REMOTE SERVICES DURING COVID-19

Introduction

The Covid-19 pandemic has impacted all aspects of our lives. In approximately mid-March 2020, most communities throughout the United States entered a period of quarantine in their homes with only essential public outings. This had a significant impact on family-serving agencies and their clients. The National Family Preservation Network sought to support these agencies through virtual training and technical assistance. NFPN also sought to assemble guidance for service delivery by collecting information about how agencies adapted during the quarantine. Seven agencies completed a questionnaire regarding their actions and experiences. The following is a compilation of their responses.

1. How did you modify services to families and program/agency procedures during the quarantine?

"We had to think outside the box for the welfare of our staff as well as the clients and families we serve." Dr. Marc Crandall, Lifestream Behavioral Center

When the quarantine began, all agencies transitioned to virtual services either partially or fully. One agency reported allowing staff and families to choose the form of treatment with which they felt most comfortable. In cases where in-person contact was chosen or deemed necessary, guidelines from the Centers for Disease Control (CDC) were implemented regarding personal protective equipment (face coverings), social distancing, widespread use of hand sanitizer, increased cleaning of facilities, and staff and visitor temperatures being taken. In some cases, in-person visits were conducted outdoors. If youth visited their home environment, items from the home were not allowed to be brought back into a facility. In addition, some staff changed their clothes when leaving a facility, some facilities washed staff clothing, specific staff were assigned for Covid-19 positive clients and these clients were segregated from the general population.

Virtual services for family visitation, case management, individual and group therapy were provided in various ways that differed from in-person services. Agencies reported using Zoom, GoToMeeting, the Virtual Care App and Microsoft Teams to deliver telehealth services. Most agencies had not provided telehealth prior to the quarantine and so it was necessary for them to develop protocols and for staff to receive training on using this technology.

In several cases, agencies already had a remote workforce for in-home services. Those that did not were able to set up virtual files for each case, to accommodate staff working from home. Some workers were also provided with hotspots for internet access. Having virtual files enabled supervisors to access to their staff's files so they could continue checking for fidelity without

having to obtain a physical file. Some supervisors had weekly team trainings to assist staff in communicating online to ensure that all families felt welcomed.

Emails were used in lieu of signatures on forms and several agencies began utilizing DocuSign for documents requiring signatures. DocuSign was reported to be a preferable method. In programs where flex funds are provided to families, most of the needed items were purchased online and shipped directly to families when possible.

Despite the above adaptations, some agencies are advocating to be allowed into families' homes for safety checks and possibly their first sessions. It is believed that this can be done safely by following CDC guidelines and keeping the visits as short as possible.

2. What modifications worked well? Are there best practices you would recommend?

One agency highly recommended that staff and families have mutual input about how and where services would be performed during this time. Allowing staff to choose the way they would provide services raised their morale during a very difficult period. Families also reported a feeling of respect for being allowed to state their preference in the way services would be delivered. Many families reported that they have never had any influence on service delivery before this.

Many intensive home-based programs require 8-10 hours of service per week with most families, which was challenging during the quarantine. In order to meet this requirement, some agencies conducted shorter sessions (usually 1-3 hours) more often (4-6 times each week).

Another agency recommended daily contact with families, possibly multiple times per day so that required service hours could be completed realistically without overwhelming families. Most of the families had an hour session in the morning and an hour in the evening. Workers also encouraged families to bring the computer tablet into situations so that workers could give immediate feedback to parents. This happened during bedtime routines and other times in which struggles occurred in the past. This approach received positive feedback from parents.

"The downside to engagement was shorter periods of time for work and issues not always being addressed in real time. The absence of the worker hindered the relationships since in-home workers become part of family." Tammy Miller & Beth McNamee, Canopy Children's Services

An agency that largely serves teens with self-harming behaviors stressed the importance of ensuring that clients remain on-screen during their sessions. This allowed for complete status checks and helped with full engagement during sessions.

For younger kids and/or kids with shorter attention spans, many workers found games to play during sessions. They shared their screens with clients so that they both could share music and videos, take turns playing a game, draw and write. This also helped with engagement.

The various modifications from CDC about remote services seemed to work well, but there have been unintended consequences with the change in services. For example, home-based staff have

typically had less billable hours due to lack of travel to the family. These modifications are being monitored on an on-going basis.

3. What were the barriers/challenges with providing remote services? How were families served who had no/limited access to technology?

The most widely reported issue with remote services was lack of technological devices and/or limited access to internet services. This included slow internet speeds and inadequate minutes on cell phone plans. These issues were addressed in various ways.

Several agencies were able to purchase computer tablets and laptops for families so that they could have access to video sessions. The families who did not have video technology received services via telephone, and Tracfones and phone cards were purchased for them in some cases. Families without computers and/or access to internet were asked to have in-person services (with precautions) either in their home or at the office.

Some families had a difficult time navigating video-conferencing services. Workers assisted them with setting up video-conferencing, but this did not always resolve issues such as not understanding technology, poor internet service and forgetting appointments.

An agency that was unable to provide technological devices to all families prioritized those with younger children who might have more difficulty talking on the phone. There were also issues with the younger population who suffer with attention-deficit issues, as they were unable to focus on a screen for extended periods of time.

"We had one case that brought concerns about possible domestic violence in the home and we had to change how communication occurred so that conversations were not overheard by the partner." Joshua Main, Coastal Horizons Center

There were some families who were hesitant and even uncooperative about using telehealth. It seemed that they had a harder time building rapport, feeling safe with therapists, and complying with hourly and weekly requirements. Occasionally families refused services because they did not want to communicate through technological devices.

4. How many families did you serve remotely during the quarantine? What were the dates? Have referrals decreased during the quarantine?

The seven agencies who contributed to this report generally provided client numbers from mid-March to June 2020. Most of them reported that their numbers served had remained the same or only slightly decreased during this time. Some of these cases began in-person before the quarantine and were completed virtually. Others were virtual during the entire course of services. In a few cases, families refused virtual services or withdrew during this period, but these numbers do not appear to be higher than they would with standard in-person services.

In situations where referrals had decreased, this seemed to be due to the quarantine and children's lack of interaction with people who would report signs of abuse or neglect. Crisis

Stabilization Units also saw a decrease in clients, which affected referrals. Agencies have worked to maintain/increase referrals through marketing outreach, networking, trainings and frequent communication with referral sources.

5. How did the outcomes for the families you served remotely compare to families you served in-person before the quarantine (i.e. staying intact, reunifying)?

"I believe outcomes are about the same … maybe a little worse overall due to issues with compliance we've run into that we didn't have before." Rachelle Long, Centerstone

The consensus among all agencies that contributed to this report is that there has been no significant change in outcomes for remote services compared to in-person services prior to the quarantine. In areas where outcomes were minimally affected, there were various explanations for this.

A few families withdrew from services which perhaps could have been prevented if workers had been able to maintain in-person contact, such as dropping by the home to assess barriers to participation. Some agencies indicated that reunifications may have been adversely affected due to the lack of home visits. Programs that measure school attendance noted a slight decrease in this metric due to the transition to online classes.

One agency reported that its workers continued to receive the same level of supervision as before the quarantine, including weekly one-on-one meetings with their supervisor, weekly group meetings with the clinical director and therapist peers, and weekly individual clinical supervision. These workers received a great deal of support and they shared ideas and helped each other problem-solve.

6. Are you going to permanently alter your services to include a remote component? If so, what will this look like? What internet platforms do you recommend and why?

"As long as our funders (private insurance and various grants) allow us to provide services remotely, we will probably continue to offer this as an option." Paul Rappaport, Hillside

All contributors expressed an interest in continuing to provide remote services in some form, and they noted several advantages to them. There are families who have time barriers and the ability to connect remotely has been helpful for them. Families who live in more remote/rural areas can get services that do not exist in their communities. Some families live too far away for agencies to be able to deliver services to them in-person. A couple agencies stated that remote services could be provided during extreme weather situations in order to maintain contact with families during that time.

The preferred arrangement is to have a combination of both in-person and remote services. One agency stated that they are beginning to go back into the homes of families who wish to have in-person services, and they will continue to provide telehealth services for those families who prefer it. Another agency is working on creating a virtual support group for families who have

participated in their program. Of course, funding sources will mostly dictate modes of service delivery and some of them seem to support a combination of in-person and remote services.

The preferred platforms for remote services have been Zoom and FaceTime, but there is some concern with HIPAA compliance. The move to remote services occurred quickly and resulted in a relaxing of expectations. HIPAA compliance will need to be addressed if agencies continue to provide remote services. Also, Title IV-E reimbursements will need to be adjusted by the federal government.

7. How will you return to providing services in families' homes? What are your strategies for keeping staff and families safe?

Several agencies have continued to provide in-person services throughout the quarantine, while following CDC guidelines. One agency is only going into families' homes on an emergency basis. They are also developing a phase-in plan to be used with each individual family. Others are beginning to provide in-person services again with certain procedures in place.

These procedures include requiring workers and families to use face coverings, maintaining a distance of 6 feet, using hand sanitizer, and asking screening questions (sometimes via telephone) prior to entering homes. In some cases, face coverings are being provided for clients who do not have their own. Some staff are provided with hand sanitizer and thermometers so they can take their temperature daily and also take the families' temperatures. Outdoor sessions are encouraged whenever possible.

A few agencies reported that their state reopening plans are not allowing them to start seeing families in-person yet. One agency is advocating for their families to be considered "emergency cases" that will be permitted to have in-person contact.

"We are not ready to provide in-home support until the state requirements for phase 3 go into effect. Once we are safely in phase 3, we will re-evaluate the timeline." Amy Hobson, Caring for Children

Agencies are also implementing standards for allowing staff into their offices. This includes temperature checks and using personal protective equipment as necessary. These agencies emphasize the continued importance of self-care and putting client safety first.

Conclusion

At this point, nobody knows when the Covid-19 pandemic will end. Agencies may continue to provide remote services in some form for a long time. Fortunately, remote services do not seem to adversely affect the number of families served or their outcomes. Agencies have been innovative in developing strategies for serving families remotely and technology has played a big part in this. The lessons learned from this experience can be applied to other scenarios when remote services may be necessary or preferable.

Sources

Dr. Marc Crandall, CAT Program Director
Agency: LifeStream Behavioral Center
Program: Children's Community Action Team

Mark Hess, Outcome Project Coordinator
Agency: Indiana Association of Resources and Child Advocacy
Program: Outcome Measures Project

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