

Using Centralized Intake Systems to Support Home Visiting Outreach and Referral: Cross-Site Findings from Six Systems

September 2026

OPRE Report #2026-038

Using Centralized Intake Systems to Support Home Visiting Outreach and Referral: Cross-Site Findings from Six Systems

OPRE Report #2026-038
September 2026

AUTHORS:
Mathematica: Jill Spielfogel, Rebecca Kleinman, Abby Capella, Milena Raketic, Yuri Feliciano, Jessica F. Harding, and Charlotte Cabili
Brazelton Touchpoints Center: Catherine Ayoub, Christina Mondi-Rago, John Hornstein, Angelica Guerrero
Social Grove: Ashton Chapman

Submitted to:

Laura Nerenberg and Jesse Coe
Office of Planning, Research, and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

Submitted by:

Rebecca Kleinman, Project Director
Mathematica
1100 First Street, NE, 12th Floor
Washington, DC 20002-4221

Contract number: 47QRAA18D00BQ/75ACF121F80023

This report is in the public domain. Permission to reproduce is not necessary. Suggested citation: Spielfogel, Jill, Rebecca Kleinman, Abby Capella, Milena Raketic, Yuri Feliciano, Jessica F. Harding, Charlotte Cabili, Catherine Ayoub, Christina Mondi-Rago, John Hornstein, Angelica Guerrero, and Ashton Chapman (2026). *Using Centralized Intake Systems to Support Home Visiting Outreach and Referral: Cross-site Findings from Six Systems,* OPRE Report #2026-038, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Disclaimer:
The views expressed in this publication do not necessarily reflect the views or policies of the Office of Planning, Research, and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

This report and other reports sponsored by the Office of Planning, Research, and Evaluation are available at www.acf.hhs.gov/opre.

Mathematica Progress Together
Brazelton Touchpoints Center™
SOCIAL GROVE
OPRE

The Understanding and Expanding the Reach of Home Visiting (HV-REACH) project

The HV-REACH project developed and disseminated evidence-informed resources and strategies that home visiting programs can use to increase access to and participation in home visiting services among eligible families. Mathematica conducted this project in partnership with the Brazelton Touchpoints Center and Social Grove on behalf of the Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF), in collaboration with the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA).

Acknowledgments

We extend our sincere appreciation to our federal project officers and partners in ACF and HRSA for their leadership and guidance: Laura Nerenberg, Jesse Coe, and Katie Pahigiannis of OPRE; Maggie Kane, Soohyun Kim, and Ayanna Williams of HRSA; Kristyn Wong VanDahm, formerly of ACF; with a special thanks to Kelly Jedd McKenzie of ACF for her direction and leadership as project officer until the project neared its end. We are also grateful to our colleagues for their contributions to the early stage of the study, including with tasks such as developing plans for analysis, site selection, recruitment, and interviewing — Julius Anastasio, Patricia Del Grosso, Ana Maria Melendez Guevara, Brandon Hollie, Nuzhat Islam, Joe O'Brien, Jaimie Orland, and Lauren B. Rosenberg. In addition, Nikki Aikens and Elizabeth Cavadel provided thoughtful quality assurance. We appreciate the efforts of other colleagues at Mathematica: Effie Metropoulos, Maura Butler, Carol Soble, and Donovan Griffin for editorial support; Sheryl Friedlander and Allison Pinckney who managed production; and Yvonne Marki and Jon Owolabi, who contributed graphic design. In addition, the HV-REACH Centralized Intake Committee provided input on site selection, interview guides, recruitment processes, and the findings—thank you to Stephanie Beverly, Julie Leis, Katy Leopard, Maria Maestas, Melissa Miller, Allison Parish, Laura Taylor, Allison West, and Susan Zaid. Finally, we extend our deepest thanks to the staff at the centralized intake systems and staff and families with the home visiting programs that participated in the study for generously sharing their time and insights.

Overview

A. Introduction

Centralized intake (CI) systems, also referred to as coordinated intake and referral systems, are one-stop entry points where families can learn about and be screened and referred to services that meet their needs and preferences, including home visiting. States or local entities can use CI systems to streamline outreach, screening, and referral processes. This approach may improve efficiency and reduce duplication in the home visiting services and other supports that families receive (IGrow Illinois 2020; National Home Visiting Model Alliance n.d.). Families, in turn, may benefit from coordinated access to services. CI systems are also one strategy states or local entities can use to help home visiting programs reach more families and support service expansion.

B. Purpose

The Understanding and Expanding the Reach of Home Visiting (HV-REACH) project conducted case studies of six CI systems that match families with home visiting programs. The project team sought to understand how CI systems are designed and implemented to conduct outreach, screening, and referrals to support enrollment in home visiting services. The study was conducted on behalf of the Administration for Children and Families, in collaboration with the Health Resources and Services Administration.

Study findings can inform different audiences about the role of CI systems in supporting home visiting enrollment. Staff from existing CI systems and leaders who are considering implementing a CI system can use these study findings to deepen their understanding of the role and benefit of CI systems, what is involved in implementing them, and whether there are opportunities to strengthen them. This report can also help state MIECHV Program and local home visiting program administrators learn how CI systems can potentially support home visiting programs in reaching more families. Researchers can use the information to inform future studies of CI systems. These efforts can help build more efficient CI systems and help staff and families use them more effectively.

C. Primary research questions

1. What are the features, strengths, and challenges of six established CI systems?
2. How do CI systems support outreach and enrollment of families in home visiting programs?
3. What are enrolled families' experiences with CI systems?

D. Key findings and highlights

CI system structure

- Governing agencies, which are state or quasi-governmental agencies, oversee implementing agencies, which carry out the system's daily activities. Five of the CI systems operate statewide, and three of those are run by different regional implementing agencies that cover different geographic areas. The sixth CI system operates countywide.
- All six CI systems were designed to make it easier for providers and families to find the right home visiting program for a family and thereby improve families' maternal and child health outcomes.

Referral sources for the CI systems

- Staff at all six CI systems intentionally cultivate referral partnerships with community organizations—including medical providers or child welfare agencies—and directly engage families at community events.
- Medicaid agencies or statewide screening initiatives generate a long list of potentially eligible families for three of the CI systems.

Approaches to referring families to home visiting programs

- In Missouri, families are matched to a home visiting program after completing information in an online form. In the other five CI systems, staff talk with families before matching them. All six CI systems established rules to ensure fair matching of families with programs.
- In order for CI system staff to refer families to home visiting programs with immediate availability, home visiting program staff regularly share program capacity information with staff in all six CI systems.
- All CI and home visiting staff use shared data systems, encrypted emails, and phone calls to share referral information while maintaining family privacy.

Successes and challenges

- Across the six systems, home visiting program staff believed the CI systems helped them reach more families, and families described the handoff and enrollment process as seamless and easy.
- Home visiting programs are important CI system partners. They provide input on the matching rules and work with CI system leaders to refine and improve processes. Building and sustaining these trusting relationships takes time and ongoing effort.
- Inaccurate family contact information and general apprehension among some families make it difficult for some of the CI systems to reach or engage all families that might benefit from services.

E. Methods

Study findings are based on interviews with 76 CI system and home visiting program managers and staff and 36 families connected to home visiting programs through one of the six CI systems, as well as information from documents. The project team conducted interviews between March and October 2025. To be included in the study, a CI system had to centralize or coordinate outreach, screening, and referrals to make it easier to enroll families in a home visiting program. It also had to have been operational and actively referring families for at least six months. The CI systems then recommended home visiting programs for staff interviews and for recruiting families.

The project team analyzed the data by coding interview notes and then identifying themes across the coded data. The team first compiled findings into a summary for each CI system and then analyzed information across the summaries to identify cross-cutting themes. The individual CI summaries are included in "Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting," available on the Office of Planning, Research, and Evaluation website using the website's search function.

Contents

Overview iv

Executive Summary vii

I. Introduction 1

II. Methods 5

III. CI System Structure and Operations 8

IV. Pathways into CI Systems and Home Visiting 18

V. Data Systems and Data Sharing 23

VI. Successes, Challenges and Opportunities for Improvement, and Directions for Future Research 26

References 32

Appendix A. Site Selection, Interview Approach, and Analysis Methods A.1

Exhibits

ES.1. Governing and implementing agencies for the six centralized intake systems ix

ES.2. The centralized intake system process and core centralized intake functions x

I.1. The centralized intake system process and implementation supports 3

II.1. Map of the six centralized intake systems that participated in the case studies 5

II.2. Number of individuals interviewed, by role and centralized intake system 7

III.1. Overview of the six centralized intake systems in this study 8

III.2. Information or services that centralized intake systems offer beyond home visiting 12

III.3. Centralized intake system funding sources and amounts 13

III.4. Governing and implementing agencies for the six centralized intake systems 14

III.5. Centralized intake system staffing levels and role divisions at implementing agencies 17

IV.1. Main ways families learn about or are referred to the centralized intake systems 19

V.1. Key data system functions for centralized intake operations 23

A.1. Eligibility criteria and prioritization considerations A.1

A.2. Process for recruiting sites for the case studies A.2

A.3. Home visiting models represented in interviews, by centralized intake system A.2

A.4. Interview topics, by type of interview participant A.4

Executive Summary

Evidence suggests that home visiting programs help support maternal and child health (Coughlin et al. 2025; Maternal Child Health Bureau 2025b). In 2024, evidence-based home visiting programs reached an estimated 284,000 families nationwide, including about 75,000 families served through the federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Health Resources and Services Administration 2025; National Home Visiting Resource Center 2025). Yet these programs still do not reach many of the families that could benefit from home visiting services.

Centralized intake (CI) systems, also referred to as coordinated intake and referral systems, offer a single entry point where families can learn about and be screened and referred to services that meet their needs and preferences, including home visiting. CI systems that refer families to home visiting programs are one of several referral pathways to enrollment. By streamlining outreach, screening, and referral processes, state or local entities can use CI systems to improve efficiency and reduce duplication in the home visiting services and other supports that families receive (IGrow Illinois 2020; National Home Visiting Model Alliance n.d.). Families, in turn, may benefit from coordinated access to services. CI systems are also one strategy states or local entities can use to help home visiting programs reach more families and support service expansion.

A. Study purpose

The Understanding and Expanding the Reach of Home Visiting (HV-REACH) project conducted case studies of six CI systems that match families with home visiting programs. The project's aim was to understand how CI systems are designed and implemented to conduct outreach, screening, and referrals while supporting enrollment in home visiting services. The study was conducted on behalf of the Office of Planning, Research, and Evaluation in the Administration for Children and Families, in collaboration with the Health Resources and Services Administration.

The study's three goals were to:

1. Understand the features, strengths, and challenges of the six CI systems
2. Explore how staff and families think the CI systems promote and expand family enrollment in home visiting programs
3. Document families' experiences with the CI systems

This report can help administrators of state MIECHV Programs and local home visiting programs learn how CI systems can help home visiting programs reach more families that are eligible for and interested in their services, especially as some states expand their MIECHV Program capacity (Social Security Act 2023; Health Resources and Services Administration 2025). In addition, staff from existing CI systems and leaders who are considering implementing a CI system can use the study findings to deepen their understanding of the role and benefit of CI systems, what is involved in implementing the systems, and opportunities for strengthening them. Researchers can use the information to guide future studies of CI systems.

B. Methods

To identify CI systems, we reviewed publicly available information about 30 systems to gauge whether they were fully operational and referring families to home visiting programs. Then, we identified systems that vary in their approach and geography and recruited their staff to participate in the study. Staff of six CI systems agreed to participate: Delaware's Help Me Grow at 211; Florida's Connect; Indiana's My Healthy Baby; Missouri's Coordinated Intake and Referral System; New Jersey's Connecting NJ; and Tehama County, California's Pregnancy to Preschool Partnership.

Between March and October 2025, we interviewed managers and staff who implement or govern the six CI systems along with managers and direct services staff at the home visiting programs the CI systems refer families to. In addition, within each home visiting program, we spoke with families that had been referred to home visiting through the CI system. In total, we interviewed 76 centralized intake or home visiting staff and 36 families (13 to 24 participants per system).

One CI system operates at the county level (Tehama County, California). The other five CI systems operate statewide, and three of these five (Florida, Missouri, and New Jersey) use regional implementing organizations to operate their systems. For the latter type of CI system, we interviewed CI staff at the governing agency (state agencies or their contractors) and staff from implementing agencies (agencies that carry out CI activities for a specific region of the state) in two regions. We reviewed publicly available documents (reports, guidance, or other information) and CI system documents we received from the CI system contacts.

C. Key findings from the case studies

This report describes CI systems' goals, funding sources, governance, oversight, and staffing approaches.

- **Goals and funding sources.** All six CI systems are designed to make it easier for providers and families to identify home visiting programs in their areas and, in turn, strengthen maternal and child health in their county, region, or state. Staff in all CI systems also aim to refer families evenly across the home visiting programs available in their area. Five CI systems (Delaware, Florida, Indiana, New Jersey and Tehama County) refer families to services beyond home visiting or provide information about other services available in the community. All six systems rely on state funding sources, and some also use federal funding that flows through state governing agencies, such as funding from the MIECHV Program and Medicaid.
- **Governance.** State or quasi-governmental organizations govern the CI systems and oversee the implementing agencies that carry out daily CI activities (Exhibit ES.1). In three of the statewide systems (Florida, Missouri, and New Jersey), governing agencies fund separate implementing agencies to carry out CI activities for a specific region of the state. These regional implementing organizations build local partnerships and tailor operations to meet local needs.

Exhibit ES.1. Governing and implementing agencies for the six centralized intake systems

Centralized intake system	Governing agency or agencies	Implementing agency or agencies
Statewide		
Delaware Help Me Grow at 211	State health agency	Contracted social services provider
Indiana My Healthy Baby	State health, Medicaid, and child and family social services agencies	State health agency
Statewide with regional implementation		
Florida Connect	State health agency in coordination with quasi-governmental organizations	Thirty-two coalitions (social service providers and one local health department)
Missouri Coordinated Intake and Referral System	Quasi-governmental organization	Five contracted providers (hospitals and community-based organizations)
New Jersey Connecting NJ	State health and child and family services agencies	Seven contracted providers (social service or health organizations)
Countywide		
Tehama County Pregnancy to Preschool Partnership	Quasi-governmental organization	The quasi-governmental organization and seven early childhood providers in the partnership network

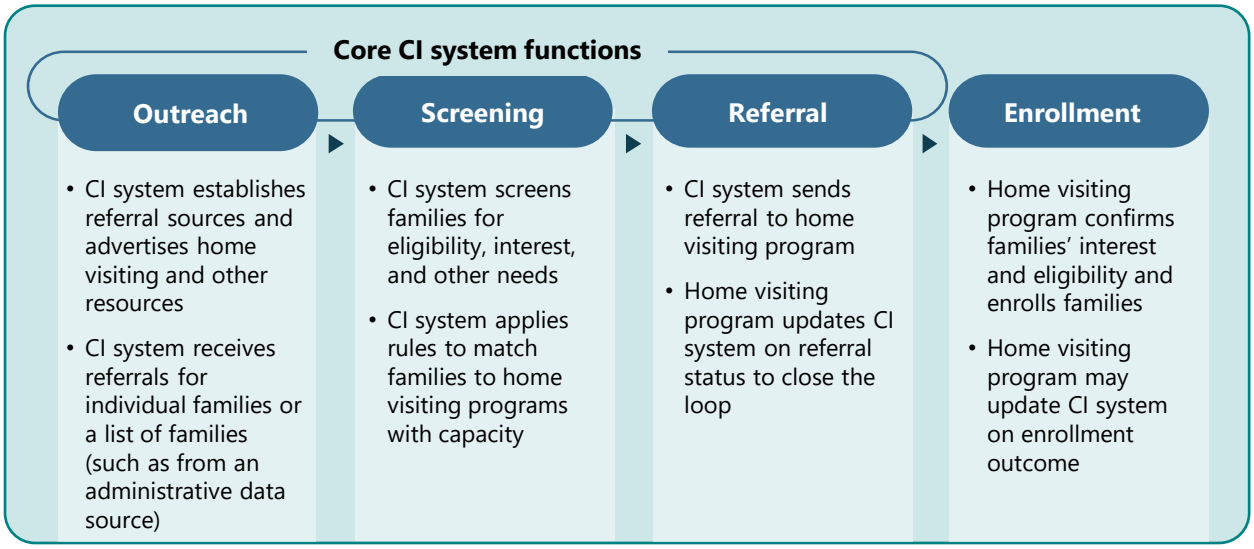
- **Oversight.** All six CI systems rely on a core team to set the strategic direction, convene partners, and ensure consistency across the system. They also gather feedback from advisory groups and others to help guide home visiting efforts in the state.
- **Staffing.** Staff in the six CI systems either carry out specialized task roles (such as screening families) or perform a combination of roles (such as screening, matching, and referral). All six CI systems said community outreach is typically a shared responsibility among staff who work for the CI system. One CI system (Missouri) is designed to be fully automated, enabling families to be referred to home visiting without first speaking with CI staff.

The core activities of the CI systems include conducting outreach, screening families, and matching and referring them to home visiting programs. We summarize the overall process in Exhibit ES.2.

- **Several referral sources help connect families to CI systems.** Across the six CI systems, the most common referral sources are medical providers (such as hospitals), child welfare agencies, and direct outreach to families attending community events. In Florida, Indiana, and New Jersey, Medicaid agencies or statewide screening initiatives generate long lists of families that may be eligible for services available through CI systems.
- **The CI systems screen families and match them with home visiting programs.** Before matching families with home visiting services, five CI systems screen families to supplement information received from referral sources. All six CI systems use established rules (such as decision trees or algorithms) to match families with home visiting programs. Home visiting programs regularly provide information on their capacity so CI systems can refer families to programs with immediate availability. In all six CI systems, families can express preferences for particular home visiting programs.

- **The CI systems send referrals to home visiting programs.** The CI systems use shared data systems, encrypted emails, and phone calls to send the referrals. CI staff communicate regularly with home visiting programs to refine and improve referral processes.

Exhibit ES.2. The centralized intake system process and core centralized intake functions



Note: This figure represents a generalized approach and does not fully capture the specific approaches used in each of the six CI systems we studied.

CI = centralized intake.

The CI systems use data systems to maintain up-to-date information on referrals and monitor performance.

- **Data systems have several key functions.** All six CI systems allow partners and/or families to submit web-based referral forms. In three of these CI systems (Delaware, Missouri, New Jersey), the forms automatically populate in the CI data systems. Five of the six systems give home visiting programs limited access to the CI data system so they can send and track referrals directly. Three CI data systems (Florida, Indiana, and Missouri) use algorithms that automatically match families to home visiting programs based on the families' screening information.
- **All six CI data systems generate reports to support performance monitoring and operational improvement.** Across data systems, common metrics include the number of referrals the CI system receives, capacity of the home visiting programs, the number of referrals sent to home visiting programs, and the number of families that ultimately enroll in home visiting.
- **Protecting family privacy is a central concern when sharing data.** To protect privacy, CI systems typically restrict access to sensitive information and, when sharing data with other agencies, rely on data use agreements and/or business associate agreements to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements.

Across the CI systems, families reported positive experiences.

- **Families described the handoff and enrollment process as seamless and easy.** Families in all six CI systems often do not distinguish between the CI system and their home visiting program, suggesting that the linkage to home visiting is working seamlessly and as intended.

- **Families learn about CI systems from various sources, but some families believe CI systems could do more to promote their services and home visiting in general.** The families we interviewed first learned about the CI system from health care providers, schools, income support offices, word of mouth, or community events. Families' ideas for boosting awareness of or receptivity to home visiting include increasing promotion in health care settings (such as displaying posters in doctors' offices), providing more information about home visiting during the first call with the CI system, and advertising on social media.
- **Families describe their interactions with CI staff as friendly and supportive.** In the five CI systems that screen families by phone (Delaware, Florida, Indiana, New Jersey, and Tehama County), families said they received brief descriptions of home visiting from CI staff, and that the home visiting program provides more detail once they connect with a family. Families in all six CI systems said they received straightforward referral information from the CI system during the screening call or, for Missouri families, via email or text after being matched with a program.

D. Successes, challenges, and opportunities for improvement

Notable successes include the following:

- **Across all CI systems, home visiting staff think the CI system helps them reach more families.** They said CI system staff are an integral part of the early childhood community, and their strategic partnerships with CI system staff help them reach more pregnant women and families with young children than the home visiting programs could have reached alone. CI staff intentionally cultivate relationships with providers and organizations that consistently refer families to the systems.
- **CI system staff develop efficient processes for sharing information with home visiting programs and closing the loop on referrals.** In the five systems where home visiting programs have access to CI data systems, that access streamlines the flow of information between CI system and home visiting program staff. In addition to this data sharing capacity, some systems use more advanced capabilities, such as links to other state data systems. CI system staff also use the data systems to generate reports to support continuous quality improvement.
- **CI system partners regularly assess their processes and make needed adjustments.** All the systems are designed to evolve in response to experience, data, and family needs. CI system staff are committed to refining outreach, referral, and data processes iteratively, demonstrating a culture of continuous learning.

Challenges and opportunities across the CI systems include the following:

- **Relationships and trust with home visiting programs need time to develop and require ongoing effort to sustain.** In all the systems, at least some staff at home visiting programs were either initially uncertain of the value of involving the CI system in identifying and screening families for their programs, or concerned about the time commitment or fairness of allocating referrals across competing programs. However, their understanding and buy-in improved over time. Staff in all CI systems said that maintaining relationships takes an ongoing investment.

- **Incomplete or inaccurate family contact information and general apprehension on the part of families makes it difficult to reach or engage all the families that might benefit from services.** Staff in four of the systems struggle to receive accurate or complete family contact information, whether through automated data exchanges or from community providers. Many CI staff say families can be reluctant to answer phone calls from unknown numbers and may be unaware of or apprehensive about home visiting services.
- **CI systems demand ongoing investment.** Staff of all the CI systems suggested opportunities for strengthening their data systems or point to the need for additional funding to support long-term sustainability.

E. Directions for future research

This study describes how six CI systems make it easier for families to enroll in home visiting, but these six systems do not represent all CI systems and the findings are based mostly on qualitative interview data. More research involving other types of data—such as cost data or other quantitative data—would broaden understanding of the scope of CI systems nationwide and help guide state or local administrators in making decisions about CI system improvements and investments. We suggest the following five topics for further research: (1) the reach of CI systems, including trends in referral volumes and the types of families that are referred to the CI systems and ultimately to home visiting programs; (2) CI system effectiveness in improving home visiting enrollment; (3) the costs of different CI system features or approaches; (4) the types of data system platforms and technologies that are useful for different contexts; and (5) the landscape of CI systems operating across the country.

I. Introduction

Evidence suggests that home visiting programs help support maternal and child health (Coughlin et al. 2025; Maternal Child Health Bureau 2025). In 2024, evidence-based home visiting programs reached about 284,000 families nationwide, and around 75,000 of these families were served by programs funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (Health Resources and Services Administration 2025; National Home Visiting Resource Center 2025).[1] Yet, these programs do not reach many of the families that could benefit from home visiting services (National Home Visiting Resource Center 2025).

Centralized intake (CI) systems, also referred to as coordinated intake and referral systems, are one-stop entry points whereby families can learn about services that meet their needs and preferences and then undergo screening for and referral to services. In communities that have them, CI systems are one source of referrals to home visiting programs. By streamlining outreach, screening, and referral processes, state or local entities can use CI systems to improve efficiency and reduce duplication in the home visiting services and other supports that families receive (IGrow Illinois 2020; National Home Visiting Model Alliance n.d.). Families, in turn, could benefit from coordinated access to services.

A. Purpose

The Understanding and Expanding the Reach of Home Visiting (HV-REACH) project conducted case studies of six CI systems that match families with home visiting programs. The project's goals were to:

1. Understand the features, strengths, and challenges of the six CI systems
2. Explore how staff and families think the CI systems promote and expand family enrollment in home visiting programs
3. Understand families' experiences with the CI systems

Box I.1. Additional centralized intake study resources from the HV-REACH project

Additional resources from the project are on the Office of Planning, Research, and Evaluation website. **For more information on any of the CI systems,** search the website for the individual summaries:

- "Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting"

For more ideas on designing or implementing a CI system, search the website for the companion briefs:

- "A Guide to Building or Expanding Centralized Intake Systems to Support Home Visiting Enrollment"
- "Building and Sustaining Partnerships to Support Centralized Intake Systems for Home Visiting"

This report summarizes what we learned about the six systems. Staff from existing CI systems and leaders who are considering CI system implementation can use this report to deepen their understanding of the role and benefit of CI systems, what is involved in implementing the systems, and opportunities for enhancing them. This report can also help state MIECHV Program and local home visiting program administrators learn how CI systems can

[1] The MIECHV Program is a federal initiative dedicated to funding voluntary, evidence-based home visiting services nationwide for expectant parents and families with young children. The Program aims to improve the health of mothers and children, strengthen families, support positive early childhood development, and connect families to other resources in their community (Health Resources and Services Administration 2025).

reach more families that are eligible for and interested in their services. As many states expand their service capacity with increased funding from the MIECHV Program's 2022 reauthorization it will be particularly important to find innovative ways to reach and enroll families (Social Security Act 2023; Health Resources and Services Administration 2025). In addition, researchers can use the information in this report to plan future studies of CI systems. These efforts ultimately could contribute to more efficient CI systems and improve staff and families' use of the systems. In Box I.1, we provide a list of additional resources from the CI study. All study resources represent the CI systems' practices based on data collected in 2025 and, given the CI systems are continually evolving, may not reflect current practices.

B. Background

Uses and definitions of CI systems

CI systems are used in a range of sectors and contexts, yet there is no single, standardized definition of CI. Large health care providers offering several services and clinics, for example, have used CI to triage clients at the point of entry into the health care system before referring them to needed services (Isaacs et al. 2023). Some states have moved toward centralizing public benefits that have historically involved separate application processes and departments—such as Medicaid and food assistance. They do so by relying on common applications, data linkages, or unified enrollment processes. For instance, in 2022, South Carolina launched a web-based portal for families with young children to learn about more than 60 publicly funded programs, figure out whether they are eligible for them, and apply for one or more of the programs by using a common application (First Five SC 2026). The terminology for these types of systems varies, with some CI systems adopting narrower terms tied to their specific functions (for example, coordinated applications or coordinated referrals).

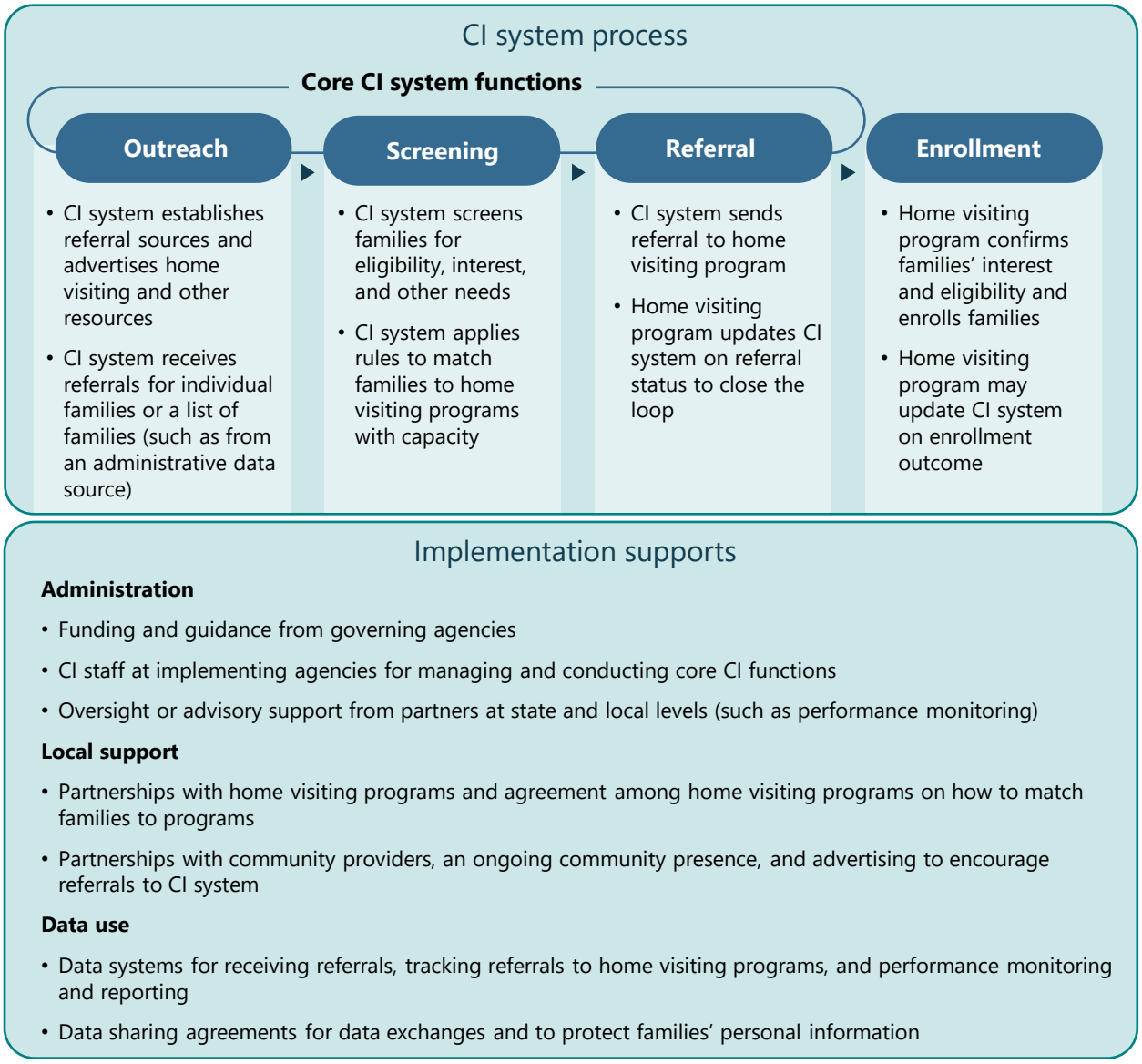
Increasingly, federal and state leaders in the early childhood care and education system are using CI to connect fragmented delivery of early childhood services, including home visiting. At the federal level, one of the goals of the MIECHV Program is to improve coordination and referrals for community resources and supports (HRSA 2025). To accomplish this goal, MIECHV-funding recipients can use a portion of the funds for costs associated with establishing and maintaining CI systems. Beyond the MIECHV Program, HRSA has invested in states' efforts to build comprehensive statewide systems of care. Beginning in 2002, HRSA issued competitive Early Childhood Comprehensive Systems Program grants to build connected, family-centered systems through several strategies, including CI systems (Association of Maternal and Child Health Programs 2021; Maternal and Child Health Bureau 2026).

Overview of CI systems that support home visiting

CI systems that support home visiting enrollment vary in structure, but typically perform several core functions: outreach to identify potentially eligible families, screening to determine which home visiting program (and sometimes other services) would best meet families' needs, and referrals to home visiting programs that match those needs (National Home Visiting Model Alliance n.d.). In Exhibit I.1, we summarize these core functions and list the key implementation supports that enable them to operate, based on information collected from the six CI systems studied. For example, a governing entity typically establishes rules and monitors performance; an implementing agency—which may differ from the governing entity—staffs and manages the workflow; partners such as health care providers make referrals to the implementing agency; home visiting programs receive referrals; and data systems record and track

contacts and outcomes. Different CI systems rely on different implementation supports, resulting in a diverse set of approaches to CI.

Exhibit I.1. The centralized intake system process and implementation supports



Note: This figure represents a generalized approach and does not fully capture the approaches used in each of the six CI systems in this report.

CI = centralized intake.

To date, little publicly available research describes CI systems' role in supporting home visiting enrollment or compares different CI systems. This study seeks to fill this knowledge gap by examining how six CI systems are designed and implemented to conduct outreach, screening, and referrals to support enrollment in home visiting programs.

In Chapter II, we explain the study's methods, including the study design and site selection. In Chapter III, we present an overview of how the CI systems are structured. We describe the pathways into CI systems and home visiting programs in Chapter IV and, in Chapter V, the use of data systems to support CI system operations and reporting. Finally, in Chapter VI, we explore CI system successes, challenges and opportunities for improvement, and directions for future research.

II. Methods

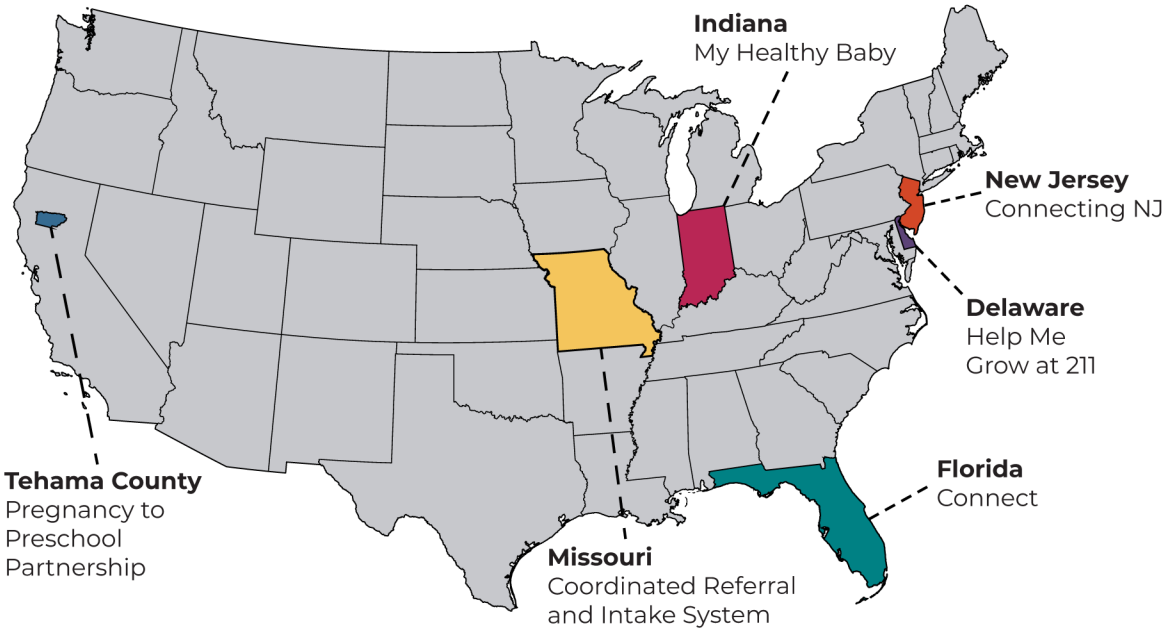
In this section, we provide an overview of the study methods, with more detail in Appendix A.

A. Site selection and recruitment

Site selection. To choose sites, we first searched the web for publicly available documents related to CI systems. We also received suggestions from the project team, including federal staff knowledgeable about CI systems, and from the HV-REACH CI committee.[2] Through this process, we identified 30 CI systems. Next, we applied eligibility and prioritization criteria to narrow to a pool of 17 potential sites. To be included in the study, a CI system had to centralize or coordinate outreach, screening, and referrals to make it easier to enroll families in a home visiting program. It also had to have been operational and actively referring families for at least six months. In Appendix Exhibit A.1, we present the full set of eligibility criteria.

Recruitment. We successfully recruited six of the CI systems to participate in the case studies that varied in geographic location, scope, and structure, as shown in Exhibit II.1. In Appendix Exhibit A.2, we outline the recruitment process.

Exhibit II.1. Map of the six centralized intake systems that participated in the case studies



[2] The CI study team asked nine experts who were familiar with CI systems to comment on the study approach throughout the project. The group included CI administrators, researchers, and technical assistance providers who support or study CI systems. In addition to supporting site selection, the committee provided input on the draft interview protocols, study recruitment process, and preliminary findings.

B. Data collection and analysis

Data collection

Site visits. Two project team members conducted one virtual site visit for each of the six sites between March and October 2025. Site visits featured interviews with:

- Staff from organizations that operate the CI system
- Staff and families from at least two home visiting programs that receive referrals from the CI system

Three states (Florida, Missouri, and New Jersey) operate statewide CI systems that are implemented regionally throughout the state. In those states, we spoke with (1) the CI system's governing agency or funder, (2) staff from an implementing agency in each of two regions, and (3) staff from one to three associated home visiting programs in each region.

Identifying home visiting programs and families. To identify home visiting programs, we asked the CI system administrator at each implementing agency to recommend programs to which they had referred families in the past few months.[3] After we contacted home visiting program directors and they expressed interest in participating in the study, they assisted with recruiting staff and a small number of families in their program. In Appendix Exhibit A.3, we list the models that these home visiting programs use.

Types of data collected. The interviews with CI and home visiting staff and families covered the features of the CI systems; documentation, guidance, and staffing; the outreach, screening, and referral process; family experiences; and successes and challenges of the CI systems. To inform and supplement what we learned from the interviews, we reviewed available documents about the CI systems, including practice and policy guidance, reports, and other documents. In Appendix Exhibit A.4, we provide more detail on these topics.

Interview participants

We interviewed a total of 112 people, ranging from 13 to 24 per site. In Exhibit II.2, we show the number of individuals interviewed at each site, organized by role. When conducting a family interview, we interviewed one parent in each family. Although not intentional, all interviewed family members were mothers.

[3] Given CI systems recommended home visiting programs, it is possible that the home visiting programs we interviewed have a more favorable relationship with the CI system than others they did not recommend.

Exhibit II.2. Number of individuals interviewed, by role and centralized intake system

Role	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P	**Total**
Centralized intake staff	3	9	5	5	11	1	34
Home visiting program							
Director, manager, or supervisor[a]	4	3	7	5	6	4	29
Home visitor or related staff	0	2	5	1	1	4	13
Families	7	7	7	6	5	4	36
Total for each system	**14**	**21**	**24**	**17**	**23**	**13**	**112**

[a] Some supervisors also conducted home visits but are counted only once (as supervisors). Their interviews included questions from the supervisor and home visitor perspectives.

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

Analysis

Individual site analysis. We cleaned interview notes for accuracy and completion and used a codebook to code the notes in qualitative coding software (NVivo). The codebook mapped to topics in a standardized template that we used to develop six individual case study summaries. After coding, we analyzed the coded interview notes to identify key themes by topic and to write the individual case summaries.

Cross-site analysis. To synthesize cross-site findings, we entered information from the individual summaries into a spreadsheet organized by site and topic. We examined each topic to identify commonalities and variations across sites. When needed, we returned to the coded interview notes for additional examples or illustrative quotes.

Approach to reporting themes. In our analysis, we summarized the number of systems reporting a particular approach, issue, or experience—for example, the number of systems in which home visiting programs can access the CI data system. Given that the interviews were semi-structured, we did not ask all interview participants the same questions, and participants did not always report the same information. As a result, it is important to note that the counts in this report reflect the number of CI systems in which interview participants described a given approach, issue, or experience. The counts may not capture all systems with those experiences, as staff in other systems may have had similar experiences that they did not mention. Appendix A has more detail about the analysis approach.

III. CI System Structure and Operations

We begin with an overview of the six CI systems and then describe their goals, funding, oversight, and staffing approaches.

A. Overview of the six CI systems

In Exhibit III.1 we list each CI systems' scope, start year, ages of children of interest, referral sources, process for matching families to home visiting, data sharing, and annual number of referrals (if we were able to obtain that information). Five of the CI systems operate statewide, and three of these are implemented regionally, meaning that several organizations are responsible for implementing the systems throughout the state, with oversight provided by a state agency or other governing body. Tehama County's Pregnancy to Preschool Partnership is the only CI system implemented in just one county, and, unlike the other systems, it is a collaborative referral system rather than a single entity (Box III.1).

Box III.1. Tehama County's Pregnancy to Preschool Partnership is a collaborative referral network

Pregnancy to Preschool (P2P) Partnership differs from the other CI systems described in this report because it is a collaborative referral network comprising the county's early childhood service providers—referred to as P2P partners. P2P partners co-developed and use a single process to screen, match, and refer families to available services in the P2P network based on families' needs. In this system, many providers are responsible for screening, but they centralize referrals by using a shared process and data system. For more information about how the P2P collaborative operates, see the detailed summary in "Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting," available on the Office of Planning, Research, and Evaluation website using the website's search function.

Exhibit III.1. Overview of the six centralized intake systems in this study

Delaware Help Me Grow at 211
Scope: Statewide
Start year: 2011
Focal ages: Prenatal to age 8
Referral sources: Delaware at 211 Helpline; community health providers; child welfare agencies; and other community partners
Matching to home visiting: Staff screen families by phone and assess their interest in home visiting. They use a decision tree to refer families to a home visiting program and follow up with families and home visiting programs via phone or email to confirm that families are linked to a program.
Data sharing: Home visiting programs do not access the CI system's data system. Help Me Grow at 211 uses the state 211 Helpline data system.
Annual number of referrals: 1,034

Florida Connect

Scope: Statewide with regional implementation

Start year: 2018

Focal ages: Prenatal to age 3

Referral sources: Florida's universal system for prenatal and infant risk screening

Matching to home visiting: Staff screen families by phone and assess their interest in home visiting. The data system's algorithm identifies program options for families; staff may also use a decision tree during conversations with families to match them to a home visiting program.

Data sharing: A closed-loop data system sends and tracks referrals to home visiting programs.[4]

Annual number of referrals: 161,339

Indiana My Healthy Baby

Scope: Statewide

Start year: 2018

Focal ages: Prenatal to age 3

Referral sources: Medicaid data on women who have identified themselves as newly pregnant in Medicaid applications; child welfare agencies

Matching to home visiting: Staff screen women by phone and assess their interest in home visiting. The data system's algorithm automatically matches families to a program.

Data sharing: A closed-loop data system sends and tracks referrals to home visiting programs.

Annual number of referrals: 16,724

Missouri Coordinated Referral and Intake System (CRIS)

Scope: Statewide with regional implementation

Start year: 2012

Focal ages: Prenatal to age 5

Referral sources: Medicaid data on pregnant women; health care providers; child welfare agencies; and other community partners

Matching to home visiting: Staff do not typically speak with families. After a family or referral source completes the referral form, the data system's algorithm automatically matches families to a program.

Data sharing: A closed-loop data system sends and tracks referrals to home visiting programs.

Annual number of referrals: 2,580

New Jersey Connecting NJ

Scope: Statewide with regional implementation

Start year: 2010

Focal ages: Prenatal to age 5

Referral sources: Universal screenings completed by perinatal health care providers or community health workers; child welfare agencies; community partners

Matching to home visiting: Staff screen families by phone and assess interest. They use a decision tree to refer them to a home visiting program and follow up with home visiting programs to confirm that programs have connected with families.

Data sharing: A closed-loop data system sends and tracks referrals to home visiting programs, though CI staff may email the home visiting programs and close the loop on referrals through other communication.

Annual number of referrals: Information not provided

[4] Closing-the-loop refers to two-way information sharing and communication between the CI system and the home visiting programs to track the final status or outcome of a referral (Missouri Perinatal Quality Collaborative 2025).

Tehama County Pregnancy to Preschool (P2P) Partnership

Scope: Countywide
Start year: 2017
Focal ages: Prenatal to age 5
Referral sources: Community partners within the P2P collaborative referral network (see Box III.1); self-referrals
Matching to home visiting: Staff from each P2P partner screens families and assesses interest by phone or in person. They use a decision tree to refer families to a home visiting program and then follow up with home visiting programs to confirm that they connected with families.
Data sharing: A closed-loop data system sends and tracks referrals between P2P partners.
Annual number of referrals: 223

Note: Annual referral numbers represent different time frames across CI systems. Missouri: January 1, 2025, to December 31, 2025; Florida and Tehama County: July 1, 2024, to June 30, 2025; Delaware: January 1, 2024, to December 31, 2024; Indiana: July 1, 2023, to June 30, 2024.

B. Goals for starting the CI system

The states and county designed their CI systems to connect families to available home visiting programs more efficiently and evenly, often with the express goal of improving family health and safety.

"The beauty of Connect is that the community agencies. . . no longer have to know what program [to refer a family to]. . .because they don't need to think about the eligibility of each specific family and every single program anymore."

— CI staff, Florida

All six CI systems are designed to make it easier and more efficient for providers and families to identify home visiting programs in their areas. The aim across all systems was to reduce the burden on families interested in learning about and enrolling in home visiting. For instance, staff from Indiana noted that they wanted families to know about home visiting earlier in their children's lives and believed that a CI system could help build awareness of home visiting's benefits. To help families learn about home visiting and direct interested families to home visiting, all CI systems intentionally collaborate with maternal and early childhood systems, such as Medicaid, health care, child welfare, early education, and others. These collaborations make it easier for providers to know where to refer eligible families and to help families more easily identify programs for which they may qualify.

Staff from all the CI systems aim to allocate referrals evenly across home visiting programs. Staff from all CI systems noted that some programs in their areas were at capacity while others did not receive enough referrals. By designing their systems to allocate referrals evenly, programs could collectively serve more families. For example, launch of the Tehama County system was in part a response to a new home visiting program that could serve families immediately, including those waiting for other services to become available. The addition of a new home visiting program provided an opportunity to develop a system that would direct families to that program. Staff from the CI system in Florida emphasized that enrolling families in more than one home visiting service was financially inefficient and hoped that their CI system could reduce duplication. The other systems either did not mention preventing dual enrollment as

a main goal or noted that dual enrollment was not necessarily inefficient if families received the services they needed.[5]

The CI systems often support state or county goals for maternal and child health and safety. Staff in New Jersey and Indiana noted that improving outcomes—such as reducing infant mortality—was a key motivation for strengthening referrals to home visiting and other services. In Missouri, staff reported that improving access to home visiting was linked to the state's goal of reducing child maltreatment. In Delaware, the CI system contributed to the state's effort to build an Early Childhood Comprehensive System.[6] In addition, three CI systems (Delaware, New Jersey, and Tehama County) partnered with the Help Me Grow National Center to support systems coordination beyond home visiting in their state or county.[7]

> *"The main goal [of My Healthy Baby] was to identify women as early as possible in their pregnancy to get them referred over to home visiting. The ultimate goal is the goal of the Indiana Maternal and Child Health [office], and that is to lower our infant mortality rate."*
>
> — CI staff, Indiana

Most of the CI systems also provide information about other services that may benefit families. From their first interactions with families, five CI systems provide information about community resources beyond home visiting (Exhibit III.2). Staff in these CI systems are knowledgeable about a range of resources, including for child care, early childhood education, physical and behavioral health, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and housing. In three CI systems, if needed, staff conduct developmental screenings with parents (Delaware) or refer parents to other staff within the system to conduct such screenings (New Jersey and Tehama County). All six CI systems also provide families with information to help them acquire in-demand supplies for their children such as diapers, car seats, or portable cribs. In New Jersey, the system started with referrals to home visiting and expanded to offer alternatives, such as short- or long-term case management. Case

> *"How wide-reaching our referral system is really is amazing. Because we are talking to so many families, even if they don't want to participate in a home visiting program, we're able to offer them helpful education that they might not have known or heard before—like [about] safe sleep or how to get family planning help, or about WIC. So even if they don't want home visiting, we've provided a good service."*
>
> — CI staff, Florida

[5] CI systems enroll families in home visiting programs that are funded by the MIECHV Program, as well as other programs in their area. The MIECHV Program directs awardees to develop policies and practices to avoid dual enrollment in more than one MIECHV-funded home visiting model (Health Resources and Services Administration 2024).

[6] The Early Childhood Comprehensive Systems Program is a grant funded by HRSA that aims to support states in aligning child-serving systems and connecting families to a range of services that support children's healthy development (Maternal and Child Health Bureau 2026).

[7] Help Me Grow is a national system designed to comprehensively support families with children age 0 to 5 and several states use its model, which includes a centralized access point, family and community outreach, child health care provider outreach, and data collection and analysis (Help Me Grow National Center 2026).

management is also available in Tehama County through a partner in the referral network. Partnerships are essential for ensuring that CI system staff stay informed about available community resources or opportunities for integrating additional services into their systems.

Exhibit III.2. Information or services that centralized intake systems offer beyond home visiting

Information or services offered	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Information on concrete resources (for example, diapers, wipes, formula, car seats, portable crib)	✓	✓	✓	✓	✓	✓
Information on income support, food assistance, and emergency services	✓	✓	✓		✓	✓
Information on Medicaid, medical care, or mental and behavioral health care	✓	✓	✓		✓	
Information on early childhood education or child care		✓	✓		✓	✓
Developmental screening[a]	✓				✓	✓
Case management[a]			✓		✓	✓

[a] Either provided by CI staff or provided through a referral to another provider connected to the CI system.

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

C. Funding

In this section, we summarize the funding sources and levels for the five CI systems that provided this information (Exhibit III.3). Since we collected the funding information through qualitative interviews, this report does not have a uniform level of detail or a comprehensive accounting of any system's costs for start-up, current operations, long-term sustainability, or other financial considerations. Such analyses would require a systematic cost study.

As of 2025, all the CI systems reported reliance on state funding sources, and some also reported that they drew on federal funding that flows through state governing agencies. Four CI systems mentioned that they receive funding from more than one source (Exhibit III.3). State departments of health reportedly contribute funding to three systems; two systems rely on Medicaid funds (which may include state and federal dollars); and two systems use MIECHV Program funds. In New Jersey and Florida, staff indicated that some regional implementing agencies may add their own funds or identify supplemental funding sources available locally.

The funding levels reflect the systems' different approaches to CI. Excluding those supplemental funds, staff from five CI systems reported funding in the range of $18,000 in Tehama County, CA, which has one part-time staff and sends about 230 referrals between partners annually, to about $10.5 million in Florida, which has over 240 staff and contacts more than 161,000 families annually. Although the study did not yield complete information about funding or about the number of referrals processed in each CI system, based on the available estimates, more funding and staff help to process more referrals. (Annual referral numbers are shown in Exhibit III.1 and staffing levels are shown in Exhibit III.5).

Exhibit III.3. Centralized intake system funding sources and amounts

Funding	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Estimated annual amount	$250,000	> $10.5M[a]	$3.3M	< $1M	Information not provided	$18,000
Medicaid		✓	✓			
MIECHV Program	✓				✓	
Other federal grants to states	✓ Early Childhood Comprehensive Systems Program				✓ Early Childhood Comprehensive Systems Program	
Other state sources	✓ Department of Health (Delaware Birth to Three Early Intervention Program)	✓ Department of Health	✓ Obstetric Navigator funds	✓ Line item in state statute	✓ Department of Health and Department of Children and Families	✓ First 5 Tehama

[a] This amount is only from Florida's Medicaid program. The Florida Department of Health also provides a fixed lump sum for Connect activities for families that do not receive Medicaid (not shown).

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

Notable funding arrangements include the following:

- **Collaboration with minimal funding.** Tehama County's system stands out for its low funding level. First 5 Tehama allocates a small portion of its annual funding under the California Children and Families Act for one staff member to convene the partners and support the shared data system and performance monitoring. The system operates without dedicated staff because partners in the collaborative referral network conduct screening and make referrals to one another.
- **Braided funding.**[8] New Jersey's Department of Children and Family Services and Department of Health braid funding sources to jointly support the CI system. The state also uses a portion of its federal Early Childhood Comprehensive Systems Program grant to improve CI system quality.
- **Payments for successful contacts.** Florida's Medicaid agency (Agency for Health Care Administration) adds a fixed, per-person payment when the CI system successfully contacts individuals receiving Medicaid.

D. Oversight and advisory

In this section, we describe CI system oversight and administration, including the roles of advisory groups. In Exhibit III.4, we show the governing and implementing agencies for the six CI systems.

[8] Braided funding is when multiple funding streams support the total costs of a common goal but each individual funding stream is tracked separately to maintain its specific identity (Gonzalez and Caronongan 2021).

State or quasi-governmental agencies govern the CI systems.[9] State agencies govern three of the CI systems (Delaware, Indiana, and New Jersey) and quasi-governmental organizations govern two systems (Missouri and Tehama County) (Exhibit III.4). To operate Florida's CI system, the Florida Department of Health maintains agreements with quasi-governmental organizations (Florida Association of Healthy Start Coalitions and the Healthy Start MomCare Network), but the health department is ultimately responsible for the CI system. In Missouri and Florida, quasi-governmental organizations oversee the regional agencies that implement their CI systems. Two state agencies in New Jersey co-govern the regional agencies with which they contract for system implementation.

Exhibit III.4. Governing and implementing agencies for the six centralized intake systems

Centralized intake system	Governing agency or agencies	Implementing agency or agencies
Statewide		
Delaware Help Me Grow at 211	**State agency:** Department of Health	Contracted social service provider
Indiana My Healthy Baby	**State agencies:** Department of Health, Family Social Services Administration, and Department of Child Services	Department of Health
Statewide with regional implementation		
Florida Connect	**State agency:** Department of Health **Quasi-governmental organizations:** Florida Association of Healthy Start Coalitions and Healthy Start MomCare Network	Thirty-two coalitions (social service providers and one local health department)
Missouri CRIS	**Quasi-governmental organization:** Children's Trust Fund	Five contracted providers (hospitals and community-based organizations)
New Jersey Connecting NJ	**State agencies:** Department of Health and Department of Children and Families	Seven contracted providers (social service or health organizations)
Countywide		
Tehama County P2P	**Quasi-governmental organization:** First 5 Tehama	First 5 Tehama and seven early childhood providers in the partnership network

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

Governing agencies typically support the implementing agencies in carrying out day-to-day CI system operations. For instance, the Delaware Division of Public Health governs the CI system, but contracts with the United Way to implement the system. The governing agencies manage contracts and hold meetings with implementing agencies, provide guidance and ad hoc support to the teams responsible for day-to-day operations, and review performance measures. In regionally implemented systems, governing agencies perform these duties for several implementing agencies. Indiana is the only state in which the implementing agency is also a governing agency.

In all three regional systems, the governing agencies establish statewide guidelines that promote consistency across regions while encouraging implementing agencies to tailor CI operations to

[9] A quasi-governmental entity is established by government to manage services while operating with a degree of independence similar to that of a nonprofit or private organization.

local needs and develop local partnerships. For instance, the Florida governing agencies develop detailed policies and procedures while granting 32 implementing agencies discretion over their staffing and decisions about implementing the CI system in-house or by contracting with another organization. New Jersey's Department of Health and Department of Children and Families develop statewide guidelines with which the regional implementing agencies must comply; those implementing agencies then develop their own policies and procedures. Implementing agencies in the three regional CI systems also establish partnerships with home visiting programs, participate in local maternal and child health events to learn about potential new partners, conduct outreach to possible partners, and contract with those partners when they agree to participate in the CI systems.

All the CI systems employ a core team to set strategic direction, host partner meetings, and ensure consistency across the system. Core teams usually include staff from governing agencies, managers who supervise system operations, data consultants or evaluators, and directors of home visiting and other early childhood programs.

The CI systems gather feedback from advisory groups and others to help guide home visiting in the county, region, or state. In all six CI systems, an advisory group generally reviews data and provides feedback on the system and opportunities for improvement. Advisory groups often include representatives from home visiting programs and community-based organizations that serve young children and families; they also tend to focus on the broader home visiting landscape. Staff from all six CI systems noted that advisory group meetings help strengthen connections between home visiting programs and other local organizations that support maternal and child health. Home visiting programs' involvement in system planning reflects the programs' central role in CI system operations. In Box III.2, we provide more information about the partnerships between CI systems and home visiting programs. CI system staff in New Jersey and one region in Missouri also mentioned that they invited families to participate in advisory groups.

> *"[You] have to have checks and balances from home visiting and potential partners that would be using [the CI system], so you can really make sure everyone has input so they collaboratively use it together."*
>
> — CI staff, Missouri

Box III.2. Partnerships with home visiting programs are essential for centralized intake systems that refer families to home visiting

All six CI systems build and maintain relationships with home visiting programs that participate in the CI system. These relationships require ongoing effort and a willingness to address challenges as they arise, but they form a necessary foundation for CI system operations. CI systems adopted the following strategies at the outset of system creation and continue to rely on these strategies to strengthen partnerships:

- **From the start, establishing strong partnerships with home visiting programs was critical.** Staff from all six systems, whether employed by the governing agency or the implementing agency, worked with local home visiting programs to develop rules for matching families, along with clear expectations for referring families to programs. For example, the Tehama County system's home visiting partners noted that identifying shared goals helped align their efforts and reduce competition for referrals. Home visiting program staff in four other CI systems also mentioned that, over time, they trusted that the CI system was working to allocate referrals fairly across programs.

- **To help maintain their working relationships, staff in all systems communicate frequently about individual referrals, seek input on CI system operations, and share information about capacity and referral outcomes.** For example, CI staff in one regional implementing agency in New Jersey meet regularly with home visiting partners from each county to discuss program capacity, referral and enrollment data, and any challenges in the referral process. In Missouri, CI staff updated the online referral form based on feedback from home visiting programs to ensure that the form collects the information needed to match a family to appropriate programs. Home visiting programs also support CI systems by providing clear language and messaging about home visiting.

For more information on how the CI systems partner with home visiting programs and others, see the brief, "Building and Sustaining Partnerships to Support Centralized Intake Systems for Home Visiting," available on the Office of Planning, Research, and Evaluation website using the website's search function.

"We've done a lot of work to foster this collaboration [with home visiting programs and community organizations]—a retreat, a workforce symposium, incorporating everyone in wraparound training, lots of professional development. The more connections we can make within this system, the better." — CI staff, Delaware

E. Staffing approaches

In CI systems designed to streamline referrals and reduce access barriers, staff play a pivotal role in ensuring that processes operate efficiently and respond to families' needs. In this section, we examine common staff responsibilities and the staffing arrangements.

All six CI systems have staff (or partners, in Tehama County) who perform key implementation roles, but they structure staffing in different ways (Exhibit III.5). Two CI systems (Florida and Indiana) created specialized staff roles, charging certain individuals or teams with responsibility for processing a large volume of referrals sent via electronic lists. In Delaware, where staff process fewer referrals, staff perform several roles (we consider them generalists). In New Jersey, staff in both regions reported that dedicated staff conduct screening and refer families, but outreach responsibilities vary by region. In Florida, implementing agencies have the option to contract with CI staff to perform in-person intake and screening in community locations such as hospitals or clinics. In Tehama County, the collaborative referral network operates without dedicated full-time employees. Instead, network partners (including home visiting programs) conduct outreach, receive referrals, and screen and refer families to other network partners as part of usual program practice; a First 5 Tehama staff member assists by convening partners and contracting with an evaluation coordinator to manage and report on the shared data system. Missouri's CI system is the only statewide system designed for electronic-only interactions with families and automated processes for receiving, screening, and referring families, which minimizes the number of CI staff involved.

Exhibit III.5. Centralized intake system staffing levels and role divisions at implementing agencies

Centralized intake system	Approximate number of staff	Staff role division			
		Manage the overall system	Conduct outreach	Receive referrals	Screen and refer
Delaware Help Me Grow at 211	4	Combined	Combined	Combined	Combined
Florida Connect	240+	Distinct	Distinct	Distinct	Distinct
Indiana My Healthy Baby	25	Distinct	Distinct	Distinct	Distinct
Missouri CRIS	15	Combined	Combined	Automated, typically no staff	Automated, typically no staff
New Jersey Connecting NJ	28	Distinct	Varies by region	Combined	Combined
Tehama County P2P	Part-time paid support from one person at the governing agency	Distinct	Varies by partner	Varies by partner	Varies by partner

Note: "Distinct" indicates that staff perform only one of three functions shown—outreach, receiving referrals, or screening and referring—but may perform other duties in addition to these core functions.

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

CI systems are staffed for building awareness and generating referrals into the CI system. Some CI systems rely on staff to perform outreach as part of their responsibility to promote other initiatives. For example, in Florida and Indiana, staff conduct outreach for the CI systems along with promoting other systems for which they are responsible (MOMS Helpline in Indiana; Healthy Start in Florida). In New Jersey and Tehama County, outreach might be the responsibility of the system manager (or, in Tehama County, managers of the programs in the partnership) or someone in another position. In New Jersey, staff at the two regional implementing agencies interviewed reported taking different approaches to outreach. At one regional agency, the organization's leadership team conducts outreach, whereas the other regional agency partners with another program for community outreach. One Tehama County home visiting program reported that a supervisor conducts outreach and receives referrals from the Pregnancy to Preschool network; another program supervisor also receives referrals from the Pregnancy to Preschool network but assigns outreach to dedicated outreach staff.

Additional responsibilities of CI staff include data and reporting. CI system staff track referrals, ensure that data are current, and generate reports to flag areas for system improvement and for governing agencies. CI system program managers typically share data with CI system partners for accountability purposes and to co-develop solutions to implementation problems, but some of the CI systems outsource data reviews and reporting to technical experts.

IV. Pathways into CI Systems and Home Visiting

In this section, we describe the main activities of CI systems: outreach to families, screening families, and matching families with and referring them to home visiting. We also report on families' experiences learning about home visiting.

A. Outreach

Families learn about and connect to the CI systems in different ways, though the systems rely on one or two pathways for most referrals. In this section, we first summarize the different ways that families find out about the CI systems; in Exhibit IV.1, we show the *main* ways families connect to each CI system.

Every CI system emphasized the importance of building partnerships to create a variety of referral pathways to the CI system. The following approaches were commonly described across the CI systems:

- **Partnering with community providers.** To raise awareness of the CI system, staff from all six systems noted they share resources, such as flyers and posters, and encourage other agencies or organizations in their areas to use the CI system. The CI systems commonly partner with health clinics, hospitals, and schools, all of which then refer families to the CI system (typically through an online form). Some systems engage WIC, local resource lines such as 211, and food pantries as other referral sources.

> *"[Some] think that outreach is [like] advertisement, but in my case, it wasn't. . . . There are relationships that have been built, [and] I continue making those relationships and maintaining those relationships with those organizations that can help our families."*
>
> —CI staff, New Jersey

- **Direct outreach to families.** All six CI systems market directly to families by, for example, distributing informational packets at community events and conducting statewide marketing campaigns that take advantage of social media. Such outreach can inspire families to apply to the system themselves. All CI systems provide phone numbers or offer online referral forms that families can complete on their own.

> *"I think our marketing made a huge difference and we were getting a lot of uptick in incoming calls and landing page clients because of the marketing. . . . I think it helped a lot."*
>
> — CI staff, Indiana

- **State or local child welfare agencies.** Child welfare agencies use home visiting programs, among other services, to support families involved or at risk of involvement with the child welfare system. Staff in four systems (Delaware, Indiana, Missouri, and New Jersey) noted that state or local child welfare offices commonly refer families to the systems.
- **Medicaid data-sharing partnerships.** A noteworthy strategy for reaching more families involves CI systems obtaining lists of currently pregnant women enrolled in or eligible for Medicaid. Three systems rely on data-sharing partnerships for this information. Indiana's state Medicaid agency sends weekly lists of pregnant women to the CI system, which CI staff then upload into the system's database. Florida's Medicaid plans send lists of pregnant women to the CI system, and the state child welfare

agency (which is also responsible for approving Medicaid applications) sends a list of newly expectant families that may qualify for Medicaid because of pregnancy. At the time of the study, Missouri's CI system was starting to receive referrals from Medicaid managed care organizations for expectant families.

Although all six CI systems receive referrals from several sources to maximize their reach, most families connect to the CI system through one or two main sources. As shown in Exhibit IV.1, medical providers are a main pathway to four of the six CI systems. For example, in Delaware, most referrals come from community health providers located in doctors' offices and clinics. Universal prenatal and infant screening leads to a high volume of referrals in Florida and at least one of the regions in New Jersey (Box IV.1). In contrast, Medicaid agencies in Indiana and Missouri (through data sharing agreements) provide the CI systems with lists of families. Other referral pathways were prominent in a relatively rural New Jersey region and Tehama County. The New Jersey regional administrator attributed most referrals to efforts to build families' and community providers' awareness of all services their organization offers (rather than CI system–specific services); most referrals within the Tehama County partnership network are from other partners in the network—including early childhood education providers and Help Me Grow—rather than external partners or self-referrals. In Box IV.2, we discuss families' experiences in learning about home visiting.

Box IV.1. Transmitting universal screening forms in Florida and New Jersey

In **New Jersey**, perinatal care providers complete *perinatal risk screens* with pregnant women who are typically Medicaid clients. Community health workers and others complete *community health screens*. They send the forms electronically to the CI system with a parent's permission. In **Florida**, *infant screens* are electronically filed after birth when birth certificates are created. In addition, Florida doctors' offices complete *prenatal screens* and send them to local health departments (either through a physical form or via electronic file transfer).

Exhibit IV.1. Main ways families learn about or are referred to the centralized intake systems

Referral pathway	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Doctors' offices, health clinics, and hospitals (including universal screenings)	✓	✓		✓	✓	
Medicaid agencies (state agencies or managed care organizations)		✓	✓	✓		
State 211 line	✓					
Other					✓	✓

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

Box IV.2. Families' perspectives on learning about home visiting services

- Families in all systems named various sources when asked how they first heard about home visiting. Most of them first learned about home visiting from CI system outreach or upon referral to the CI system.
- Others first learned about home visiting from health care providers, schools, WIC, word of mouth, or the programs themselves at community events.
- A few families (from all six CI systems) said they thought that CI systems could do more to promote their services and home visiting in general. Some suggestions called for providing more information about home visiting during the first call to the CI system, advertising on social media, and increasing promotion in health care settings (for example, displaying more posters in doctors' offices).

"I think [enrolling through the CI system] honestly was pretty simple, because they were the ones that reached out to me. I didn't have to go out of my way to figure out who they were and what they wanted. . . I didn't have to put any work into it besides answering the phone."

—Parent, Missouri

B. Screening and matching families to home visiting programs

All six CI systems gather information about families and most confirm information received in the referral. The CI systems match families to home visiting programs based on their responses to screening questions, which ask about the child's due date or date of birth and family contact information. Screening may also include questions about demographics (family income, preferred language, other children, employment status, marital status) and maternal health. Missouri's CI system is designed to match families to a program based solely on screening questions in the referral form, without a phone call. In the other five systems, CI staff supplement information from the referral form or source by asking families about their needs during screening conversations. Four CI systems (Delaware, Florida, Indiana, and New Jersey) rely on a standard phone or in-person process for screening families. In Tehama County, each provider in the network uses its own approach to considering whether a family might benefit from a referral to a home visiting program or other network service.

Screening calls are brief, but it can be hard to reach families. For the systems that conduct phone screening, the average call takes about 5 to 10 minutes, though staff said that it may take longer depending on circumstances, such as when translation services are needed. However, most CI staff said it was difficult to get in touch with families—sometimes because family members did not answer calls or texts from unknown numbers, and sometimes because families did not seem interested in home visiting.

All six CI systems follow agreed-upon criteria to guide how families are matched to home visiting programs. Home visiting programs provide input into systems' matching rules to ensure that systems correctly match families to appropriate programs. In addition, Missouri discussed incorporating a round-robin approach into its matching process to assign families to programs that have not recently received a referral, thus helping allocate referrals more evenly. For CI systems that conduct screening calls with families (Missouri excluded), staff identify which programs the families match with during the call.

The CI systems use a manual matching process, an automated process, or a mix of both. CI staff in Delaware, New Jersey, and Tehama County manually match families to home visiting programs by using

decision trees—a structured map that incorporates branches for different factors related to program eligibility (such as age of child or whether a pregnancy is the parent's first). They also use information they collect about program capacity. In contrast, CI staff in Florida, Indiana, and Missouri use automated algorithms embedded in the CI data systems to perform matching. The algorithms incorporate information about program capacity, data from referral forms, and in Florida and Indiana, data from screening calls. Even with automated matching, staff can intervene when needed (for example, if a family prefers a particular program), and staff in Florida use a decision tree alongside the algorithm to consider local, non-evidence–based home visiting programs not reflected in the state's algorithm.

To support appropriate matching, home visiting programs in every CI system provide regular information on capacity. Obtaining information on capacity prevents CI systems from connecting families with programs that cannot quickly serve them. Staff of several CI systems noted that home visiting programs also frequently contact CI staff with real-time capacity updates, including their ability to support families in their home language. In Indiana, home visiting programs must provide monthly capacity reports to the CI system for uploading into the data system, but they may call CI staff if they reach capacity. In Florida, home visiting programs can report capacity directly within the shared data system. In Missouri, home visiting programs provide capacity information during regular meetings with CI staff and can update the CI system data system if they do not want to receive referrals (when programs reach capacity). Staff in Delaware and in one New Jersey region created a monthly form for home visiting programs to report their capacity to the CI system, while partners in the Tehama County system discuss capacity during meetings.

CI systems provide families with program descriptions and an opportunity to express a preference for a particular program. When telling families about the programs they matched with, all CI system representatives provide a brief description of home visiting, with the expectation that home visiting staff will provide more detailed information when they contact the family. Staff from every CI system said that family choice was a key consideration when more than one home visiting option was available. The systems accommodate family choice by allowing a family to add preferences for programs when completing the online referral form (Missouri and Tehama County) or discussing options when families are eligible for more than one program (Delaware, Florida, Indiana, New Jersey, and Tehama County). Staff in Tehama County and New Jersey noted that family preference can override a program identified through the decision tree.

C. Referral to home visiting programs

The CI systems use shared data systems and encrypted emails to share family referral information with home visiting programs. Five of the six CI systems give home visiting programs access to the CI system data system and can therefore send referrals to the home visiting programs via the data system (see Section V. Data Systems and Data Sharing for more information). All six CI systems also have the option to send referrals via encrypted email or other means when needed. Delaware CI staff send referrals through encrypted emails. In Florida, smaller programs that are not connected to the CI system's data system receive referral information exclusively by email.

CI system staff communicate regularly with home visiting programs about referral status. To "close the loop" on each referral, home visiting programs update all the CI systems on referral status, typically

through the CI system's data system or via email. CI systems may send reminders to programs to follow up on referral status. Program staff may also refer a family back to the CI system if a family is ineligible for a given program or determines that another program would be a better fit.

> *"When we get a referral, I usually feel like it's a good referral for us. . . . The conversation has already happened with mom, and she knows [we'll] be contacting [her]."*
>
> — Home visiting staff, Indiana

For some home visiting programs, CI system referrals account for most of their enrollees. In two CI systems (Delaware and Florida), home visiting staff reported that they receive most of their referrals from the CI system. At least some home visiting program staff in Indiana, Missouri, New Jersey, and Tehama County, however, said the CI system is not their main referral source. For instance, one home visiting staff in Indiana reported receiving fewer referrals from the CI system than from community partners or self-referrals. Home visiting programs in almost all CI systems appreciated that when they receive referrals from the CI system, they are typically appropriate for their program.

D. Enrollment in home visiting programs

After receiving a referral, home visiting programs in all CI systems confirm a family's interest and eligibility for home visiting. Home visiting programs are expected to contact families within as little as two business days to up to two weeks. Staff from many home visiting programs said that they call families as soon as possible, even if their guidelines allow for more time, though a few other staff (from Missouri and Tehama County) noted that it can sometimes be difficult to call families quickly because of other obligations. In Missouri, CI staff provide monetary incentives to home visiting programs that complete initial contacts within 48 hours of receiving a referral. The home visiting programs follow their own enrollment processes to check eligibility, typically by confirming information from the CI system and asking additional questions. From there, they move ahead with scheduling the first home visiting session. In Box IV.3, we describe families' experiences with being referred to and enrolling in home visiting.

Box IV.3. Families' experiences with referral to and enrollment in home visiting through centralized intake systems

- Families described a seamless transition from the CI system to the home visiting program. Most families said that they experienced quick handoffs from the CI systems to the programs and that enrolling through the CI system was fast and easy. One mother stated, "It really did not take much time at all to get into everything and start setting up the visits and moving forward."
- Across all CI systems, families described receiving accurate program descriptions from CI systems, followed by more detailed descriptions from home visiting programs. Most families described enrollment as straightforward, with home visitors meeting them in person to complete paperwork and additional screenings. Families in Florida and New Jersey said they received follow-up information from the CI system via email or text with a summary of their conversation and the referral.
- Because calls with CI systems can be quick, families often do not remember their conversation with system staff. In Missouri, families are often unaware of the CI system, which typically does not require contact with CI staff; when referral sources complete CI screening questions for families, the families hear back directly from the home visiting programs.

V. Data Systems and Data Sharing

Strong data infrastructure supports consistent screening, efficient referral management, meaningful follow-up, and performance monitoring. In addition, data sharing agreements help programs collaborate and maintain family privacy. In this section, we describe the data system functionalities that CI systems rely on, how partners share information, and common performance measures.

A. Data system functions

Data systems support key CI system functions, including the following (Exhibit V.1):

- **Tracking referral status.** Fundamentally, the data systems are necessary for tracking the status of a referral at each step of the screening and referral process. Where home visiting programs have access to the data system, they can record referral progress, such as whether and when the home visiting program contacted the family. While five data systems also have the capacity to record whether a family ultimately enrolls in home visiting, all reported that they do not always obtain this information from home visiting programs, in part to protect family privacy.

> *"The data system is the make or break for coordinating all these referrals that come in."*
>
> — CI staff, Florida

- **Automatically populating or transmitting referral information.** All CI systems allow partners or families to submit a web-based referral form. In three CI systems (Delaware, Missouri, and New Jersey), the referral forms automatically populate in the data system. In Florida and New Jersey, the data systems receive universal health screening forms directly from the state screening systems when families consent. In addition, Medicaid health plans in Florida can refer families to the CI system directly through a portal in the data system.
- **Maintaining information about community resources.** Three CI systems store information on community resources in their data systems for staff to use as needed during screening conversations with families. Indiana's data system, for example, includes more than 10,000 resources that staff can recommend.

Exhibit V.1. Key data system functions for centralized intake operations

Centralized intake system data system capacity	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Track status of referrals	✓	✓	✓	✓	✓	✓
Produce reports for performance monitoring	✓	✓	✓	✓	✓	✓
Send referrals and reminders to home visiting programs	No shared data system	✓	✓	✓	✓	✓
Web-based referral form automatically populates in the data system	✓			✓	✓	

Centralized intake system data system capacity	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Algorithm automatically matches or suggests home visiting program matches for families		✓	✓	✓		
Store information on other resources available in communities	✓		✓		✓	
Automatically populate health screens or assessments in the data system		✓			✓	

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

Four CI systems used existing infrastructure to build their data systems, and two others built custom data systems. Delaware, Florida, Indiana, and Missouri either used existing data systems with maternal and child health partners or expanded existing data systems to develop their CI data systems. For instance, Florida uses the Well Family System, which is the existing case management system for Florida's Healthy Start home visiting programs and regional implementing agencies. Delaware's iCarol data system is used for Delaware's 211 line. In contrast, Tehama County used Microsoft Dynamics 365 software to build a custom system for its CI operations, and New Jersey built a custom platform to link the Connecting NJ data system with the state system used for health screenings.

Staff and partners also share information outside data systems. Even though most CI systems use automated reminders and email to notify home visiting programs of referrals, staff often manage referrals by following up with home visiting programs by phone or email. Missouri's data system sends notifications to programs via a referral dashboard and emails reminders every seven days to update referral status in the system, but staff of both regional implementing agencies emphasized the importance of calling and emailing home visiting programs to stay current. In Florida and New Jersey, some partners either lack access to the data system or choose not to use it. Program partners communicate by phone and encrypted email to report referral and/or enrollment status to the CI systems; CI staff then manually enter the information into the data systems. This approach can reduce the data-entry burden among home visiting staff, who often also use their program's data system or tools to track referrals.

B. Performance monitoring and improvement

Staff at all CI systems use data for monitoring CI operations and reporting. Staff at all CI systems analyze data on CI operations and then submit the data to the relevant governing agencies. They also report regularly to home visiting programs and discuss the data during advisory group meetings or other partner meetings. For example, Tehama County staff review data monthly and contact any partners with open referrals to keep the data system up-to-date. In Box V.1, we list performance monitoring metrics that are common among the six CI systems. To make monitoring easier, New Jersey created a data dashboard that aggregates information on eight key performance measures, including the time it takes to initiate family contact and the time it takes to enroll in a home visiting program. CI system staff in Delaware, Florida, Indiana, and New Jersey discussed using their data to report to state governing agencies and state legislatures. For example, Indiana provides its state legislature with an annual report

that evaluates progress on five performance measures.

The CI systems also use their data to improve operations. Florida CI system staff analyze referrals by county annually to check that referrals are allocated fairly across home visiting models. Missouri uses a capacity map in its CI data system to identify gaps in home visiting capacity across communities and to consider new home visiting programs to potentially partner with. In New Jersey, the state governing agencies support a statewide continuous quality improvement effort in which implementing agencies choose a metric in their dashboard for improvement. For example, one implementing agency explored whether screening families in the office would improve the family recruitment process. Indiana staff use data to identify trends, such as the times of day or days of the week that families are most likely to answer the phone.

Box V.1. Common metrics for performance monitoring

- Total number of referrals to the CI system
- Home visiting programs' capacity
- Number of referrals sent to home visiting programs
- Number of families that enroll in home visiting
- Number of home visiting referrals declined and reasons (including families declining services and programs declining a referral)

C. Protecting family privacy

The CI systems use several procedures to protect family privacy. All CI systems restrict access to the data systems that store family information. Those that grant data system access to home visiting programs incorporate into partner contracts and agreements a set of privacy practices for exchanging and managing data. Florida, Indiana, Missouri, and New Jersey provide access through a portal that limits what home visiting programs can view, whereas all partners in the referral network in Tehama County can view the full data system. Four of the systems (Florida, Indiana, New Jersey, and Tehama County) have entered into data use or business associate agreements with partners to exchange family information and access CI data. Staff from three CI systems (Florida, Indiana, and New Jersey) mentioned incorporating information security and/or Health Insurance Portability and Accountability Act (HIPAA) compliance into trainings so that all CI system staff understand what information they can share and how to share it securely. Florida, Indiana, Missouri, and New Jersey take extra measures to ensure that partners have access only to information on the specific families referred to them.

Some CI systems confirm families' identities at the outset of a screening call. Florida and Indiana, which largely receive referrals through data exchanges, require staff members to start the screening call by confirming the identity of each referred person before revealing that they are calling from the CI system or sharing any information about home visiting. This approach protects the CI system from sharing a person's sensitive information (such as about a pregnancy) with anyone else in the family. Indiana staff also noted that, to ensure confidentiality, they do not share information with families through texts or web chats because staff cannot identify the person answering the text or chat.

Home visiting programs also comply with requirements and expectations for protecting family privacy. For example, one home visiting program in the Tehama County partnership network does not report individual families' enrollment decisions to the CI system. As a local health department, it avoids sharing family-specific information to comply with privacy requirements; instead, the partner shares total monthly enrollment numbers for performance monitoring purposes.

VI. Successes, Challenges and Opportunities for Improvement, and Directions for Future Research

A. Successes

In this section, we highlight the CI systems' successes, including the development of strong partnerships and clear pathways to home visiting programs, along with the use of data to enhance coordination and reporting.

CI systems are a significant part of the landscape of partners serving families with young children. All the CI systems in this study are an essential element in the home visiting landscape in their states or localities. CI staff engaged in and supported ongoing collaboration with home visiting and other family-serving organizations by meeting with advisory groups and other partners to review data, discuss challenges, and keep improving the system.

CI systems developed partnerships with home visiting programs and others that made outreach and referral to home visiting programs more seamless. Some CI system representatives said that home visiting staff were hesitant at first to enter into partnerships. CI staff intentionally cultivated relationships so that, over time, the process worked as intended. CI and program staff said that it was important to develop shared goals and recognize that building trust takes time, perseverance, recognition of mutual benefits, belief in the greater value of coordinated referrals, agreement on clear expectations (including through formalized agreements), and strong, ongoing communication. Regular meetings and one-on-one conversations kept partners aligned, especially during periods of staff transition or other challenges. Such qualities are also pivotal to building other needed partnerships, including those involving state offices and partners that make referrals to the CI system.

Across all CI systems, home visiting and CI staff believe the CI system helps reach more families for home visiting. The CI systems use a variety of strategies to connect families to home visiting. Staff from four CI systems (Delaware, Florida, Missouri, and New Jersey) explained that CI systems expanded awareness of home visiting by providing a single, recognizable place where families and community partners can learn about services and be connected to those services through a simple process. Similarly, program staff in Tehama County reported that several partner organizations linking families to home visiting expanded families' awareness of services more than any one program could. Staff from almost all the systems noted that referrers did not need to understand home visiting eligibility, capacity, or model distinctions to refer families to home visiting. Instead, they could rely on the CI system to direct families to appropriate programs, reducing the burden on home visiting staff who are often stretched thin.

Shared data systems enhance coordination, monitoring, and communication between CI systems and home visiting programs. These data systems provide CI and home visiting staff with a real-time picture of referral activity, improving the quality and timeliness of referrals. Five CI systems allow home visiting program staff to view assigned referrals, track outreach attempts, and monitor referral status. In Delaware, Florida, Missouri, New Jersey, and Tehama County, CI staff said that they can see some families' program enrollment outcomes. Some CI systems (Florida and Missouri) can also track program capacity within their data systems, helping to quickly match families to programs with openings. New Jersey and

Florida data systems also connect with their state data system for health screenings, which supports a large transfer of referrals into the CI systems.

CI system partners regularly assess their processes and make needed adjustments. The systems were designed to evolve in response to experience, data, and family needs. All six CI systems described a commitment to making iterative improvements in their outreach, referral, and data processes, demonstrating a culture of continuous learning. New Jersey, for instance, planned from the outset to expand its CI system services and has made updates as funding opportunities permit. To strengthen operations, one New Jersey governing agency hosts quarterly continuous quality improvement meetings for regional implementing agencies and home visiting programs. Indiana tests and refines communication strategies by, for example, improving phone scripts to increase engagement. CI staff in Delaware work with an external evaluator to identify gaps and develop strategies to address them. Across all systems, staff emphasized the importance of remaining receptive to testing ideas, making adjustments, and revisiting processes over time.

> *"[Continuous quality improvement] has a spirit of continued growth and learning. It's not about finger pointing. It's coming from a place of 'Let's improve together and let's pull each other up.' That spirit trickles down to the different agencies."*
>
> — CI staff, New Jersey

Across all CI systems, families described the screening and referral process as supportive and easy to navigate. Families described their movement through the CI system to home visiting enrollment as "easy" or "straightforward." Contact with CI system staff and clear information about what to expect helped reduce apprehension, build trust, and smooth the handoff to home visiting services. Many families were grateful for receiving information about additional supports, such as WIC and community resources. Some home visiting program staff in five CI systems reported that families referred through the CI system were prepared for and comfortable with home visiting because CI staff had clearly explained the services in advance. At the same time, in all systems, CI staff noted that families often do not distinguish between CI communication and home visiting program communication, an indication that families perceive the transition as seamless.

B. Challenges and opportunities for improvement

Although the six CI systems have been operating for years, they are still evolving as their priorities and circumstances shift and system leaders seek improvements. In this section, we describe common challenges—and opportunities for improvement—across the six CI systems. Suggestions from CI staff on starting a CI system are shared in Box VI.1.

CI systems must sustain buy-in from home visiting programs and other important referral partners. Although the ability to build partnerships with home visiting programs is a strength of all six CI systems, staff across the systems acknowledged that maintaining positive working relationships requires an ongoing commitment. In Missouri, for instance, regional administrators in rural areas

> *"Make sure they are in a systems-building mindset at all times and understand that that it's not gonna happen overnight."*
>
> — CI staff, Indiana

or areas that recently adopted the CI system struggled to persuade programs to join the CI network. Some home visiting programs in those areas were reluctant to commit to an additional data system, training sessions, and work groups, despite the offer of a stipend and other benefits of participating in the system. In addition, as Tehama County staff noted, even when partners agree to collaborate, leadership turnover may raise new obstacles. To help maintain a shared vision following turnover in 2025, the governing partner in the Tehama network surveyed and spoke individually with other partners about the usefulness of the referral network and ideas to shape its direction.

Family contact information is often incomplete or missing. CI staff in four of the systems (Delaware, Florida, Indiana, and New Jersey) raised concerns about the quality of families' contact information. They use different strategies to try and resolve the problems. For instance, Florida established a data sharing agreement allowing the state to access parts of the WIC and Medicaid data systems, both of which contain more accurate contact information for families enrolled in those two programs compared with the family contact information they may otherwise receive. Alternatively, one CI staff in New Jersey thought that more training and assistance for large hospital systems that refer families through health screening forms could improve the contact information included in the screening forms.

> *"The piece that's still the issue is referrals coming from hospitals and what those referrals look like—the initial outreach to the [family] and how that [family] either moves through or doesn't move through the system. . . . What has been a through-line is that the quality of the referrals coming into the [CI] system are not as good.*
>
> — CI staff, New Jersey

Many families are apprehensive and lack awareness of home visiting and CI systems. CI staff in all systems but Missouri (which does not contact families) said that families are reluctant to answer phone calls. To improve responses, staff in Delaware, Florida, and New Jersey mentioned texting families as part of their CI system outreach, though it does not always help. In addition, in Florida and Indiana, CI staff must ask the referred parent to verify their identity when explaining their reason for calling, and a parent is sometimes unwilling to do so. Furthermore, when describing home visiting, families often express apprehension about services offered in their homes. Staff said that some families may perceive home visiting as surveillance, potentially putting them at risk of involvement with the child welfare system. To address this concern, staff in all CI systems receive training to provide families with friendly and supportive descriptions of home visiting services. Similarly, informing home visiting staff and the public about the CI system takes ongoing investment. Staff in five systems described plans for raising the system's visibility with potential families and partners.

> *"Creating and training on that language for how we need to describe home visiting—that we don't say it in a way that turns people off to a home visitor."*
>
> —Home visiting staff, Tehama County

Although the data systems perform critical functions, they do not address every need. Some New Jersey and Missouri CI staff members mentioned they find it burdensome to use both the CI data system and their own organization's data system to track referrals and enrollments. Staff in Florida and New Jersey noted that manual data entry is unavoidable when exchanging information with home visiting programs that do not use the CI data system (whether by choice or because of restricted access).

In addition, the performance reports generated by data systems reflect only the referrals made within the system, potentially leading to an incomplete picture of the total uptake and capacity of home visiting. New Jersey addresses this challenge by asking home visiting partners to inform CI staff when families are referred directly to the programs so they can be logged and counted in the CI data system, or program staff can log the referrals into the data system themselves.

> *"You can tell me until you're red in the face that you've enrolled a hundred families, but if you don't update that in our database, we can't see it and report on it."*
>
> — CI staff, New Jersey

Funding may limit efforts to expand or sustain CI system workloads. CI staff in Delaware, Florida, and New Jersey said that funding has not kept pace with referral volume or responsibilities, and staff in both New Jersey regions and one Florida region pointed to low pay as a challenge in retaining staff. Some New Jersey and Florida regional administrators also reported that they rely on supplemental funds from their organizations, though not all can do so. Tehama County's partnership network operates mainly through partners' in-kind time because partners are paid employees of their own organizations; with more funding, Tehama County partners noted they would update their data system and believe that they could accomplish more in their community. Some staff in Indiana and New Jersey also expressed uncertainty about the sustainability of CI system funding.

Box VI.1. Suggestions for starting a centralized intake system

Staff in all six systems reflected on the successes and challenges they experienced in building referral pathways into the CI system and then to home visiting programs. They offered the following suggestions for those considering starting a CI system:

- **Involve home visiting programs from the start.** This helps ensure that the CI system meets the needs of home visiting programs, which can be different in different programs or communities. As a CI staff member in Missouri recommended, "Definitely getting home visiting programs involved in the process to ensure it meets their needs and not just what you think they need. We really adapted our referral forms at each [implementing agency] so it meets the community needs as well because we are all a bit different."
- **Know your community.** When designing a system to help local communities, be sure to get to know the places and people the CI system will be serving. A presence in the community can encourage buy-in.
- **Advertise to get the word out.** Marketing is essential to build awareness among those who can refer to the CI system and promote a sense of trust and legitimacy among families.
- **Prioritize staff retention.** Staff turnover is a common challenge for CI systems. Higher pay can help to retain staff.
- **Seek advice from established systems.** To learn more about a particular CI system, it is worthwhile to engage in direct conversations with those who oversee or operate it. They can help fill in knowledge gaps and potentially become an ongoing source of information.
- **Keep looking for ways to improve.** Ultimately, there is no perfect plan. The six CI systems were willing to test their ideas and keep iterating. As a partner in the Tehama County network said, "We're gonna iterate until we can't iterate anymore... So [don't] try to plan it perfectly for so long before just trying it, 'cause you won't know what's working or not until you do it."

C. Opportunities for future research to support decision making

These case studies provide an in-depth, descriptive understanding of how six CI systems make it easier for families to enroll in home visiting, how each system operates in its context, and how system strengths and challenges foster or impede success. However, these six systems do not represent all CI systems, and more research is needed to understand the scope of CI systems, their associated costs, the ideal technology platforms for different functions and contexts, and their benefits. The project team did not identify any studies examining the degree to which CI systems are achieving their stated outcomes (such as increased enrollment in home visiting). We suggest the following five topics for further research that can guide decisions about CI system improvements and investments:

- **The reach of CI systems.** Although most of the CI systems shared a data snapshot with the project team, the study did not comprehensively analyze any system's reach. CI systems collect detailed data on the referrals to CI systems and from CI systems to home visiting programs, which future researchers could study. Analyses of longitudinal trends—such as total referral volumes and patterns by referral source and family characteristics—would address questions about the number of families served, which families are consistently reached by the systems, and which families are least likely to be reached. Such analyses could point to opportunities for strengthening an existing system's outreach and, for policymakers or funders, help quantify the benefits of a CI system.
- **CI systems' effectiveness in enrolling families in home visiting.** Given that CI systems can require significant investment, an important question for policymakers or funders is whether the systems achieve their intended goal of supporting family enrollment in home visiting. This cross-site analysis offers qualitative evidence that CI and home visiting staff believe that established CI systems promote home visiting enrollment. However, quantitative analyses would strengthen the evidence. Data on referral outcomes (such as timeliness and results of contact attempts) and family enrollment outcomes (such as number of families enrolled in home visiting programs and reasons for any decline) would provide important information on the transition from CI systems to home visiting programs. Collecting comparable enrollment data from non-CI referral sources would offer a benchmark for comparison.
- **Costs of CI systems.** The study collected information about funding sources and levels, but it did not capture detailed cost data. A comprehensive and standardized approach to collecting cost information could guide decisions about whether to develop or possibly expand a CI system. State and local governments may benefit from a detailed breakdown of component costs and in-kind contributions, accompanied by a range of examples to compare options—including the costs for different data system platforms, administrative structures (state versus regional), staffing models, and data linkages.
- **Considerations for data system platforms and other technology.** Some data system functions, including closed-loop referral tracking and reporting, are integral to CI operations; other functions, such as linkages with other data systems and integration with web-based referral forms, are worthy of consideration. While this study provides a brief overview of how six CI systems use technology, deeper exploration into their features, costs, scalability, security, and trade-offs may help jurisdictions make informed decisions when selecting or upgrading their data infrastructure. Such guidance may be especially helpful for identifying opportunities to modernize data infrastructure in the face of rapidly evolving technological capacities.

- **A national survey of CI systems.** This study began with a web-based search and project team members' and advisers' recommendations on which systems to include in the study—a process that revealed 30 diverse CI systems. As described in the Introduction, the definition of a CI system can refer to anything from a web-based, common application portal to a coordinated referral platform to a highly centralized, state-supported system. As CI systems continue to evolve and more are developed, a national survey of CI systems would clarify the breadth of CI systems (including their important features) and point administrators to examples of interest.

References

Association of Maternal and Child Health Programs. "A Roadmap for Collaboration among Title V, Home Visiting, and Early Childhood Systems: Recommendations and Framework for Improved Early Childhood Collaboration." September 2021. https://amchp.org/wp-content/uploads/2023/09/EC-Roadmap_August-2023.pdf.

Coughlin, R., A. Dunn, J. Lugo-Gil, L. Akers, and C. Baxter. "Early childhood home visiting models: Reviewing evidence of effectiveness." OPRE Report #2025-171, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2025.

First Five SC. "About First Five SC," 2026. https://first5sc.org/about/.

Gonzalez, K. and P. Caronongan. "Braiding Federal Funding to Expand Access to Quality Early Care and Education and Early Childhood Supports and Services: A Tool for States and Local Communities," Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2021. https://aspe.hhs.gov/reports/early-childhood-braiding.

Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Base and Matching Grant Awards (Funding Opportunity Number HRSA-24-049)." Washington D.C. Department of Health and Human Services, 2024. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/hrsa-24-049-miechv-nofo.pdf.

Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting Program: Report to Congress 2025." Rockville, MD: Health Resources and Services Administration, 2025. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/home-visiting/miechv-fy-2025-report-congress.pdf.

Help Me Grow National Center. "The Help Me Grow Model." 2026. https://helpmegrownational.org/hmg-system-model/.

IGrow Illinois. "Developing Coordinated Intake for Your Community: What It Is and How to Start or Maintain a Strong System." 2020. https://igrowillinois.org/wp-content/uploads/2024/06/Coordinated-Intake-Toolkit-August-2020-1.pdf.

Isaacs, A., A. Bonsey, and D. Couch. "Centralized Intake Models and Recommendations for Their Use in Non-Acute Mental Health Services: A Scoping Review." *International Journal of Environmental Research and Public Health*, vol. 20, no. 9, 2023, p. 5747.

Maternal and Child Health Bureau. "Early Childhood Comprehensive Systems." 2026. https://mchb.hrsa.gov/programs-impact/early-childhood-systems/early-childhood-comprehensive-systems.

Missouri Perinatal Quality Collaborative. "Closing the Loop: How Referral Systems Are Transforming Health Care." October 2025. https://mopqc.org/news/closing-the-loop-how-referral-systems-are-transforming-health-care.

National Home Visiting Model Alliance. "Centralized Intake: Lessons Learned and Recommendations." n.d. https://www.nationalalliancehvmodels.org/copy-of-resources.

National Home Visiting Resource Center. "2025 Home Visiting Yearbook." James Bell Associates and the Urban Institute, August 2025. https://nhvrc.org/yearbook/2025-yearbook/.

Social Security Act, Title V, Section 511 (42 U.S.C. § 711), Maternal, Infant, and Early Childhood Home Visiting Programs, as amended by Section 6101 of Division FF of the Consolidated Appropriations Act, 2023 (Public Law 117-328).

Appendix A. Site Selection, Interview Approach, and Analysis Methods

This appendix presents an overview of how we selected sites, details about the interview process and the topics covered, and our methods for analysis.

A. Process for selecting and recruiting CI systems and home visiting programs

This section describes the multistep process we used to select and recruit six CI systems and their home visiting program partners for the case studies.

1. Identified CI systems that refer families to home visiting

We began by reviewing information about CI systems found through web searches (such as publicly available reports and issue briefs). We also asked a group of nine CI system administrators, technical assistance providers, and researchers that formed the project's external expert committee as well as federal partners to recommend CI systems known to them. Through this process, we identified 30 states with CI systems. We reviewed available information about the systems that aligned with the study's criteria for eligibility and prioritization (Exhibit A.1). Of the 30 CI systems identified, 17 had enough information to indicate they met the eligibility criteria; the other 13 had insufficient information and were not considered further. Of the 17 systems with sufficient publicly available information, we prioritized recruitment of those that met eligibility criteria and at least some of the prioritization considerations (such as variation in geographic location).

Exhibit A.1. Eligibility criteria and prioritization considerations

Eligibility criteria. CI systems had to meet these criteria to be considered for inclusion in the study:

- The system centralizes or coordinates outreach, screening, referrals, or enrollment processes for a home visiting program (defined as an organization that delivers early childhood home visiting services) and at least one other organization.
- The system is well-established, is currently up and running, and has been actively referring families for at least six months.
- At least one home visiting program has received a referral in approximately the past two months from the system.

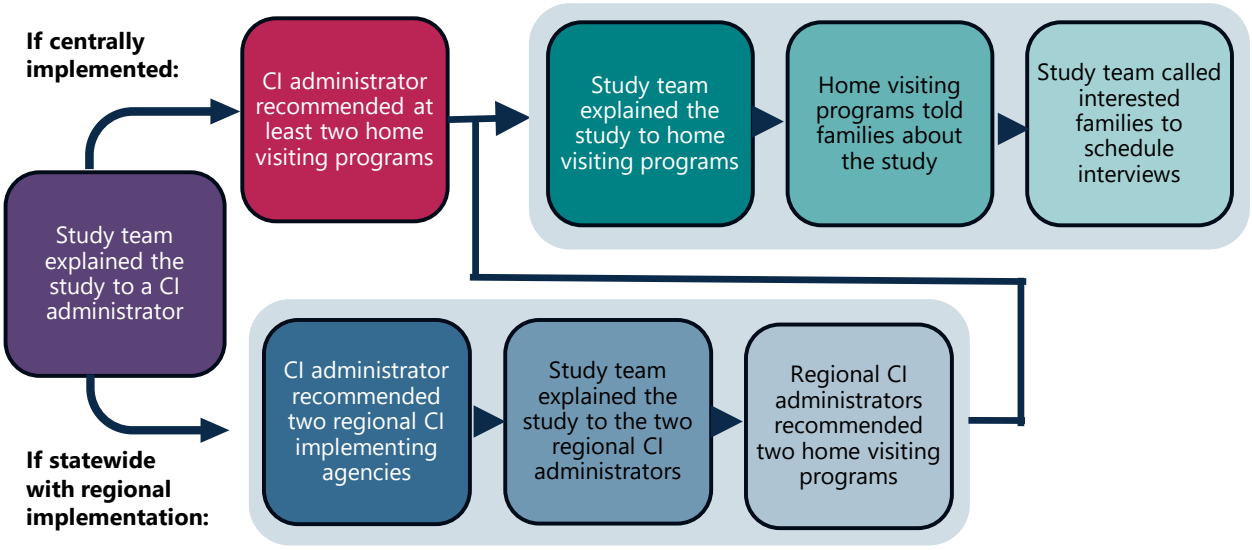
Prioritization considerations. We used the following considerations to select CI systems from those that met the eligibility criteria:

- The CI system has a high level of centralization, coordination, or collaboration based on an assessment of the following:
  - Processes for outreach, screening, and referrals (for example, refers families to home visiting instead of just providing information; processes involve more than just a phone number or shared materials)
  - Staffing models (to accomplish core tasks such as outreach, screening, and referral)
  - Data sharing about referrals between the CI system and home visiting programs or state agencies
  - Documented partnerships and formal processes for collaboration (for example, Memoranda of Understanding or advisory boards)
- CI systems represent a variety of characteristics:
  - Approach to centralizing intake
  - Geographic scope (statewide, regional, or local)
  - U.S. geographic region
  - Home visiting program model offered by associated home visiting programs
  - Length of time the CI system has been operating
  - Variation in service scope (home visiting only versus home visiting plus other services)

2. Recruited prioritized CI systems, their home visiting program partners, and participating families

Two site visitors led the recruitment and virtual site visits. Exhibit A.2 shows our recruitment process. The site visitors emailed an administrator listed on the CI organization's website to introduce the study and offer to discuss it further. If the contact at the CI organization was interested, the person connected us with two home visiting programs that recently received a referral from the CI system. For statewide CI systems with regional implementation, we asked the initial contact at the CI organization to suggest staff from implementing agencies in two regions of the state, to include their region as part of the case study.

Exhibit A.2. Process for recruiting sites for the case studies



CI = centralized intake.

We sought to include two home visiting programs for each recruited CI implementing agency that, altogether, represented a variety of home visiting models (Exhibit A.3). Site visitors emailed the managers or directors of the recommended home visiting programs to set up a call to describe the study and invite them to participate. We considered a site recruited if at least one home visiting program agreed to participate. Ultimately at least two home visiting programs participated from all sites, for a total of 17 programs. For regionally implemented CI systems, we included more programs (one to three per region).

Exhibit A.3. Home visiting models represented in interviews, by centralized intake system

Home visiting model	**Delaware** Help Me Grow at 211	**Florida** Connect	**Indiana** My Healthy Baby	**Missouri** CRIS	**New Jersey** Connecting NJ	**Tehama County** P2P
Early Head Start						✓
Healthy Families America			✓	✓	✓	✓
Nurse–Family Partnership		✓	✓		✓	
Parents as Teachers	✓	✓		✓	✓	
Other, non–evidence based		✓				

CRIS = Coordinated Referral and Intake System; P2P = Pregnancy to Preschool.

After agreeing to participate, CI organizations and home visiting programs recommended staff for interviews and provided names of families we could invite to participate. To recruit families, home visiting program staff (such as home visitors) shared a study flyer with families and asked if they would like to be contacted by the project team to schedule an interview. We provided a frequently asked questions document for program staff to answer families' questions. For interested families that agreed to share their contact information with the project team, the program transmitted the contact information via the project's secure file transfer protocol. A member of the project team then called or texted the family to answer any questions and to schedule an interview. We stopped recruiting families when we completed interviews with two to four families per participating program.

In addition, during the recruitment process and interview process, we invited CI system administrators to share documents relevant to their system governance, operations, or reporting, building on the publicly available documents about the CI systems we identified during the site selection phase. Documents included policy or practice guidance, annual reports, and system profiles. We used the documents to (1) gather general information about the CI system for recruitment purposes; (2) tailor interview questions; and (3) verify or add to information provided during interviews—such as referral numbers or information about system start-up.

B. Interview approach and topics

Trained interviewers obtained verbal consent before starting each interview. We scheduled interviews with home visiting staff and families for 60 minutes and with CI staff for 90 minutes. Family interviews typically lasted 30 minutes because family interactions with the CI systems had been brief, and families shared their experiences more quickly than planned. We offered participants an e-gift card as a token of appreciation: a $60 gift card for 90-minute interviews and a $40 gift card for interviews that were 60 minutes or less. Interviews with families were conducted in English or Spanish.

At the end of each interview, interviewers sent participants a web-based link to an anonymous, secure demographic form. Of the 32 parents (89 percent) who completed the form, most identified as White (38 percent), Hispanic or Latino (29 percent), or Black or African American (24 percent). All identified as female, most were ages 18 to 34, and they had, on average, one or two children. Of the 65 staff who responded (86 percent), two-thirds identified as White, nearly all identified as female, and half were ages 25 to 44.

The interviews covered the topics shown in Exhibit A.4. We used interview protocols that mapped to the listed topics. The project's external committee reviewed and provided feedback on the protocols. The study received approval from the U.S. Office of Management and Budget and Health Media Lab's Institutional Review Board. Four CI systems required us to submit research applications with the state Departments of Health: Delaware, Florida, Indiana, and New Jersey.

After each interview, the notetaker created detailed notes, which the interviewer then reviewed for accuracy and completion. As noted, after some staff interviews, site staff sent us documents about their CI system, such as decision trees, recruitment materials, or reports. Most of this information we did not already have from reviewing publicly available documents during site selection or from our document requests during recruitment.

Exhibit A.4. Interview topics, by type of interview participant

Interview topic	CI staff	Home visiting program director	Home visitor or outreach staff	Families
Features of CI systems				
Structure of CI system (such as scope and staffing)	✓	✓	✓	
Funding and role of MIECHV awardee	✓			
Development of CI systems	✓	✓	✓	
Governance of CI systems	✓	✓		
Features of home visiting programs				
Structure of home visiting programs (such as scope and staffing)		✓		
Enrollment capacity		✓	✓	
Referral sources beyond CI system		✓	✓	
Using data to consider balanced enrollment across programs	✓	✓	✓	
Documentation, guidance, and staff hiring and training				
CI staff hiring and retention	✓			
Staff training on CI processes	✓	✓	✓	
Data collection and documentation for screening, referrals, and enrollment	✓	✓	✓	
Data infrastructure, privacy, and data capacity	✓	✓	✓	✓
Outreach, screening, and referral process				
Outreach approaches taken by CI system or home visiting programs	✓	✓	✓	✓
Who is missed through current referral pathways	✓	✓	✓	✓
Screening and eligibility determination	✓	✓	✓	✓
Family matching to home visiting programs based on their preferences	✓	✓	✓	✓
Referral from CI system to home visiting programs	✓	✓	✓	✓
Family enrollment processes, including data collected	✓	✓	✓	✓
Communication about home visiting program availability and family prioritization	✓	✓	✓	
Enrollment efficiency and timeline	✓	✓	✓	✓
Differences between families referred by CI system and other sources		✓	✓	
Outcomes of CI system	✓			
Local contexts, community needs, and family experience				
Understanding local contexts and community needs	✓	✓	✓	✓
CI feedback loops with families and programs	✓	✓	✓	
Family experience navigating programs			✓	✓
Alignment between services and family needs			✓	✓
Successes and challenges of the system and opportunities for technical assistance				
Strengths of CI system	✓	✓	✓	✓

Interview topic	CI staff	Home visiting program director	Home visitor or outreach staff	Families
Areas for improvement	✓	✓	✓	✓
Technical assistance needed	✓	✓	✓	

CI = centralized intake.

C. Data analysis methods

We completed data analysis in two stages: the project team analyzed data from each site to complete individual case summaries and then analyzed the data across sites to identify cross-cutting themes for this report.

1. Completing case summaries

The project team conducted qualitative analysis using qualitative coding software (NVivo). We developed a codebook with a comprehensive list of codes based on the topics in Exhibit A.4. Each two-person site team then uploaded the site's interview notes into NVivo and assigned interview responses to a relevant code in the codebook. Each team also assigned attributes, such as participant type and the associated CI system or program, to help categorize interviews.

To establish coding reliability, all site visitors practiced coding one set of notes. We used a coding comparison query in NVivo to assess agreement with the task leader's reference codes, which enabled us to see how the site team's coding differed from the task leader's coded file and identify differences for the site teams. The site lead for each site also reviewed all coding done by the other site visitor for that site, and a case study task lead (who oversaw all site visits) reviewed about 10 percent of each site team's coded notes. They discussed any discrepancies and updated the codebook as needed.

After coding in NVivo, site teams exported the data to a spreadsheet to review data by code and determine key themes and takeaways for each site. These analysis files were organized to match the topics in the case summary template, which site teams then populated based on this thematic coding. The team also pulled supplemental information from the documents collected (for example, the numbers of system referrals or information on start-up), as needed. The resulting case summaries are included in the companion report, "Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting," available on the Office of Planning, Research, and Evaluation website using the website's search function.

2. Identifying cross-cutting themes

After preparing all six case summaries, we conducted cross-site analyses. To conduct these analyses, we populated analysis tables in a spreadsheet with key data extracted from each case summary. Team members then analyzed the data, looking for similarities and differences across the case-specific data to develop cross-cutting tallies and themes, such as about the structure, operations, and implementation supports and challenges of the CI systems. Specifically, we tallied the number of CI systems in which interview participants described a given approach, issue, or experience. Given that interviews were semi-structured, it is possible that participants from other CI systems may have had similar experiences they did not mention and that we would not have included in the tallies. In our cross-cutting analysis, we also noted examples of processes or implementation supports that might be especially sophisticated. When needed, we returned to the NVivo file for more examples or quotes.

Mathematica Inc.

Our employee-owners work nationwide and around the world.

Find us at **mathematica.org** and **edi-global.com**.



Mathematica, Progress Together, and the "spotlight M" logo are registered trademarks of Mathematica Inc.