HEALTH RESOURCES AND SERVICES ADMINISTRATION

ASSESSING AND DESCRIBING PRACTICE TRANSITIONS AMONG EVIDENCE-BASED HOME VISITING PROGRAMS IN RESPONSE TO THE COVID-19 PUBLIC HEALTH EMERGENCY (ADAPT-HV)

ENVIRONMENTAL SCAN SUMMARY REPORT

OCTOBER 2023

HRSA Maternal & Child Health

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EXECUTIVE SUMMARY

The *Health Resources and Services Administration* (HRSA) funded the Assessing and Describing Practice Transitions Among Evidence-Based Home Visiting Programs in Response to the COVID-19 Public Health Emergency (ADAPT-HV) project. The goal of the project is to identify and study early childhood home visiting (ECHV) and related social support program practices implemented in response to the coronavirus disease of 2019 (COVID-19) public health emergency (PHE) that have the potential to enhance ECHV programming in the future.

As part of this work, the project team conducted an environmental scan to identify practice changes in ECHV and related social support programs. The scan also gathered information to understand the context for the changes and how they might help advance ECHV service quality and delivery in the future. The research questions were:

1. What types of changes in practices occurred in Maternal, Infant, and Early Childhood Home Visiting (MIECHV)-funded program service delivery during the COVID-19 PHE (January 27, 2020 through May 11, 2023)?[1, 2]
2. What types of changes in practices occurred in other ECHV and closely related social support program service delivery during this period?[3]
3. What approaches are used to evaluate these changes in practices? What approaches are used to assess the strength of evidence?
4. How feasible are testing and implementation of the practice changes in the future?

Through the environmental scan, we identified 15 practice changes. These practice changes were in the areas of service delivery modality, visit delivery and implementation, visit content, staffing practices and patterns, and family reach. The project team worked with HRSA and the *Office of Planning, Research, and Evaluation* (OPRE) in the *Administration for Children and Families* (ACF) to select six of these practice changes to focus on for this report. We selected six practice changes to align with future work to develop study design reports to examine the practice changes that show the potential for high impact on ECHV programs. Below, we provide an overview of the key findings for the six practice changes in MIECHV-funded programs and other ECHV and closely related social support programs during the COVID-19 PHE.

- **Practice Change 1:** Home visitors more frequently contacted families between formal home visits to informally check on families' well-being, connect them to resources, and offer support with child development issues and parenting skills.
- **Practice Change 2:** Programs developed new referral partnerships and formalized existing partnerships to accommodate families' changed needs during the COVID-19 PHE. In addition, some programs refined their referral processes to provide more assistance to families in completing applications for services from referral partners.
- **Practice Change 3:** Home visitors increased focus on identifying and addressing families' mental health needs by increasing the number of formal relationships with mental health providers and offering mental health discussions, counseling, and stress-relieving activities to families.
- **Practice Change 4:** Home visitors increased use of *coaching* families in positive family–child interactions as opposed to *modeling* positive family–child interactions. Some programs that

[1] The COVID-19 PHE began January 27, 2020. Retrieved April 27, 2023, from https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx

[2] Resources included in the environmental scan were identified through early 2023. The COVID-19 PHE expired May 11, 2023. Retrieved April 27, 2023, from https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html

[3] Closely related programs are Healthy Start, infant mental health, early intervention, parent training, and two-generation programs.

already focused on coaching during in-person home visits used new guidelines to coach during virtual home visits.

- **Practice Change 5:** Programs supported professional development for home visitors in three ways: (1) offering virtual training and meetings as opposed to in-person training and meetings; (2) providing guidelines and skills development for new practices, such as conducting virtual home visits; and (3) offering supports for self-care and work–life balance.
- **Practice Change 6:** Programs implemented four new techniques to increase families' active participation in the program: (1) engaging families in the planning of home visits; (2) using music and visuals to keep families engaged during home visits; (3) offering virtual peer groups; and (4) distributing activity kits and similar materials to families.

We identified studies evaluating or collecting information on these six practice changes. Most of the research on these practice changes was from mixed-method studies. Commonly, these studies relied on qualitative interviews with home visiting program staff, qualitative focus groups with families, and quantitative data analysis of surveys of staff and families.

Table ES.1 presents a summary of the findings we identified on the six practice changes. These findings represent the gathering of information from a variety of sources, including research studies, practice or technical assistance materials, and input from interested parties.

Table ES.1. Summary of Findings on the Six Practice Changes of Focus

Practice Change	Findings
Practice Change 1: Increased frequency of informal contacts	The family–home visitor partnership grew stronger with a less formal relationship, and informal contacts enabled home visitors to better understand and effectively support families.
Practice Change 2: Improved referral partnerships and processes	The practice change was key for families to be able to access mental health services in a timely manner after the onset of the COVID-19 PHE.
Practice Change 3: Increased focus on families' mental health needs	Findings from two pre-PHE studies might help inform how the practice change affects families, home visitors, and programs. Lessons indicate that the practice change increased families' access to mental health services.
Practice Change 4: Increased use of coaching families in positive family–child interactions	Some home visitors prefer the increased use of coaching as opposed to modeling, but some families do not. In one study, families shared that modeling offers them a chance to step back from daily caregiving and the opportunity for children to interact with other adults. In addition, some families expressed "missing out" on in-person demonstrations of positive family–child interactions.
Practice Change 5: Increased supports for professional development	Offering virtual training and meetings as opposed to in person led to greater accessibility and frequency of home visitor training and meetings. Also, offering peer groups in both English and Spanish increased the accessibility and cultural relevance for some Spanish-speaking home visitors. In addition, some program staff indicated that the practice change led them to feel more supported in their roles.
Practice Change 6: New techniques for supporting families' active participation	These new techniques might improve the quality of services home visitors provide to families by, for example, developing a deeper sense of partnership between home visitors and families.

Finally, we assessed the extent to which the six practice changes are feasible for testing and implementation in the future. To do so, we drew on existing research on implementation factors necessary to deliver high-quality services (e.g., Caronongan et al., 2016; Crowne et al., 2021; Sparr et al., 2021), to identify factors that might facilitate or hinder implementation of the six practice changes. Table ES.2 summarizes the key factors we identified.

Table ES.2. Key Factors That May Affect Practice Change Implementation

Practice Change	Examples of Key Factors
Practice Change 1: Increased frequency of informal contacts	• Home visitors' understanding of families' availability to engage with home visitors • Flexibility for home visitors to individualize frequency of engagement based on families' needs, preferences, and capacity • Mode of, or reason for, informal contacts • Program systems and policies that allow or accommodate informal contacts
Practice Change 2: Improved referral partnerships and processes	• Program supports and infrastructure to deepen referral networks or change referral processes (e.g., staff, time, and resources)
Practice Change 3: Increased focus on families' mental health needs	• Availability of mental health providers in the area
Practice Change 4: Increased use of coaching families in positive family–child interactions	• Home visitors' or families' buy-in for using coaching instead of, or in combination with, modeling • Coaching style (e.g., strengths-based coaching) • Coaching content (e.g., goal setting, positive reinforcement, or specific feedback on an interaction)
Practice Change 5: Increased supports for professional development	• A leader or champion at the organization to advance professional development • Home visitors' tolerance for virtual training and meetings
Practice Change 6: New techniques for supporting families' active participation	• Home visitors' understanding of families' availability to engage with home visitors • Flexibility for home visitors to individualize frequency of engagement based on families' needs, preferences, and capacity • Families' learning styles

In addition, when considering the potential of implementing the practice changes in the future, the project team found that most of the six practice changes have the potential to advance equitable access of ECHV services for families or home visitors. For example, home visitor assistance with applications to referral partners can help families address barriers they might face during the application process (such as the application form's complexity) that would ultimately prohibit or prolong timely receipt of necessary services.

The key findings for the six practice changes of focus offer several recommendations to better understand how programs can deliver services and engage with families in the new and evolving ECHV landscape (Table ES.3).

Table ES.3. Recommendations for MIECHV Program Implementation, Research, and Policy

Relevant Practice Change(s)	Recommendation
Practice Change 1: Increased frequency of informal contacts **Practice Change 6:** New techniques for supporting families' active participation	Assess families' availability to frequently engage with home visitors and individualize frequency of engagement to align with families' needs, preferences, and capacity.
Practice Change 1: Increased frequency of informal contacts	Identify appropriate parameters for the family–home visitor professional partnership.
Practice Change 2: Improved referral partnerships and processes **Practice Change 3:** Increased focus on families' mental health needs	Identify systems-level best practices for referrals, with a focus on addressing families' mental health needs.
Practice Change 4: Increased use of coaching families in positive family–child interactions	Explore how and when programs implement coaching when supporting families in positive family–child interactions.
Practice Change 5: Increased supports for professional development	Examine the effect of new supports for professional development on home visitor confidence, well-being, and effectiveness in delivering ECHV. Examine home visitor professional development across modes of service delivery.

Thematically, many of the recommendations are similar in that they prescribe further study to improve our understanding of the six practice changes, how best to implement the practice changes, and their potential to improve service delivery. Our review of the literature on practice changes finds that the literature is modest and descriptive in nature. This is not surprising given the disruption caused by the COVID-19 PHE and our proximity to those events, but it underscores the need for further research. In addition, the state of research suggests that initial studies should continue to focus on process and exploratory questions, to help build foundational knowledge about the practice changes.

The key findings and recommendations from this environmental scan serve as a framework for the ADAPT-HV project team as it develops study design reports, conducts studies to test the implementation of some of the practice changes, and designs efficacy studies for future implementation. The findings and recommendations from the scan, combined with findings from the studies, will contribute to a deeper understanding of the practice changes that have the potential to improve how families are served in ECHV. This includes gaining a deeper understanding of whether and how the ECHV field might sustain the practice changes.

TABLE OF CONTENTS

INTRODUCTION

Early childhood home visiting (ECHV) has a long history of engaging with families to help address families' health, education, and other needs. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was authorized in 2010 and most recently extended through the Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 (H.R. 8876).[4, 5] The MIECHV Program has six statutory benchmark areas:[6, 7]

1. Improvement in maternal and child health
2. Prevention of childhood injuries and child abuse and maltreatment, and reduction of emergency department visits
3. Improvement in school readiness and achievement
4. Reduction in crime and domestic violence
5. Improvement in family economic self-sufficiency
6. Improvement in the coordination of and referrals to other community resources and supports

With the onset of the coronavirus disease of 2019 (COVID-19) public health emergency (PHE) in early 2020, both family and program staff needs changed drastically, along with societal norms for in-person interactions, thereby changing the broader landscape in which ECHV operates. In response, many ECHV models and programs changed their practices to better serve families and program staff. These practice changes have the potential to be implemented across ECHV models and programs, further advancing how models and programs deliver services and engage with families and program staff in the new and evolving ECHV landscape.

Box 1. Key Definitions

Home visiting model is an evidence-based intervention that follows an established curriculum, such as Parents as Teachers, Healthy Families America, and Early Head Start Home-Based Option.

Program refers to the local agency that implements early childhood home visiting (ECHV) and delivers services to families, sometimes referred to as the local implementing agency (LIA).

Program staff include local program managers or directors, supervisors, home visitors, and other support staff.

Administrator refers to representatives from health departments and other agencies that oversee implementation of ECHV for a state, territory, or tribe.

Home visitor refers to the individual who conducts home visits with families. In some cases, we use the term "provider" to refer to both home visitors and other types of service providers.

Family refers to different caregiving structures, which can include a single parent and one child or a unit of multiple caregivers and children. We use this term rather than "parents" to be inclusive of diverse caregiving structures.

Engagement occurs when programs and families interact; interactions begin at outreach and recruitment and, for families that enroll, extend to retention and active participation.

Active participation refers to a family's responsiveness during services. It encompasses a family's responsiveness to the home visitor and program content, perceptions of or satisfaction with ECHV, and application of new skills learned through ECHV.

Findings refer to summarized key takeaways and outcomes of a practice change across research studies, practice or technical assistance (TA) materials, and information from interested parties.

Resource broadly refers to any source material used in this scan. This includes material such as impact and implementation studies, TA materials, and input from interested parties.

Equitable access broadly refers to the idea that all eligible families can fairly access ECHV services, but that each family might need a different level of support to access the services.

Level of effort refers to the amount of effort needed to successfully complete an activity. We use this term neutrally. The term is not meant to imply that families and home visitors are not already investing effort in participating in or delivering ECHV services.

[4] Maternal and Child Health, Health Resources and Services Administration. (2020b). *Maternal, infant, and early childhood home visiting orientation guide*. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/miechv-orientation-guide.pdf

[5] Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022, H.R. 8876, 117th Congress. (2022).

[6] Maternal and Child Health, Health Resources and Services Administration (2020b).

[7] Maternal and Child Health, Health Resources and Services Administration. (2016). *Demonstrating improvement in the maternal, infant, and early childhood home visiting program: A report to Congress*. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/reportcongress-homevisiting.pdf

The *Health Resources and Services Administration* (HRSA) funded the Assessing and Describing Practice Transitions Among Evidence-Based Home Visiting Programs in Response to the COVID-19 Public Health Emergency (ADAPT-HV) project. The goal of the project is to identify and study ECHV and related social support program practices implemented in response to the COVID-19 PHE that have the potential to enhance ECHV programming in the future. In launching the ADAPT-HV project, HRSA aims to inform research, policy, and implementation of MIECHV-funded home visiting programs. The project's three main tasks are to (1) identify practices that changed in response to the COVID-19 PHE (environmental scan), (2) identify and test the efficacy of some practice changes (rapid cycle evaluations), and (3) inform future research by designing studies for the practice changes that show the potential for high impact on ECHV programs (research designs).

As part of this work, the project team conducted an environmental scan to identify practice changes in ECHV and related social support programs. The scan also gathered information to understand the context for the changes and how they might help advance ECHV service quality and delivery in the future. The environmental scan is a critical step in understanding practices that changed due to the COVID-19 PHE. In addition, the scan summarizes the available research on the practices and findings from research and practice. It also provides information on the potential for testing and implementing the practice changes in the future.

In the remainder of this report, we summarize our methodology; describe our key findings; offer recommendations for how the findings can be used to inform MIECHV program implementation, research, and policy; and summarize next steps. Additional detail on methodology can be found in Appendix A. Summary tables of research study designs and findings from the literature for the six practice changes of focus for this report can be found in Appendix B. Additional detail on the potential of the six practice changes to advance equitable access of ECHV for families or home visitors can be found in Appendix C.

METHODOLOGY

The project team worked with HRSA and the *Office of Planning, Research, and Evaluation* (OPRE) in the *Administration for Children and Families* (ACF) to develop four research questions to guide our selection of information for inclusion in the environmental scan.[8] The research questions were:

1. What types of changes in practices occurred in MIECHV-funded program service delivery during the COVID-19 PHE (January 27, 2020 through May 11, 2023)?[9, 10]
2. What types of changes in practices occurred in other ECHV and closely related social support program service delivery during this period?[11]
3. What approaches are used to evaluate these changes in practices? What approaches are used to assess the strength of evidence?
4. How feasible are testing and implementation of the practice changes in the future?

[8] HRSA and OPRE first developed potential research questions for the request for proposals for the ADAPT-HV project. After award of the contract, we worked with HRSA and OPRE to refine the questions. This included soliciting (subject matter expert) SME feedback on research question 2.

[9] The COVID-19 PHE began January 27, 2020. Retrieved April 27, 2023, from https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx

[10] Resources included in the environmental scan were identified through early 2023. The COVID-19 PHE expired May 11, 2023. Retrieved April 27, 2023, from

[11] Closely related programs are Healthy Start, infant mental health, early intervention, parent training, and two-generation programs.

When considering the potential of implementing practices in the future, the project team considered two additional factors: (1) the potential of the practices to advance equitable access to ECHV for families (e.g., whether a practice reduces barriers to participation); and (2) whether practices affect the time and effort put forth by families to participate in services and programs to deliver services.

To answer these questions, we gathered information from five sources:

1. **Project team recommendations** for foundational literature
2. **Recommendations from federal staff, model developers, program administrators, implementers, and subject matter experts (SMEs)** to identify additional research manuscripts and gray literature[12]
3. **Bibliographic database searches** of databases such as Academic Search Complete for research manuscripts
4. **Google searches** of model developer websites and organizations for gray literature
5. **Input from interested parties** to provide additional context and detail (see Box 2); input was gathered through virtual discussions and email communication

For each resource identified through the first four sources, we used a set of screening criteria to review the title and front matter of the document (such as Abstract and Executive Summary) to assess the resource for relevance (see Table 1).[13] For websites, we reviewed the website headers and landing page to find relevant information. In addition, we used a set of prioritization criteria to identify high-priority resources that screened in (see Table 2). We prioritized resources that described at least one practice change that met the mandatory criterion and at least three of the six additional prioritization criteria.

Table 1. Environmental Scan Screening Criteria

Category	Criterion
Date range[14]	Contains information on an implementation change that was initiated in 2020 or after
Language	Resource is written in English
Program	Includes information on early childhood MIECHV-funded programs, other ECHV programs, or closely related social support programs
Relevance to research questions	Directly addresses or adds insight to one of the four research questions

[12] Gray literature includes information and reports that are not published in journals.

[13] Throughout the report, we use the term "resource" to collectively refer to any material identified through sources one to five.

[14] We included some resources that fell outside of our date range because they contained relevant detail that was not identified in more recent resources.

Table 2. Environmental Scan Prioritization Criteria

Category	Criterion
Mandatory Criterion	
Implementation information	Provides information about how the change was implemented. This includes how the change was executed (this could include a guide or instructions, details on roles and responsibilities, facilitators, and challenges, etc.).
Additional Prioritization Criterion	
Program components	Provides information about the types of changes made to home visiting program components and factors that were implemented during the COVID-19 PHE, such as service delivery modality, content, or dosage.
Staffing	Describes staffing-related changes that were implemented during the COVID-19 PHE, such as staffing patterns, professional development, training, supervision, or hiring.
Outreach, recruitment, and retention	Describes changes in the strategies programs used for participant outreach, recruitment, and retention that were implemented during the COVID-19 PHE.
Accessibility	Describes changes in pursuit of equitable access to services for participants eligible for home visiting, such as technology support.
Scalability	Describes the extent to which the change could be scaled up and replicated/adapted for other settings, and/or describes the cost of implementing the change.
Measurability	Discusses approaches for measuring or evaluating the change.

After prioritizing resources, we worked with HRSA and OPRE to identify six practice changes that the environmental scan would focus on. The six practice changes were selected based on three primary criteria: (1) if MIECHV-funded programs were likely to continue to execute the practice change after the PHE ended; (2) if families served by MIECHV-funded programs were likely to benefit from the practice change; and (3) if no other HRSA- or OPRE-funded project was focusing on the practice change or a related topic.

We then fully reviewed the resources pertaining to those six practice changes. The resources included qualitative studies, mixed-methods studies, practice or technical assistance materials, input from interested parties, and legislation. For the practice change focused on mental health, we also identified two evaluations conducted prior to the onset of the COVID-19 PHE on the effectiveness of formal mental health partnerships. These evaluations might help to inform how the practice affects families, home visitors, and programs. In addition, one practice – improved referral partnerships and processes – was not the focus of any studies in our review, but two studies noted that respondents talked about referrals in response to open-ended questions in listening sessions with, and a survey of, home visiting representatives (including program staff).

Throughout each phase of the environmental scan, we gathered interested parties' feedback and incorporated it into the scan:

1. SMEs provided feedback on research question 2, helping to identify Healthy Start, infant mental health, early intervention, parent training, and two-generation programs as the closely related social support programs we should focus on.
2. Model developers, program administrators, implementers, and SMEs provided recommendations for research manuscripts and gray literature to screen.
3. Program administrators, implementers, and family representatives participated in virtual discussions and email communication to provide insights, context, and detail on practice changes.
4. SMEs provided feedback on sections of an early draft of this summary report.

Box 2. Interested Parties Consulted for the Environmental Scan

Model developers: Developers of models eligible for implementation as an evidence-based model with MIECHV funding

Program administrators: MIECHV and Tribal MIECHV grant awardees and administrators with expertise in social service program delivery

Implementers: LIA representatives, such as supervisors and home visitors

Subject matter experts (SMEs): Academic researchers, representatives from quality improvement initiatives, and ECHV program technical assistance (TA) providers

Family representatives: Representatives from family advocacy groups and committees or tasks forces for social support programs

To identify the findings described in this report, trained members of the project team extracted relevant information from each fully reviewed resource into an Excel-based tool organized by the four research questions. The team then reviewed the tool to synthesize the information and identify themes and nuances. As part of this process, we grouped the information we extracted based on our own analysis. In other words, we did not limit our analysis based on the way that a resource or interested party labeled a specific practice change. For example, if an interested party described a practice change as a change to home visitor training but we, in our analysis of the practice change details, found that practice change was better categorized as a change to supervision of home visitors, we categorized the practice change as a change to supervision. Additional detail on the environmental scan methodology, including search terms, can be found in Appendix A.

There are two key limitations of the environmental scan.

1. The environmental scan was not designed to be a comprehensive scan of home visiting models, home visiting and social support programs, or available research on practice changes in response to the COVID-19 PHE across possible sources. Therefore, it does not include all possible information on practice changes implemented in response to the COVID-19 PHE.
2. The environmental scan is a narrative scan, not a systematic scan. Therefore, we did not assess the quality of the research we identified against a set rubric. Instead, we focused the environmental scan on data sources deemed relevant by HRSA, OPRE, and the project team, regardless of research quality. As such, we do not include an analysis of the effectiveness of practice changes, though we include relevant findings on each practice change when available.

KEY FINDINGS

In this section, we describe our key findings for the six practice changes of focus. We begin by describing each of the six practices before and after the onset of the COVID-19 PHE, the research study designs and findings related to the practice change, and available findings on the practice change from both research and practice. We then describe how the six practice changes advance equitable access of ECHV services for families and home visitors. We also describe the extent to which the practice changes might affect the level of effort required for families to participate in ECHV and programs to deliver ECHV. In addition,

we describe how feasible testing and implementation of the practice changes are in the future. Table 3 presents the six practice changes of focus, along with nine other practice changes identified through the environmental scan but which are not the focus of this report. Additional detail on research study designs and findings from the literature for each practice can be found in Appendix B.

When reviewing the information on the practice changes, it is important to note that some programs might have discussed or executed the practice changes before the PHE. However, in the new and evolving ECHV landscape, the practice changes may have different consequences and meaning to families, home visitors, and programs than before the PHE.

Table 3. Practice Changes Identified Through the Environmental Scan

Domain	Practice Change	Description	Example
Practice Changes of Focus in the Environmental Scan			
Service delivery modality	Increased frequency of informal contacts	Home visitors more frequently contacted families between formal home visits to informally engage with them.	Some home visiting programs in one state increased the frequency of informal contacts with families to provide support to families as they navigated the disruptions caused by the PHE.[15]
Visit delivery and implementation	Improved referral partnerships and processes	Programs developed new referral partnerships, formalized existing partnerships, and provided referral assistance to families to accommodate families' changed needs during the COVID-19 PHE.	Some home visiting programs developed new referral partnerships with pro bono lawyers, cash assistance programs, and food banks to address families' housing, financial, and food security needs.[16, 17, 18]
	Increased use of coaching families in positive family–child interactions	Home visitors focused on coaching families in positive family–child interactions (as opposed to modeling family–child interactions) and used new guidelines to coach families during video home visits.	One home visiting webinar indicated that home visitors served as "a coach in the air" during virtual home visits because families, as opposed to home visitors, were physically present with the child and were poised to play a leadership role during the visit.[19]
Visit content	Increased focus on families' mental health needs	Home visitors developed formal relationships with mental health providers and offered mental health discussion, counseling, and stress-relieving activities to families.	A few infant mental health and home visiting programs offered counseling to families directly through their programs.[20]
Staffing practices and patterns	Increased supports for professional development	Programs increased supports for professional development for home visitors by offering virtual training and meetings (as opposed to in person), providing guidelines and skills development for new practices, and offering supports for self-care and work–life balance.	One program administrator created virtual, drop-in meetings for home visitors to share with each other after particularly positive or difficult home visits.[21]
Family reach	New techniques for supporting families' active participation	Programs implemented new techniques to increase families' active participation in programs, including engaging families in home visit planning, using music and visuals to keep families engaged during home visits, offering peer groups, and distributing activity kits and similar materials to families.	One program implementing the ParentChild+ model conducted home visitor–family debriefs at the end of each home visit to solicit families' feedback and co-create strategies to address challenges experienced during the home visit.[22]

[15] Interested Party A (personal communication, January 31, 2023).

[16] Chazan-Cohen, R., Fisk, E., Ginsberg, I., Gordon, A., Green, B. L., Kappesser, K., Lau, S., Ordonez-Rojas, D., Perry, D. F., Reid, D., Rodriguez, L., & Tomkunas, A. (2021). *Parents' experiences with remote home visiting and infant mental health programs during COVID-19: Important lessons for future service delivery*. Perigee Fund. https://perigeefund.org/wp-content/uploads/2021/10/ParentVoices-FullReport-English.pdf

[17] Ferrara, A. M., Kaye, M. P., Abram-Erby, G., Gernon, S., & Perkins, D. F. (2022). Army home visitors' implementation of military family violence prevention programming in the context of the COVID-19 pandemic. *Couple and Family Psychology: Research and Practice*, *11*(1), 60–73. https://doi.org/10.1037/cfp0000193

[18] Marshall, J., Kihlström, L., Buro, A., Chandran, V., Prieto, C., Stein-Elger, R., Koeut-Futch, K., Parish, A., & Hood, K. (2020). Statewide implementation of virtual perinatal home visiting during COVID-19. *Maternal and Child Health Journal*, *24*(10), 1224–1230. https://doi.org/10.1007/s10995-020-02982-8

[19] Rapid Response – Virtual Home Visiting Collaborative. (2020b). *Engaging families in virtual visits: A protective factors' approach* [Webinar]. Retrieved April 21, 2023, from https://rrvhv.earlyimpactva.org/webinar/engaging-families-in-virtual-visits-a-protective-factors-approach

[20] Chazan-Cohen et al., 2021.

[21] Rapid Response – Virtual Home Visiting Collaborative. (2020a). *Building the virtual home visiting knowledge base: Lend your voice to the conversation* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/building-the-virtual-home-visiting-knowledge-base-lend-your-voice-to-the-conversation

[22] Bultinck, E., Falletta, K., Stoeppelwerth, P., Crowne, S. S., & Hegseth, D. (2022). *Understanding the needs of ParentChild+ staff and families during the COVID-19 pandemic*. Child Trends. https://doi.org/10.56417/3442g5692k

Table 3. Practice Changes Identified Through the Environmental Scan (Continued)

Domain	Practice Change	Description	Example
Other Practice Changes Identified Through the Environmental Scan			
Service delivery modality	Shorter and more frequent home visits	Programs changed the duration and frequency of home visits to better accommodate families' capacity for participating in virtual home visits.	One home visiting program conducted shorter home visits that were more focused on content.[23]
	Increased flexibility in home visit modality	Programs conducted home visits and other types of meetings with families in various modes, including virtually, through a hybrid in-person-virtual approach, and through yard visits and outdoor drive ups.	Some infant mental health and home visiting programs offered families the option of participating in home visits via Zoom or telephone to make the programs more accessible.[24]
Visit content	Increased focus on social determinants of health	Programs shifted their focus from delivering educational topics to meeting families' most pressing basic needs.	One home visiting program developed materials with resources for families in need of food assistance, rent and utilities assistance, and behavioral health services.[25]
Visit delivery and implementation	Adapted screening and assessment protocols and procedures	Programs adapted screening and assessment protocols and procedures to accommodate for the changed ECHV landscape during the COVID-19 PHE.	Some home visiting programs used versions of the Ages and Stages Questionnaires that were adapted for virtual use.[26]
	Adapted enrollment and intake protocols	Programs adapted enrollment and intake protocols, including enrolling families via telephone and video and updating consent forms to include virtual service delivery.	One home visiting webinar indicated that some programs, during the intake meeting with a family, included time for families to practice using the meeting technology.[27]
	Monetary and material support	Programs changed or increased funding provisions to better support families in the changed ECHV landscape during the COVID-19 PHE.	One state increased program funding for its home visiting programs to meet families' basic needs.[28]
Staffing practices and patterns	New supervision techniques and practices	Programs implemented new techniques to supervise home visitors, including developing a supervisory approach to be used in a virtual setting.	Some home visiting programs conducted nearly all supervision via telephone and video.[29]
	Increased supports for program staff well-being	Programs increased supports for staff well-being by boosting staff morale, fostering team building, and conducting initiatives to reduce staff stress.	One program boosted staff morale by celebrating staff at each meeting through kudos and applause.[30]
Family reach	Adapted recruitment approach for families	Programs adapted their approaches to recruit families in home visiting in the changed ECHV landscape during the COVID-19 PHE.	One home visiting program developed partnerships with organizations in the community to get help recruiting families because the program could no longer recruit families in person at hospital birthing wards.[31]

[23] Bultinck et al., 2022.

[24] Chazan-Cohen et al., 2021.

[25] Stark, D. R. (2022). *Sustaining a light of hope for families: How tribal home visiting programs persevere despite COVID-19 challenges* [Issue Brief]. Programmatic Assistance for Tribal Home Visiting (PATH) for the Administration for Children and Families. https://www.acf.hhs.gov/sites/default/files/documents/occ/THV_Covid_Challenges.pdf

[26] Brooks Publishing. (n.d.). *Using ASQ in a virtual environment*. Ages & Stages Questionnaires. https://agesandstages.com/using-asq-in-a-virtual-environment/

[27] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[28] Interested Party A (personal communication, January 31, 2023).

[29] Korfmacher, J., Molloy, P., & Frese, M. (2021b). *Virtually the same? Virtual home visits in response to COVID-19* [Research Brief]. Erikson Institute. https://www.erikson.edu/wp-content/uploads/2021/10/Research-Brief-1-HV-COVID-Survey.pdf

[30] Marshall et al., 2020.

[31] Rybińska, A., Best, D. L., Goodman, W. B., Bai, Y., & Dodge, K. A. (2022). Transitioning to virtual interaction during the COVID-19 pandemic: Impact on the family connects postpartum home visiting program activity. *Infant Mental Health Journal*, *43*(1), 159–172. https://pubmed.ncbi.nlm.nih.gov/34997622/

PRACTICE CHANGE 1: INCREASED FREQUENCY OF INFORMAL CONTACTS

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

The literature and information gathered from interested parties suggests that, before the COVID-19 PHE, it was not common practice for home visitors to contact families between formal home visits.[32, 33, 34] After the onset of the PHE, some home visitors from both MIECHV-funded and non-MIECHV-funded programs used telephone, text, and social media direct messaging to informally contact families on a more frequent basis – in some instances, on a daily basis.[35, 36, 37] For example, one infant mental health and home visiting program that conducted informal check-ins with families before the PHE reported that, after the onset of the PHE, home visitors began to use the informal check-ins to ask families about their mental health needs. Before the PHE, the program limited the informal check-ins to topics related to children's health and development.[38] All home visiting programs under the jurisdiction of one program administrator in Texas increased the frequency of informal contacts with families between formal home visits to provide support to families struggling with basic needs.[39] Home visitors in a Montana program, after dropping off activity materials to families' homes, started making telephone calls to families to ask them how the activity worked and offer support.[40]

OVERVIEW OF RESEARCH STUDY DESIGNS

Two studies noted evaluating or collecting information on the practice either through a pre/postsurvey or interviews. An evaluation of ParentChild+ virtual home visits included a pre/postsurvey of families and home visitors. The survey included a question about respondents' perceptions of support outside of formal home visits, which included support through text messages.[41] Another study included interviews with 100 families and early childhood service providers from seven infant mental health and home visiting programs representing different infant/toddler program models, geographies, and community and family characteristics.[42] Informal contacts between providers and families were discussed during interviews.

FINDINGS FROM RESEARCH AND PRACTICE

Both families and home visitors favored the practice. In one study that conducted interviews with ECHV and infant mental health service providers and families, families reported that the family–home visitor partnership grew stronger with a less formal relationship.[43] In addition, one program administrator reported that the informal contacts between home visitors and families enabled home visitors to better understand families and more effectively support them.[44] The study that conducted interviews with ECHV and infant mental health service providers and families also noted that, theoretically, more check-

[32] Interested Party A (personal communication, January 31, 2023).

[33] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[34] Chazan-Cohen et al., 2021.

[35] Korfmacher, Molloy, & Frese, 2021b.

[36] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[37] Chazan-Cohen et al., 2021.

[38] Chazan-Cohen et al., 2021.

[39] Interested Party A (personal communication, January 31, 2023).

[40] Interested Party B (interview, February 27, 2023).

[41] Bultinck et al., 2022.

[42] Chazan-Cohen et al., 2021.

[43] Chazan-Cohen et al., 2021.

[44] Interested Party A (personal communication, January 31, 2023).

ins between families and home visitors provided more opportunities to discuss child development and related issues.[45]

PRACTICE CHANGE 2: IMPROVED REFERRAL PARTNERSHIPS AND PROCESSES

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

Even before the COVID-19 PHE, ECHV programs developed and maintained referral partnerships to help address families' needs and goals.[46, 47, 48, 49] After the onset of the PHE, as families' needs changed, some home visitors from both MIECHV-funded and non-MIECHV-funded programs frequently developed new referral partnerships and formalized existing partnerships or were encouraged by program administrators and other experts in the field to do so.[50, 51, 52, 53, 54, 55] For example, several home visiting programs reported developing new referral partnerships with pro bono lawyers, cash assistance programs, and food banks to address families' housing, financial, and food security needs.[56, 57, 58] One Tribal MIECHV grantee developed and maintained a resource binder to store referral information for services such as financial housing support, behavioral health services, and food access. It also shared referral information with other Tribal home visiting programs and two large learning communities.[59] In addition, home visitors in some Texas programs refined their referral processes to provide more assistance to families in completing applications to submit to referral partners.[60]

OVERVIEW OF RESEARCH STUDY DESIGN

Two studies, one that included listening sessions and another that included a survey and focus groups, noted that study respondents talked about referrals in response to open-ended questions.[61, 62]

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[45] Chazan-Cohen et al., 2021.

[46] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[47] Interested Party A (personal communication, January 31, 2023).

[48] Marshall et al., 2020.

[49] Chazan-Cohen et al., 2021.

[50] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[51] Hadley, A., Hayes, J., Pai-Samant, S., & Stern, F. (2023). *Virtual home visiting during the COVID-19 pandemic: Lessons learned for research, practice, and policy* (OPRE Report No. 2023-005). Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/virtual-home-visiting-during-covid-19-pandemic-lessons-learned-research-practice-policy

[52] Stark, 2022.

[53] Interested Party A (personal communication, January 31, 2023).

[54] Fruner, Rhiannon Riccillo. (2023). *Serving families during COVID-19: A Parent Educator's story*. Parents as Teachers. https://parentsasteachers.org/2020-5-14-serving-families-during-covid-19-a-parent-educators-story/

[55] Healthy Families America. (n.d.) *Guidance for HFA sites in response to COVID-19*. https://www.healthyfamiliesamerica.org/hfa-response-to-covid-19/

[56] Chazan-Cohen et al., 2021.

[57] Ferrara et al., 2022.

[58] Marshall et al., 2020.

[59] Stark, 2022.

[60] Interested Party A (personal communication, January 31, 2023).

[61] Hadley, Hayes, Pai-Samant, & Stern, 2023.

[62] Marshall et al., 2020.

FINDINGS FROM RESEARCH AND PRACTICE

The practice was key for families to be able to access mental health services in a timely manner after the onset of the PHE. One program administrator noted that home visitors helped expedite receipt of services for families with critical or complex needs by intentionally and formally partnering with mental health providers and assisting families with applications to submit to referral partners.[63] In addition, interested parties believe home visitors referring families to needed services during the PHE demonstrates how providing referrals is a component for effective home visits, and that families appreciated receiving needed supports through referrals.[64, 65]

PRACTICE CHANGE 3: INCREASED FOCUS ON FAMILIES' MENTAL HEALTH NEEDS

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

The literature and information gathered from interested parties suggest that after the onset of the PHE, families presented with more mental health needs or their mental health needs changed in other ways.[66, 67, 68] In response, some home visitors from both MIECHV-funded and non-MIECHV-funded programs increased focus on identifying and addressing families' mental health needs.[69, 70, 71, 72] For example, one program administrator focused on developing formal relationships with mental health providers. It encouraged LIAs under its jurisdiction to build formal partnerships with mental health providers in the community and to leverage mental health consultations to support staff and assist in program planning.[73] In contrast, a few infant mental health and home visiting programs offered counseling to families directly through their programs, supplementing the counseling with resources and activities to help reduce families' stress.[74] One Parents as Teachers home visitor described inviting families to participate in yoga and mindfulness activities to reduce stress.[75] In addition, one program administrator changed funding provisions to allow programs to spend funds on mental health consultations for families.[76]

OVERVIEW OF RESEARCH STUDY DESIGN

One study noted collecting information through interviews on the increased focus on identifying and addressing family mental health needs. In addition, a couple studies noted evaluating mental health consultations before the COVID-19 PHE. Findings from pre-PHE studies might help inform how the

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[63] Interested Party A (personal communication, January 31, 2023).

[64] Hadley, Hayes, Pai-Samant, & Stern, 2023.

[65] Marshall et al., 2020.

[66] Interested Party A (personal communication, January 31, 2023).

[67] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[68] Chazan-Cohen et al., 2021.

[69] Chazan-Cohen et al., 2021.

[70] Interested Party C (interview, February 22, 2023).

[71] Interested Party B (personal communication, January 31, 2023).

[72] Illinois Department of Human Services. (2022). *The state of home visiting: Reflections of infant and early childhood mental health consultants on family and home visitor experiences*. Retrieved April 21, 2023, from https://igrowillinois.org/wp-content/uploads/2023/01/MIECHV-IECMHC-brief_2.7.22.pdf

[73] Interested Party A (personal communication, January 31, 2023).

[74] Chazan-Cohen et al., 2021.

[75] Fruner, 2023.

[76] Interested Party C (interview, February 22, 2023).

practice affects families, home visitors, and programs. For example, one study included interviews with 100 families and early childhood service providers from seven infant mental health and home visiting programs representing different infant/toddler program models, geographies, and community and family characteristics. The provision of mental health supports was discussed during interviews, among other topics.[77] Before the PHE, Colorado MIECHV evaluated the implementation of mental health consultations by interviewing home visitors, supervisors, and mental health consultants from home visiting agencies throughout the state.[78] Also before the PHE, the Center for Prevention Research and Development at the University of Illinois evaluated mental health consultations via online surveys of home visiting program staff and consultants, focus groups with consultants and grant sites, and interviews with leaders.[79] Both studies contribute to learnings on formal partnerships between ECHV programs and mental health professionals.

FINDINGS FROM RESEARCH AND PRACTICE

Both the literature and information gathered from interested parties indicate that the practice increased families' access to mental health services. One program administrator reported that developing formal relationships with mental health providers was a critical element to accessible mental health services for families.[80] Infant and early childhood home visiting programs offering virtual mental health counseling to families increased accessibility of mental health services, and programs also reported seeing an increase in demand of mental health counseling.[81, 82]

Two resources point to theoretical or pre-PHE data that might help inform how the practice change affects families, home visitors, and programs. One resource noted that, theoretically, identifying and addressing families' mental health needs might lead to more responsive parenting.[83] A different resource focusing on mental health services before the PHE reported that the use of infant and early childhood mental health consultants provided long-term benefits, such as increased staff capacity to address mental health concerns, reduced stress for home visiting staff, increased family engagement, additional referral pathways, and improved coordination of care.[84]

PRACTICE CHANGE 4: INCREASED USE OF COACHING FAMILIES IN POSITIVE FAMILY–CHILD INTERACTIONS

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

Before the PHE, home visiting programs generally encouraged home visitors to both coach families on positive behaviors in family–child interactions and model for families what the behaviors should look

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[77] Chazan-Cohen et al., 2021.

[78] Colorado Department of Public Health & Environment. (2020). *Mental health consultation evaluation: Summary of interviews with home visitors, supervisors, & mental health consultants*. https://create.piktochart.com/output/33907635-mental-health-consultation_interviews-summary_co-miechv

[79] Illinois Children's Mental Health Partnership. (2020). *Early childhood mental health consultation to home visiting programs: Addressing the unmet mental health needs of families with young children*. https://www.icmhp.org/wp-content/uploads/2020/03/Early-Childhood-Mental-Health-Consultation-To-Home-Visiting-Programs.pdf

[80] Interested Party A (personal communication, January 31, 2023).

[81] Williams, K., Ruiz, F., Hernandez, F., & Hancock, M. (2021). Home visiting: A lifeline for families during the COVID-10 pandemic. *Archives of Psychiatric Nursing, 35(*1), 129–133. https://doi.org/10.1016/j.apnu.2020.10.013

[82] Chazan-Cohen et al., 2021.

[83] Chazan-Cohen et al., 2021.

[84] Maternal and Child Health, Health Resources and Services Administration. (2020a). *Embedding infant and early childhood mental health consultation in maternal, infant, and early childhood home visiting programs*. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/iecmhc-roadmap.pdf

like.[85] For example, home visitors who use a more hands-on approach in their work might coach families whereas home visitors working with families who are hesitant to play with their child in front of the home visitor might model the positive behaviors.[86, 87, 88] After the onset of the PHE, home visitors from both MIECHV-funded and non-MIECHV-funded programs increased use of coaching families in positive family–child interactions. This was largely due to the shift to virtual home visits from in-person home visits given that it is difficult for home visitors to model positive behaviors in family–child interactions if they are not in the same physical room with the child.[89, 90, 91] For example, a 2020 Rapid Response – Virtual Home Visiting Collaborative webinar on engaging families during virtual home visits reported that the shift to virtual home visits from in-person home visits led to families taking more leadership during home visits because they were physically present with the child as opposed to the home visitor. One webinar presenter indicated that, with families' increased leadership and home visitors unable to observe the family–child interactions in person, home visitors primarily served as "a coach in the air."[92] One program placed a greater focus on coaching but still modeled positive family–child interactions virtually. The program led a video group session with six families. The home visitor first modeled a family–child activity with their own child in their own home, then focused on coaching the families for the rest of the session as they conducted the same activity with their children in their homes.[93] Programs implementing the Attachment and Biobehavioral Catch-up (ABC) and modified ABC (mABC) home visiting curriculum already focused on coaching or "in-the-moment commenting" during in-person home visits – a practice that ABC model developers consider to be an active ingredient of the program.[94, 95] ABC and mABC guidelines for coaching during in-person home visits relied on home visitors being able to see a family's full environment. However, home visitors were unable to see a family's full environment during virtual home visits, either because of the limited view of the camera during video visits or because of the lack of a camera during telephone visits. Therefore, programs followed new guidelines to coach families during virtual home visits, modifying comments to respond to what was in view and what could be heard during the virtual engagement.[96, 97]

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[85] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[86] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[87] Shanty, L. (2022). *Facilitating parent-child interaction in home visiting: Staff experiences and supervisory support* (Publication No. 29259753) [Doctoral Dissertation, University of Maryland, Baltimore County]. ProQuest Dissertations and Theses Global.

[88] Korfmacher, J., Molloy, P., & Frese, M. (2021a). *"But it's not the same" What happens in virtual home visits?* [Research Brief] Erikson Institute. https://www.erikson.edu/wp-content/uploads/2021/10/Research-Brief-2-HV-COVID-Obs-Int.pdf

[89] Behl, D. D., Blaiser, K., Cook, G., Barrett, T., Callow-Heusser, C., Brooks, B. M., Dawson, P., Quigley, S., & White, K. R. (2017). A multisite study evaluating the benefits of early intervention via telepractice. *Infants & Young Children*, *30*(2), 147–161. https://doi.org/10.1097/IYC.0000000000000090

[90] Cole, B., Pickard, K., & Stredler-Brown, A. (2019). Report on the use of telehealth in early intervention in Colorado: Strengths and challenges with telehealth as a service delivery method. *International Journal of Telerehabilitation*, *11*(1), 33. https://doi.org/10.5195/ijt.2019.6273

[91] Olsen, S., Fiechtl, B., & Rule, S. (2012). An evaluation of virtual home visits in early intervention: Feasibility of "Virtual Intervention." *The Volta Review*, *112*(3), 267–281. https://www.proquest.com/scholarly-journals/evaluation-virtual-home-visits-early-intervention/docview/1266509694/se-2

[92] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[93] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[94] Roben, C. K. P., Kipp, E., Schein, S. S., Costello, A. H., & Dozier, M. (2022). Transitioning to telehealth due to COVID-19: Maintaining model fidelity in a home visiting program for parents of vulnerable infants. *Infant Mental Health Journal*, *43*(1), 173–184. https://doi.org/10.1002/imhj.21963

[95] Labella, M. H., Benito-Gomez, M., Margolis, E. T., Zhang, J., & Dozier, M. (2023). Telehealth delivery of modified attachment and biobehavioral catch-up: Feasibility, acceptability, and lessons learned. *Attachment & Human Development*, *25*(2), 250–253. https://doi.org/10.1080/14616734.2023.2179577

[96] Roben et al., 2022.

[97] Labella et al., 2022.

OVERVIEW OF RESEARCH STUDY DESIGN

Four studies included information on evaluating the practice. Two studies analyzing programs that included coaching as one of their active ingredients (ABC and mABC) described reviewing and coding video clips from home visits by frequency and quality of coaching comments. One of these studies also reviewed supervision fidelity reports and the other included comments on coaching and virtual service delivery from home visitors during supervision conversations.[98, 99] One study reported evaluating the practice based on interviews with, and a survey of, home visitors and supervisors. Another study reported evaluating the practice based on interviews with, and a survey of, home visitors and caregivers. Both studies reported comparing recorded virtual home visit data with in-person, pre-COVID-19 home visit data. However, the studies did not provide details on the comparison outcomes.[100, 101]

FINDINGS FROM RESEARCH AND PRACTICE

Findings indicate that some home visitors prefer increased use of coaching as opposed to modeling, but some families do not. Home visitors expressed that coaching led to a greater sense of family–home visitor partnership. They also suggested that the emphasis on coaching in virtual home visits helped them identify new strategies to center the family, thereby enhancing the way that they worked with families.[102, 103] Some program staff noted that the increased emphasis on coaching increased family engagement in virtual home visits.[104] (Active participation of families is discussed in detail under Practice Change 6.) Families in one program implementing ABC preferred modeling because it gave the child an opportunity to interact with another adult and the caregiver an opportunity to step back from caregiving. [105] Some other families in different programs noted a feeling of "missing out" on in-person demonstrations during virtual home visits. [106, 107]

A few resources reported that coaching during virtual home visits had similar or increased fidelity to coaching during in-person home visits, or increased implementation quality and impact. One resource stated and another implied that researchers, using coded video clips from home visits, found that coaching during virtual home visits exceeded fidelity standards of the home visiting models compared to in-person visits.[108, 109] A different resource reported that providers perceived an increase in the quality of family engagement when families interacted with the child more. They indicated that this led to families finding new ways to help their children engage with the home visit content and that their confidence increased.[110, 111]

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[98] Labella et al., 2022.

[99] Roben et al., 2022.

[100] Shanty, 2022.

[101] Korfmacher, Molloy, & Frese, 2021a.

[102] Chazan-Cohen et al., 2021.

[103] Roben et al., 2022.

[104] Shanty, 2022.

[105] Chazan-Cohen et al., 2021.

[106] Hadley, Hayes, Pai-Samant, & Stern, 2023.

[107] Korfmacher, Molloy, & Frese, 2021a.

[108] Roben et al., 2022.

[109] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[110] Chazan-Cohen et al., 2021.

[111] Shanty, 2022.

In addition, a few resources reported findings about coaching from before the PHE. These pre-PHE studies might help inform how the practice affects families, home visitors, and programs. The studies found that coaching is positively related to family engagement and the quality of the home visit.[112, 113, 114]

PRACTICE CHANGE 5: INCREASED SUPPORTS FOR PROFESSIONAL DEVELOPMENT[115]

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

Before the PHE, programs generally offered in-person staff training and peer meetings to discuss program implementation and content. They also encouraged staff mental health and wellness. After the onset of the PHE, programs supported professional development by (1) offering virtual training and meetings, (2) providing guidelines and skills development for new practices, and (3) offering self-care and work–life balance supports for home visitors. For example, in April 2020, one program administrator created virtual drop-in groups to support peer learning among home visitors from different home visiting models across the state. They called these groups "the meeting after the meeting" and styled them as breakroom conversations for home visitors to convene, share, and learn from each other.[116] Also, after the onset of the PHE, several programs issued guidance for home visiting staff to execute changes in standard practice. One program serving the Washington, DC area issued guidelines encouraging home visitors implementing the MIECHV-funded Healthy Families America (HFA) and Parents as Teachers models over the telephone to ask families open-ended questions about family–child interactions and to narrate their children's cues.[117] In addition, HFA provided guidance on documenting program components via video home visits and emphasized observation of the family and environment via video.[118] A Tribal MIECHV-funded program in Anchorage, Alaska, offered staff a monthly wellness stipend that could be applied to products such as relaxation apps, journals, and online exercise classes. It also allowed staff 30 minutes per day, during work hours, for wellness activities.[119] Other programs offered guidance to staff on managing work–life balance, such as turning off their telephones after-hours, and helping staff address mental health needs through guidance and counseling.[120]

OVERVIEW OF RESEARCH STUDY DESIGN

A couple of studies described evaluating the practice change via survey. ParentChild+ and Child Trends conducted pre- and post-implementation surveys with families and home visitors to learn about virtual and hybrid service delivery, including professional development practice changes.[121] One study, which

[112] Roggman, L. A., Boyce, L. K., Cook, G. A., & Jump, V. K. (2001). Inside home visits: A collaborative look at process and quality. *Early Childhood Research Quarterly*, *16*(1), 53–71. https://doi.org/10.1016/S0885-2006(01)00085-0

[113] Filene, J. H., Kaminski, J. W., Valle, L. A., & Cachat, P. (2013). Components associated with home visiting program outcomes: A meta-analysis. *Pediatrics*, *132*(Suppl. 2), S100–S109. https://doi.org/10.1542/peds.2013-1021H

[114] Peterson, C. A., Hughes-Belding, K., Rowe, N., Fan, L., Water, M., Dooley, L., Wang, W., & Steffensmeier, C. (2018). Triadic interactions in MIECHV: Relations to home visit quality. *Maternal Child Health Journal*, *22*(Suppl. 2), 3–12. https://doi.org/10.1007/s10995-018-2534-x

[115] The practice of increased supports for professional development includes information on onboarding.

[116] Bultinck et al., 2022.

[117] Williams, Ruiz, Hernandez, & Hancock, 2021.

[118] Shanty, 2022.

[119] Stark, 2022.

[120] Chazan-Cohen et al., 2021.

[121] Bultinck et al., 2022.

assessed levels of support provided to home visitors during the PHE, conducted a telephone survey of lead site supervisors at 16 South Carolina MIECHV-funded LIAs.[122]

FINDINGS FROM RESEARCH AND PRACTICE

Offering virtual training and meetings as opposed to in person led to greater accessibility and frequency of home visitor training and meetings because it eliminated travel and cost barriers for home visitors and, presumably, programs.[123] Also, one program administrator offered peer groups in both English and Spanish, which increased the accessibility and cultural relevance for some Spanish-speaking home visitors.[124]

In addition, some program staff indicated that the practice led them to feel more supported in their roles. Some home visitors indicated that the changes to professional development increased their confidence in identifying family strengths and supporting family–child interactions, and improved their ability to develop strengths-based texts to send to families.[125] In one study, authors found that lead site supervisors at South Carolina MIECHV-funded LIAs provided home visitors with medium to high levels of overall support and noted that this, along with the study's other findings, demonstrated that home visitors feel supported by the changes to professional development during the PHE.[126]

PRACTICE CHANGE 6: NEW TECHNIQUES FOR SUPPORTING FAMILIES' ACTIVE PARTICIPATION

PRACTICE CHANGE IN RESPONSE TO THE COVID-19 PHE

After the onset of the PHE, when many programs shifted from in-person to virtual home visits in response to social distancing requirements and guidelines, as well as families' preferences, programs began developing new techniques to engage families in virtual home visits. Programs made this change in four main ways: (1) engaging families in the planning of home visits; (2) using music and visuals to keep both children and adults engaged during home visits; (3) offering virtual peer groups; and (4) distributing activity kits and similar materials to families. For example, after the onset of the PHE, a California program added home visitor–family debriefs, which it called Reflection Records, at the end of home visits. The debriefs were a chance for home visitors to solicit families' feedback and co-create strategies to address challenges experienced during the home visit.[127] After the onset of the PHE, some providers across programs reported engaging families during video home visits by playing music, displaying visuals through screenshare functionality, placing an inspirational poster within view, and showing the home visitor's dog on video for a child who likes dogs.[128, 129] The literature indicated that this approach took skill to successfully implement because providers had to have a high level of awareness of families' capacity to focus and their emotions and interests. Providers also had to quickly

[122] Crouch, E., Radcliff, E., Browder, J., Workman, L., & McClam, M. (2022). Assessing levels of support provided to home visitors in the US during the COVID-19 pandemic. *Journal of Health Visiting*, *10*(10), 428–433. https://doi.org/10.12968/johv.2022.10.10.428

[123] Hadley, Hayes, Pai-Samant, & Stern, 2023.

[124] *Building the Virtual Home Visiting Knowledge Base: Lend Your Voice to the Conversation* [Webinar], 2020.

[125] Bultinck et al., 2022.

[126] Crouch et al., 2022.

[127] Bultinck et al., 2022.

[128] Chazan-Cohen et al., 2021.

[129] Rapid Response – Virtual Home Visiting Collaborative. (2020d). *Engaging with fathers virtually* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/engaging-with-fathers-virtually

respond to any diminishing interest.[130] In addition, one program implementing the Early Head Start model created a virtual peer group via Facebook Messenger. Families used the private peer forum to share videos of themselves reading and cooking and communicating tips for other families.[131] One California home visiting program, after noticing that caregivers found it challenging to keep children occupied during virtual group meetings, distributed activity kits to keep children of all ages occupied, allowing caregivers to focus on the meeting. [132] The Maryland-based MIECHV-funded program also prepared and distributed activity kits that allowed caregivers to engage in family–child activities.[133]

OVERVIEW OF RESEARCH STUDY DESIGN

A few studies described evaluating the practice via interviews and survey. ParentChild+ and Child Trends partnered to conduct focus groups with home visitors and families, and also fielded surveys in both English and Spanish.[134] Other studies reported feedback from supervisors and home visitors, including one study that conducted 100 interviews with providers and families from seven home visiting and infant mental health programs.[135, 136]

FINDINGS FROM RESEARCH AND PRACTICE

Programs used a variety of approaches to support families' active participation, such as engaging families in the planning of home visits, offering virtual peer groups, and dropping off activity kits for children. Findings point to the ways these practices helped programs keep families engaged. For example, the practice of engaging families in home visit planning might improve the quality of services by increasing families' buy-in to try different tips discussed during home visits and developing a deeper sense of partnership between home visitors and families.[137] In the California-based program implementing ParentChild+, one home visitor reported that the Reflection Records kept caregivers more engaged with their children because the caregiver could tie the activities back to their goals. Families in this program reported feeling more supported because of these reflections.[138] Several programs reported increased family engagement in virtual peer groups compared to in-person peer groups before the PHE. In some cases, this was because families did not have to secure transportation to in-person groups, spend time on travel, or secure childcare. Families reported that receiving activity kits and materials motivated them to stay in their program.[139] Finally, program staff reported that engagement of family members living outside of the child's home improved with the virtual home visiting format.[140]

POTENTIAL TO ADVANCE EQUITABLE ACCESS OF ECHV SERVICES

The practices to improve referral partnerships and processes, increase focus on families' mental health needs, and implement new techniques for supporting families' active participation in home visits show

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[130] Chazan-Cohen et al., 2021.

[131] Rapid Response – Virtual Home Visiting Collaborative. (2020f). *Parent-child groups in a virtual world* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/parent-child-groups-in-a-virtual-world

[132] Rapid Response – Virtual Home Visiting Collaborative. (2020b). *California virtual groups* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/california-virtual-groups

[133] Shanty, 2022.

[134] Bultinck et al., 2022.

[135] Shanty, 2022.

[136] Chazan-Cohen et al., 2021.

[137] Chazan-Cohen et al., 2021.

[138] Chazan-Cohen et al., 2021.

[139] Chazan-Cohen et al., 2021.

[140] Hadley, Hayes, Pai-Samant, & Stern, 2023.

potential to advance equitable access of ECHV services for families. For example, one program administrator noted that home visitors intentionally and formally partnering with mental health providers and assisting families with applications to submit to referral partners helped expedite receipt of services for families with critical or complex needs.[141] New or enhanced professional development offerings for home visitors also present an opportunity to support a more diverse workforce. One program administrator, as part of its increased supports for professional development, offered home visitor peer groups in both English and Spanish, which increased the accessibility and cultural relevance of professional development for some Spanish-speaking home visitors.[142]

The potential for the four practices to advance equitable access of services for families or home visitors depends on several factors, such as the type and cost of the service being provided. For example, home visiting programs interested in addressing families' mental health needs might not be able to feasibly offer virtual mental health counseling to families if they receive a low reimbursement rate, or are not reimbursed, by Medicaid or private insurance companies for virtual counseling services.[143] Additional detail on the six practice changes and their potential to advance equitable access of ECHV services for families or home visitors can be found in Appendix C.

POTENTIAL TO AFFECT LEVEL OF EFFORT TO DELIVER OR PARTICIPATE IN ECHV

Of the six practice changes of focus, three have the potential to affect families' level of effort to participate in ECHV, whereas all six have the potential to affect programs' level of effort to deliver ECHV. One practice – increased use of coaching families in positive family–child interactions – has the potential to increase families' level of effort to participate in ECHV. The practices of increased frequency of informal contacts and new techniques for supporting families' active participation have the potential to both decrease and increase families' level of effort to participate in ECHV. All six practice changes have the potential to increase programs' level of effort to deliver ECHV, but one practice – increased supports for professional development – has the potential to also decrease programs' level of effort. Detail on the six practice changes and their potential to affect families' level of effort to participate in, and programs' level of effort to deliver, ECHV is shown in Table 4.

[141] Interested Party A (personal communication, January 31, 2023).

[142] *Building the Virtual Home Visiting Knowledge Base: Lend Your Voice to the Conversation* [Webinar], 2020.

[143] Chazan-Cohen et al., 2021.

Table 4. Potential of Practice Changes to Affect Level of Effort for Families to Participate in ECHV and Programs to Deliver ECHV

Practice Change	Potential to Affect Families' Level of Effort	Potential to Affect Programs' Level of Effort
Practice Change 1: Increased frequency of informal contacts	Potential to both decrease and increase. More frequent contact, although informal and short in duration, can place pressure on some families to engage with providers beyond what they have the bandwidth and availability for. Other families might find it easier to have shorter and less intensive interactions with home visitors rather than a longer and more intensive formal home visit. *Example:* One resource found that families in the United Kingdom, especially those deemed high risk by local programs, felt that more frequent contact with their providers was distressing and frustrating.[144]	Potential to increase. Presumably, home visitors might make informal calls and send informal texts and direct messages on top of their standard workloads. *Example:* Not reported
Practice Change 2: Improved referral partnerships and processes	No change identified.	Potential to increase. Some programs might only need to consistently update referral partnership records, which might require a low level of effort. In contrast, other programs might need to develop multiple new referral partnerships, which might require a high level of effort. *Example:* One resource suggested that programs with existing relationships with community-based organizations generally only needed to update their information and ensure that they had a direct point of contact.[145] In contrast, one resource reported that connecting families to other services during unexpected crises can be time- and energy-consuming, taking away from families and program staff meeting their home visiting goals, such as explicit parenting goals.[146]
Practice Change 3: Increased focus on families' mental health needs	No change identified.	Potential to increase. Some programs might need to expend a high level of effort depending on the availability of mental health providers in a program's area and other factors. *Example:* Interview respondents in Texas reported a statewide mental health provider shortage and suggested that it may be burdensome for home visiting programs to identify mental health providers to work with.[147]

[144] Cook, L. L., & Zschomler, D. (2020). Virtual home visits during the COVID-19 pandemic: Social workers' perspectives. *Practice*, *32*(5), 401–408. https://doi.org/10.1080/09503153.2020.1836142

[145] Williams, Ruiz, Hernandez, & Hancock, 2021.

[146] Chazan-Cohen et al., 2021.

[147] Interested Party C (interview, February 22, 2023).

Table 4. Potential of Practice Changes to Affect Level of Effort for Families to Participate in ECHV and Programs to Deliver ECHV (Continued)

Practice Change	Potential to Affect Families' Level of Effort	Potential to Affect Programs' Level of Effort
Practice Change 4: Increased use of coaching families in positive family–child interactions	Potential to increase. Caregivers might have to engage in more intensive interaction during home visits when coaching is used over modeling because coaching requires a greater level of active participation. *Example:* Not reported	Potential to increase. Home visitors might have to engage in more preparation to be deliberate in what and how they choose to coach. In addition, home visitors might have to spend more time explaining to families their coaching plan and method. *Example:* One resource reported that planning before the home visit is required to initiate deliberate family–child interactions, particularly for families that do not engage in frequent family–child interactions.[148]
Practice Change 5: Increased supports for professional development	No change identified.	Potential to both decrease and increase. Presumably, increased accessibility of training and meetings for home visitors might decrease the level of effort for home visitors, but adding training for new skills development and expectations to engage in wellness during the workday might increase the level of effort for home visitors. In addition, increased effort via one support might be offset by decreased effort via a different support. *Example:* Not reported
Practice Change 6: New techniques for supporting families' active participation	Potential to both decrease and increase. Receiving activity kits for children might make it easier for caregivers to actively participate in peer groups because their children are engaged with the kits, but engaging families in the planning of home visits might place pressure on families to engage with providers beyond what they have the bandwidth and availability for. *Example:* One resource reported that a home visiting program in California distributed activity kits to families in response to caregivers finding it challenging to keep children occupied during virtual group meetings. The activity kits occupied the children while caregivers focused on the meetings.[149]	Potential to increase. Home visitors might need to spend more time preparing for home visits and delivering or shipping activity kits and materials. They may also need to reallocate funds to ship activity kits and materials. In addition, the level of home visitor creativity and resourcefulness required to keep families engaged in virtual home visits can require more time to prepare, learn, and refine techniques.[150, 151, 152] *Example:* In a study of the program that implemented Reflection Records, home visitors reported that the guided debriefs increased their workload – 83% surveyed needed additional time to prepare for sessions and 75% required additional time to prepare post-visit paperwork.[153]

[148] *Engaging Families in Virtual Visits: A Protective Factors' Approach* [Webinar], 2023.

[149] *California Virtual Groups* [Webinar], 2020.

[150] O'Neill, K., Korfmacher, J., Zagaja, C., & Duggan, A. (2020). *COVID-19's early impact on home visiting: First report from a National HARC-beat survey of local home visiting programs*. Home Visiting Applied Research Collaborative.

[151] Hadley, Hayes, Pai-Samant, & Stern, 2023.

[152] Korfmacher, Molloy, & Frese, 2021b.

[153] Bultinck et al., 2022.

FEASIBILITY FOR FUTURE TESTING AND IMPLEMENTATION

As described in previous sections, available information on each practice change is limited. Therefore, it is important to learn more about each practice change, how it is implemented, and its implementation outcomes. Individuals and entities that are interested in how the six practice changes might improve ECHV programming can benefit from new research that describes the practice changes and identifies the key factors that support their high-quality implementation.

Box 3. Example Study Designs to Learn More About Practice Changes

A **survey** could capture information on how ECHV programs are implementing practice changes and program staff perceptions of implementation outcomes.

A **case study** could capture rich detail on a single program's implementation of practice changes and program staff perception of outcomes.

A **rapid cycle evaluation (RCE)** could quickly test and assess practice changes. It could also help programs identify refinements to the practice changes.

Note: Various study designs could be used to learn more about the practice changes. Individuals and entities might select a study design based on several factors, including their desired timelines for results, their available resources, and their ability to align the timing and occurrence of a specific practice change with a study's timeline.

Box 4. Implementation Factors Common Across Implementation Science Frameworks

Provider factors: (1) qualifications, skills, and competencies to offer the practice change; (2) buy-in and belief in intended goals; (3) self-efficacy and motivation; (4) relationship and degree of commitment to organization; (5) professionalism, or participation in professional organizations and activities; and (6) low turnover.

Organizational factors: (1) openness to change; (2) work climate (e.g., frequent communication with feedback loops); and (3) supports and infrastructure (e.g., leadership and responsibility for implementation, program champion, and coordination with other agencies).

Contextual factors: (1) the existing theory and research; (2) funding priorities; (3) policies; (4) community readiness to identify and address need; (5) interests of local consumers; (6) policy mandates or incentives; and (7) interorganizational norm setting and networks.

Principles from the field of implementation science can be used to identify provider, organizational, and contextual factors that facilitate or hinder an ECHV program's capacity to implement the practice changes effectively. Drawing on research on implementation factors necessary to deliver high-quality services, we identified potential key factors that might facilitate or hinder implementation of the six practice changes of focus.[154, 155, 156] For example, the practice of increased frequency of informal contacts might be facilitated or hindered by the degree to which home visitors are attuned to families' availability to engage with home visitors. Other key implementation factors for this practice might be the mode of the informal contacts, the reason for the informal contacts, and whether program systems and policies allow or accommodate informal contacts. The practice of improved referral partnerships and processes might be affected by the program's supports and infrastructure (including staff, time, and resources) to deepen referral networks and change referral processes. The practice of increased focus on families' mental health needs might be facilitated or hindered by the availability of mental health providers in the area. The increased use of coaching families in positive family–child interactions might be affected by home visitor or families' buy-in on the use of coaching over modeling or in combination with modeling. Other key implementation factors for this practice might be the coaching style (e.g., strengths-based coaching) and what the coaching entails

[154] Caronongan, P., Kirby, G., Boller, K., Modlin, E., & Lyskawa, J. (2016*). Assessing the implementation and cost of high-quality early care and education: A review of the literature* (OPRE Report No. 2016-31). Administration for Children and Families, Office of Planning, Research, and Evaluation, U.S. Department of Health and Human Services.

[155] Crowne, S., Rosinsky, K., Goldberg, J., Sparr, M., Ulmen, K., & Huz, I. (2021). *A conceptual framework for implementation quality in home visiting*. Child Trends in partnership with James Bell Associates for the U.S. Department of Health and Human Services, Health Resources and Services Administration. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/conceptual-framework-report.pdf

[156] Sparr, M., Goldberg, J., Thomson, A., Ryan, K., Kane, M., & Haas, M. (2021). *Quality considerations across levels of the home visiting system: A literature and measure review.* Child Trends in partnership with James Bell Associates for the U.S. Department of Health and Human Services, Health Resources and Services Administration. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/hviq-literature-measure-review.pdf

(e.g., goal setting, positive reinforcement, and specific feedback on an interaction). The practice of increased supports for professional development might be facilitated or hindered by the degree to which the organization has a leader or champion to advance professional development and whether home visitors are burned out by virtual training and meetings. The practice of new techniques for supporting families' active participation might be affected by the degree to which home visitors are attuned to families' availability to engage with home visitors and families' learning styles.

RECOMMENDATIONS AND NEXT STEPS

In this section, we offer recommendations for how the key findings can be used to inform MIECHV implementation, research, and policy. This is followed by a description of ways the project team will incorporate the key findings and recommendations into future work.

RECOMMENDATIONS

The key findings for the six practice changes of focus offer several recommendations to better understand how programs can deliver services and engage with families in the new and evolving ECHV landscape:

1. Assess families' availability to frequently engage with home visitors and individualize frequency of engagement to align with families' needs, preferences, and capacity
2. Identify appropriate parameters for the family–home visitor professional partnership
3. Identify systems-level best practices for referrals, with a focus on addressing families' mental health needs
4. Explore how and when programs implement coaching when supporting families in positive family–child interactions
5. Examine the effect of new supports for professional development on home visitor confidence, well-being, and effectiveness in delivering ECHV
6. Examine home visitor professional development across modes of service delivery

These recommendations are discussed in more detail in Table 5. Thematically, many of the recommendations are similar in that they prescribe further study to improve our understanding of the six practice changes, how best to implement the practice changes, and their potential to improve service delivery. Our review of the literature on practice changes finds that the literature is modest and descriptive in nature. This is not surprising given the disruption caused by the COVID-19 PHE and our proximity to those events, but it underscores the need for further research. In addition, the state of research suggests that initial studies should continue to focus on process and exploratory questions, to help build foundational knowledge about the practice changes.

NEXT STEPS

The key findings and recommendations from this environmental scan serve as a framework for the ADAPT-HV project team as it develops study design reports, conducts studies to test the implementation of some of the practice changes, and designs efficacy studies for future implementation. The findings and recommendations from the scan, combined with findings from the studies, will contribute to a deeper understanding of the practice changes that have the potential to improve how families are served in ECHV in the future. This includes gaining a deeper understanding of whether and how the ECHV field might implement and sustain the practice changes consistently across programs.

Table 5. Recommendations for MIECHV Program Implementation, Research, and Policy

Recommendation	Relevant Practice Change(s)	Overview	Example Research Questions
Assess families' availability to frequently engage with home visitors and individualize frequency of engagement to align with families' needs, preferences, and capacity	**Practice Change 1:** Increased frequency of informal contacts **Practice Change 6:** New techniques for supporting families' active participation	• The frequency of engagement between families and home visitors may be driven by several factors including the families' availability to engage, their goals and preferences, the age of their child(ren), and the home visiting model guidelines on service frequency. • Families' availability to engage frequently with home visitors may be dynamic, changing as families' needs change. • Assessing a family's availability for frequent engagement throughout their tenure in programs may ensure the frequency of engagement aligns with families' needs, preferences, and capacity.	Taking into account that each ECHV model may have a different minimum threshold for family engagement, how should model developers, programs, and home visitors work with families to determine the optimal frequency of engagement with each participating family? How should model developers, programs, and home visitors work with families to determine the optimal combination of in-person and virtual engagement? How does individualizing the frequency of engagement by family affect family and child outcomes?
Identify appropriate parameters for the family–home visitor professional partnership	**Practice Change 1:** Increased frequency of informal contacts	• Although some families reported that the family–home visitor partnership grew stronger with a less formal relationship, a high level of informality might blur the professional partnership and possibly result in families and home visitors not achieving their program goals. • Future research might examine whether, and at what level, informal contacts between families and home visitors might help or hinder family, child, and program outcomes.[157]	How do frequent, informal contacts between families and home visitors affect the family–home visitor relationship? How do less formal family–home visitor relationships influence family satisfaction, home visitor perceptions of family engagement, and home visitor efficacy to meet families' needs and preferences?
Identify systems-level best practices for referrals, with a focus on addressing families' mental health needs	**Practice Change 2:** Improved referral partnerships and processes **Practice Change 3:** Increased focus on families' mental health needs	• Multiple resources touched upon the importance of collaboration among ECHV programs and referral partners, including partners able to help address families' mental health issues (which some resources described as increasing with the onset of the COVID-19 PHE). • However, our scan did not identify systems-level best practices for referrals and addressing families' mental health needs. • Future research might examine modifiable best practices at the systems level that can be replicated among various permutations of cross-sector referral partners, particularly mental health referral partners.	What systems-level best practices are most effective for mental health referrals, and why? How do these systems-level best practices differ from those used for other types of cross-sector referrals?

[157] Chazan-Cohen et al., 2021.

Table 5. Recommendations for MIECHV Program Implementation, Research, and Policy (Continued)

Recommendation	Relevant Practice Change(s)	Overview	Example Research Questions
Explore how and when programs implement coaching when supporting families in positive family–child interactions	**Practice Change 4:** Increased use of coaching families in positive family–child interactions	• Not all families prefer home visitors' greater focus on *coaching* positive family–child interactions as opposed to *modeling* it. Families' preferences can depend on several factors, such as whether the caregiver is able to take a step back from daily caregiving, the caregiver's confidence level when engaging with their child, and whether the child has opportunities to interact with other adults. • Future research might examine how coaching is implemented, which factors are associated with how coaching is received by families, and how the use of coaching or modeling based on family preference might affect implementation, as well as family and child outcomes. This could include both qualitative and quantitative assessments.	How is coaching implemented by programs? How do programs and home visitors tailor the implementation of coaching to families' preferences? What factors affect whether and how families respond to coaching? How does providing coaching or modeling based on family preference affect when and how coaching is implemented? How does it affect family and child outcomes?
Examine the effect of new supports for professional development on home visitor confidence, well-being, and effectiveness in delivering ECHV	**Practice Change 5:** Increased supports for professional development	• Although some programs implemented new supports for home visitor professional development, it is unclear how these supports affect home visitor confidence, well-being, and effectiveness in delivering ECHV. For example, virtual trainings are easier for home visitors to attend, but home visitors may not feel the same level of support or develop the same level of understanding from virtual trainings as they do when attending in-person trainings. • Future research might examine whether and how these professional development supports affect home visitor confidence, well-being, and effectiveness in delivering ECHV, including whether modality or new content are achieving an increase in these outcomes.	Which combinations of professional development supports increase home visitor confidence, well-being, and effectiveness in delivering ECHV, and how?

Table 5. Recommendations for MIECHV Program Implementation, Research, and Policy (Continued)

Recommendation	Relevant Practice Change(s)	Overview	Example Research Questions
Examine home visitor professional development across modes of service delivery	**Practice Change 5:** Increased supports for professional development	• The final 2022 MIECHV reauthorization legislation requires that standards for home visitor training be equivalent for virtual and in-person modes of service delivery within a home visiting model.[158] • Individuals and entities might further examine professional development across the modes of virtual and in person, and develop an approach for assessing different or additional training requirements for home visitors conducting virtual home visits.[159]	What are best practices in assessing whether home visitor training is equivalent for virtual and in-person modes within a home visiting model? How prepared do home visitors feel to deliver virtual home visits in ways that align with evidence-based standards for service delivery?

Note: While we discuss some of the recommendations as applying generally to families served by ECHV programs, it is important to note that a one-size-fits-all approach cannot be taken when serving families and that programs and staff serving families should identify what works best for each individual family.

[158] The final MIECHV reauthorization legislation states, "…the term 'virtual home visit' means a visit conducted solely by use of electronic information and telecommunications technologies." It also states, "The standards for training requirements applicable to virtual service delivery under a home visiting model shall be equivalent to those that apply to in-person service delivery under the model." Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022, H.R. 8876, 117th Congress. (2022).

[159] Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022, H.R. 8876, 117th Congress. (2022).

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APPENDIX A. DATA SOURCES AND SEARCH METHODOLOGY

As described in the report, we gathered information from five sources: (1) foundational literature identified through Mathematica's other projects, (2) recommendations from federal staff, model developers, program administrators, implementers, and subject matter experts, (3) research manuscripts, (4) gray literature, and (5) input from interested parties.

To identify research manuscripts, the project team searched the following bibliographic databases: Academic Search Complete, PubMed, E-Journals, APA PsycInfo, CINAHL Ultimate, Health Policy Reference Center, Family & Society Studies Worldwide, ERIC, Education Source, and Sociology Source Ultimate.

To identify gray literature, we searched a targeted set of ECHV model developer and organization websites (Table A.1).

Table A.1. ECHV Model Developer and Organization Websites Targeted for the Gray Literature Search

Model Developer or Organization	Website
Parents as Teachers	parentsasteachers.org
SafeCare	safecare.publichealth.gsu.edu
Healthy Families America	healthyfamiliesamerica.org
Healthy Start EPIC Center	healthystartepic.org
Attachment and Biobehavioral Catch-up	abcintervention.org
Association of Maternal and Child Health Programs	amchp.org
Start Early	startearly.org
Child First	childfirst.org
Family Connects International	familyconnects.org
Nurse-Family Partnership	nursefamilypartnership.org
Institute for the Advancement of Family Support Professionals	rrvhv.earlyimpactva.org
Home Visiting Applied Research Collaborative	hvresearch.org
Home Instruction for Parents of Preschool Youngsters	hippyus.org
The Ounce of Prevention Fund of Florida	ounce.org
Head Start Early Childhood Knowledge and Learning Center	eclkc.ohs.acf.hhs.gov/programs/article/home-based-option
ParentChild+	parentchildplus.org

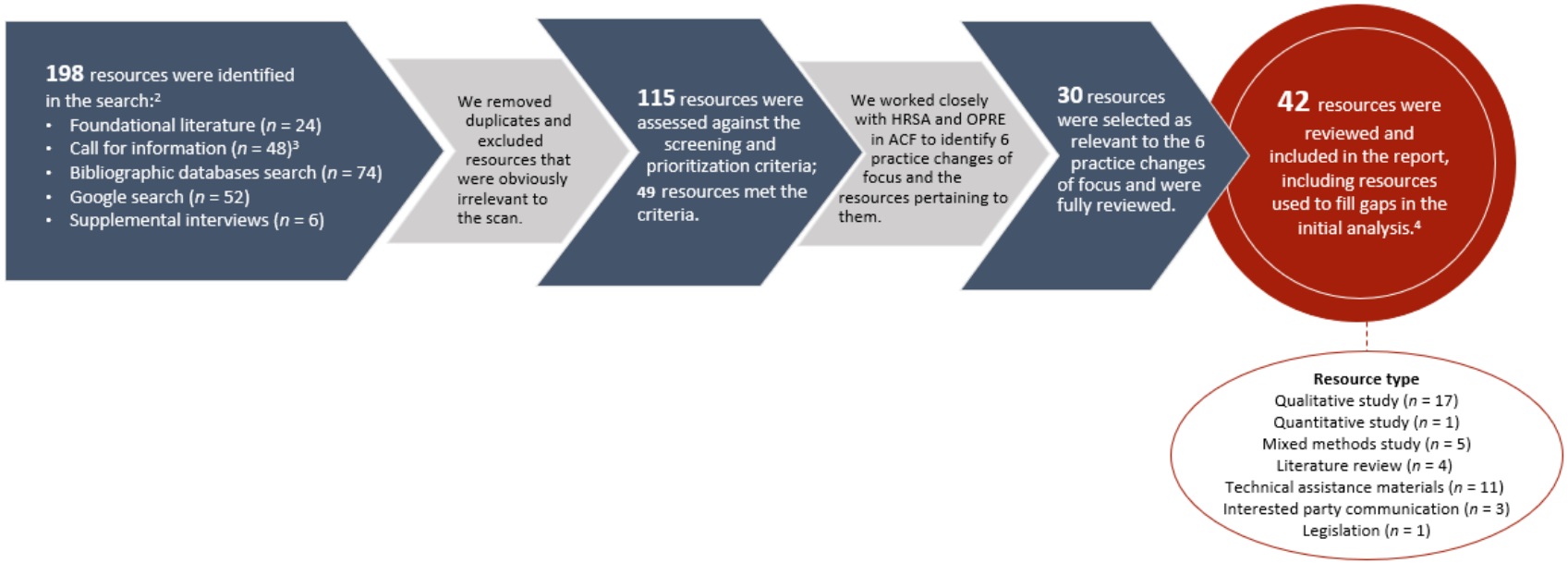
We used a set of targeted search terms to conduct the bibliographic database and Google searches (Table A.2).

Table A.2. Search Terms

Category	Search Term
Subject	COVID, home visiting
Population of interest	MIECHV, Head Start, early childhood, early intervention, infant mental health
Topic	Program, implement, practice, incentive, initiative, change, transition, virtual, recruitment, retention, engagement, supervision, training, professional development, assessment, screening, referral, observation

Figure A.1. provides information on how many resources we identified through each of the five sources, how many resources screened in and met the prioritization criteria, how many resources pertained to the six practice changes of focus, how many resources we fully reviewed, and resource characteristics.

Figure A.1. Resources Identified, Screened and Prioritized, Reviewed, and Included in Report[1, 2, 3,4]



[1] Supplemental interviews are not included in the bolded counts.

[2] The bolded count does not match the total number of resources identified by each source because the bolded count includes duplicates identified from more than one source.

[3] We received 74 resources one month after the deadline for the call for information. These resources were not included in the environmental scan unless already identified by a different source.

[4] The 42 resources reviewed and included in the report are resources that pertain to the six practice changes either specifically or generally. Some of these resources were identified after the screening and prioritization stages of the environmental scan, through our search to fill gaps in the initial analysis.

APPENDIX B. SUMMARY OF KEY FINDINGS FOR PRACTICE CHANGES OF FOCUS

This appendix contains a summary table of research study designs and findings from the literature for the six practice changes of focus for this report. The key findings listed in the table are distinct from findings, which we describe in previous sections of this report.

Table B.1. Summary of Research Study Designs and Findings From the Literature for Each of the Six Practice Changes of Focus

Resource	Study Design Related to the Practice Change	Relevance to the Practice Change	Summary of Key Findings
Practice Change 1: Increased frequency of informal contacts			
Bultinck et al. (2022) Qualitative	• Pre/postsurvey of families and home visitors	• The survey included one question on informal contacts. However, most of the survey covered other topics.	• Families reported that home visitors informally provided encouragement via text message outside of formal home visits. • Home visitors noted that families positively responded to motivational text messages sent outside of formal home visits.
Chazan-Cohen et al. (2021) Mixed methods	• Interviews with ECHV staff and families • Supplemental survey	• The interviews included discussion of informal contacts. However, the interviews broadly focused on the transition from in-person to virtual service delivery. • The survey included one question to caregivers about the effectiveness of engagement strategies, including text messages, and another to program staff gauging whether they used remote technologies like text messaging. However, the survey broadly focused on capturing demographic and quantitative information about attitudes on virtual engagement.	• Families and program staff reported feeling a stronger bond with each other through the less formal relationship structure. • Theoretically, the practice change can provide more opportunities for families and home visitors to discuss child development and related issues. • In a survey question about the effectiveness of various remote or distance engagement strategies, 88% of caregivers ranked text messages "mostly effective" or "very effective." However, the study did not describe the content of the text messages and whether they included informal check-ins, connections to resources, and support for child development and parenting as opposed to, for example, simple reminders about upcoming home visits. • In a survey question, 91% of program staff indicated that they used text messaging as a mode of virtual engagement. However, as indicated above, the study did not describe the content of the text messages.
Practice Change 2: Improved referral partnerships and processes			
Hadley et al. (2023) Qualitative	• Listening sessions with home visiting representatives	• Listening session participants discussed the practice change in response to open-ended questions. The survey and focus groups focused on a broader set of topics.	• Participants, especially families, noted that service providers increased collaboration across systems after the shift to virtual service delivery. • Participants noted challenges with referrals due to lack of availability (services at capacity or discontinued).
Marshall et al. (2020) Qualitative	• Survey of MIECHV staff and focus groups with staff, administrators, and supervisors	• Focus group participants and survey respondents discussed the practice change in response to open-ended questions. The survey and focus groups focused on a broader set of topics. • Focus group topics were related to Florida MIECHV-funded programs.	• One Florida MIECHV-funded program connected with a local food bank to drop off food to families during the PHE. • Families needed this support because of job loss or limited financial resources during the PHE.

Table B.1. Summary of Research Study Designs and Findings From the Literature for Each of the Six Practice Changes of Focus (Continued)

Resource	Study Design Related to the Practice Change	Relevance to the Practice Change	Summary of Key Findings
Practice Change 3: Increased focus on families' mental health needs			
Chazan-Cohen et al. (2021) Mixed methods	• Interviews with ECHV staff and families • Supplemental survey	• The focus of this research was family engagement during the COVID-19 PHE. The evaluation was not solely focused on mental health referrals.	• Some programs began offering mental health therapy and counseling to families. It is implied that they did not do this prior to the PHE. • In one program, providers changed the types of topics about which they would informally check in with families to include mental health. • Receiving mental health services from the same organization as home visiting increased accessibility of mental health services for some families.
Colorado Department of Public Health & Environment (2020) Qualitative	• Interviews with home visitors, supervisors, and mental health consultants	• The evaluation explored challenges and facilitators of mental health consultations in Colorado MIECHV. • The evaluation took place prior to the onset of the COVID-19 PHE.	• The mental health consultant was a support system and mental health supervision provider for home visitors. • Mental health consultation was provided in individual and group settings. • Mental health consultations and reflective supervision created both challenges and benefits for home visitors.
Illinois Children's Mental Health Partnership (2020) Qualitative	• Surveys of home visiting program staff and consultants, focus groups with consultants and grant sites, and interviews with leaders	• The evaluation explored challenges and facilitators related to the mental health consultation program partnership with Illinois MIECHV. • The evaluation took place prior to the onset of the COVID-19 PHE.	• The partnership model between mental health consultants and Illinois MIECHV programs was designed to train and empower home visiting staff. The consultant was seen as a trainer. • The partnership model was designed to fill gaps in the mental health services for families and young children in parts of Illinois.
Practice Change 4: Increased use of coaching families in positive family–child interactions			
Roben et al. (2022) Qualitative	• Video clips from home visits, coded by frequency and quality of coaching comments • Supervision fidelity reports	• The study examined virtual delivery of the ABC program, a program that emphasizes coaching. • The study did not have a randomized comparison sample.	• The study found that in-the-moment commenting during video home visits exceeded fidelity standards compared to in-person in-the-moment commenting. • Some parent coaches said that coaching during video home visits was easier.
Labella et al. (2023) Qualitative	• Video clips from home visits, coded by frequency and quality of coaching comments • Supervision conversations	• The study examined virtual delivery of the mABC program, a program that emphasizes coaching. • The study did not have a randomized comparison example.	• The study found that home visitors were able to deliver in-the-moment commenting consistently through the transition from in-person to virtual home visits.
Korfmacher et al. (2021a) Qualitative	• Interviews with home visitors and caregivers • Recorded virtual home visits • Survey of home visitors and caregivers	• This study is based on observations and interviews broadly studying the shift from in-person to virtual visits.	• Some home visitors became more intentional about the use of coaching, as opposed to modeling, during the shift to virtual home visits. • Some home visitors delivered coaching asynchronously through recorded video or texts.

Table B.1. Summary of Research Study Designs and Findings From the Literature for Each of the Six Practice Changes of Focus (Continued)

Resource	Study Design Related to the Practice Change	Relevance to the Practice Change	Summary of Key Findings
Shanty (2022) Mixed methods	• Survey of home visitors and supervisors • Interviews with home visitors and supervisors	• This study sought to explain how home visitors promote positive parent–child interactions, including using coaching or modeling, and the supervisory structures that support this.	• Home visitors reported difficulty coaching or modeling behaviors in a virtual setting.
Practice Change 5: Increased supports for professional development			
Bultinck et al. (2022) Qualitative	• Pre/postsurvey of families and home visitors	• Researchers examined the shift from in-person to virtual home visit delivery, not specifically professional development. • The study examined ParentChild+ programs in California.	• ParentChild+ developed a Best Practice Principles (BPP) for Coaching and Supervision. Home visitors reported that this framework helped increase their understanding of families' needs and their confidence.
Crouch et al. (2022) Qualitative	• Telephone survey of MIECHV-funded site administrators or supervisors	• The telephone survey was conducted with lead site administrators or supervisors at MIECHV-funded LIAs in South Carolina. • The survey was not focused on professional development.	• LIAs transitioned to virtual meetings with home visitors and provided their staff with mental health support, gift cards, and gift baskets during the COVID-19 PHE. • LIAs reported providing medium to high levels of overall support to home visitors during the COVID-19 PHE.
Practice Change 6: New techniques for supporting families' active participation			
Bultinck et al. (2022) Qualitative	• Focus groups and a pre/postsurvey of families and home visitors	• Researchers examined the shift from in-person to virtual home visit delivery, not specifically techniques for active participation. • The study examined ParentChild+ programs in California.	• ParentChild+ programs in California implemented a Reflection Record to co-create support plans for families. • One home visitor reported feeling that families were more engaged after completing the Reflection Record. • Families and home visitors reported positive feedback about the Reflection Records.
Chazan-Cohen et al. (2021) Qualitative	• Interviews with ECHV staff and families, supplemented with a survey	• The focus of this research was family engagement during the COVID-19 PHE. The evaluation was not solely focused on active participation.	• Families reported that getting activities/materials motivated them to stay in the program. • Several programs reported increased family engagement in peer groups compared to in-person, pre-pandemic peer groups. Programs said that they wanted to continue to offer the virtual groups because it was more convenient for families. • Engaging parents in the planning of home visits might have helped parents to remember to try different ideas/tips discussed with the home visitor during visits, reduce no-shows by reminding parents of the upcoming home visit and allowing them to reschedule, and develop a sense of partnership in approaching the home visits. As a result, this practice might increase service quality.

APPENDIX C. POTENTIAL OF PRACTICE CHANGES TO ADVANCE EQUITABLE ACCESS OF SERVICES

Table C.1. Practice Changes With Potential to Advance Equitable Access of Services

Practice Change	Population	Description of Potential Impact
Practice Change 2: Improved referral partnerships and processes	Families, particularly those in need of mental and behavioral health services and housing, financial, and food security support	Programs that develop new referral partnerships and formalize existing partnerships have the potential to facilitate and expedite connections between families and service providers. *Example:* One program administrator noted that home visitors intentionally and formally partnered with mental health providers and assisted families with applications to submit to referral partners to help expedite receipt of services for families with critical or complex needs.[1]
Practice Change 3: Increased focus on families' mental health needs	Families, particularly those in need of mental health services	Programs that place greater focus on identifying and addressing families' mental health needs have the potential to increase families' access to mental health services. *Example:* Infant and early childhood home visiting programs offering virtual mental health counseling to families increased accessibility of mental health services, and programs also reported seeing an increase in demand of mental health counseling.[2, 3]
Practice Change 5: Increased supports for professional development	Home visitors, particularly those facing barriers in attending in-person trainings and meetings and those whose primary language is not English	Programs that offer virtual training and meetings, as opposed to in-person training and meetings, have the potential to increase home visitors' access to professional development by eliminating travel and cost barriers. In addition, programs that offer home visitor peer groups in multiple languages can increase access to professional development for some home visitors whose primary language is not English. *Examples:* For some programs, offering virtual training and meetings, as opposed to in person, led to greater accessibility and frequency of home visitor training and meetings.[4] In addition, one program administrator offered groups in both English and Spanish, which increased the accessibility and cultural relevance for some Spanish-speaking home visitors.[5]

[1] Interested Party A (personal communication, January 31, 2023).

[2] Williams, K., Ruiz, F., Hernandez, F., & Hancock, M. (2021). Home visiting: A lifeline for families during the COVID-19 pandemic. *Archives of Psychiatric Nursing*, *35*(1), 129–133. https://doi.org/10.1016/j.apnu.2020.10.013

[3] Chazan-Cohen, R., Fisk, E., Ginsberg, I., Gordon, A., Green, B. L., Kappesser, K., Lau, S., Ordonez-Rojas, D., Perry, D. F., Reid, D., Rodriguez, L., & Tomkunas, A. (2021). *Parents' experiences with remote home visiting and infant mental health programs during COVID-19: Important lessons for future service delivery*. Perigee Fund. https://perigeefund.org/wp-content/uploads/2021/10/ParentVoices-FullReport-English.pdf

[4] Hadley, A., Hayes, J., Pai-Samant, S., & Stern, F. (2023). *Virtual home visiting during the COVID-19 pandemic: Lessons learned for research, practice, and policy*. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/virtual-home-visiting-during-covid-19-pandemic-lessons-learned-research-practice-policy

[5] Rapid Response – Virtual Home Visiting Collaborative. (2020a). *Building the virtual home visiting knowledge base: Lend your voice to the conversation* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/building-the-virtual-home-visiting-knowledge-base-lend-your-voice-to-the-conversation

Table C.1. Practice Changes With Potential to Advance Equitable Access of Services (Continued)

Practice Change	Population	Description of Potential Impact
Practice Change 6: New techniques for supporting families' active participation	Families, particularly those facing barriers in attending in-person peer groups and obtaining child development materials	Programs that offer virtual family peer groups, as opposed to in-person peer groups, have the potential to increase families' access to peer groups because families do not have to secure transportation and childcare, and spend time traveling to and from a meeting venue. In addition, programs that distribute activity kits and similar materials to families have the potential to increase families' access to child development materials. *Examples:* A West Virginia program and a Maryland program created virtual forums for families to connect to their peers and share information and resources.[6, 7] In addition, programs in California and Maryland distributed activity kits with child development materials.[8,9]

[6] Rapid Response – Virtual Home Visiting Collaborative. (2020f). *Parent-child groups in a virtual world* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/parent-child-groups-in-a-virtual-world

[7] Rapid Response – Virtual Home Visiting Collaborative. (2020b). *California virtual groups* [Webinar]. https://rrvhv.earlyimpactva.org/webinar/california-virtual-groups

[8] *California Virtual Groups* [Webinar], 2020.

[9] Shanty, L. (2022). *Facilitating parent-child interaction in home visiting: Staff experiences and supervisory support* (Publication No. 29259753) [Doctoral Dissertation, University of Maryland, Baltimore County]. ProQuest Dissertations and Theses Global.