Expanding Reach and Strengthening Systems: Innovations in Care Coordination for Home Visiting

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Disclaimer

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FY 2022 MIECHV Innovation Awards

- Funding Announcement (HRSA-22-089 & HRSA-22-102)
  - HRSA launched the MIECHV Innovation Awards in 2021 to support new approaches in home visiting.
  - Goal: leverage technology and data innovations to improve service delivery and coordination for families.
  - Projects required to align with at least one program priority:
    - Integrate administrative data on community health factors.
    - Create or enhance integrated early childhood data systems.
    - Develop recruitment and retention strategies (e.g., centralized intake).
    - Advance workforce development through new technologies

The Common Theme Across OK, DE, WV

- Strengthening **care coordination** through innovative system changes:
  - Building and using **referral portals** .
  - Streamlining referral paperwork and communication.
  - Employing **referral specialists** (e.g., CHWs) to facilitate both inbound and outbound connections.

Oklahoma Innovation

Project Topic: Care Coordination

Why we chose this topic: to streamline and amplify the methods of care coordination among home visiting programs to narrow gaps exacerbated by the pandemic in client access to care and supports

- Housing and food insecurity
- Concerns of developmental delays
- Spikes in alcohol and substance abuse

Innovative Strategy

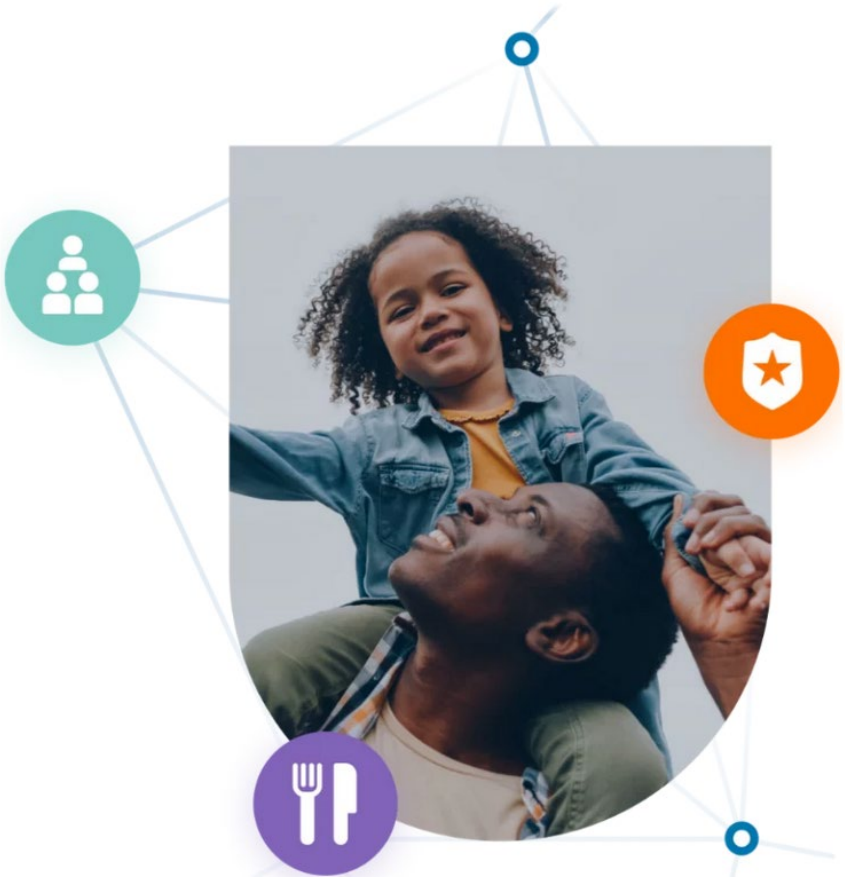
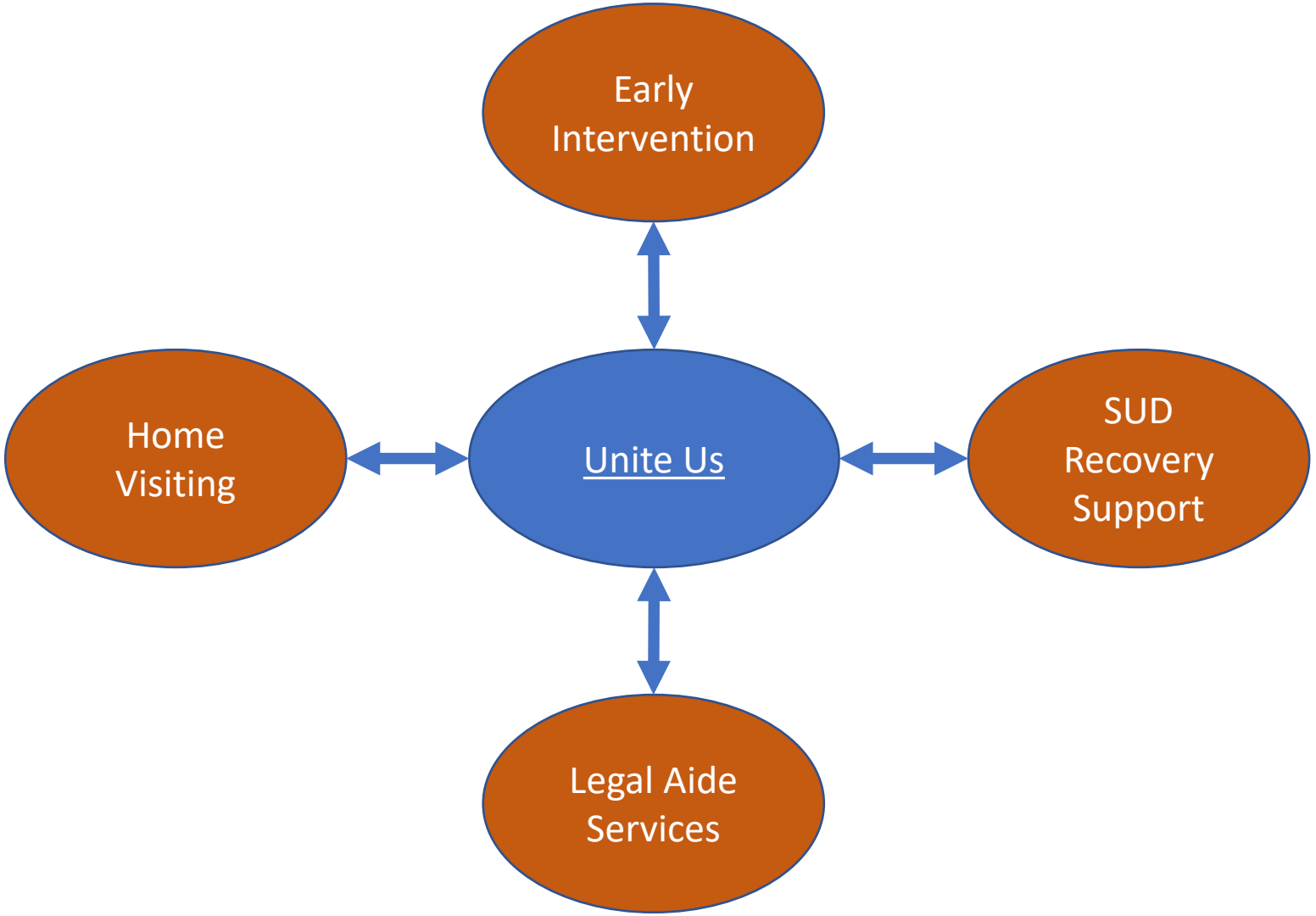


Image from uniteus.com



Project Leads

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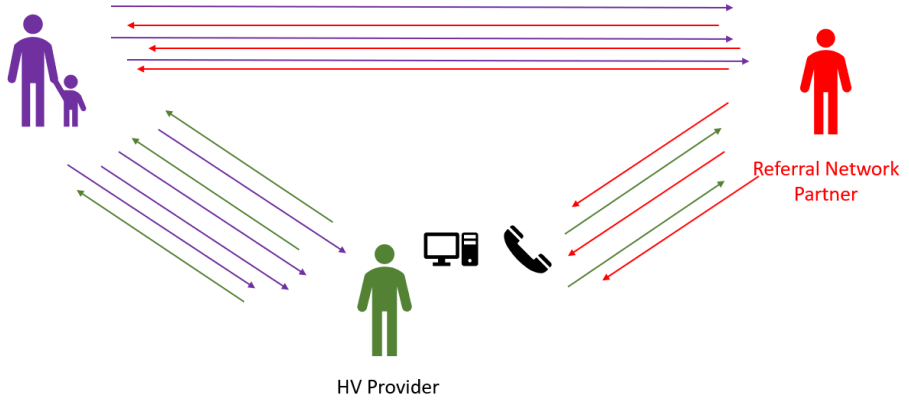
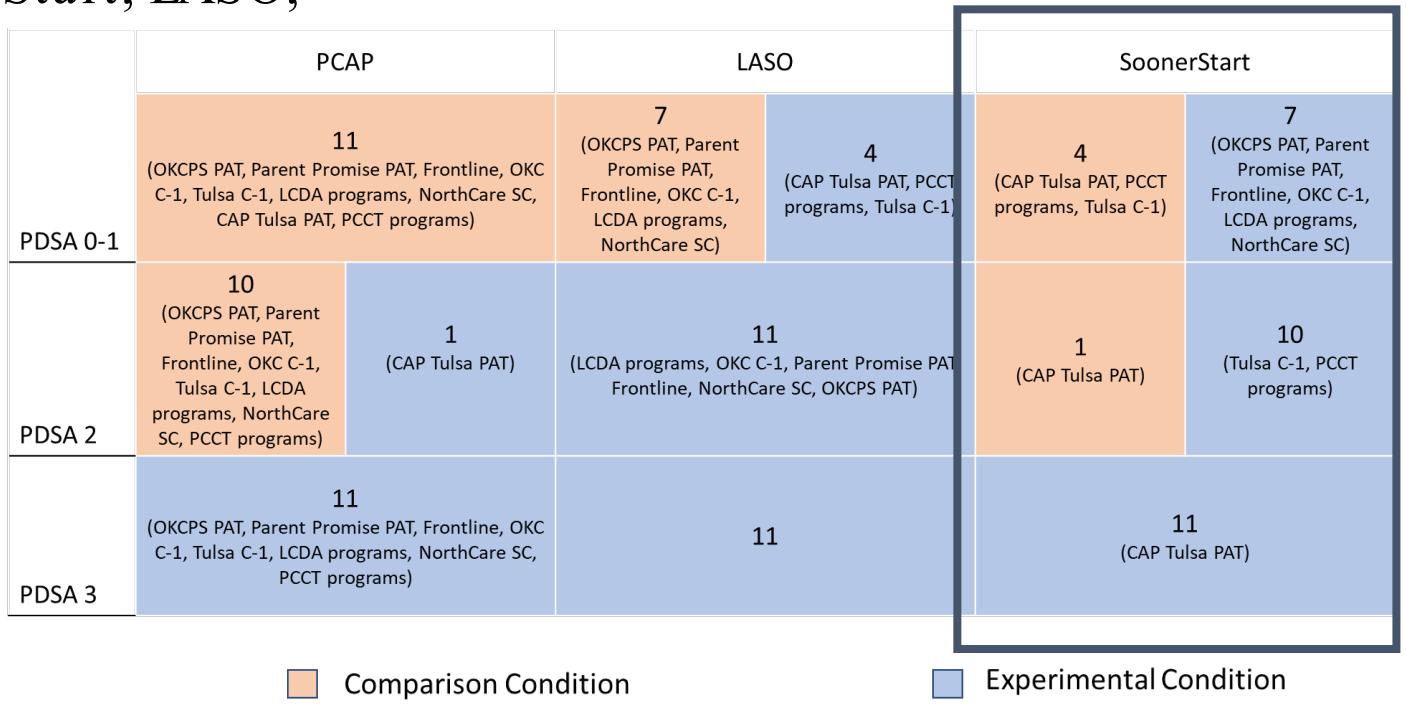


Implementation Overview

- Learning Collaborative on Care Coordination
  - 9 LIAs (6 PAT, 2 NFP, 3 SC; 11 total programs)
  - 3 Referral Network Partners (SoonerStart, LASO, PCAP)
  - Stepped-Wedge Design Timeline
    - Phase 0: Jan 2023 – Jul 2023
      (Prep for 1st PDSA)
    - Phase 1: Aug 2023 – Dec 2024
      (1st Network Partner PDSA)
    - Phase 2: Jan 2024 – May 2024
      (2nd Network Partner PDSA)
    - Phase 3: Jun 2024 – Sep 2024
      (3rd Network Partner PDSA)



Innovation Impact on Incoming HV Referrals

Methods Note

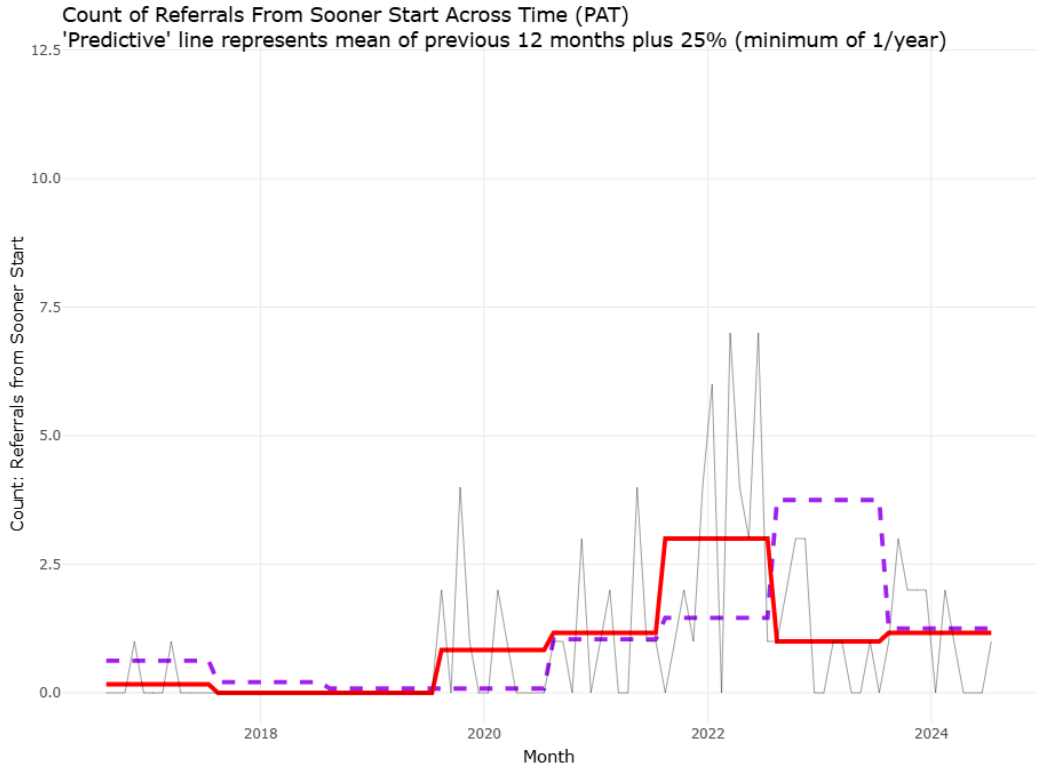
- Explored count of incoming referrals from the community partners and similar services of interest
- Limited by reliability of referral source tracking prior to the Innovation
- Compared rates by year preceding the Innovation to the rates per year after the Innovation

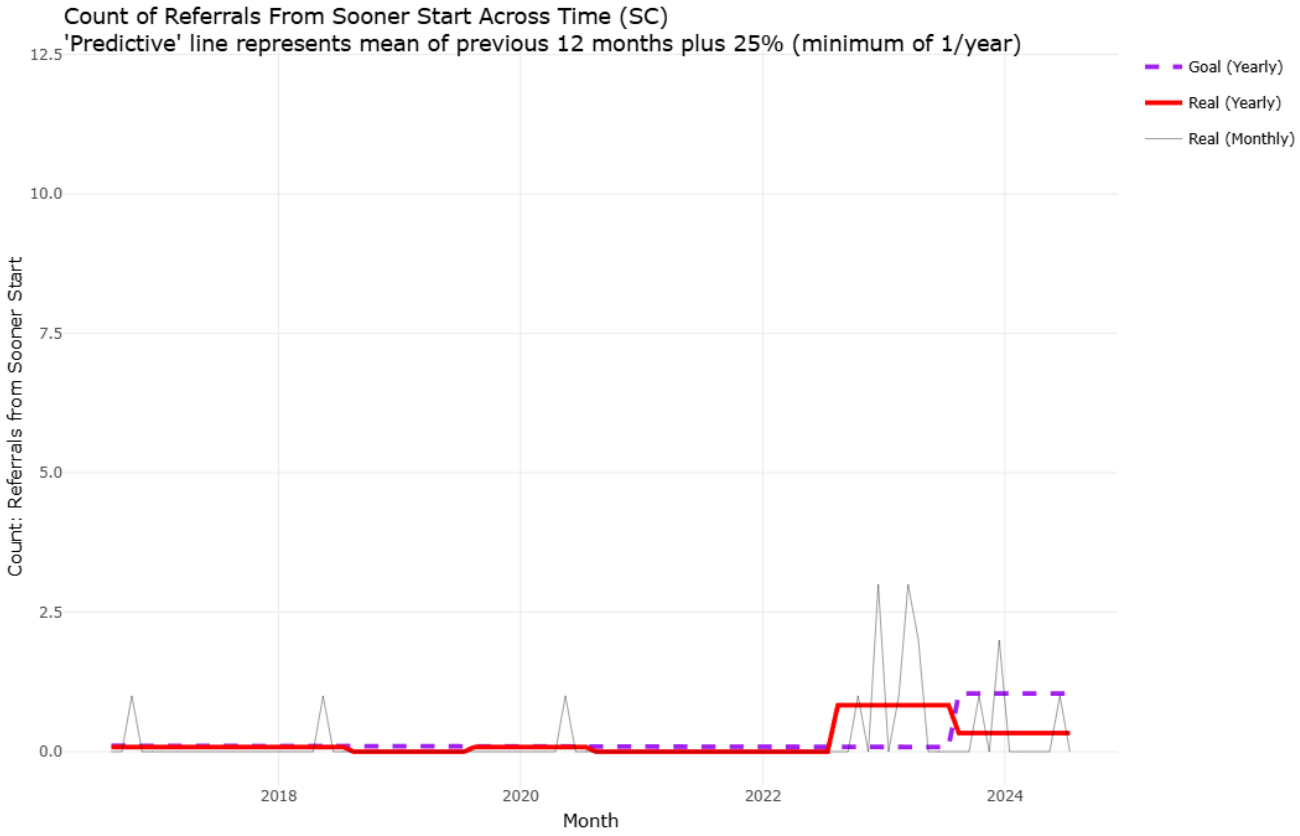
Incoming Referrals

Incoming Referrals Before and After Unite Us	
Recruitment Period	Count Recruited by Year
Before Unite Us	15.1
During/After Unite Us	16.3

Rates of referrals to HV from other organizations inched upwards, though not dramatically

HV Referrals from Early Intervention





Innovation Impact on Outgoing Referrals

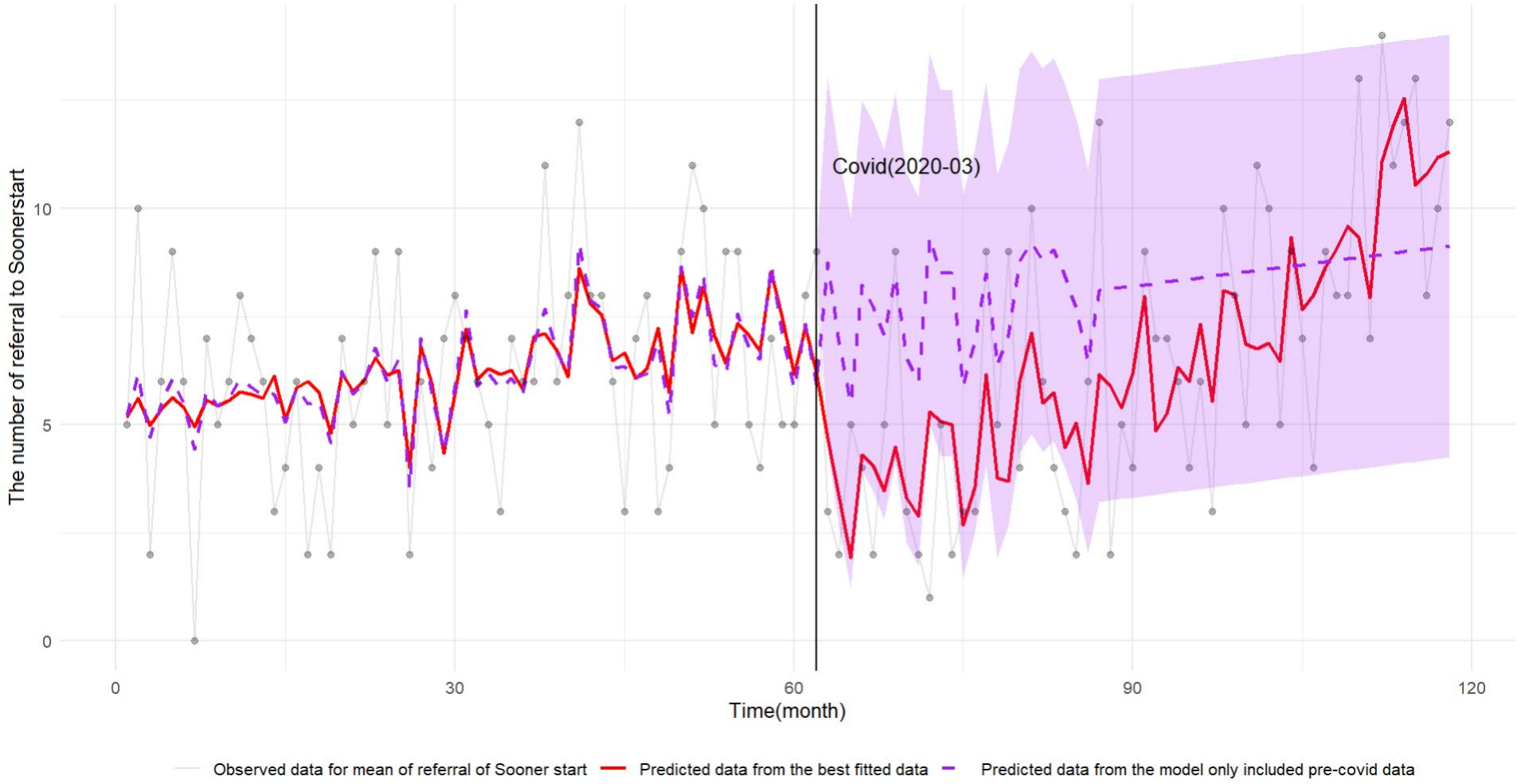
Methods Note

- Presenting results with one partner, 8 HV programs
- Outgoing referrals measured monthly

- Interrupted time series analysis

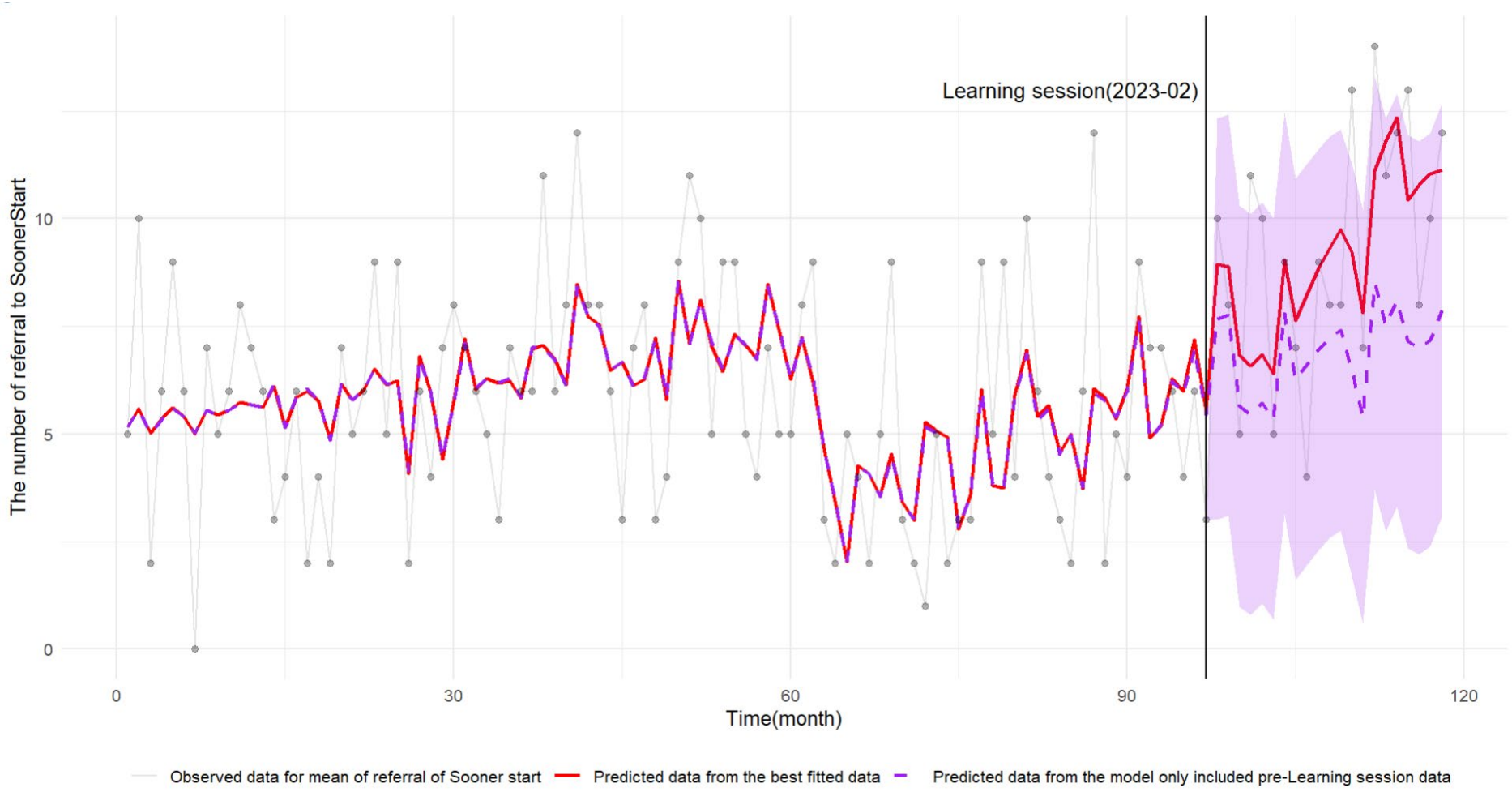
- Three important "interruptions"
  - Onset of COVID-19 pandemic
  - Learning Session (LS) overviewing our community partners
  - Launch of Unite Us

Referrals to EI: Interrupted Time Series Model



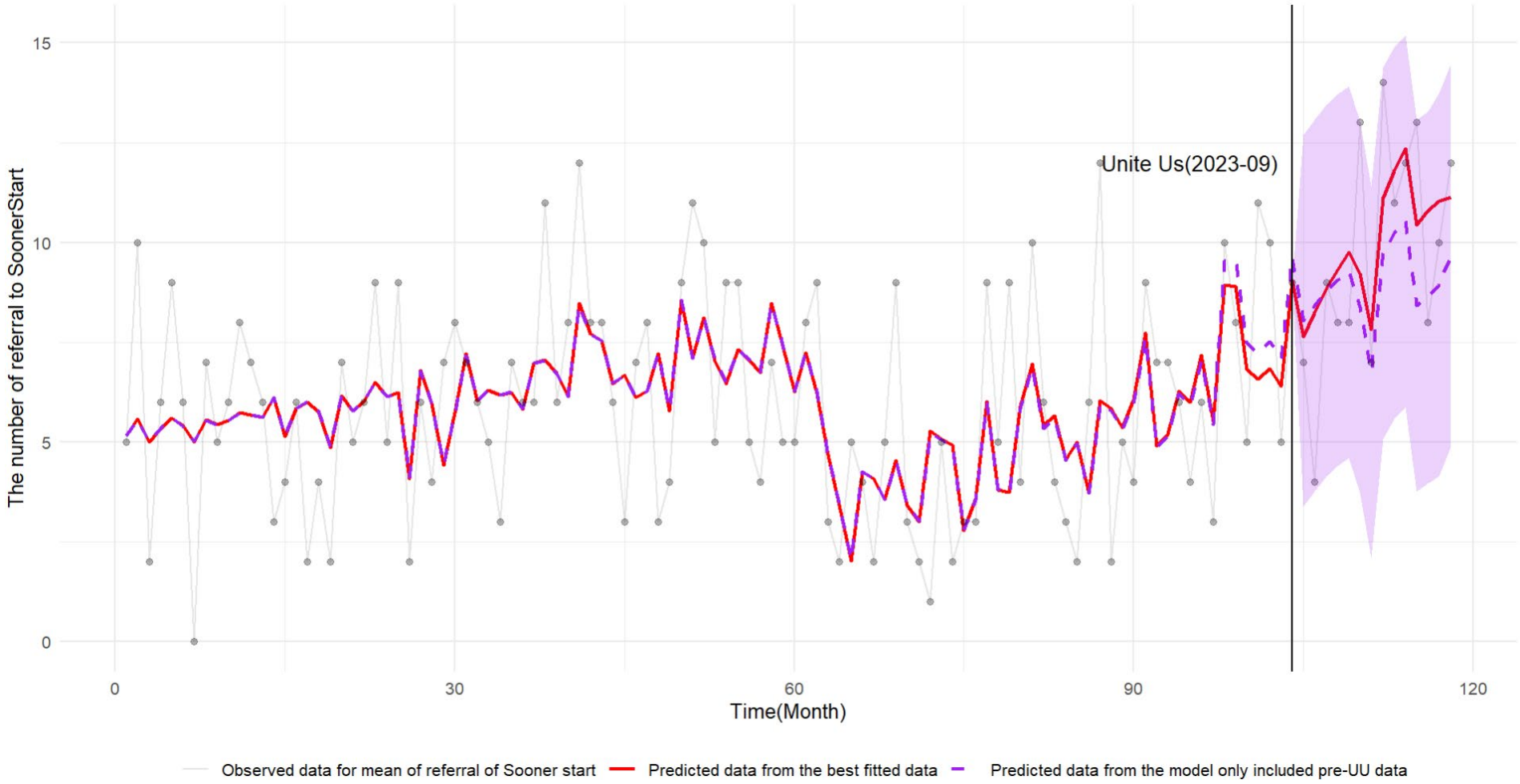
Purple line: if we do not experience COVID-19, do not have a learning session about care coordination, and do not use Unite Us

Referrals to EI: Interrupted Time Series Model 2



Purple line: if we do not have a learning session about care coordination, and do not use Unite Us

Referrals to EI: Interrupted Time Series Model 3



Purple line: if we do not use Unite Us

Outgoing Referrals

- Cumulative impact of the LS and Innovation was an estimated **48% increase** in monthly referrals to EI compared to counterfactual scenario
- These events, overall, had positive impacts on outgoing referrals to our three partners (>30% increase aggregately)
- Referrals sent by HV were managed or closed *within 30 days* of submission **76.5%** of the time
- The majority **(62.4%)** of outgoing referrals were accepted

Experiencing with Referral Placement

"The referral got me in super quick. And dealt with super quick."

"It's nice just to have the referral call about the specific need instead of having to waste the time going through whole screening process, just repeating things over and over again to somebody."

90% identified having a positive experience with their referral being placed through Unite Us
30% noted it was less work for them
70% cited an emotional benefit

How the Innovation Impacted Client Engagement in Referred Services

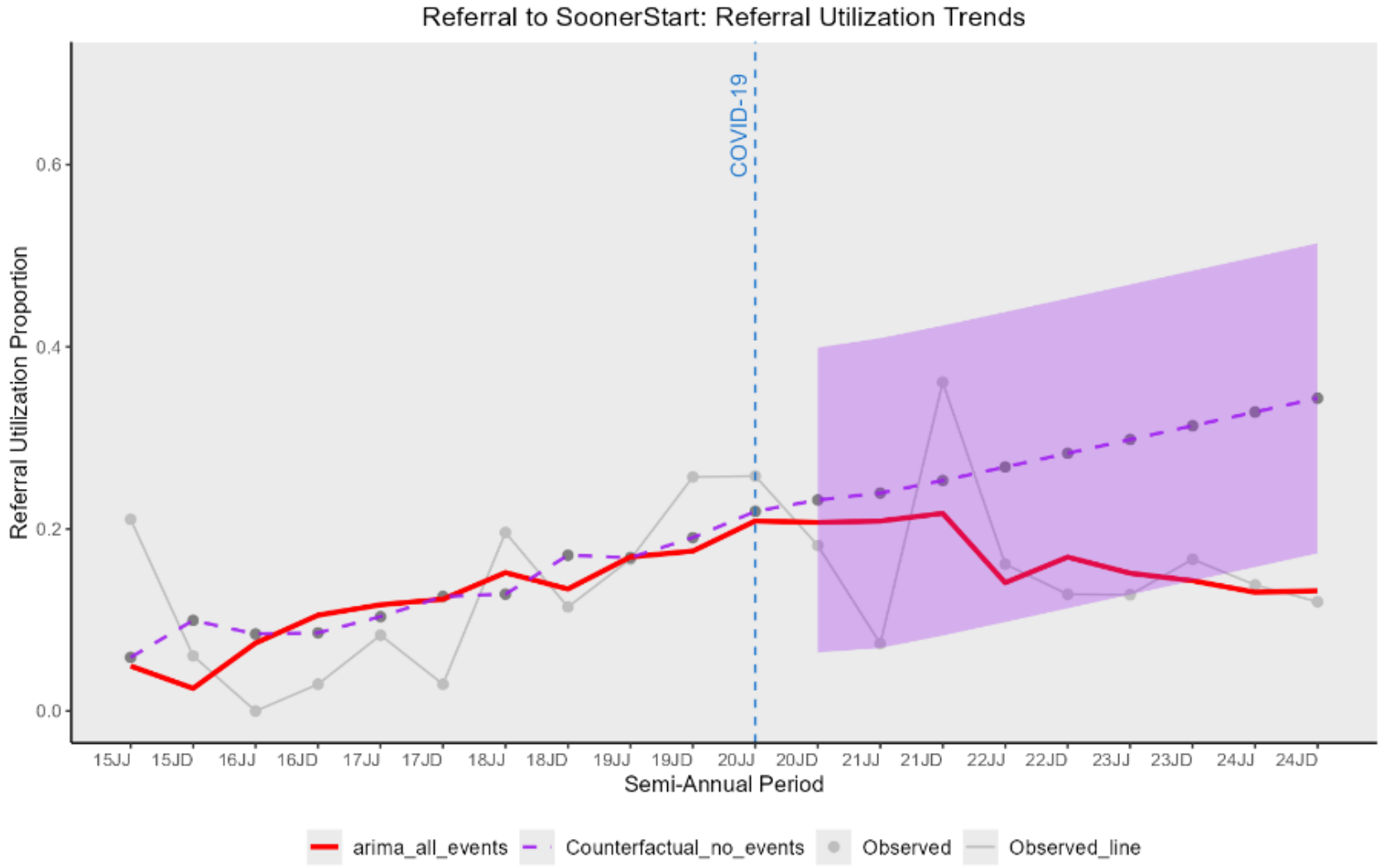
Methods Note

- Utilization rates of partner services measured in 6-month intervals

- Interrupted time series analysis

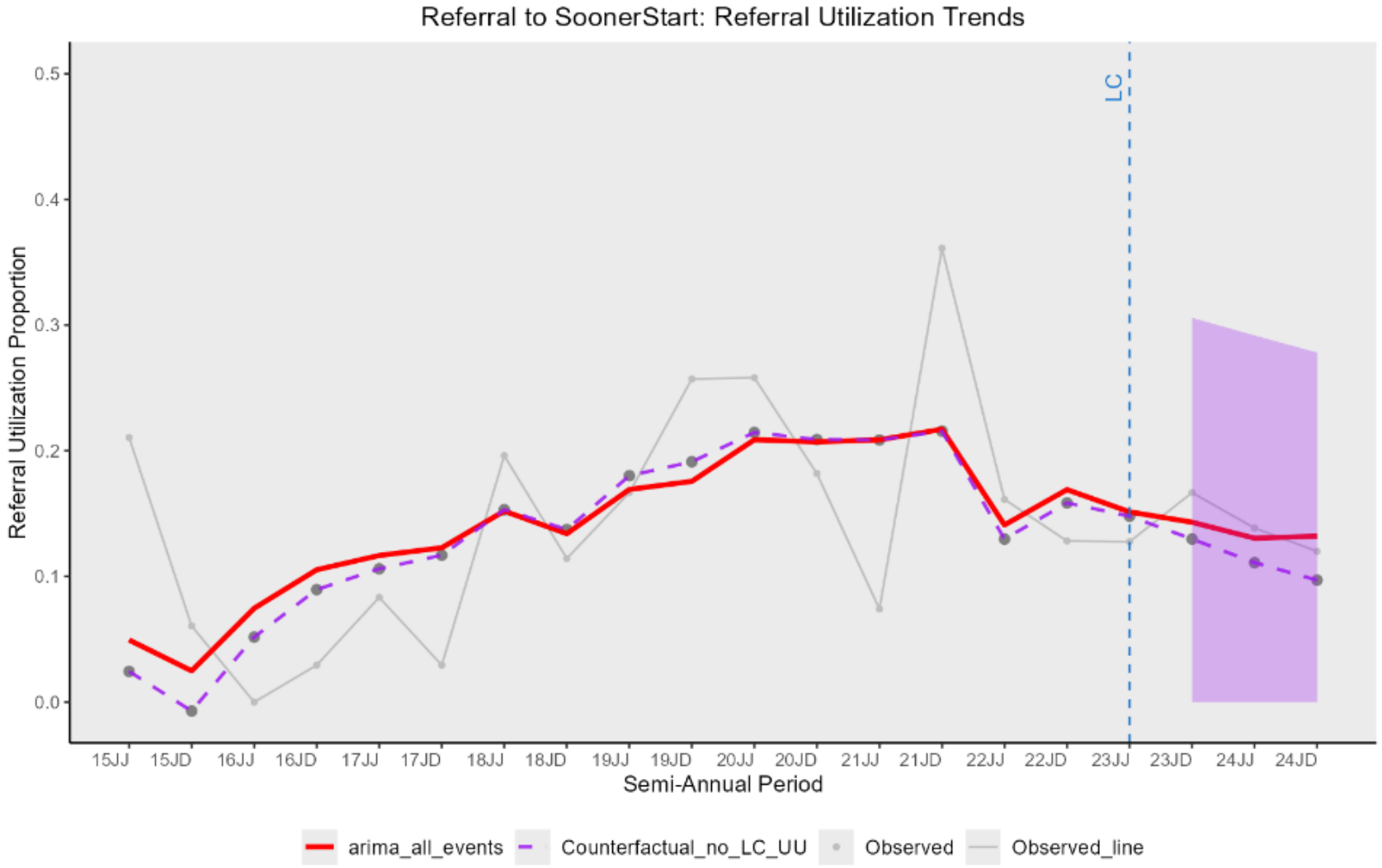
- Three important "interruptions"
  - Onset of COVID-19 pandemic
  - LS overviewing our community partners
  - Launch of Unite Us

Utilization of EI: Interrupted Time Series Model 4



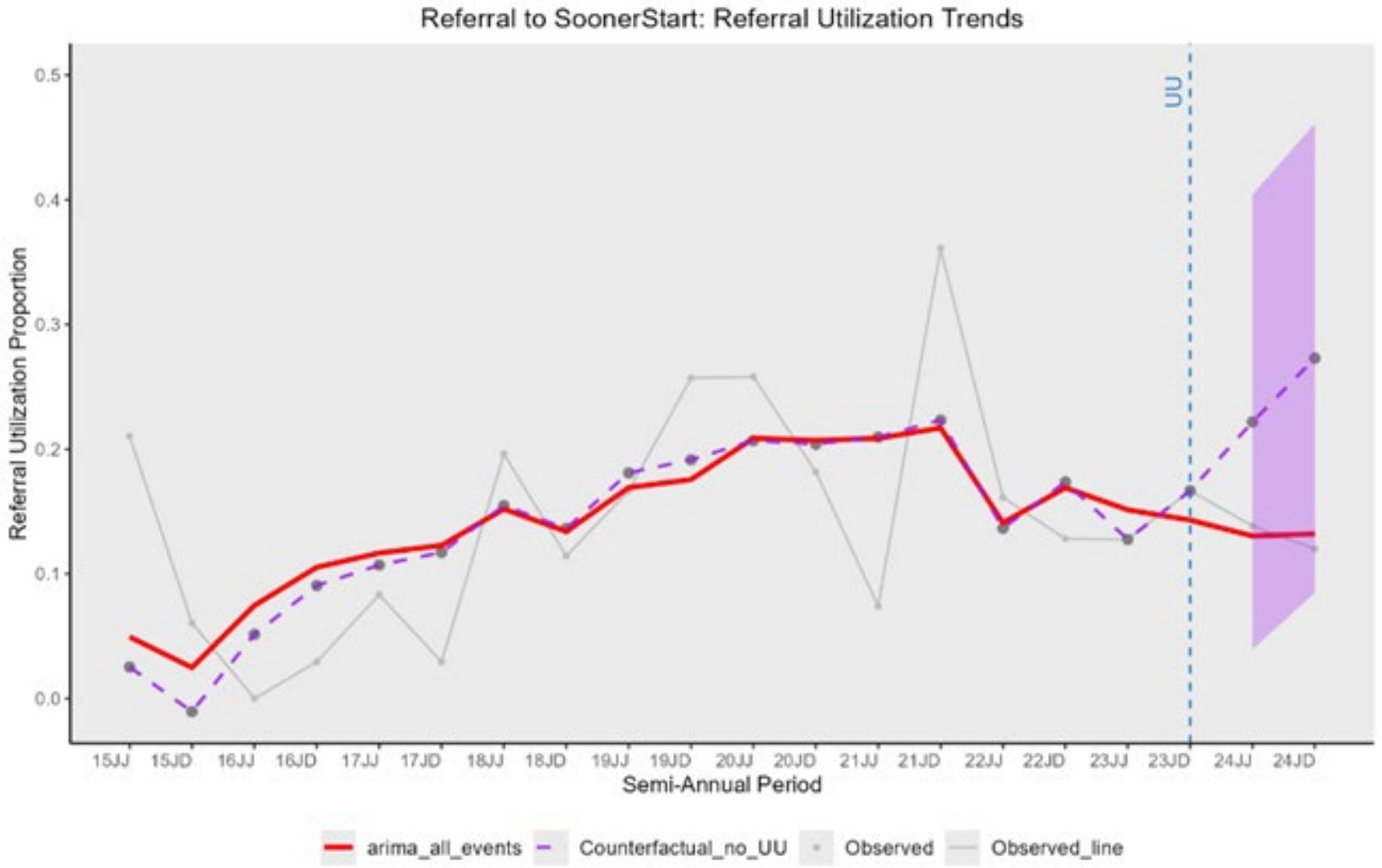
Purple line: if we do not experience COVID-19, do not have a learning session about care coordination, and do not use Unite Us

Referrals to EI: Interrupted Time Series Model 5



Purple line: if we do not have a learning session about care coordination, and do not use Unite Us

Referrals to EI: Interrupted Time Series Model 6



Purple line: if we do not use Unite Us

Client Engagement/Utilization

- Despite increased referral activity and positive trends in utilization, there was no statistically significant change in rate of client engagement in services

- Increased communication efficiency does not necessarily lead to higher service utilization rates

- That said, a flat utilization rate + increasing referral rate did lead to more overall utilization than prior trends predicted

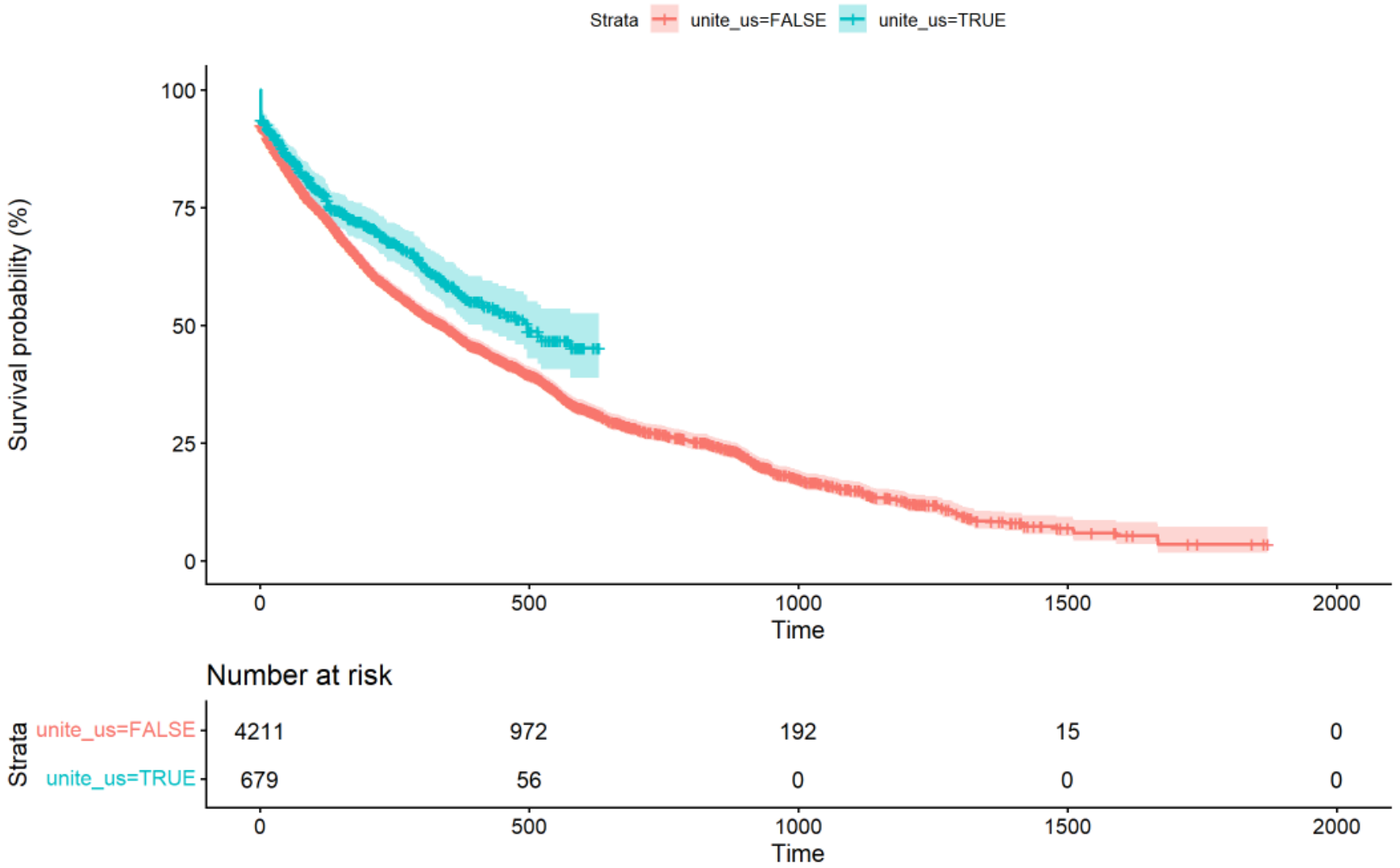
How the innovation Impacted Client Engagement in HV

Methods Note

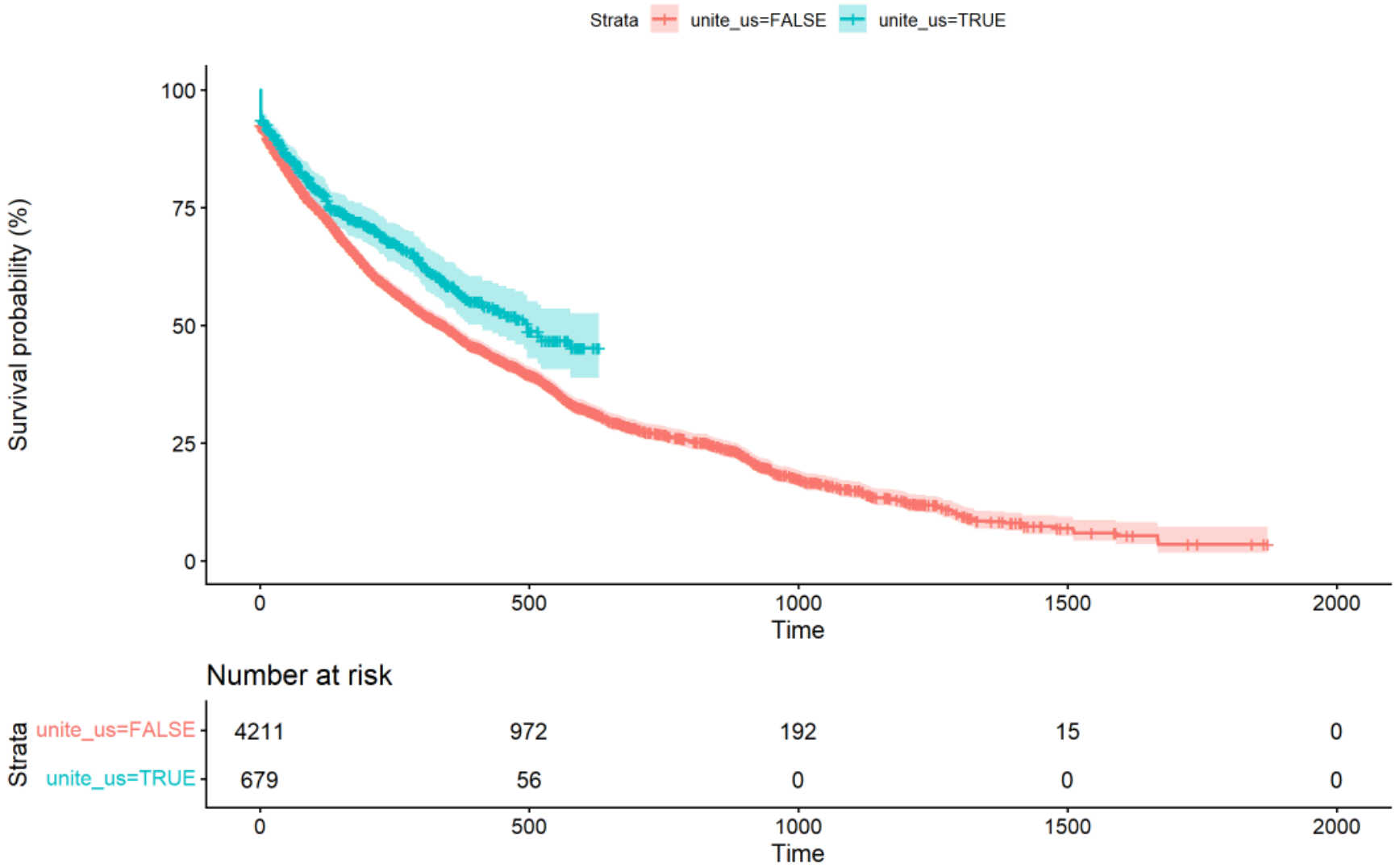
- Explored retention of HV clients referred to network partners
- Drop out = last visit > 90 days from data extraction
  - Program graduates and those reaching C1 age limit not counted in attrition
- Retained = last visit < 90 days from data extraction

- Survival model analysis across HV models

PAT Survival Model: Change in Client Retention over Time



PAT Survival Model: Change in Client Retention over Time 2



Model Name	Target Period	Retention - No Unite Us Exposure	Retention - Any Unite Us Exposure
PAT	3 Months	75% (3073 / 4118)	71% (654 / 916)
PAT	6 Months	61% (2470 / 4026)	60% (600 / 1008)
PAT	12 Months	42% (1631 / 3904)	50% (440 / 886)
SC	3 Months	61% (611 / 1007)	60% (345 / 578)
SC	6 Months	44% (425 / 968)	44% (257 / 582)
SC	12 Months	25% (240 / 950)	21% (102 / 475)
NFP	3 Months	68% (2562 / 3760)	65% (490 / 750)
NFP	6 Months	55% (2054 / 3703)	58% (433 / 746)
NFP	12 Months	38% (1374 / 3608)	49% (346 / 705)

Client Engagement in HV

- The survival model indicates that clients in PAT & NFP programs after the start of the Learning Collaborative had an **8-11% reduction** in 12-month drop-out

- Increased focus on tracking referrals and outcomes may have led to a meaningful reduction in clients dropping out of their HV program

Innovation Sustainment in OK

- Unite Us contract not renewed due to funding restrictions
- Renewed focus on referral process CQI projects
- Sustained liaison relationship with LASO

Delaware Innovation

Background

- **August 2022 Needs Assessment Survey:** MIECHV home visitors felt ill-equipped to deal with specific issues related to structural and social determinants of health (SSDOH)-related issues (e.g., housing, food insecurity, etc.).

- COVID-19 exacerbated unmet SSDOH issues.

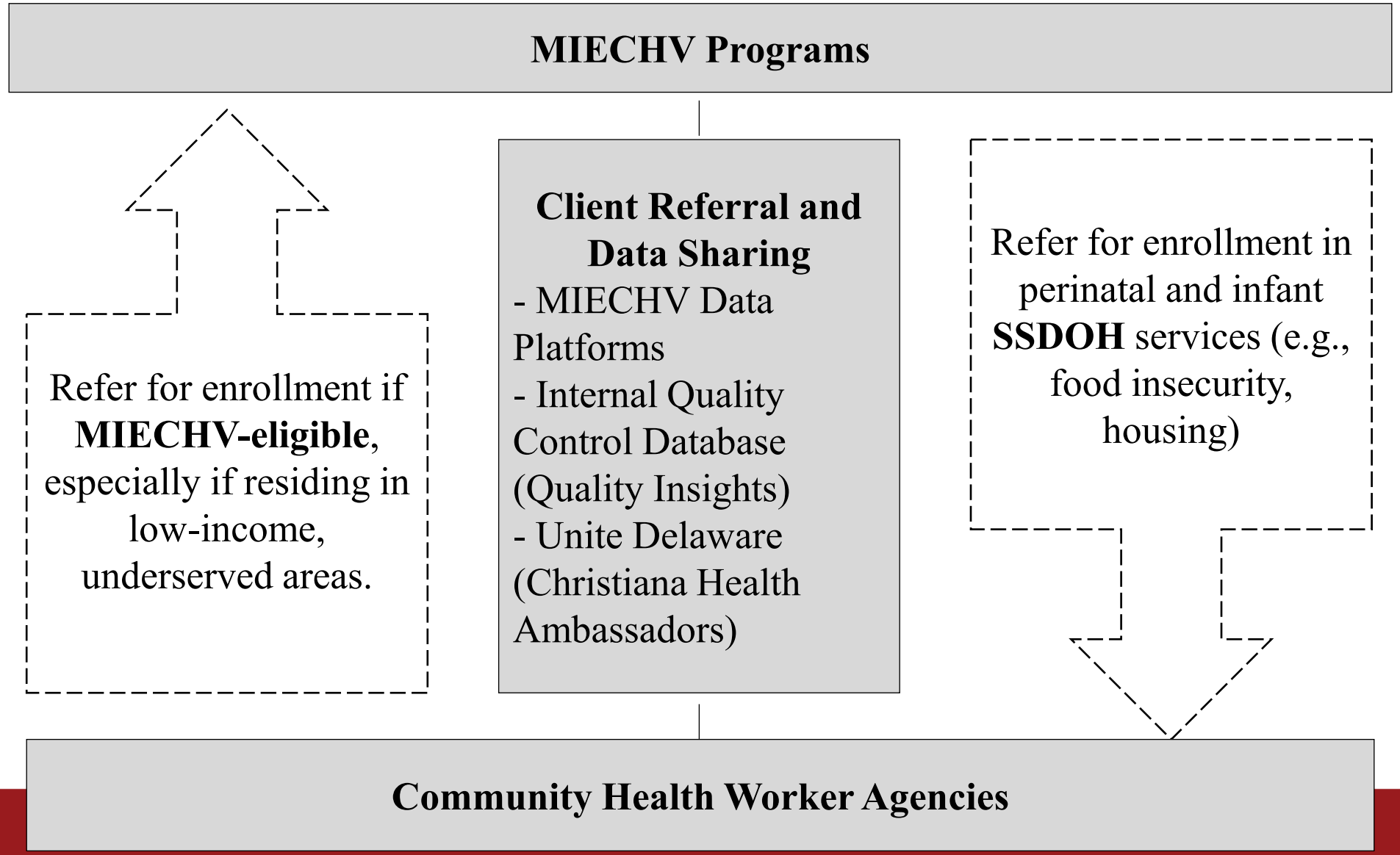
Background 2

- Innovation centered on strengthening the referral linkages across evidence-based home visiting programs (MIECHV) and community health worker (CHW) agencies.

- MIECHV clients with unmet SSDOH (e.g., inadequate housing, food insecurity) that could not be readily nor robustly addressed by home visitors were referred to CHWs.

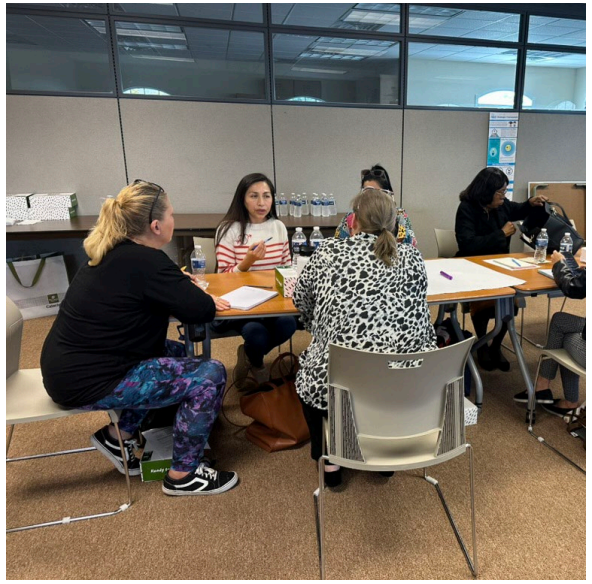
- Clients who (1) have worked with CHW agencies, (2) reside in communities historically unserved by home visiting, and/or (3) face disproportionate barriers to accessing or participating in services yet who are eligible and not enrolled in MIECHV were referred to MIECHV programs by their respective CHW agency.

Conceptual Framework



Integration of MIECHV and CHWs

- Held Zoom and in-person sessions so that MIECHV home visitors and CHWs could learn about each others' services and interact with one another.



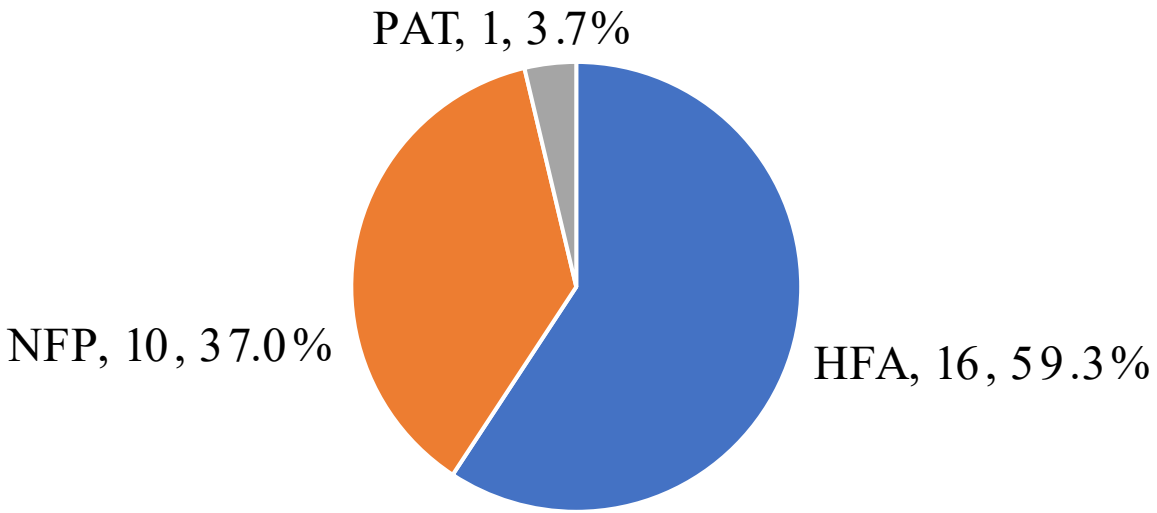
How Innovation Impacted Referrals to MIECHV

- Between September 2023 and September 2024:
  - **53** unduplicated CHW clients met the criteria for enrollment in at least one MIECHV program.
  - There were **23 (43.4 percent)** unduplicated CHW clients who were referred from CHWs to MIECHV home visitors.
    - Lower referral rate as CHWs stated that clients' needs could be addressed directly by the CHW.
  - **Six (26.1 percent)** were ultimately enrolled in MIECHV programs – three at HFA, two at PAT, and one at NFP.

How Innovation Impacted Referrals to CHWs

- Between September 2023 and September 2024:
  - 27 unduplicated client referrals reported from MIECHV to CHWs.

- MIECHV Referred Clients to CHWs.



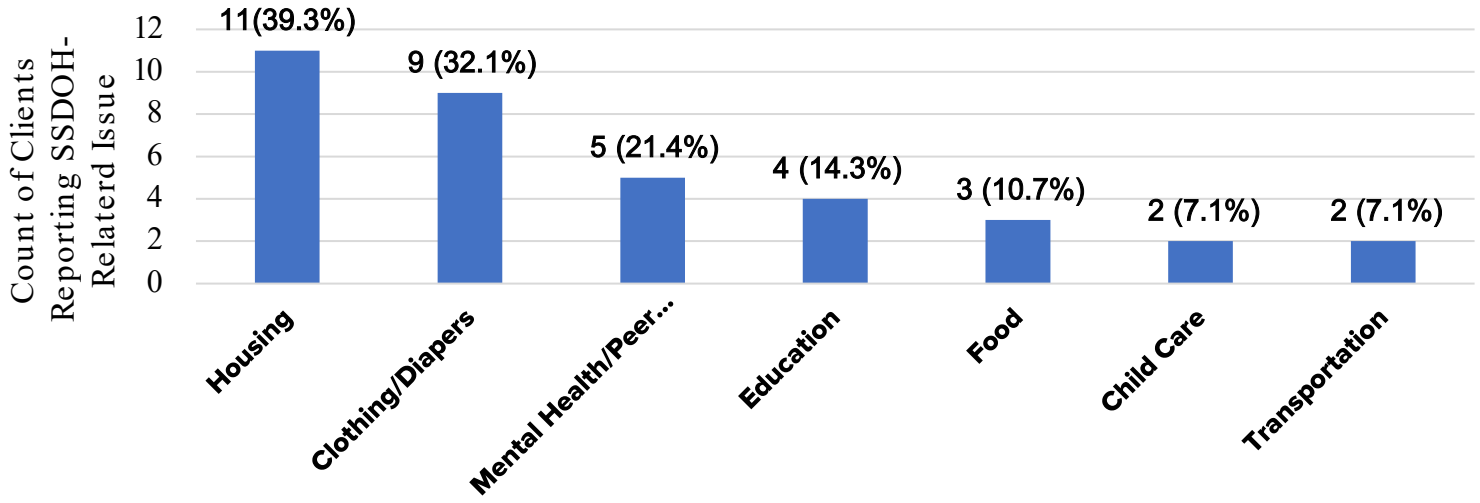
How Innovation Impacted Client Engagement w/MIECHV

- Despite the small number, **all six clients were retained in their respective programs** for at least three months.
- Almost all of the clients referred from MIECHV programs to CHWs were reportedly retained for at least three months in MIECHV (26/27 = **96.3 percent**).
- Note that majority of MIECHV enrollees not involved with this project were also retained for at least three months (284/316 = **89.9 percent**).
- "The CHWs are an extension of us – there is teamwork…They have helped provide car seats to the families, [facilitating] lunch and learns, chat 'n chews." – MIECHV PAT Parent Educator

How Innovation Impacted Client Engagement w/CHWs

- **"Partnered Arrangement".** Specific CHWs and MIECHV home visitors work **together** to identify and refer clients that they serve, especially in similar geographies and/or communities.

- **SSDOH Needs of Referred Clients Addressed by CHWs.**



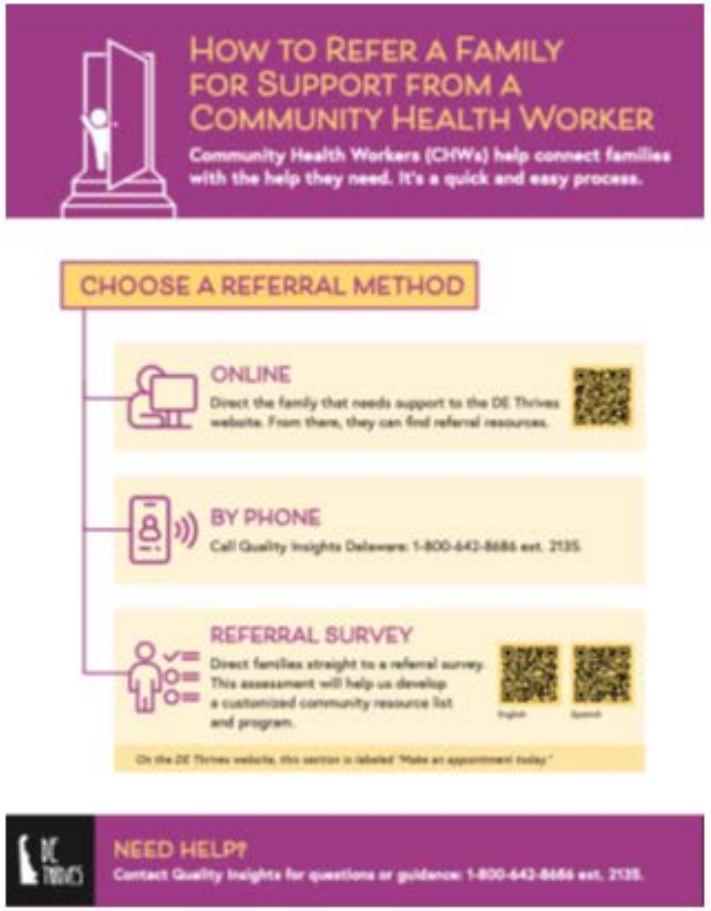
Innovation Sustainment in DE

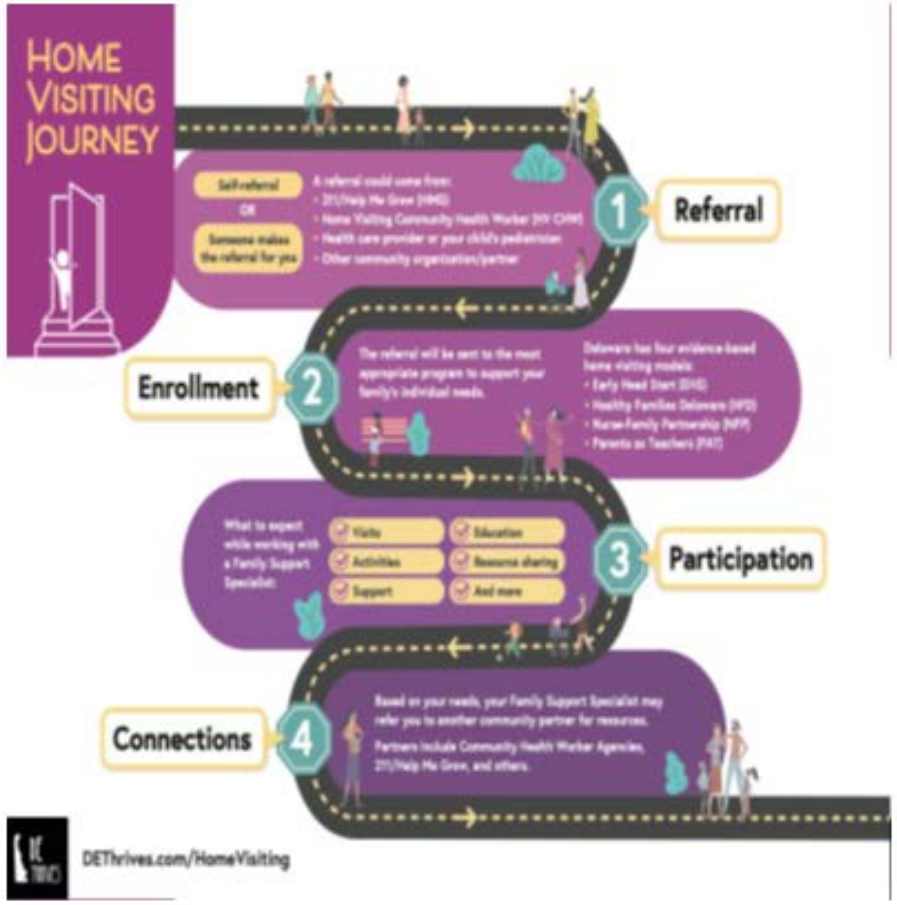
- **September 2025:** Some MIECHV LIAs have referenced their continued partnership w/CHWs.
  - Conduct referrals, assist with specific needs.
  - Especially true in more urban areas within the state.

- Other MIECHV LIAs have reported decreases in referrals/communication with CHWs.
  - Revisit the innovation/use of dyads.
  - Demonstrate "what good looks like" when working with CHWs.

Check Out Our Website!

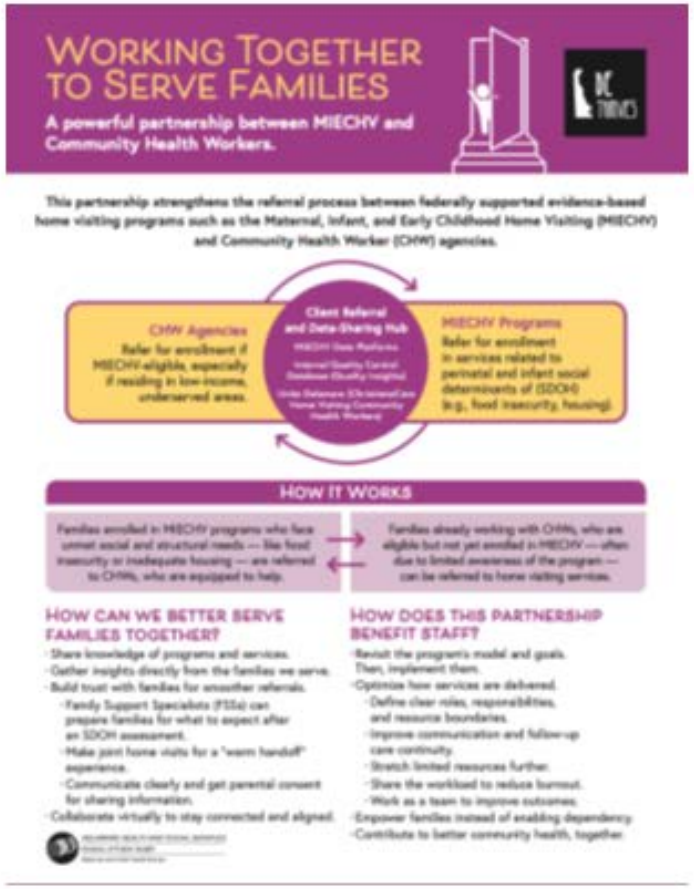
https://materials.dethrives.com/toolkits/home-visiting-chw





Check Out Our Website ! 2

https://materials.dethrives.com/toolkits/home-visiting-chw



West Virginia Innovation

MIECHV Innovation

Overview

West Virginia Connections, a web-based search and referral platform, was created in partnership with findhelp..

Purpose

Facilitated family-guided support services, tracking, and closed-loop referrals for home visitation programs and key partners

Key Features

Ensured privacy, security, and interoperability in data sharing.

Innovation Results

HMG Hub Role: Central hub for home visitation referrals in West Virginia.

Streamlined Process: One access point for assessments and referrals.

Family Support: Assists families in navigating services efficiently and effectively.

Impact on Incoming HV Referrals

Year	Total Referrals to HMG	In-Home Visitation Accepted	West Virginia Connections Link Accepted	Referrals received through findhelp©
2023	144	8	44	74
2024	352	37	193	226
2025 (to Aug.)	529	35	126	397

Key Effect: This innovation centralized referral access, making it easier for families and partners to send referrals to Local Implementing Agencies (LIAs). As a result, the visibility and accessibility of HV services improved dramatically.

Key Outcomes

- Innovation enabled referrals to a broad network of providers meeting family/child needs in MIECHV.
- Home visitation staff gained skills and confidence using a closed-loop referral system.
- WV Connections became central to HMG growth, with most referrals now processed through the platform allowing for expansion of services and new staff.
- Strengthened communication between child welfare and MIECHV programs, fostering collaboration and shared referral discussions.

Factors Supporting Success

- **Pilot Experience**: County-level *findhelp* pilot (2021) provided valuable insights.
- **Strong Leadership**: Dedicated to operationalizing WV Connections, leveraging provider relationships.
- **Regional Engagement**: Home visiting leaders supported local implementation and system adoption.
- **Robust Training & Support**:
  - Multiple online and in-person training opportunities.
  - State-level point person: WV Connections expert, responsive, and collaborative.
- **Built-In Practice**: WV Connections integrated into training and home visiting practice expectations.

Impact on Outgoing Referrals

Closed-Loop Referrals

WV Connections allowed HV providers to send referrals out digitally and receive confirmation that families connected with those services.

Range of Services

Referrals extended beyond HV to food, housing, health, education, legal, and child/teen resources—expanding HV's role as a connector.

Efficiency

Automated processes reduced referral "loss" (no wrong door). LIAs were able to route families more quickly to early intervention and other family support systems.

Result

Improved collaboration between HV LIAs and early childhood systems through a shared platform

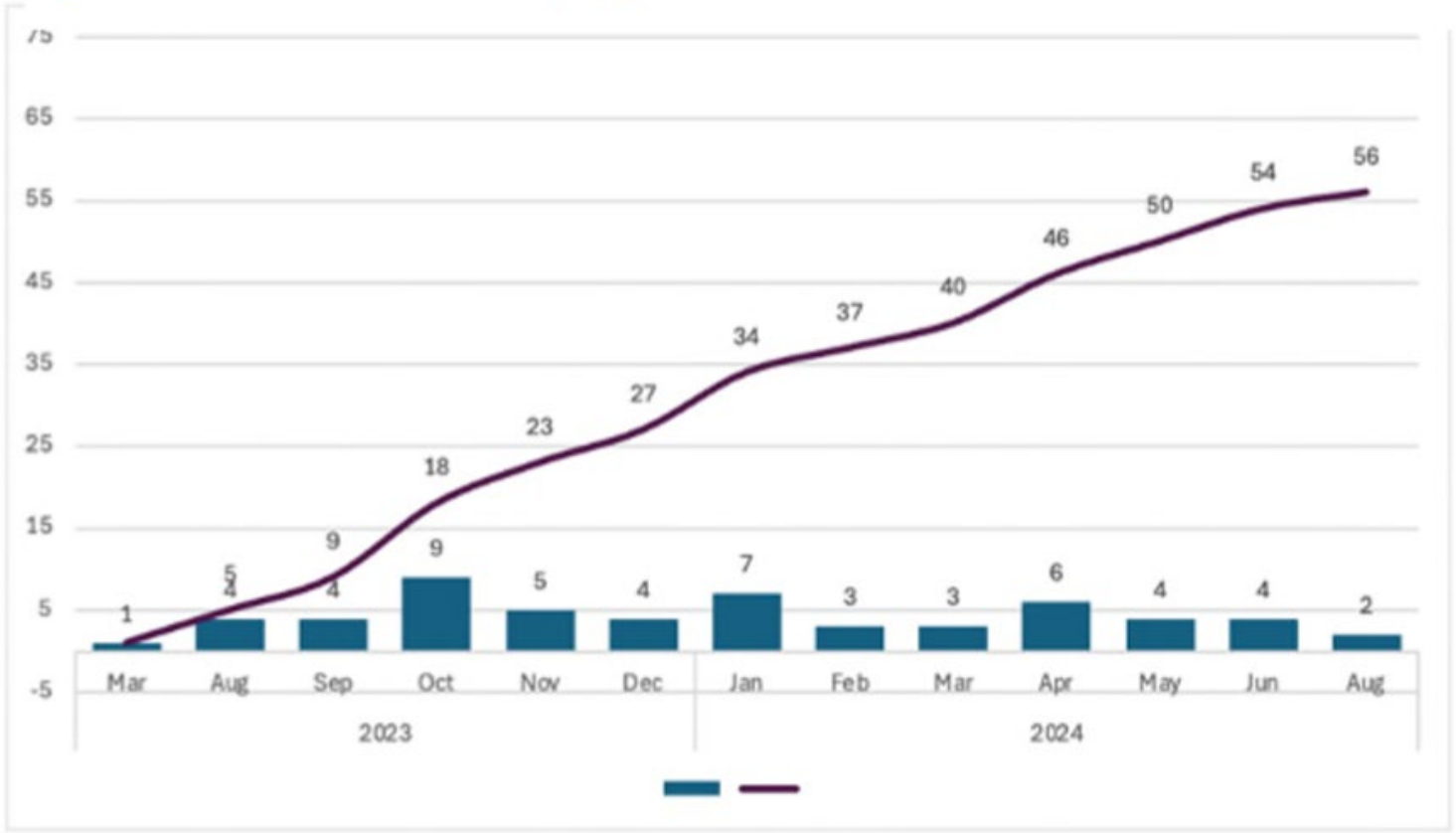
Outreach Activities and People Reached

Figure 5: Number of Outreach Activities and People Reached

Year	Month	Number of Outreach Events	# Attendees
2023	Aug	3	29.0
	Sep	9	415.0
	Oct	2	18.0
	Nov	7	108.0
	Dec	5	200.0
2024	Jan	5	117.0
	Feb	5	170.0
	Mar	10	284.0
	Apr	4	90.0
	May	7	191.0
	Jun	4	108.0
	Jul	7	357.0
	Aug	8	137.0
Grand Total		**76**	**2,224.0**

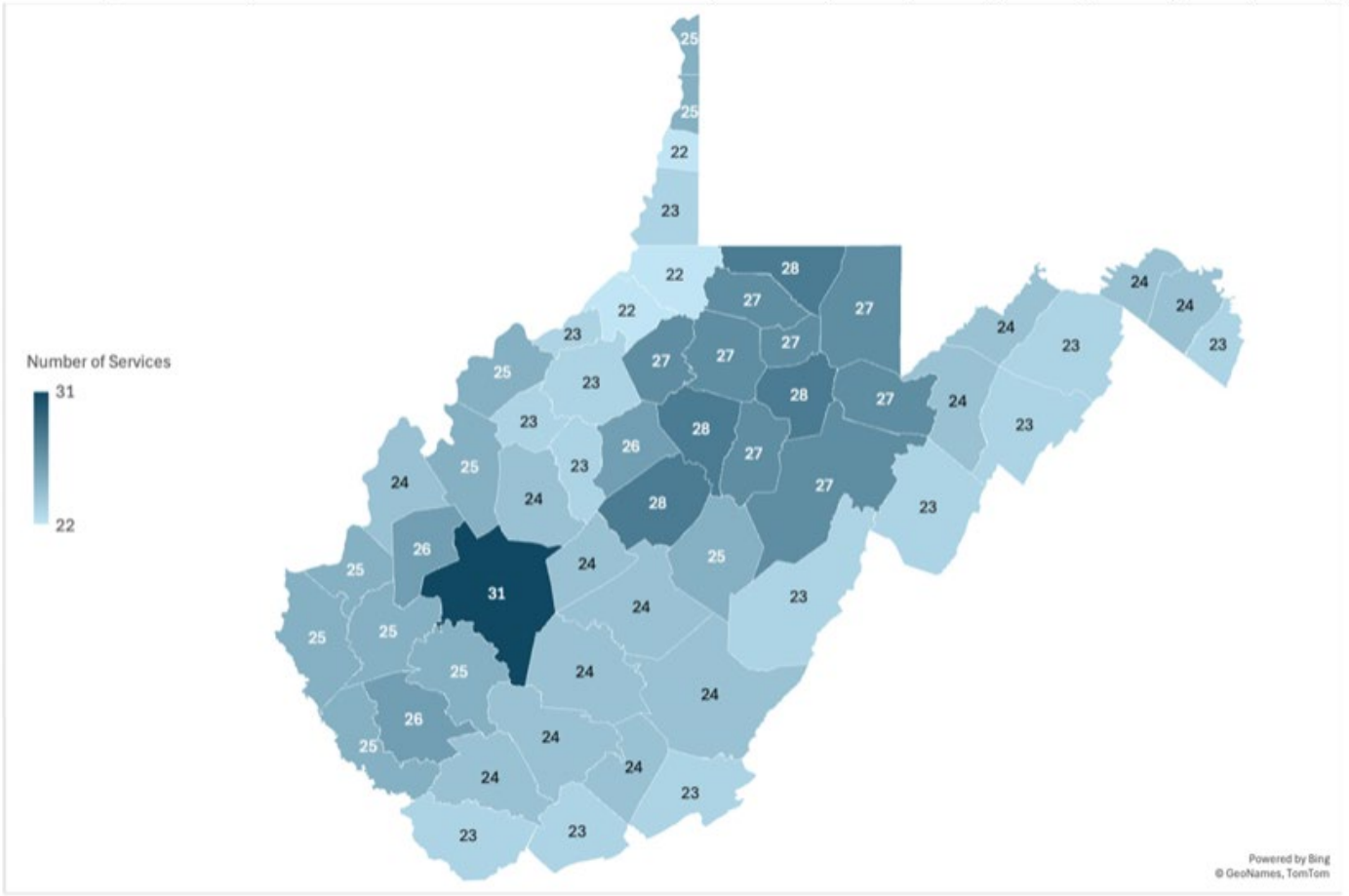
Services Claimed by Key Partners

Figure 3: Services Claimed by Key Partners



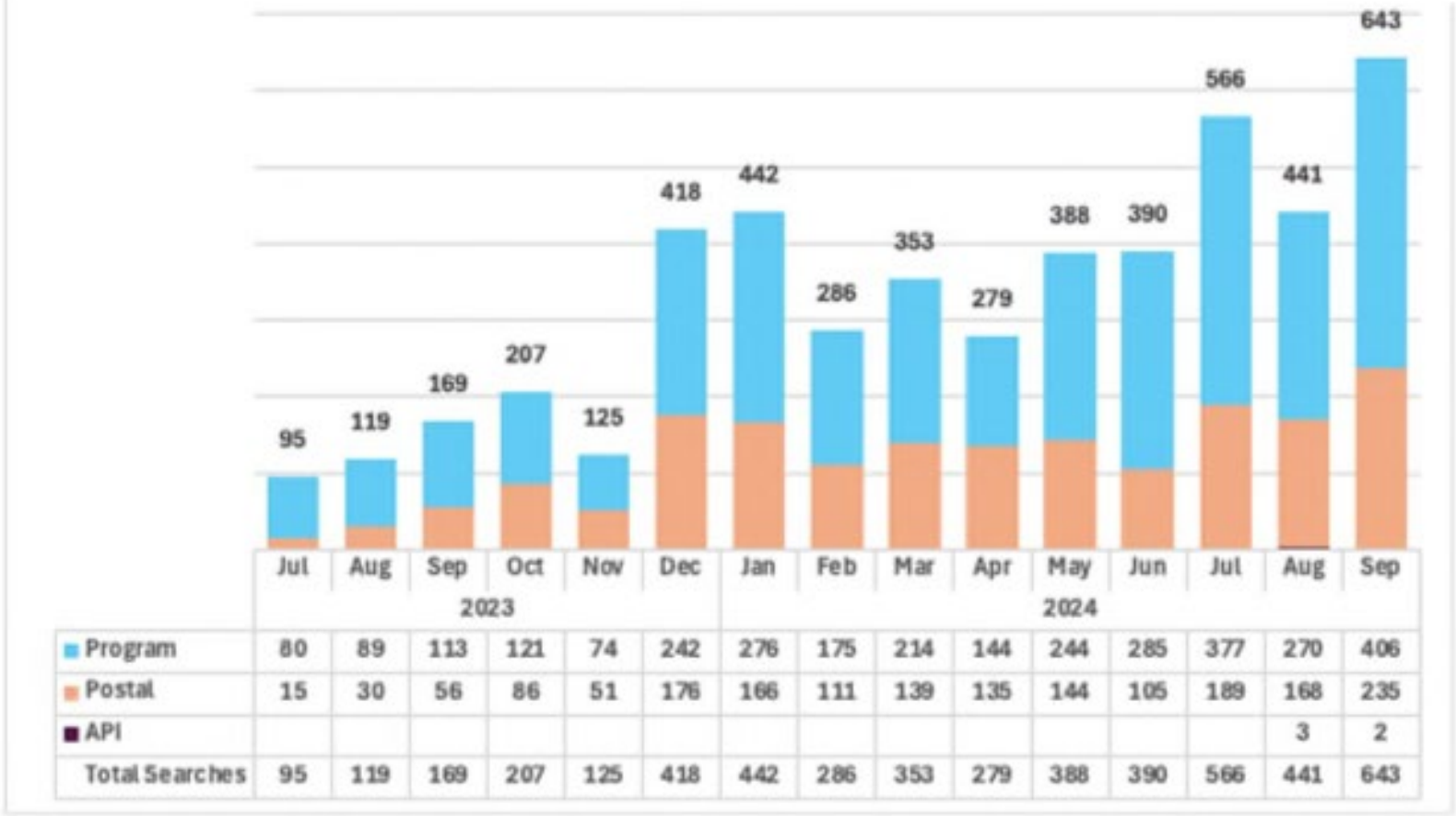
Available Services Added to WV Connections

Service Map 3: Number of Available Services added to WV Connections after March 1, 2023 by County (Including those offered by State Agencies)



WV Connections Searches

Figure 7: WV Connections Searches per Month



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	2023						2024								
Program	80	89	113	121	74	242	276	175	214	144	244	285	377	270	406
Postal	15	30	56	86	51	176	166	111	139	135	144	105	189	168	235
API														3	2
Total Searches	95	119	169	207	125	418	442	286	353	279	388	390	566	441	643

Client Engagement Impact - Referred Services

Feedback Loops

WV Connections tracks referral outcomes to support HV re-engagement efforts.

Family-Centered Access

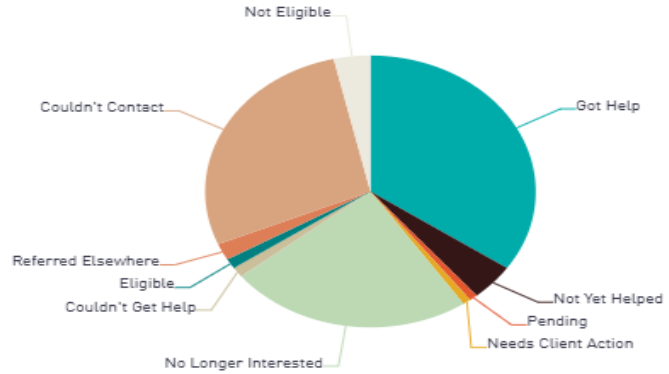
Families could directly search and self-navigate, increasing ownership of their referral process.

Outcome

Clients were more likely to follow through with services (e.g., early intervention, food support, housing), since the system reduced barriers and gave real-time information to HV staff and families.

Seekers and Referrals

Current Referral Statuses | 2023-08-01 to 2024-09-30



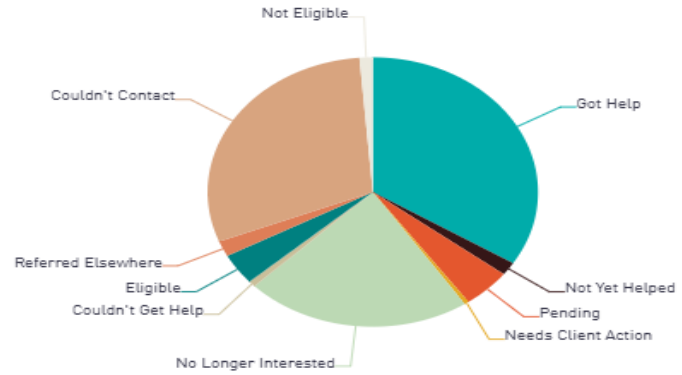
241
Referrals with Responses | 2023-08-01 to 2024-09-30

234
Closed Loop Referrals | 2023-08-01 to 2024-09-30

238
Seekers Referred | 2023-08-01 to 2024-09-30

83
Seekers that Got Help | 2023-08-01 to 2024-09-30

Current Referral Statuses | 2023-08-01 to 2025-08-31



686
Referrals with Responses | 2023-08-01 to 2025-08-31

624
Closed Loop Referrals | 2023-08-01 to 2025-08-31

679
Seekers Referred | 2023-08-01 to 2025-08-31

229
Seekers that Got Help | 2023-08-01 to 2025-08-31

Impact on Client Engagement in HV

Strengthened Partnerships

As LIAs became more integrated with other systems via WV Connections, community partners were more likely to refer to HV and see HV as part of the larger coordinated system.

Trust & Visibility

When families experienced successful connections through WV Connections, it increased their trust in HV staff as effective navigators.

Retention

Families who received holistic support (social determinants + child development services) were more likely to stay engaged with HV programs.

Result

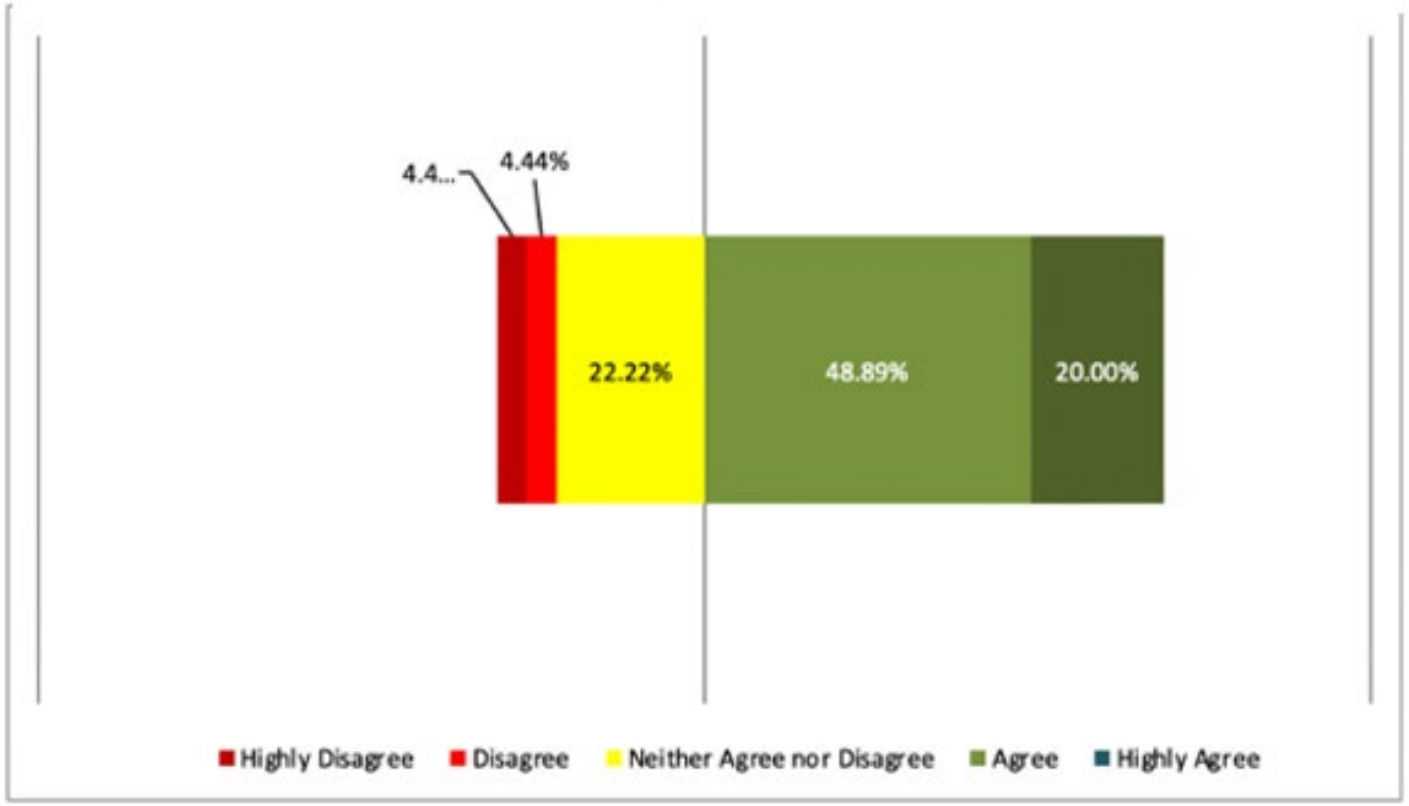
Improved engagement and retention in HV, as the innovation positioned HV not only as a service provider but as a hub for family connections.

Partner Readiness Survey

Statement	Highly Disagree	Disagree	Neutral	Agree	Highly Agree
West Viriginia Connections is a needed resource in our community.	3 (2.9%)	2 (1.9%)	9 (8.7%)	28 (27.2%)	61 (59.2%)
West Virginia Connections will streamline my ability to search for and identify available services or resources in our community.	3 (2.9%)	4 (3.9%)	6 (5.8%)	39 (37.9%)	51 (49.5%)
West Virginia Connections will improve my ability to coordinate the provision of client services with other agencies or organizations.	2 (1.9%)	6 (5.8%)	6 (5.8%)	38 (36.9%)	51 (49.5%)
Using West Virginia Connections will NOT be a duplication of work for me or our agency's staff.	9 (8.8%)	16 (15.7%)	39 (38.2%)	26 (25.5%)	12 (11.8%)

WV Connections Caregiver Survey

Figure 9: WV Connections will Empower Me as a Caregiver



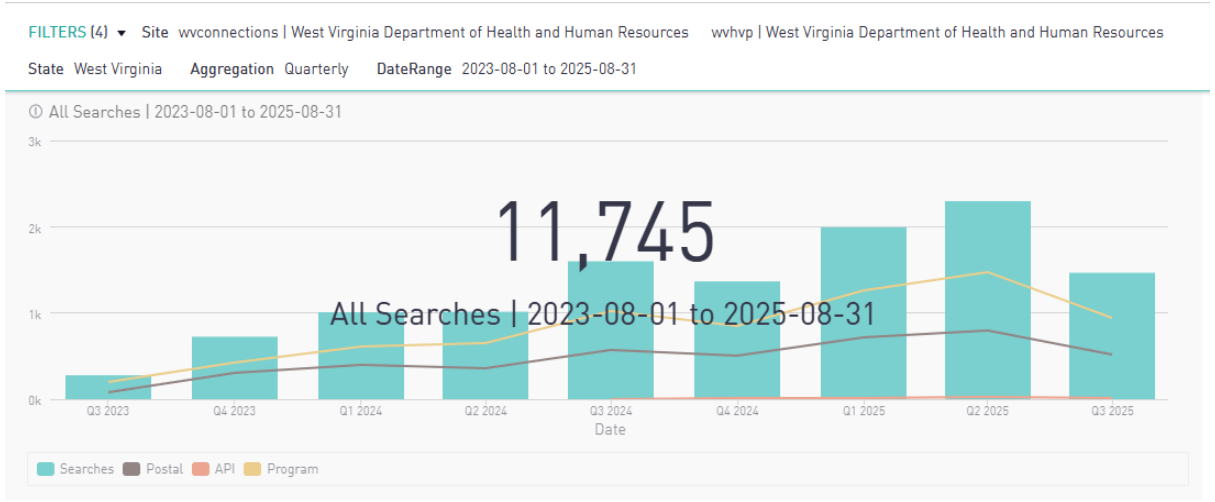
WV Connections Site Analytics

159

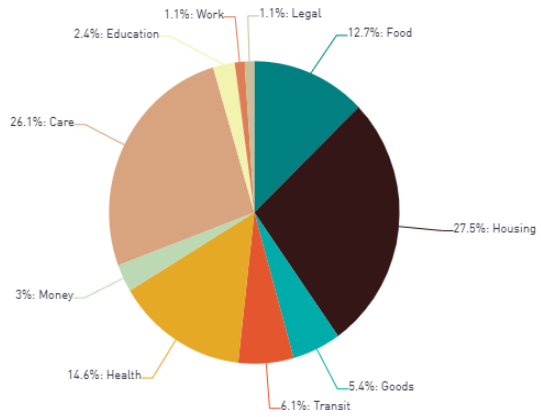
Distinct Identified Users

3,608

Distinct Anonymous Users



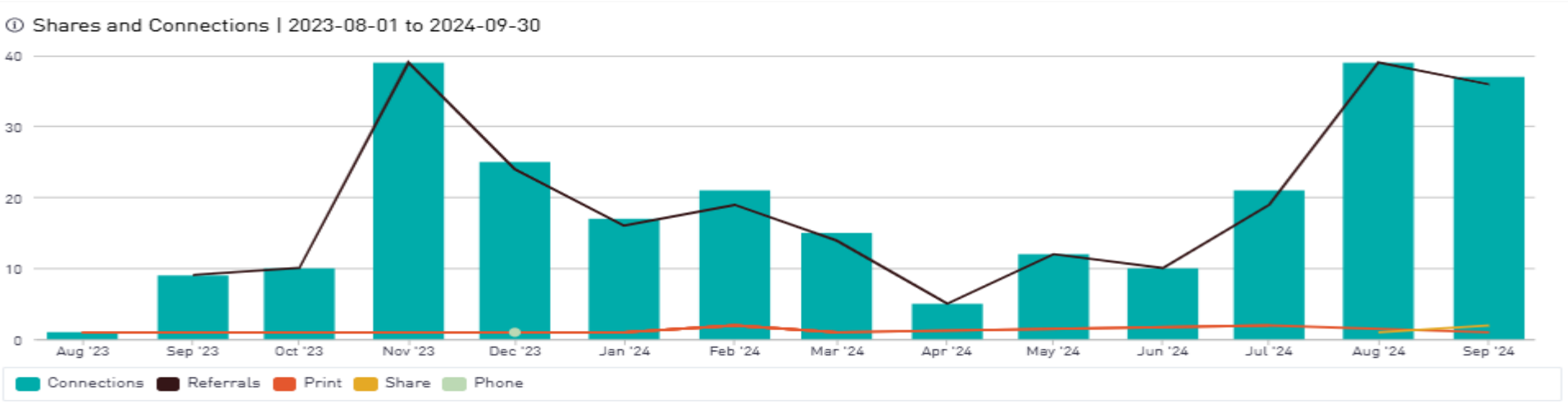
Searches by Category | 2023-08-01 to 2025-08-31

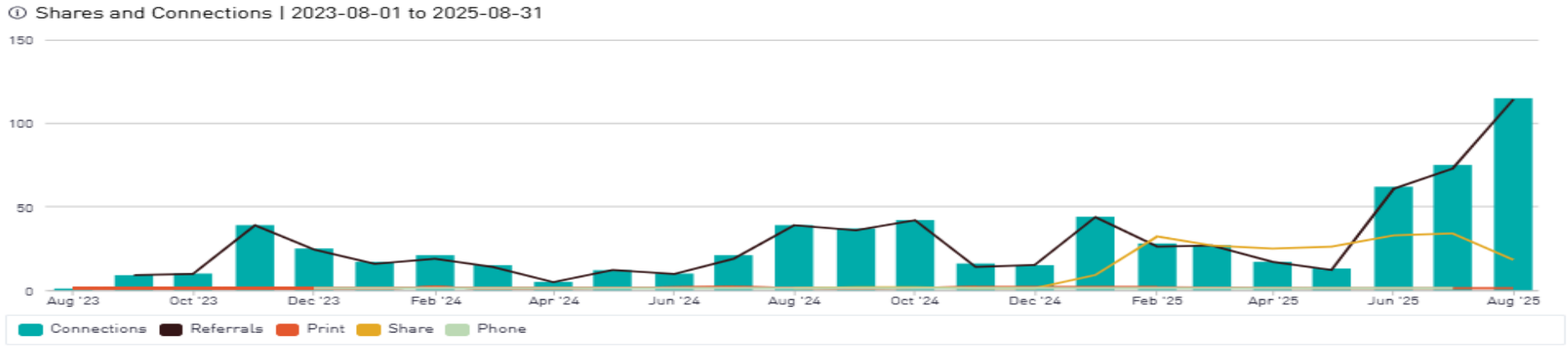


Most Common Search Terms | 2023-08-01 to 2025-08-31

TERM	DOMAIN	SEARCHES
help me grow	care	748
housing	housing	493
home visiting program		323
utilities	housing	229
family support centers		189
transportation	transit	182
food pantries	food	154
mental health	health	135
parenting education	health	133
food pantry	food	119
early intervention	care	112
childcare	care	94
children with special health care needs		93
diapers & formula	goods	87
food	food	69

Shares and Connections





Innovation Sustainment in WV

Secured Funding

Contract with *findhelp* extended → WV Connections continues beyond project.

Centralized Access Point

WV Connections remains core to HMG, supporting Navigators' outreach.

Partner Engagement

Encourage card claiming, information updates, and referral flow.

Visibility & Outreach

Showcase at conferences, collaboratives, community meetings, and through marketing (QR code + link).

Family Empowerment

Staff assist families to navigate WV Connections independently.

Reproducible Results

Proven Impact

- Significant increase in referrals and families connected.
- Documented processes + six-cohort implementation = measurable growth.

Continuous Improvement

Learned from early challenges → refined reporting, improved reproducibility.

Transparency & Flexibility

Open discussions shaped priorities for the future.

Future Confidence

Robust training, outreach, and lessons learned support continued investment.

Replication Potential

WV Connections model can be successfully reproduced elsewhere.

Common Themes & Conclusions

Conclusions

- Focus on Care Coordination **increases referral traffic**
- Referral improvement may need to be **intentional** (incoming vs outgoing)
- Innovation **champions** appear to be key (e.g., OK liaisons, DE CHWs, WV Connections Expert & HV leaders)
- Importance of **training**
- Importance of **partner interactions** (OK learning sessions, DE virtual & in-person sessions, WV community meetings)

Future Directions

- Sustainment efforts
- Better data tracking (e.g., timing info is key)
- Replication & expansion
  - Final reports and kits available from awardees

Question & Answer Discussion