

# New York State Perinatal and Infant Community Health Collaborative Initiative

## 2022 -2023 Annual Report

**Reporting Time Period: July 1, 2022 – June 30, 2023**

### **An Overview:**

The Perinatal and Infant Community Health Collaborative (PICHC) initiative supports both individual and community-level strategies that are designed to improve the health and well-being of high-need, low-income birthing people and their families and improve health outcomes. PICHC programs also work to reduce persistent racial, ethnic, and economic disparities in those outcomes.

PICHC was launched on July 1, 2022, to continue to enhance New York State's previously supported Maternal and Infant Community Health Collaborative (MICHHC) program. Twenty-six PICHC programs, which serve 32 counties statewide, were funded for the five-year period ending June 30, 2027.

### **Outcomes are broadly categorized as follows:**

- ❖ Services Provided
- ❖ Referrals to Healthcare and Family Social Support
- ❖ Community Outreach and Engagement

This report presents annual summary statistics that describe clients served and services rendered across New York State by participating PICHC programs between July 1, 2022 and June 30, 2023. Data used in this report were obtained from the PICHC Data Management and Information System (DMIS) as entered by the individual PICHC programs. The PICHC DMIS is a web-based data collection and reporting system used to inform the Department and participating programs about services provided and progress towards program goals.

### **Using this Report:**

This report is designed for multiple audiences including PICHC programs and the public. PICHC programs can use the information in this report to understand the work they have accomplished together across the state and to identify areas for potential improvement.

The public can utilize this report to understand more about the services offered by PICHC programs, the geographic areas served, and who the PICHC programs have supported and engaged across the state. The PICHC program and the public can use the information in this report to talk about the program with their communities, local organizations, and eligible individuals.

## Table of Contents

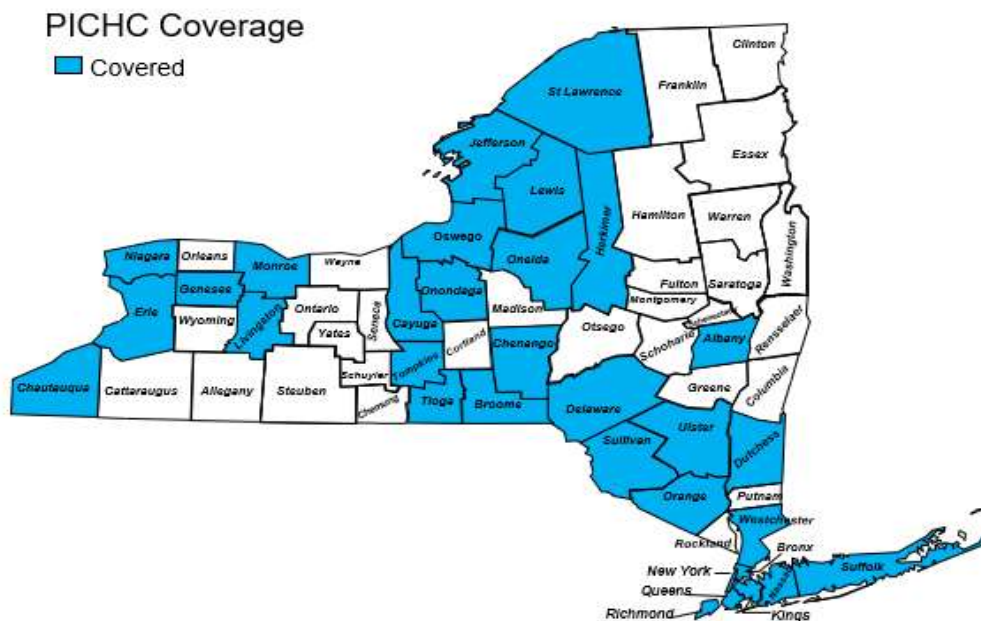
About PICHC.....	2
New York State Clients Utilizing PICHC Services .....	3
❖ Client Demographics.....	3
❖ Pregnancy Status at Enrollment.....	5
Service Delivery.....	7
❖ All Clients.....	7
❖ Healthcare Screenings.....	8
❖ Healthcare Referrals .....	9
❖ Family and Social Support Referrals .....	9
❖ Community Outreach and Engagement .....	11
❖ Sources of Client Referrals to PICHC Services.....	11
Summary .....	12

## About PICHC

The goal of the PICHC initiative is to support individual and community-based efforts to improve overall health and well-being of birthing people and their families and improve health outcomes. The PICHC program works together with communities to reduce racial, ethnic, and economic disparities in health outcomes and address the factors that affect racial and ethnic disparities. PICHC programs use a reproductive justice framework, which means ensuring that every person understands their right to make decisions about their own bodies, including whether they want to have children or not, and have access to and the ability to parent children in safe and healthy communities.

PICHC programs collaborate with community partners to strategize and strengthen community capacity to address social determinants of health through community mobilization, collaboration, and engagement with those most impacted by disparities. PICHC programs employ Community Health Workers trained to assist high-need, low-income, and/or Medicaid-eligible individuals of reproductive age and their families access continuous quality healthcare and other needed community support services. The community health workers engage pregnant, postpartum, and interconception individuals and their families in healthcare and other supportive services (e.g., group activities like childbirth/parenting classes and breastfeeding and lactation support cafes) through outreach, screening, care coordination, referral, and follow-up.

Twenty-six PICHC programs, which serve 32 counties statewide, were funded for the five-year period ending June 30, 2027.



In their efforts to conduct outreach to engage and serve eligible clients and provide them with essential services during the reporting period July 2022 through June 2023, PICHC programs across New York State served **5,186 clients**. Their collective Community Health Workers conducted a total of **26,563 encounters**. Encounters included **11,873 (45%) in-person encounters** (8,298 home visits (31%) and 3,575 (14%) in-person visits at other locations such as a PICHC program site or other community location) and **14,690 (55%) virtual encounters**. Collectively, these encounters resulted in **22,007 referrals provided** and **17,518 (80%) referrals completed**.

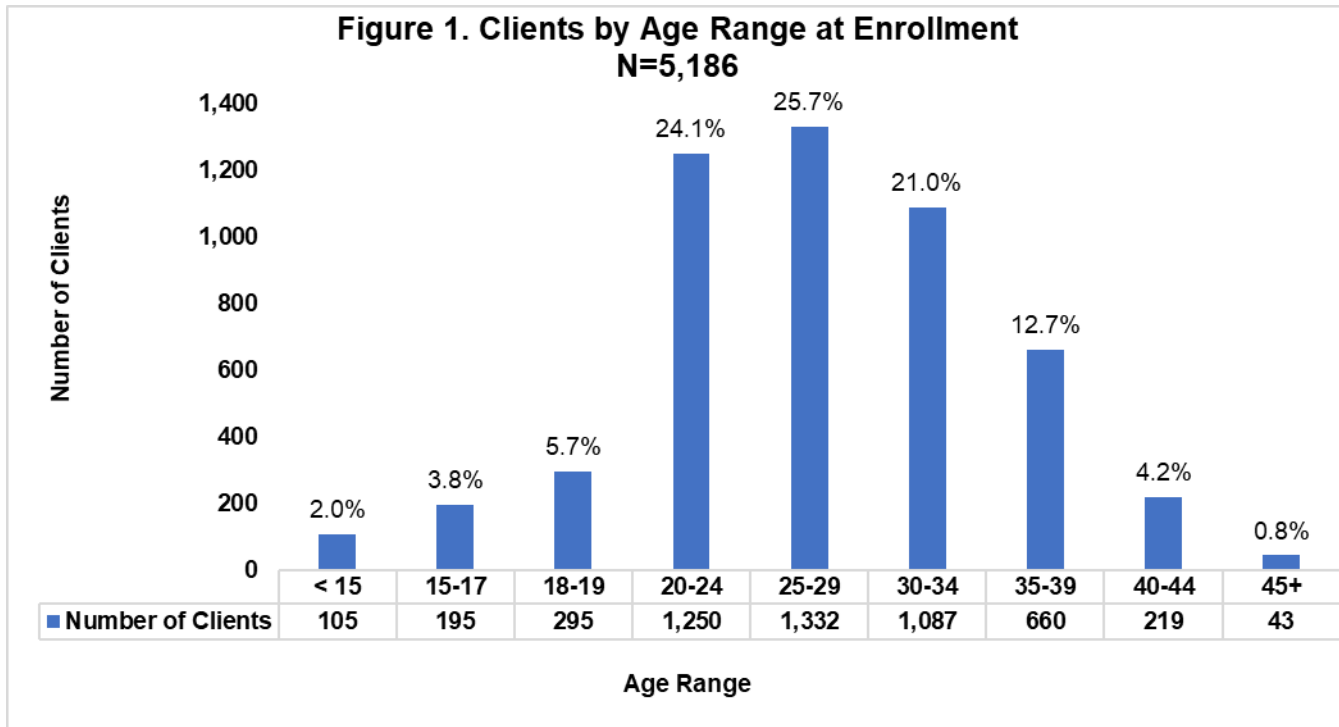
## July 2022 – June 2023 Report Highlights

- ❖ Clients Utilizing PICHC Services
- ❖ Services Most Utilized by PICHC Clients
- ❖ Program Encounter and Outreach Analysis

### New York State Clients Utilizing PICHC Services

#### ❖ Client Demographics

The Community Health Workers assisted families who lack access to resources with accessing and navigating healthcare and other essential support services, conducted in-person and virtual visits, and provided group and individual education. This section provides a demographic overview of PICHC clients for the twelve-month period between July 1, 2022, and June 30, 2023. PICHC clients ranged broadly in age between those under 15 and those 45 and above. The highest proportions of clients (70.8%) ranged in age from 20-34 years, with 11.5% under age 20 years, 12.7% between ages 35 and 39 years, and 5.0% aged 45 years or older (Figure 1).



Clients served were of various racial/ethnic backgrounds. Clients of Hispanic/Latinx ethnicity comprised 49% of those served. Both Black/African American, non-Hispanic and White, non-Hispanic clients each comprised nearly 21.5% of clients served. Clients identifying as American Indian/Alaskan Native, non-Hispanic; Asian/non-Hispanic; Native Hawaiian/Pacific Islander, non-Hispanic; Other/Multiracial, non-Hispanic; and who declined to or did not specify their race/ethnicity comprised 3.0% of clients served. (Table 1). Please note: Pursuant to Chapter 745 of 2021 of the Laws of New York, this report does not include separate tabulations for the required Asian or Pacific Islander ethnic groups and languages, because the data collection period precedes the date the law took effect.

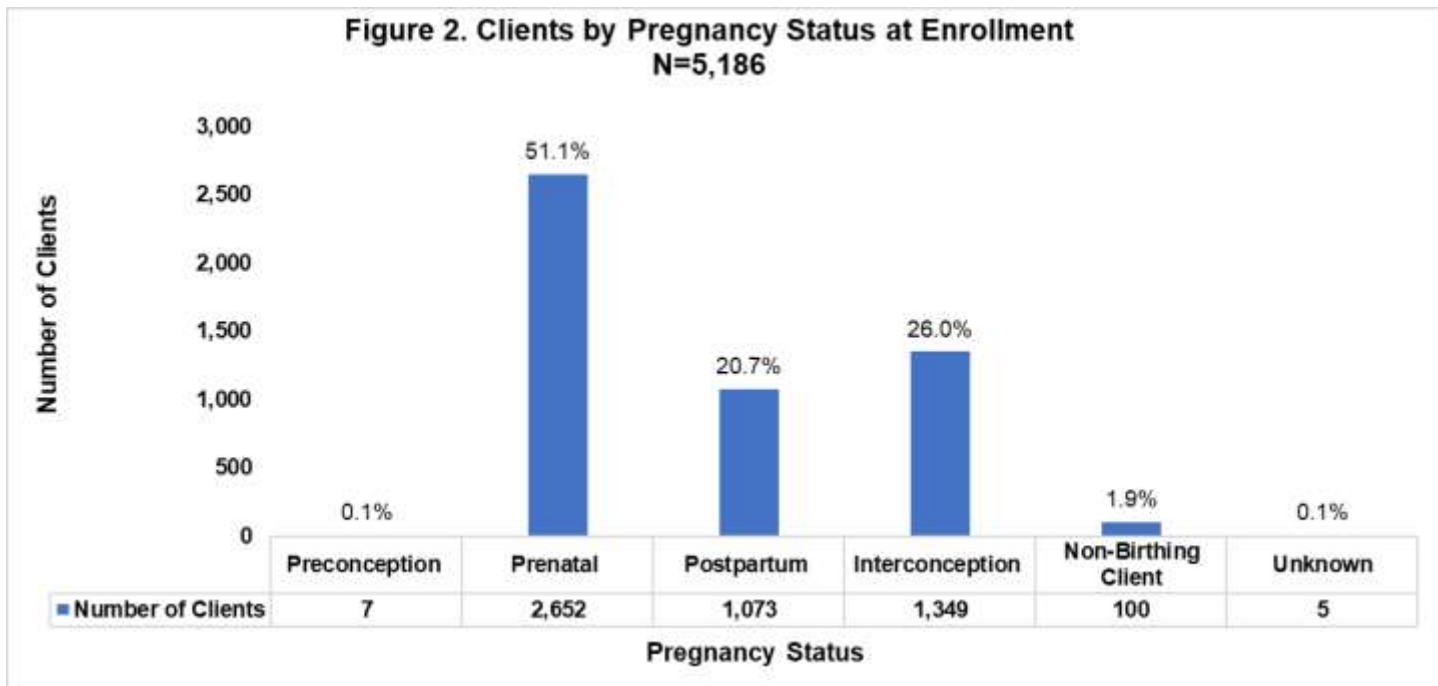
<b>Race / Ethnicity</b>	<b>Clients</b>	<b>Percent</b>
Hispanic / Latinx (with/without any specified race)	2,560	49.4%
Black / African-American, Non-Hispanic / Latinx	1,116	21.5%
White, Non-Hispanic / Latinx	1,112	21.4%
American Indian / Alaskan Native, Non-Hispanic / Latinx	11	0.2%
Asian, Non-Hispanic / Latinx	112	2.2%
Native Hawaiian / Pacific Islander, Non-Hispanic / Latinx	5	0.1%
Other / Multi-racial, Non-Hispanic / Latinx	114	2.2%
Declined / Unspecified Race, Non-Hispanic / Latinx	74	1.4%
Unspecified Ethnicity*	82	1.6%
<b>Total</b>	<b>5,186</b>	<b>100.00%</b>
* Unspecified Ethnicity category includes any of the races listed, but with unspecified Hispanic/Latinx ethnicity		

Upon enrollment, 86.0% of clients were insured by Medicaid, through Fee for Service, managed care, the Family Planning Extension Program (FPEP) or the Family Planning Benefit Program (FPBP) coverage (Table 2). Slightly more than 4% (4.4%) were privately insured, fewer than 2% (1.6%) were covered by Child Health Plus, and 12.1% had some other form of insurance. Nearly 4% (3.6%) were uninsured.

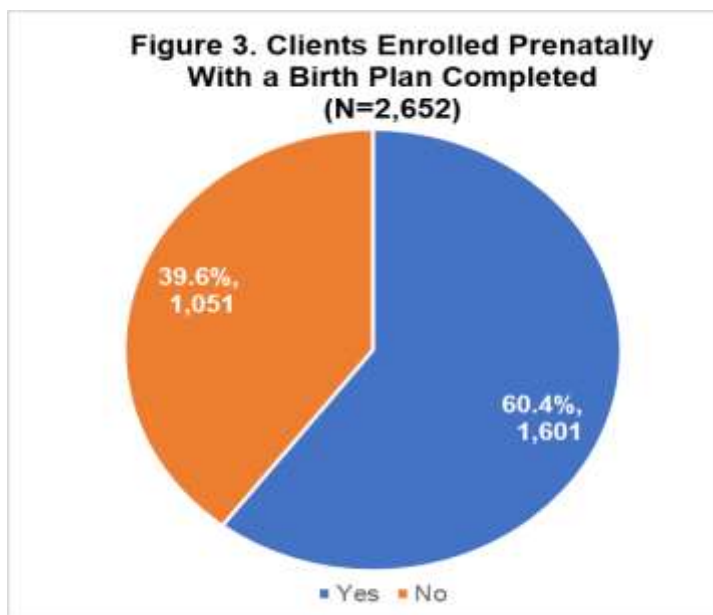
<b>Health Insurance Type</b>	<b>Number of Clients</b>	<b>Percent</b>
Medicaid / Medicaid Managed Care	4,460	86.0%
Medicaid Family Planning Extension Program or Medicaid Family Planning Benefit Program	28	0.5%
Child Health Plus	82	1.6%
Private Insurance	227	4.4%
Other	626	12.1%
Uninsured	185	3.6%
Unknown/Unrecorded	71	1.4%
Note: Percentages do not total to 100% because clients may have more than one type of insurance.		

### ❖ Pregnancy Status at Enrollment

The Community Health Workers serve clients in the prenatal, postpartum, and interconception phases of their reproductive lives. Clients in the prenatal phase are pregnant at enrollment; clients who are enrolled within the first eight weeks after giving birth are included in the postpartum phase, and those enrolled eight weeks or later after giving birth are included in the interconception phase. Nearly all PICHC clients (5,074 of 5,186; 97.8%) who were active between July 1, 2022 and June 30, 2023, enrolled either prenatally (2,652; 51.1%) or in either of the two reproductive life course phases following delivery, postpartum (1,073, 20.7%) or interconception (1,349, 26.0%) (Figure 2).



Of the 2,652 clients who enrolled in PICHC prenatally, 1,601 (60.4%) completed a birth plan during encounters with Community Health Workers (Figure 3).



Of the 2,422 total clients enrolling after delivery (postpartum/interconception), 1,879 reached their eighth week postpartum during the twelve-month reporting period. Only 578 (30.8%) of these clients attended postpartum visits within eight weeks of giving birth (Figure 4)

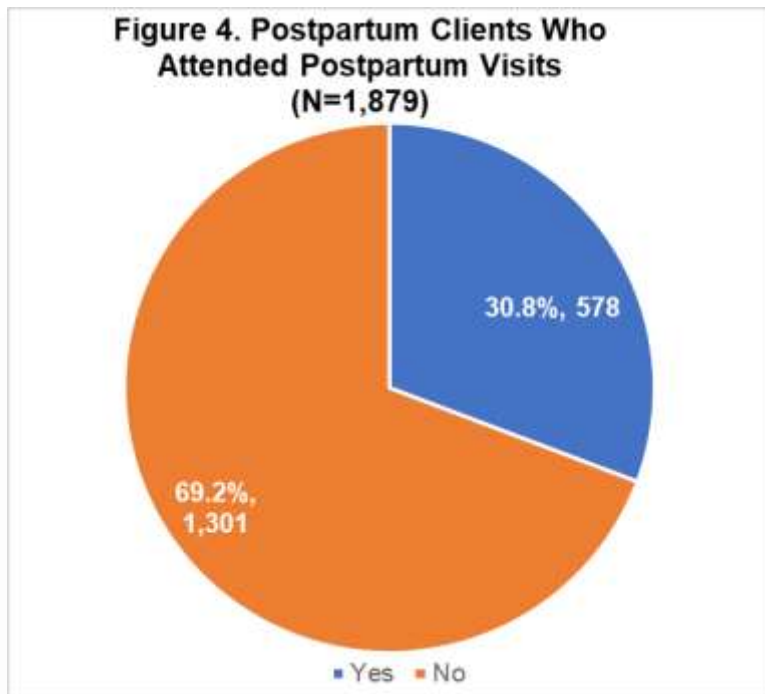
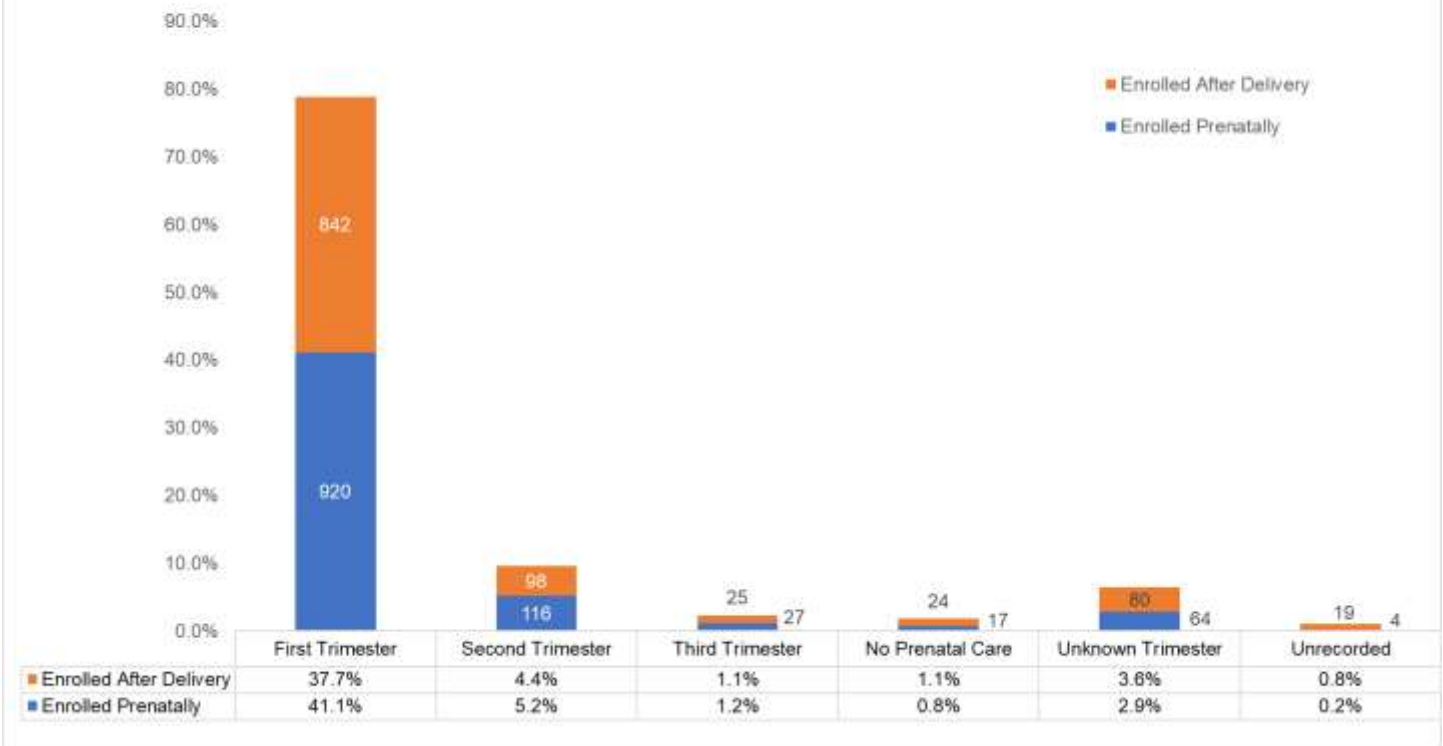


Table 3 shows the birth history of preterm and low birth weight (LBW) deliveries for the clients enrolled in the prenatal and postpartum/interconception reproductive life course phases. It is notable that there were more than twice as many clients with a history of a preterm or LBW births who enrolled postpartum/interconception (7.3% preterm and 8.1% LBW) compared with those enrolled prenatally (3.4% preterm and 3.4% LBW).

Birth History	Pregnancy Status at Enrollment	
	Prenatal	Postpartum/Interconception
Total Clients	2,652	2,422
Clients with a known previous preterm birth	3.4%	7.3%
Clients with a known previous low birth weight birth	3.4%	8.1%

Of the 2,195 PICHHC clients who gave birth during the reporting period, 78.8% initiated prenatal care with any provider in the first trimester. 41.1% of clients who enrolled in PICHHC prenatally initiated prenatal care in the first trimester giving them a 3.4% higher early initiation rate than the 37.7% rate for those who enrolled after delivery. Of the 9.6% of clients initiating prenatal care in the second trimester, those who enrolled in PICHHC prenatally did so at a slightly higher rate than those enrolling after delivery, at 5.2% and 4.4% respectively. Among the 4.2% of clients known to have initiated prenatal care in the third trimester (2.3%) or not at all (1.9%), 2.0% had enrolled prenatally and 2.2% after delivery. For the remaining birthing clients, the trimester of prenatal care initiation was unknown (6.5%) or unrecorded (1.0%); among these, 3.1% enrolled prenatally and 4.4% enrolled after delivery. (Figure 5).

**Figure 5. Prenatal Care Initiation by Pregnancy Status at Enrollment among Birthing Clients (N=2,195)**



There were 2,243 children born amongst 2,195 PICHC clients between July 1, 2022 and June 30, 2023. Birth outcomes for these children are shown in Table 4. Among these, 43.2% were first births, 11.2% were preterm, 9.9% were low in birth weight, and 2.1% were multiple gestation births.

<b>Birth Outcomes</b>	<b>Total Children</b>	<b>Percent</b>
First Births	968	43.2%
Preterm Births	251	11.2%
Low Birth Weight	222	9.9%
Multiple Births	48	2.1%
<b>Total Children Born</b>	<b>2,243</b>	100.0%
<b>Total Birthing Clients</b>	<b>2,195</b>	

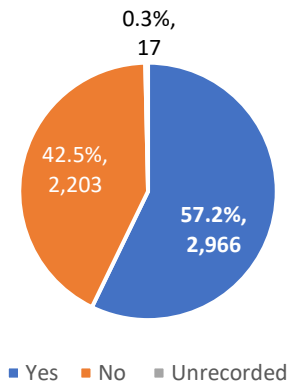
## Service Delivery

### ❖ All Clients

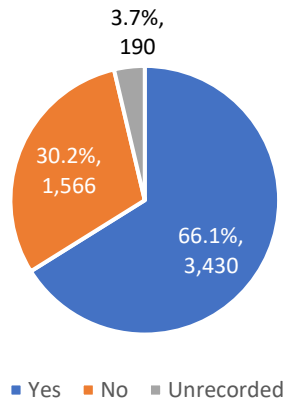
The information in this section provides an overview of services delivered to the 5,186 clients enrolled in PICHC in all life course stages during the twelve-month reporting period, including primary and reproductive care provided, screenings and referrals for health care, and referrals made to social and support services.

More than 57% of all enrolled clients reported having a primary care physician (Figure 6). Nearly two thirds of all enrolled clients reported having attended well woman visits (Figure 7). Half of clients received family planning information or had a reproductive life plan completed (Figure 8).

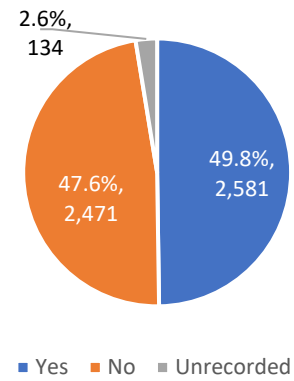
**Figure 6. Clients with a Primary Care Physician**



**Figure 7. Clients Who Attended Well-Woman Visits**



**Figure 8. Clients Who Received Family Planning Information / With Reproductive Life Plan Completed**



❖ **Healthcare Screenings**

Healthcare screenings provided as a part of PICHHC services are essential for assessing clients' health care needs. Some of the major health care screenings provided to PICHHC clients during the twelve-month reporting period are summarized in Table 5. Note that clients may have been screened multiple times during their participation in the PICHHC program. A total of 34,731 screenings were conducted overall, and the percentages of clients screened ranged from lows of nearly 54% for depression and 69% for alcohol to highs of 89% for oral health, 95% for smoking and 99% for insurance coverage. Both substance use and domestic violence screenings were provided to nearly three-fourths of clients.

<b>Table 5. Health Care Screenings among 5,186 Total Clients</b>			
<b>Screening Type</b>	<b>Number of Screenings</b>	<b>Number of Clients Screened</b>	<b>Percent of Clients Screened</b>
Health Insurance	5,137	5,137	99.1%
Substance Use	5,079	3,775	72.8%
Domestic Violence	4,969	3,682	71.0%
Smoking	4,909	4,909	94.7%
Alcohol	4,756	3,557	68.6%
Oral Health	4,609	4,609	88.9%
Depression	3,662	2,777	53.5%
<b>Total</b>	<b>34,731</b>		

### ❖ Healthcare Referrals

In follow up to screenings, healthcare referrals also are provided as a part of PICHC services, to ensure clients and their families are connected with essential care. The top healthcare referrals issued to clients were to services for dental and mental health, with 901 and 742 referrals respectively, followed by primary care, with 539 referrals for adults and 457 for children, and family planning with 344 referrals (Table 6). The 419 “Other” referrals were made to physical therapy, childbirthing class, Covid-19 vaccine, and urgent care, among others. Referral completion rates ranged from a low of 69.2% for early intervention to a high of 86.6% for family planning, with an overall average of 79.0%.

Referral Category	Referrals Issued		Referrals Completed	
	Number	Percentage of Referrals	Number	Percentage Completed
Dental services	901	21.3%	642	71.3%
Mental health services	742	17.6%	541	72.9%
Adult primary care	539	12.8%	438	81.3%
Child primary care	457	10.8%	394	86.2%
Family planning	344	8.1%	298	86.6%
Prenatal care	292	6.9%	248	84.9%
Postpartum care	246	5.8%	210	85.4%
Immunization	127	3.0%	109	85.8%
Early intervention	107	2.5%	74	69.2%
Lead testing	50	1.2%	43	86.0%
Other	419	9.9%	339	80.9%
<b>Total</b>	<b>4,224</b>	<b>100.0%</b>	<b>3,336</b>	<b>79.0%</b>

### ❖ Family and Social Support Referrals

Family and Social Support referrals are an essential part of PICHC services, connecting clients and their families to appropriate services and care. The types of referrals given to clients for various Family and Social Support services in their community during this reporting period are detailed in Table 7, in descending order of the number issued. Totalling nearly 18,000 referrals, among the greatest needs identified for clients were physical supports, such as clothing and/or baby care items (3,703), food pantry (1,314), Special Supplemental Nutritional Assistance Program for Women, Infants, and Children (WIC) (1,060), housing (1,016), and Supplemental Nutritional Assistance Program (SNAP), commonly referred to as the Food Stamp Program (917), which in combination comprised 45% of the total referrals. Families also received 1,705 referrals to “Other” additional local services, which included school supply giveaway, holiday resources, parenting classes, after school programs, and other additional supports for families. Completion rates for these referrals were relatively high, averaging 79.7% overall, and ranging from 50.6% (smoking cessation counseling) to 98.9% (translation services), with the single exception of substance use referrals at just 35.0%, albeit with a very small number of referrals made.

**Table 7. Family and Social Service Referrals**

<b>Referral Category</b>	<b>Number of Referrals Issued</b>	<b>Percentage of Referrals Issued</b>	<b>Number of Referrals Completed</b>	<b>Completion Rate</b>
Clothing / Baby Care Items	3,703	20.8%	3,237	87.4%
Food Pantry	1,314	7.4%	1,089	82.9%
WIC*	1,060	6.0%	858	80.9%
Housing	1,016	5.7%	724	71.3%
SNAP (Food Stamps)*	917	5.2%	717	78.2%
Transportation	833	4.7%	754	90.5%
Breastfeeding	721	4.1%	578	80.2%
Child Care	597	3.4%	477	79.9%
Educational Attainment	489	2.7%	404	82.6%
Car Seat	482	2.7%	385	79.9%
Safe Sleep	482	2.7%	426	88.4%
Health Insurance	480	2.7%	389	81.0%
Support Groups	454	2.6%	404	89.0%
Employment / Vocational Services	430	2.4%	264	61.4%
Evidence-Based Home Visiting Programs	417	2.3%	290	69.5%
Family Resource Center	391	2.2%	208	53.2%
Translation	360	2.0%	356	98.9%
Legal Services	280	1.6%	209	74.6%
English as a Second Language (ESL)	270	1.5%	197	73.0%
Nutrition, General	263	1.5%	241	91.6%
TANF/LDSS* Cash Assistance	211	1.2%	151	71.6%
Immigration Services	165	0.9%	129	78.2%
Furniture	162	0.9%	137	84.6%
Child Development	127	0.7%	107	84.3%
Environmental Health / Safety	123	0.7%	118	95.9%
Domestic Violence	97	0.5%	48	49.5%
HEAP*	82	0.5%	51	62.2%
Smoking Cessation	81	0.5%	41	50.6%
Child Support	42	0.2%	34	81.0%
Substance Use	20	0.1%	7	35.0%
Public Health Nurse / Local Health Department	9	0.1%	6	66.7%
Other	1,705	9.6%	1,145	67.2%
<b>Totals</b>	<b>17,783</b>	<b>100%</b>	<b>14,182</b>	<b>79.7%</b>

**\*Note:** WIC is the Special Supplemental Nutritional Assistance Program for Women, Infants, and Children; SNAP is the Supplemental Nutritional Assistance Program commonly referred to as "Food Stamps"; TANF/LDSS is the Temporary Assistance for Needy Families via local departments of social services program, and HEAP is the Home Energy Assistance Program.

As noted in Table 7 above, 417 clients were referred to evidence-based home visiting programs as appropriate to their needs. Evidence-based programs have been shown in rigorous studies to produce sizable, sustained benefits to participants and/or society. During the reporting period, PICHC clients were referred to programs detailed in Table 8. Nearly two-thirds (63.5%) were referred to Healthy Families New York (24.2%), Early Head Start (17.5%), Head Start (11.5%), and/or Parents as Teachers (10.3%). A little more than a quarter (26.9%) of these clients were referred to other

effective best practices and evidence-informed programs, including stand-alone doula services, the New York State Early Intervention Program, etc. Referral completion rates averaged 69.5% in this group, with 80.0% or more completing referrals to Early Head Start (86.3%), Parents as Teachers (83.7%), Parent Child Home Program (83.3%), and Nurse-Family Partnership (80.0%).

<b>Referral Category</b>	<b>Number of Referrals Issued</b>	<b>Percent of Referrals Issued</b>	<b>Number of Referrals Completed</b>	<b>Completion Rate</b>
Healthy Families New York	101	24.2%	49	48.5%
Early Head Start	73	17.5%	63	86.3%
Head Start	48	11.5%	36	75.0%
Parents as Teachers	43	10.3%	36	83.7%
Parent Child Home Program	18	4.3%	15	83.3%
Nurse-Family Partnership	15	3.6%	12	80.0%
Healthy Start	4	1.0%	1	25.0%
Other Home Visiting Program	115	27.6%	75	65.2%
<b>Total Home Visiting Programs</b>	<b>417</b>	<b>100.0%</b>	<b>290</b>	<b>69.5%</b>

### ❖ **Community Outreach and Engagement**

PICHC programs engage with clients and the community through door-to-door outreach, group education classes, and partnerships with community-based organizations. While engaging in community outreach activities, the Community Health Workers may provide information, education, and referrals to healthcare and social services. Clients are often engaged through direct community outreach and enrolled in the program as a result. As shown in Table 9, PICHC programs conducted 876 group sessions and 1,078 coordinated outreach events during the reporting period. With 9,658 attendees, there were about 11 participants per group session on average. Coordinated outreach events resulted in just under 5 partners per event, with a total of 5,018 partners engaged (not de-duplicated) The 2,468 total outreach activities resulted in 458 referrals and 2,943 requests for information.

<b>Group Sessions</b>		<b>Coordinated Outreach</b>		<b>Total Outreach Events</b>	
Number of Sessions	876	Number of Events	1,078	Total Sessions / Events	2,468
Attendees at Sessions	9,658	Number of Partners Engaged	5,018	Referrals	458
Average Attendees @ Session	11	Average Partners @ Event	4.7	Count of individuals requesting information	2,943

### ❖ **Sources of Client Referrals to PICHC Services**

Of the 5,186 clients enrolled during the reporting period, 3,365 (65%) were referred to the PICHC program from a variety of sources as shown in Table 10. Of these, 2,616 (77.7%) were outside referrals, with the top three being prenatal care providers (16.1%), birthing hospitals (12.3%), and other specified services (9.4%), such as doulas, evidence-based home visiting programs, and service directories such as Unite Us, Queens Connect, etc. Nearly 15% (14.4%) of referrals were self-

referrals (6.7%), or referrals from another client (4.9%) or a relative or friend (2.8%). Additional clients were referred to the PICHC program through street outreach and group sessions (11.3%), and other sources (10.6%), such as walk-ins and community events.

<b>Referral Source</b>	<b>Number of Clients</b>	<b>Percentage of Clients</b>
<b>Outside Referrals to PICHC Programs</b>	2,616	77.7%
<i>Prenatal Care Provider</i>	542	16.1%
<i>Birthing Hospital</i>	414	12.3%
<i>Other Service</i>	316	9.4%
<i>Self</i>	226	6.7%
<i>WIC</i>	222	6.6%
<i>Community - Based Organization</i>	165	4.9%
<i>Other Client</i>	164	4.9%
<i>Social Service Agency</i>	113	3.4%
<i>Relative / Friend</i>	95	2.8%
<i>Other Health Care Provider</i>	77	2.3%
<i>Primary Care Physician</i>	57	1.7%
<i>Insurance Navigator</i>	36	1.1%
<i>Pediatrician</i>	34	1.0%
<i>School</i>	33	1.0%
<i>Public Health Nurse / LHD</i>	31	0.9%
<i>Other PICHC Program</i>	23	0.7%
<i>Mental Health / Behavioral Health</i>	19	0.6%
<i>Family Planning Provider</i>	14	0.4%
<i>Faith - Based Organization</i>	14	0.4%
<i>Health Home</i>	12	0.4%
<i>Managed Care Plan</i>	7	0.2%
<i>Dental Provider</i>	2	0.1%
<b>Street Outreach</b>	357	10.6%
<b>Group Sessions</b>	24	0.7%
<b>Other Sources</b>	358	10.6%
<b>Unrecorded</b>	10	0.3%
<b>Total</b>	<b>3,365</b>	<b>100.0%</b>

## Summary

During the first year following the transition from the MICHC program for providing Community Health Worker services, PICHC programs have continued to enhance the implementation of individual-level strategies to address perinatal and infant health behaviors, and community-level strategies using a collective impact approach, to address the many social determinants that impact health outcomes. The transition from the MICHC to the PICHC seems to have been beneficial overall. While the actual total numbers of clients, encounters, visits, and referrals reported for the 15-month MICHC reporting period as outlined in the [Final MICHC Summary Report](#) are higher in comparison to the PICHC totals outlined in this report, quite the opposite is found when they are adjusted to a 12-month period (annualized). As shown in Table 11, there have been improvements in all performance measures, with the exception of virtual encounters which remained flat. The total numbers of clients, encounters, and home visits increased by 19.0%, 12.0%, and 70.7% respectively, and the average

home visits per client increased from 1.1 to 1.6. Total referrals increased by 27.3%, and the average referrals issued per client increased slightly from 4.0 to 4.2. Substantial increases have occurred in key services. These include birth plan completion during encounters with the Community Health Workers among prenatal clients, which improved by 39.2%; postpartum visits which improved by 21.3%; and prenatal care initiation in the first trimester which improved by 46.2%. By these measures, it appears that the PICHC has been successful in enhancing community-based perinatal service provision to individuals in need.

**Table 11. MICHC vs. PICHC Comparison**

Performance Measure	MICHC		PICHC	Comparison	
	4/1/21-6/30/22	Annualized	7/1/22-6/30/23	Difference (PICHC – MICHC Annualized)	% Improved
Total Number of Clients	5,448	4,358	5,186	828	19.0%
Total Number of Encounters	29,639	23,711	26,563	2,852	12.0%
Total Number of Virtual Encounters	18,360	14,688	14,690	2	0.0%
Total Number of Home Visits	6,085	4,868	8,310	3,442	70.7%
Home Visits per Client	1.1	1.1	1.6	0.5	45.5%
Total Number of Referrals Issued	21,608	17,286	22,008	4,722	27.3%
Referrals Issued per Client	4.0	4.0	4.2	0.2	5.0%
Birth Plan Completion	43.4%	N/A	60.4%	17.0%	39.2%
Postpartum Visit	25.4%	N/A	30.8%	5.4%	21.3%
Prenatal Care Initiation (First Trimester)	53.9%	N/A	78.8%	24.9%	46.2%

Most of this improvement is likely attributable to the PICHC’s expansion with three additional programs and covering one additional county. However, some may be attributable to a decline in services during the last three quarters of 2021 related to the lingering Covid-19 pandemic, and some may be attributable to the enhancement of the initiative’s Data Management and Information System, which has been ongoing since the transition between the initiatives. With basic system functionality completed, the concentration on further development has shifted to addressing additional data collection and reporting needs. The latter has incorporated input from the PICHC staff and their Data Management and Information System users. This likely has improved their ability to monitor and direct their activities, while affording the Department’s program managers the ability to better assess progress in reaching the overarching goals of the initiative. Going forward, this will help to ensure that the PICHCs will continue to provide access to continuous quality healthcare, health insurance, and family and social services and supports for pregnant and parenting families in New York State.