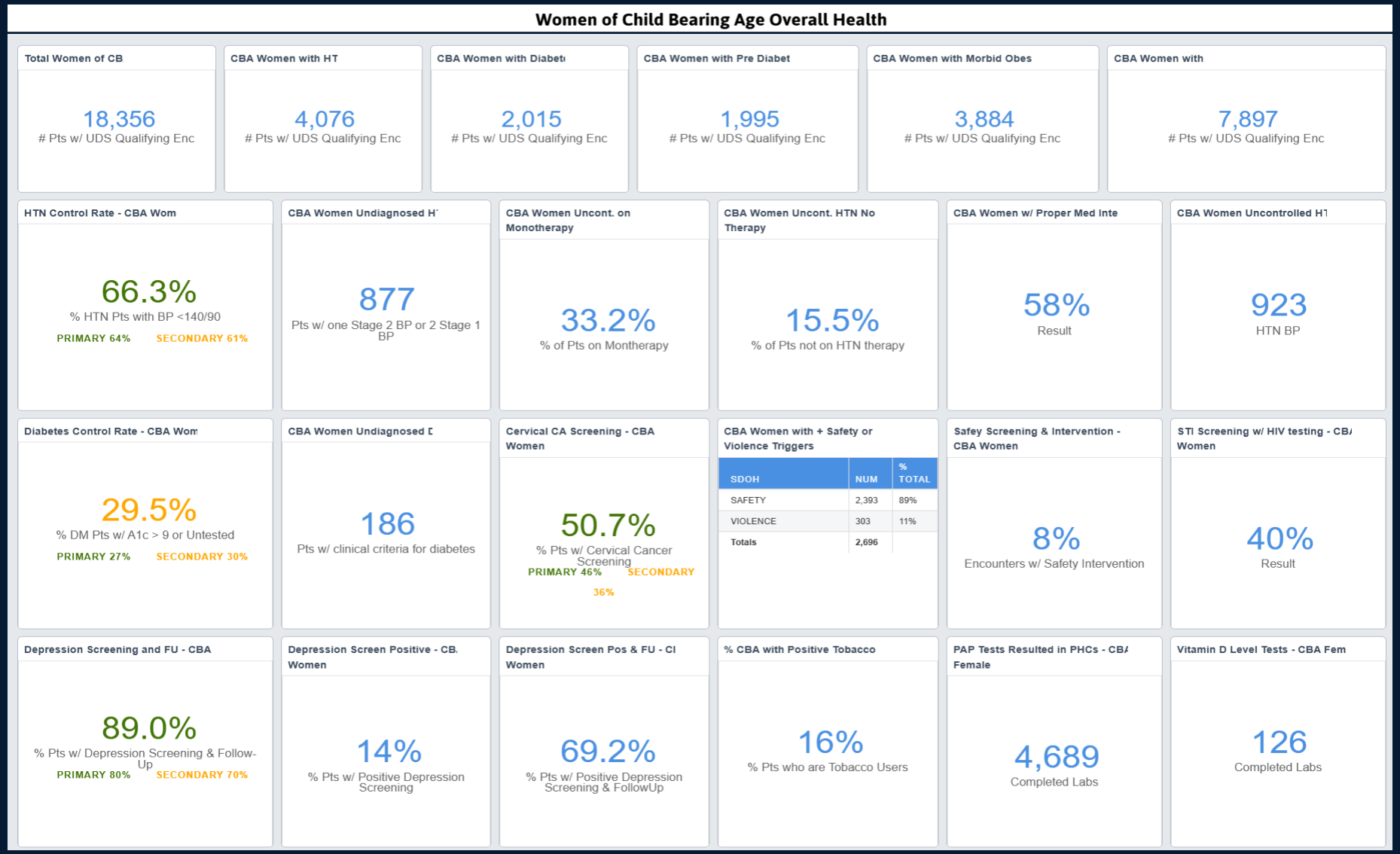
Denominator:
Encounters with any patient of any age in the filtered period.

- Any encounter identified as a patient interaction during the filtered period

Exclusions:
Encounters where a screening for safety or domestic violence screening has been documented and the answer to the question is uninterpretable, or indicates that the patient declined to answer.

- Use the stock Safety Screening and Intervention Encounters
- For post partum use, apply filter for Post Partum diagnosis
- Measure includes screening for IPV and if positive having an intervention
- Requires non-medical social needs structured screening OR IPV screening
- Mapping is critical for both screening and the follow up

Women of Child-Bearing Age Overall Health



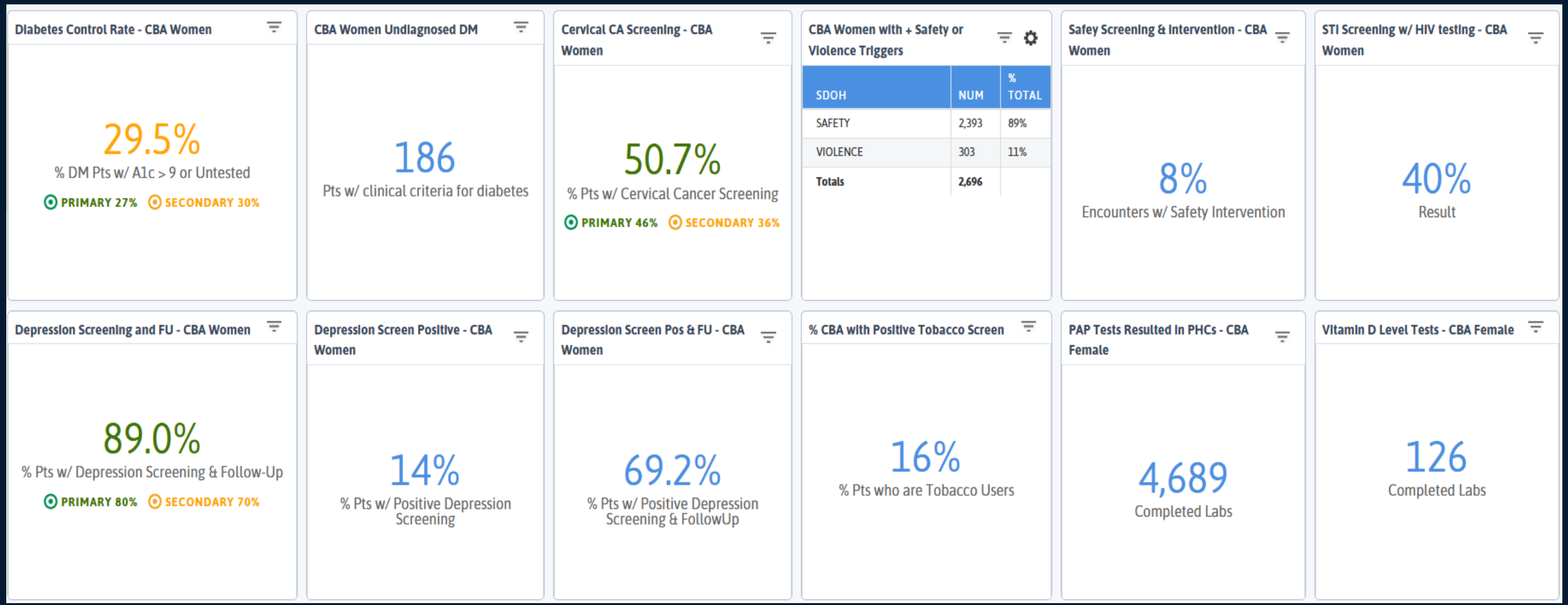
Connecting to patient lives

Total Women of CBA	CBA Women with HTN	CBA Women with Diabetes	CBA Women with Pre Diabetes	CBA Women with Morbid Obesity	CBA Women with Anxiety/Depression
18,356	4,076	2,015	1,995	3,884	7,897
# Pts w/ UDS Qualifying Enc	# Pts w/ UDS Qualifying Enc	# Pts w/ UDS Qualifying Enc	# Pts w/ UDS Qualifying Enc	# Pts w/ UDS Qualifying Enc	# Pts w/ UDS Qualifying Enc

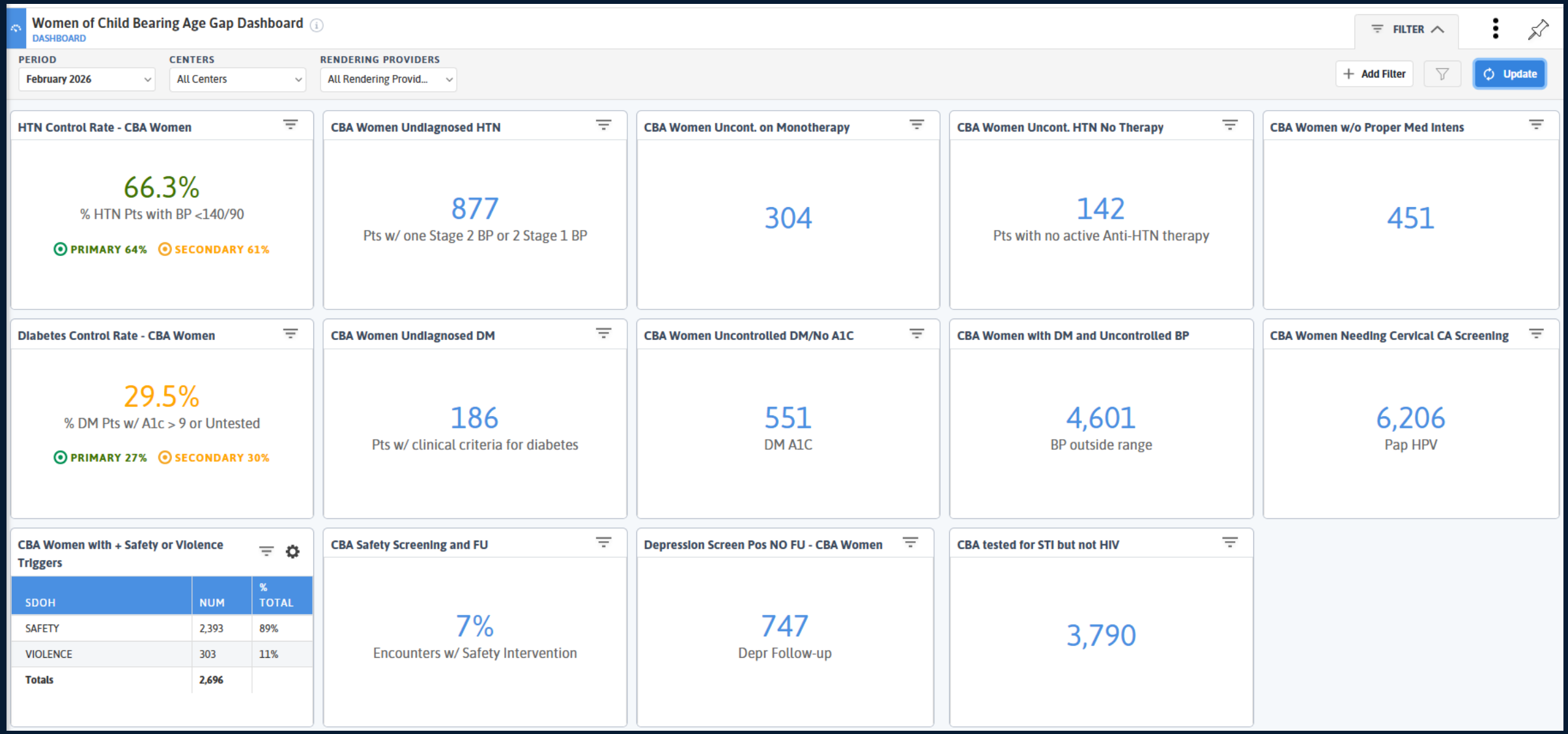
Overall Care for HTN

HTN Control Rate - CBA Women	CBA Women Undiagnosed HTN	CBA Women Uncont. on Monotherapy	CBA Women Uncont. HTN No Therapy	CBA Women w/ Proper Med Intens	CBA Women Uncontrolled HTN
66.3%	877	33.2%	15.5%	58%	923
% HTN Pts with BP <140/90	Pts w/ one Stage 2 BP or 2 Stage 1 BP	% of Pts on Montherapy	% of Pts not on HTN therapy	Result	HTN BP
PRIMARY 64% SECONDARY 61%					

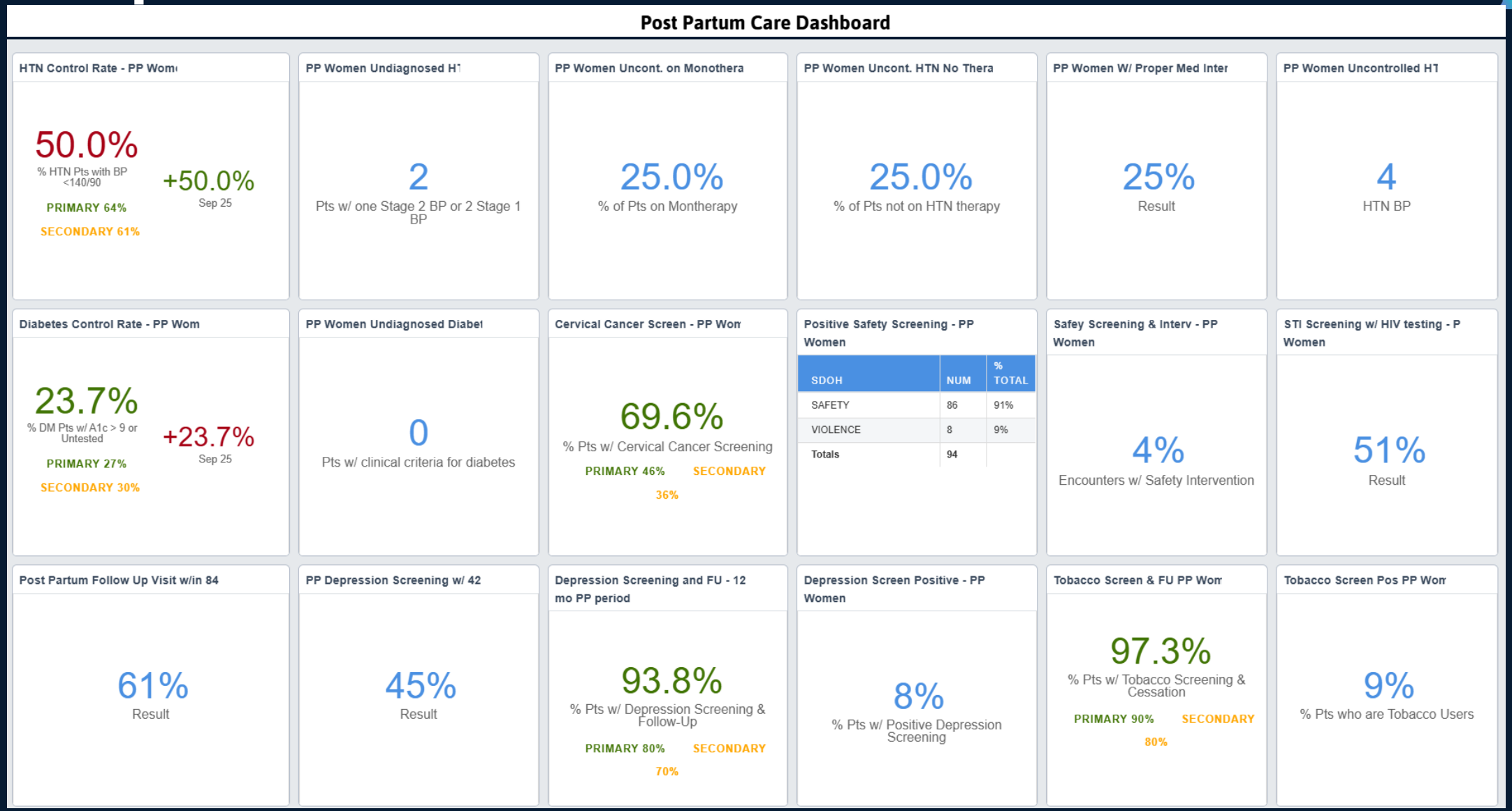
Diabetes Care and Safety/MH Metrics



Women of Child-Bearing Age Gap



Comprehensive Post Partum Care



Future Plans | Geomapping Tools

Software that incorporates data from nationally validated sites to allow visual representation of data with multiple layers in one view:

- Utilize prevalence trends from Azara with appropriate gender/age filters as layers to identify further high-risk areas.
- Incorporate non-medical health related data at a zip code level from Azara.
- Identify target areas for mobile units, collaborations, and rural areas who would benefit from care coordination and/or maternity services.

Massachusetts League of Community Health Centers

Closing data gaps and building solutions for maternal care

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Identifying the Need for Perinatal Health Data

The Problem: Inconsistent EHR perinatal data collection for point-of-care and population health

Providers documenting in multiple EHR systems.

- Lack of standardized workflows.
- Reliance on spreadsheets.

Lack of interoperability among EHR systems across multiple care settings.

Inaccurate downstream information tools (such as dashboards).

The Need: Methods & procedures to ensure collection of high-quality perinatal data

- Standardized data and workflows
- Useful for population and state-of-health analyses

From Data to Solutions: The PDLC

The Perinatal Data Learning Collaborative (PDLC) is a health center led effort launched by the Institute for Health Equity Research, Evaluation and Policy, Inc. to **directly enhance standardization, collection, and access to perinatal data.**

Establish a statewide Learning Collaborative pilot with two “superuser” health centers: Brockton Neighborhood Health Center and NeighborHealth

Develop technical capabilities and disseminate best-practices statewide

Fund Azara Maternal Care Module for up to **9 health centers** to enhance perinatal data capacity.

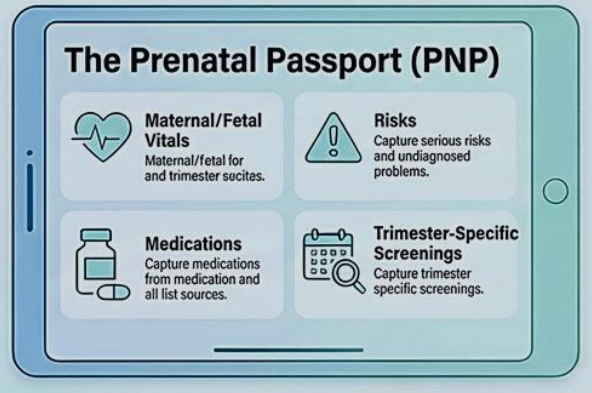
PDLC Goals

Develop standardized, shared, EHR-aligned workflows using tools such as **Azara DRVS**, that are useful for population health and UDS reporting, including dashboards integrated into population health platforms.

From Data to Solutions: Maternal Care in DRVS

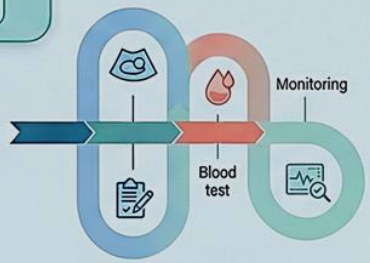
Optimizing Maternal Care: Clinical Capabilities of Maternal Care Module

Comprehensive Patient Tracking



16 Enhanced Registry Data Elements

Provides 16 additional pregnancy-specific RDEs to capture granular clinical data.



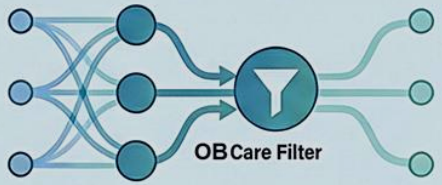
OB Pregnancy Details Report

Automatically monitors and tracks essential screenings and tests performed during the pregnancy.

Clinical Compliance & Reporting

UDS Table 7 OB Care Filter

Identifies prenatal patients treated at the center for accurate birthweight reporting.



Prenatal Program Mapping

Feeds the care filter to ensure all enrolled patients are correctly categorized.

Azara Maternal Care Module Program Rollout

Phase 1: Strategic Planning & Selection Process (Spring 2025)

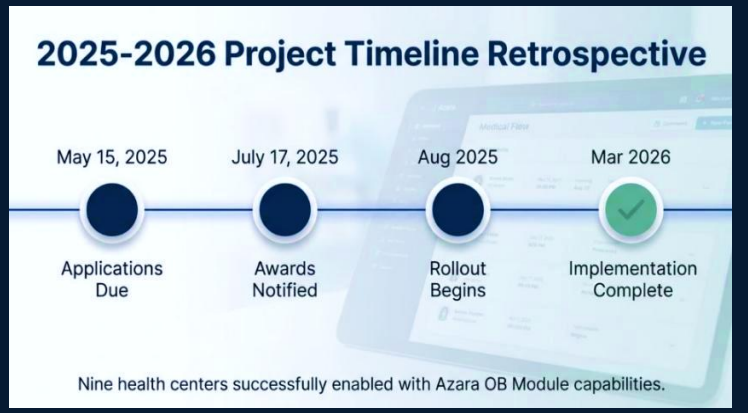
- Discovery: Partnered with Azara to define Maternal Care module capabilities, costs, and SOW.
- Funding: Secured private funding to subsidize health center costs.
- Engagement: Conducted webinar series and launched a competitive application process.
- Selection process : **Nine Health Center applications have been awarded.**

Phase 2: Phased Implementation

(Aug 2025 – Mar 2026)

- Cohort 1: Launched initial 3 CHCs in August 2025.
- Scale: Coordinated rollout sequence with Azara to ensure technical stability.
- Completion: All 9 CHCs successfully implemented by March 2026.

Application Review Process & rollout timeline



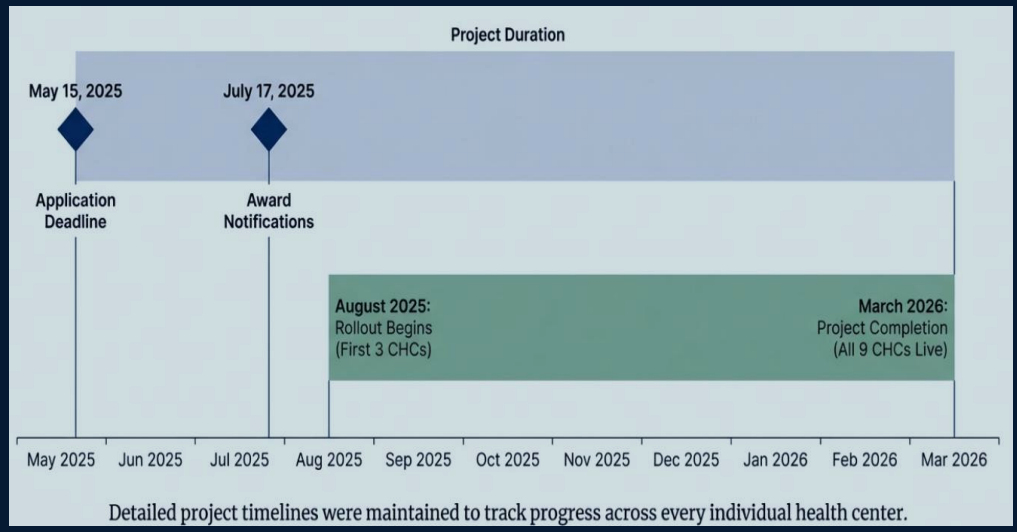
The HCCN & Institute for Health Equity role in the Maternal Care Project

Led the Strategic Planning & Selection Process (Spring 2025)

- Managed the transition from contract execution to live implementation.

Provided support, coordination, and oversight throughout Phased Implementation

- Maintained **thorough documentation** throughout the engagement
- Developed and maintained the **project timeline** to track individual CHC progress
- Provided **timely updates** to leadership on status and rollout progress
- Led **formal closeout communication**
- **Post-implementation survey** to capture feedback and document outcome. **(***Work in progress***)**



Detailed project timelines were maintained to track progress across every individual health center.

Setting a Standard for Network Implementation

Successfully navigated from needs assessment to full implementation in under 12 months.

The Perinatal Data Learning Collaborative, led by health centers, IHE, and MLCHC, removed financial barriers for 9 health centers to access vital OB care data tools.

This project serves as a blueprint for future centralized technology rollouts, demonstrating the value of HCCN, IHE research infrastructure and vendor partnership.

Edward M. Kennedy Community Health Center

Applying analytics tools at the point of care and beyond

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Edward M. Kennedy OB Team

EDWARD M. KENNEDY COMMUNITY HEALTH CENTER 15

1 Location with OB services – Tacoma

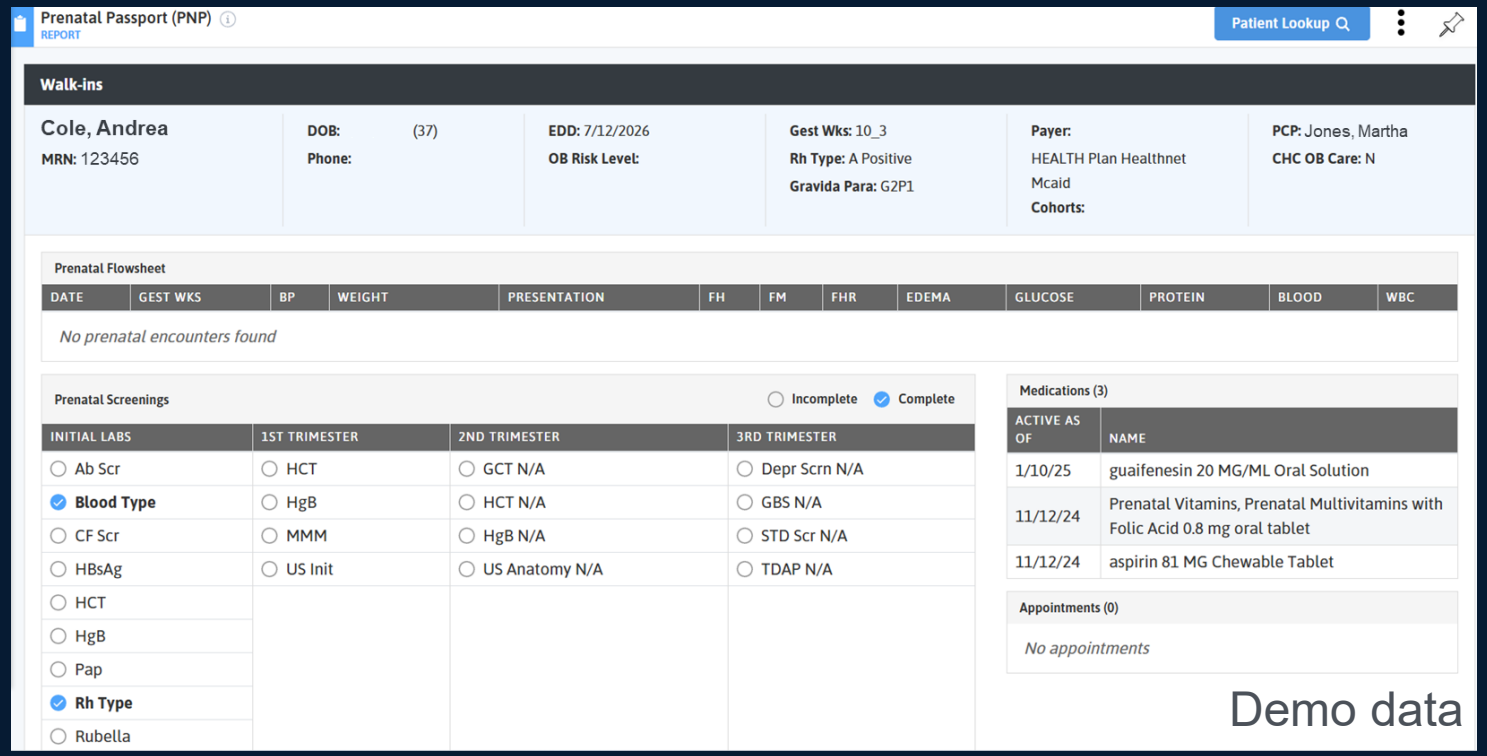
19 Providers see OB Patients

5 Members of the OB team

- 1 Nurse Manager
- 1 Medical Assistant
- 1 Community Health Worker
- 2 Navigators

Prenatal Passport

- Used for pre-visit planning
- Easy review and ordering of labs and other testing
- Follow up on open referrals
- Utilized by the entire care team

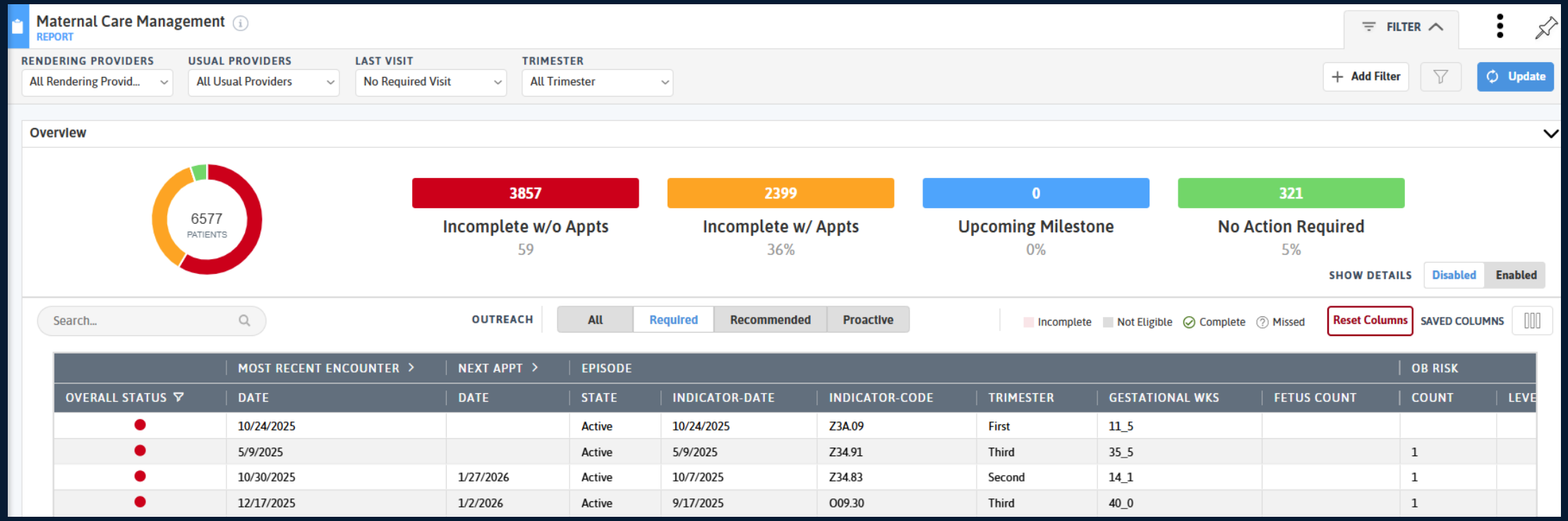


Maternal Care Management

Used by the support team

Great for a quick glance & patient overview

Once need is identified, team uses the OB Episode report or does a chart review



Non – OB Visits

Primary Care providers review the changes on the Patient Visit Planning report

High-level OB detail give all providers some knowledge of patients' current state

6:15 AM Wednesday, January 7, 2026 Visit Reason: **Mental Health and Counseling Canceled**

Wrighton, Taylor PNP
MRN: 1100323
DOB: 02/19/1994 (31)
Gest Wks: 39_5

Sex at Birth: F (She/Her/Hers)
GI: Choose not to disclose
SO: Lesbian or gay

Phone: 413-095-3254
Lang: Spanish

Portal Access: 05/01/2024
Cohort: Carrie's CM

PCP: Decelles, Larry
Payer: BCBS
CM: Kellen McDonnell

DIAGNOSES (3)

Asthma	DM I or II	HIV

RISK FACTORS (5)

Act Preg	ANTICOAG	Chronic Opioid Tx
IDD	SMI	

SDOH (15)

ALERT	MESSAGE	DATE	RESULT	OWNER
Maternal Care Screenings	Incomplete			
Depression Screen	Overdue	4/19/2025	Positive	MA
Tobacco Scr	Overdue	5/1/2024	N	MA
Foot	Overdue	5/1/2024	N	
Prenatal	Missing			

Demo data

Benefits for UDS Reporting

- Track all patients throughout OB episode – both those receiving care at Tacoma location and those receiving care elsewhere.
- Capture post-partum data and follow up as needed.

PREGNANCY END			DELIVERY			BIRTH WEIGHT		PRENATAL PROGRAM ENTRY		
EST-DELIVERY-DATE	EST-DELIVERY-TYPE	PREGNANCY END DATE	DATE	OUTCOME	LIVE-BIRTH	VALUE	STATUS	DATE	TRIMESTER	HERE
12/4/2025	Est Delivery Date	11/25/2025	11/25/2025	Live Birth Delivery	Y	2790.00		10/14/2025		N
11/29/2025	LMP Date + 280 days									N
12/3/2025	Est Delivery Date	12/5/2025	12/5/2025	Live Birth Delivery	Y	3655.00		5/22/2025	1	Y
11/27/2025	Est Delivery Date	11/16/2025	11/16/2025	Live Birth Delivery	Y	2910.00		5/7/2025	1	Y
11/22/2025	Est Delivery Date	11/20/2025	11/20/2025	Live Birth Delivery	Y	3205.00		8/15/2025	2	Y
12/7/2025	Est Date of Conception + 265 days									N
11/13/2025	Est Delivery Date	11/17/2025	11/17/2025	Live Birth Delivery	Y	3919.00		4/30/2025	1	Y
11/26/2025	Est Delivery Date	11/19/2025	11/19/2025	Live Birth Delivery	Y	3645.00		4/17/2025	1	Y
11/16/2025	LMP Date + 280 days									N
12/7/2025	Est Delivery Date							5/30/2025	1	Y
12/7/2025	LMP Date + 280 days									N
5/12/2026	Est Delivery Date	11/20/2025		Other Pregnancy En...				9/25/2025	1	Y
10/14/2025	Est Date of Conception + 265 days									N
12/2/2025	LMP Date + 280 days									N
7/6/2026	Est Delivery Date	12/30/2025		Other Pregnancy En...				12/11/2025		N

Questions?

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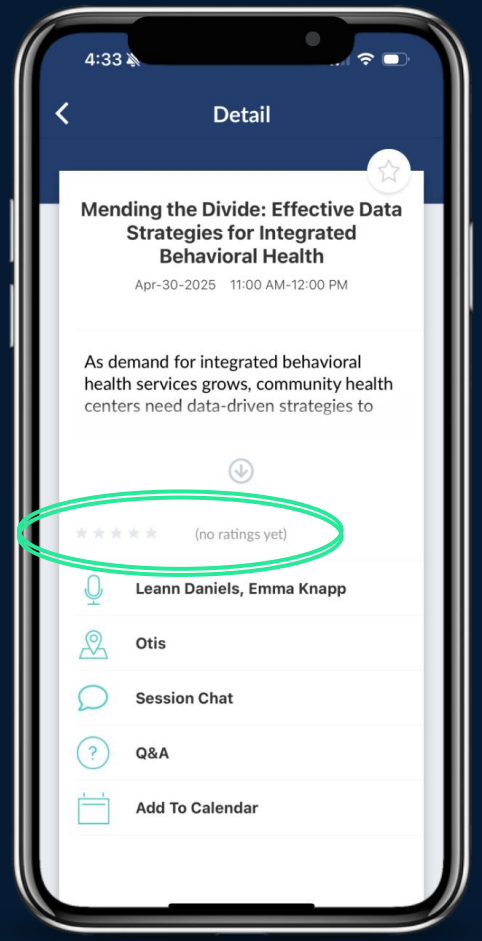

Quick and Easy

Provide brief feedback or ideas

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Help us continue to improve

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Thanks for attending!