Implementation during the COVID-19 pandemic of interventions rated by Blueprints as Model/Model Plus and Promising

This survey covers multiple topics, all relevant to the changing prevention environment, as programs respond and begin to plan for the aftermath of the COVID-19 pandemic ("COVID"). **Blueprints for Healthy Youth Development surveyed contacts listed for all Model/Model Plus and Promising programs in our database.** The self-funded survey was administered in collaboration with Evidence Based Associates (https://evidencebasedassociates.com/) between May and June 2020 and 58 of 94 programs responded (for a response rate of 62%). Some open-ended responses have been aggregated and others have been redacted to preserve anonymity.

Thank you to our colleagues for sharing your feedback with us!

Status of dissemination or implementation

Which of the following describes the status of the dissemination/implementation of your intervention because of COVID?

Check all that apply.

- We have had requests for changes to the delivery modality **(78%)**
- We have had requests for changes to training and/or support **(76%)**
- We have suspended implementation **(10%)**
- We have discontinued/cancelled implementation **(0%)**
- We have experienced new requests for the adoption of our intervention model **(48%)**
- None of the above **(0%)**

Other (please describe): (29.3%)

- Our program has been available in a web-based platform. We are now providing training of facilitators in a virtual environment instead of the [standard] in-person training.
- Implementation is continuing, but with a shift to online learning and the need to modify policies to address COVID-19 issues.
- Offering adapted online versions of both the middle school and high school curricula.

- Many customers are continuing, or planning to continue, their implementations as normal. In some instances, we have provided support to customers who have adapted to various remote learning platforms. We have started addressing remote learning in our training services.
- Use of the program has increased during this crisis and no teams have closed or ceased operations to families. Very encouraging and impressive work by all involved including policy makers allowing for modified service delivery worldwide.
- We are making updates and introducing some modifications to support virtual learning.
- We are rapidly developing a virtual training option and have developed guidance for tele-delivery of the program.
- We have developed and pilot tested a school/home hybrid program that allows continuity for children in the activities and skills and keeps the focus on play, playful learning, social-emotional development, self-regulation, and core skills in both settings.
- We had to cancel three Train-the-Trainer Workshops. We have scheduled one for [fall] 2020 and others in [spring] 2021, with fingers crossed that we will be able to proceed.
- We have recommended and supported that teams at our affiliates provide services remotely rather than in the home (preferably via teleconferencing if possible, otherwise by phone). We have already been providing training virtually, but generally had live videoconferencing sessions in groups in various locations at the same time. We have adapted so that individuals can do live videoconferencing training at home with opportunities to work in small virtual breakout groups.
- We moved a few thousand program participants from in-person classes and in-person internships to virtual training and work settings.
- We have temporarily postponed in-person training until it is safe to resume.
- We made changes to our delivery modality and education/training proactively, rather than waiting for requests.

Modifications to service delivery

Which, if any, of the following modifications have been made to your intervention or its delivery to ensure the safe continuity of programming in the context of the COVID outbreak?

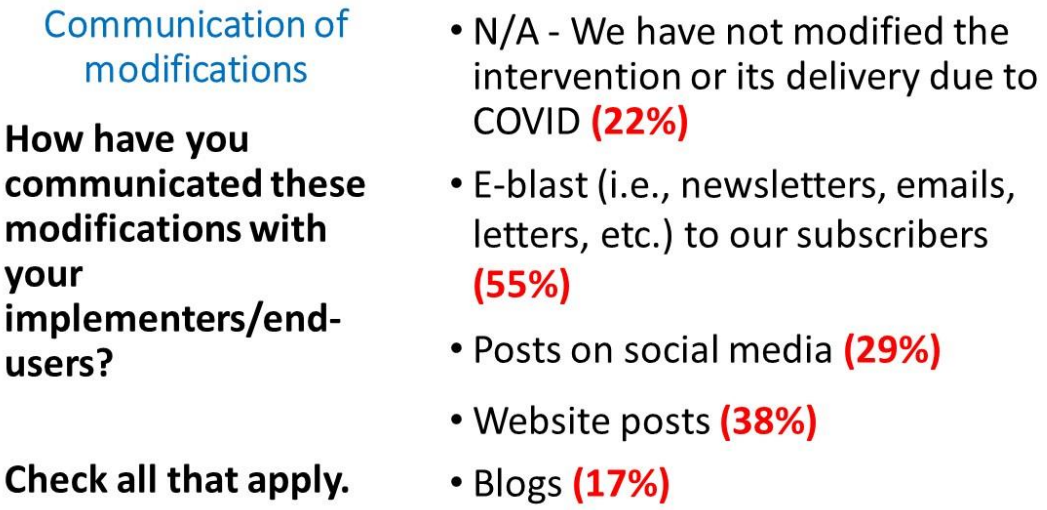
Check all that apply.

- We have not modified the intervention or its delivery due to COVID **(22%)**
- Provided online resources to support implementation **(55%)**
- Turned to tele-sessions and/or video conferencing to support service delivery **(60%)**
- Offered online training workshops or lessons **(72%)**
- Started a blog page to provide a forum for conversation **(12%)**

Other (please describe): (35%)

- Because of the interactive nature of the program and no data to support online implementation, we cannot recommend changes to delivery at this time until we have data to support the implementation change.
- Mentors are keeping contact with their mentees through texting and phone.
- We offer a free compilation of materials and resources including webinars, fillable PDF forms for clinicians, telemedicine guides, etc.
- We were developing a digital delivery system when the outbreak began. The pandemic and the rapid shift to remote learning has altered the scope and timing of the development efforts. We are currently working with multiple customers on interim efforts to bridge with various platforms.
- Provided virtual office hours for questions and conversation.
- We already had all our materials online to support implementation, as well as an online training course. We already have a place for people to interact on our website.
- We are beginning to work through ways to provide the intervention through telehealth but have not yet done this.
- In response to the need for options that can support virtual delivery, we are creating presentation slides that can be used with the program to help facilitate teaching the lessons in an online learning situation, and making the workbook pages into fillable PDF versions.
- We are making updates and introducing some modifications to support virtual learning.
- We are offering a guide for implementation of the sessions in a tele-conference platform. Videos are available online.
- We coach school districts on adopting one of three modalities for delivery of the curriculum: 1. Teach the current lessons using an online classroom. 2. Implement fully online instruction using our Independent Study materials including narrated slides and fillable worksheets. 3. Have the teacher lead an online classroom using the narrated Independent Study slides, with pauses for directions and discussions.

- We developed a micro-coaching app that allows teachers to help parents set goals and work together to support learning at home. We developed parent webinars in English and Spanish.
- We created a newsletter that addresses services and support solutions during Covid-19, as well as updates on social media.
- We have provided a series of webinars related to implementation in a COVID environment.
- We have two social media groups, one exclusively for supervisors and [implementors] that provide a forum for conversation. We also have an advisory group consisting of [implementors] and supervisors providing input. We have hosted several webinars with active chats.
- We provided all participants who needed it not just online resources but actual hardware (laptops, Wi-Fi/hotspot devices with licenses for online platforms) to support virtual learning and working.
- We send a weekly "Practice Memo" to all practitioners in our national network, and share this with the Senior Leadership of our affiliate agencies. We set up additional teleconferencing with groups of practitioners on a regular basis to discuss challenges and solutions.



Other (please describe): (48%)

- We are in regular contact via teleconferencing and shared adaptations of our practices through [a national prevention network].
- Email and conversations with relevant parties.
- Hosted online meetings with national partners and posted resources on our proprietary online data system.
- Individual communication with agencies/schools implementing the program as questions arise. We will publicize more broadly once changes and new features are completed.
- Individualized communication with implementation sites.
- Internal-use intranet pages and micro-sites for current staff/participants.
- Invited sites to attend online meetings with program manager over the past two months to keep them informed of what we were doing for sites to help reach their families in various capacities (resources, programming, promotional work for future programming).
- Multiple emails and web blog posts.
- Network calls and through the licensed program experts working with each team.
- Personal contact phone or text.
- Responding to e-mail and phone inquiries from current users.
- Tele-sessions, telephone calls, video chats.
- Emails and webinars.
- We have communicated directly with teams through consultation and calls with agency leadership. We have conducted readiness calls, stakeholder engagement presentations, and clinical training via virtual/online formats.
- We have responded to email requests from users.
- We personally talked to each of the agencies who are delivering the program to assist in online delivery and technical issues that they may encounter.
- We will communicate via our website mostly.
- We have contacted all providers and provided training in virtual meetings.

Impact of modifications on service delivery

Are you collecting data to examine the relationship between modifications made due to COVID and intervention outcomes?

- We are presenting collecting these data **(24%)**
- We are planning to collect these data soon **(14%)**
- These data are not necessary as we have not modified our intervention or its delivery due to COVID **(5%)**
- We do not have the resources to collect these data **(28%)**
- Do not know **(0%)**

Other (please describe): (29%)

- We are considering ways to measure implementation, readiness and sustainability.
- Depending on the duration of changes related to COVID, we may examine the impact of virtual versus in-person delivery on engagement/attendance and outcomes.
- Mentors have always been asked to report mentoring fidelity data online each week. Emailed requests for those data have continued, even though schools have been closed.
- We are writing a grant to study virtual compared to in-person program training and delivery.
- We participated in a multi-year RCT; we have submitted a proposal to evaluate the Independent Study (online) program using a similar research design and instrumentation. Anything less by us or any other publisher would be anecdotal at best, lacking the rigor and validity needed.
- Surveys are in development.
- The company itself is not collecting data but several customers may collect data this fall.
- There is talk of a group data collection and several calls about uniform measures. Cautiously optimistic.
- This data includes both ongoing outcomes in our electronic health record, as well as results from a randomized trial with families that we were serving when COVID-19 began. We have been tracking since the beginning of the pandemic what type of contact teams are having with families (in-person, videoconferencing, phone), how often, and for how long. We are also looking at retention of families during this period. This data has shown us that by April, virtually all contact with families has been by videoconferencing (telehealth) or phone, except for delivery of essential items.
- We are collecting limited satisfaction data.
- We collect data of outcomes as part of our intervention. We may evaluate for trends if warranted due to COVID.
- We do not have a way to collect outcome measures but are collecting parent and group leader satisfaction forms for tele-sessions.

What questions do you have of Blueprints or of other Blueprints-certified interventions as you consider implementing your evidence-based intervention in the context of COVID?

- Because documenting online learning is so difficult, we are interested in what kinds of instruments people are using. For example, we are going to use a parent efficacy scale to see if our micro-coaching model worked. Other instruments would be welcome.
- How have other evidence-based interventions adapted to the context?
- I am interested in learning how other group-based programs are modifying their delivery and training/communicating with providers about these modifications. I am also interested to learn how developers/coordinators who normally provide in-person trainings are modifying their training process.
- I would like to know what other programs are finding as they work via tele-visit and how this is affecting outcomes.
- I would love to hear from other interactive programs how virtual programming has gone for them. We are compiling a list of lessons learned, things to consider before virtually programming, and rules of engagement for sites to use.
- Interested in how groups are dealing with modifications to training requirements in light of 1) established in-person training requirements vs. need to switch to online training formats and 2) possible need to extend or reduce clinical requirements to achieve certification because clinicians in training have faced work interruptions due to Covid-19.
- Billing issues and agency requirements for telemedicine and/or return to clinic have been shifting and confusing. Some training programs have different requirements for staff vs. trainees (e.g., staff can return to office, but practicum students must be telemedicine).
- The current pandemic has provided both challenges and opportunities to understand and learn regarding implementation and sustainability. It appears ever clearer that utilizing evidence-based models is critical. How can we best engage political and community leaders?
- We have developed an online version of our program and had to stop with the national pilot test due to the pandemic. Was anyone else conducting further testing of their programs during this time? Since this model of delivery is new for us (our program is delivered in person), we felt that the circumstance within homes/families currently would not be conducive to generalization about the pilot test. If other programs suspended testing or studies related to their Blueprints program, I would like to know when they are planning on resuming.
- We would be interested in how other group-based interventions are adapting to video meetings and maintaining engagement with families.

Please comment on any other issues you have experienced with your intervention in the wake of COVID (e.g., Hurdles you have experienced? Positive changes to your work? Lessons learned? Future concerns?).

- Online training is a must, given the current crisis.
- Technology does not always work the way you anticipate; alternative platforms or delivery modes must be considered. We have heard both ends of the continuum. Some are finding more

time for training so want to move forward with virtual training and implementation. Others are overwhelmed and have put the program on hold.

- Future funding is a very big concern.
- The micro-coaching addition with a text message system that includes instantaneous translation has enabled teachers to help non-English speaking parents to provide coaching to their child. Being able to interact over a video the parent makes on their phone of the child and then both the parent and teacher watch it and discuss it together has been transformative.
- We realized that phones are the way to be able to reach almost everyone and so we are converting all our assets to something that can be done on the phone.
- Our main concerns moving forward are coordinating logistics for a return to an in-person program delivery and office setting for staff. We operate in so many different states with different approaches to Covid-19. We are trying to be as nimble as possible and plan for multiple options, e.g., 1) staying totally virtual vs. 2) returning to the office/in-person environment but then transitioning back to virtual partway through the program cycle if Covid-19 cases increase and physical distancing practices resume. We need to be ready for any possibility.
- An independent research group has a federal grant to study our program's impact. They have found it difficult to get commitments from schools for the research. Furthermore, participant selection and pre-program data cannot be collected this Spring.
- Because our agencies deliver the program in person, we had to do a quick shift to webinar style classes. We found that we are very nimble with change and were able to do this within days. As a result, we are considering this a new option for delivery.
- The pandemic has made it more difficult to raise funds for replication.
- Conducting training workshops have been the biggest challenge. Positive changes are that all staff are very comfortable with multiple video chat platforms and the many features available to making training virtually possible. We have slightly shorter training days with virtual - trainees and trainers are more exhausted than usual at the end of workshop days.
- COVID has caused us to start to consider what a remote implementation would look like. While we have not made concrete plans to adapt to online implementation, we have conducted meetings with other agencies to help inform the potential for that work.
- Delivering the intervention virtually may make it easier for the leader to follow the script (from a computer rather than when in a room with the group members). Virtual delivery always takes more time than in-person delivery, and the therapist needs to be more active when delivering the intervention virtually.
- Future concerns: Uncertainty for the upcoming academic year in terms of social distancing, closures, potential for opening and then closure, remote teaching, technology access for teachers and students, etc. There is no one model that stands out and the variance can be significant between states, counties, districts, and schools. The entire world had to pivot on short notice to continue instruction remotely so there is the potential for ineffective programming or resources to be adopted due to ease of access, time, etc.
- Hurdles: Mobilizing for a rapid change from in-clinic to telemedicine. Obtaining institutional permission/guidelines for a telemedicine platform. This entailed many hours of documentation to justify and many levels of approval. Positive Changes: We will be able to offer telemedicine services to rural families who struggle to come to clinic. Many families may benefit from a mix of in-home telemedicine service and in-clinic for specific treatment sessions. Supervision of trainees/co-therapy is working very well via telemedicine. Future concerns: Training and treatment both show promise in telemedicine, but both are more awkward and less efficient at

this point. I worry that we will just say it works rather than do the hard work and evaluation needed to make it "really" work.

- It has been surprisingly easy to change to a virtual format. Parent attendance rates are high.
- We are planning new research to contribute to the science of early childhood adversity through close study of parenting, teaching, and adult and child mental health during the pandemic.
- Positive -- young people staying connected, facilitators have adapted and maintained strong relationships. Ability to make adaptations is very site dependent--some sites better able to innovate than others. Future concern -- ongoing lack of in-person connections (we know virtual is not the same and does not produce the same outcomes).
- Lessons Learned: COVID has affected the referral process and we have had to work with stakeholders and teams to develop new processes. Future Concerns: Will agencies be able to economically sustain their service to the community?
- We have developed online pretest-posttest surveys and program tools that may save provider time, result in more data assessing program outcomes and help providers monitor program implementation success.
- Since our intervention is school based, we have experienced significant delays in training and funding as schools have closed or moved to online modalities. We have a recent resurgence in requests for training and are moving to online training for sessions later in the summer. Once training is complete, schools may still be challenged with implementation as the intervention is delivered face-to-face. The biggest hurdle is internet connectivity for some of the families, which sometimes prevents video visits. We have conducted training for providers on how to build relationships virtually since we are not able to rely on in-person connection. We have found that once families (and providers) get comfortable with the technology, we are able to do our work quite well via tele-visits. Sometimes parents can move to a more private locations using their device to facilitate deeper conversations than is possible during an in-person home visit.
- The outbreak has been a catalyst for certain features for our digital product that we had not previously considered. We have most of our employees still working from home. Some elements of this transition have been healthy for the organization, but it has presented certain challenges. Overall, our collective productivity is slightly higher than normal but the loss of culture that we enjoy in the office has been felt by everyone. The use of online tools to deliver services needs to be measured and these findings embedded as a resource to teams in the future.
- Virtual programming takes a lot more effort and planning than most people understand. We put fidelity to the curriculum as the top priority. As the program manager, I have asked sites to involve me at every planning meeting as well as every virtual session so that we can fine tune the virtual programming before delivery. Families are not as willing to participate virtually as we had originally anticipated. We are collecting data from the facilitators and families on their thoughts of how virtual programming went, conducting fidelity observations, and using retrospective pre and post surveys as we would with face-to-face programming.
- We are concerned that if classrooms do not open and it is still unsafe to travel, we will have to further postpone trainings and sites will have to discontinue use of the program because of the lack of interaction with groups of youth. We may have to consider online training, but fear that it will not be as effective as in-person training, which can be problematic.
- We are in the process of learning and adapting. Being flexible in implementation delivery while still adhering to certain principles is a key component of any future intervention. We have learned all future interventions should have a telehealth/video/phone aspect to them to be used efficiently in different settings and in different global crises.
- We had begun research to see if an online-facilitated version of the program was possible. We will begin a pilot trial in 2021 with the hope of grant funding to do a full RCT. It will be several

years before we will know whether this new format is effective and can be made available. Given this work and the discoveries we have made already about safety, privacy, etc., we are even more concerned that prevention programs are being rushed to the online format. We are also concerned that universities who had committed funds to evidence-based prevention will now withdraw those commitments, not renew them, and will not make new commitments in the new economic landscape caused by Covid-related deficits. This obviously goes beyond our program to the entire field.

- We have done one write-up of the benefits and limitations of providing services virtually (although most of the comments would apply to our whole network). Lessons Learned: Lack of access to telehealth resources presents a major challenge and an issue of equity for mental health service delivery via telehealth. This is an issue that should be considered at the program and State levels. Telehealth can be an effective way to engage clients when it is a preferred method of communication and they have access to the proper technology. Clinicians observe that some caregivers are better able to discuss their thoughts, feelings, share reflections and observations through telehealth. There are challenges in providing dyadic treatment via telehealth. While the dyad might be more focused on one another without the direct presence of the clinician, young children (birth to six) are developmentally not ready to engage virtually in the same way that they would in a face-to-face interaction. Caregivers appeared at times to feel a pressure to keep their child engaged, creating more stress and a distraction for treatment. Further study, training, and evaluation on conducting dyadic treatment through telehealth may be helpful. Telehealth offers an increased ability to reschedule appointments and reduces travel time and expense. This may help to decrease missed appointments, increase retention rates, reduce fatigue for staff, and save money for agencies. The use of telehealth during family illness or weather-related events or emergency declarations (like a hurricane or global health crisis) are good reasons to consider the use of telehealth as a continued method of service delivery despite the ability to be in person most of the time. However, it should be noted that clinicians can also experience fatigue from telehealth, which may impact the numbers of clients that can be seen in a day, despite saving time from travel.
- We have found that teams across the globe are doing better than expected with both webinar-based trainings and providing services via telehealth.