2021 Final Summary Report

Reporting Time Period: April 1, 2021 – June 30, 2022

Maternal and Infant Community Health Collaborative (MICHC) Initiative

An Overview

The 2021 Final MICHC Summary Report represents New York State's (NYS) continued efforts to improve maternal and infant health outcomes for high-need, low-income women and their families while reducing persistent racial, ethnic, and economic disparities in those outcomes.

Outcomes are broadly categorized as follows:

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

This report presents final summary statistics based on data obtained from participating MICHC programs that utilize Community Health Workers (CHWs), representing clients served and services rendered by CHWs for the time period between April 1, 2021 and June 30, 2022. Data were obtained from the online Data Management Information System (DMIS) as entered by the individual MICHC programs. The MICHC DMIS is a web-based data collection and reporting system that was implemented on 4/1/2021 to inform the NYS Department of Health's (DOH) MICHC program administration.

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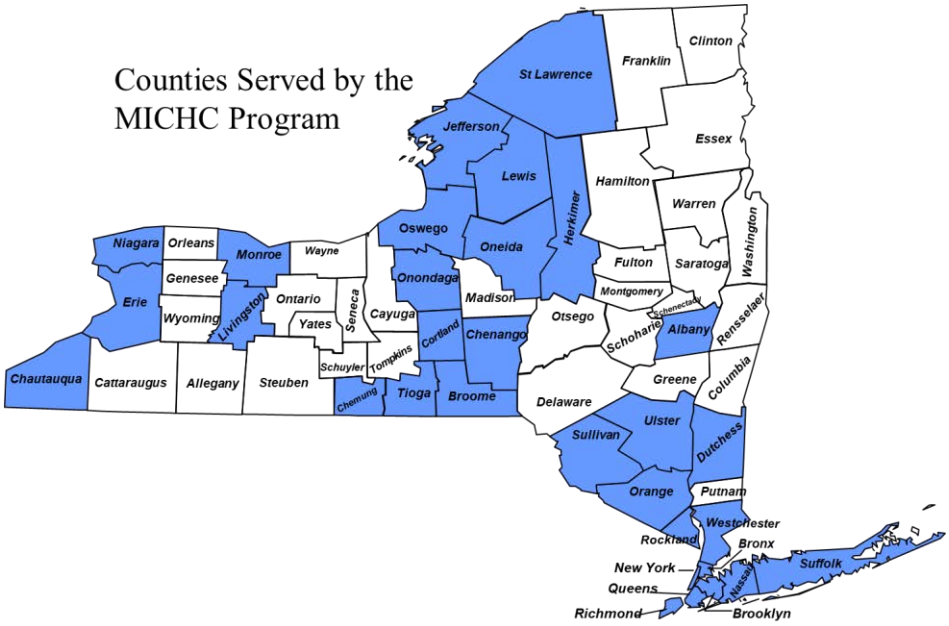
About MICHC

The MICHC initiative sought to improve maternal and infant health outcomes through the development of multi-dimensional community systems of integrated and coordinated programs and services designed to address maternal and infant health behaviors and ensure support and service systems across the reproductive life course. MICHC programs utilized CHWs to assist high-need, low-income, and/or Medicaid-eligible individuals of reproductive age and their families with accessing continuous quality healthcare and other needed community support services. MICHC supported 23 programs in 31 counties across NYS.



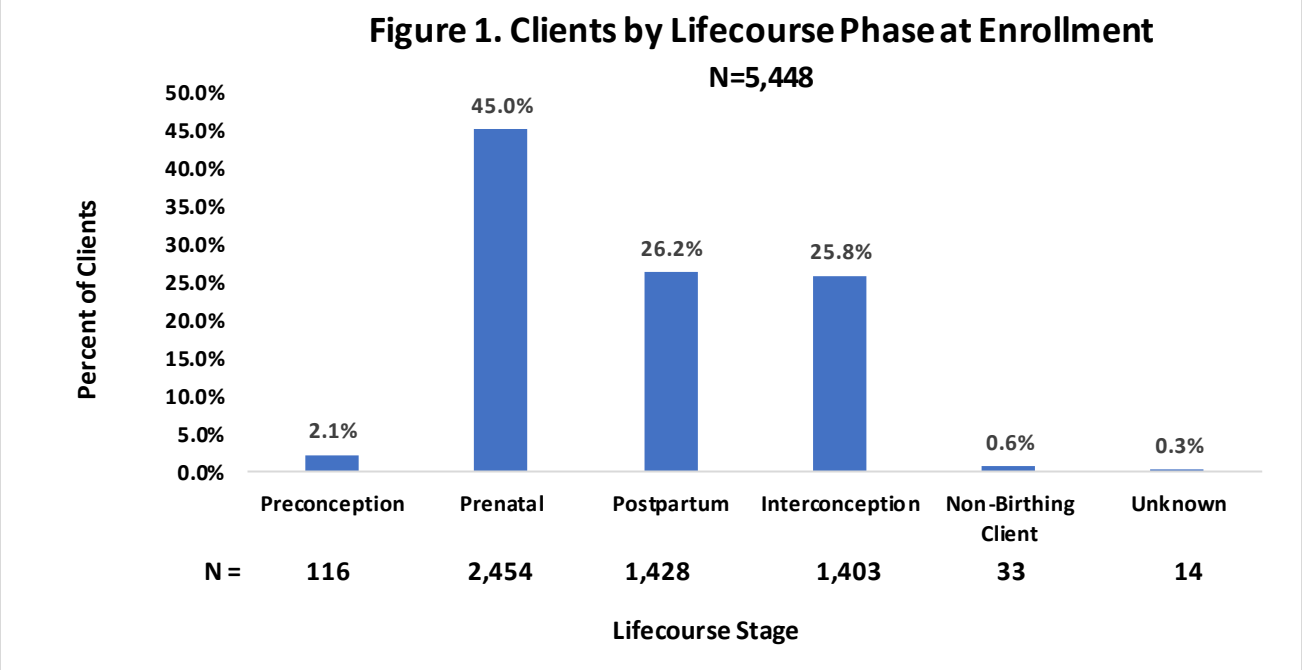
MICHC programs conducted outreach to engage and serve eligible clients and provide them with essential services. During the reporting period, MICHC programs across New York served **5,448 clients**. There were **11,279 in person encounters (including 6,085 home visits) and 18,360 virtual encounters** conducted by CHWs, resulting in **21,608 referrals issued and 15,714 referrals completed (73%)**.

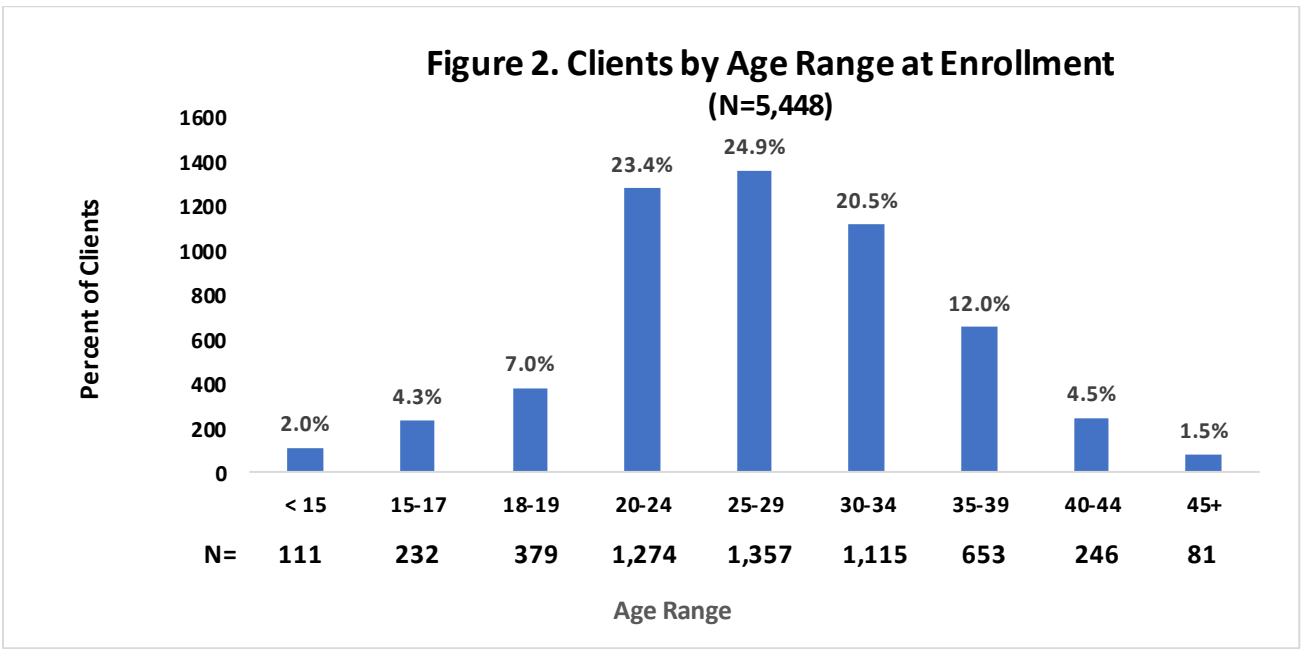
April 2021 – June 2022 Report Highlights

- **Clients Utilizing MICHC Services**
- **Services Most Utilized by MICHC Clients**
- **Program Encounter and Outreach Analysis**

New York State Clients Utilizing MICHC Services April 2021 – June 2022

CHWs 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 MICHC clients for the fifteen-month period between April 1, 2021, and June 30, 2022. CHWs served clients during various lifecourse phases: 45% prenatal; about 26% for both postpartum and interconception; and 2% preconception. Fewer than 1% were either unknown or non-birthing clients (Figure 1). Two-thirds of clients ranged in age from 20-34, with 13% under age 20 and 12% between ages 35 and 39 (Figure 2).





Clients of Hispanic ethnicity comprised 43% of those served, with non-Hispanic Whites comprising 25%, non-Hispanic Blacks comprising nearly 22%, and non-Hispanic minorities (Asian, Indigenous, multiracial, other) comprising 6% of clients served. The remaining 4% of clients were of unspecified Hispanic ethnicity or had neither ethnicity nor race recorded (Table 1). Nearly 80% of clients were insured by Medicaid, through FFS, managed care, or family planning extension (FPEP/FPBP) coverage (Table 2).

Table 1. Clients by Race / Ethnicity

Race / Ethnicity	Clients	Percent
Hispanic / Latinx	2,348	43.1%
Not Hispanic / Latinx, American Indian / Alaska Native	20	0.4%
Not Hispanic / Latinx, Asian	121	2.2%
Not Hispanic / Latinx, Black / African-American	1,175	21.6%
Not Hispanic / Latinx, Native Hawaiian / Pacific Islander	5	0.1%
Not Hispanic / Latinx, White	1,372	25.2%
Not Hispanic / Latinx, Other / Multi-racial	93	1.7%
Not Hispanic / Latinx, Declined / Unspecified Race	90	1.7%
Unspecified Hispanic / Latinx, American Indian / Alaska Native	0	0.0%
Unspecified Hispanic / Latinx, Asian	10	0.2%
Unspecified Hispanic / Latinx, Black / African-American	34	0.6%
Unspecified Hispanic / Latinx, Native Hawaiian / Pacific Islander	0	0.0%
Unspecified Hispanic / Latinx, White	16	0.3%
Unspecified Hispanic / Latinx, Other / Multi-racial	4	0.1%
Unspecified Race / Ethnicity	43	0.8%
Unrecorded	117	2.1%
Total	**5,448**	**100.0%**

Table 2. Client Health Insurance Type

Health Insurance Type	Number of Clients	Percent
Medicaid / Medicaid Managed Care	4,309	79.1%
FPEP or FPBP Medicaid Extension	36	0.7%
Child Health Plus	57	1.0%
Private Insurance	270	5.0%
Other	514	9.4%
Uninsured	265	4.9%
Unknown/Unrecorded	307	5.6%
Total	**5,448**	**100.0%**

❖ Prenatal / Postnatal Clients

As noted previously, nearly all MICHC clients (5,285 of 5,448; 97%) who enrolled between April 1, 2021 and June 30, 2022, did so either prenatally (2,454; 45%) or in either of the two postnatal lifecourse phases, postpartum (1,428, ~26%) and interconception (1,403, ~26%). Clients in the prenatal phase were pregnant at enrollment; those in the two postnatal phases enrolled after having given birth.

Of the 2,454 clients who enrolled in MICHC prenatally, 1,066 (43%) completed a birth plan during encounters with CHWs (Figure 3). Of the 2,831 total clients enrolling postnatally, 1,843 reached their eighth week postpartum during the fifteen-month reporting period. Only 468 (25%) of these clients attended postpartum visits within eight weeks of giving birth (Figure 4).

Figure 3. Clients Enrolled Prenatally With a Birth Plan Completed (N=2,454)

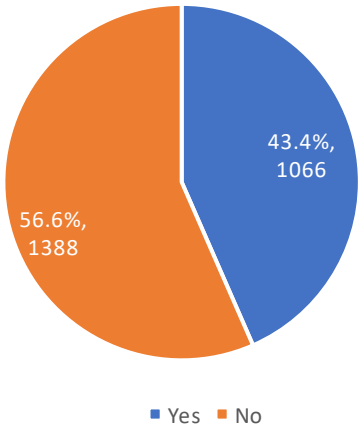


Figure 4. Postpartum Clients Who Attended Postpartum Visits (N=1,843)

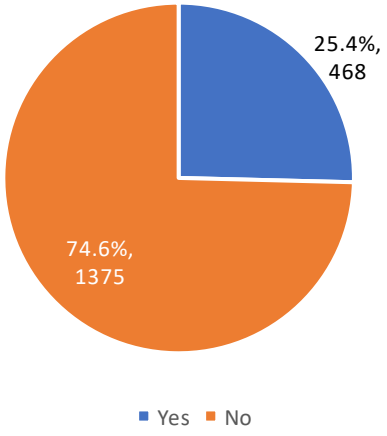


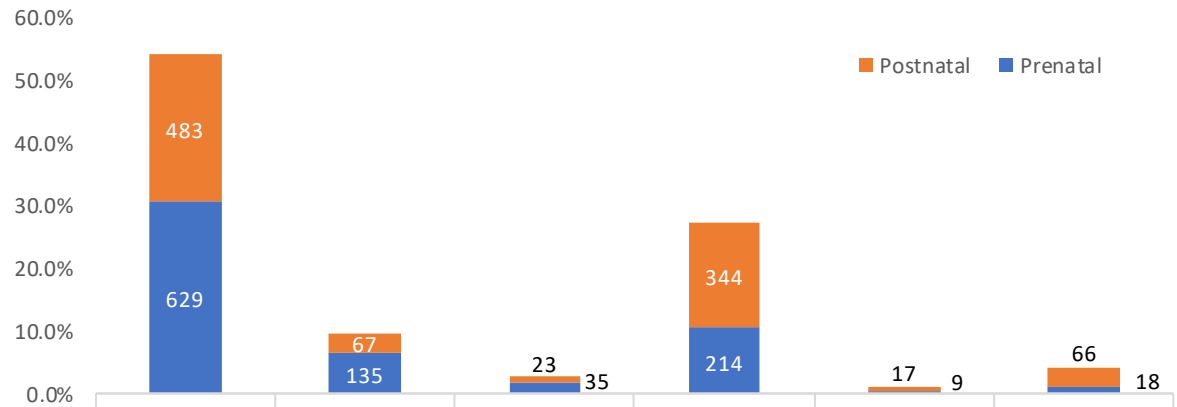
Table 3 shows the birth history of preterm and low birth weight (LBW) deliveries for the clients enrolled in the prenatal and postnatal lifecourse phases. It is notable that there were more than twice as many high risk births clients enrolled postnatally (6.4% preterm and 6.7% LBW) compared to those enrolled prenatally (2.7% preterm and 2.8% LBW).

Table 3. Pre/Postnatal Client Birth History and Lifecourse at Enrollment (N=5,285)

Birth History	Lifecourse at Enrollment	
	Prenatal	Postnatal
Total Clients	2,454	2,831
Clients with a known previous preterm birth	2.7%	6.4%
Clients with a known previous low birth weight	2.8%	6.7%

Of the 2,062 clients giving birth during the reporting period, 54% initiated prenatal care in the first trimester, with those enrolling prenatally having a 7% higher initiation rate at 30.5% compared to just over 23% for those enrolled postnatally. Of the nearly 10% of clients initiating prenatal care in the second trimester, those enrolled prenatally did so at twice the rate of those enrolling postnatally, at 6.5% and 3.2% respectively. Among the 4% known to have initiated prenatal care in the third trimester (2.8%) or not at all (1.2%), 2% had enrolled prenatally and 2% postnatally. For nearly a third of the birthing clients, the trimester of prenatal care initiation was unknown (27%) or unrecorded (4%); among these, 11% enrolled prenatally and 20% enrolled postnatally. (Figure 5).

Figure 5. Prenatal Care Inititation by Lifecourse at Enrollment among Birthing Clients (N=2,062)



	First Trimester	Second Trimester	Third Trimester	Unknown Trimester	No Prenatal Care	Unrecorded
Postnatal	23.4%	3.2%	1.1%	16.7%	0.8%	3.2%
Prenatal	30.5%	6.5%	1.7%	10.4%	0.4%	0.9%

Note: 22 (1.1%) clients with unknown lifecourse are not shown.

There were 2,124 children delivered by 2,062 of the clients enrolled in MICHC between April 1, 2021 and June 30, 2022. Birth outcomes for these children are shown in Table 4. Among these, 43% were first births, 11% were either preterm and/or low birth weight, and nearly 3% were multiple gestation births.

Table 4. Birth Outcomes for Children Born in the Reporting Period (N=2,124)

Birth Outcomes	Total Count	Percent
First Births	916	43.1%
Preterm Births	236	11.1%
Low Birth Weight	240	11.3%
Multiple Births	62	2.9%
Total Children Born	**2,124**	100%
Total Birthing Clients	**2,062**	

Service Delivery

❖ All Clients

The information in this section provides an overview of services delivered to the 5,448 clients enrolled in MICHC in all life course stages during the fifteen-month reporting period, including primary and reproductive care provided, screenings and referrals for health care, and referrals made to social and support services.

Nearly 60% of all enrolled clients reported having a primary care physician as well as attending well woman visits (Figure 6 & Figure 7). Nearly half (47%) of clients received family planning information or had a reproductive life plan completed (Figure 8).

Figure 6. Clients with a Primary Care Physician

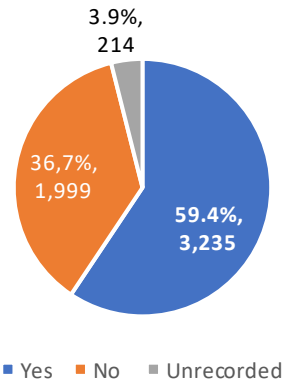


Figure 7. Clients Who Attended Well-Woman VIsits

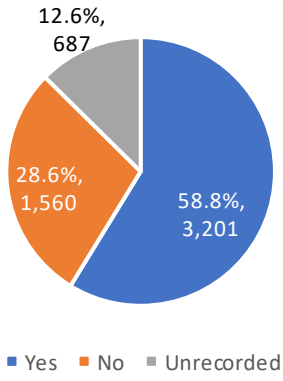
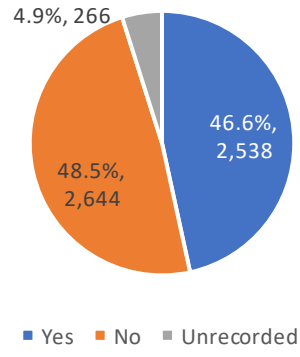


Figure 8. Clients Who Received Family Planning Information / With Reproductive Life Plan Completed



❖ Healthcare Screenings

Healthcare screenings provided as a part of MICHC services are essential for assessing clients' health care needs. Some of the major health care screenings provided to MICHC clients during the fifteen-month reporting period are summarized in Table 5. Note that clients may have been screened multiple times during their participation in the MICHC program. A total of 32,238 screenings were conducted overall, and the percentages of clients screened ranged from lows of nearly 51% for depression and nearly 58% for alcohol use to highs of 87% for smoking and 95% for insurance coverage. Oral health screenings were provided to three-fourths of clients and both substance use and domestic violence screenings were provided to nearly two-thirds of clients.

Table 5. Health Care Screenings

Screening Type	Number of Screenings	Number of Clients Screened	Percent of Clients Screened
Alcohol	4,321	3,155	57.9%
Substance Use	5,052	3,676	67.5%
Depression	3,853	2,758	50.6%
Domestic Violence	4,968	3,585	65.8%
Health Insurance	5,176	5,176	95.0%
Oral Health	4,114	4,114	75.5%
Smoking	4,754	4,754	87.2%
Ages and Stages Questionnaire	1,411	875	62.0%
Total	**32,238**		

❖ Healthcare Referrals

In follow up to screenings, healthcare referrals also are provided as a part of MICHC services, to ensure clients and their families are connected with essential care. The top healthcare referrals issued to clients in all lifecourse phases were to services for dental and mental health, with 1,306 and 874 referrals respectively, followed by family planning with 639 referrals and primary care with 569 referrals for children and 568 for adults (Table 6). The 511 "other" referrals were made to healthy weight programs, and clinical specialists including optometrists, heart specialists, otolaryngologists, and COVID-19 vaccinations, among others.

Table 6. Health Care Referrals

Referral Category	Number of Referrals Issued	Number of Referrals Completed	Completion Rate
Dental Services	1,306	856	65.5%
Mental Health Services	874	564	64.5%
Family Planning	639	525	82.2%
Child Primary Care	569	485	85.2%
Adult Primary Care	568	398	70.1%
Prenatal Care	389	286	73.5%
Postpartum Care	364	290	79.7%
Immunization	329	228	69.3%
Early Intervention	93	77	82.8%
Lead Testing	42	31	73.8%
Other	511	386	75.5%
Total	**5,684**	**4,126**	**72.6%**

❖ Family Social Support Referrals

Family social support referrals also are an essential part of MICHC services for connecting clients and their families to appropriate services and care. Nearly 16,000 such referrals were made during the reporting period, with nearly three-quarters (73%) completed. The types of referrals given to clients for various Family and Social Support services in their community are detailed in Table 7, in descending order by the number issued. Included among the greatest needs identified for clients were concrete supports such as clothing and/or baby care items (2,762), food pantry (1,223), Special Supplemental Nutritional Assistance Program for Women, Infants, and Children (WIC) (1,205), housing (1,179), and Supplemental Nutritional Assistance Program (SNAP), commonly referred to as the Food Stamp Program (880), which in combination comprised 45.5% of the total referrals. Families also received 1,832 referrals to "Other" additional local services, which included COVID-19 personal protective equipment and cleaning supplies, parenting classes, after school programs, and other additional supports for families. Completion rates for these referrals were relatively high averaging 73% overall, and ranging from 53% to nearly 93%, with the single exception of smoking cessation at 23%.

Table 7. Family and Social Service Referrals			
Referral Category	**Number of Referrals Issued**	**Number of Referrals Completed**	**Completion Rate**
Clothing / Baby Care Items	2,762	2,283	82.7%
Food Pantry	1,223	912	74.6%
WIC*	1,205	957	79.4%
Housing	1,179	783	66.4%
SNAP (Food Stamps)*	880	674	76.6%
Transportation	664	580	87.3%
Breastfeeding	633	428	67.6%
Child Care	568	400	70.4%
Health Insurance	486	402	82.7%
Car Seat	404	274	67.8%
Evidence-Based Home Visiting Programs	397	278	70.0%
Employment/Vocational Services	376	202	53.7%
Safe Sleep	332	255	76.8%
Support Groups	311	253	81.4%
TANF/LDSS* Cash Assistance	302	216	71.5%
Legal Services	264	174	65.9%
English as Second Language (ESL)	244	159	65.2%
Educational Attainment	228	149	65.4%
Nutrition, General	227	132	58.1%
Immigration Services	200	106	53.0%
Family Resource Center	194	105	54.1%
Furniture	194	155	79.9%
Environmental Health/Safety	146	135	92.5%
Child Development	144	109	75.7%
Translation	137	135	98.5%
Domestic Violence	134	71	53.0%
HEAP*	105	69	65.7%
Smoking Cessation	90	21	23.3%
Child Support	32	19	59.4%
Substance Use	16	9	56.3%
Public Health Nurse / Local Health Department	15	9	60.0%
Other	1,832	1,134	61.9%
Totals	**15,924**	**11,588**	**72.8%**

***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, nearly 400 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. Those to which MICHC clients were referred during the reporting period are detailed in Table 8. Nearly 70% were referred to Healthy Families New York (22.4%), Early Head Start (21.7%), Head Start (17.6%), and Parents as Teachers (7.1%). Nearly another quarter (24%) of these clients were referred to other evidence-based programs, including Attachment Bio-behavioral Catch-Up (ABC) Program, NYS Early Intervention Program, etc. Referral completion rates averaged 70% in this group and were highest among the Healthy Start, Early Head Start and Head Start programs, all nearing or at 80%.

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
Healthy Families New York	89	22.4%	54	60.7%
Early Head Start	86	21.7%	67	77.9%
Head Start	70	17.6%	55	78.6%
Parents as Teachers	28	7.1%	15	53.6%
Nurse-Family Partnership	11	2.8%	8	72.7%
Parent Child Home Program	10	2.5%	5	50.0%
Healthy Start	5	1.3%	4	80.0%
Home Instruction for Parents of Preschool Youngsters	2	0.5%	1	50.0%
Other Home Visiting Program	96	24.2%	69	71.9%
Total Home Visiting Programs	397	100%	278	70.0%

❖ Outreach and Engagement

MICHC programs engage clients in the community through door-to-door outreach, group education classes, and through various partnerships with other community-based organizations. During outreach, CHWs may provide information, education, and referrals to healthcare and social services. Clients are engaged and enrolled in the program through direct community outreach or through outside referrals to MICHC from a network of community partners.

As shown in Table 9, MICHC programs conducted 767 group sessions and 836 coordinated outreach events during the reporting period. With 5,549 attendees, there were about seven participants on average attending group sessions, and with 3,653 partners engaged, about four partners on average per coordinated outreach. The 1,578 total outreach activities resulted in 164 referrals and 2,299 requests for information.

Table 9. Outreach Status

Group Sessions		Coordinated Outreach		Total Outreach Events	
Number of Sessions	767	Number of Events	836	Total Sessions / Events	1,578
Attendees at Sessions	5,549	Number of Partners Engaged	3,653	Referrals	164
Average Attendees @ Session	7.2	Average Partners @ Event	4.4	Count of individuals requesting information	2,299

Nearly 4,000 (3,931; 73%) of the 5,488 clients enrolled during the reporting period were referred to the MICHC program from sources as shown in Table 10. Of these, 3,275 (84%) were outside referrals, with the top three referral sources being birthing hospitals (22.6%), prenatal care providers (19.4%), themselves (Self) (10.5%), and WIC (9.6%). The 7.1% of outside referrals from other sources included social media, Empire Justice Centers, evidence-based home visiting programs, etc. Additional clients were referred to the MICHC program through street outreach (6%), group sessions (1.3%), and other sources (9%), which included walk-ins, community events, etc.

Table 10. Referrals to MICHC by Source of Encounters

Source of Encounters	Clients	Percent
Outside referrals to MICHC programs	3,275	83.3%
Birthing Hospital	740	22.6%
Prenatal Care Provider	635	19.4%
Self	343	10.5%
WIC	314	9.6%
Other	233	7.1%
Other Client	210	6.4%
Community-Based Organizations	162	4.9%
Other Health Care Provider	147	4.5%
Relative/Friend	123	3.8%
Social Service Agency	92	2.8%
Mental Health/Behavioral Health	48	1.5%
Primary Care Physician	44	1.3%
Public Health Nurse / Local Health Department	39	1.2%
Other MICHC Program	29	0.9%
Pediatrician	25	0.8%
School	24	0.7%
Insurance Navigator	22	0.7%
Health Home	14	0.4%
Family Planning Provider	12	0.4%
Faith-Based Organization	11	0.3%
Managed Care Plan	7	0.2%
Dental Provider	1	0.0%
Street Outreach	240	6.1%
Group Sessions	52	1.3%
Other Sources	356	9.1%
Unrecorded	8	0.2%
Total	**3,931**	**100.0%**

Conclusion

During the period April 1, 2021 through June 30, 2022, MICHC programs across New York State served a wide range of individuals and families in communities with limited access to resources, working diligently to provide outreach, assess needs, and find available supports and services, including increased engagement with healthcare providers. As the COVID-19 pandemic continued, MICHC programs continued to utilize remote visits through telephone, video, and other virtual methods, as well as in-person home visits to engage with clients. The existing networks and strong community partnerships built and sustained by MICHC programs were a valuable resource for NYS families throughout the pandemic. As of June 30, 2022, the NYS MICHC program ended, and was replaced by a new program, Perinatal and Infant Community Health Collaborative (PICHC) which was launched on July 1, 2022 in 31 counties statewide. Twenty-six PICHC programs were funded for the five-year period ending June 30, 2027: Perinatal and Infant Community Health Collaboratives (PICHC) Initiative (ny.gov). PICHC programs will implement individual-level strategies to address perinatal and infant health behaviors, and community-level strategies using a collective impact approach, to address the social determinants that impact health outcomes. The core individual-level strategy is the use of community health workers (CHWs) to outreach and provide supports to high-need, low-income, and/or Medicaid-eligible individuals of reproductive age (15-44 years old) most vulnerable to, or with a previous history of, adverse birth outcomes. Community-level strategies involve collaboration with diverse community partners, including community residents, to mobilize community action to address the social determinants impacting perinatal and infant health outcomes.

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 NYS.

FOR ALL YOUR AMAZING WORK AND DEDICATION

Livingston County Department of Health

Chautauqua County Health Department

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Resources, Education, Advocacy, and Collaboration for Health

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NCPPC Every Woman, Every Child, Every Family
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