Telehealth Capacity of Maternal & Child Health Public Health Systems in Response to the COVID-19 Pandemic: Environmental Scan, July 2020

The Association of Maternal & Child Health Programs leads and supports programs nationally to protect and promote the optimal health of women, children, youth, families, and communities. AMCHP envisions a nation that values and invests in the health and wellbeing of all women, children, youth, families, and communities so that they can thrive

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INTRODUCTION

In May 2020, the Association of Maternal & Child Health Programs (AMCHP) received an award through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to support Maternal and Child Telehealth Capacity for Public Health Systems. The funding will be used to support and enhance the use of telehealth (TH) in Title V and Children and Youth with Special Health Care Needs (CYSHCN) programs, newborn screening functions, and maternal, infant, and early childhood home visiting (MIECHV) services. AMCHP is partnering with several organizations with specific expertise in these program areas, to plan how best to use the CARES Act grant to support maternal and child health (MCH) program needs in these unprecedented times. The first step in this process was to rapidly understand immediate needs of jurisdictions by gathering information directly from program representatives about current program changes and implementation of TH solutions in response to evolving population needs, as well as jurisdiction capacity to sustain and/or expand the TH system to maintain MCH services and systems. AMCHP contracted with Altarum to collect this information in a rapid response scan via phone and video key informant interviews in July 2020, and a web-based survey of Title V & CYSHCN directors in August 2020.

This brief summarizes themes emerging from analysis of the key informant interviews. These themes were consistent across program areas and were confirmed by the subsequent nationwide survey of Title V & CYSHCN directors.

METHODOLOGY

On July 1, 2020, AMCHP contacted 30 jurisdictions, requesting participation in a one-hour key informant interview focused on one or more of the following MCH programs:

- Title V and CYSHCN
- MIECHV
- Newborn Bloodspot Screening (NBS)
- Early Hearing Detection and Intervention (EHDI)

Altarum followed up via email with invitees to schedule the interviews and sent up to two reminder emails. Between July 6 – July 17, 2020, Altarum completed interviews via virtual platforms with 57 interviewees representing 39 programs in 26 states and 2 territories. Additionally, Medicaid was represented in 1 interview and the Program for Infants and Toddlers with Disabilities (Part C of IDEA) was represented in 1 interview. **Appendix A** lists the jurisdictions with whom interviews were completed. Two invited jurisdictions were unable to participate within the study timeframe: one due to scheduling challenges; the other indicated that clearance was needed to participate, which was not obtained within the study timeframe.

Altarum developed discussion guides with questions tailored for each of the 4 programs based on input from AMCHP's project steering group and a discussion held with steering group members during their weekly meeting on June 29, 2020. The interview guide for each program covered the following broad topic areas:

- Current use of TH and distant/remote services
- Capacity to provide TH services
- Opportunities to provide or improve TH services
- Gaps in TH services

- Opportunities that provision of TH services have created and early lessons learned

Data from the interviews were captured by a notetaker and through audio recordings. To enhance continuity of data collection, a primary interviewer was assigned to each of the 4 targeted programs. Themes were identified through manual review of notes by the interviewer. Cross-cutting themes were identified jointly across interviewers through comparison of program highlights and through a second review completed by the project director.

RESULTS

Below is a discussion of the high-level themes identified across the data gathered in the interviews.

Overview of Cross-Cutting Themes

Several themes emerged across programs based on the preliminary scan of interview data.

- **There is significant variance in the level of TH implementation occurring across jurisdictions**. The wide range of TH services being implemented is evident when examining all the programs included in this scan. Our findings indicate that even within each program type (i.e., Title V, EHDI, NBS, MIECHV) this variation persists. The extent of TH services currently being provided range from none to comprehensive. In addition, while some services offered by each of the 4 programs lend themselves to TH-based solutions (e.g., family education, many intervention services), others present significant logistical and/or technological challenges when transitioning to remote delivery (e.g., comprehensive developmental assessments, home visits, teleaudiology). Still, other services – such as laboratory analysis– cannot be performed remotely.
- **Systemic and wide-spread connectivity issues exist for families and some programs**. Programs consistently reported that many families have limited broadband access, and a lack of the devices needed for participating in TH. Several interviewees noted significant connectivity disparities among their most underserved and marginalized families (i.e., racial and ethnic minorities, those living in rural/remote geographic areas, families who speak a language other than English, Deaf/hard-of-hearing (D/HOH) families). These challenges are being addressed at varying levels, with some programs providing hotspots and/or devices (e.g., tablets, cellphones, hotspots, phone cards) to families, and others reporting that they are not providing TH services since many of their families would not be able to access them. These findings, along with the importance of a family-centered approach to service delivery, align with what was heard from several interviewees: considering family preferences and offering them choices in how they receive services must be prioritized moving forward.

  At the program level, while most interviewees reported having access to technology to conduct TH services, they often found they did not have IT support, and were challenged to find platforms that sufficiently met their programs' needs and those of their families (e.g., Health Insurance Portability and Accountability Act (HIPAA) compliant, interpretation capacity).
- **Telehealth is viewed as a viable modality to continue and expand in the future, despite current challenges**. Many interviewees reported that the COVID-19 pandemic accelerated and expanded the adoption and acceptance of TH service provision, among

families, providers, leaders, and policymakers. Despite the fact that not all families have access, several program representatives noted that other families – particularly those who were previously challenged by long-distance travel to access services in person – can now more easily participate in services and associated virtual support events and educational offerings. Interviewees also noted that due to the pandemic, families have become more comfortable with using virtual technologies in general, as they have shifted to remote work, school, and social connectivity. This increased facility has carried over into their engagement in TH.

Many providers, who may previously have felt ill-equipped or resistant to implementing TH services, have increased their comfort-level, buy-in, and ability to do their work remotely. Newly implemented policies (such as expanding Medicaid reimbursement for TH services) have further enabled widespread adoption of TH services that had previously been a significant hurdle.

- **There is a lack of evidence by which to make decisions about if and how to continue or expand telehealth to best meet families' needs**. Many program representatives reported that their understanding of families' access, acceptability, and preferences around TH services are based on observation, limited discussion with families, and input from staff. Several programs expressed concern about potential privacy issues in TH (e.g., HIPAA compliance of technologies, youth being able to speak confidentially with others in the home) but lacked the data to understand the extent of this issue. Some jurisdictions have begun engaging families – usually through online surveys – to develop a more comprehensive understanding of their TH-related barriers, preferences, and needs, and are using this information to increase their ability to reach more families in better ways.
- **Improved mechanisms are needed to connect available educational and training resources with the providers and staff who need them, when they need them**. Several jurisdictions discussed a significant lack of education for providers, who often had to "train themselves" or get themselves up to speed using whatever information they were able to find. The level of need for training and support varied by jurisdiction, program, and service being delivered. A handful of interviewees noted that they had identified or developed tools (e.g., webinars, guidelines) or leveraged relationships with partners who were already adept at providing services remotely to support their providers in implementing TH solutions.

THEMES BY PROGRAM

High-level themes from each program are presented below. There was significant overlap in key themes for all focus areas (like family-access challenges and opportunities for future use of TH); program-specific topics also emerged.

Title V & CYSHCN

Interviews were completed with Title V and CYSHCN representatives in 13 jurisdictions.

Current Use of Telehealth

Programs fell into 3 general categories on use of TH services: those who had not previously been providing TH *and* had not implemented any new Title V-supported TH efforts since the COVID-19

pandemic; those who expanded beyond their limited pre-COVID-19 TH offerings; and those who had a longer-term history in provision of TH and were maintaining or expanding those efforts.

Several programs described limited pre-COVID-19 use of TH due to billing restrictions; these efforts generally involved clinical hub-spoke models. TH services that programs mentioned as being currently in use include:

- providing health education to families; training for providers
- care coordination services
- developmental screening with families in their home (as opposed to using a clinical site as the point of origin)
- home visits for maternal-infant post-partum HV programs (separate from the jurisdiction's MIECHV program)
- follow-up visits for existing clients' management of dietetic, behavioral, and mental health service needs

Some CYSHCN programs described existing TH infrastructure for clinical services in the community. Programs are working to support families to be able to use those resources. In some areas, multidisciplinary care coordination virtual visits are being conducted using TH platforms, which was rarely practicable in-person.

Jurisdictions are supporting local programs in a variety of ways, including provision of professional education to local health departments (LHDs), funding technology solutions like purchase of laptops to allow staff to work from home; and local sites providing remote prenatal care screening and monitoring using mobile devices provided by the jurisdiction.

Capacity to Provide Telehealth Services

Interviewees representing Title V & CYSHCN programs noted several **capacity challenges** for families. These include:

- **Connectivity and technology** (e.g., limited broadband access, lack of devices). These challenges are exacerbating existing disparities in access to care for more underserved and marginalized groups (e.g., racial and ethnic minorities, those living in very rural/remote geographic areas).
- **Comfort level** with using TH and virtual services in place of in-person visits.
- **Privacy concerns** (although mixed feedback was received, with some families feeling the move to TH has been good and had no concerns in this area).

Programs are implementing a range of **strategies to address** these family challenges. Some are providing and/or utilizing mobile hot spots in partnership with other agencies (e.g., Department of Education) or local entities. Others are providing devices (e.g., tablets) for families to access TH platforms and services. Several interviewees discussed developing and providing tip sheets and other training for families on use of, and what to expect from, a TH visit.

In discussing programs' **organizational capacity**, several challenges were noted. First, a lack of **IT support** was reported frequently. Interviewees explained that their organizations lacked "in-house" expertise, and, since staff had to transition to TH so rapidly, there was no time allotted for training. Programs have had to "educate themselves" to problem-solve, and to help local staff to provide IT support to individual families. However, CYSHCN programs that contract with larger regional

entities (e.g., specialty care clinics) were described as having better access to IT support within those organizations. **Reimbursement** has historically been a barrier, but virtual visit billing code modifiers can now be used with pay parity, at least temporarily, in many jurisdictions. Only one jurisdiction mentioned more permanent Medicaid billing changes that will support continuation of expanded TH solutions.

Interviewees also reported that local agencies are in need of **equipment**. For example, Title V programs have received requests from LHDs (e.g., TH system equipment) and partners (e.g., laptop for staff to telework).

Programs also reported that they are lacking **data**. Much of what is "known" is anecdotal and based on "check-in" meetings with partners and existing networks, and there is a need to gather feedback from staff and families. Some programs are starting to do this, while others expressed concern about limited capacity to do so, given that staff are re-assigned to the COVID-19 response without a clear timeframe for returning to pre-pandemic duties.

Programs mentioned relying on telephone visits, Facetime, and Zoom to continue providing services to the MCH population. There are concerns that a return to more stringent rules on **HIPAA compliance** will create insurmountable barriers to continuation of services following the public health emergency. Several programs also indicated a lack of capacity to address the connectivity and billing/reimbursement issues, since this would require broader action at the administration/leadership level or through legislative bodies.

Gaps and Needs for Provision of Telehealth Services

Among Title V programs, several gaps and needs were identified:

- **Connecting with transient families**. The use of temporary, disposable, or borrowed mobile phones can leave the provider unable to follow up with a family.
- **In-home services for CYSHCN through Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**. One jurisdiction mentioned growing unmet needs for in-home services (e.g., personal care and private duty nursing) for children and youth with complex medical conditions. Previously, care coordination nurses conducted home visits to authorize such services. Now, those authorization "visits" are completed by telephone and require flexibility in Medicaid rules. That jurisdiction is working on a Medicaid 1135 waiver to allow for longer term flexibility in use of telephone-based authorizations.
- **Therapies youth were receiving in school** (e.g., occupational therapy, physical therapy, speech-language therapy) stopped when schools closed. In some situations, these therapies are not covered by insurance. Where they are, they are not always reimbursable TH services, even when they can be implemented remotely.
- **TH platforms that adequately serve parents with disabilities and non-English speakers**. Mixed input was received on the effectiveness of language interpreters, but overall, there was agreement that solutions that work well for D/HOH families are lacking.

Opportunities: Changes Catalyzed by COVID-19 Pandemic

The transition to TH services has presented some positive opportunities. Many interviewees noted that they are perceiving an **increase in families accessing or receiving services** in general,

particularly for WIC, some types of HV, and children's behavioral health counseling visits. They also noted that it is **beneficial to see children in their 'natural' (home) environment** for behavioral and developmental visits.

The COVID-19 pandemic has also brought about the **accelerated expansion and adoption of telehealth** among leaders, policymakers, and providers. Interviewees noted that some who had been reluctant or slow to support the use of TH solutions pre-COVID-19 are now more motivated and are even embracing it. TH is seen as "just the way we do business now," and there is a widespread perception that service provision will not entirely go back to the way it was previously done. Two jurisdictions report there have been legislative changes to support the expansion and long-term use of TH in their programs.

Lessons Learned and Unexpected Changes Catalyzed by COVID-19 Related Changes

Overall, programs have found that they have the ability to use TH in ways that were previously not seen as appropriate use or not supported by existing practice guidelines (for example, in-person HV, initial teledentistry exams for urgent issues, autism assessments, family planning, and child care consultations). The COVID-19 pandemic is also spotlighting ongoing equity issues. Several programs discussed concerns about resource-limited families being able to access services while offices are closed. While some services have moved rather seamlessly to TH platforms, there are concerns about how to make the services accessible to more families. Finally, interviewees often stressed that flexibility is important, noting that a range of modalities are needed to meet families' needs, and that they should not be required to only provide services through one modality (whether that is in-person or via TH).

Home Visiting

Interviews were completed with representatives of home visiting programs in 13 jurisdictions.

Government Mandate

All 13 programs interviewed halted in-person home visits in Spring 2020. Some did so because of jurisdiction-wide stay-at-home orders, and others because of departmental or program-issued policy or guidance.

Resuming In-Person Visits

None of the programs interviewed had resumed in-person HV across the board. In some cases, a phased approach to in-person visits has begun, such as outdoor meetings or when deemed absolutely necessary, permission has been granted to visit families. In these circumstances, providers must document safety measures taken (e.g., wearing masks). However, in all jurisdictions, virtual home visits continue to be the predominant way of working. One jurisdiction has issued a new protocol that provides a framework for assessment of individual scenarios to determine whether a face-to-face home visit is necessary. They used the Health Resources and Services Administration (HRSA) guidance to develop their procedures.

Workforce Hiring and Retention

None of the programs interviewed reported any broad scale issues with hiring or staff retention. Some examples of challenges reported include: a hiring/contracting freeze; loss of local, supplemental funding for programs due to COVID-19; and challenges training new hires virtually.

Some interviewees noted that their staff had been re-assigned due to the COVID-19 pandemic, but none reported program disruption as a result.

Family Access and Challenges

All programs reported some family challenges related to technological access, including costs associated with **data, minutes, bandwidth,** and **internet**. Programs reported that these challenges are particularly evident in rural areas, where families are often relying on telephone-only virtual home visits. Many programs also reported that families are experiencing **fatigue** with technology and virtual services.

Some interviewees stated that **privacy** was a barrier for families. With most family members home from school or working from home, finding a private location where the family can participate in a non-disruptive virtual visit can be hard. **Language barriers and online interpretation** have also been a challenge for families in some areas, and some refugee populations are refusing services rather than receive them via TH.

Solutions to Address Family-Related Challenges

Several solutions to these family challenges were identified. Many have found ways to **provide the technologies needed to conduct telehealth services directly to families**, understanding that TH "is the only way we are reaching our families right now." For example, the national Nurse Family Partnership program provided mobile phones with four months of pre-paid service to families who needed them in spring 2020. Some programs, including local implementing agencies, have used resources and funds from other initiatives to meet the technology needs of families. One jurisdiction had tablets left over from a different federal initiative that they were able to share with families receiving virtual home visiting services. A local program in another jurisdiction used a separate funding stream to offer mobile hot spots to families, while the program was able to offer some phone cards to families to cover minutes and data.

Other solutions include **adapting the models to meet the needs of the family**. For example, some national models adhere to one 45-minute meeting per week, but home visitors found that was often too long and unreasonable for families for a TH visit. In those cases, visitors pivoted to conducting shorter, more frequent sessions throughout the week. This was reported to be particularly helpful when there are other children in the home or other household distractions.

Organizational and Staff Capacity and Challenges

While most programs identified some staff challenges, none identified barriers large enough to interrupt services. Interviewees reported that some **staff lacked the capacity and ability to use virtual platforms**. None of the programs offered any formal IT support, so they relied on other staff to help build the capacity of those who were struggling to use the technology.

Other concerns included the challenges inherent in **not being there in person**. One interviewee stated, "It's fantastic that we can provide families with support, but there are limitations. For example, you can't do a physical assessment of a baby." Challenges of virtual care were of particular concern; for example, providers feel unable to gauge whether there were any abuse issues in the home when conducting services remotely. Some providers were concerned about the lack of toys available if they were not there in person to bring them.

Finally, staff reported their own COVID-19 related challenges of working from home (i.e., having

their own small children to care for while working).

Training/Educational Opportunities for Providers

Most of the programs interviewed reported that they **rely on the national HV programs for training**. One interviewee stated, “After being given very clear guidance, providers felt prepared to get started with virtual HV.” A few examples of training sources were identified from sources ranging from local to national home visiting programs:

- One jurisdiction’s coalition against domestic violence provided a training to four hundred home visitors on how to address and screen for domestic violence through TH.
- One jurisdiction has shared the Rapid Response Videos from the Institute for the Advancement of Family Support Professionals (a national resource shared with all home visiting programs).
- Another program has their own jurisdictional training institute. This program’s resources on providing HV through TH are on a webpage that includes Blackboard, allowing a platform for providers and program staff to use for communicating with others throughout the jurisdiction.

Several jurisdictions also reported holding bi-weekly online provider meetings for peer support and problem-solving.

Systems and Policies Needed

Most programs reported that they have been able to meet families’ needs if families have the necessary technological access. However, several made suggestions for systems and policies necessary to improve virtual access. Those suggestions focused largely on funding and technology infrastructure:

- Need **flexibility from existing and new funding sources**
- A lot of funding does not support **purchase of technology** for TH programs
- Making sure TH services are **billable**
- Better **jurisdiction-wide infrastructure** for access. Programs suggest looking at what is available in a given geographic area and assessing what facilitates an individual family’s access to that technology.

Changes Catalyzed by the COVID-19 Pandemic

Many of the programs interviewed reported that the **pandemic was a catalyst** for finally pushing the programs to try TH. In some cases, programs and providers alike had been hesitant to implement TH due to perceived barriers and issues related to confidentiality. **Relaxed HIPAA and Family Educational Rights and Privacy Act (FERPA) rules** helped these providers feel comfortable trying new approaches. Some programs reported that the pandemic **forced them to get creative** in how care and content is delivered. In one case, video language interpretation was only started due to the pandemic and may continue. Another interviewee said that TH may change the way HV works going forward, and that virtual HV will be a tool in their toolbox into the future.

Lessons Learned/Surprises

When asked about lessons learned and surprises, most interviewees reported surprise at **how quickly people and systems adapted and learned to be flexible** in delivery of services. One interviewee stated, “A virtual visit does not have to be as long as a face-to-face visit.” Some

expressed surprise that some families prefer virtual HVs. They hope that the national models will pay attention to that and include virtual HVs as an option. One program noted that national models can be protective of their educational materials. The pandemic allowed the implementing agencies to become more flexible. One interviewee stated, “Everyone was on the same page straight out of the gate.”

Most reported that their HV retention rates are still good and virtual **HV is a viable option for families who have the technological access**.

Newborn Bloodspot Screening

Interviews included representatives of newborn blood spot screening programs in 6 jurisdictions.

Current State of Program and Use of Telehealth Strategies

Some jurisdictions described what they saw as successes in maintaining services and systems through nurses and clinical care coordinators who continue to complete short term follow-up, maintain connections to primary care providers, provide specialty care coordination, and share information with staff and providers through fax, email, and telephone – services that were never conducted in-person.

Genetic counselors and specialists in some jurisdictions are implementing telehealth solutions to follow-up with families after receiving a referral. One program described using Zoom to provide technical assistance to care coordinators. Others indicated that not much has changed in terms of screening and laboratory services since COVID-19 began.

Capacity to Provide NBS Services

When asked how COVID-19 impacted the services they were providing, and their ability to maintain their usual levels of screening and intervention services, programs cited **staffing concerns, particularly regarding laboratory staff**, as a critical issue during the pandemic. These staff are considered essential workers, who are unable to telework, and social distancing in their work setting can be challenging. Some jurisdictions addressed this through reduced staffing, or rotating days off, although they found burnout to be a resulting issue. With the fluctuation in COVID-19 cases, it is challenging for organizations to know when and how they will be able to return to a more routine schedule for staff.

Programs that were able to get **laptops assigned to team leads and group managers in non-laboratory roles** found this contributed to success in switching staff to telework. Teleworking has had some benefits such as allowing staff to get standards of practice (SOPs) updated, and catch up on training, performance evaluations, and administrative functions. Those tasks seemed to have the greatest backlog prior to the COVID-19 pandemic, due to the daily demand of travel and day-to-day work.

Some programs mentioned offering telehealth related courses and continuing medical education for physicians (**formal education**) and webinars (**informal education opportunities**).Training for local programs on TH regulations have been offered by local universities. Generally, programs indicated that **IT support is available for staff** using TH but not as readily available for families (although a few programs mentioned this is occurring at the local level).

Gaps and Needs for Provision of Telehealth Services in NBS Programs

While some programs found the transition to TH was a smooth and seamless, others experienced challenges. These include:

- **Lack of access to funds** to implement/continue programs
- Challenges with **timely specimen delivery**
- Lack of **provider comfort and familiarity with technology**
- **Limited technology access among families** (e.g., limited data, lack internet connectivity)
- Difficulty **obtaining family consent**

One jurisdiction conducted metabolic clinical services via TH for the first time. The challenges encountered included paper charts not being located where the physician was, obtaining completed paperwork from families, and coordinating timing of physician and registered dietitian visits for each family. The metabolic clinic is now conducting TH visits with families as soon as a child is diagnosed, rather than the family having to wait until the next local, in-person clinic.

Many representatives noted that in order to have a more robust TH program, the above challenges need to be addressed. Interviewees noted that several NBS services are not well-suited for use of TH solutions, including most lab activities, as well as some essential physical assessments, such as height and weight monitoring, and specimen collection. While many programs expressed that there are some areas of uncertainty in the potential applications of TH solutions, some are heavily considering data review, virtual site visits and quality improvement activities, CME and educational opportunities, sharing results and scheduling as potential areas in NBS that are well-suited for routine TH.

Opportunities Catalyzed by COVID-19 Pandemic and Lessons Learned

Representatives reported that there are opportunities to offer NBS using TH, but that to do so on a routine basis, protocols for acceptable use will require revision. Currently, programs are using evidence-based protocols put in place prior to the pandemic to deliver care, but they are finding that some services, such as follow-up and delivery of results, can be performed remotely. Many of the programs reported that, despite initial reservations, programs and providers are seeing that there are program activities and components that can be done via TH. This is not only giving the families a sense of hope (if they have access) but providing comfort in knowing they do not have to travel long distances to access their provider.

Early Hearing Detection & Intervention

Interviews included EHDI program representatives in 8 jurisdictions.

Current State of Program and Use of Telehealth Strategies

Most, but not all, EHDI program representatives interviewed reported implementing teleintervention services**.** In addition, some reported that family support groups and education are occurring virtually (e.g., Facebook, Google Hangouts).

Teleaudiology, a service that is technically one that could be performed, requires a great deal of planning, infrastructure, billing allowances, training, and coordination, and is not currently being performed by any of the jurisdictions interviewed. One program is nearly prepared to offer

teleaudiology services but has not been successful in obtaining funding ($50,000) to purchase one final piece of equipment needed.

While literature indicates that teleaudiology can be implemented by having trained technicians and equipment in remote locations where they can do home visits to the family or the family can come to them at an accessible location, a few interviewees felt that some audiological screening cannot be performed via TH strategies, and thus, those interviewees did not see any opportunity for future use of telehealth solutions for this service.

Impact of COVID-19 on EHDI Program & Services

The COVID-19 pandemic has affected aspects of EHDI program services in different ways:

- **Screening**: Several programs report that early discharge from hospitals due to the pandemic is widespread and has likely resulted in suboptimal newborn hearing screenings (because the baby is screened earlier than the recommended age) or missed screenings. Programs also noted that for newborns who do not pass the initial screen and are referred for follow-up, parents are often unwilling to bring their children back to the hospital or center due to safety concerns, or are unable to return due to clinic closures and hospitals opening only for procedures deemed “non-elective.”
- **Diagnosis/audiological services**: In many areas, the COVID-19 pandemic has caused a backlog due to facility closures. While many jurisdictions are re-opening, this is not the case where COVID-19 rates are still high or rising.
- **Intervention**: Most programs have scaled up their teleintervention services. While one jurisdiction reports that numbers are down, many other jurisdictions feel they are now providing intervention services to most of their families.
- **Parent education/support**: Support also appears to be continuing, with several innovative strategies (e.g., providing a great deal of support on what teleintervention is like/how it works). Several interviewees noted that families are often dealing with children who have complex needs, and COVID-19 has just added one more complication that can compete with prioritizing EHDI-related needs.

Family Access and Challenges

Interviewees reported several challenges pertaining to families accessing EHDI services. These include **parent discomfort** with or resistance to technology, as well as with bringing their children in for additional screening, and **lack of access to technology** (including internet connectivity, devices, limited data). Interviewees noted that in many families, there is only one laptop being shared among many people, as well as competing priorities/issues, and parents being over-stretched. Several interviewees highlighted that families living in rural areas and tribal communities, and those for whom English is not the primary language are disproportionately impacted by technology access challenges and other confounding factors that impede their capacity to engage in TH services. D/HOH families and their service providers face the specific added obstacles of coordinating interpreters and identifying HIPAA-compliant platforms with adequate captioning services.

Organizational Capacity to Provide EHDI Telehealth Services

Many EHDI services do not lend themselves to TH strategies easily (teleaudiology) or at all (screening). For that reason, the majority of the EHDI services delivered via TH by the programs represented pertained to teleintervention and family support/education.

For the most part, **capacity exists to provide Early Intervention (EI)/Part C** of IDEA services. However, in one jurisdiction, the technological and infrastructure barriers are so great that no TH services are being provided.

Organizational challenges in capacity include **training/increasing comfort level of providers** (particularly those who were not previously using the parent coaching model), **gaining parent buy-in**, and obtaining and **coordinating interpreters** and adequate transcription technologies for D/HOH families (and staff).

Existing **partnerships and innovative programming have enhanced/enabled capacity**. For instance, one program has drawn on the long-held experience of local school experts – who have been conducting teleintervention services for years pre-COVID-19 – to help support the other providers in the jurisdiction with this transition. In another jurisdiction, where the EHDI coordinator is housed at a non-profit rather than in a government agency, the coordinator has enhanced family capacity to access TH services by identifying funds **to purchase tablets and data plans for families** so that they can engage in teleintervention services, as well as increasing their many family support offerings virtually. The same jurisdiction also utilizes parent volunteers to help families use these technologies, in lieu of formal IT support (which the program does not have access to).

Several programs are providing **education and support for families**. Some are using social media to educate families about what teleintervention sessions will be like, as well as what to expect, as well as reassurance about going to in-person audiological appointments. Many programs are also providing opportunities for **virtual parent-to-parent support groups** and topical education sessions. Several have had success in **engaging families in developing and evaluating telehealth solutions**. For example, they have employed a National Center for Hearing Assessment and Management (NCHAM) survey to gauge parent concerns around teleintervention.

Opportunities Catalyzed by COVID-19 Pandemic and Lessons Learned

Several interviewees mentioned that the **success of teleintervention demonstrates its viability and effectiveness** and expressed the **expectation that this will continue** beyond the COVID-19 pandemic, especially since it increases reach to families previously challenged to access in-person services, and potentially saves money. Likewise, programs see promise in **holding virtual family support and education** events beyond the pandemic, noting that while some families will require or prefer in-person options, others are able to access these opportunities for the first time via TH.

More EHDI **providers are now trained** in the parent coaching model – which is recommended practice for D/HOH intervention – and are considerably more comfortable providing it and using technology solutions to do so. Several interviewees expressed hopefulness that teleaudiology may become a reality, potentially precipitated by increased need during the COVID-19 pandemic.

APPENDIX A: JURISDICTIONS REPRESENTED IN SCAN INTERVIEWS

Jurisdictions
Alaska
Arizona
Arkansas
Connecticut
Guam
Hawaii
Illinois
Iowa
Louisiana
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
North Carolina
North Dakota
Ohio
Oregon
Pennsylvania
Puerto Rico
South Carolina
Texas
Vermont
Virginia
Washington
Wisconsin