New York State Perinatal and Infant Community Health Collaboratives 2023 - 2024 Annual Report

March 2026

Reporting Time Period: July 1, 2023 – June 30, 2024

An Overview:

The Perinatal and Infant Community Health Collaboratives (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. The programs also work to reduce persistent racial, ethnic, and economic disparities in those outcomes.

The Initiative focuses on individuals who are pregnant; in the postpartum period, including the 8 weeks following the birth of a child; and in the interconception period, the time between the postpartum period and before a future pregnancy, to support ongoing health and well-being. Individual services are provided to pregnant and parenting people through their youngest child's second birthday.

The Initiative was launched on July 1, 2022, to continue to enhance New York State's previously supported Maternal and Infant Community Health Collaborative (MICHC) program. Twenty-six 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 programs between July 1, 2023, and June 30, 2024. Data used in this report were obtained from the Perinatal and Infant Community Health Collaboratives Data Management and Information System as entered by the individual programs. The Data Management and Information System 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.

This report also includes client success stories submitted by individual Programs to illustrate the impact the Program has had for individuals across the state.

Using this Report:

This report is designed for multiple audiences including Perinatal and Infant Community Health Collaboratives programs and the public. 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 Perinatal and Infant Community Health Collaboratives programs, the geographic areas served, and who the programs have supported and engaged across the state. The Programs and the public can use the information in this report to talk about the program with their communities, local organizations, and eligible individuals.

Executive Summary

Perinatal and Infant Community Health Collaborative programs engage with families and community partners each day to ensure pregnant, postpartum, and interconception individuals are aware of community services, and have knowledge and skills to seek out and receive needed care. They also work to increase community capacity to address social determinants of health through community mobilization, collaboration, and engaging those most impacted by disparities.

During the reporting period of July 2023 through June 2024, there were improvements in nearly all performance measures. For example, programs across New York State served 5,403 clients, a 4% increase from the previous reporting period (April 1, 2022-June 30, 2023).

Collectively, community health workers conducted a total of 27,571 encounters, both in-person and virtually. During the 2023-2024 project period, 11,466 of these encounters occurred in-person. This means that in-person encounters, which are preferrable to virtual visits, when possible, increased by 38%.

Collectively, these encounters resulted in 24,768 referrals to health care and family and social supports; 20,790 (84%) of these referrals were completed by families. This represents 13% increases in the total number of referrals issued and completed during this project period.

The program also saw increases in both birth plan completion and postpartum visit attendance during the 2023-2024 reporting period.

Programs completed 1,834 total outreach activities with 7,232 community partners.

The annual report now includes client success stories that highlight the unique and tailored services Perinatal and Infant Community Health Collaboratives and Community Health Workers provide and the impact and empowerment this leads to across the state.

Table of Contents

About the Perinatal and Infant Community Health Collaborative Initiatives 4

- **Client Demographics** 5
- **Pregnancy Status at Enrollment** 7

Service Delivery **9**

- **All Clients** 9
- **Healthcare Screenings** 10
- **Healthcare Referrals** 11
- **Family and Social Support Referrals** 12
- **Sources of Client Referrals to Program Services** 16

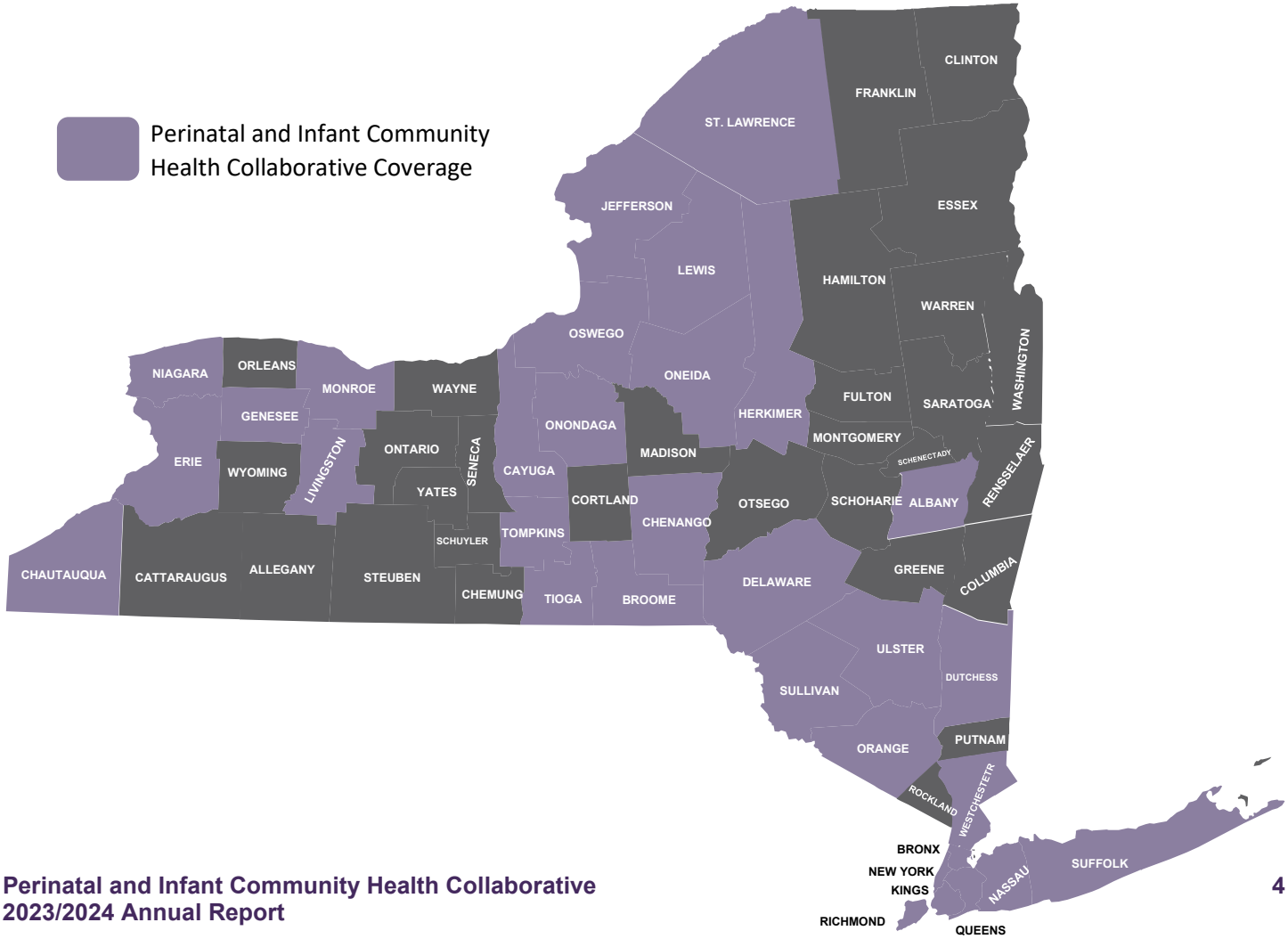
Summary **18**

About the Perinatal and Infant Community Health Collaborative Initiatives

The goal of this 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. Local programs work together with communities to reduce racial, ethnic, and economic disparities in health outcomes and address the factors that affect racial and ethnic disparities. Programs are grounded in both birth justice and reproductive justice frameworks, which means ensuring that every person understands their right to make decisions about their own body, including whether they want to have children, has the ability and the resources to parent children in safe and healthy communities, and has access to safe, respectful, and empowered care.

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. Programs employ community health workers trained to assist high-need, low-income, and/or Medicaid-eligible individuals of reproductive age and their families. 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 programs, which serve 32 counties statewide, were funded for the five-year period ending June 30, 2027.



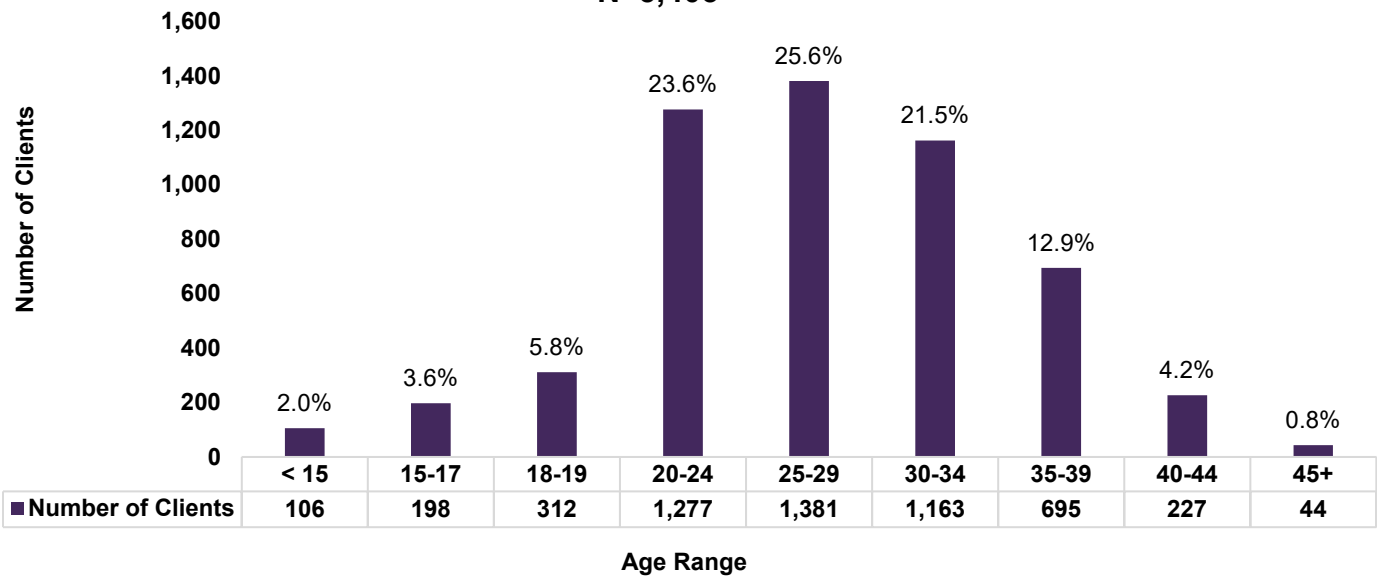
In their efforts to conduct outreach to engage and serve eligible clients and provide them with essential services during the reporting period July 2023 through June 2024, programs across New York State served **5,403 clients**. Collectively, community health workers conducted a total of **27,571** encounters. Encounters included **15,968 (58%) in-person encounters** (11,466 home visits (42%) and 4,502 (16%) in-person visits at other locations such as a program site or other community location) and **11,603 (42%) virtual encounters.** Collectively, these encounters resulted in **24,768 referrals,** and **20,790 (84%)** of these referrals **were completed** by families.

New York State Clients Utilizing Program 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 clients for the twelve-month period between July 1, 2023, and June 30, 2024. Clients ranged broadly in age between those under 15 and those 45 and above. The highest proportions of clients (70.7%) ranged in age from 20-34 years, with 11.4% under age 20 years, 12.9% between ages 35 and 39 years, and 5.0% aged 40years or older (Figure 1).

Figure 1. Clients by Age Range at Enrollment
N=5,403



Clients served were of various racial/ethnic backgrounds. Clients of Hispanic/Latinx ethnicity comprised 55% of those served. Both Black/African American, non-Hispanic and White, non-Hispanic clients each comprised nearly 18.8% of clients served. Clients identifying as American Indian/Alaskan Native, non-Hispanic; Asian, non-Hispanic; Native Hawaiian/Pacific Islander, non-Hispanic; All Other Races Combined or Multiracial, non-Hispanic*; and those who declined to or did not specify their race/ethnicity comprised 7.5% 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.

Table 1. Clients by Race / Ethnicity

Race / Ethnicity	Clients	Percent
Asian, Non-Hispanic / Latinx	89	1.7%
Black / African American, Non-Hispanic / Latinx	1,012	18.7%
Hispanic / Latinx (with/without any specified race)	2,972	55.0%
White, Non-Hispanic / Latinx	1,018	18.8%
All Other Races Combined or Multiracial, Non-Hispanic/Latinx*	116	2.2%
Declined / Unspecified Race, Non-Hispanic / Latinx	89	1.6%
Unspecified Ethnicity**	107	2.0%
Total	**5,403**	**100.0%**

* All Other Races Combined or Multiracial, non-Hispanic/ Latinx category includes American Indian / Alaskan Native, Non-Hispanic / Latinx, Native Hawaiian / Pacific Islander, Non-Hispanic / Latinx, and Other / Multi-racial, Non-Hispanic / Latinx

**Unspecified Ethnicity category includes any of the races listed, but with unspecified Hispanic/Latinx ethnicity

Upon enrollment, 87.2% of clients were insured by Medicaid, through Fee for Service, Managed Care, the Family Planning Extension Program or the Family Planning Benefit Program coverage (Table 2). Nearly 4% (3.6%) were privately insured, a little over 1% (1.1%) were covered by Child Health Plus, and 15.1% had some other form of insurance. Nearly 4% (3.7%) were uninsured.

Table 2. Client Health Insurance Type

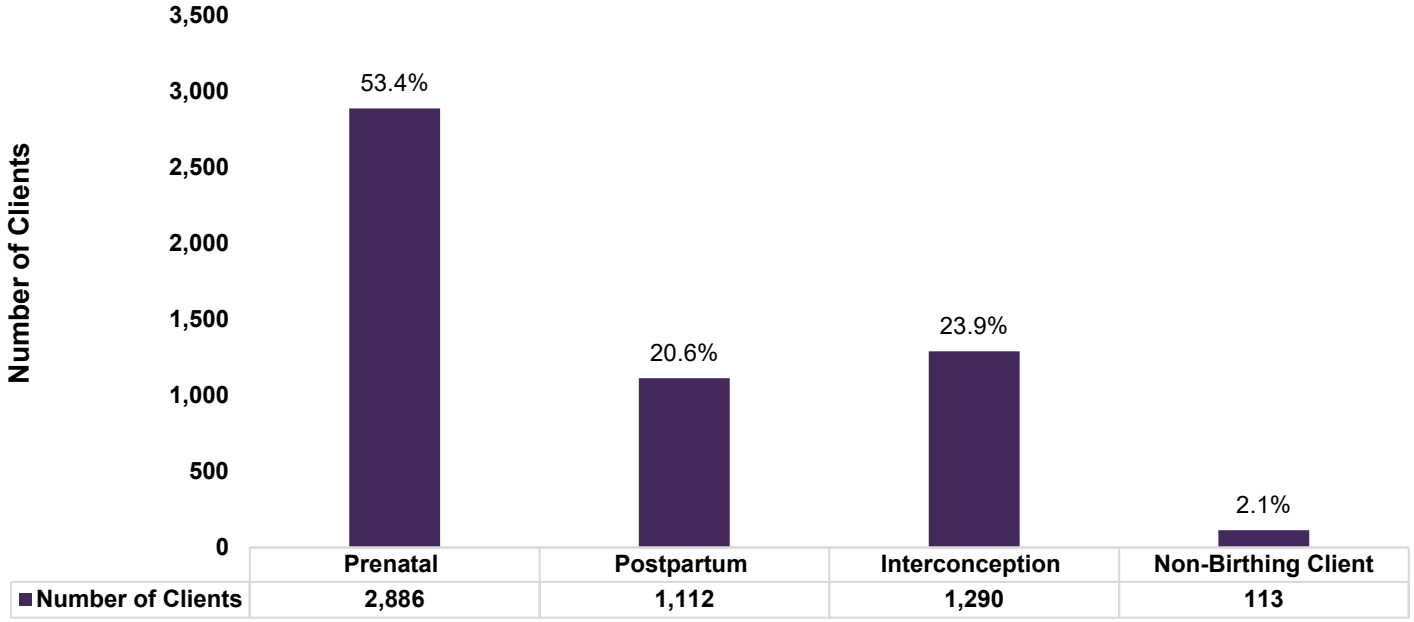
Health Insurance Type	Number of Clients	Percent
Medicaid / Medicaid Managed Care	4,675	86.5%
Medicaid Family Planning Extension Program or Medicaid Family Planning Benefit Program	38	0.7%
Child Health Plus	57	1.1%
Private Insurance	196	3.6%
Other	817	15.1%
Uninsured	200	3.7%
Unknown/Unrecorded	45	0.8%

Note: Percentages do not total 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 clients (5,288 of 5,403; 97.9%) who were active between July 1, 2023 and June 30, 2024, enrolled either prenatally (2,886; 53.4%) or in either of the two reproductive life course phases following delivery, postpartum (1,112, 20.6%) or interconception (1,290, 23.9%) (Figure 2).

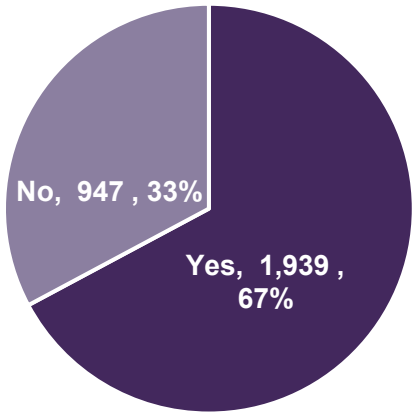
Figure 2. Clients by Pregnancy Status at Enrollment
N=5,403



Note: In addition, there was one preconception client and one client with unknown pregnancy status at enrollment.

Of the 2,886 clients who enrolled in the Program prenatally, 1,939 (67.2%) completed a birth plan during encounters with community health workers (Figure 3).

Figure 3. Clients Enrolled Prenatally With a Birth Plan Completed
(N=2,886)



Among the 1,281 clients who reached their twelve-week postpartum during the twelve-month reporting period, 676 (52.8%) attended postpartum visits within that period. (Figure 4).

Figure 4. Postpartum Clients Who Attended Postpartum Visits (N=1,281)

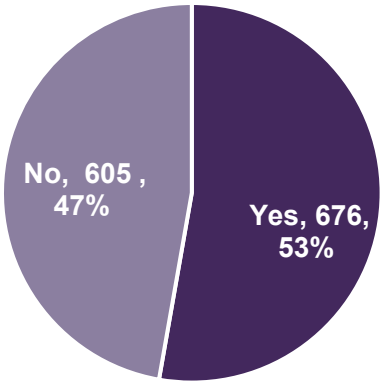


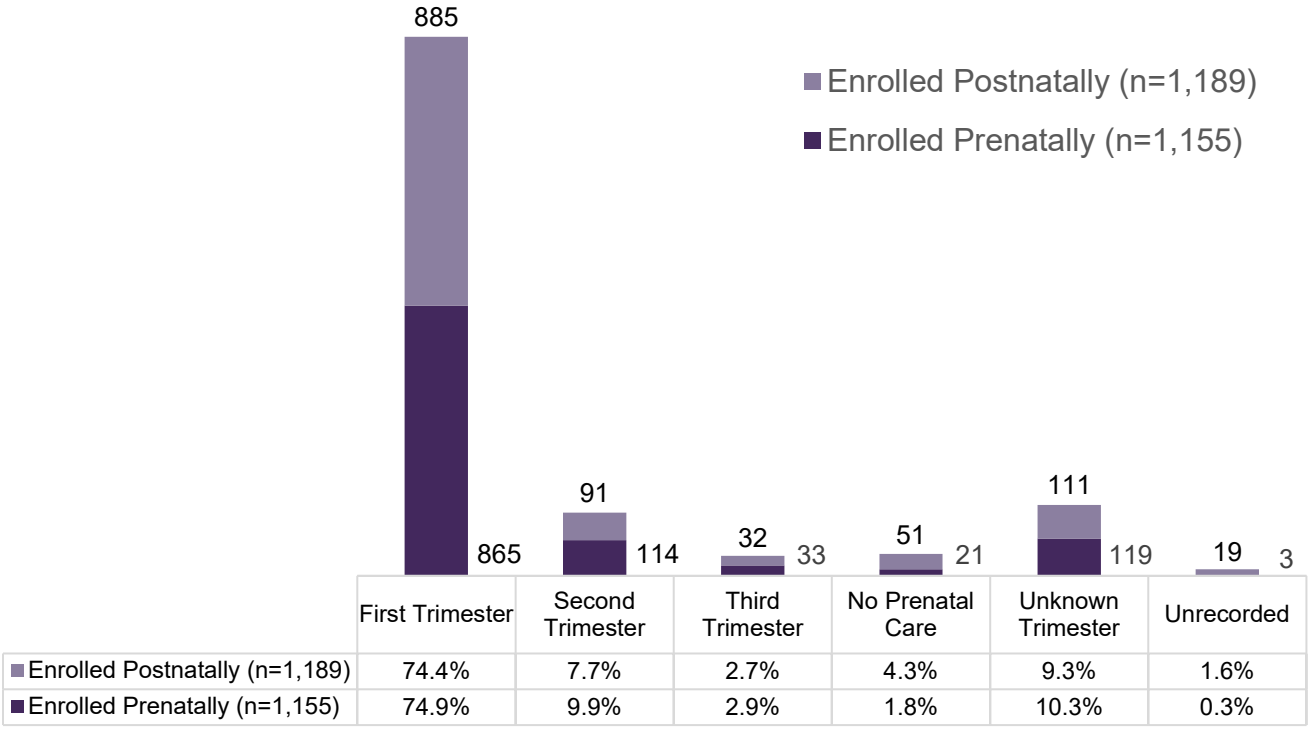
Table 3 shows the birth history of preterm and low birth weight deliveries for the clients enrolled in the prenatal and postpartum/interconception reproductive life course phases. It is notable that there were twice as many clients with a history of a preterm or low birth weight births who enrolled postpartum or during interconception (7.4% preterm and 8.0% low birth weight) compared with those enrolled prenatally (3.6% preterm and 4.0% low birth weight).

Table 3. Client Birth History and Pregnancy Status at Enrollment (N=5,288)

Birth History	Pregnancy Status at Enrollment	
	Prenatal	Postpartum/Interconception
Total Clients	2,886	2,402
Clients with a known previous preterm birth	3.6%	7.4%
Clients with a known previous low birth weight birth	4.0%	8.0%

Of the 2,344 clients who gave birth during the reporting period, nearly 75% of all clients initiated prenatal care with any provider in the first trimester. There were slight differences between those who enrolled in the program postnatally (10.4%) engaged care in the 2nd or 3rd trimester compared to those who enrolled prenatally (12.8%). Additionally, a higher percentage of individuals that enrolled in the program postnatally (4.3%) had no prenatal care, compared to individuals that enrolled while pregnant (1.8%). (Figure 5).

Figure 5. Prenatal Care Initiation by Pregnancy Status at Enrollment among Birthing Clients (N=2,344)



	First Trimester	Second Trimester	Third Trimester	No Prenatal Care	Unknown Trimester	Unrecorded
Enrolled Postnatally (n=1,189)	74.4%	7.7%	2.7%	4.3%	9.3%	1.6%
Enrolled Prenatally (n=1,155)	74.9%	9.9%	2.9%	1.8%	10.3%	0.3%

There were 2,410 children born amongst 2,344 clients between July 1, 2023 and June 30, 2024. Birth outcomes for these children are shown in Table 4. Among these, 41.5% were first births, 11.5% were preterm, 9.5% were low in birth weight, and 2.7% were multiple gestation births.

Table 4. Birth Outcomes for Children Born in the Reporting Period (N=2,410)

Birth Outcomes	Total Children	Percent
First Births	1,000	41.5%
Preterm Births	276	11.5%
Low Birth Weight	230	9.5%
Multiple Births	66	2.7%
Total Children Born	**2,410**	100.0%
Total Birthing Clients	**2,344**	

Service Delivery

❖ All Clients

The information in this section provides an overview of services delivered to the 5,403 clients enrolled in the Program in all life course stages during the twelve-month reporting period, including having primary and reproductive care provided, screenings and referrals for health care, and referrals made to social and support services.

More than half (53.7%) of all enrolled clients reported had a primary care physician (Figure 6). More than two thirds (69.2%) of all enrolled clients reported having attended well woman visits (Figure 7). Nearly half (47.7%) of clients received family planning information or had a reproductive life plan completed (Figure 8).

Figure 6. Clients with a Primary Care Physician

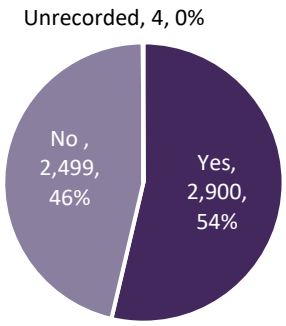


Figure 7. Clients Who Attended Well-Woman VIsits

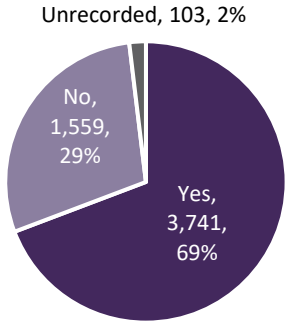
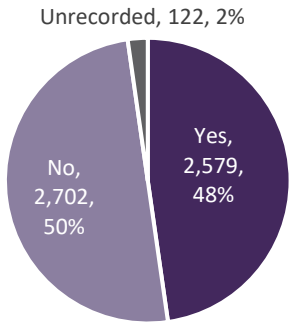


Figure 8. Clients Who Completed a Reproductive Life Plan and Received Family Planning Information



Client Story: Service Delivery – Attending Prenatal Appointments

At 26-weeks pregnant, a new client enrolled in her local program without having received any prior prenatal care. The client expressed that she was hesitant to seek care due to severe substance use, distrust of community organizations and fear of being judged. Over the course of several weeks, the community health worker built trust with the client by providing consistent support and open communication both over the phone and in-person. Together the community health worker and client attended a prenatal appointment where the client received an ultrasound, bloodwork and a physical check-up. With the support of her community health worker, the client continued to attend prenatal appointments until she gave birth. During this time, the client actively worked on her sobriety and worked with her community health worker to establish a Plan of Safe Care for her infant. With a clear plan in place, the client was able to take her newborn home. The community health worker has remained in contact since delivery and is assisting with necessary referrals and providing ongoing support to both the mother and infant.

This client's journey highlights the program's effectiveness in addressing significant barriers to care, particularly among those hesitant to engage with the healthcare system. Her experience reflects the program's impact in reducing the percentage of clients without a primary care physician (currently at 46.3%) and increasing the portion of clients who received family planning information and had a reproductive life plan completed (47.7%).

❖ Healthcare Screenings

Healthcare screenings provided as a part of Program services are essential for assessing clients' health care needs. Some of the major health care screenings provided to 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 Program. A total of 40,513 screenings were conducted overall and nearly 100% of clients were screened for health insurance coverage (99.5%). Birthing

clients are screened for depression within 3 months of giving birth (62.3%) but all clients are eligible and overall 53.0% of clients are screened for depression. Other high screening rates above 90% occurred for oral health (90.4%), safe sleep (95.8%), and smoking (96.5%) %). Approximately 70% of enrolled clients were screened for substance use (71.4%), alcohol (69.5%), and domestic violence (68.9%).

Table 5. Health Care Screenings among 5,403 Total Clients

Screening Type	Number of Screenings	Number of Clients Screened	Percent of Clients Screened
Health Insurance	5,376	5,376	99.5%
Smoking	5,213	5,213	96.5%
Substance Use	5,205	3,860	71.4%
Safe Sleep	5,175	5,175	95.8%
Domestic Violence	5,070	3,722	68.9%
Alcohol	5,053	3,756	69.5%
Oral Health	4,883	4,883	90.4%
Depression	3,823	2,862	53.0%
Total	**40,513**		

Client Story: Healthcare Screenings – Mental Health

An expectant mother enrolled in her local program while navigating significant stress within her relationship. During her community health worker visits she expressed a strong desire to improve her relationship and overall mental well-being. Through a routine depression screening conducted by her community health worker, she was encouraged to seek mental health services to support both her emotional health and her family goals. With this guidance, she completed a formal mental health screening, began attending weekly individual counseling sessions and participated in partner sessions. Over time the client reported noticeable improvement in her relationship dynamics, a greater sense of emotional stability and an overall increase in happiness.

This client's story highlights the critical role of depression screening with home visits. By identifying needs early and connecting families to the right resources, the program not only supports maternal mental health but also strengthens family well-being. This client's story demonstrates the critical impact of timely healthcare referrals, ongoing support, and the trusted relationship provided by community health workers which helps to improve healthcare outcomes for families facing complex medical challenges.

❖ Healthcare Referrals

In follow-up to screenings, healthcare referrals also are provided as a part of Program services, to ensure clients and their families are connected with essential care. The top healthcare referrals issued to clients were to services for mental and dental health, with 1,023 and 823 referrals respectively, followed by primary care, with 634 referrals for adults and 536 for children, and family planning with 276 referrals (Table 6). The 384 "Other" referrals were made to healthy weight programs, abortion services, childbirth classes, podiatry, and optometry, among others. Referral completion rates ranged from a low of 70.0% for mental health services to a high of 93.3% for prenatal care, with an overall average of 80.4%.

Table 6. Health Care Referrals

Referral Category	Referrals Issued		Referrals Completed	
	Number	Percentage of Referrals	Number	Percentage Completed
Dental Services	1,023	22.9%	769	75.2%
Mental Health Services	823	18.4%	576	70.0%
Adult Primary Care	634	14.2%	497	78.4%
Child Primary Care	536	12.0%	491	91.6%
Family Planning	276	6.2%	244	88.4%
Prenatal Care	252	5.7%	235	93.3%
Postpartum Care	219	4.9%	185	84.5%
Immunization	169	3.8%	155	91.7%
Early Intervention	89	2.0%	69	77.5%
Lead Testing	59	1.3%	51	86.4%
Other	384	8.6%	318	82.8%
Total	**4,464**	100.0%	**3,590**	**80.4%**

Client Story: Healthcare Referrals – Prenatal Care- Child Primary Care

An expectant mother facing a high-risk pregnancy due to a diagnosed fetal congenital heart defect enrolled in her local Program and was provided with support and resources by her community health worker. The community health worker was able to refer the client to a hospital experienced in delivering high-risk babies, including access to specialized pediatric heart surgeons, who could address the baby's heart condition after birth.

Following the delivery, the baby had a suppressed immune system which required limiting in-person contact. The community health worker continued to support the client through virtual visits and the family remained actively engaged in the Program over the course of a year. This continuous interaction helped the family monitor their baby's cogitative and socio-emotional development and practice developmental activities from the safety of their home. The family reported that at 13 months the baby was thriving!

❖ Family and Social Support Referrals

Family and Social Support referrals are an essential part of Program 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. Totaling nearly 21,000 referrals, among the greatest needs identified for clients were physical supports, such as clothing and/or baby care items (5,118), transportation (1,454), food pantry (1,338), housing (1,244), Special Supplemental Nutritional Assistance Program for Women, Infants, and Children (WIC) (952), and Supplemental Nutritional Assistance Program (SNAP), commonly referred to as the Food Stamp Program (870), which in combination comprised 54% of the total referrals. Families also received 1,748 referrals to "Other" miscellaneous local services, which included unemployment benefit and Department of Motor Vehicles assistance, holiday resources, stress relief workshops, aquatic therapy and other additional

supports for families. Completion rates for all of these referrals were relatively high, averaging 84.7% overall, and ranging from 60.7% (domestic violence) to 99.7% (translation services).

Client Story: Family and Social Support Referrals – Doula & Breastfeeding

A family expecting a new baby and experiencing a housing crisis was referred to their local program. The expectant mother expressed interest in learning about the doula and lactation support available through the program. Using this insight into the family's goals and interests, the community health worker helped them navigate available resources and enroll in parenting classes. The mother joined a Baby Café meeting for ongoing lactation support and the father was introduced to a father's support group. With ongoing support from their community health worker, the family was also able to obtain a housing voucher and access stable housing during a critical time in their lives.

This family's journey highlights how programs that focus on coordinated and client-centered referrals can connect individuals and families to community resources and wraparound services and address social determinants of health.

Client Story: Family and Social Services Referrals

A young family who migrated to the United States just a year ago faced significant challenges as they adjusted to a new country. When they first enrolled into their local program, they were living in a shelter, both parents were unemployed, and they were navigating life with limited resources. The family consisted of a 27-year-old expectant mother, her husband and their 4-year-old son, who was diagnosed with autism. At the time, the mother did not have health insurance and was unable to receive prenatal care. Through the support and guidance of the community health worker, the family was connected to critical community resources, including WIC and SNAP, to help address their immediate nutritional needs. The mother successfully applied for and obtained health insurance, enabling her to begin regular visits with an obstetrician for prenatal care. They were also connected to legal services to assist with processing their immigration documents.

This family's journey highlights how comprehensive and coordinated care can transform lives.

Table 7. Family and Social Service Referrals

Referral Category	Number of Referrals Issued	Percentage of Referrals Issued	Number of Referrals Completed	Completion Rate
Clothing / Baby Care Items	5,118	25.2%	4,602	89.9%
Transportation	1,454	7.2%	1,401	96.4%
Food Pantry	1,338	6.6%	1,115	83.3%
Housing	1,244	6.1%	983	79.0%
Women, Infant, and Children Benefits	952	4.7%	798	83.8%
Supplemental Nutritional Assistance Program (SNAP)	870	4.3%	675	77.6%
Breastfeeding	645	3.2%	521	80.8%
Translation	614	3.0%	612	99.7%
Childcare	556	2.7%	437	78.6%
Educational Attainment	522	2.6%	474	90.8%
Health Insurance	514	2.5%	433	84.2%
Support Groups	495	2.4%	441	89.1%
Employment / Vocational Services	459	2.3%	323	70.4%
Safe Sleep	440	2.2%	391	88.9%
Car Seat	424	2.1%	361	85.1%
Nutrition, General	385	1.9%	362	94.0%
Evidence-Based Home Visiting Programs	352	1.7%	278	79.0%
Family Resource Center	316	1.6%	265	83.9%
Environmental Health / Safety	282	1.4%	270	95.7%
Legal Services	266	1.3%	211	79.3%
Temporary Assistance for Needy Families (TANF)	225	1.1%	145	64.4%
English as a Second Language (ESL)	211	1.0%	166	78.7%
Child Development	206	1.0%	178	86.4%
Immigration Services	187	0.9%	145	77.5%
Home Energy Assistance Program (HEAP)	148	0.7%	113	76.4%
Furniture	143	0.7%	103	72.0%
Domestic Violence	89	0.4%	54	60.7%
Smoking Cessation	47	0.2%	32	68.1%
Child Support	30	0.2%	21	70.0%
Substance Use	16	0.1%	13	81.3%
Public Health Nurse Local Health Department	8	0.1%	7	87.5%
Other	1,748	8.6%	1,270	72.7%
Totals	**20,304**	**100%**	**17,200**	**84.7%**

As noted in Table 7 above, 352 clients were referred to evidence-based home visiting programs as appropriate to their needs**.** These programs have been shown in rigorous studies to produce sizable, sustained benefits to participants and/or society. During the reporting period, clients were referred to programs detailed in Table 8. Nearly two-thirds (66.2%) were referred to Early Head Start (27%), Healthy Families New York (23%), and Head Start (16.2%). Nearly a quarter (24.7%) of these clients were referred to other effective best practices and evidence-informed programs, including behavioral attachment, Help Me Grow, Pathway of Hope*,* the New York State Early Intervention Program, etc. Referral completion rates averaged 79% in this group, with 80.0% or more completing referrals to Parents as Teachers (100%), Nurse-Family Partnership (92.9%), and Early Head Start (86.3%).

Table 8. Referrals to Evidence-Based Home Visiting Programs

Referral Category	Number of Referrals Issued	Percent of Referrals Issued	Number of Referrals Completed	Completion Rate
Early Head Start	95	27.0%	82	86.3%
Healthy Families New York	81	23.0%	58	71.6%
Head Start	57	16.2%	40	70.2%
Nurse-Family Partnership	14	4.0%	13	92.9%
Parent Child Home Program	11	3.1%	7	63.6%
Healthy Start	3	0.8%	2	66.7%
Home Instruction for Parents of Preschool Youngsters	2	0.6%	1	50.0%
Parents as Teachers	2	0.6%	2	100.0%
Other Home Visiting Program	87	24.7%	73	83.9%
Total Home Visiting Programs	**352**	**100.0%**	**278**	**79.0%**

Community Outreach and Engagement

Perinatal and Infant Community Health Collaborative 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, Programs conducted 883 group sessions and 960 coordinated outreach events during the reporting period. With 8,790 attendees, there were about 10 participants per group session on average. Coordinated outreach events resulted in just under 8 partners per event, with a total of 7,232 partners engaged (not de-duplicated). The 1,834 total outreach activities resulted in 604 referrals and 3,352 requests for information. Programs have also collaborated with other community programs to achieve shared goals, including coordination of outreach, screening and referral, and service delivery. A total of 675 coordinated outreach and referrals were reported. Also, as part of community and civic engagement, Programs participated in a total of 314 collaborative projects during the reporting period, Outreach events could cover multiple topics and are not mutually exclusive.

Table 9. Outreach Status

Group Sessions		Coordinated Outreach		Total Outreach Events	
Number of Sessions	883	Number of Events	960	Total Sessions / Events	1,834
Attendees at Sessions	8,790	Number of Partners Engaged	7,232	Referrals	604
Average Attendees at each Session	10	Average Partners at Events	7.5	Count of individuals requesting information	3,352

Client Story: Community Outreach and Engagement – Breastfeeding Support

An expectant first-time mother enrolled in her local program. Her community health worker became a vital asset to her - helping her obtain health insurance and secure reliable transportation to her prenatal appointments. Throughout her time with the program, the mother shared that her experience was overwhelmingly positive. She was connected to prenatal and birthing classes that helped ease her anxieties and prepare her both mentally and emotionally for the arrival of her baby. Over time, she accepted an invitation to join her program's community advisory board ('the board'). This opportunity allowed her to contribute her voice, share her experiences and influence community-driven programming. This client has shared that through involvement with the program and board, "I have been given the tools to help me grow. This experience and being a part of [the board] will allow me to share my story, and I hope I can help others stand up for what they want and truly need, and I hope I can help someone to be the best version of themselves and help them use their own voice." This client also began participating in community lactation support groups, where she continued to build confidence, expand her knowledge, and eventually grow into an advocate for breastfeeding within her community.

This client's journey reflects the transformative power of community outreach and engagement. By providing accessible support, fostering participation, and creating spaces for community voices to be heard.

❖ Sources of Client Referrals to Program Services

Of the 5,403 clients enrolled during the reporting period, 3,234 (60%) were referred to the program from a variety of sources as shown in Table 10. Of these, 2,668 (82.5%) were outside referrals, with the top three being prenatal care providers (14.9%), birthing hospitals (12.1%), and other specified services (12%), such as doula, homeless shelters, family justice center, and evidence-based home visiting programs etc. Another 16.5% of referrals were self-made (8%), or referrals from another client (5.2%) or a relative or friend (3.3%). Additional clients were referred through street outreach and group sessions (7.8%), and other sources (9.1%), such as walk-ins and community events.

Table 10. Sources of Client Referrals to Program Services

Referral Source	Number of Clients	Percentage of Clients
Outside Referrals to Programs	**2,668**	**82.5%**
Prenatal Care Provider	483	14.9%
Birthing Hospital	392	12.1%
Other Service	387	12.0%
Self	258	8.0%
Other Client	168	5.2%
Women, Infant, and Children Programs	153	4.7%
Community - Based Organization	137	4.2%
Other Health Care Provider	113	3.5%
Relative / Friend	106	3.3%
Social Service Agency	92	2.8%
Public Health Nurse / Local Health Departments	70	2.2%
Primary Care Physician	53	1.6%
Other Perinatal and Infant Community Health Collaborative Program	49	1.5%
Insurance Navigator	47	1.5%
Social Service - Temporary Assistance	29	0.9%
Health Home	26	0.8%
Mental Health / Behavioral Health	25	0.8%
Pediatrician	25	0.8%
School	15	0.5%
Family Planning Provider	13	0.4%
Managed Care Plan	13	0.4%
Faith - Based Organization	10	0.3%
Other Home Visiting Program	4	0.1%
Street Outreach	**231**	**7.1%**
Group Sessions	**23**	**0.7%**
Other Sources	**294**	**9.1%**
Unrecorded	**18**	**0.6%**
Total	**3,234**	**100.0%**

Summary

Programs have continued to enhance the implementation of individual-level strategies to address perinatal and infant health behaviors, as well as community-level strategies using a collective impact approach, to address the many social determinants that impact health outcomes. As shown in Table 11, there have been improvements in nearly all performance measures. The total numbers of clients, encounters, and home visits increased by 4.0%, 4.0%, and 38.0% respectively, and the average home visits per client increased from 1.6 to 2.1. Total referrals increased by 13.0%, and the average referrals issued per client increased slightly from 4.2 to 4.6. Total referrals completed also increased by nearly 13% (12.7%). 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 11.0%; and postpartum visits which improved by 14%. There were two performance measures showing declines, virtual encounters (-21.0%) and first trimester prenatal care (-5%). The decline in virtual encounters was expected as programs transition back to in person encounters and move on from virtual encounters related to COVID. The lower percentage of clients engaging in prenatal care in the first trimester is concerning and will receive particular emphasis for attention going forward.

Table 11. Program Comparison 1st Year vs. 2nd Year

Performance Measure	4/1/22-6/30/23	7/1/23-6/30/24	Difference	% Difference
Total Number of Clients	5,186	5,403	217	4%
Total Number of Encounters	26,563	27,571	1,008	4%
Total Number of Virtual Encounters	14,690	11,603	-3,087	-21%
Total Number of Home Visits	8,310	11,466	3,156	38%
Home Visits per Client	1.6	2.1	0.5	33%
Total Number of Referrals Issued	22,008	24,768	2,760	13%
Referrals Issued per Client	4.2	4.6	0.4	9%
Total Referrals Completed by Families	17,468	20,790	3,322	19%
Birth Plan Completion	60.4%	67.2%	6.8%	11%
Postpartum Visit	46.3%	52.8%	6.5%	14%
Prenatal Care Initiation (First Trimester)	78.8%	74.7%	-4.1%	-5%