

Vermont Coordinated Intake and Referral (CIR) Systems Study:

Phase I Findings Report: Final

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Mathematica's mission focuses on using evidence to improve public well-being and drive meaningful change. The opportunity to explore, understand, and summarize key features of Vermont's current early childhood system has given our team incredible insight into the people, structures, and policies that work to help every child and family in Vermont thrive. It is our privilege to share what we learned with a broader audience.

This report benefitted from the input of many voices. The authors wish to thank the Vermont Department of Health, especially Dr. Emily Smith, for a collaborative, engaging partnership and for helping ensure the success of this project. We also offer our deep appreciation for the input of those who participated in study activities, sharing their experiences, perspectives, lessons, and hopes about their important work in the early childhood system with us. We are humbled by the generosity of your time and candor and hope we have done justice to the lessons you shared with us.

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The work of systems change is both exciting and challenging. Our team has learned so much from the opportunity to engage with key partners in Vermont's early childhood system. We hope this report provides a strong foundation to continue the invaluable work of strengthening the system that helps Vermont's children and families thrive.

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Acronyms

ACF	Administration for Children and Families
AHS	Agency of Human Services
AMCHP	Association of Maternal & Child Health Programs
AOE	Agency of Education
ASQ	Ages and Stages Questionnaire Online
BBF	Building Bright Futures
CAAs	Community action agencies
CCDBG	Office of Child Care Child Care and Development Block Grant Program
CCFAP	Child Care Financial Assistance Program
CCR	Child Care Resource
CDD	Child Development Division
CIR	Coordinated Intake and Referral
CIS	Children’s Integrated Services
DCF	Department for Children and Families
DMH	Department of Mental Health
DULCE	Developmental Understanding Legal Collaboration for Everyone
DVHA	Department of Vermont Health Access
ECFMH	Early Childhood and Family Mental Health
ECICT	Early Childhood Interagency Coordination Team
EI	Early Intervention
ESD	Economic Services Division
FCH	Division of Family and Child Health
FSD	Family Services Division
HHS	U.S. Department of Health and Human Services
HMG	Help Me Grow
HRSA	Health Resources & Services Administration
HSCO	Head Start Collaboration Office
IDEA	Individuals with Disabilities Education Act
MCHB	Maternal and Child Health Bureau

Acronyms

MECSH®	Maternal Early Childhood Sustained Home-Visiting
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MMHSUD	Screening and Treatment for Maternal Mental Health and Substance Use Disorders Program
OCC	Office of Child Care
OEO	Office of Economic Opportunity
OFA	Office of Family Assistance
OHS	Office of Head Start
PAT®	Parents as Teachers
PCC	Parent Child Center
PDG B-5	Preschool Development Grant Birth Through Five Grant Program
Perinatal CARES	Perinatal Consultation, Access, Referral, Education & Screening
PMADs	Perinatal mood and anxiety disorders
RQ	Research question
SAC	State Advisory Council
SCC	Specialized Child Care
SFVT	Strong Families Vermont Home Visiting
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Aid for Needy Families
UPK	Universal Prekindergarten Education, within AOE, Act 166
UVMCMC	University of Vermont Medical Center
UW-HMG	Help Me Grow Vermont
UWsVT	United Ways of Vermont
VCHIP	Vermont Child Health Improvement Program
VDH	Vermont Department of Health
VNAVt	Visiting Nurses Association of Vermont
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WSCC	Whole School, Whole Community, Whole Child model

Executive Summary

Inspired by the goals outlined in Vermont’s Early Childhood Strategic Plan, the Vermont Department of Health contracted Mathematica to conduct a six-month study of Vermont’s early childhood system of intake and referral. The study was designed to respond directly to statewide recommendations by examining the landscape of these systems and offering data-driven recommendations for feasible, efficient, family-centered, and integrated approaches.

This report describes the study’s qualitative design and methods, presents findings about Vermont’s current intake and referral system—including mapping the current intake and referral landscape, understanding family and provider experiences, and identifying current system-level barriers and promising practices—and shares actionable recommendations for building a more integrated and coordinated intake and referral model statewide that is in alignment with national standards and the Early Childhood Strategic Plan’s goals.

The study team reviewed and analyzed over 40 policy, strategy, and operational documents and 3 recent family needs assessments, and facilitated discussions with more than 55 key actors in the system, including state agency staff, service providers, non-profit partners, and healthcare representatives.

Mapping Vermont’s intake and referral system

- **Vermont’s early childhood system is comprised of both state agency actors and non-profit organizations, and is also supported by partners in the health care system.** The state-funded services in the system are also sometimes supported by braiding federal funding streams. There are a wide range of referral sources into the system, including formal sources like medical providers and educators to informal sources such as playgroups and personal contacts.
- **Children’s Integrated Services (CIS) was designed to allow Coordinators to centralize some state-funded early childhood services within designated regions.** This design reflects Vermont’s commitment to local control, and allows regions to structure CIS leadership and supporting staff in unique ways, depending on the needs of the Fiscal Agency operating the CIS office. While cross-agency collaboration occurs routinely within regions, it occurs less frequently at the statewide level. However, CIS coordinators are required to collect consistent intake and referral data for semiannual reporting to the state. CIS was built under the assumption that such infrastructure—including the One Plan case management document—would be consistently used and shared across the system.
- **Although ideally referrals are made directly to a CIS Coordinator as a regional, centralized access point, CIS emphasizes a No Wrong Door approach, enabling clients to enter the system of care through different paths.** When a referral comes through a CIS Coordinator, the client must give authorization to the Referral and Intake Team to share outcome information instead of giving it to a single agency.
- **In 2014, the state brought in United Ways Help Me Grow (UW-HMG) to serve as a centralized, statewide access point for connecting families and professionals to services and supports.** Because UW-HMG partners with Vermont 211, staff are able to provide families and providers with

information about a broad range of community human services in addition to the state's early childhood services.

Understanding family and provider experiences

What we learned about families

- **Generally, families were satisfied with the intake and referral process.** Relationships with staff and providers, communication, timeliness of services, and close distance to services were identified as supporting families' ability to connect with resources. **However, families face multiple challenges along the way**, such as finding it difficult to (1) identify the services they need, (2) access some services due to availability or cost, and (3) complete paperwork or communicate with service providers.
- **There were mixed results on the extent to which the current intake and referral system reflects family-centered, equitable, and culturally responsive practices.** While discrimination and stigma were noted as key challenges in navigating and engaging with the system, a 2022 Family Needs Assessment also found that over 80 percent of respondents agreed that their family's culture and values were understood and respected by CIS providers.

What we learned about providers

- **Building warm, trusting relationships with the families they serve is critical to success.** This can look like providing personal warm hand-offs to other providers, rather than just providing another provider's contact information to a family.
- **There are inconsistencies in how providers refer families to services.** Providers do not always know where to refer, or they prefer to refer directly to a service rather than through a referral hub. **In such a complex system, even providers can struggle to understand all the services available to families.** Interviewees said there can sometimes be an unreliable loop closure between service referral and service receipt.

System-level barriers and duplication

Complexities with CIS

- **CIS is designed to allow for flexibility of referrals (through a No Wrong Door policy), but is also complex.** When referrals do bypass CIS, it can take time for CIS to become aware, which impacts their ability to provide follow-up information to other providers. Guidance for CIS Coordinators can also sometimes result in a scarcity mindset, where CIS Coordinators said they were expected to (1) meet monthly case rates of families served and (2) receive at least 51 percent of referrals directly. Some referrers find the CIS referral form difficult to use.
- **CIS services are managed regionally, and quality and access varies** based on local implementation.
- **CIS regions share performance measures with the state, but the process lacks consistency.** Currently, CIS Coordinators collect intake and referral data manually in Excel spreadsheets designed by individual Coordinators, which makes it time-consuming for state staff to compile and summarize.

- **Hitting non-Medicaid caps can limit access to services.** CIS Fiscal Agents have specific allocations for non-Medicaid funds they can be reimbursed for in serving non-Medicaid clients. Once CIS Fiscal Agents hit non-Medicaid caps, they cannot keep being reimbursed for services offered. This results in offices feeling like they either cannot continue to offer services or they have to offer them for free if the service is required.

Challenges with UW-HMG

- **UW-HMG serves as a statewide central access point, but perceptions in the system have sometimes been skeptical.** Although UW-HMG staff noted that the role of HMG is “to drive families to our partners, not take them,” they feel that some CIS staff think of HMG as a competitor in reaching their referral targets.
- **Perceptions of and experiences with HMG remain mixed, often based on whether or not providers are already embedded in Vermont’s early childhood system.** For providers who are not deeply embedded in the system, HMG is an easy-to-use, trusted partner for referrals; however, for providers that are deeply embedded in the community, HMG feels like an offering that duplicates CIS.

System-wide barriers

- Organizations in the system often cannot share data, either easily or at all. Data are often restricted to within-agency or within-region sharing. Although interviewees acknowledged the importance and value of data protections for families, a lack of access to data makes it hard for providers to follow families in their care journey or to support shifts in care if families move regions or transition into school.
- The system has multiple procedural and regional borders that can be tricky to navigate, including both age-related eligibility cut-offs and geographic boundaries.
- Braided funding can sometimes introduce complexity for both providers and families. When a service relies on funds from different sources, intake requirements for each funding source might differ, leading to duplicative paperwork.
- Staffing retention and turnover affects both CIS and referring partners. When turnover occurs for partners who refer to CIS, it can mean those partners—such as hospital staff or pediatricians—do not know where to refer families. The system faces broader challenges around program awareness, and lack of shared understanding of common terms is a challenge.
- In high-pressure systems such as this, trust is more quickly lost than built. Across the system, one challenge that has slowed attempts to streamline is the inclination of system partners to quickly give up on imperfect pathways.
- **Several interviewees shared concerns about the feasibility and potential negative impact of coordinating too many services.** Interviewees pointed to failed efforts to establish data sharing agreements or data systems within Vermont as evidence that coordination is not easy.

Promising practices and lessons learned

- **Many of the people we interviewed acknowledged that the regional structure of CIS reflects Vermont’s values and commitment to local control.** Interviewees were near-unanimous in

endorsing this structure, saying it helps local providers center relationship-building, personal connections, and trust, both with families and other system partners. CIS's flexibility in supporting both a No Wrong Door policy and centralized regional coordination has allowed for personalization in navigating the system.

- **UW-HMG has supported streamlining the intake and referral process for those who use it.** Recent efforts taken in 2025 have allowed the UW-HMG team to collect all the necessary intake information CIS needs to process a referral. Some providers also reported that they had more consistent feedback loop closures about the family's referral when going through UW-HMG. Multiple interviewees mentioned UW-HMG's hosting of the Ages and Stages Questionnaire (ASQ) Online for providers and families to use for free as another benefit to avoid duplication in re-screening families.
- **Interagency collaboration has supported coordination, especially for complex care.** CIS Coordinators attend weekly interagency meetings with service providers to coordinate case management and care, which supports both care provision and provider relationships. A CIS consultation team also meets monthly to focus on systemic issues or, occasionally, unusually complex family cases. In both instances, these regular touchpoints with others in the system of care help providers and implementers continually focus on partnership and collaborative problem-solving.
- **Providers across the system noted that centering families is a key to success,** and identified useful strategies to support building relationships and trust, such as avoiding the use of jargon, helping families build the skills to advocate for themselves, and having translation services easily available.
- **For regions where CIS services are co-located within single organizations or buildings, interviewees noted benefits for both providers and families in ease of access and use.** Physical proximity results in greater convenience for both providers and families to engage with multiple services.
- **Organizations that have their own internal data system or data-sharing partnerships said this improved efficiency and coordination.**
- **Interviewees shared that CIS has a strong focus on training and professional development.**

Actionable recommendations

Recommendations from participants

Below, we summarize recommendations made by study participants in interviews and focus groups. We organize these recommendations by their expected impact on Vermont's current system of intake and referral as well as the level of effort (such as cost, time) that implementation would require.

1. Low priority: Low impact and high effort

a. *Note, we did not identify any recommendations in this category.*

2. Low-hanging fruit: Low impact and low effort

- Revise CIS and HMG intake forms
- Translate materials into more languages

- c. Create and implement a common CIS data template

3. Best bets: High impact and low effort

- a. Build coordination across the state
- b. Ensure stakeholder voices are heard in decisions about changes to the system
- c. Conduct ongoing statewide education and outreach to referral sources about available services

4. Moonshots: High impact and high effort

- a. Build a statewide shared data system
- b. Ensure Coordinator positions are full time and fairly compensated
- c. Consider the structure of regions and agencies to ensure more consistency in offered services
- d. Co-locate services when possible
- e. Create consistent, universal intake application and referral forms

Mathematica's recommendations

To move toward a more coordinated system, we recommend that Vermont:

- **Convene a cross-agency state task force with regional and family representation to make decisions about feasible and effective features of a coordinated system.**
- **Create and disseminate a unified framework for intake and referral** with consistent definitions and protocols across agencies and community partners to support uniform operationalization.
- **Ensure there is a centralized access point** so families and providers that are not yet connected can find services.
- **Support strong partnerships at the state and regional levels** through regular partner meetings that allow for bidirectional feedback.
- **Develop a more integrated data system** that supports standardized data collection and reporting practices. Plan for maintenance and the flexibility needed for sustainability.
- **Create a statewide governance structure overseeing interagency interaction and coordination** with clear oversight, role delineation, and transparent decision-making processes.
- **Develop a long-term, sustainable financing plan.**

The report outlines tiered options for transformation for different system features—from moderate alignment improvements to full systems integration—recognizing that more centralization is not always better and that Vermont's strong regional identity should be preserved where effective.

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I. Introduction

There is a growing national effort to strengthen early childhood services, prompted by a substantial body of research demonstrating the importance of high-quality services during early childhood.¹ Many different organizations, state agencies, and funders provide a range of services to families with low incomes who have children younger than 5. This variety of providers and funders means families must navigate a complex system of care with different requirements for eligibility, enrollment, and service provision, with services often provided in different physical locations and requiring unique sets of paperwork.² Furthermore, direct service providers and program staff sometimes face challenges coordinating their clients' care without ample communication channels, access to information about other services families are receiving, or data management systems to track families' progress.³

States and localities across the United States have explored strategies for better alignment of the early childhood service systems and programs for children and families.⁴ Some states have worked to apply centralized features to their systems, where a single point of entry manages intake, screening, referrals or other aspects of enrollment across multiple programs. Some states have also focused on supporting interagency collaboration while maintaining local or regional control of programming.

The State of Vermont is a unique environment in which "Vermont children have some of the best access to health care in the [United States] with 97 percent of children ages 0-17 having some type of health insurance," while the state simultaneously experiences "significant disparities in health, family and community indicators whereby publicly insured (Medicaid) children experience poorer outcomes than privately insured children."⁵ However, the state has committed to taking steps to reduce disparities, including disparities that affect children younger than age 5.

The Vermont Early Childhood Strategic Plan, informed by Vermont's 2020 Early Childhood Systems Needs Assessment, presents an action plan of changes needed to ensure all Vermont's children and families have access to high-quality services to meet their needs and are benefiting from a system that is integrated, well resourced, and informed by evidence.^{6,7,8} The plans emphasize the importance of coordination by taking a developmental approach centered on the relationships between the child, the family, the community, and the systems that, when well supported, equitable, and accessible, promote children's well-being. Aligned with the Vermont Department of Health (VDH) Whole School, Whole Community, Whole Child (WSCC) model, these plans reflect a comprehensive and collaborative vision of child development that integrates education, health, and family supports to address the whole child.⁹

A. The present study

Steps taken by the state to deepen coordination within the early childhood intake and referral system and to offer regional and state-level central access points (described in Chapter III) have had success as families report largely positive experiences, yet challenges and barriers to successful navigation of the system remain.¹⁰ A 2022 data brief published by the nonprofit organization Building Bright Futures' (BBF) Early Childhood and Data Center has shown that some families are still frustrated with the service gaps, silos, and duplicated efforts.¹¹

Inspired by the goals outlined in Vermont’s Early Childhood Strategic Plan, VDH contracted Mathematica to conduct a six-month study of Vermont’s early childhood system of intake and referral. The study was designed to respond directly to statewide recommendations by examining the landscape of these systems and offering data-driven recommendations for feasible, efficient, family-centered, and integrated approaches. Exhibit I.1 describes the study goals and research questions (RQs).

Exhibit I.1. Study goals and research questions

Study Goal 1: Mapping the intake and referral landscape

- **RQ1.** What agencies, roles, and referral pathways currently make up Vermont’s intake and referral systems for early childhood services? How do these systems operate across geographic regions and populations?
-

Study Goal 2: Understanding family and provider experiences

- **RQ2.** To what extent do current intake and referral systems reflect family-centered, equitable, and culturally responsive practices? How do families experience access to and navigation of the intake and referral systems? What barriers do they encounter? What challenges do providers experience when navigating or coordinating intake and referral services across agencies?
-

Study Goal 3: Identifying system-level barriers and duplication across entities responsible for family engagement, screening, intake, and referrals

- **RQ3.** What system-level barriers and inefficiencies exist in current intake and referral processes?
-

Study Goal 4: Identifying promising practices and infrastructure elements that support seamless coordination and access

- **RQ4.** What strategies or infrastructure elements are currently enabling effective coordination and access? What local innovations or cross-agency models could inform statewide scaling?
-

Study Goal 5: Developing a set of actionable recommendations for building a comprehensive, statewide coordinated intake and referral model aligned with the Early Childhood Strategic Plan

- **RQ5.** What improvements do providers recommend to enhance system integration and coordination? What are the most feasible and impactful opportunities for improving integration, equity, and efficiency across Vermont's intake and referral systems?
-

This report describes the study’s design and methods (Chapter II), presents findings about Vermont’s current intake and referral system that correspond with Study Goals 1 through 4 (Chapters III–VI), and shares actionable recommendations for building a more integrated, coordinated intake and referral model statewide that is in alignment with national standards and the Early Childhood Strategic Plan’s goals (Chapter VII, corresponding with Study Goal 5).

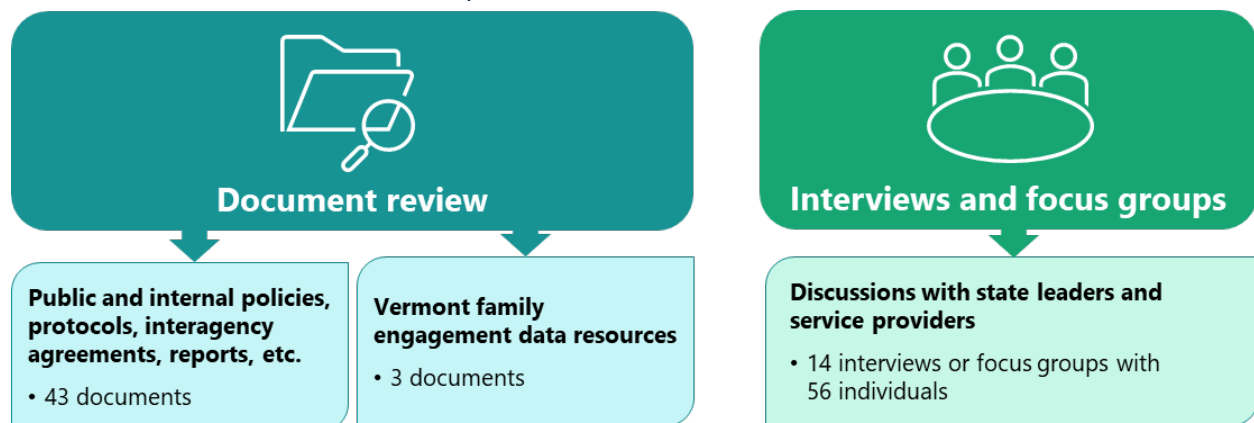
II. Study design and methods

This chapter describes the study's qualitative design and methods. To ensure a comprehensive understanding of Vermont's intake and referral systems and to capture the lived experiences of system partners, the study used complementary data collection methods. Data sources included:

1. Results of a comprehensive document review and additional review of documents on families to establish a baseline understanding of the intake and referral system (described in Section II.A).
2. Focus groups and interviews designed to dig deeper into understanding the experiences of system leaders and providers in the current system and elevate their recommendations for the future (described in Section II.B).

Exhibit II.1 summarizes the samples for the document review and qualitative data collection effort.

Exhibit II.1. Data sources and sample sizes



A. Document reviews

1. Document types

Our team conducted a comprehensive document review of relevant policies, protocols, forms, and interagency agreements. With support from VDH, we compiled a list of both public and internal documents and reviewed them to identify patterns, trends, challenges, equity considerations, and promising practices. After identifying 43 key documents, the team constructed an analysis template that allowed us to capture descriptions of key referral pathways, agency roles, and workflows of intake and referral, and to gather information that helped us understand systems-level barriers, demonstrations of promising practices, and indicators of feasibility for proposed changes in Vermont's system of early childhood care. A full list of the documents we reviewed is in Appendix A.

We also reviewed documents the State compiled in recent data collections with families. We intentionally built on recent family-centered data collection efforts in Vermont to inform this work, recognizing that many questions related to barriers and access to services have already been explored in depth. Rather than asking families to repeatedly share their experiences, we leveraged existing data sources to honor their time and ensure their perspectives continued to meaningfully shape this work. We

reviewed three key documents in lieu of conducting additional interviews and focus groups with families. This allowed us to incorporate family and provider experiences and voice into our final report. Two documents were reports providing findings and quotes from data collection with Vermont families about their experiences with early childhood services; one report (the Vermont Early Childhood Family Needs Assessment from 2022)¹ used a survey, and the other report (the BBF Network Engagement Summary from 2025) used pulse-check interactions and conversations. The third document was the qualitative coding appendix for the forthcoming VDH Division of Family and Child Health (FCH) Title V 2025 Needs Assessment, which included quotes and themes from focus groups with community members. Themes presented in Section IV.A are supported by conclusions made after reviewing these three documents.

2. Review process

Using information collected during the document review, we mapped systems and processes to visualize the current structure of intake and referral workflows, referral pathways, and interagency relationships. These maps highlight areas of duplication and fragmentation along with opportunities for alignment. A summary of the findings from these activities is in Chapter III.

We also conducted a gap analysis to help compare existing intake and referral practices to national best practices and prioritize areas of focus for qualitative data collection. For example, we referenced the [National Care Coordination Standards](#) put forth by the National Academy for State Health Policy to surface areas where services or responsibilities are under- or overrepresented. The analysis enabled us to find gaps in our understanding of Vermont's intake and referral system and helped us develop qualitative protocols to address those gaps.

Finally, we analyzed themes and direct quotes from the family assessment document review to synthesize findings about family experiences for this report.

B. Qualitative data collection

In fall 2025, we conducted focus groups and interviews with key partners in the system to understand their experiences. We partnered with FCH to help identify and recruit potential interviewees.² To capture rich data, we held semi-structured discussions with key partners and stakeholders. Due to the short timeline of the study and the depth and quality of Vermont's needs assessment data, we did not conduct focus groups with families. A summary of the partners who participated in the focus groups and interviews is in Exhibit II.2.

We analyzed the interview and focus group data to reveal themes across our research questions (Exhibit I.1), including themes that would inform our recommendations. We used [NVivo](#) Version 12 qualitative data analysis software to code and categorize data according to the research questions, which enabled the thematic analyses. In addition to highlighting key themes across all research questions, the

¹ We did not include the more recent (2024) Vermont Early Childhood Family Needs Assessment in this document review for the family analysis because it used a meta-analysis, rather than primary data collection, as its approach.

² Throughout the report, we use the term "interviewee" to refer to participants of the study's qualitative data collection.

qualitative analysis also helped us refine our mapping of the intake and referral system, revealing additional areas of duplication or fragmentation and opportunities for stronger alignment.

Exhibit II.2. Agencies or organizations included in focus groups and interviews

Agency or organization	
Agency of Education (AOE)	
Agency of Human Services (AHS), Department for Children and Families (DCF), Child Development Division (CDD)	
AHS Department of Mental Health (DMH)	
AOE, Act 166 Universal Prekindergarten Education (UPK)	
Building Bright Futures (BBF) ^a	
Children’s Integrated Services (CIS)—State Team and regional Coordinators	
Community hospitals/health centers	
Developmental Understanding Legal Collaboration for Everyone (DULCE)	
Head Start, Early Head Start	
Help Me Grow/Vermont211	
Perinatal Consultation, Access, Referral, Education & Screening (Perinatal CARES)	
Vermont Child Health Improvement Program (VCHIP)	
Vermont Department of Health (VDH), Division of Family and Child Health (FCH)	
Vermont Parent Child Center (PCC) Network	
Total interviewees	N = 56

Note: Information from many interested parties was collected during the Child Outcomes Accountability Team committee meeting with people employed outside of Building Bright Futures.

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III. Study Goal 1: Mapping Vermont’s intake and referral landscape for early childhood services

In this chapter, we document key components of the current intake and referral system for early childhood services. In Section A, we outline and map key actors in the state and its partnering agencies, and in Section B, we describe how these partners operate and collaborate, including a discussion of their funding sources. Finally, in Section C, we outline current referral pathways for Vermont’s early childhood services.

A. Mapping the system

In the State of Vermont, more than a dozen key government agencies oversee early childhood services, working with partners that support children and families in adjacent sectors such as education. Exhibit III.1 describes some of these key system actors and the services they offer in the State.

Exhibit III.1. Glossary of key state agency actors in Vermont’s early childhood service system

Agency of Education (AOE). AOE oversees and implements state and federal laws, policies, and regulations to “ensure all Vermont learners have equitable access to high-quality learning opportunities, including Universal Pre-K and Early Childhood Special Education.”¹²

Agency of Human Services (AHS). AHS is the umbrella organization for all human service activities in the state government.¹³ AHS holds an interagency agreement with AOE to administer the Individuals with Disabilities Education Act (IDEA) Part C.¹⁴

Department of Mental Health (DMH). One of the six departments in AHS, DMH’s mission is “to promote mental health as a vital part of overall well-being by advancing prevention, early intervention, and recovery-focused care.”¹⁵ DMH oversees publicly funded, community-based, and inpatient [mental health] services to Vermont residents, including children and adolescents.¹⁶

Department of Vermont Health Access (DVHA). One of the six departments in AHS, DVHA’s mission is to “improve overall access, quality, and affordability of health care, and to assist Medicaid members in Vermont.”¹⁷

Vermont Department of Health (VDH), Division of Family and Child Health (FCH). Another of the six departments in AHS, VDH has a vision that “all people and communities in Vermont have equitable opportunities to achieve their highest level of health and well-being.”¹⁸ Within VDH, the FCH division is one of 11 divisions and offices providing programs and services.¹⁹ Specifically, FCH oversees Strong Families Vermont Home Visiting (via a bundled agreement with Children’s Integrated Services; Perinatal Consultation, Access, Referral, Education & Screening; Help Me Grow Vermont; Developmental Understanding Legal Collaboration for Everyone; Special Supplemental Nutrition Program for Women, Infants and Children; doula services; the maternal mortality review; and maternal health innovation grants). We describe the most relevant of these programs next.

Developmental Understanding Legal Collaboration for Everyone (DULCE). DULCE funds six Parent Child Centers (PCCs) across Vermont to implement a universal program promoting the healthy development of infants and providing support to caregivers during the critical first six months of their child’s life, particularly caregivers and children who are eligible for Medicaid, the Children’s Health Insurance Program (CHIP), or are uninsured.²⁰ DULCE family specialists at local PCCs work at eight pediatric and family medicine practices as part of the newborn care team at no cost to families.²¹

Perinatal Consultation, Access, Referral, Education & Screening (Perinatal CARES). Perinatal CARES provides clinical consultation on the diagnosis, treatment, and pharmaceutical management of perinatal mood and anxiety disorders (PMADs) for postpartum individuals.²²

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Vermont WIC is a nutrition program for pregnant and recently pregnant individuals; infants; and children up to age 5. WIC has many cross-division and within-VDH collaborations with Help Me Grow, Strong Families Vermont Home Visiting, and others.²³

Department for Children and Families (DCF), Child Development Division (CDD). One of six departments in AHS, DCF's mission is to "to foster the healthy development, safety, well-being, and self-sufficiency of Vermonters." Within DCF, CDD is one of six departments, it is built to ensure equitable access to quality child care and development services.²⁴

Head Start Collaboration Office (HSCO). Housed within CDD, Vermont's HSCO is funded by the federal Office of Head Start (OHS) and was built to serve as a voice for Head Start in state government.²⁵ The HSCO works closely with state and local Head Start and Early Head Start recipients who serve low-income children and families.

Child Care Financial Assistance Program (CCFAP). The CCFAP—operating within DCF—helps income-eligible families in Vermont pay for regulated child care.²⁶ CCFAP is an integrated service with the SCC program in CIS, meaning that families eligible for any of the three SCC services are typically eligible for CCFAP.²⁷

Children's Integrated Services (CIS). CIS offers a continuum of services to help ensure the healthy development and well-being of children, pre-birth to age 5.²⁸ CIS is organized at the regional level under 13 AHS-designated regions, with each having its own **CIS Coordinator** who serves as a point of contact to families receiving services.²⁹ CIS Coordinators are responsible for collecting and submitting required client encounter data, performance measure data, and narrative reports; monitoring CIS clients served within the region; knowing parent education resources across the community; and serving as a liaison between CIS teams. We describe the continuum of CIS services next.

Early Intervention (CIS-EI). The only service that sits exclusively within CIS, EI services are universally available to families whose children ages birth to 3 experience a developmental delay or have diagnosed conditions that have a high probability of resulting in delays.³⁰ Because CIS-EI is federally mandated (through [IDEA Part C](#)), cases are to be addressed within a 45-day window in accordance with State of Vermont Special Education Rules (§2360.5.4).

Strong Families Vermont Home Visiting (SFVT). SFVT serves (1) families during pregnancy and (2) parents with young children from birth to age 6, answering their questions or concerns about parenting or offering short-term support. Nurse home visitors work with families with children pre-birth to age 2, helping them address needs related to pregnancy or the period soon after birth, such as nutrition and early learning (using the Maternal Early Childhood Sustained Home-Visiting® model; [MECSH](#)). Family support home visitors work with families with children up to age 6 who need support developing parenting skills, accessing community supports, and assessing children's school readiness (using the Parents as Teachers® model; [PAT](#)).³¹ Both programs are funded outside of the CIS bundled service case rate but are delivered as part of the SFVT Home Visiting continuum within CIS.

Specialized Child Care (SCC). SCC provides vulnerable children and families with subsidized quality child care and supports to promote their child's development. SCC serves children and families with open cases in DCF's Family Services Division (Protective Services Child Care), families experiencing significant stress (Family Support Child Care), and children with special needs (Child with Special Health Needs Child Care).³²

Early Childhood and Family Mental Health (ECFMH). ECFMH is a service held by both CIS and DMH. This service uses a family-centered approach for families with a child from birth to age 8 who are experiencing social, emotional, or behavioral challenges and/or need to effectively use community services.³³ DMH chooses one Designated Agency in each geographic region of the state to serve children and pregnant and postpartum clients, including provision of doula services in select regions.³⁴

DCF, Economic Services Division (ESD). Within DCF, this is one of six departments that provides benefits and services to Vermonters: SNAP, emergency housing assistance, emergency heat, financial help with child care, crisis fuel, postsecondary education, and more.³⁵

DCF, Family Services Division (FSD). Within DCF, FSD is one of six departments that promotes the safety and well-being of children, youth, and families. FSD has two major roles: (1) to make sure children and youth are safe from abuse, their basic needs are met, and their families are supported to achieve these goals; and (2) to support youth at risk of harming themselves or others and youth or young adults on juvenile probation or youthful offender status.^{36,37}

Note: Agencies are shown in **navy**, and services are shown in **dark green**.

In addition, the State has collaborated with a number of organizations in the nonprofit sector (Exhibit III.2) to support its mission.

Exhibit III.2. Glossary of key early childhood system partners in the nonprofit sector

Building Bright Futures (BBF). Funded through public-private partnerships, BBF works to improve the well-being of young children and families in Vermont through 12 Regional Councils, seven Strategic Plan Committees, and a State Advisory Council. BBF is tasked with ensuring accountability and measuring the success of Vermont's Early Childhood Strategic Plan and [Act 76](#).³⁸

Child Care Resource (CCR). Child Care Resource is a nonprofit organization serving families in Chittenden County, Vermont. CCR helps families process CCFAP applications, locate quality child care for their children, and work with child care providers to enhance the child care experience. CCR provides CCFAP, SCC (as a part of CIS), and referrals for families.³⁹

United Ways of Vermont (UWsVT). A forum for mutual support and training for local United Ways across Vermont, keeping a statewide perspective to support each local United Way organization. Vermont211 and UW-HMG are programs of UWsvt.⁴⁰

Help Me Grow Vermont (UW-HMG). A centralized, coordinated intake and referral hub, UW-HMG helps families and professionals navigate resources and referrals via phone, email, or text.⁴¹ UW-HMG also administers developmental screenings (for example, the Ages and Stages Questionnaire) statewide. UW-HMG is overseen by VDH and connected to United Ways of Vermont, partnering with other agencies and nonprofits to support children and families.

Vermont211. Vermont211 is a database that connects constituents to essential resources such as emergency housing, food assistance, healthcare, and crisis support. UW-HMG uses Vermont211's free, confidential program to make referrals and connect Vermonters to a wide range of resources.⁴²

Parent Child Center (PCC) Network. Vermont's 15 PCCs are partners in the system of care for pregnant and parenting families with children younger than age 6, providing a range of services (for example, home visits, playgroups, parent education).⁴³ The Network provides leadership, advocacy, and support to PCCs.⁴⁴

Vermont Child Health Improvement Program (VCHIP). Housed at the University of Vermont Larner College of Medicine, VCHIP works at the systems level to enhance private and public maternal and child health practices, including conducting system evaluation and analyses for UW-HMG.⁴⁵

Visiting Nurses Association of Vermont (VNAVt). The nine nonprofit member agencies of the VNAs of Vermont “provide a full range of high quality, low cost home health and hospice services” in Vermont, including a range of CIS services.⁴⁶

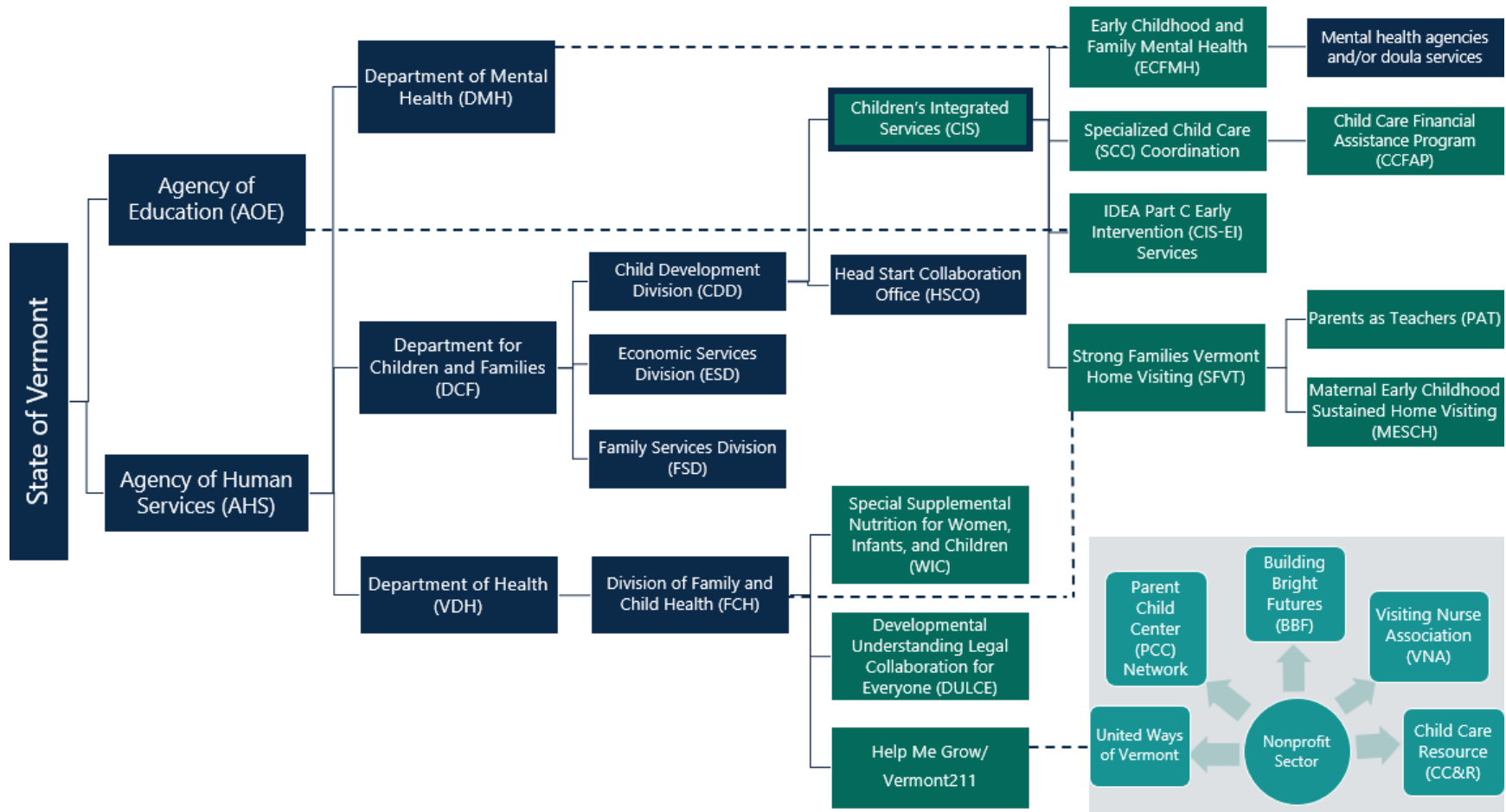
University of Vermont Medical Center (UVMHC). Under the corporate umbrella of the University of Vermont Health Network, UVMHC is the largest healthcare provider in Vermont and a major referral source to CIS.⁴⁷

Note: Nonprofit organizations and agencies are shown in **navy**, and services are shown in **dark green**.

Finally, the State’s early childhood system frequently partners with health care service providers, including primary care providers, pediatrics and obstetrics providers, and other specialists. In fact, UW-HMG reported that in 2025, over half of all referrals came directly from a provider, were sent on behalf of a provider’s order, or the provider told the caller to contact UW-HMG. Vermont families also travel to neighboring Massachusetts, New Hampshire, and New York for health care, especially to facilities considered in-network in Vermont due to close proximity (within 60 miles).⁴⁸

A key objective of this study was to map key partners and points of connection in the current system, focusing on CIS. Exhibit III.3 visually represents how these agencies and organizations connect within the system.

Exhibit III.3. Early childhood systems map



Note: Agencies are shown in navy, and services are shown in dark green. CIS is shown in both colors to represent its status as both an integrated array of services and a service provider in and of itself. Service providers in the nonprofit sector are shown in light blue. Dashed lines represent braided funded streams across agencies.

Note: For clarity, not all agencies, organizations, and services outlined in Exhibits III.1 and III.2 are included here. Many State agencies subcontract their work out to service providers, independent research firms, and nonprofits

B. Cross-agency collaboration

1. Operating within and across geographic regions

CIS was developed so Coordinators could centralize early childhood supports within specific regions, with designated sites functioning as service hubs for families. Launched in 2009, the CIS model was designed to take a burden off families and have a state-run division handle coordination procedures across CIS-EI, ECFMH, SCC, and SFVT. In years past, these services were provided through separate programs with distinct procedures and funded by distinct sources; today, each AHS-designated region has a regional Coordinator who oversees many teams responsible for intake, referral, coordination, and administration.⁴⁹

Exhibit III.4 describes a number of key elements of the CIS state and regional structures.

“The [CIS] model is designed to improve child and family outcomes by providing family-centric holistic services, effective service coordination, flexible funding to address gaps in services, prevention, early intervention, health promotion, and accountability. The prevention-focused program is designed to wrap around the whole family, including support for parents or caregivers to understand and advocate for the needs of their children, provide a point person to support care coordination, and access to high-quality child development, mental health, and prevention services.”

[Building Bright Futures, 2022](#)

Exhibit III.4. CIS structure and key elements

CIS Fiscal Agents. Each region has a Fiscal Agent, an organization that has a contract with the state to enable data sharing across agencies and tracking encounter data claims. Each of the 13 AHS-designated regions has a single CIS Fiscal Agent organization that is the formal signatory on the regional agreement. Fiscal Agents develop methodology and conduct financial modeling to help create the annual CIS budget for each region. Fiscal Agents are also responsible for reporting on and submitting paid and encounter data claims processing and tracking of service utilization.⁵⁰

CIS State Team. Overseeing statewide coordination of CIS, the State Team supervises regional CIS Coordinators and Fiscal Agents in the 13 AHS-designated regions. This team oversees contracts, budgeting, and financial modeling.⁵¹

CIS Consultation, Referral and Intake, and Administrative Teams. In each AHS-designated region, these teams are in place to meet regularly and discuss in-depth and/or complex systems and client issues and govern regional CIS activities. Confidentiality agreements are developed to allow for shared planning across different agencies.⁵²

One Plan. An inclusive planning and case management template for families accessing services, which is shared with any local professionals who work with them. A client’s One Plan—updated on an ongoing basis—includes questionnaires designed to guide discussions with families to identify community resources and document their needs. This tool is used by CIS teams across the state and is a requirement among all CIS providers.⁵³

No Wrong Door. CIS operates with a No Wrong Door approach, allowing referrals to CIS services to enter the system at multiple points, but all are eventually overseen by the regional CIS Coordinator regardless of the point of entry. Regardless of the first agency or organization that clients engage with, families should receive a consistent continuum of services.⁵⁴ No Wrong Door is designed to make it easier for children and their families to learn about and access the services they need.⁵⁵

Outreach and communication requirements. CIS is required to conduct outreach to providers and programs serving prospective CIS clients.⁵⁶ Outreach activities include ongoing regional campaigns and efforts to strengthen and improve the continuum of services. Regional CIS outreach must focus on specific populations and organizations serving the following populations:

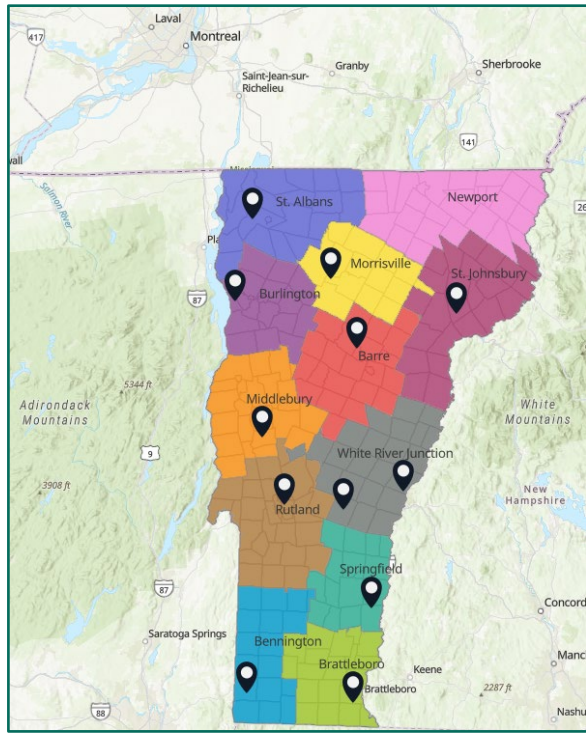
- Families experiencing homelessness
- Families living in rural areas
- Children whose families are considered low-income (for example, parents or caregivers are unemployed, or household income is below poverty guidelines)
- Families and children who have witnessed crime (including domestic violence)
- Wards of the State
- Families with a history of child abuse and neglect
- Indigenous families
- Families at risk due to prenatal, postpartum, maternal, or newborn issues, mental health conditions, or concerns about children’s health (for example, maternal depression and substance use, pre-term birth)
- Children and families experiencing health needs and/or delayed development

Note: Staff teams within CIS are shown in **navy**, and key tools and processes are shown in **red**.

The regional structure of CIS reflects Vermont’s commitment to local control. The current design intends for each [CIS Coordinator](#) to be embedded in their local communities, understanding the unique needs of their region. (A map in Exhibit III.5 outlines the geographical landscape of CIS and its 13 Fiscal Agencies across the state). This model means that families are served at the regional level instead of the state level. Services in Vermont’s early childhood system are also structured at the regional level and not the state level; as a result, depending on the region, some CIS services are co-located or may be implemented by local subcontractors, including PCCs. For example, some CIS Fiscal Agencies will subcontract certain programming out to local nonprofits and specialty providers if they do not have those services conveniently located in-house.⁵⁷ For example, at Northeast Kingdom Community Action, the CIS Fiscal Agent for the Newport and St. Johnsbury regions, CIS-EI takes place in-house, whereas the remaining services take place at three different subcontractors: Northeast Kingdom Human Services for ECFMH, Caledonia Home Health and Hospice for SFVT, and Umbrella for SCC.

Each region can structure its leadership and supporting staff in its own unique way, depending on the needs of the Fiscal Agency. CIS Coordinators serve as the single point of contact for families accessing services in the region and also liaise across resources throughout the community; in some cases, part-time CIS Coordinators may hold dual roles at PCCs or other organizations. For example, the CIS Coordinator in the White River–Orange County Area is dually employed as a part-time CIS Coordinator at Orange County PCC and a part-time family advocate at the Orange County Special Investigations Unit/Child Advocacy Center and the CIS Coordinator for the Newport and St. Johnsbury regions serves and oversees both regions.

Exhibit III.5. Vermont CIS coordinator locations



Thirteen CIS regions and Fiscal Agencies⁵⁸

- **Barre:** Family Center of Washington County (Montpelier)
- **Bennington:** Sunrise Family Resource Center (Bennington)
- **Brattleboro:** Winston Prouty Center for Child and Family Development (Brattleboro)
- **Burlington:** Howard Center (Burlington)
- **Middlebury:** Addison County PCC (Middlebury)
- **Morrisville:** Lamoille Family Center (Morrisville)
- **Newport and St. Johnsbury:** Northeast Kingdom Community Action (St. Johnsbury)
- **Rutland:** VNA & Hospice of the Southwest Region (Rutland)
- **St. Albans:** Family Center of Northwestern Counseling & Support Services (St. Albans)
- **Springfield:** Springfield Area PCC (North Springfield)
- **White River—Hartford Area:** The Family Place (Norwich)
- **White River—Orange County Area:** Orange County PCC (Tunbridge)

Note: As of 2025, the CIS Coordinator for St. Johnsbury and Newport covers both regions.

Cross-agency collaboration occurs routinely within regions, but less so at the statewide level. Each CIS region contains three unique teams to integrate service coordination: the Administrative Team, Referral and Intake Team, and Consultation Team. Although the CIS Coordinator plans and facilitates across teams, each region holds regularly scheduled meetings across teams to ensure required activities occur, to review referrals and intakes, and to support client-team relationships. On occasion, statewide coordination roundtables are held for unique and complex cases; however, this is rare and must occur with client consent.

2. Centralized funding structure

Each CIS region has a designated Fiscal Agent in place, and this arrangement was first piloted by three CIS regions in 2011 and adopted by others in 2012. This structure allocates a region’s full slate of funding to one organization to ensure all CIS services are being provided and programs are coordinating together. Fiscal Agents ensure agencies use the One Plan as the single service plan for all of CIS’s services (Exhibit III.4 gives the full definition of the One Plan).⁵⁹ Fiscal Agents are also responsible for setting regional guidelines for CIS agencies’ required data documentation. When the 2011 pilot concluded, Fiscal Agents reported that tying funding to a requirement for collaboration led to increased integration between agencies and more insightful data collection on the families being served.

Fiscal Agents financially model each CIS region. CIS reimburses Fiscal Agents for CIS service delivery using a bundled monthly case rate. To be considered billable to the CIS bundled contract, Fiscal Agents are obligated to provide the continuum of required CIS services and to collaborate effectively across their

region. Interviewees in the study's data collection noted that the Fiscal Agent first takes a 10 percent administration fee from the initial bundled case rate for handling data and reporting. Subsequently, the remaining funds are used to budget CIS Coordinator salaries and benefits according to the portion of the regional contract that each agency holds. For example, if one agency in a region holds 70 percent of clients, they hold 70 percent of the contract, and get 70 percent of the funding after the administration fee is taken off the top. As of 2025, regional allocations—accounting for both Medicaid and non-Medicaid cases—are shared widely with members of leadership among CIS regional teams and are based on claims data submitted by CIS Fiscal Agents and pulled from [Gainwell Technologies](#), Vermont Medicaid's payment system.⁶⁰

3. Data collection and sharing

CIS Coordinators are required to collect intake and referral data for semiannual reporting to CDD.

In addition to [state-required data](#), CIS Fiscal Agents may have additional data (for example, [demographic data](#)) they must collect to meet funder requirements. A significant amount of the data is collected through [billing procedures](#) for non-Medicaid and [Medicaid clients](#), as CIS Fiscal Agents are required to bill for *all* children even when not claiming payment. (Chapter IV has more information on Medicaid and non-Medicaid billing procedures within CIS.⁶¹)

CIS was built under the assumption that infrastructure would be shared across the system. CIS regional teams across the state use the same referral and intake forms as well as a One Plan case management document to enable consistency across regions. The universal forms and templates—such as the CIS-03 Authorization Form, CIS-02 Intake Form, Consent for Services Form, and One Plan—have been reviewed from a legal lens to allow for data sharing between agencies within regions.⁶² Occasionally, regional teams will sign additional releases with regional partners if required.

4. Braided federal funding

In Vermont's system of early childhood intake and referral, braided federal funding is used to support multiple programs and activities. Braiding of funds means that multiple funding streams simultaneously support programs or entities providing services.⁶³ In Vermont, funding is braided such that Title V is integrated with other sources, including WIC, MIECHV, PDG B-5, Medicaid, IDEA Part C, and competitive cooperative agreements such as MMHSUD (Exhibit III.6 lists the key federal funding sources).⁶⁴ Because CIS co-locates many different services, funding is braided to support integration and collaboration.

Exhibit III.6. Glossary of key early childhood system funders at the federal level

U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Child Care, Child Care and Development Block Grant (CCDBG) Program. CCDBG is the primary federal funding source to help families with low incomes access child care and to improve child care quality. CCDBG allows states to serve families through a single, integrated child care subsidy program under the rules of the Child Care and Development Block Grant Act of 2014.⁶⁵ In Vermont, this funding flows through DCF's CDD which oversees the grant to fund oversight of CIS and its continuum of services.⁶⁶

HHS, ACF, Office of Early Childhood Development, Preschool Development Grant Birth Through Five (PDG B-5) Grant Program. A \$250 million competitive federal grant designed to improve states' early childhood systems by building on existing federal, state, and local early care and learning investments, jointly administered by ACF and the Office of Elementary and Secondary Education in the U.S. Department of Education.⁶⁷ PDG B-5 dollars help fund UW-HMG and Vermont211 work at United Ways of Vermont, overseen at the state level by FCH.⁶⁸

HHS, ACF, Office of Head Start (OHS), Head Start Grant Programs. Through a federal-to-local funding model, OHS administers grant funding and oversight to 1,600+ agencies that offer Head Start Preschool and Early Head Start services at no cost to children ages birth to 5 in income-eligible families.⁶⁹ OHS has 12 regional offices; Vermont is part of Region 1 and is overseen by the OHS office in Boston, MA.⁷⁰

U.S. Department of Education, Office of Special Education Programs, IDEA Part C Program. IDEA makes available a free and appropriate public education to eligible children with disabilities. IDEA authorizes formula grants such that Vermont infants and children through age 3 with disabilities receive early intervention services under IDEA Part C (CIS-EI).⁷¹ In Vermont, Part C of IDEA operates under an interagency agreement between AHS and AOE that governs joint and separate responsibilities for administering services.⁷² IDEA is overseen by the U.S. Department of Education's Office of Special Education Programs.

Health Resources & Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. HRSA and ACF fund states, jurisdictions, and Tribes to develop and implement home visiting programs.⁷³ MIECHV dollars flow through FCH for sub-agreements for MECOSH® implementation and management.

HRSA, MCHB, Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) Program. This program is funded by HRSA to expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum people for mental health and substance use disorders.⁷⁴ This grant program currently helps fund Vermont's Perinatal CARES.

HRSA, MCHB, Transforming Pediatrics for Early Childhood Program. This HRSA program establishes resource hubs that build and sustain systems of care that ensure families have the full range of services and supports they need during the prenatal-to-age-5 period. This grant program currently helps fund FCH's DULCE program, focusing on serving young children and families who are eligible for Medicaid, CHIP, or are uninsured.⁷⁵

HRSA, MCHB, Title V Maternal and Child Health Services Block Grant Program. This grant program partners with states and jurisdictions to improve public health systems for mothers, children, and their families, including children and youth with special health care needs. Because Title V funds can be used at the discretion of the state, Vermont uses them to support staff and programming at FCH.⁷⁶

C. Referral sources and pathways to CIS services

1. UW-HMG

*In 2014, UW-HMG was brought to Vermont by the Help Me Grow National Center to serve as a centralized statewide access point for connecting families and professionals to services and supports.*⁷⁷ UW-HMG conducts outreach to families and health care providers, using data to guide referrals, strengthen connections, and improve early childhood systems. Because UW-HMG partners with Vermont 211, staff are able to provide families and providers with information about a broad range of community human services in addition to the state's early childhood services. When the program was first

launched, UW-HMG proactively contacted families before passing referrals to CIS, to reflect the national organization's core component of family outreach and to verify accurate client information (Exhibit III.7 describes the model's structure and key elements).⁷⁸ In 2025, the process was revised to improve efficiency and connect families to needed services as quickly as possible. UW-HMG now sends referrals directly to CIS while simultaneously contacting the family to ensure all other needs are met.

Exhibit III.7. Structure and key elements of UW-HMG⁷⁹

UW-HMG model's four core components

- 1. Centralized access point.** A single, trusted point—often a call center or online service—that families and professionals can turn to for guidance, referrals, and follow-up.
- 2. Family outreach.** Helps parents and caregivers understand child development, connects them with support, and builds relationships between providers and families.
- 3. Outreach to children's healthcare providers.** Supports pediatric and primary care providers in spotting potential concerns early and linking families to needed resources.
- 4. Data collection and analysis.** Tracks progress, highlights gaps, and informs continuous improvement so systems can become stronger and more effective.

The model's three structural requirements:

- 1. Organizing entity.** Ensures coordination and oversight, bringing together partners to align efforts and resources.
- 2. Continuous system improvement.** Uses data to guide adjustments, improve efficiency, and expand impact.
- 3. Spread and scale.** Shares innovations and lessons learned so effective strategies can expand and reach more families.

2. Other referral sources

Exhibit III.8 outlines a number of other common referral sources shared during the study's data collection. Sources range from medical providers and educators to more informal sources such as playgroups or personal contacts.

Exhibit III.8. Common referral sources to CIS and HMG

- [Vermont211](#)
- [FindHelp](#)
- Licensed childcare providers
- Public libraries and community events
- Local playgroups and parenting support groups
- Early childhood education (for example, PCCs, Universal Prekindergarten Education, Head Start, Early Head Start)
- Economic Services Division (ESD) within DCF/CDD (through WIC and SNAP benefits)
- Family Services Division within DCF/CDD (child welfare-involved families)
- School districts and [Child Find](#)
- [Early Hearing Detection & Intervention](#)
- Primary and pediatric care providers
- Obstetrics and gynecology providers and birthing centers (for example, UVMMC, Dartmouth Health, Boston Children's)
- Self-referrals, word-of-mouth, and personal contacts
- [Visiting Nurse Association \(VNAVt\)](#)
- [Community action agencies \(CAAs\)](#), including those providing Office of Economic Opportunity (OEO) grant programs
- [Mental health agencies](#)
- [Developmental disability agencies](#)

Note: This list includes many referral sources shared during data collection, but may not represent every possible referral source.

3. No Wrong Door

Although ideally referrals are made directly to a CIS Coordinator as a regional, centralized access point, CIS emphasizes a No Wrong Door approach, enabling clients to enter the system of care through different paths. As shown in Exhibit III.9, referrals to CIS services can travel through the CIS Coordinator, Help Me Grow, Head Start or Early Head Start, or directly from the referring service provider. If a CIS service provider receives a direct referral, they are expected to share the case information with the CIS Coordinator to ensure no other referrals are needed.

Exhibit III.9. Vermont’s current early childhood intake and referral workflow

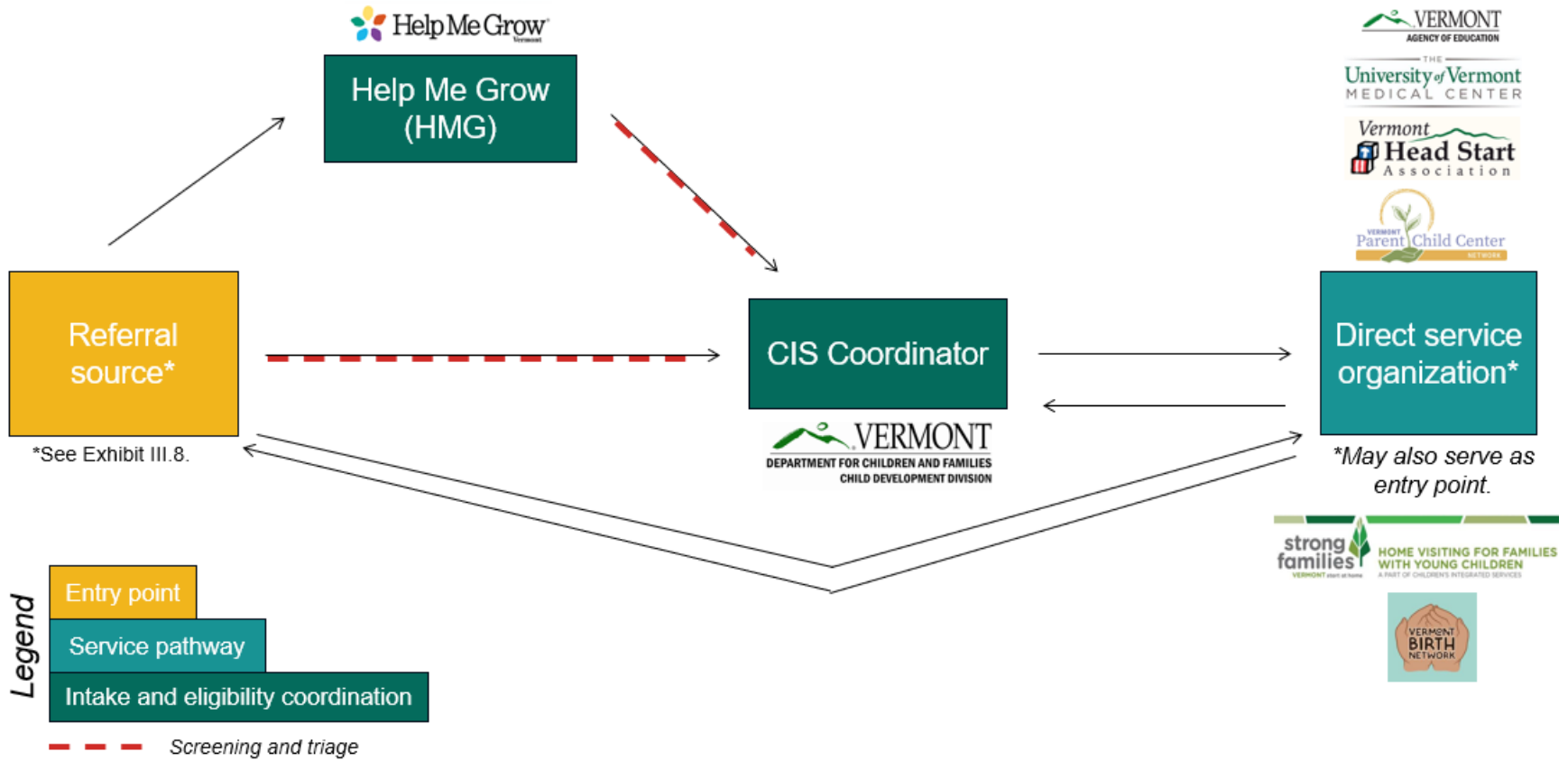
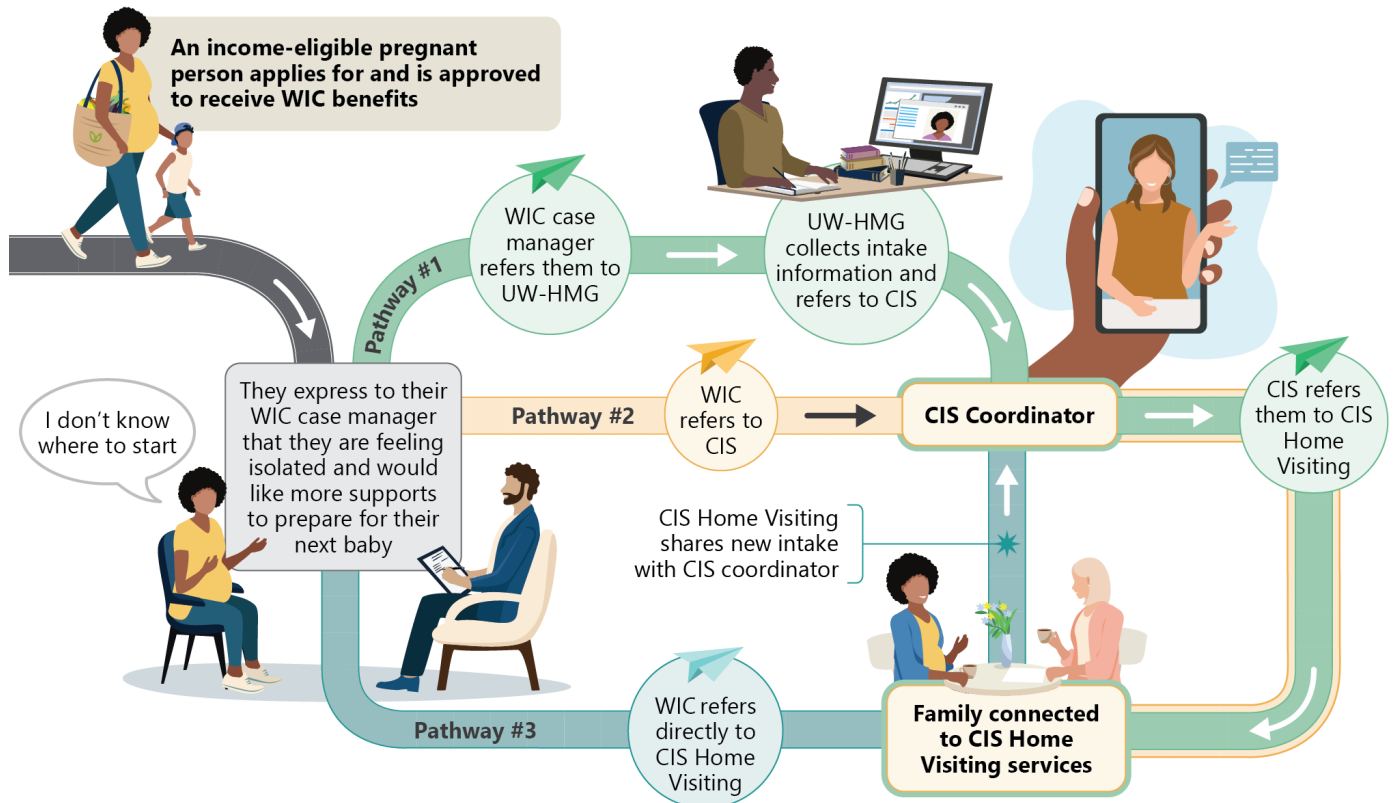


Exhibit III.10 shows a more illustrative example of the multiple pathways that families can navigate to receive services in Vermont’s early childhood system of care.

Exhibit III.10. Family-perspective pathway through Vermont’s early childhood system of care



Note: CIS = Children’s Integrated Services; ECFMH = Early Childhood and Family Mental Health; HMG = Help Me Grow; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

Clients of CIS control “how, when, and how much information is shared with the primary referral source.”⁸⁰ When a referral comes through a CIS Coordinator, the client must give authorization to the Referral and Intake Team to share outcome information instead of giving it to a single agency. For example, if a referral comes in from an OB/GYN provider, and SFVT Family Support Home Visiting is identified as the appropriate service provider, the parent or caregiver must authorize the Referral and Intake team to share referral outcomes with the OB/GYN provider rather than authorizing the SFVT agency alone.

IV. Study Goal 2: Understanding family and provider experiences

This chapter describes what we learned about the experiences of both families and providers with the current intake and referral system. Section A reports findings about families from the analysis of documents we reviewed on families^c along with themes that emerged from our qualitative data collection. Section B highlights findings about providers from the qualitative data collection. We define a provider as anyone directly providing services to families, whereas we define an implementer as someone who oversees services but does not work with families directly.

A. What we learned about families

1. Themes from the document review^d

Generally, families were satisfied with the intake and referral process. Families said their positive relationships with providers, communication, timely services, and close proximity to services supported their ability to connect with resources, along with other themes highlighted in Box IV.1. According to the 2022 Vermont Early Childhood Family Needs Assessment, 83 percent of respondents agreed that their overall experience with CIS specifically was positive.⁸¹

However, families said they faced challenges along the way. Families often find it difficult to identify or access the services they need. They may have a hard time knowing where to go for certain services, understanding complex services, or knowing how services are related to one another. They also find it difficult to access some services due to limited availability or high cost. According to the documents, families sometimes struggle to find both specialty and general medical providers. Families struggle with the paperwork and communication associated with the early childhood system when the search for providers and services is already taxing.

Responses were mixed on how successfully intake and referral systems reflect family-centered, equitable, and culturally responsive practices. The 2025 BBF Network Engagement Summary listed discrimination and stigma as key challenges in navigating and engaging with the system. Specifically, families named “racial bias, stigma around poverty and addiction, and discrimination against people with

Box IV.1. Across the early childhood system, families appreciate:

- Services that are easy to understand and access
- Friendly, supportive staff and office environment
- Ease of getting referred to services
- Great communication with staff
- Opportunities to connect with communities, such as in schools and early childhood programs, playgroups, parent-child centers, social groups, and libraries

Source: 2022 Vermont Early Childhood Family Needs Assessment. ▲



“There are so many different services offered, and it is not always clear how they are related ... Various directories are confusing and can provide conflicting information. A bunch of resources are also far away.”

Caregiver in Windham County

^c Chapter II and Appendix A describe the documents reviewed for this report.

^d Themes presented in the document review section are supported by conclusions from the three documents we reviewed.

disabilities” as key barriers to accessing needed support (p. 8).⁸² (Although it was not formally synthesized for this analysis, the more recent Vermont Early Childhood Family Needs Assessment from 2024 also highlighted language barriers and differing levels of staff capacity and resources across the state as contributing to inequitable access to services.⁸³) However, the 2022 Vermont Early Childhood Family Needs Assessment reported that 81 percent of respondents agreed that CIS service staff understood and respected their family’s culture and values.⁸⁴

The 2025 FCH Title V Needs Assessment coding revealed both positive and negative experiences related to bias and equity. Some families reported providers welcomed and embraced people of different race, ethnicity, and diversity, whereas others reported experiences of bias and discrimination.

2. Themes from qualitative data collection

Implementers recognize that intake and referral processes can be complicated on the provider side, but should be simple for families. The goal of early childhood intake and referral services is to meet families’ needs—ideally using as few steps or referrals as possible by having a central launching or connection point. Implementers acknowledged the complexities in the process of intake and referral can involve many steps on the service provider side, such as collecting a variety of required information or metrics for multiple service types or offerings. Despite these complexities, implementers want the process to feel smooth for the families themselves and work to make it smoother by, for example, crafting streamlined intake forms that meet the data requirements of multiple services. Implementers want the burden to fall on the service providers, not the families seeking care or services.

Not all referrals lead to services right away. Interviewees reported that families had mixed experiences with service receipt. Sometimes families get the referrals and services they need; sometimes they get referrals and follow-up calls, but no services; and sometimes it takes many calls and information collection points to receive referrals and services. Connecting to services might be difficult for several reasons, such as a family’s contact information changing or families not answering calls from unrecognized phone numbers. Referral forms do not always include all the information needed to begin certain services, which can slow the process from referral to service receipt.



“When we have smooth referrals ... families understand what CIS is about, and we are able to explain. When there are hiccups and bumps in the road, it adds stress and challenges to families who are accessing services, which is something we of course want to eliminate.”

CIS Coordinator

It can be confusing for families to navigate services that address different needs. Interviewees reported that some families have challenges knowing which providers or offices to go to for various services, or whom to ask for help in navigating the system. Locating many or all services within a single physical location, such as a PCC, can alleviate this. PCC representatives noted that families who initially receive one service at their center often remain connected to the PCC once they learn about additional services that are offered.

The intake and referral process can involve an exhausting paperwork burden on an already stressed family. Families (and sometimes children) may have to disclose sensitive intake information early in the

process for eligibility, referral, or reporting reasons, which can be tiresome and potentially harmful to positive relationship-building with service providers. Referrals to multiple services may mean families need to fill out similar sets of paperwork twice, contributing to exhaustion.

B. What we learned about providers from qualitative data collection

Building warm, trusting relationships with the families they serve is critical to success. Relationship-building can start with the initial referral or handoff and continue through ongoing interactions with families. The service providers we spoke to said they pay close attention to the needs and dynamics of a family and respond accordingly. For example, providers can ask about the need for additional services depending on a family's needs or stressors that day. The implementers and providers we spoke with noted that positive, warm relationships between providers and families can make a real difference in a family's willingness to ask questions and engage, and this can promote a family's success in accessing the services they need.

There are inconsistencies in how providers refer families to services. Given the importance of warm, trusting relationships, the initial referral step can be critical for laying the groundwork between providers and families. However, providers do not always know where to refer a family, or they prefer to refer them directly to a service rather than a referral hub (with an example scenario in Box IV.2). Providers noted that they often have personal or historical relationships with specific service providers, so they like to be able to refer families to that service provider directly.

What may also contribute to these inconsistencies is that there is still a lot of confusion around what CIS and UW-HMG are and what they do despite current efforts to market the referral hubs. However, for providers that know about CIS and UW-HMG, these centralized intake and referral hubs can serve a critical role of connecting families to services, especially when the referrer is unsure where to direct a family. (Box IV.3 has an example scenario.)

Even providers struggle to understand all the services available to families. Services are complex enough that even providers deeply embedded in the system do not always feel like they know everything that exists to support families, or what the eligibility criteria are for different services. Providers are frustrated when they refer a family to a service, but the family cannot receive that service because they are deemed ineligible (whether due to payment or misunderstood eligibility qualifications). One provider

Box IV.2. Example scenario

A provider in a local community has a personal relationship with someone at a CIS service agency and refers a family directly to that person by name (rather than to the regional CIS Coordinator), making the process feel more personal. According to CIS operational procedures, the CIS service agency should let the regional CIS Coordinator know and confirm if additional information is needed to meet all of the family's needs. ▲

Box IV.3. Example scenario

A healthcare provider at a New Hampshire hospital needs to refer a Vermont-based family with a new baby to follow-up services after birth. Because the healthcare provider is not embedded in the Vermont community, the provider doesn't know which regional CIS Coordinator to call. The provider calls UW-HMG, using this central access point to connect the family with services. ▲

keeps notes about how to best refer a family to a specific service based on each region; even though the regions shared the same eligibility criteria, their application of criteria and acceptance of families differed.

Interviewees said there can sometimes be an unreliable loop closure between service referral and service receipt.

Providers in the system do not always believe the feedback loop is closed on families they have referred elsewhere. The regional CIS Coordinator is supposed to do this for CIS-related services, but this process can be inconsistent, especially if the referral goes directly to a CIS service provider and does not go through the Coordinator.

Providers care deeply about their families and clients and want to know that their needs are being met. It can be

challenging for busy providers to follow up on their referrals, but knowing that families have received services is important for their relationship and care provision with that family. Moreover, if a provider is not assured that their patient or family received the care they referred them for, they may lose trust in the system (Section V.B has more on this).



“Different conversations with folks at different county [regional CIS] offices—some may say ‘Yes, absolutely. we’ll take them,’ but others will refuse and say they don’t meet criteria. It’s a statewide program so you’d think criteria would be the same.”

Early childhood service provider

V. Study Goal 3: Identifying system-level barriers and duplication

This chapter describes the system-level barriers and inefficiencies that currently exist in Vermont's early childhood intake and referral system. Sections A and B summarize complexities in the CIS and HMG models, respectively, and Section C outlines challenges throughout the broader system.

A. Complexities with CIS

CIS is designed to allow for flexibility of referrals, but is also complex. CIS was designed to provide regional central access points to a key set of early childhood services by introducing the CIS Coordinator role, while also allowing a No Wrong Door policy for referrals to the services under the CIS umbrella. This means that providers can refer directly to CIS services without going through the CIS Coordinator first, especially if that streamlines the family's experience or provides a personal touch like a warm hand-off. However, this flexibility means CIS Coordinators are sometimes not made aware of referrals and therefore cannot provide follow-up information about a family's services to other providers.

Guidance for CIS Coordinators can sometimes result in a scarcity mindset. Another tension in the system is that CIS Coordinators said they were expected to (1) meet monthly case rates of families served and (2) receive at least 51 percent of referrals directly. One of the study's interviewees noted that these kinds of criteria could make some CIS Coordinators feel "territorial" over referrals flowing through them rather than through other channels.

Some find the CIS referral form difficult to use. Interviewees called the CIS referral form "challenging," "cumbersome," and "redundant." The difficult referral process itself was noted as a barrier for both partners within the CIS system and external partners, such as medical providers, with one interviewee noting that "the workload that [process] brings is very high and taxing."

CIS services are managed regionally, and quality and access varies. CIS services and regional coordination models are driven by local teams, with services implemented by State contractors. Although this approach allows for local control over services, that autonomy results in varied experiences with services. One example: some CIS regions offer their core services out of different office locations, whereas others combine service locations, sometimes within a PCC. In addition to the convenience of having care teams physically close, PCCs have access to other funding sources, resources, and services beyond CIS, which can expand what families can easily access in a single visit.

CIS regions share performance measures with the state, but the process lacks consistency. CIS Coordinators are required to collect performance measures for the State, but no shared template exists across regions to make the process consistent. Instead, current CIS Coordinators have manually designed their own trackers in Excel spreadsheets to meet both state needs and any additional data they need to collect for regional partners. For example, CIS Fiscal Agents may sometimes have additional data that they need to collect to fulfill other funder requirements. When data are shared back with the State, it is therefore time-consuming for State staff to compile and summarize data across regions, given the unique templates and inclusion of additional data that the State does not need.

CIS was originally intended and designed to have a statewide data system. A system was developed, but difficulties around securing appropriate data sharing agreements between all agencies halted its use. One interviewee noted that a shared database is key to the CIS design “[working] correctly.”

Hitting non-Medicaid caps can limit access to services. CIS Fiscal Agents have specific allocations or caps for non-Medicaid funds they can be reimbursed for in serving non-Medicaid clients. Although the State works to update these caps, some interviewees noted they can be slow to update and thought decisions were not always driven by data on Medicaid eligibility in regions. Once CIS Fiscal Agents hit non-Medicaid caps, they cannot keep being reimbursed for services offered. This results in offices feeling like they either cannot continue to offer services or they have to offer them for free if the service is required.

“To my understanding, when CIS was first formed, it was formed with the intent to have a database to back up the system so it could work correctly, and that piece was never funded. For some regions there is a database, but it can be challenging. Our region faces the challenge that we are a Community Action agency as well—we also need a system that houses that. Because we are one small program that does many other things, it’s hard to envision a data system that houses CIS and includes all the other parts we do here at this agency.”

“Data sharing is definitely a challenge. As a Fiscal Agent who has to gather spreadsheets from every agency [that] is doing the work, combining those with our own, and somehow magically remove duplicates even though people use middle initials, spell names differently, use all-caps, etc., and then we have to add a lot of information to submit those spreadsheets for billing. We had numerous challenges with it.”

“If you think about it, for EI you can’t have a wait list or decline, you have to serve them. Why would the State do anything about it, if they know we [CIS Fiscal Agents] are in this spot where we have to serve the families? Why would they pay us more if they know we have to provide it either way? What motivation is that for them to hand over more money because they know we have to? So, there is a challenge.”

B. Challenges with UW-HMG

UW-HMG serves as a statewide central access point, but perceptions in the system have sometimes been skeptical. When HMG was launched, the perception in some areas was that HMG was “a threat to funding,” which led to feelings of mistrust around HMG’s role. Although UW-HMG staff noted that the role of HMG is “to drive families to our partners, not take them,” they feel that some CIS staff think of HMG as a competitor in reaching their referral targets. This feeling was likely exacerbated by the fact that UW-HMG staff are not based in Vermont, contributing to skepticism felt by providers who pride themselves on centering community and personal relationships in services.

“HMG is not fully realized because CIS doesn’t want it here. It is perceived as taking away clients.”

One lingering challenge is that HMG referrals can be perceived in some areas as slow. The initial process HMG followed to refer families to CIS included a requirement to connect with a family by phone, trying up to three times to reach families. Although this step aligns with the values of HMG around family agency, it did mean that some referrals got stuck if families were difficult or impossible for HMG to reach. This process was updated in 2025, allowing for referrals to CIS services to flow directly to the appropriate CIS Coordinator without contacting the family first, yet the sense that HMG was slowing down referrals has lingered in some regions.

Perceptions of and experiences with HMG remain mixed based on whether or not providers are already embedded in Vermont’s early childhood system.

For providers who are not deeply embedded in the system, HMG is an easy-to-use, trusted partner for referrals. As noted in Chapter IV, a common example given by interviewees were families that travel to hospitals out of state—typically to Massachusetts or New Hampshire—to give birth. In those instances, having a state-level centralized access point is simpler for providers that are not familiar with the regional CIS boundaries. And some interviewees praised HMG as having a strong track record of closing the feedback loop for providers.



“[CIS and HMG] have almost always been in conflict, and the take-up rate of HMG changes drastically across the state, based on how folks perceived HMG coming in and whether it was something they were going to buy into.”

However, for providers that are deeply embedded in the community, HMG feels like an offering that duplicates CIS. In cases where local providers have personal relationships with one another, the CIS Coordinator feels like a middleman, with one person noting that adding HMG feels like “a second middleman.” Some CIS Coordinators also noted that the quality of information passed to them from HMG was mixed, with some information missing or incorrect.

UW-HMG staff want to partner with CIS, but do not think they have been involved in many state-level decisions. CIS and UW-HMG staff do not regularly meet, and UW-HMG staff say they have not been involved in many state-level meetings or decision making: “Right now, there is a lot of burden and strain associated with being left out of those decisions.” UW-HMG has had to proactively ask for feedback on improving its processes, such as recent changes to streamline referrals to CIS. Although HMG staff expressed interest in collaborating to refine or streamline processes, they noted that those changes sometimes go against their mission and values of family empowerment and choice by removing family contact from their process. UW-HMG wants to support families in navigating the system, but does not want to be expected to be a “band-aid” for issues that are outside of their control in the CIS intake and referral system, such as inconsistency in CIS feedback loop closures.

C. Systemwide barriers

1. Current challenges

Organizations in the system often cannot share data, either easily or at all. Data are often restricted to within-agency or within-region sharing. Although interviewees acknowledged the importance and value of data protections for families, a lack of access to data makes it hard for providers to follow families

in their care journey or to support shifts in care if families move regions or transition into school. To support coordination, regional interagency teams—within and beyond CIS agencies—are often left to arrange data sharing agreements themselves. This can be difficult, as changes to policies around data access mean interagency sharing can stop abruptly and be challenging to restart.

Attempts to establish within-region data-sharing systems have also been mixed in success. Across the state, regions that do have data-sharing systems often do not use the same platforms, making a future statewide data system challenging to implement across existing platforms. Some attempts to establish regional data-sharing systems have also failed, even after significant time and resources (though some have been successful, as described in Chapter VI).

The system has multiple procedural and regional borders that can be tricky to navigate.

Services within and outside of CIS can have age-related eligibility cutoffs, which at least one interviewee flagged as not aligned with child development—for example, the challenging transitions families face when engaging with EI services: EI eligibility transitions at age 3 when a child is eligible for pre-K, and transitions again at age 6 for kindergarten. Especially for high-needs families, these relatively quick transitions during critical stages of child development make it more difficult to build long-term care plans and establish trusting relationships.

Geographic boundaries in the broader system can also be both confusing and restrictive. Because some early childhood services are only available in certain regions—for example, doula—if families move from one region to another, they may no longer be eligible for services they received before. This also means that a family may be physically close to a service, but cannot access it because they live on the other side of a regional border. In addition, regional CIS boundaries do not always line up with other boundaries used by partners in the system, such as counties or school districts. This lack of alignment makes the system even more difficult to navigate, especially for providers not deeply embedded in Vermont’s service system. Rural areas of the State can struggle to provide more specialty services due to the extensive travel that would be required.

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 “It used to be that we [at UW-HMG] would just close the referral loop, but the creep has gotten bigger and bigger; now, we are getting health records and completing the [CIS] intake form. In my perspective, it has not changed a single thing about the communication issues—there is still no closing of the feedback loop If anything, we are just doing more work.”

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 “You often switch from having a variety of options and supports that families are eligible for, and then new barriers, funding, services available change once the kid goes to public school.”

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 “It’s so starkly different from place to place what the offerings are; you could be five minutes away from someone who has access to different services than you because they don’t exist in your county. It’s not universal what is offered in different designated agencies.”

Braided funding can sometimes introduce complexity for both providers and families. When a service relies on funds from different sources, intake requirements for each funding source might differ, leading to duplicative paperwork. For example, a CIS Coordinator we spoke with described a scenario where a family or child starts a service under CIS funding, but if their services technically switch to DMH funding, the “services themselves do not change, but paperwork is required because funding streams change.” One interviewee noted that the complications arising from using multiple funding streams can “[create] system stress on staff and providers.”

Staffing retention and turnover affects both CIS and referring partners. Staffing was sometimes noted to be a challenge in the system, both inside and outside of CIS.

Inside CIS, one Coordinator can sometimes cover two regions, with positions not always staffed at full time. When turnover occurs for partners who refer to CIS, it can mean those partners—such as hospital staff or pediatricians—do not know where to refer families. To combat this, CIS Coordinators said they try to visit with all partners quarterly, but challenges persist.



“The feedback I’ve heard from medical side is that when [the referral process] works, it’s a very positive experience. When a referral goes nowhere, they lose all faith ... You can set up the best system in the world, but if a clinician tries to make a referral and they don’t hear back or they don’t get the response expected, they won’t do it a second time. It’s one and done!”

In high-pressure systems such as this, trust is more quickly lost than built. Across the system, one challenge that has slowed attempts to streamline is the inclination of system partners to quickly give up on imperfect pathways. Many working in this system do so because of a deep passion for helping families, and so providers may avoid using a particular referral pathway if they experience even one roadblock in routing a family to a critical service.

The system faces broader challenges around program awareness. Multiple interviewees acknowledged there can be limited awareness of CIS, HMG, or other early childhood services, with one interviewee acknowledging the link between “turnover” in staffing and “[lack of] understanding about roles, responsibilities, relationships, etc.” Lack of understanding of available services across the system—such as different types of home visiting offered by CIS and other agencies such as Head Start—can lead to duplicated or inefficient efforts to support families.



“Despite all our efforts, we still hear that people didn’t know about CIS and wish they’d heard about it earlier.”

Lack of shared understanding of common terms is a challenge. Multiple interviewees talked about the difficulty of ensuring everyone in the system has a shared understanding of common terminology. Specific terms or phrases noted as problems were *intake*, *referral*, *warm hand-off*, and *No Wrong Door*. This is especially true in a system as complex as Vermont’s, with both CIS and HMG serving as intake and referral points for the system.



“For example, when people say they want a No Wrong Door policy, what does that actually mean? How do you operationalize that?”

2. Concerns about future changes

Several interviewees shared concerns about the feasibility and potential negative impact of coordinating too many services. Interviewees pointed to failed efforts to establish data sharing agreements or data systems within Vermont as evidence that coordination is not easy. One interviewee shared an example of a time when the State had previously tried to coordinate multiple social services, but one service ended up bottlenecking the others. In the end, those services were disentangled from one another. These concerns were illustrated by historical examples that drive some interviewees' pessimism and skepticism toward proposed changes.



"We've seen the State try to centralize services and programs in other efforts, but it in turn gets overwhelmed and broken into siloed chunks."

VI. Study Goal 4: Identifying promising practices and infrastructure

This chapter examines the promising practices and supportive infrastructure that currently enable effective coordination of intake and referrals and access to services. Section A describes infrastructure and models within CIS and UW-HMG that support effective service coordination and Section B summarizes effective strategies and promising practices.

A. Effective infrastructure and models

1. Within CIS

Many of the people we interviewed acknowledged that the regional structure of CIS reflects Vermont's values and commitment to local control. Interviewees were near-unanimous in endorsing this structure, saying it helps local providers center relationship-building, personal connections, and trust, both with families and other system partners. When providers have personal connections to one another, it allows them to refer families directly to new services and provide warm handoffs to individuals—rather than to agencies—handoffs that feel friendly, welcoming, and seamless. However, most interviewees also said a centralized intake point is still necessary to allow easy access for those who are not deeply embedded in the system, such as nearby providers in Massachusetts, New Hampshire, or New York.

CIS's flexibility in supporting both a No Wrong Door policy and centralized regional coordination has allowed for personalization in navigating the system. As noted, this means that providers who are embedded in a community can make personal handoffs to system partners, and providers who are less familiar with the system have either the state-level entry point of Help Me Grow or the region-level entry point of the CIS Coordinator. Operationally, the state recently took steps to recognize the value of this flexibility, relaxing its requirements for the percentage of referrals that should flow through the CIS coordinator from 70 to 51 percent. The state team noted that this change reflects their hope that, even with a No Wrong Door model, at least “a simple majority [of cases] should go to the CIS Coordinator, respecting the role they play in coordinating the system.” When working at its best, many interviewees believe CIS's regional, centralized coordination approach does streamline system navigation for many families. When receiving a referral, experienced CIS Coordinators can make judgment calls about whether they need to engage directly with the family before passing information onto the service provision team, which allows them to weigh the benefits of a speedy referral with the need to ensure the most comprehensive service coverage. Having the referral go through the CIS Coordinator also provides those Coordinators with information to pass back to the referrer about the family's journey through the system.

2. Within UW-HMG

UW-HMG has supported streamlining the intake and referral process for those who use it. Recent efforts taken in 2025 have allowed the UW-HMG team to collect all the necessary intake information CIS needs to process a referral. This removes the previously required procedure in which UW-HMG staff made telephone contact with a family before passing the referral on to CIS. These steps have supported streamlining the process between UW-HMG and CIS by removing the time that UW-HMG might have spent struggling to reach a family. This is especially important for families being referred to Early Intervention services, where speed of referral is crucial. Some providers also reported that they had more

consistent feedback loop closures about the family's referral when going through UW-HMG. Multiple interviewees mentioned UW-HMG's hosting of the Ages and Stages Questionnaire (ASQ) Online for providers and families to use for free as another benefit to avoid duplication in re-screening families. The ASQ Online screening data is integrated with Vermont's Developmental Screening Registry, where providers are able to log in and see statewide which screenings have been completed.

B. Effective strategies and promising practices

Interagency collaboration has supported coordination, especially for complex care. CIS Coordinators attend weekly interagency meetings with service providers to coordinate case management and care, which supports both care provision and provider relationships. In addition to providing an opportunity to plan for and coordinate personalized care plans for families, these meetings are also a way for CIS Coordinators to ensure they are aware of referrals that went directly to service providers, if they do not already know about them. A CIS consultation team also meets monthly to focus on systemic issues or, occasionally, unusually complex family cases. In both instances, these regular touchpoints with others in the system of care help providers and implementers continually focus on partnership and collaborative problem-solving. One interviewee noted that families probably do not realize how much coordination is happening behind the scenes to help streamline their care.

In at least one instance, a provider noted that an interagency team had to disband due to changes in allowable data sharing, but the positives of that "interagency, team-coordinated approach" had inspired interviewees to take steps toward establishing data sharing agreements to reassemble that team.

Providers across the system noted that centering families is a key to success.

Many providers said focusing on trust-building with families early "leads to better [family] engagement and better outcomes." Another provider tries to avoid jargon and focus on descriptive language with families to avoid overwhelm—for example, describing home visiting options rather than naming them as "responsive" versus "sustained" options. A provider described a goal of their interactions with families as capacity-building, saying, "By the end of the one year I have with a family, I want them to be able to navigate moving forward. I'm trying to teach parents how to use the bus, [how] to call and set up appointments, etc." Many service providers we spoke to also said they are able to use translation and interpretation services to support families with diverse backgrounds, and a few offices have bilingual staff. In some instances, teams are working to translate informational materials into languages other than English. Another family-centered practice we heard about from interviewees was having providers fill out intake or referral forms with families on the phone, trying to make the experience feel more personal and cut down on the number of documents families must complete. Finally, another service provider talked about intentionally stocking their office with



"Our CIS admin and Coordinator meetings are really helpful. I know it's a small CIS world, but you have lots of different players at the table, so having sat at those meetings, you become familiar with the services and the families themselves. So, then you can give the family an exact road map for who they are going to call and what the process is going to look like—you aren't just going to tell a family to call someone and not be sure if they will get through to anyone."

PCC representative

helpful supplies such as food or snacks, diapers, and other resources. Box VI.1 summarizes these family-centered practices.

Box VI.1. Family-centered practices noted by interviewees

- Prioritize trust and relationship-building, especially in early interactions
- Avoid jargon when possible and use descriptive language instead
- Help build families’ capacity to navigate the system and advocate for themselves
- Have translation and interpretation services easily available
- Help families with forms to reduce paperwork
- Stock offices with helpful supplies such as snacks or diapers

HMG’s model is designed to prioritize family choice and agency, limiting the amount of information HMG typically collects and even allowing families to stay anonymous in interactions, if they prefer.

At a state level, BBF was noted for its work partnering with the State to center family voices in strategic planning, statewide trainings, and efforts such as the family needs assessments.

For regions where CIS services are co-located within single organizations or buildings, interviewees noted benefits for both providers and families in ease of access and use. Physical proximity results in greater convenience for both providers and families to engage with multiple services, with one interviewee describing the feeling of “a one-stop shop.” And when CIS services are administered by a PCC, families can more easily access non-CIS services, some of which do not require diagnoses or meeting certain income requirements.

Organizations that have their own internal data system or data-sharing partnerships said this improved efficiency and coordination. In some regions, CIS Fiscal Agents have transitioned to internal or localized data systems instead of relying solely on spreadsheets. For example, one agency established a database using QuickBase, which has allowed data-sharing partners to access case information, connect with other agencies, and scan documents. Although it was a challenge to arrange the database to follow the exact construction of the required CIS One Plan, interviewees from this site believed the time was well spent given the streamlining that has occurred in case management with their partners. Another PCC has built out the CIS referral form into an online version, and hopes to eventually include intake information as well.

“Under the Help Me Grow model with 211, we want to empower the individual—it’s up to the individual to decide the next steps. So outside of the ... programs [where we pass referrals directly, such as CIS], we just provide the resources and let the individual choose for themselves.”

“The [PCC] network really helps support the blending of statewide services for families ... We have direct access to each other, and can tap into the right person.”

PCC representative

Interviewees shared that CIS has a strong focus on training and professional development. One interviewee praised the “sizable portion of our Part C budget that goes toward professional development” for CIS staff. This interviewee noted the dedicated attention to providing resources around best practices for evaluations and that “technical assistance around federal reporting and data collection” support “fidelity for our own federal reporting.”

One interviewee noted that the state of Vermont is open to feedback and input. This individual noted that not every state system actively seeks out or is amenable to feedback on system improvements.



“I do appreciate about being in Vermont the ability to have a voice and advocate; it may not move the needle, but in some [other] places, you don’t have that opportunity at all to provide feedback.”

PCC representative

VII. Study Goal 5: Actionable recommendations

In this chapter, we highlight recommendations reported in our interviews with study participants (Section A); the study teams recommendations for developing a coordinated intake and referral system, including examples of different features (Section B); and proposed next steps for developing the system (Section C).

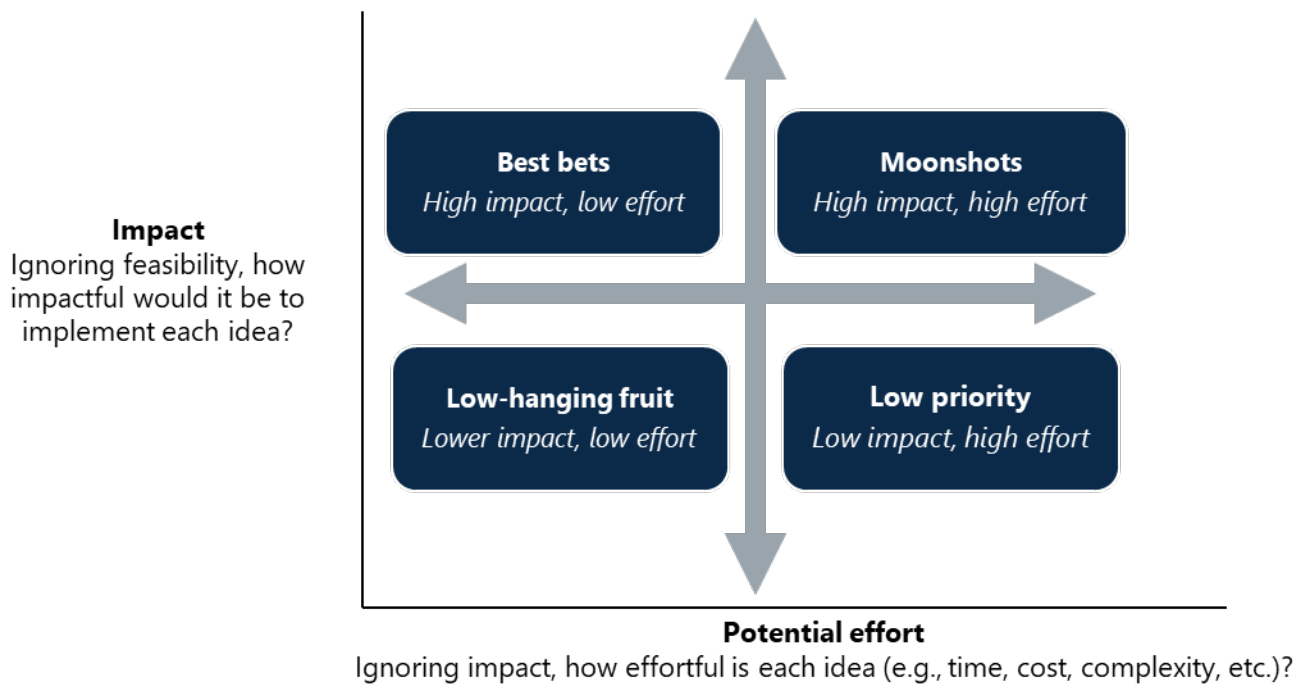
A. Recommendations reported in interviews

In this section, we summarize recommendations made by study participants in interviews and focus groups. We organize these recommendations by their expected impact on Vermont's current system of intake and referral as well as the level of effort (such as cost, time) that implementation would require. These recommendations represent the perspectives of study participants; their inclusion in this report does not signify endorsement by the study team or the State. Because recommendations reflect interviewees' views, some may be contradictory to one another.

We organize recommendations reported in interviews into four categories classified by impact and effort (Exhibit VII.1):

1. Low priority: Low impact and high effort
 - a. Note, we did not identify any recommendations in this category.
2. Low-hanging fruit: Low impact and low effort
3. Best bets: High impact and low effort
4. Moonshots: High impact and high effort

Exhibit VII.1. Prioritization matrix for estimating potential impact versus effort



1. Low-hanging fruit: Low impact and low effort

Revise the CIS and HMG intake forms. Several interviewees recommended changes to the intake forms. Some were simple, such as including CIS Coordinators' phone numbers, adding a Context box to describe the family's situation on the CIS form, and not requiring every field for the HMG form. Other recommendations were more intensive and relevant to both the CIS and HMG forms, including developing more usable digital versions and working to make the forms consistent.

Ensure families who speak languages other than English can access materials to help them navigate the early childhood intake and referral system. Several interviewees thought an ideal system would offer multilingual access to ensure families could engage in their preferred language. Although many providers we spoke to had established procedures for interpretation, one interviewee thought it would be helpful to translate digital or printed resources (for example, medical providers handouts) into more languages as a starting point in making the system more accessible.

Create and implement a common template for CIS data collection. CIS Fiscal Agents currently have a set of required data they collect under the One Plan, yet interviewees noted that CIS data systems and data-tracking spreadsheets have been developed by and for each region, resulting in inconsistencies in design. For regions using Excel spreadsheets, interviewees said a common spreadsheet structure could streamline statewide data summaries.

2. Best bets: high impact and low effort

Build coordination across the state. One interviewee recommended more coordination between state agencies, which ranged from low-effort strategies like focusing on more collaboration between the Agency of Education and Agency of Human Services to high-effort strategies like having a shared vision and funding for the Department of Health and Department of Children and Families. Another interviewee noted the importance of building a shared plan for coordination with consistent statewide definitions, including for No Wrong Door, intake, and referral.

Other interviewees emphasized the need for improved coordination between specific services, such as ensuring the medical perspective is represented in CIS, fostering greater collaboration between schools and child care providers, and strengthening alignment between CIS and Head Start to ensure state funding is used as efficiently as possible.

Ensure stakeholder voices are heard in decisions about changes to the system. Several interviewees noted the importance of communicating changes and looping back with stakeholders as decisions about the system are made.

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 "We need to get into communities and make sure the CIS Coordinators actually understand what Head Start does; we have federal dollars coming in, and we should be utilizing these and freeing up the state resources for kids who do not qualify for those services ... We need to sit down with the CIS folks and explain to them all the things we are already doing so they don't duplicate the same work they are doing with families."

Conduct ongoing statewide education and outreach to referral sources about CIS, HMG, and other services.

Several interviewees described the need for statewide, easily accessible, reader-friendly marketing materials for CIS, HMG, and associated services. They also talked about the importance of providing consistent, ongoing education and training for how referring entities can connect families to CIS and HMG. However, one interviewee noted that it can be difficult to get medical providers to participate in this kind of training given constraints on their time.

3. Moonshots: high impact and high effort

Build a statewide shared data system.

The most common recommendation was to develop a statewide data system that spans all services, reducing duplication for families and enabling referral follow-up. Interviewees emphasized the importance of building this system with provider input and ensuring transparency, particularly in regard to client consent. Although interviewees know that building this kind of system will be a challenge—considering factors such as navigating data privacy—they felt confident about its benefits.

Ensure Coordinator positions are full time and fairly compensated. One interviewee noted that CIS Coordinators should be full time. Another interviewee noted that coordinator-type positions across the state (such as PCCs) should receive increased compensation.

Consider the structure of regions and agencies to ensure more consistency in the services offered across the state.

Although many interviewees recognized the value of strong regional partnerships, one questioned whether it was necessary to have 11 different regions. Another interviewee recommended having single, well-resourced agencies to provide CIS services, and yet another suggested integrating CIS, HMG, and Child Care Resource & Referrals. The driver of these calls for integration was to ensure more consistency in the services offered to families across the state.

Co-locate services when possible. Several interviewees noted that co-location of services could facilitate access, especially in rural areas.

Create consistent, universal referral and intake application forms. Several interviewees pointed to the need to have an online referral form that is user-tested to ensure it works well for referrers and families. Although there was significant support for a consistent referral form (that is, a form that collects basic information about families), participants differed in whether they thought there should be a universal intake or application form (that is, a form that collects detailed information needed for applying for programs). One interviewee noted that Colorado experienced challenges during its rollout of a centralized

“The process is just as important as the end product—before any change is being made, it’s important to get the information out about what the process or change will look like. Giving lots of time and space for input and for an organized rollout—sometimes a new thing is not a better thing, if some of those steps are skipped, it can become more complicated.”

“I feel comfortable saying on behalf of everyone that a data system would have pretty significant benefits—[data] collection, sharing, reporting, ... long-term outcomes, analyses—all of that would be really good. I try to be practical about this because it’s not an easy thing and the sharing of data is a sensitive topic.”

intake form, as families were asked to complete lengthy questionnaires for services that required far less information. However, another service provider who had worked in Colorado believed the universal intake form improved access to services for families.

B. Mathematica recommendations

There are different ways to design a successful coordinated intake and referral system, and Vermont will need to make decisions about specific features based on what is feasible in this context.

For any system, we recommend that Vermont:

- **Convene a state task force to make decisions about feasible and effective features of a coordinated system.** This could include up to 14 representatives from state agencies and key external partners, with an illustrative list of potential participants in Exhibit VII.2.
- **Create and disseminate a unified framework for intake and referral** with consistent definitions, data elements, eligibility criteria, and referral protocols across agencies and community partners to support uniform operationalization.
- **Ensure there is a centralized access point** so families and providers that are not yet connected can find services.
 - Make a referral form available online for providers and families to access directly, with user testing.
 - Prioritize awareness of that central access point through ongoing training for partners and by developing user-friendly materials translated into commonly used languages.
- **Support strong partnerships at the state and regional levels** through regular partner meetings that allow for bidirectional feedback.
- **Develop a more integrated data system** that supports standardized screening, documentation, referral tracking, feedback loops, and reporting. Plan for maintenance and the flexibility needed for sustainability.
- **Create a statewide governance structure overseeing interagency interaction and coordination** with clear oversight, role delineation, and transparent decision-making processes.
 - Bring in non-state partners and family voices to provide feedback.
- **Develop a long-term, sustainable financing plan.**

Exhibit VII.2. Illustrative list of state task force participants

<p>Agency of Education (AOE)</p> <p>Agency of Human Services (AHS)</p> <ul style="list-style-type: none"> • Department of Mental Health (DMH) • Department of Vermont Health Access (DVHA) • Department of Health (VDH), Division of Family and Child Health (FCH) • Department of Children and Families (DCF), Child Development Division (CDD) <ul style="list-style-type: none"> – Children’s Integrated Services (CIS) State Team (such as the CIS Director and Data & Reporting Coordinator) – Head Start Collaboration Office (HSCO) <p>Building Bright Futures (BBF)</p> <p>Representatives from community organizations and with lived experience:</p> <ul style="list-style-type: none"> • For example, the Parent Child Center (PCC) Network and Family and Community Advisors
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In Exhibit VII.3, we give examples of different features of systems and how they may be implemented if the state undergoes less intensive transformation (Tier 1), moderate transformation (Tier 2), or full systems transformation (Tier 3). It is important to note that these individual models do not need to be implemented in full and that more transformation is not necessarily best. For example, less intensive transformation may be appropriate for some features, such as data systems, and more intensive transformation may be appropriate for other features, such as developing a centralized access point.

Exhibit VII.3. Example features of intake and referral systems and intensity of integration

Feature	Tier 1: Less intensive transformation	Tier 2: Moderate transformation	Tier 3: Full systems transformation
State agency coordination	More collaboration between agencies. <i>For example, Indiana's My Healthy Baby system is a joint collaboration of the Indiana Department of Health, Family and Social Services Administration, and Department of Child Services.</i> ⁸⁵	Interagency agreement to fund and administer CIR. <i>For example, New Jersey's Department of Health and Department of Children and Families co-fund centralized intake through Connecting NJ across the state.</i> ^{86, 87}	Single agency for early childhood programs. <i>For example, Illinois is moving all early childhood programs into a single agency.</i> ⁸⁸
Governance	Statewide framework with regional governance.	Statewide governance (including cross-system fiscal planning) oversees a unified structure with regional discretion.	Statewide governance (including cross-system fiscal planning) oversees a unified structure.
Level of centralization for functions: <ul style="list-style-type: none"> • Intake • Screening • Referrals 	Local and regional programs (CIS, PCCs, HMG) employ staff to provide functions. Programs adopt shared intake fields and application processes. <i>For example, in Tehama County, CA, early childhood partners developed a collaborative referral network and use common screening and referral processes.</i> ⁸⁹	Regional single entities employ staff to use shared statewide workflows, screening tools, and referral standards. <i>For example, Florida's Connect program is a state-funded system that is implemented through partnerships with 32 regional coalitions.</i> ^{90,91}	Single entity employs staff across the state—"front door." <i>For example, North Carolina's NCCare360 integrates health, behavioral health, housing, early childhood, and social services into one coordinated system with standardized screening and a statewide network of navigators.</i> ^{92,93}
Level of centralization for eligibility determination	Local and regional programs are familiar with eligibility processes for multiple programs.	Single or regional entity can determine eligibility for a few different programs.	Single or regional entity can determine eligibility for multiple different programs.
Care coordination for high needs families after intake	Local and regional programs and services (such as Head Start) deliver care coordination.	Local or regional staff from some services (such as CIS services) coordinate care.	Local or regional staff from many services coordinate care.
Centralized access forms	Services have separate referral forms but forms are aligned where possible.	Single electronic referral form that can be shared with relevant partners. <i>For example, in Tehama County, CA, early childhood partners developed a shared referral form linked to a database to enable cross-referrals.</i> ⁹⁴	Single electronic application form that can be used to apply for different services. <i>For example, the State of Colorado PEAK system enables residents to apply for food, cash, medical, transit, early childhood, and energy assistance programs in one online portal.</i> ⁹⁵

Feature	Tier 1: Less intensive transformation	Tier 2: Moderate transformation	Tier 3: Full systems transformation
Services referred to	Refers to select early childhood programs. <i>For example, the New Orleans Common Application process enables parents to apply to multiple publicly funded early care and education schools at once, removing the need to navigate many program-specific application requirements and deadlines;⁹⁶ the Missouri CRIS only refers to home visiting.^{97, 98, 99}</i>	Refers to a comprehensive range of early childhood programs (such as home visiting and early care and education). <i>For example, New Mexico has an online application and referral system for early childhood education, home visiting, and early intervention.¹⁰⁰</i>	Refers to a comprehensive range of early childhood and other family support programs. <i>For example, South Carolina's online, statewide First Five South Carolina form houses an eligibility screener for more than 40 early childhood programs in addition to WIC, TANF, and SNAP. Families are shown programs they may be eligible for in their communities based on county, school district, or zip code and can apply for these programs.¹⁰¹</i>
Service eligibility and availability	Aligns eligibility for services across the state.	Same core services are available across the state.	Same services are available across the state and families can access them in a timely way.
Partnership meetings	Regional entities responsible for coordinating partners within regions. <i>For example, Tehama County, CA, has regular meetings with all coordinated referral partners, convened by First 5 Tehama.^{102, 103}</i>	Regional entities responsible for coordinating partners within regions according to state-defined standards. <i>For example, Connecting NJ is implemented regionally, and the state requires each region to hold quarterly community advisory board meetings with partners.¹⁰⁴</i>	Single entity responsible for coordinating partners across the state. <i>For example, Delaware's 211 at HMG system has an advisory committee that partners can apply to be part of so they can network with like-minded programs while streamlining early childhood systems.¹⁰⁵</i>
Data system	Regional data systems allow referrals to included services. <i>For example, 10 health care and social service organizations in Greater Houston, TX, linked regional health information exchange technology and sector-specific care coordination platforms to allow closed-loop referrals.¹⁰⁶</i>	Statewide data system that allows referrals to be included services. <i>For example, North Carolina's NCCare 360 is a fully centralized statewide navigation and referral platform with closed loop referrals.^{107, 108}</i>	Fully integrated statewide data system that tracks children's participation across services. <i>For example, Georgia's Cross Agency Child Data System is designed to serve as a single repository of early childhood data from the Georgia Department of Early Care and Learning, Department of Education, Department of Public Health, Division of Family and Children Services, and Georgia Head Start.¹⁰⁹</i>

Feature	Tier 1: Less intensive transformation	Tier 2: Moderate transformation	Tier 3: Full systems transformation
Strengths	<ul style="list-style-type: none"> Improves transparency around program eligibility. Reduces paperwork duplication by aligning forms where possible. Centers local control. Lowers cost. 	<ul style="list-style-type: none"> Reduces administrative burden on families. Improves equitable access across the state. Centers local control while ensuring consistent policy alignment. 	<ul style="list-style-type: none"> Statewide governance enhances accountability. Reduces administrative burden for families. Improves equitable access across the state.
Challenges	<ul style="list-style-type: none"> Still need a centralized access point (online and phone number) on top of regional structure. Does not reduce governance complexity. 	<ul style="list-style-type: none"> Still needs a centralized access point (online and phone number) on top of regional structure. 	<ul style="list-style-type: none"> Statewide model loses regional identity. Largest infrastructure investment. Single entity may not be appropriate for coordinating partners across the state and coordinating across the state may not be relevant.

Note: CIS = Children’s Integrated Services; HMG = Help Me Grow; PCC = Parent Child Center; TANF = Temporary Assistance for Needy Families; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

C. Next steps

The process of making decisions about the features in Exhibit VII.1 could involve the following steps:

1. Facilitate a state task force and develop a charter to formally outline the task force's goals, expectations, structure, roles and responsibilities, meeting frequency, and decision-making processes.
2. Assess data readiness and technology by interviewing current CIS providers, key program partners, and the Agency of Digital Services; and coordinate with CIS data systems contractor.
3. Assess workforce capacity by interviewing system coordinators and state staff to understand needed skills, time, and compensation
4. Assess burden and workflow by interviewing referring entities such as early childhood and medical providers to understand how potential changes would influence workflows.
5. Understand family experiences by, for example, coordinating with existing or proposed work (for example, the journey mapping team).
6. Hold statewide workshop to get input on system options and statewide needs for early childhood and medical service referral partners.
7. Conduct regional case studies (one high capacity and one rural region) of existing partners and workflows to understand strengths and challenges.
8. Hold facilitated consensus-building session with state leaders and partners to establish a common vision and select key features of the proposed system.
9. Conduct cost modeling and draft fiscal allocation scenarios.
10. Develop a road map of statewide implementation for intake and referral, including governance structure, data integration plan, and workforce strategy.

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Appendix A

Document and Data Review

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Exhibit A.1. List of reviewed documents and authoring bodies

Document name	Authoring body or bodies
2022 Vermont Early Childhood Family Needs Assessment	BBF
2022 Vermont Early Childhood Family Needs Assessment: Appendices A–L	BBF
Assessing and Supporting Collaboration Among Early Childhood Programs: Title V MCH, ECCS, MIECHV	AMCHP
Assessing the System of Care for Screening, Referral, and Treatment of PMADs in Vermont	VCHIP
CDD Grant Proposal for CCRR (Final)	UWsVT, on behalf of UW-HMG
Centralizing and Integrating Early Childhood Data (Meeting Notes)	BBF Data Team
Child Health Annual Report 2024 (Draft)	VDH, FCH
Child Health Grant Application Year 2026 (Final)	VDH, FCH
Children's Integrated Services 2023 Workforce Report: 2022 Data on the CIS Workforce (Published 1.2.2024)	AHS, DCF, CDD and CIS
CIS Manual: Bundled Claims for Non-Medicaid Populations & Zero-pay Encounter Claims	DVHA, CIS, and Gainwell Technologies
Data Brief: Examining Perspectives of Children’s Integrated Services (CIS) from Families Served by CIS Early Intervention	Vermont Early Childhood Data & Policy Center and BBF
Developmental and Behavioral Screening Guidelines, January 2024	VDH
Developmental Screening in Vermont, by county, and Social Determinants of Health, 2023	VCHIP
Developmental Screening in Vermont, over time, 2015-2023, and by Insurance	VCHIP
Early Childhood Interagency Coordinating Team (ECICT) – PDG Planning (Meeting Notes)	BBF Early Childhood Interagency Coordination Team (ECICT)
Early Intervention (EI) Parental Rights	AHS, DCF and CIS
FCH Program Snapshot: DULCE (Presentation)	VDH
FCH Program Snapshot: Help Me Grow VT (Presentation)	VDH
FCH Program Snapshot: PerinatalCARES (Presentation)	VDH
FCH Program Snapshot: Strong Families VT Home Visiting (Presentation)	VDH
FCH Program Snapshot: WIC (Presentation)	VDH
FCH Title V Needs Assessment (Dataset from Forthcoming Report)	VDH, FCH
FCH Title V Needs Assessment: Appendix (Qualitative Coding Summary)	VDH, FCH
FY26 Title V State Action Plan: Child Health (Draft)	VDH
Goal 2, VT Early Childhood Strategic Plan 2030	BBF SAC
Goal 3, VT Early Childhood Strategic Plan 2030	BBF SAC
Goal 4, VT Early Childhood Strategic Plan 2030	BBF SAC
Goal 5, VT Early Childhood Strategic Plan 2030	BBF SAC
Goals 1-5 (COMBINED), VT Early Childhood Strategic Plan 2030	BBF SAC
Guide for Communicating the Strategic Plan for a Comprehensive, Statewide ECCE System	PDG B-5 TA Center and SRI Education
Help Me Grow National Center Business Case (Presentation)	HMG National Center and Manatt Health

Document name	Authoring body or bodies
Help Me Grow Vermont: A Call to Action for CIS Strong Families Vermont Home Visiting (Presentation)	VDH
Early Childhood Comprehensive System: Health Integration Prenatal-to-Three Program Building Integration in Vermont’s P-3 Early Childhood and Maternal Child Systems (VIP-3)—NCC Progress Report	VDH, FCH
Needs Assessment Guide for PDG B-5 Planning and Renewal Grantees 2023	PDG B-5 TA Center; ACF, Office of Family Assistance (OFA)
Network Engagement Summary for Building Bright Futures	The Creative Discourse Group
Part C Interagency Agreement Between AHS and AOE	AOE; AHS
State Governance Structures	Prenatal-to-3 Policy Impact Center (Vanderbilt University)
STATE PERFORMANCE PLAN / ANNUAL PERFORMANCE REPORT: PART C for STATE FORMULA GRANT PROGRAMS under the IDEA	CDD (Part C Program Administrator), CIS
Vermont Children's Integrated Services and the MECOSH Program	VDH and CIS
Vermont Early Childhood Action Plan (VECAP) 2020	BBF VECAP committee leadership and members; AOE; AHS; DCF; VDH; VDMH; Let's Grow Kids; Vermont Association of the Education of Young Children; PCC Network
Vermont Home Visiting Research Findings (10.20.22)	VDH and Crowdproof
Vermont PDG B-5 Early Childhood Systems Needs Assessment 2020	BBF VECAP committee leadership and members; VDH; AOE; AHS; VDMH; Let's Grow Kids; PCC Network; Noonmark Services; PDG-B5 leadership
Vermont: Title V MCH, ECCS & MIECHV Survey (Presentation of State responses to the Association of Maternal & Child Health Programs’ (AMCHP) survey on early childhood collaboration for CIRS administered in early 2022)	AMCHP
Vermont’s Early Multi-tiered System of Supports Impact Report: Fall 2022 – Spring 2024	AOE
Vermont's Help Me Grow Resource Hub Case Study	ZERO TO THREE

Note: Hyperlinks have been added to documents that are publicly available for further reading. Documents that are not hyperlinked are internal to the State of Vermont and not publicly available, but have been listed for transparency.

Note: Bolded items indicate family needs assessment data that were reviewed along with other documents.

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