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The Impact of the COVID-19 Pandemic on the Delivery of Community Resources in Georgia's Home Visiting Program

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An abstract of
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ABSTRACT

The Impact of the COVID-19 Pandemic on the Delivery of Community Resources in Georgia's Home Visiting Program

By Dianne Louise Maglaque

Background: Home visiting programs are a key early intervention strategy to promote positive health and social outcomes for at-risk expectant mothers and families with young children. The Georgia Home Visiting Program is comprised of 21 program sites implementing evidence-based home visiting models such as Healthy Families Georgia, Nurse-Family Partnership, and Parents as Teachers. The unprecedented novel COVID-19 pandemic forced home visiting programs to transition to a virtual environment as in-person visits were halted to prevent the spread of the virus.

Purpose: To assess the factors affecting the coordination of community resources by home visitors and the subsequent receipt of these resources by home visiting clients during the pandemic in order to provide recommendations to strengthen this key home visiting service.

Methods: The concurrent mixed methods study collected data from all 21 program sites. Data collection included online surveys and in-depth interviews (IDIs) with home visiting staff (120 surveys, 8 interviews) and clients (317 surveys, 5 interviews). Surveys and IDIs were analyzed separately, and findings were compared and contrasted in a final stage of data interpretation.

Results: Since the start of the COVID-19 pandemic, home visiting clients reported specific community resource and social support needs, such as housing, employment, food, and mental health care. Home visiting staff were able to assist clients with these needs by expanding their collaboration with local agencies. Clients appreciated the support they received from their home visitors to connect to these agencies and identified this as a key factor in receiving the services they needed. However, community resource linkages were not always successful, due to either a lack of understanding of the available community resources and the discontinuation of community resources due to the pandemic. In some cases, clients faced barriers to resources when services could only be accessed online.

Discussion: The coordination of community resources is a crucial home visiting service more than ever during a global pandemic with economic repercussions to many home visiting clients and their families. Fortunately, home visitors are able to successfully continue serving clients and addressing their needs with referrals to wrap around services.

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I. Introduction

Introduction and Rationale

Understanding the impact of the novel Coronavirus Disease 2019 (COVID-19) pandemic on home visiting programs in Georgia is crucial to adapting and strengthening public health practices during times of uncertainty and onward. COVID-19 is a respiratory illness caused by a new coronavirus (SARS-CoV-2) that was first discovered in Wuhan, China (Centers for Disease Control and Prevention [CDC], 2020a). The first cases of COVID-19 in Georgia were reported on March 2nd, 2020, and almost two weeks later on March 14th, the Governor of Georgia announced a Public Health State of Emergency where residents are to be in quarantine to slow the spread of the virus (Georgia Department of Public Health [GDPH], 2020a, 2020c). This administrative order halted in-person home visiting (HV) services that provide support to at-risk pregnant women and families with children up to five years of age.

This special studies project is part of a larger Emory COVID-19 Response Collaborative (ECRC)-funded project titled "Assessing the Impact of the COVID-19 Pandemic on Home Visiting Services in Georgia". This project builds upon the recent needs assessment of the Georgia Title V and Maternal, Infant, and Early Child Home Visiting (MIECHV) programs conducted by Dr. Sarah Blake and her team for the Georgia Department of Public Health (GDPH) in 2019. Home visiting programs are evidence-based programs with goals of increasing healthy pregnancies, improving parenting confidence and competence, improving child health, development and readiness, and increasing family connectedness to community and social support (GDPH, 2020b). During fiscal year 2019, over 2,000 families in Georgia received services from 17 local implementing agencies (LIAs) (Center for Family Research, 2019). Families who are eligible for Georgia's home visiting programs are deemed "at-risk" whether it

is due to unemployment, unstable housing, history/current substance abuse and other social factors. Due to the unique circumstances posed by the COVID-19 pandemic, families are undoubtedly facing new challenges and stressors that increase the need for home visiting services more specifically connection to community resources (Yard & Lewy, 2020). According to Minkovitz et al. (2016), home visiting programs can be critical for at-risk families to achieve economic self-sufficiency through linking them to community resources such as job training and adult education opportunities. The novel COVID-19 pandemic presents the opportunity to understand how the delivery of these critical community services through home visiting programs are impacted. As home visiting programs provide a wide array of services, this project will focus on the delivery of community services to understand whether the home visiting goal of "increasing family connectedness to community and social support" is upheld during the pandemic.

Problem Statement

The novel COVID-19 pandemic has stunned communities around the world with the unprecedented rapid spread of this respiratory virus. After the COVID-19 pandemic was declared a national emergency in the United States, states began implementing their own "stay-at-home" orders to mitigate the virus spread. This led to the closure of facilities and forced services such as home visiting programs in Georgia that primarily provide in-person support services to change their operations due to COVID-19. Since the pandemic hit Georgia, the Georgia Department of Public Health has not formally studied the effectiveness of the 21 HV programs in continuing to provide services to families and more importantly, how families have reacted to any programmatic changes and subsequent satisfaction with the services. The GDPH

has recognized that HV programs in Georgia may have adapted in various ways to continue their services to families and the needs of families may have changed during the pandemic.

Purpose Statement

The purpose of this special studies project is to assess changes to the delivery of community resources by home visitors due to the COVID-19 pandemic and its subsequent ramifications to the overall program and home visiting clients. The report will ultimately provide recommendations for the GDPH to strengthen and adapt linkages to community resources as an essential home visiting service during COVID-19 and beyond.

Research Questions

To accomplish this goal, the project is guided by the following research questions from the perspectives of home visitors and clients.

1. What are home visiting clients' community resource needs during the pandemic?
2. What factors affect the ability of home visitors to connect clients to community resources and for clients to access them during the pandemic?
3. What new strategies can be used to enhance the connection to community resources for home visiting clients?

Significance Statement

This multifaceted report provides timely information to the Georgia Department of Public Health and the broader community during a once-in-a-lifetime global public health emergency. Documentation of the impact of the novel coronavirus pandemic will capture the real-time needs of Georgia families. These findings are necessary to guide the GDPH in leading the 21 HV programs to respond to the needs of Georgia mothers and their children. Most importantly, this

assessment provides pertinent knowledge to inform future planning to adapt public health programs to be flexible for both program staff and clients during times of crises.

Definition of Terms

Community Resources	Includes social service needs such as employment, food, or housing
COVID-19	Coronavirus Disease 2019
GDPH	Georgia Department of Public Health
GHVP	Georgia Home Visiting Program
Home Visitor	Individuals delivering support services to families
HV	Home Visiting
HFG	Healthy Families Georgia
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
NFP	Nurse Family Partnership
PAT	Parents as Teachers

II. Literature Review

Introduction

Home visiting (HV) programs are a key service delivery strategy to enhance maternal and child health outcomes where visits in the home are a major component. They are founded on evidence-based early childhood intervention models that aim to improve maternal outcomes, child development and parenting confidence and competence (County Health Rankings & Roadmaps, 2018). While HV programs may vary in model framework and focus populations, they correspondingly support at-risk families to affect long-term health and development. Key indicators for maternal and infant health provide a snapshot of the health status of mothers and babies in the United States. A study by Tikkanen et al. (2020) for the Commonwealth Fund reports the United States as leading other high-income countries with the highest maternal mortality ratio of 17.4 deaths per 100,000 births in 2018 (CDC, 2020c). In terms of infant health, an annual report by March of Dimes highlights the infant mortality rate in 2018 in the U.S. as 5.7 infant deaths per 1,000 live births and a preterm birth rate of 10.2% (March of Dimes, 2020). Furthermore, maternal and child health are influenced by factors such access to prenatal care and social determinants of health contributing to widespread racial and ethnic disparities (Phares et al., 2004).

Understanding the impact of home visiting programs in Georgia on mothers and their children especially during the COVID-19 pandemic will demonstrate the continued need to improve maternal and child health in Georgia and the rest of the U.S. This literature review 1) broadly describes home visiting programs and services, 2) describes the state of maternal and child health in Georgia and the need for home visiting programs, 3) defines the evidence-based

home visiting models implemented in Georgia, and 4) introduces the COVID-19 pandemic and its potential impact on home visiting programs.

What is Home Visiting?

Home visiting programs originated from England decades before arriving in the United States during the late 1800s (Gomby et al., 1993). Investment in home visiting as part of social service programs became clear early on under the Sheppard-Towner Act of 1921 when funds were appropriated to states in order to strengthen maternal and child health programming and address prenatal health and infant mortality in the U.S. (Madgett, 2017; Meckel, 1990). This led to an increase in home visits by nurses across the U.S. including Georgia where over "15,000 infants, children and pregnant women" were served annually after the fund appropriation (Meckel, 1990). However, this funding soon ended years later in 1929 along with other philanthropic support resulting in a decline in home visits during subsequent decades.

Despite years of diminished interest, the second half of the 1900s restored enthusiasm for home visiting services as an intervention strategy to provide at-risk families with in-home education and community support services (Duffee et al., 2017; Gomby et al., 1993). A shift in service delivery approach and focus rendered home visiting services as pertinent due to new understanding of the value of providing services in the home, actively involving parents with the child's development as well as providing social support (Wasik, 1993). The allure of home visiting in bolstering families living in impoverished communities manifested in the federal initiative "War on Poverty" during the 1960s and in other early childhood programs developed at the time such as Home Start and Parents as Teachers where home visiting became an important component of the intervention (Powell, 1990). Many of these programs later transitioned into focusing on the entire family versus the individual and included a case management element to

strengthen families through parenting support and connection to community resources (Finello, n.d.). As enthusiasm and positive outcomes continued for home visiting programs, available funding from local organizations and state governments increased. The number of home visiting programs across the U.S. exploded with this renewed interest such that by the late twentieth century a national survey conducted by Wasik and Roberts (1994) identified over 4,100 home visiting programs. This rapid expansion led to the recommendation of home visiting by the U.S General Accounting Office (1990) as an encouraging early childhood intervention strategy for at-risk families after a review of the existing HV programs (U.S. General Accounting Office, 1990). Not only was this recommendation an important step in conducting a comprehensive review of home visiting programs, but it also culminated in the passing of legislation to fund family preservation and family support with $1 billion over five years (Duffee et al., 2017; Gomby et al., 1993).

The continued evolution of HV programs complemented with the growing body of evidence demonstrating its impact on families solidified federal commitment to home visiting with the passing of the 2009 American Recovery and Reinvestment Act (ARRA Public Law 111-5) and the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program in 2010 under the Patient Protection and Affordable Care Act (ACA) (Boller et al., 2010). The ARRA Public Law 111-5 authorized the spending of $2.1 billion for Head Start and Early Head Start while MIECHV, signed into law by President Obama, authorized $1.5 billion over 5 years for states to coordinate home visiting services for women and children especially families from at-risk communities (Boller et al., 2010; U.S. Congress, 2009). MIECHV funding became critical in spurring states to establish coordinated efforts in ensuring prenatal care and early childhood development support for families (Adirim & Supplee, 2013). Two important

stipulations to MIECHV funding were the requirements to spend most of the grant funding on implementing evidence-based home visiting models and to prioritize serving at-risk populations (Health Resources and Services Administration [HRSA], 2020). The MIECHV program brought the health of mothers and children to the forefront and has been one of the biggest federal investments in the field of maternal and child health.

The State of Maternal and Child Health (MCH)

Substandard maternal and child health outcomes continue to plague the United States. While developed regions as a whole experienced a drop in maternal mortality ratio (MMR) by 48% between 1990 to 2015, the U.S. falls behind other high income and developed countries with about 700 women dying annually due to pregnancy or delivery complications (Petersen, Davis, Goodman, Cox, Syverson, et al., 2019; World Health Organization [WHO], 2015). Research published by the Institute for Health Metrics in 2014 reported the U.S. landing in 60th place in the world for its MMR defined as the number of maternal deaths while pregnant or within 42 days of delivery per 100,000 live births (CDC, 2020d; Kassebaum et al., 2014). The last reported MMR for the U.S. in 2018 revealed 17.4 deaths per 100,000 live births, which has steadily increased over the past decades from 12.4 deaths per 100,000 live births in 1990 (CDC, 2020c; WHO, 2015). Serious racial and ethnic disparities exist in pregnancy-related deaths where non-Hispanic black women experienced a mortality ratio of 41.7 deaths per 100,000 live births, which is three times the mortality ratio of non-Hispanic white women (13.4 deaths per 1000,000 live births) between 2014 and 2017 (Petersen, Davis, Goodman, Cox, Syverson, et al., 2019). These maternal deaths are defined by “the death of a woman while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy” (CDC, 2020d). While challenges continue to be present in appropriately reporting maternal and

pregnancy-related deaths, information on perinatal mortality ratios remain an important indicator of a nation's overall health status.

Many, if not most, of these maternal deaths were preventable and have been attributed to pregnancy and delivery complications. Data from 14 Maternal Mortality Review Committees (MMRCs) included in a 2019 Morbidity and Mortality Weekly Report (MMWR) revealed that about two-thirds of the pregnancy-related deaths were preventable (Davis et al., 2019). These deaths also occurred consistently throughout pregnancy, delivery and the postpartum period reiterating the importance of appropriate education and healthcare during the entire perinatal period. With data on pregnancy-related deaths during 2013 - 2017 from 13 MMRCs, researchers categorized contributing factors to these pregnancy-related deaths into five groups: community, health facility, patient, provider, and system-level factors (Petersen, Davis, Goodman, Cox, Mayes, et al., 2019). In the community level, MMRCs identified factors such as access to clinical care, unstable housing and chronic disease complications as contributing to increased risk of pregnancy-related deaths. Within the system level, factors such as inadequate receipt of care and issues with case coordination or management were determined. These factors among several others contribute to pregnancy-related deaths and subsequently to the racial/ethnic disparities that exist. Adequate prenatal care has been an important strategy to ensure positive birth outcomes. The National Center for Health Statistics (NCHS) reported data from 2016 - 2018 where 23.1% and 27.5% of live births born to Black and American Indian/Alaska Native mothers, respectively received inadequate prenatal care (National Center for Health Statistics [NCHS], n.d.). A clear disparity exists across racial/ethnic groups when these rates are compared to the rate of 11.2% for non-Hispanic white mothers (NCHS, n.d.). Inadequate prenatal care is one of the many risk factors that lead to complications or even death for mothers in the U.S.

Thus, understanding the current state of maternal health is critical to bolstering targeted programming to alleviate these disparities.

Access to prenatal care allows for positive birth outcomes and aids in decreasing the risk of complications such as preterm birth and infant mortality. While about 15% of live births were born to U.S. women who received inadequate prenatal care during 2016 - 2018, the preterm birth rate in the U.S stagnated around 10% during the same time (March of Dimes, 2020; NCHS, n.d.). However, the U.S. preterm birth rate has been increasing during the past five years from 9.6% in 2015 to 10.2% in 2019. With the HealthyPeople2020 goal of reducing total preterm births to 9.4%, the U.S has been heading towards the opposite direction (HealthyPeople, 2017). Moreover during 2016 - 2018, Black infants experienced a preterm birth rate of 13.8%, which was 50% higher than the preterm birth rate for other women (NCHS). Preterm birth is also considered the second leading cause of infant mortality. While any infant death affects the family and the larger community, infant mortality in the U.S. unfortunately mirrors the troublesome trends seen in the measures described above. A National Vital Statistics Report reported the 2018 U.S. infant mortality rate at 5.7 infant deaths per 1,000 live births (Ely & Driscoll, 2020). This rate has slowly decreased from a rate of 6.9 infant deaths per 1,000 live births in 2000. Overall, this decreasing trend might look promising, but it would be uninformed without considering how the impact of infant mortality continue to vary among populations. When looking at the impact of infant deaths by race/ethnicity in 2018, the highest rate of infant mortality affected Black women at 10.8 infant deaths per 1,000 live births (Ely & Driscoll, 2020). Variation among these key indicators of MCH also exist across states, thus it is important to take a closer look at the granular level to understand how states are impacted differently.

Georgia's Maternal and Child Health Status

While not all states have an MMRC to perform a comprehensive review of deaths and determine whether they are pregnancy-related, the Georgia MMRC was formed in 2013 and has since been conducting maternal death reviews. During 2012 - 2016, the Georgia MMRC reported 26 pregnancy-related deaths per 100,000 live births where non-Hispanic black women were 2.7 times more likely to die from a pregnancy-related cause than non-Hispanic white women (GDPH, n.d.). This pregnancy-related mortality ratio was higher than the U.S. national value of 17.3 deaths per 100,000 live births in 2017 (CDC, 2020d). On top of the high pregnancy-related mortality, Georgia reported an MMR of 27.7 maternal deaths per 100,000 live births in 2018 compared to the national MMR of 17.4 in 2018 (NCHS, 2018). Furthermore, among the 25 selected states that reported their MMR in 2018, Georgia ranked 5th for the highest MMR. These mortality ratios are further exacerbated with the high rates of inadequate prenatal care among women in Georgia. Between 2016 - 2018, NCHS reported 17.6% of live births were born to women who received inadequate prenatal care in Georgia with Black mothers experiencing the highest rate at 23.9% of live births (NCHS, n.d.). While the receipt of inadequate prenatal care in Georgia is comparable to the U.S., Georgia's preterm birth rate is worse than the national rate.

Given a grade of an 'F' by March of Dimes for its 11.7% preterm birth rate in 2019, Georgia has seen this rate steadily increase in the past five years (March of Dimes, 2020). This high rate has also placed Georgia as the 6th highest preterm birth rate in the country. Coupled with another bleak ranking of 4th place in the highest percentage of babies born with low birthweight in 2019, Georgia continues to trail behind other states in cultivating positive maternal and child health outcomes (NCHS, 2021b). In terms of infant mortality, Georgia also joins other Southern states in the highest rates ranking 7th with a rate of 7.0 infant deaths per

1,000 live births (NCHS, 2021a). Again, the racial/ethnic disparity in infant mortality was evident during 2015 - 2017 where black infants (11.7 deaths per 1,000 live births) died at twice the rate of non-Hispanic white infants (5.1 deaths per 1,000 live births) and thrice the rate of Asian/Pacific Islander infants (3.4 deaths per 1,000 live births) (NCHS, n.d.). This alarming disparity in infant deaths within one year of age has a chilling effect in the health of communities as one of the most vulnerable populations continues to be at risk.

Social Determinants of Health of Mothers and Children in Georgia

Social and economic factors play a critical role in generating positive health outcomes for mothers and children. These factors may affect families' ability to experience improved quality of life and even to access healthcare services, which can subsequently impact their health outcomes. Factors such as access to health insurance, employment and education may impact families' long-term health outcomes as well as perpetuate disparities among racial/ethnic groups. Between 2017 - 2019, 15.2% of women ages 15 - 44 experienced poverty in Georgia defined as living at or below 100% of the Federal Poverty Level, which was $20,598 for a family of 3 in 2019 (IPUMS-CPS, 2019). This rate was higher compared to the U.S.'s measure of poverty among women at 14.7%. Comparatively, 21% of children in Georgia experienced poverty in 2018 where Hispanic and Black children experienced poverty at higher rates over 25% (County Health Rankings & Roadmaps, 2020). Living in poverty has long-term impacts to health and academic achievement especially for children when they enter adulthood. Low-income households are more susceptible to poorer health outcomes and quality of life. The stress and challenges from living in poverty contribute to the increased likelihood of low-income mothers to experience preterm births and low birthweight babies (Braveman et al., 2011). The Kids Count project found that out of all the children in Georgia who were subject to a maltreatment report

with child protective services in 2018, 45% (4,906 children) were between the ages 0-4 (Kids Count, 2020). The health and social consequences of child maltreatment include negative impacts to brain development and educational achievement (WHO, 2020). While pre-kindergarten programs contribute to school readiness, Georgia saw 50% of children ages 3 and 4 not enrolled in any enrichment programs such as nursery schools in 2018 (Kids Count, 2020). Ensuring that children live in safe environments and are provided with opportunities to succeed educationally are not easy tasks and may benefit from supportive programs such as home visiting programs.

Effectiveness of Home Visiting

Research on the importance of a child's early years as a key intervention period to promote healthy development fueled the popularity of home visiting programs in the U.S. and subsequently the need to understand their effectiveness and attributable health outcomes (Carnegie Corporation of New York, 1994). Researchers in the past few decades have systematically reviewed and critiqued literature on existing and newly developed HV program models finding desirable outcomes such as reduced child abuse and neglect, enhanced parenting skills and improved family economic security (Bilukha et al., 2005; Daro, 2006; Gomby, 2005). More recent systematic reviews in the past decade have found improved birth outcomes and children's cognitive development when comparing between groups that utilized home visiting versus those that did not (Goyal et al., 2013; Issel et al., 2011; Peacock et al., 2013; Sweet & Appelbaum, 2004). These effects have also been found to endure up until the child is 7 years old (Michalopoulos et al., 2017). However, no single model of home visiting can accomplish all beneficial outcomes associated with early childhood HV programs suggesting the importance of implementing the appropriate HV model that has been evaluated for the intended outcomes.

Due to the wide variety of goals and service populations, home visiting programs show varying results when evaluating focus areas such as parenting outcomes, child development, and maternal health. Despite differences in program aspects such as home visit frequency, many HV programs share a similar timing strategy when engaging clients by beginning prenatally or after birth and extending until the child turns 5 years of age or earlier. Some of these HV programs include large national models such as Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). These three models are among the 21 models that have been reviewed by the Home Visiting Evidence of Effectiveness (HomVEE) staff and approved to have met the Department of Health and Human Services (HHS) criteria for evidence-based models (HomeVEE, 2020). Models that have met the HHS criteria are eligible for implementation by MIECHV funding grantees.

Home Visiting in Georgia

Since the birth of the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program in 2010, Georgia has received funding to expand evidence-based home visiting programs under its own MIECHV program, Georgia Home Visiting Program (GHVP). The Georgia Department of Public Health currently oversees GHVP when it moved from the Department of Health Services in 2017 allowing for a more coordinated system for early childhood services (Astho, 2018). According to GHVP, its programs aim to provide support to new parents and their children during the critical early years of the child's life. The HRSA-approved models employed in Georgia through MIECHV funding include Parents as Teachers (PAT), Nurse-Family Partnership (NFP), and Healthy Families America (HFA). Currently, there are 21 active programs implemented in 15 counties during FY2021 with funding support from

the MIECHV program and other sources including the Title V Block Grant Program and the Georgia DPH.

The 3 HV models in GA implemented have demonstrated impacts in the following domains: 1) improving maternal and child health, 2) reducing child maltreatment, 3) improving school readiness, 4) reducing domestic violence, 5) increasing positive parenting practices, 6) improving family economic self-sufficiency, and 7) improving coordination and referrals to community resources (GDPH, 2020b; HRSA,2021). These models affect each domain to varying degrees due model-specific curriculum and home visit structure.

Healthy Families America (HFA)

Developed in 1992 by Prevent Child Abuse America (PCAA) and Hawaii Family Stress Center, HFA was launched with the primary goals of improving parenting, reducing child abuse, and improving the overall development of children and their health. The initial 22 sites in 1992 quickly grew to 261 sites in 36 states by late 1996 (Healthy Families America, n.d.-b). HFA's focus population had always been first-time parents and their children. The program model is characterized by its pre-outlined 12 critical elements that act as guiding principles for each implemented site, which are grouped in 3 main categories: service initiation, service content, and service provider selection and training. To evaluate the initial effectiveness of HFA sites, PCAA developed the HFA Research Network. This group engaged about 50 researchers with diverse backgrounds including social work and public health and completed 17 HFA evaluations by 1999 (Daro & Harding, 1999). The outcomes of these evaluations were first shared in the *Future of Children* journal where a highlighted randomized control trial study conducted on the Hawaii Healthy Start Program over a 2 year observation period demonstrated a reduction in reported child maltreatment. Other early promising outcomes included improved parent-child interactions

as well as timely access to healthcare services and child developmental screenings (Daro & Harding, 1999). The growing number of evaluations on HFA's effectiveness began to solidify its main effect in reducing child maltreatment as confirmed by a study by Healthy Families New York (2005). This longest running randomized control trial study on HFA reported that families enrolled in HFNY engaged in severe physical abuse about 7 times less than the control group (Mitchell-Herzfeld et al., 2005). The impact of HFA programs has continued to show reduced child abuse and neglect and improved parenting attitudes and practices. It has also demonstrated favorable results in all 8 domains outlined by HomVEE and nationally acknowledged by HHS as an evidence-based home visiting strategy (HFA, n.d.-b).

HFA maintained the flexibility for sites to add any program enhancements needed to appropriately serve the intended population as long as it does not interfere with the fidelity of the model's implementation. As of early 2020, there were 590 HFA sites implemented across 38 states (HomVEE, 2020). HFA sites were also able to specify the characteristics of their intended population such as single parents, low income, or parents in a certain geographic region as HFA primarily aims to support parents dealing with a variety of challenges. Clients were voluntarily enrolled into the program either prenatally or after birth with services continuing until the child reaches the age of 3 or 5. The home visits were typically offered weekly and may be less frequent depending on client need. Services included screenings for child maltreatment, assessment of parent-child interactions and monitoring of child development (HomVEE, 2020). Home visitors came from various backgrounds such as social work, education, and nursing.

The HFA program in Georgia is known as Healthy Families Georgia (HFG). There were 7 HFG sites serving 8 counties in FY2020 (HFA, n.d.-a). Trained home visitors were referred to as Family Support Workers/Specialists who provide parenting and child development education

and support with community resources to strengthen families and prevent child abuse and neglect. The program's goals included nurturing parent-child relationships and promoting healthy child development through the long-term comprehensive home visiting services (Brightpaths, n.d.; Coastal Coalition for Children, 2021).

Nurse-Family Partnership (NFP)

First imagined by Dr. David Olds during the 1970s as an intervention to support at-risk first-time mothers, NFP now has program sites in 40 states and the U.S Virgin Islands supporting 38,756 families as of December 2020 (Nurse-Family Partnership [NFP], 2021). Early randomized-control trials in Elmira, NY, Memphis, TN, and Denver, CO produced positive outcomes from 1970s - 1990s leading to the model's expansion throughout the U.S. beginning in 1996 and solidifying the NFP home visiting model (Kitzman et al., 1997; Olds et al., 1986; Olds et al., 2002). The Elmira study involved low-income white women living in rural areas who were placed either in the control group, receiving no nurse-home visitation services from the research project, or in one of the three treatment arms: 1) received prenatal care and well-child care visits along with free transportation, 2) received everything in treatment arm 1 plus a nurse-home visitor during pregnancy, and 3) received everything in treatment arm 2 plus a nurse-home visitor during pregnancy and up until the child turned the age of 2 (Olds et al., 1986). Within the first two years of the study, results demonstrated the reduction of preterm births among nurse-visited mothers who smoked compared to mothers in the control group as well as a reduced incidence in child abuse and neglect among nurse-visited mothers. While these results were promising, Dr. Olds hoped to strengthen the success of the nurse-home visitation model by duplicating it in urban settings and among families of color. This led to the Memphis study in 1988 where a majority of participants were African American women, and again preliminary

results demonstrated that nurse-visited women experienced hypertensive disorders during pregnancy at 23% less than women in the control group (Kitzman et al., 1997). Finally, to truly uncover the robustness of the NFP model, a final trial in Denver, CO involving mainly Hispanic women tested the difference between a nurse-home visitor and a paraprofessional-caregiver. This study in 1995 demonstrated that nurse-visited mothers were more likely to be employed compared to non-visited mothers (Olds et al., 2002). However, when comparing paraprofessional-visited mothers and the control group, there were very little differences besides potential improvements in parent-child interactions. It became clear after the completion of these three key trials that the NFP model was robust in its ability to build positive relationships between mothers and their infants in usually stressful environments regardless of race and geographic location (Goodman, 2006).

From the trials, NFP's main outcomes became 1) to improve prenatal and maternal health and birth outcomes, 2) improve child health and development, and 3) improve families' economic self-sufficient and/or maternal life course development (HomVEE, 2019a). As with the trials, NFP's focus population were first-time mothers who are also low-income. Enrollment into the program was optimally as early into the pregnancy but no later than 28th week of pregnancy. The clients then continued in the program until the child was two years of age. Nurse home visitors along with the mothers determined the frequency and content of the visits but were guided by the NFP Strengths and Risks Framework. Nurses also ensured that mothers were receiving appropriate prenatal care as well as provided support and education to promote a healthy pregnancy, birth outcomes, and proper child development (NFP, 2020). All of this combined allowed for a client-centered approach driven by the mothers' specified goals.

There is currently one NFP program site in Georgia, which was established in 2012. This site serves 2 Georgia counties and has served over 684 families since its inception. In 2019, 94% of babies born to mothers enrolled in NFP were born full-term and 67% of clients were employed at 24 months who were 18 years or older. Most clients enrolled as of 2019 were African American women, of low-income households, not married at time of enrollment, and insured through Medicaid (NFP, 2019).

Parents as Teachers (PAT)

As a pilot project in 1981 by the Missouri Department of Elementary and Secondary Education, the Parents as Teachers program aimed to improve children's school readiness upon entering kindergarten ("Appendix B: Parents as Teachers," 1999). Results from this pilot involving four school districts demonstrated positive outcomes in child school readiness as shown through higher scores by children enrolled in PAT on the Kaufman Assessment Battery for Children and the Zimmerman's Preschool Language Scale, which assess cognitive ability and language ability, respectively (Pfannenstiel & Seltzer, 1989). This led to a statewide expansion of PAT to all Missouri school districts in 1985, which has now grown to 1,031 affiliates across all U.S. states and 6 other countries (Parents as Teachers [PAT], 2021b).

The PAT model has four primary goals: 1) increase parent knowledge of early childhood development and improve parent practices, 2) provide early detection of developmental delays and health issues, 3) prevent child abuse and neglect, and 4) increase children's school readiness and success (PAT, 2021a). With its four components of home visits, group connections, developmental screenings and family linkages to resources, the PAT model has been rated in its role in improving child development and school readiness, promoting positive parenting practices, and reducing child maltreatment. Two randomized control trials that have been rated

as “high” by the HomVEE team at the Department of Health and Human Services has shown these improvements including promoting family economic self-sufficiency (Drotar et al., 2009; Wagner & Clayton, 1999). The 3-year prospective study conducted by Drotar et al. (2009) used a mixed sample of clients who are either mid-high socioeconomic status (SES) or low socioeconomic status. While no major differences in cognitive development were found between the treatment group receiving the PAT curriculum and the control group, the study revealed that among children of low SES, those that received the PAT curriculum showed significantly higher scores in the Bayley Scale of Mental Development compared to other low SES children in the control group. Another important finding in the Drotar et al. study was the higher scores for task competence found in children receiving the PAT curriculum compared to the control group including a similar pattern among low SES children.

The Wagner & Clayton (1999) study included results from two randomized control trials, one in Northern California and the other in Southern California. Again, while no major differences were noted between the PAT group and the control group, there were notable benefits to Spanish-speaking Latino families. Improvements in cognitive development as measured by Developmental Profile II Cognitive Development Scale were found among children of Latino families enrolled in PAT compared to Latino children in the control group (Wagner & Clayton, 1999). These children receiving the PAT curriculum also scored higher on the Bayley Scales of Infant Development than their control group counterparts. Overall, the receipt of PAT benefitted children of Latino families the most especially in areas of cognitive development and in small improvements in parenting behaviors and attitudes.

The implementation of the PAT model requires the inclusion of all four components mentioned earlier. However, there is flexibility in selecting the characteristics and criteria of the

affiliates' focus population, which can include children with special needs, low-income families, teen parents, and immigrant families (HomVEE, 2019b). Families voluntarily enroll into the PAT program at any point during pregnancy up until the child's enrollment to kindergarten. The home visitors employed by the program are known as parent educators, and they provide the structured curriculum during home visits. The PAT model require that families receive at least 12 home visits in a year lasting a minimum of 60 minutes per home visit. On top of the home visits, the PAT model includes monthly group connections for families to attend events such as parenting groups or presentations led by parent educators to share parenting and child development resources and information. Annual developmental screenings are also another key required component of the PAT model to allow for the early detection of any developmental delays and health issues among children. The frequency of home visits change depending on the families' needs. Currently in Georgia, there are 24 PAT affiliates overall where 13 of them are managed by the Georgia Department of Public Health in fiscal year 2020 serving 10 GA counties (PAT, 2021c).

These three models are currently employed in Georgia and have been vetted by the HomVEE team as evidence-based models. Each program incorporates community resource linkages and referrals as a component to achieving the program model's goals. The intensity of this service may vary by home visiting model and depending on the needs of the families.

Home Visiting Programs' Role in Community Resource Linkages

The Georgia Home Visiting Program (GHVP) outlined one of its goals for home visits as to "increase family connectedness to community and social support". The coordination of resources and direct referrals to them are common services provided by home visitors especially to at-risk families. Families enrolled in GHVP typically meet one or more of the following

condition: low-income, first-time parent, under 21 years old, unemployed, unstable housing, low educational attainment, late or no prenatal care, survivor of child abuse or neglect, history or current substance abuse, history or current special education services, history or current depression or other mental health concerns, have children with developmental delays or disabilities, or have family members who are serving or formerly serving in the US military (GDPH, 2020b). Families in Georgia with any of these qualities may self-refer to enroll in the program or be recruited by the First Steps Program. GHVP employs First Step Coordinators to screen families to determine any resources and support needed, and if more regular support is needed, referrals to home visiting programs are made. Sometimes community resource referrals are made by First Steps Coordinators to supports such as childcare, housing supports, and health care. However, once enrolled in a home visiting program, each program model approaches families' resource needs similarly.

Linkage to community resources were used by home visitors to ensure families are supported especially as providing these resources are usually out of scope from the direct services provided by home visiting programs. Past research studies have demonstrated that families enrolled in home visiting programs were more likely to be connected to other community resources than families not enrolled in HV programs (Caldera et al., 2007; Silovsky et al., 2011). The MIECHV Program has identified the importance of referrals to community resources through home visiting by including it as one of the domains under "improved coordination and referral for other community resources and supports" that MIECHV-funded HV programs have to demonstrate improvements in (HRSA, 2020). Thus, in order to appropriately connect families to resources, HV programs developed partnerships with community services providers.

With oversight from the Georgia DPH, home visiting programs were integrated into a broader early childhood system of care. This integration allowed HV programs to collaborate with other programs housed under GDPH's Maternal and Child Health Section to facilitate further coordination of maternal and child health-focused resources (Astho, 2018). While community resources may vary by location, HV programs in Georgia partnered with the Georgia Division of Family & Children Services (DFCS) and First Steps to identify resources for HV families. Referrals to community services are contingent on the availability of those resources in the community, and subsequently, the HV families' receipt of those services are dependent on both their accessibility and effectiveness. While a formal evaluation on the coordination of and referral to community resources in Georgia has yet to be completed, six of its HV programs were included in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) implementation research analysis (Duggan et al., 2018). This analysis of randomly selected MIECHV-funded HV programs reported on 88 local programs across 12 states using interviews from program managers regarding the accessibility and availability of community resources. About 80% of program managers reported the presence of resources for each of the four domains: maternal and newborn health and well-being, child health and development, family economic self-sufficiency, and access to community resources and public services. While this was promising, two-thirds of program managers reported their communities lacking "accessible and effective providers for any given type of service" (Duggan et al., 2018). Given that six of the HV programs included in the study were from Georgia, gaps in community resources were echoed by other home visiting programs across the U.S. This analysis further demonstrated not only the importance of home visitors in facilitating these resource connections for their clients but also the availability of these resources in the community. While there is interest in further

understanding the role of home visitors in community resource referrals for families and whether the subsequent receipt of services occurs, few states have undertaken this evaluation (Goldberg et al., 2018; Minkovitz et al., 2016).

The COVID-19 pandemic landscape

The year 2020 was characterized by distressing changes to lives around the world brought on by the novel COVID-19 pandemic. The first reported outbreak of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection causing COVID-19 occurred in Wuhan, China in December 2019, which later spread to over 30 countries by February 2020 (Jernigan, 2020). With the first case of COVID-19 arriving in the U.S. on January 2020, the U.S Department of Health and Human Services (HHS) soon declared COVID-19 a public health emergency on January 31st, 2020 (U.S. Department of Health and Human Services, 2020). The first cases in Georgia were reported in March 2020 with a subsequent declaration of the state's public health emergency. Community mitigation strategies were implemented throughout the country such stay-at-home orders, mask mandates, and social distancing in community settings to slow the spread of the virus as person to person spread occurs through respiratory transmission (Schuchat, 2020). Symptoms have included a cough, fever and shortness of breath while sometimes COVID-19 cases can be fatal when underlying health conditions are present. As of April 2021, there have been 30.5 million cases of COVID-19 and 550,000 deaths in the United States (CDC, 2021).

This pandemic however has disproportionately affected vulnerable populations during such an isolating time. Communities living in poverty and those with "higher percentages of racial and ethnic minority residents and people living in crowded housing conditions" were more susceptible to rapid COVID-19 infections and subsequent negative health outcomes (Dasgupta et

al., 2020). Studies have also uncovered bleak findings on the disparities on the burden of COVID-19 among racial minority groups where one revealed that 34% of deaths due to COVID-19 were among non-Hispanic Black individuals (Figueroa et al., 2020; Holmes et al., 2020; Price-Haywood et al., 2020; Wadhera et al., 2020). Stay-at-home orders have forced businesses and schools to close down contributing to increased stressors for families such as job loss and managing home schooling (Cluver et al., 2020). An October 2020 survey on individuals dually eligible for Medicaid and Medicare demonstrated exacerbated social needs such as food and housing insecurity due to the COVID-19 pandemic (Archibald, 2021). While community resources may be more critical than ever, organizations providing these resources to address social needs are now "struggling to survive" the COVID-19 pandemic with limited funding for the increased needs (Tsega et al., 2020). A survey of nonprofit leaders across social service sectors such as housing and employment providers expressed concerns of "destabilizing conditions" including decreased workforce availability and issues with long-term financial survival due to potential decreases in grants and fundraising events (Tsega et al., 2020). The impact on community resource providers coupled with the increasing demand for services from communities demonstrate the magnitude of the COVID-19 pandemic not just as a health crisis but as an economic and resource crisis.

Potential impact of the COVID-19 pandemic on Home Visiting services

Originally delivered in-person in families' homes prior to the pandemic, home visits transitioned virtually given the nature of the virus to allow for the continuation of services to families (GDPH, 2020b). Each HV program had to adapt their services to ensure fidelity to the home visiting models and compliance to public health safety guidelines. The economic and mental health crisis brought on by the pandemic to many vulnerable and low-income families has

demonstrated an increased need for community resources (Williams et al., 2021). Families enrolled in home visiting often already experience greater needs for support services such as connections to employment training programs and access to Medicaid insurance, and these needs are most likely exacerbated by the COVID-19 pandemic (Williams et al., 2021). As seen with the literature, home visitors are an important bridge for families to access the community resources they need. Furthermore, the current environment in which essential home visiting programs are operating in presents a key opportunity to understand how the delivery of essential community services are affected by the COVID-19 pandemic. This special studies project aims to assess the delivery of community resources to home visiting clients including changes in social needs, facilitators and barriers for home visitors in coordinating community resources, and challenges experienced by clients in accessing these resources during COVID-19 in order to provide recommendations to improve community resource delivery in communities during the pandemic and beyond.

III. Methods

Introduction

This special studies project was guided by three major research questions:

1) What are home visiting clients' resource needs during the pandemic?

2) What factors affect the ability of home visitors to connect clients to community resources and for clients to access them during the pandemic?

3) What new strategies can be used to enhance the connection to community resources for home visiting clients?

Perspectives from both home visiting staff and clients were obtained across 21 sites in the Georgia Home Visiting Program (GHVP) during the COVID-19 pandemic. Since referrals to community resources is one of the key services provided by home visitors, this mixed-methods study utilized both surveys and in-depth interviews (IDIs) with home visiting staff and home visiting clients. Data collection materials were developed in the fall of 2020 while data collection occurred in the spring of 2021. The author was actively involved in both survey and IDI guide development as well as conducting the interviews. This section describes the project's research design including the population involved, the data collection instruments and processes, plans for data analysis, IRB considerations, and limitations inherent with the project.

Research design

The project utilized a concurrent mixed methods design using the convergence model outlined by Creswell and Plano Clark (2007). The collection of quantitative and qualitative data was simultaneous while analysis was conducted separately, and then results were merged during the interpretation stage. Data collection for those included in this project occurred between December 2020 until March 2021. Survey data collection was conducted using Qualtrics XM

(Provo, UT), and in-depth interviews were conducted virtually over Zoom Video Communications (San Jose, CA) with a lead interviewer and a note-taker. Both sources of data were integrated during the interpretation of results to develop a robust understanding of community resource delivery during the pandemic.

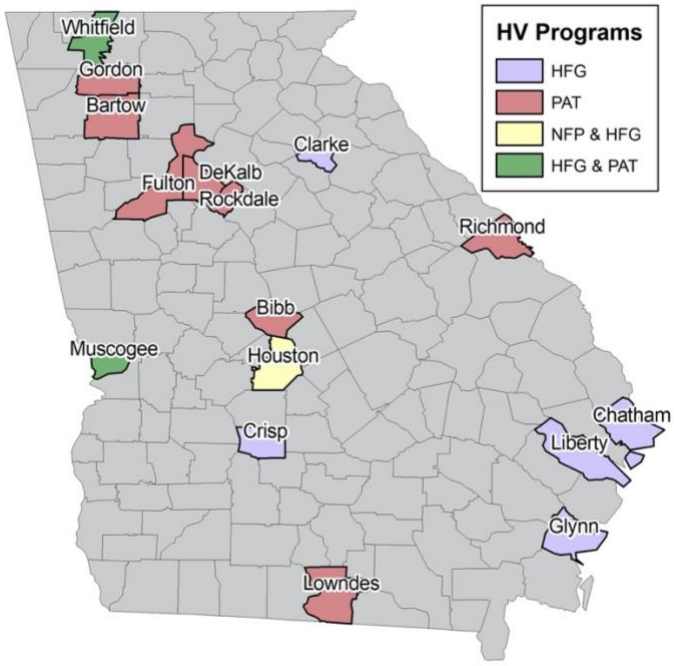
Procedures

Prior to data collection, the Emory team attended one of the monthly home visiting staff meetings to introduce the study and provide background information as well as what to expect in the coming months. Direct communication regarding the study to the home visiting programs was led by the team's project manager (MMaster). Once data collection tools were finalized in fall 2020, an email communication from the Emory research team via the DPH home visiting program to the 21 sites signaled the beginning of data collection. Survey administration to HV staff occurred prior to inviting a select number to complete an in-depth interview. The client data collection process soon followed upon near completion of staff interviews. The entire project team contributed to conducting virtual interviews and note-taking during the interviews.

Population and sample

This assessment was conducted on home visiting programs located throughout Georgia spanning 16 counties (**Figure 1**). All home visiting staff as of September 2020 (n = 113) including both home visitors and supervisors across the 21 HV programs were invited to complete a web-based survey, and at the end of survey data collection, 120 HV staff completed it. Since new staff have taken on roles as home visitors during the pandemic, the 120 respondents reflect this change. A select number of home visitors and supervisors who completed a survey were invited to participate in interviews (n = 22). The interviewees were selected from each of the HV program sites and were a mix of home visitors (n = 10) and supervisors (n = 13). While

Figure 1. Map of Georgia counties with a home visiting site by program model



22 interviews were conducted, one interview involved a home visitor and a supervisor from the same program generating a total of 23 staff participants. Enrolled HV clients across all 21 programs were recruited to complete surveys, and 23 of them were selected to complete interviews. The goal of recruiting 25% of home visiting clients to complete the online survey (n = 350) resulted in the completion of 317 surveys (90.5%). This project included all survey data from both HV staff and clients and a select sample of interviews amounting to 8 HV staff and 5 clients as data collection and analysis are still ongoing for the broader study.

Data collection

Web-based Surveys

The structured staff and client surveys were developed by the project team in collaboration with a representative [KBrantley] from the Georgia DPH home visiting staff. Suggested domain topics from the DPH home visiting staff were incorporated during survey development. The final domains covered in the staff survey were 1) demographics, 2) services delivered, 3) service provision since COVID-19, 4) barriers with virtual home visits, 5) personal mental well-being, 6) readiness to return to in-person visits, and 7) perceived COVID-19 risks [Appendix A]. These questions allowed for a robust understanding of what home visiting

services were like during the pandemic and the extent of difficulty for home visitors in providing services. The client survey followed a similar design to the staff survey. Questions obtained client perspectives on the receipt of home visiting services during a pandemic. Main domains covered were 1) demographics, 2) family environment, 3) home visits, 4) health and social needs, and 5) mental well-being during COVID-19 [Appendix A]. Both the HV staff and HV client surveys were piloted among four staff members (two supervisors and two home visitors) and two clients. Edits on the wording of questions and answer choices were completed after. The client survey was translated into Spanish by a graduate MPH student (RPerez) with its own Qualtrics link to accommodate for Spanish-speaking clients in HV programs.

The 36-item HV staff survey was deployed between December 2020 and February 2021. A single unique survey link was generated from Qualtrics XM and deployed to all home visiting program sites. The online survey was self-administered and took about 20 to 30 minutes to complete. All HV staff across the 21 home visiting programs were invited to complete the survey and received an incentive upon survey completion. The incentive provided was an electronic gift card redeemable at Walmart. The DPH staff (KBrantley) in the project team ensured all program staff had a chance to complete the survey and resulted in 120 completed surveys (response rate = 100%). With regards to the HV client surveys, a similar survey data collection process was conducted using a 44-item questionnaire. A unique Qualtrics link was provided to each HV program (21 total program surveys plus a Spanish survey), and each program was given a goal to recruit 25% (N = 350) of their clients to complete the survey. All surveys were self-administered with an option to use an interpreter in completing the Spanish client surveys. A quota was placed for each survey to automatically prevent any further survey responses once it was met. An incentive was also provided to each client who completed a survey in the form of an electronic

Walmart gift card. There were 317 completed surveys (response rate = 90.5%) with 28 completed (8.8%) in Spanish.

In-depth Interview Guides

The project team also collaboratively designed in-depth interview (IDI) guides for both home visiting staff and clients.

I. *HV Staff IDI Guide.* The author completed the initial pass at developing the staff IDI based on the survey topics to allow for further elaboration on these domains. The project team provided feedback to finalize the staff IDI. Areas of inquiry included the staff's reflection on the current state of home visiting during a pandemic, any resource needs, and recommendations to continually support HV programs. The three main domains were 1) home visits during the COVID-19 pandemic, 2) continuity of services during COVID-19, and 3) managing stress and well-being as a home visitor [Appendix B]. Four pilot interviews were conducted with the same two HV supervisors and two home visitors who completed the pilot survey. The team subsequently improved the flow and wording of the IDI guide based on feedback from the interviews.

II. *HV Client IDI Guide.* The team's project manager began the initial draft of the HV client IDI guide and with feedback from the team, was prepared for piloting. The main areas covered in the guide also stemmed from the HV client survey and included 1) COVID-19 experiences and information, 2) home visiting during COVID-19, and 3) home visiting going forward [Appendix B]. These questions aimed to garner client perspectives on the receipt of home visiting services during the pandemic including the quality of engagement with their home visitors and

recommendations to improve home visiting during the pandemic and beyond. Two client pilot interviews were completed in December 2020 after completing the pilot surveys. Further revisions on the flow and wording of the questions were made by the team.

Interviews with staff were scheduled starting January 2020 until February 2021. Each HV program site selected one home visitor or supervisor from the program to participate in an interview based on a position designation provided by the project team. The designations allowed for roughly equal coverage of home visitors and supervisors as well as by program model. While a total of 22 staff interviews and 12 client interviews were completed, a select number of those interviews were included in this project (**Table 1**). One staff interview involved two HV staff, a supervisor and a home visitor, bringing a total of 9 staff participants in 8 interviews. The interviews were conducted over Zoom by project team members, lasted 45 - 60 minutes, and were audio-recorded. During each interview, there was an assigned interviewer and a note-taker using a pre-developed note-taking template. The audio files were transcribed through Rev.com and de-identified by the team. In terms of client interviews, a total of 12 clients were invited to complete an interview as April 2021 with data collection still ongoing for the larger study. Clients were recruited by home visitors from each program across the three program models and based on the number of years enrolled in the program.

Table 1. Breakdown of HV staff and client interview included in this project.

Home Visiting Staff and Client Interviews Breakdown			
HV Model	# of supervisors	# of home visitors	# of clients
Parents as Teachers	2	2	1
Nurse-Family Partnership	0	1	2
Healthy Families Georgia	1	3	2
Total	3	6	5

Plans for data analysis

Quantitative data

Both HV staff and client data were cleaned and analyzed using SAS v9.4 (Cary, NC). Response duplicates were removed, and surveys with over a 95% completion rate were included in the sample. Descriptive analyses were conducted across demographic variables and those pertaining to the delivery of community resources. Subsequent descriptive sub-analyses by home visiting model were completed to explore any variations between models.

Qualitative data

Analyzing this portion of the data used a descriptive thematic analysis approach to interpret the community resource delivery system during the COVID-19 pandemic from both staff and client perspectives (Braun & Clarke, 2006). The focus on qualitative data analysis for staff and client interviews was capturing the current client resource needs since the start of the pandemic (Aim 1), the ability of home visitors to connect clients to resources (Aim 2), the accessibility of those resources for clients (Aim 2), and strategies to improve coordination of these resources (Aim 3). Analysis was organized into shared and distinct themes identified inductively between the two study populations.

Transcripts were cleaned and de-identified prior to analysis. Beginning with the HV staff interview data analysis, deductive and inductive codes were initially developed by a project team member (KHowell). There were three iterative rounds in applying and refining the codebook. The process began with the application of the initial codebook collectively as a team to a single transcript, followed by another simultaneous codebook application by two project team members using a newly revised version, and lastly another joint codebook application by three pairs of project team members on three different transcripts using a further cleaned up codebook. Memos

were created during each step to flag confusing codes and were added to an excel sheet to discuss the appropriate code application. With a finalized codebook, the rest of the transcripts were coded using a team-based approach where each transcript was coded by at least two team members and reconciled to produce a final coded transcript. This approach allowed for team consensus with code definitions and applications (MacQueen et al., 1998). The codes were then pulled into larger themes across transcripts. A similar process was followed for the client interview data analysis. Due to time constraints, the client codebook went through two iterative rounds of application and refinement: the first round with three team members and the second round with another pair of team members. Analyses of HV staff and client interviews were completed using MAXQDA2020 (Berlin, Germany).

After the completion of transcript coding, codes pertinent to the delivery of community resources were analyzed. The coded segments were reviewed with regard to the research questions and emerging themes were identified.

Interpretation

While both quantitative and qualitative data analysis were analyzed using the respective techniques for each data type, the data are integrated with each other during data interpretation. Each data type was weighted equally during this convergence stage, and both were utilized together to respond to the research questions. Comparisons were conducted between the two datasets as well as merging them to provide a more complete discussion of the identified themes.

International Review Board (IRB) Determination

This project was provided an exemption from the Emory and Georgia Department of Public Health IRB as it was deemed as “Public Health Practice”. As the purpose of this study

was not to generate or contribute to generalizable knowledge, it was not considered human subjects research. This project fell under Public Health Practice with its purpose to improve a public health program or service and aimed to "benefit the clients participating in a public health program". HV staff and clients were not required to provide any personal information unrelated to the study goals. Verbal informed consent was obtained prior to all interviews as well as to record the interviews. All interview participants were provided with the option to terminate the interview at any time or skip any question that they do not feel comfortable responding to. They were also informed that their information will be kept confidential along with the recordings of their interviews in a cloud-based drive. Only the Emory team members had access to these recordings and transcripts to preserve the HV staff's anonymity.

Limitations and delimitations

This project has a number of limitations. This study involves only home visiting programs housed under the Georgia Home Visiting Program and managed by the Georgia Department of Public Health. The convenience sample of home visiting clients decreases the generalizability of the findings. Issues of social desirability bias may have impacted clients' responses to topics on resource needs and satisfaction with home visiting services during the pandemic as they were recruited by home visiting staff to participate in the study. This project is limited in the select number of HV staff and client interviews included.

IV. Results

> "*I would probably say the main benefits is just having that support, having that help and that guidance, and someone there to listen and help you when you need it. Just that support I would definitely say is the main benefit, especially in a time like now when everyone feels so secluded because you really can't go anywhere, you really can't do much of anything. You're kind of cut off from a lot, especially with your doctor's visits and things like that. They limit them, so having that support and that help I definitely would say is the main benefit of it. Just having that is amazing.*" (NFP Client2)

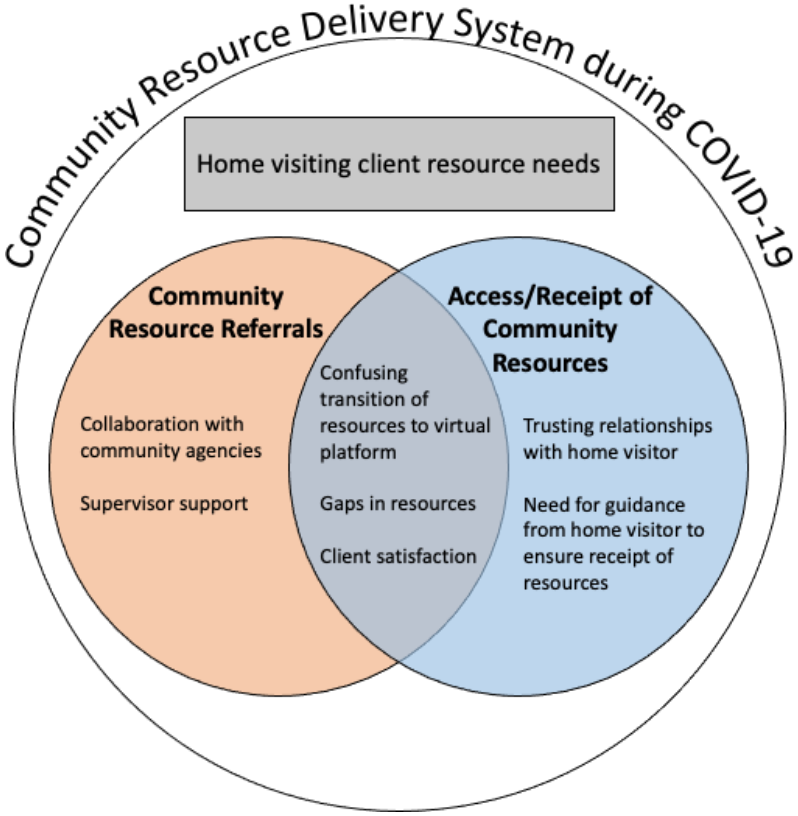
This home visiting client reflected on the various types of support home visitors provide to them, and the increased importance of that support during the COVID-19 pandemic. Since virtual home visiting services in Georgia were implemented in March 2020 with no clear end in sight, both home visiting staff and clients had to adapt to a new environment filled with many unknowns and having to make sense of the new "normal" during a global pandemic.

Introduction

To understand how Georgia home visiting programs are continuing the coordination of community resources during a time of economic crisis, this results section presents a combination of quantitative data from 120 HV staff surveys and 317 HV client surveys and qualitative data from 8 HV staff interviews and 5 HV client interviews. This Results chapter is organized into four sections: I) participants demographic characteristics, II) client resource needs during the pandemic, III) community resource referrals, and IV) client access/receipt of community resources. Furthermore, our findings reveal several key themes (**Figure 2**). The project uncovered increased resource needs among home visiting clients since the start of the COVID-19 pandemic in multiple areas such as housing, employment, food, transportation, and other emerging needs such as childcare and mental health care. We identified major facilitators to the referral-making process for community resources and to the clients' receipt of these resources. These include the increased collaborations with local agencies and warm referrals by

home visitors. However, we also identified several barriers as well such as the lack of understanding of available community resources and the disjointed and confusing transition of services to a virtual platform.

Figure 2. Overview of emerging themes from triangulation of survey and interview data from home visiting staff and clients.



I) Participant Characteristics

Home Visiting Staff Characteristics and Caseload

Survey responses were received from representatives of all home visiting programs. This included PAT (54%), HFG (42%) and NFP (4%) (**Table 2**).

Table 2. Home visiting programs and staff in Georgia by model

Home visiting program model	Total # of HV programs N=21	# of HV Staff N=120 n (%)
Healthy Families Georgia (HFG)	7	50 (41.7%)
Nurse-Family Partnership (NFP)	1	5 (4.2%)
Parents as Teachers (PAT)	13	65 (54.2%)

Survey participants included mainly home visitors (73.3%, n = 88) and have held their position for less than 2 years (42.5%, n = 51). There is a wide range of educational backgrounds across HV staff where half have obtained a college degree (50.0%, n = 60) and almost a quarter have a graduate degree (22.5%, n = 27). About half of HV staff identified as Black/African American (50.8%, n = 61) followed by White/Caucasian (39.2%, n = 47). A majority of HV staff identified as not Hispanic or Latinx (70.0%, n = 84) (**Table 3**).

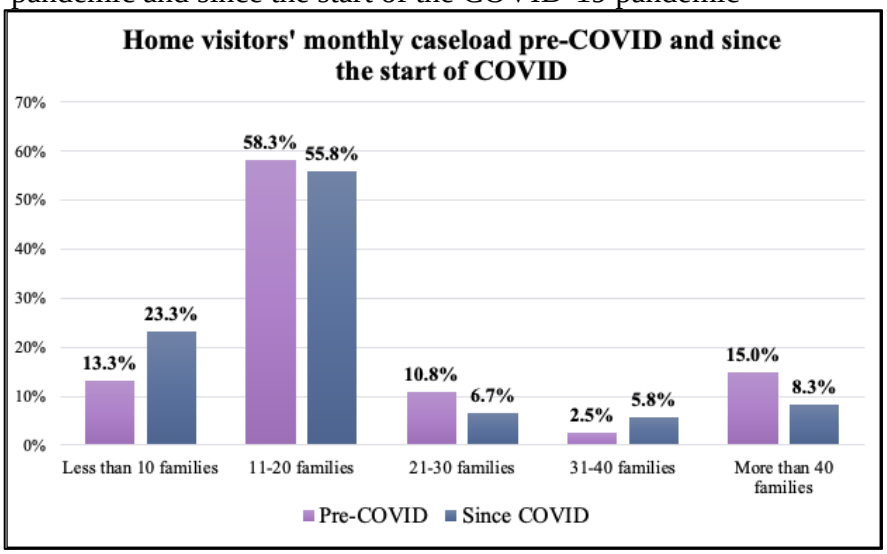
Table 3. Home visiting staff demographic characteristics

Characteristics	**N = 120 n (%)**
Staff Position	
Home Visitor	88 (73.3%)
Supervisor	21 (17.5%)
Other	11 (9.2%)
Length in Position	
0 – 2 years	51 (42.5%)
3 – 5 years	39 (32.5%)
6 – 10 years	18 (15%)
More than 10 years	12 (10.0%)
Education level	
High school diploma	6 (5.0%)
Some college	17 (14.2%)
College degree	60 (50.0%)
Some graduate school	8 (6.7%)
Graduate degree	27 (22.5%)
Other	2 (1.7%)
Ethnicity*	
Hispanic or Latinx	20 (16.7%)
Not Hispanic or Latinx	84 (70.0%)
Other	9 (7.5%)
Race*	
Black or African American	61 (50.8%)
White or Caucasian	47 (39.2%)
Asian	3 (2.5%)
2 or more races	2 (1.7%)
Other	2 (1.7%)

*7 respondents preferred not to answer the Ethnicity question along with 5 respondents for the Race question.

Most home visiting staff carried a monthly caseload between 11 to 20 families prior to the COVID-19 pandemic (58.3%, n = 70), and most still carry a caseload of 11 to 20 families since the start of the COVID-19 pandemic (55.8%, n = 67) (**Figure 3**). However, a number of HV staff currently carry a monthly caseload of over 40 families (8.3%, n = 10) where a majority of staff belong to an HFG program (80.0%, n = 8).

Figure 3. Home visiting staff caseload comparison pre-COVID pandemic and since the start of the COVID-19 pandemic



Most informants have held their position for at least 3 years (n = 5) with the longest one as 10 years. Two of the three supervisors have also previously been home visitors prior to being promoted as a supervisor.

Home Visiting Client Characteristics

A total of 317 home visiting clients completed the survey, representing 22.6% of the total HV client population (N = 1400). A majority of clients (55%) are enrolled in a Parents as Teachers program, 36% with Healthy Families Georgia and about 9% with Nurse-Family Partnership. Over half of home visiting clients identified as Black or African American (53.9%, n = 171) and not Hispanic or Latinx (62.5%, n = 198). The majority were insured by Medicaid

(57.7%, n = 183) while a portion of clients were uninsured (17.4%, n = 55). About a third of clients have delivered since the start of the COVID-19 pandemic (33.1%, n = 105) (**Table 4**).

Table 4. Home visiting client demographic characteristics

Demographics	**N = 317 n (%)**
Program model	
Healthy Families Georgia	114 (36.0%)
Nurse-Family Partnership	29 (9.2%)
Parents as Teachers	174 (54.9%)
Ethnicity*	
Hispanic or Latinx	68 (21.5%)
Not Hispanic or Latinx	198 (62.5%)
Other	47 (14.8%)
Race*	
Black or African American	171 (53.9%)
White or Caucasian	82 (25.9%)
Asian	22 (6.9%)
American Indian or Alaskan Native	1 (0.3%)
Two or more races	11 (3.5%)
Other	19 (6.0%)
Insurance	
Medicaid	183 (57.7%)
Tricare/Military	7 (2.2%)
Private/Commercial/Employer	49 (15.5%)
Uninsured	55 (17.4%)
Self-Pay	5 (1.6%)
I don’t know	5 (1.6%)
Other	12 (3.8%)
Perinatal Status	
Pregnant	35 (11.0%)
Delivered since COVID-19	105 (33.1%)
Not applicable	177 (55.8%)

*4 clients preferred not to answer the Ethnicity question and 11 for the Race question.

Most clients interviewed for this study are first-time mothers (n = 4), and all are married. In terms of employment status, three are currently employed while others are either in school or staying at home with their child.

II) Resource Needs During the Pandemic

There are multiple key themes describing home visiting clients' community resource needs since the start of the pandemic. These themes related to specific community resources, include housing, employment, food, utility bill/financial assistance, and additional needs such as mental health care and childcare.

IIa) Housing insecurity

Home visiting clients experience increased housing instability due to COVID-19's economic impact.

Approximately one-third report housing instability due to the pandemic. Survey responses reveal that clients had either "no confidence" or "slight confidence" in their ability to pay the next rent or mortgage payment on time since the start of the pandemic (n = 100) (**Table 5**).

Table 5. Clients' housing needs since the start of the pandemic.

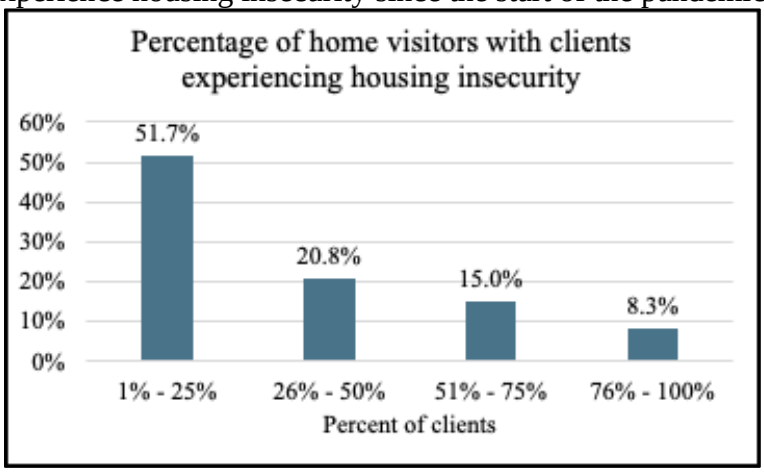
	N = 317 n (%)
Since the start of the COVID-19 pandemic, how confident are you that your household will be able to pay your next rent or mortgage payment on time?	
No confidence	34 (10.7%)
Slight confidence	66 (20.8%)
Moderate confidence	90 (28.4%)
High confidence	100 (31.6%)
Payment is/will be deferred	4 (1.3%)

Client interviews confirm the finding that housing instability was a major adverse outcome of the pandemic. One client shares that because her husband contracted COVID-19, her family struggled to pay rent during a time where they are already struggling. When asked about the impact of the pandemic on her family, she shares:

> My husband ended up catching it [COVID-19] at one point too and during that time we were struggling because we didn't know how we were going to pay rent or anything like that because he didn't find out until after he was supposed to go back to work after having it that he didn't get paid for the time he had off. (HFG Client1)

Almost half of home visiting staff indicate that at least a quarter of their clients experience housing insecurity since the start of the COVID-19 pandemic (44.1 %, n = 53) (**Figure 4**).

Figure 4. Percentage of home visitors with clients who currently experience housing insecurity since the start of the pandemic



Half of home visiting staff (n = 4) specifically express the increased need for housing support among their clients especially due to changes in employment including a complete loss of employment or reduced hours. As one home visitor explains:

> It [housing] seems to have gotten a lot worse. Even though like my clients have gone back to work. Several of them took a pay cut. Now, it wasn't a whole lot of a pay cut, but it was still a pay cut. And if they were already struggling before COVID, they're really struggling now. (NFP Home Visitor1)

IIb) Financial Assistance and Employment

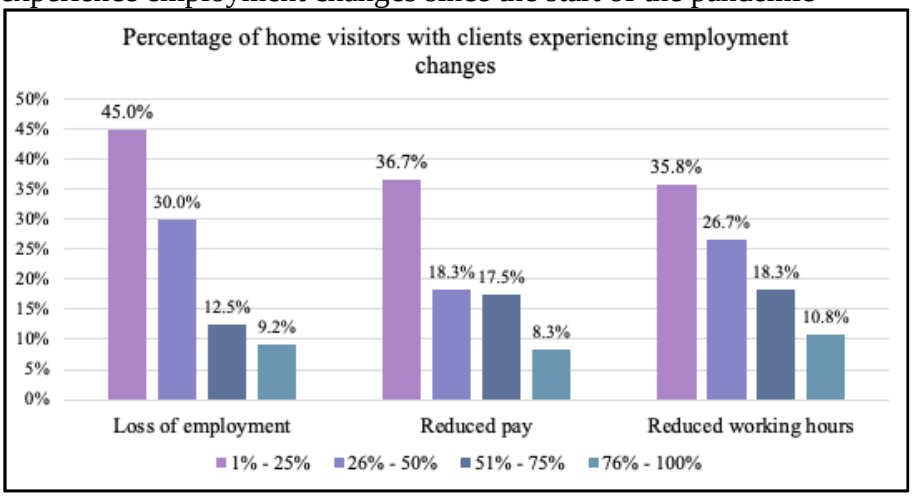
Most home visiting clients need financial assistance due to changes in employment during the pandemic.

About one third of home visiting clients report needing financial assistance due to a loss of employment or being unemployed during the pandemic. Some clients were laid off or lost a job (12.3%, n = 39) during the pandemic, while others reported being unemployed and currently looking for a job (15.8%, n = 50). Others have decided to leave their job to take care of family at home (22.4%, n = 71). With regards to married clients or those living with a partner, about 6% (n

= 18) indicated that their spouse/partner was laid off or lost their job due to COVID-19 while some received flexible work hours (8.2%, n = 26).

Most home visiting staff observed changes in employment among clients since the start of the COVID-19 pandemic. Over 40% of HV staff indicated that at least a quarter of their clients experienced a loss of employment (n = 62) and reduced pay (n = 53) while about 55% (n = 67) of staff indicated that at least a quarter of their clients experience reduced working hours (**Figure 5**).

Figure 5. Percentage of home visitors with clients who currently experience employment changes since the start of the pandemic



Changes in employment due to the pandemic have been a major stressor for clients and their families.

Over half of home visiting clients reported the pandemic's "impact on work" as source of major stress (55.8%, n = 177). A majority of clients echoed similar sentiments of unemployment as a major stressor brought on by the pandemic where one shared:

> My husband ended up losing his job because of layoffs and things like that ... That was scary because we were so close to the end of it [pregnancy] and it's like, oh my God, now we have this little life coming. It's like how are we going to do this ... so we were lucky there. (NFP Client2)

This slight hiccup in employment was enough to cause stress on this client's family as she was pregnant at the time and feared financial instability.

Clients employed various strategies to mitigate the consequences of changes in employment during the pandemic.

To address lost wages, some clients accessed unemployment benefits (15.1%, n = 48) or worked additional jobs during the pandemic (12.9%, n = 41). Most clients are able to bounce back from financial adversity during the pandemic through their persistence in finding employment during a time where jobs may be limited due to business closures. The client above later shared that her family was able to recuperate from longer term financial instability with her husband's ability to obtain another job: "But he finally was able to get a job about a month ago, so he's getting back to working, which is great" (NFP Client2).

However, one client mentioned that despite her husband regaining employment, there is still fear of losing it again. Thus, she has had to remain vigilant with expenses where she "only spent money on diapers and wipes". When praised for her resourcefulness by the interviewer, she responded, "I was trying because I didn't know how much longer I'd have my job and if my husband would still have his due to COVID" (NFP Client1).

Home visiting clients experience heightened financial awareness during the pandemic.

Most clients indicated "financial concerns" as a major source of stress since the start of the COVID-19 pandemic (60.6%, n = 192). The uncertainty of how long the pandemic will last and continue to make employment unstable worry many clients and their families. One home visiting client shared her unique situation in which it is difficult during this time as a military family to decide whether they should get out as she fears that the job market might be tough right now due to the pandemic. She noted this concern in the following:

> I mean financially we're getting out of the military so we're trying to figure out if that's something that we should do during the pandemic because if there are jobs available for us right now … now that as we get closer to our contract date, the more that we are leaning towards getting out … but it would mainly be for my husband looking for a job. Me staying at home with the kids right now. It would affect his job search, maybe look for a remote job I'm not sure. (PAT Client1)

Changes in employment have downstream effects on HV clients' ability to pay utility bills.

Two home visiting staff shared that changes in employment resulted in the increase in various resource needs especially financial assistance for utility bills. One home visitor directly shared how changes in employment affect families' financial stability:

> From my particular case load, I've noticed a lot more of my clients needed financial assistance. They needed assistance with some type of utilities or rental assistance. And that's typically, we have clients who normally need that even before COVID, but I've seen it a lot more frequently those questions being asked during COVID because of course, a lot of people they're not working. (HFG Home Visitor3)

Additionally, half of home visitors described the increased need for utility bill assistance such as electricity and water bills. When asked about the most needed resources among clients, one home visitor not only shared the needs she has observed but also noted how these needs are not new. She shares the resource needs as:

> ... lights and, I mean, jobs. I have had so many referrals for those. Like I said, lights and water, utilities. They needed help to pay that. It's been the same resources, but a lot of them are using them more now. (HFG Home Visitor1)

This home visitor describes the multitude of resource needs among her clients and the clear increased usage of resources than prior to the pandemic.

IIc) Food insecurity

Home visiting clients and their families experience food insecurity since the start of the pandemic.

A majority of home visiting clients indicated that they did not have enough money to pay for food for their household. One third (n = 103) answered they "sometimes" did not have

enough money to pay for food, while about one-fifth (n = 63) answered they “fairly often” or “very often” lacked food for the entire household (**Table 6**).

Table 6. Clients’ food needs since the start of the pandemic.

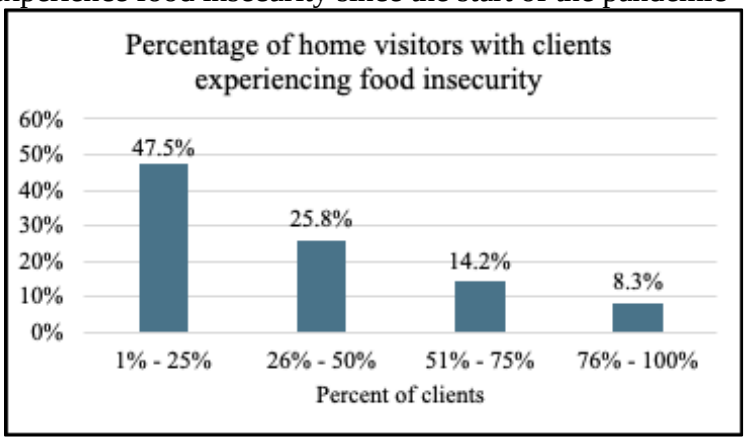
	N = 317 n (%)
How often is this statement true? "*Since the start of the COVID-19 pandemic, I do not have enough money to pay for the food my household needs."*	
Never	82 (25.9%)
Almost never	52 (16.4%)
Sometimes	103 (32.5%)
Fairly often	25 (7.9%)
Very often	38 (12.0%)

Four interviewed clients in the sample currently have WIC, but one client in particular lost access to WIC before her home visitor was able to step in and provide guidance. However, the client describes this need for food access as a point in time where her family had to figure out how to make ends meet:

> There was one point I had lost my WIC vouchers. And we had used what little bit of money we did have to get food for her. But we didn't have enough money to get food for ourselves. Because like, when something like that happens, I'm more worried about her than anything else. And if it came down to it, I'd rather go without something to eat before that little one has to go without something to eat. (HFG Client1)

One fifth of HV staff reported that at least half of their clients currently experience food insecurity (**Figure 6**).

Figure 6. Percentage of home visitors with clients who currently experience food insecurity since the start of the pandemic



Moreover, a majority of HV staff (n = 5) described the increased need of their clients for food access through food pantries, food stamps, or WIC. However, when the pandemic initially hit, services had to shut down right away before opening back up under new guidelines. One home visitor recollected the time when the pandemic was declared a public health emergency stating, "I know when the pandemic hit, a lot of families needed help with the food pantries but a lot of them were closed. They didn't know how to handle this. We were not prepared" (HFG Home Visitor2). This sentiment was shared by another home visitor where another resource need affects food access.

IId) Transportation

Barriers to public transportation due to the pandemic affect clients' access to food pantries.

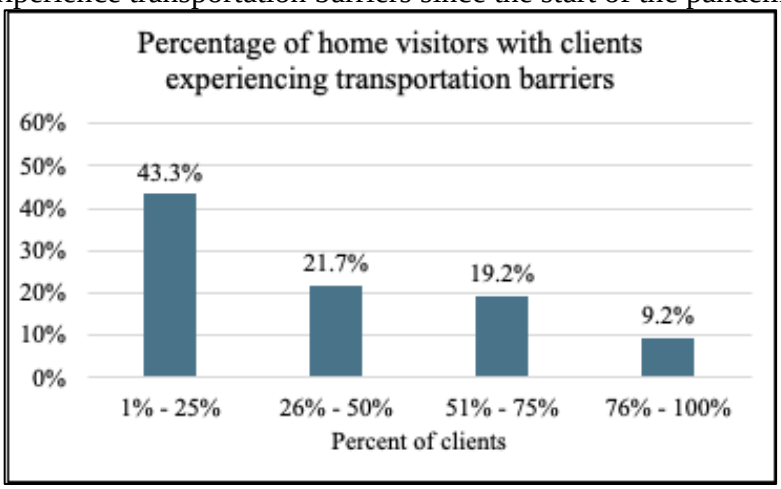
One fifth of clients indicated concerns on the increased difficulty to obtain reliable transportation for daily activities since the start of the COVID-19 pandemic (n = 66) (**Table 7**).

Table 7. Clients' transportation needs since the start of the pandemic.

	N = 317 n (%)
In the past month, has the lack of reliable transportation been harder to obtain for any needed appointments/work/activities?	
Yes	66 (20.8%)
No	244 (77.0%)

Most home visiting staff also reported at least a quarter of their clients experience transportation barriers (**Figure 7**).

Figure 7. Percentage of home visitors with clients who currently experience transportation barriers since the start of the pandemic



Without reliable transportation, accessing food pantries became more difficult for the home visiting clients during the pandemic as one home visitor said:

> If there's food available, but if you don't have a way to get there, then it doesn't help. So I think that was a really big problem with a couple of people. They just didn't have transportation there or they were scared to get on the public transportation, so they can get what they needed. (PAT Home Visitor3)

Another home visitor expanded on this complex issue that with limited hours for food banks, transportation may be even more difficult to access for home visiting clients:

> It makes it a little bit harder to get to the food banks because they might only be open or in serving during very specific times, where you can go and get some stuff and so they have a hard time finding a ride at that point to get over there. (NFP Home Visitor1)

The decreased availability of public transportation during the pandemic brought this issue to the forefront as it affects families' access to other resources. Another home visitor poignantly stated that this need is also not new for the community:

> Transportation has always been an issue before the pandemic … But like I said, our area has always had a problem with transportation, always transportation… We do have one little Medicaid transit. What's all we have. I don't even think we have a cab service at this time for them to get around. That, I wish there was something that we could do as far as transportation. (HFG Home Visitor1)

These transportation concerns shared by HV staff regarding their own clients demonstrate how it adds an extra layer of difficulty when accessing other community resources.

IIe) Other needs: Mental Health Care and Childcare

The COVID-19 pandemic increased home visiting clients' stress levels and the lack of mental health care services has left this need unchecked.

Over half of clients indicated that in general, the COVID-19 pandemic has worsened their stress levels or mental health (52.0%, n = 165) (**Table 8**).

Table 8. Changes to clients' stress levels or mental health due to the COVID-19 pandemic.

	N = 317 n (%)
How has the COVID-19 pandemic changed your stress levels or mental health?	
Worsened it significantly	53 (16.7%)
Worsened it moderately	112 (35.3%)
No change	127 (40.1%)
Improved it moderately	15 (4.7%)
Improved it significantly	10 (3.2%)

When further asked what a source of major stress since the start of the pandemic has been, one third of clients indicated that it was "access to medical care, including mental health care" (33.8%, n = 107). All five clients interviewed for this study also shared how the pandemic affected their mental health and stress levels due to feelings of isolation from being at home, experiencing a death in the family, or taking care of kids in the home while trying to work or attend school. One client expressed this feeling of hopelessness due to the pandemic and being at home:

> I would say it affects me in the fact that yes, we are home all the time. I think it's just the never ending, there is no end in sight. I should say that ... So it just affects me just being home all the time doing the same thing over and over again. (PAT Client1)

Another client described the multitude of things she is currently trying to balance and how it has been stressful:

> I'm trying to juggle school, a newborn, having nobody there. And then I had a boss who really wanted me to come back as soon as possible. She called me at two weeks and asked me if I was good. The whole thing was stressful because I just had one factor on top of one factor and then not having anybody there to be like, I'll take the baby go study or I'll take the baby just go nap or go take a shower. And my husband worked six days a week. He works nine to six every day. He was trying to provide for us and so I couldn't ask him to be there. (NFP Client1)

Three clients also recently delivered during the pandemic and have expressed how the pandemic has made them feel a lot more isolated than expected as well as experiences with postpartum depression. Two of them are also first time mothers, and they shared how the pandemic affected their social support during pregnancy and after delivery where less family and friends were able to physically be around. One client shared this challenge during pregnancy:

> But it was kind of sad for us because this is our first child and we wanted that experience together and it was hard at the fact that I had to go by myself. And not to mention at that 35 week appointment, I did get the bad news that I was having issues. And it's hard enough getting bad news and then, when you're pregnant, you're so emotional and hormonal that getting bad news while you're pregnant is even more difficult. So, to not have that support person there with you is even more difficult. And then the fact that he wasn't there, if he had any questions for them he could've asked them how to help or what to do. So, that was harder. (NFP Client2)

Stay at home orders have kept people at home prompting a concern for intimate partner violence (IPV). Since the start of the pandemic, 8.5% (n = 27) indicated that they have experienced physical, sexual or emotional aggression from their partner (**Table 9**).

Table 9. Clients' experience with intimate partner violence during the COVID-19 pandemic.

	N = 317 n (%)
Since the start of the COVID-19 pandemic, have you experienced any physical, sexual or emotional aggression by a spouse or partner?	
Yes	27 (8.5%)
No	246 (77.6%)
Not applicable	33 (10.4%)

* Clients were provided the option "Prefer not to answer" due to the sensitive nature of these questions. These responses are not reported above. There is no missing data.

IPV concerns are an example of the need for mental health care services during the pandemic.

Two home visitors also shared clients' need for mental health services during the pandemic. One home visitor specifically pointed out the lack of linguistically accessible MH services:

> I mean, the only resource that I really can think of that we do need is for the Spanish speaking families, for the help, mental health service. We really don't have any mental health services that provide services in Spanish. (HFG Home Visitor2)

The nature of the pandemic has created this need for mental health care services due to the many stressors shared by clients and their home visitors.

Another key stressor for clients due to the pandemic is the need for childcare.

Many home visiting clients reported being the primary caregiver for children and others as well as sometimes the only adult to manage household responsibilities. One third of clients are the primary caregiver for anyone in the family other than their children (33.4%, n = 106). Over half of clients also indicated that there is not another adult in the household who assists with caregiving responsibilities (51.4%, n = 163) and about 40% (n = 125) of clients have school-aged children at home who are currently attending school virtually due to the pandemic. The burden of having to care for others in the home, being the only adult carrying out caregiving responsibilities, or having children in virtual learning can be difficult for parents. Over half of clients subsequently indicated that their role caring for their children and others has conflicted with their work responsibilities since the start of the pandemic (51.5%, N = 163). One client specifically shared how the lack of childcare has been tough especially as she seeks healthcare:

> I did have a C-section, so I had to go for my two week postpartum and everything was great there. And then I had to go back again for my six week postpartum and they said everything was great there, but there was those restrictions of no visitors. You can't bring your husband. You can't have your child with you, which again is a little bit challenging because if he [inaudible], I would have to find somebody to watch the baby. And just poses its own challenges. (NFP Client2)

This client expressed how the lack of access to childcare is a challenge for her to attend doctor visits as clinics have imposed restrictions on the number of people allowed in a certain space due

to the pandemic. Another client further shared how the lack of childcare heightens her awareness to stay healthy and not get sick:

> I feel more stressed with, like I said, with the house, with the work, being with the kids … Like I told him [husband], if I get sick, who's going to take care of the kids? We don't have anyone here to take care of the kids. Where are they going to go? (HFG Client2)

While some facilities may have reopened since the initial lockdown across the U.S., two home visiting staff mentioned their clients' hesitation with sending their children back to daycare due to the potential risk of COVID-19 exposure despite the need for this support while working. One supervisor explicitly explained that limited finances during COVID affected her clients' access to childcare: "And of course, childcare, they don't feel comfortable sending their children to childcare or, it's just not in the budget for it" (HFG Home Visitor3). However, despite all these needs that have been brought on or exacerbated by the pandemic among clients, the home visitor further elaborated that while these needs existed prior to the pandemic, clients are now "really hitting the pavement and really following up with their referrals because they actually are in need of them" demonstrating the dire need for community resources (HFG Home Visitor3).

III) Community Resource Referrals

To understand the facilitators and barriers surrounding community resource referrals, home visiting staff shared their experiences making these referrals to various service areas since the start of the pandemic. Home visiting staff reported two major facilitators to making referrals to community resources including support of their supervisors and increased collaborations with local agencies during the pandemic. HV staff also identified major barriers to making referrals including the lack of understanding on community resources' availability and gaps in community resources.

Home visiting clients are generally satisfied with the referrals received to community resources.

Home visiting clients have expressed an overwhelming general satisfaction to the referrals to community resources during the pandemic (87.7%, n = 278). Most HV staff have had clients test positive for COVID-19 (66.7%, n = 80), and they have subsequently provided support services to clients in the form of referrals for medical assistance (15.8%, n = 42) or referrals for assistance with social services (9.8%, n = 26).

Facilitators

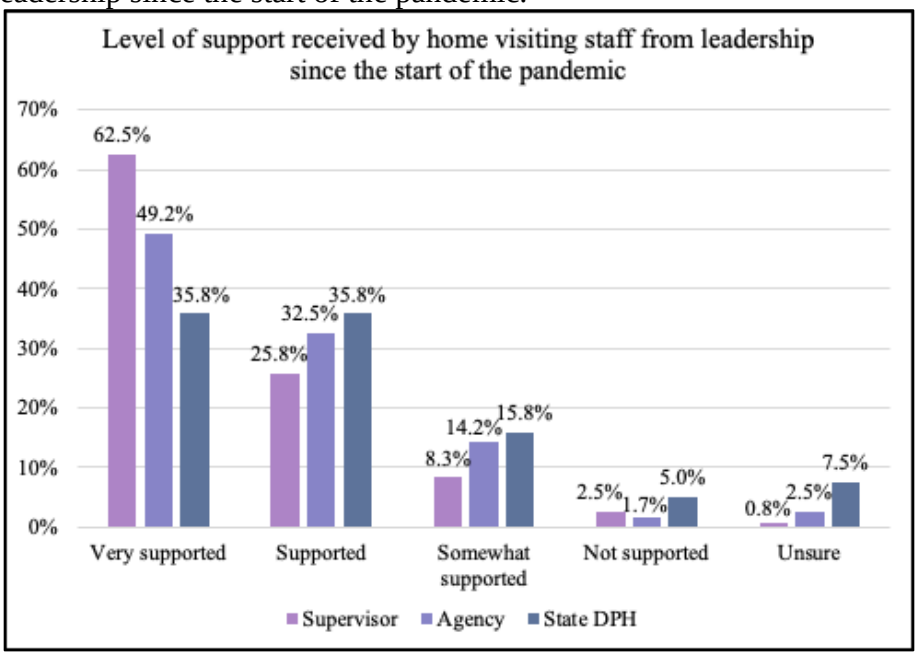
Adaptations to a virtual environment since the start of the pandemic allowed for the continuation of home visiting services including referral-making to community resources.

In response to the pandemic, HV staff transitioned into a virtual environment and were required to use a video conferencing platform to communicate with clients instead of in-person home visits. Staff are also currently working from home as buildings remain closed due to the pandemic. Most home visiting staff are "describing over the phone" (95.8%, n = 115) and "emailing/texting" (89.2%, n = 107) to share resources with home visiting clients. Some also indicated "sharing my screen via Cisco WebEx during a visit" (75.0%, n = 90) and "dropping off handouts before a visit" (70.0%, n = 84).

Home visitors are well-supported by their supervisors to continue being able to serve clients with community resource referrals.

A majority of home visiting staff felt "very supported" by their supervisor (62.5%, n = 75) and their local agency (49.2%, n = 59). HV staff felt equally "very supported" and "supported" by the Georgia Department of Public Health (**Figure 8**).

Figure 8. Perceived level of support received by home visiting staff from leadership since the start of the pandemic.



Two home visitors shared how support from their supervisors is crucial in connecting their clients to the appropriate community resources. One of the home visitors shared that her supervisor is knowledgeable about the available community resources and seeks her support with clients needing referrals:

> [She] is also really good about if there's a program going on, maybe a food drive or something like that, she's very good at letting all of us know, sending it out to everybody. Or if we need something for our client or if I'm, for example, I feel like my client needs a resource but I don't know where to send them. She's very quick at being right there on the spot going okay, well, we can tell them about this place, this place, and that place. I'm like oh, okay, I didn't even know about those places. So she's really good at resources. (NFP Home Visitor1)

Other home visiting programs have support from a designated staff within the program who gathers updated information on available resources in the community and disseminates that information with the HV staff team. One of the four HV staff from a program with this support elaborated how their staff person conducts their information gathering: “She attends virtually the community resource network meetings … So all the agencies come together and stuff to say,

'Hey, this is what we're offering,' kind of deal or whatever. And then she passes that information on to us" (PAT Supervisor4).

Home visiting staff have increased collaborations with local agencies to address the needs of clients.

Increased collaborations between HV programs and community agencies were noted in a majority of HV staff interviews (n = 7) to respond to the needs of the community through hosting new events together or sharing any information on resources. Some HV staff shared that the increased events allowed for an influx of resources in the community, which in turn benefit their clients as there are more services to make referrals to. As one home visitor said:

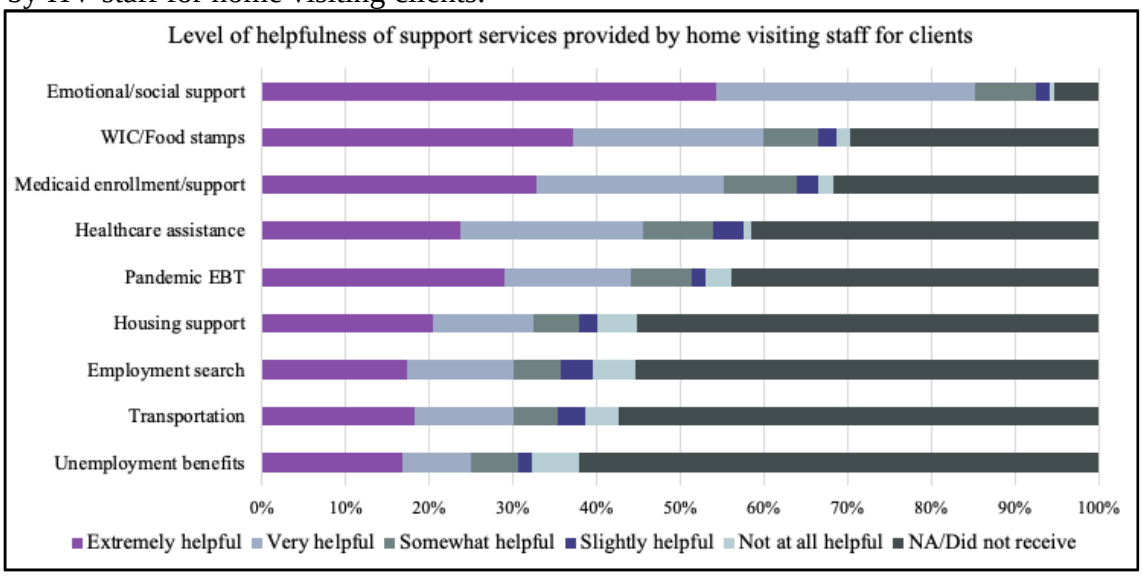
> Resources have actually really amped up. We have been able to give more resources due to COVID than before and a lot of community partners and places that we got resources from have adapted very quickly as well. And grant money opens up. We didn't spend a lot of it last year. We currently have $8,000 worth of diapers to give to our families that we would never had. (PAT Home Visitor1)

Collaborations between HV programs and community agencies to support clients and communities during an unprecedented pandemic have been crucial to making appropriate referrals based on the availability of community resources.

Referrals for food pantries are manageable as community agencies have stepped up to directly meet this need.

Food: About two-thirds of clients (n = 190) found support services for WIC and food stamps to be "very helpful" or "extremely helpful" (**Figure 9**). With referrals to food, home visiting staff (n = 4) shared how community organizations have stepped up to fill this need allowing them to refer clients.

Figure 9. Level of helpfulness of support services and community resources provided by HV staff for home visiting clients.



As one home visitor shared:

> I think we have a lot of groups, especially informal resources of people gathering in some way or form to help and they're trying to meet a need. I mean, we had a local restaurant come and donate pizzas to our people just as their way to help because COVID is stressful. We've had a lot of things like that, that we might've had before, but it would not have been at the frequency that we're having it now. (PAT Home Visitor1)

Community groups and service providers are recognizing the need and are directly filling it. On top of this, some are being more flexible to clients in terms of hours as one home visitor shared:

> There have been a lot more places that are now doing like giving food and things like that. And I think a couple of the food banks around here have extended their hours to try to be more accommodating to make it a little bit easier for people to come in. (NFP Home Visitor1)

Barriers

There is a lack of understanding of available community resources since the start of the pandemic making it difficult to make referrals.

A majority of home visiting staff expressed that it has been "somewhat difficult" (58.3%, n = 70) to provide home visiting services since the start of the pandemic while a quarter stated that it has been "difficult" (22.5%, n = 27). In general, it has been difficult to make referrals for

community resources due to the lack of awareness of what resources are currently available in the community. With services having to adapt to the remote environment, home visitors are left figuring out what exactly is available for their clients to access. One home visitor spoke of this difficulty:

> I think it's the accessibility that just made it harder because we are not too sure if some people are just a hundred percent virtual, if some people are in the office, when are they in office? That was the challenge is, you tell them to call or you try to call and nobody's answering. You send email and no one responds, so it's kind of hard. (HFG Home Visitor 3)

The inability to reach and communicate with community resource providers during the pandemic has also affected the work of home visitors in making referrals for their clients.

Food: Clear information on changes to services was often not communicated appropriately as demonstrated by the difficulties shared by home visiting staff where they had to "call around" to get a sense of what resources are available and how to access them. Home visitors are not the only one having to "call around" in the community as a client recounted calling the WIC office repeatedly until pressure from her home visitor to the agency prompted the referral and subsequent connection:

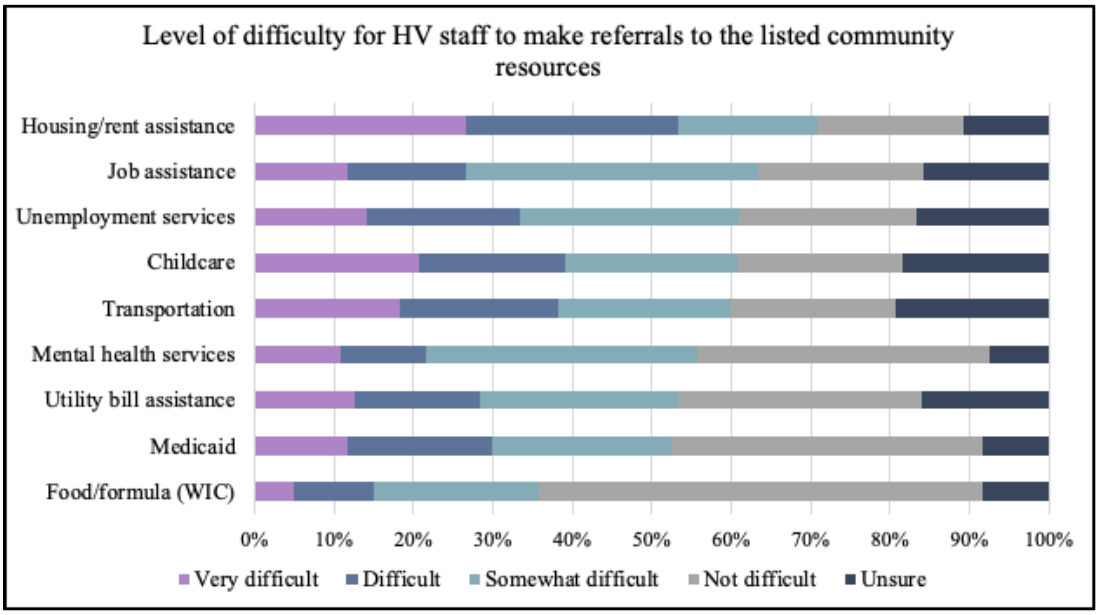
> I was having a hard time for about a week, or no it was like two weeks, after I had my son where I was trying to get a hold of the WIC office, so that way I could get them updated. And they weren't answering or returning any of my phone calls. So, she [home visitor] reached out to them as well and was like, "Hey, please call her. She needs assistance. She's been trying to reach out to you guys and she hasn't heard anything." And within I would say probably 20 minutes of her reaching out to them, they called me. (NFP Client2)

The frustration and difficulty shared by this client demonstrate just how challenging it can be to access community resources during the pandemic. Fortunately, her home visitor was able to step in and provide a warm referral to facilitate the resource connection. This client also believed that her home visitor's involvement with the referral ensured the connection by sharing, "I feel like if

it wasn't for her getting involved in that aspect, I probably wouldn't have heard from them for another month" (NFP Client2).

When HV staff are asked about the level of difficulty making referrals to food/WIC and transportation, roughly a third of HV staff reported some degree of difficulty making referrals for food stamps and WIC and over half reported difficulty with transportation support referrals (**Figure 10**).

Figure 10. Level of difficulty for HV staff to make referrals to the listed community resources.



One home visitor gave her honest thought when asked about how it has been like connecting clients to resources during a pandemic:

> From what I can tell, I think I'm not even sure what is even open at this point, I just hear about some things, it's just depending on what my families need at the time … So, just knowing about them, I can let my families know, Hey, they're virtual or if I hear about anything, but as far as referrals, I think other places have adapted too with their referral process as to doing things online. And I think maybe some of the problems come in where it's just communicating, what do people actually do because it's everybody, nobody really knows, I guess, unless you start calling around and asking to see (PAT Home Visitor3)

Another home visitor expressed the need for improved collaboration with local community agencies to address clients' and the community's needs voicing her concern in the following:

> I mean, the only thing that I can think of is, I wish there was a little bit more collaboration with all of our local agencies. Before we used to have meetings, our supervisors would have meetings with all the local agencies to see what's going on in our community. What is lacking, what is something that we need. And now with COVID, I think they just really dropped the ball on that and I haven't heard them having community agency network. (HFG Home Visitor2)

Major gaps in community resources combined with the increased need for community resources make referral-making difficult.

Most home visitors (n = 5) expressed the limited access to resources, or the sheer absence of the resources needed contributing to the difficulty in referral-making since the start of the pandemic. One home visitor observed that one community resource that she makes referrals to "... has cut a lot of the programs within it. They're still standing, they're still going, but they're cutting some programming" (PAT Home Visitor1).

Housing: Home visiting staff indicated major difficulty making referrals for housing support as it has always been limited even prior to the pandemic or that there is a sheer lack of it. About 40% (n = 127) of HV clients indicated some degree of helpfulness for housing support services provided by their home visitor since the start of the pandemic. HV clients have also indicated not receiving housing support or that it was not applicable to their situation since the start of the pandemic (55.2%, n = 175) (**Figure 9**). One client shared that while she did not need housing support at the moment, she felt comfortable and "sure that she [home visitor] would connect us with something or someone" if and when she and her family need it (PAT Client1).

When HV staff are asked specifically about which referrals to community resources have been difficult, over two thirds of home visiting staff expressed some level of difficulty referring

clients to housing and rent assistance (70.9%, n = 85) (**Figure 10**). One of the noted reasons why referrals for housing support resources have been difficult during the pandemic is because they were already an issue prior to the pandemic. Thus, now when the need is more than pre-pandemic times, one home visitor shared, “It’s always been hard with housing for sure and financial resources because the reality of it is, is they’ll get it and it goes so fast, it’s no longer there, It’s no longer available” (HFG Home Visitor3). The housing need has been overwhelming during the pandemic that home visitors are left with no options for referrals as one home visitor described, “There’s not a really a good program around here to help with rent assistance or even housing in general. That would be really, really the only other thing I can think of that's lacking” (NFP Home Visitor1).

Another HV staff shared the sheer lack of shelter services to make referrals to for clients who may be experiencing homelessness such that, “if a girl is homeless or needs somewhere to stay, we don't have anything in our area, like a shelter that they can go to, to stay, or something like that” (HFG Home Visitor1). However, support from housing agencies in some communities have been helpful for home visitors to make referrals as expressed by a home visitor, “They have been really helpful with the girls that needed places to stay. They try to make our families their top priority, trying to get them into something” (HFG Home Visitor1).

Home visiting staff found it difficult to make referrals financial assistance due to the complexity of the process.

Employment and Financial Assistance for Utility Bills: A majority of HV clients indicated not receiving support with employment search or that it was not applicable to their situation (55.5%, n = 176) while 62.2% (n = 197) of clients indicated not receiving support services for unemployment benefits (**Figure 9**). Over half of HV staff reported some degree of difficulty

making referrals to job assistance (63.4%, n = 76), unemployment services (60.9%, n = 73), and utility bill assistance (53.3%, n = 64) (**Figure 10**). To begin addressing the increased need for financial assistance, one home visitor shared that “a lot of 211’s going out, a lot of EOA referrals going out, just anything” (HFG Home Visitor3). In this case, the home visitor is making referrals to the 2-1-1 information resource managed by United Way and to the Economic Opportunity Authority (EOA), which is a nonprofit with emergency assistance resources as both these nonprofits provide information available resources for financial assistance. Sometimes the barrier to making referrals such as for employment has been due to a recurring issue that clients do not follow up on them as one home visitor shared:

> Most of my families, I give them a resource and they never follow up and that's pre COVID. After COVID, "Oh, I'm really struggling to find a job." "Well, here's six different places you can go." And I called and made you an appointment and they just never go. We have that barrier that's going to be here regardless of COVID or not. (HFG Home Visitor1)

However, referrals for financial assistance can be very complex with all the steps required just to request the assistance. One home visitor recounted this experience:

> I've got to come with my need and say, "Hey, I have a family that needs energy assistance," so [NonProfitOrganization1] I think right now they're able to help, but we have to provide XYZ about the family and see if they will help or we can go to [NonProfitOrganization2] and say, "Hey," I think there's, family advancement ministries. They have an emergency fund where we can go and ask and say, "Hey, my family, they're going through this hardship. Mom is working, but she just lost her job. She's got to start", you have to prove if they can able to sustain, it's a process that we go through. (PAT Home Visitor3)

In this case, even home visitors have to spend a substantial amount of time making a financial assistance request such as vouching for the client’s character.

Transportation referrals are almost impossible to make due to limited options.

Transportation: One third of home visiting clients found transportation support received from home visitors as either “very helpful” or “extremely helpful” (30.0%, n = 95) (**Figure 9**). Home

visiting staff expressed difficulty making referrals to transportation support due to the limited options they have to send clients to. For example, one home visitor shared that while there is an option, sometimes it is not enough:

> "We do have one little Medicaid transit, That's all we have. I don't even think we have a cab service at this time for them to get around. That, I wish there was something that we could do as far as transportation." (HFG Home Visitor1)

There is a lack of competent MH services to make referrals to according to home visiting staff.

Mental health (MH) care: Over half of HV clients indicated some degree of helpfulness for health care assistance (57.5%, n = 182) provided by their home visitor since the start of the pandemic (**Figure 9**). Most home visiting staff reported some degree of difficulty making referrals to mental health services (55.8%, n = 67) where 20% (n = 26) of HV staff reported that it was "difficult" or "very difficult" (**Figure 10**). The gap between the clients' needs and the available resources in the community has been another point of discussion among HV staff regarding why referral-making during the pandemic has been difficult. One home visitor shared that when asked for resources on mental health services, she plainly just does not have anything to share with her clients:

> Unfortunately, we do not have a lot of options. Unfortunately, we don't and there's a couple of places I've thought to my clients. I wouldn't even go to them, so I don't really want to tell you about them. I don't want you to go. (NFP Home Visitor1)

In this segment, the home visitor also reflects on the quality of service as a deterrent to making a referral indicating that not making a referral at all might be better than making a referral to a poor-quality resource. While some services are still available even if they are not necessarily competent, other communities have experienced a complete loss of resources due to the

pandemic. For example, one home visitor shared that their community "... used to have a free clinic that would provide free services, and they stopped" (HFG Home Visitor2).

Referrals for childcare are tough as clients often do not have the budget or have been denied for assistance.

Childcare: About 40% (n = 47) of HV staff reported referrals to childcare as "very difficult" or "difficult" (**Figure 10**). When making referrals to childcare, one home visitor shared that she uses Childcare and Parents Services (CAPS). However, some of her clients either "couldn't afford it" or were "denied for CAPS" (HFG Home Visitor1). She further added that fortunately, "most of them [clients] does have someone that has been looking after their children, or somebody stable to keep them (HFG Home Visitor1).

IV) Access/Receipt of Community Resources

As community services had to adapt to the new remote environment, so did the clients who needed to access them. Home visiting staff and clients shared the facilitators and barriers to the receipt of community resources since the start of the pandemic. Key facilitators involved warm referrals by home visitors to clients and trusting relationships between them in ensuring resource connection. Major barriers to accessing the community resources included the confusing and disjointed transition of community resources to a virtual platform and the complex and time-intensive process to access these already limited resources.

While a majority of clients are generally satisfied with their home visitors' referrals to community resources (87.7%, n = 278), 11.4% (n = 36) did not receive this support service. However, some clients have found some support services provided by home visitors more helpful than others. From the resource connection and access standpoint, clients faced hurdles in

interacting with the community resource delivery system but have received guidance and warm referrals from their home visitors to facilitate the connection.

Accessing housing support resources are helpful to clients, and they trust their home visitors to connect them to resources if and when needed.

Housing: While a majority of clients did not receive housing support from their home visitor or that it was not applicable to their situation, 20.5% (n = 65) of HV clients found the housing support they received to be "extremely helpful" (**Figure 9**). While none of the HV clients specifically discussed the current need for housing support resources in the interviews, one of the clients shared that as her family decides whether or not they are leaving the military, she would "reach out to her [home visitor] and say I need help" and ask "Is there any programs wherever we're moving to, is there any housing programs? … I'm sure she would connect us with something or someone" (PAT Client1). This client has not currently sought out housing support assistance but trusts that her home visitor will connect her to these resources if and when the time comes.

Home visiting clients are having to jump through hoops and spend excessive amounts of time to access unemployment benefits and financial assistance.

Employment and Financial/Utility Bill Assistance: About 40% (n = 125) of HV clients indicated some degree of helpfulness for employment search support provided by their home visitor since the start of the pandemic while 32.2% (n = 102) of clients indicated a similar degree of helpfulness for accessing unemployment benefits during the pandemic (**Figure 9**). However, a small portion of surveyed clients also indicated that the unemployment benefits (5.7%, n = 15) and employment search support (5.1%, n = 16) were "not at all helpful". There are over 61% (n = 73) of HV staff that shared some degree of difficulty in making referrals to unemployment

services with 14.2% (n = 17) indicating that it has been “very difficult”. Additionally, 53.3% (n = 64) of home visiting staff indicated some degree of difficulty when making referrals to utility bill assistance with 12.5% (n = 15) of staff indicating that this is “very difficult” (**Figure 10**). One home visitor described how her clients were able to access unemployment support during the pandemic:

> Luckily, Georgia never did get on the lockdown like I've heard this happened in New York and California and places like that. I did have several clients that did lose their job at the very beginning of the pandemic, but they did qualify, although it took a while for them to qualify for the COVID Relief Fund. I think it's what it was called. And then about the time that was stopping they were able to find a new job. So around the [Georgia County] it wasn't as bad as it might have been maybe in Atlanta as far as like the lockdowns and things like that. (NFP Home Visitor1)

In this case, her clients were able to receive the emergency financial assistance and obtain another form of employment prior to the end of the assistance. While access to unemployment assistance was observed by this home visitor, another home visitor expressed the common barrier her clients experience:

> It's always been hard with housing for sure and financial resources, because the reality of it is, is they'll get it and it goes so fast, it's no longer there. It's no longer available. So now that the moms that I've had, they get discouraged when they follow up on these referrals sometimes because you're on hold for a long time or you have to do certain things and they get discouraged and it never happens. So now they're still in financial need. (HFG Home Visitor3)

The overwhelming need for financial assistance during COVID-19 has made it increasingly difficult to access and subsequently deterred clients to follow up on these resources as clients have to spend a lot of time attempting to access the resources just to learn that it is no longer available. The complexity of accessing financial resources as described by this home visitor is a key barrier during the pandemic when home visiting clients are balancing various changes to their everyday lives.

Applications for food stamps and WIC have been confusing to clients as these resources have since transitioned to a virtual platform due to the pandemic but with guidance from home visitors, they are able to eventually access and obtain them.

Food: A majority of HV clients indicated some degree of helpfulness for WIC and food stamp support services (68.7%, n = 218) while only about 38.6% (n = 122) of clients indicated this similar degree for transportation support (**Figure 9**). About 30% (n = 94) of clients did not receive WIC and food stamp support services compared to 57.4% (n = 182) of clients with regards to transportation resources. A very small number of HV clients indicated that the WIC and food stamp support provided by their home visitor was "not helpful at all" (1.6%, n = 5) (**Figure 9**). Two of the five interviewed clients had firsthand experiences in accessing community resources during the pandemic, and one shared how confusing and challenging it was to access food stamps. She recounted how challenging the food stamp application process was:

> And we did try applying for food stamps, but the whole process is complicated … It was different because most of the time before COVID hit they would rather you apply in person, but a lot of places even if you're looking for a job, most places prefer you go online now. And I called the DFCS office at first they said that they would prefer us fill out the application online. So, it was a whole bit confusing mess. (HFG Client1)

Despite these challenges, the client was persistent and was able to eventually apply. However, she ran into more challenges:

> Oh, I'm confused on how their system works. Because when the lady called and talked to me, she said that all I needed to bring to her was a proof of income and I think my ID or something like that. And on my application online, I said I was approved for it. Well, I never had got a card for it. So, I called the system, and they said that my application had been denied but online it said it had been approved. So, it was a mess. (HFG Client1)

This client further shared that she did not want to discuss this food stamp issue with her home visitor because:

> … the more I talked about it, it frustrated me, it irritated me just a little bit. So, I never really talked about it with her. And that was my doing because I didn't want to get

> frustrated with it, because the more I thought about it the more frustrated I got with it. (HFG Client1)

This client's discouraging experience with applying for food stamps deterred her from further attempting to access this resource with the assistance of her home visitor as she simply no longer wanted to continue to be burdened with this frustration. None of the interviewed clients shared issues or experiences accessing transportation resources especially as three clients are staying in the home to take care of their young children and one client is attending school remotely. Only one client is currently employed in person, and she did not share any barriers to accessing transportation.

Home visiting clients expressed a number of barriers to accessing mental health care such as no insurance coverage, lack of time and the uncertainty on the mode of service delivery.

Mental health (MH) care: In terms of health care assistance including mental health services, 41.6% (n = 132) of clients did not receive this support from their home visitors or that it was not applicable to their situation. When asked whether her home visitor has connected her to any health or mental health resources, one home visiting client replied, "No, but if I asked her she would definitely put me in contact with someone or give me a way to reach out" (PAT Client1). She and another client expressed hesitancy to accessing mental health resources as they felt that they have no time due to a "strict schedule" (NFP Client1), but one client did share her hesitancy was because she, "didn't know if it would be virtual or in person because of everything that is going on" (PAT Client1). Four home visiting clients discussed feelings of isolation such that one client voiced it as feeling "secluded and cut off" (NFP Client2).

Furthermore, one client shared her current experience with postpartum depression and anxiety. She described the barrier to accessing mental health services as due to her "insurance not being able to afford it" and that "it's a little bit expensive for me to try to see somebody"

(HFG Client1). Fortunately, this client did seek her home visitor's guidance, and "she [home visitor] helped me figure out some ways that I could try to channel some of that out without having to go through somebody else" (HFG Client1). Despite not being able to access professional MH services, some clients (n = 2) expressed that they are able to receive support from their partners where one client shared that: "When I do feel stressed and overwhelmed, I ask him to help me. I just, I need help" (HFG Client2).

Accessing childcare is challenging due to cost and concerns with contracting COVID-19.

Childcare: In accessing childcare during the pandemic, clients are hesitant due to the potential risk of contracting COVID-19. One client pointed this out and shared that "because of COVID, I don't want to send the kids to daycare for me to go back to work. We'd have to wait until at least we're vaccinated. We'll be a little bit better off" (HFG Client2). Even if it would be helpful in terms of attending work, this hesitancy to send children back into childcare is also a concern shared by two home visitors regarding their own clients. One home visitor shared that her clients "don't feel comfortable sending their children to childcare" due to the pandemic or that it's "not in the budget". Another home visitor pointed out that while one of her clients "couldn't afford it", she had other clients "denied" for childcare services (HFG Home Visitor1).

Generally, across the five clients, they all expressed satisfaction in terms of assistance received from their home visitor. One client in particular stated that while she does not need resources now, she can rely on her home visitor: "I haven't thought of anything right now but if for some reason I need to reach out to her, I will" (PAT Client1). This was also corroborated in another client interview where the home visiting client simply expressed that she is "pretty happy with everything" that her home visitor has been able to support her with (NFP Client2). Lastly, most clients expressed their satisfaction with their home visitor as an indicator for their trust and

faith in them as a source of support. One client described this relationship with her home visitor: “If I need help with something, I text her and she'll help me the best way she knows she can” (HFG Client1).

V) Recommended Actions to Improve Resource Coordination

Home visiting staff and clients shared recommendations to improve the knowledge and accessibility of available resources both during the pandemic and beyond. HV staff also shared strategies to strengthen relationships between HV programs and community resource providers to better serve clients.

HV staff (n = 4) expressed difficulty in making referrals to resources when they are not aware of the availability of resources as a home visitor. One suggested strategy is to have a recurring gathering involving all community resource providers and those who work directly with clients in order to facilitate information sharing. The home visitor who shared this strategy described it as a “community agency network” (HFG Client2). The other half described already having a designated person who either attends group meetings such as this proposed strategy or personally seeks current information on community resources as part of their job and subsequently disseminates it to the HV staff. Whereas HV staff wish to have a better understanding of the available community resources, most clients have expressed their satisfaction with the support services received from their home visitor.

However, two clients described the excessive back and forth communication with community agencies as an accessibility issue where one client described the food stamp application process as a “confusing mess” (HFG Client1). As some resources transitioned to a virtual platform, this client shared the confusion on the preferred application process as “before COVID hit they would rather you apply in person”, but now “the DFCS office at first they said

that they would prefer us fill out the application online" (HFG Client1). This confusion is an example of an issue a "community agency network" can alleviate and prevent to ensure that the process to access resources is more straightforward. One home visitor also echoed this need to understand "what their [community agencies] intake process is or how they're getting stuff out, is it a Facebook page or think like that, it's just finding out how to get to these resources" (PAT Home Visitor3). Overall, improved strategic communication is needed as this home visitor described, "I think maybe some of the problems come in where it's just communicating, what do people actually do because it's everybody, nobody really knows, I guess, unless you start calling around and asking to see" (PAT Home Visitor3). One recommendation to improve the accessibility of resources for clients is to offer them in different languages as one home visitor mentioned that "a lot of my clients they speak different dialects. That's hard to meet. So that would be the only amazing thing would be having it [resources] offered in different dialects" (HFG Home Visitor2). Awareness of the available resources and their accessibility to clients are key components in facilitating the connection to these resources.

One common recommendation from interviewed clients was to improve opportunities to interact with other families and socialize their children. One client expressed that it would help, "if there were more family events to go to so the kids can have play dates, meet people" (HFG Client2). One client even mentioned being willing to attend events at the "program center" to facilitate this interaction with other families (PAT Client1). Some local organizations have stepped up to fill this need, and according to one home visiting supervisor, the Medicaid Care Management Organizations (CMOs) in her community have "been doing a great job of hosting events for our families to come to" (PAT Supervisor6). On the other hand, one home visitor would like more guidance from the Department of Public Health on "how to help support them

[clients] during this pandemic. And them [leadership] giving us different resources that they know of that we can send to our families about health and safety, especially with the pandemic. That would be helpful" (HFG Home Visitor2). Other HV staff also shared wanting to strengthen relationships with other community resource providers to be able to support their clients. A home visiting supervisor provided this example: "Amerigroup, they host a round table, and they invite all the different agencies to come together and that's how we get the resources and know who's still operated and how they're operating" (HFG Supervisor1). These recommendations to improve resource coordination in the community would facilitate smoother referrals and strengthen the community network of providers to deliver quality resource connections for clients.

V. Discussion, Implications & Recommendations

Introduction

Home visiting programs offer crucial support services for many families especially those with specific community resource and social service needs. Thus, they are often seen as a lifeline for families since the start of the COVID-19 pandemic (Williams et al., 2021). As most families enrolled in home visiting programs are low-income and reside in underserved communities, the COVID-19 pandemic brings additional stressors to those who already are experiencing social and economic challenges. It is important to understand how home visiting programs continue to address families' resource needs during this unprecedented tough environment.

The findings from this mixed methods study reveal that home visiting clients experience increased resource needs since the start of the pandemic across various identified areas, including housing, food, transportation, childcare, and mental health care services. These heightened resource needs subsequently demonstrate the difficulties for home visitors to make referrals when limited resources have been further reduced or completely discontinued. Despite these challenges, home visitors are still able to successfully coordinate resources for clients and address their social needs during a challenging time where they themselves may also be personally affected by the pandemic. Home visiting programs are in a unique position to serve as a bridge to the social service system by working directly with many expectant mothers and vulnerable families with young children who require community resource support. This examination of the Georgia Home Visiting Program highlights home visitors as essential community health workers equipping families with the tools to mitigate and persevere through the COVID-19 pandemic. This final chapter presents the interpretation of the study's key

findings, their implications and the proposed practice recommendations to improve the linkages to community resource support for overburdened clients.

Home visiting clients and their families are faced with the detrimental social and economic consequences of the pandemic.

The first key result centers around the new and increased community resource needs such as housing, employment, food, and mental health care services that home visiting clients and their families are experiencing due to the pandemic. The Georgia Home Visiting Program (GHVP) aims to support women and children facing these social and economic challenges (GDPH, 2020b). Thus, according to home visitors, a lot of these resource needs existed prior to the pandemic and were later worsened as the pandemic progressed. A recent analysis of calls to the 2-1-1 helplines across the U.S since the start of the pandemic revealed the skyrocketing of requests for housing and food but as the pandemic continued, increases in employment and mental health assistance emerged (Kreuter et al., 2020). This demonstrates the magnitude of the social and economic crisis that immediately emerged across the country since the pandemic began. Home visiting clients are often from underserved communities affected by social and economic inequities, and as a result are more susceptible to the pandemic's social and economic impact (Williams et al., 2021). COVID-19 infections and deaths have already been reported to disproportionately affect low-income and minority populations since the start of the pandemic where a study on a select number of states revealed that over 34% of the deaths were accounted for by non-Hispanic Black individuals when they only account for 12% of the U.S. population (CDC, 2020b; Holmes et al., 2020).

A recent cross-sectional study by Sharma et al. (2020) on low-income families with children enrolled in a school-based nutrition program found increased community and social

service needs due to disruption in employment among participants since the start of the pandemic. It succinctly described the economic impact of the pandemic and how it "further destabilized people who were already struggling" (Sharma et al., 2020). As the GHVP supports many families from low-income households or with socioeconomic stressors such as housing and employment instability, HV clients are often vulnerable families already experiencing economic instability. Thus, they bear the brunt of pandemic due to the compounding nature of the resource needs making the pandemic an added degree of vulnerability for their families.

Findings also revealed mental health care as an additional unique resource need generated by the pandemic. The emerging need for mental health care services has been predicted by researchers due to psychological distress from either contracting the virus or from any of the mitigation measures such as quarantine (Choi et al., 2020; Gordon & Borja, 2020). Home visiting clients expressed this fear of potentially contracting the virus and how it may affect their families' employment and financial stability. Thus, it has become a major stressor for many and is a clear contributor to the emerging need of mental health care services. The Sharma et al. (2020) study additionally revealed that the program's families had concerns with working in frontline jobs or in workplaces that do not provide sufficient personal protective equipment due to the risk of contracting COVID-19. However, many families also indicated the disruption of employment status as a key concern during the pandemic. This presents a dilemma facing families due to the pandemic on deciding whether to either accept the risk of potentially contracting the virus at their workplace or losing employment. The consequences of the pandemic on home visiting clients and their families are multifaceted and affect various aspects of their lives such as their employment and their physical and mental health. Understanding the complexity of these resource needs is crucial as home visiting clients and their families continue

to deal with the challenging environment created by this once-in-a-lifetime public health emergency.

Resource coordination and access during a global pandemic has been increasingly challenging to navigate.

The second key result of this study uncovers the unique pandemic-driven challenges to referral-making by home visitors and the clients' subsequent receipt of these community resources. As home visiting services transitioned to a virtual platform due to stay-at-home orders to contain the spread of the virus, home visiting staff often described confusion and lack of understanding on which community resources are still available during the pandemic as a major challenge to referral-making. They also pointed out further confusion regarding the modality that these services are being offered through. These difficulties are similar to those described by Mary's Center Home Visiting Department since the start of the pandemic where ongoing stay-at-home guidance challenged the communication with community resource providers regarding resource availability (Williams et al., 2021). They additionally shared issues with constant changes in logistics and eligibility criteria among community resources, which has made it challenging for home visitors to address the needs of clients. Home visiting staff expressed having to "call around" to simply get a sense of available resources and information on how to access them. This inability to communicate appropriately with community resource providers due to the pandemic impedes their work in making much-needed referrals for their clients.

With the abrupt descent of the pandemic in the U.S., home visiting clients needed resources immediately, but not all community resources were readily available. Home visiting staff shared a reduction or discontinuation of some community resources such as free clinics and limited hours at food pantries in their communities. Resources that home visitors referred to have

been disrupted due to the pandemic making it increasingly challenging to make referrals for clients. Other communities have also experienced this disruption as shared by community health workers and case coordinators at the New York City (NYC) Health + Hospitals health system. They noted the complex and time-intensive nature of accessing resources from existing resource providers in the community due to "suspended services, shifted hours of operation, or were transitioning from in-person to telephonic services" (Clapp et al., 2020). The project's findings demonstrate a more complex and harder to navigate community resource and social service environment for home visitors who serve as a crucial access point for home visiting clients to obtain the resources they need.

While making referrals is an essential step to getting clients the resources they need, there are often barriers when it comes to the direct receipt of those resources. Similar to barriers experienced by home visitors, clients described issues regarding the inability to communicate with the resource providers as well as the complexity of the process during the pandemic. Applications to services such as food stamps and WIC have been confusing for clients to complete as they have transitioned to a virtual platform whereas prior to the pandemic, they are able to walk in-person to complete them. Referrals can only be beneficial if clients are actually able to access the resource and obtain it. Therefore, this project reveals that simply providing referrals to resources are not usually enough to ensure that clients receive the assistance they need. Despite the changes to the landscape of resource coordination, home visiting programs continued to operate and connect clients to needed services.

Home visitors are essential community health workers who continued to meet the immediate needs of clients via referrals to community resource and social service organizations.

The final key result show that home visitors are successful in serving clients and addressing their needs during the COVID-19 pandemic. Despite the transition to a virtual environment, home visitors shared continued communication with clients especially regarding accessing the resources they and their families currently need. The process of making referrals to community organizations by home visiting programs can be complex as home visitors need to understand the relationships between their programs and community organizations (Rosinsky et al., 2019). Therefore, established relationships with resource providers allow home visitors to gain the knowledge and awareness on available services and the ability to subsequently refer clients to the appropriate resources. Home visiting staff described increased collaborations with local agencies since the start of the pandemic to improve coordination of resources for clients. These collaborations facilitated resource information sharing between agencies and the home visiting programs, which subsequently contributed to home visitors' timely response to clients' needs.

A report to Congress in 2016 on the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program demonstrated an improvement in the coordination and referrals for community resources and support across all performance measures (HRSA & ACF, 2016). This improvement was attributed to the increased community collaborations and partnerships captured by these two of the performance measures: "increased number of primary contacts in community agencies or amount of information sharing with community agencies" and "increased number of memoranda of understanding with community agencies". The increased referrals and rate of

referrals among MIECHV programs coupled with improvements in these two measures demonstrate the key role of relationships between home visiting programs and community organizations to facilitate success resource coordination for clients.

Findings also revealed the instrumental role home visitors play in ensuring the receipt of community resources by home visiting clients. Clients described the support from home visitors as a key facilitator in accessing the resources they needed. Home visitors were able to guide clients in navigating the challenges they faced when attempting to contact agencies or in completing the application process for services. Clients frequently have trusting relationships with their home visitor where they can rely on them for any needed support that may come up. Clients also shared that the likelihood of accessing resources increased when their home visitors were involved and most have attributed the success in receiving resources to home visitors' support. A qualitative study found similar remarks from home visiting clients regarding the value of home visitors in facilitating the process to obtain needed services (Allen, 2007). This further demonstrates the importance of home visitors' knowledge and skills in supporting clients navigate the community resource and social service delivery systems especially during times of crises.

Home visitors ultimately act as community health workers in their role in resource coordination for clients. Community health workers (CHWs) support families in their communities by providing health and wellness education as well as bridging them to "health care and social service systems" (National Center for Chronic Disease Prevention Health Promotion, 2016). By acting as liaisons between families and the social service system and other community resources, home visitors strengthen communities by ensuring that their needs are addressed the best way possible with the available resources. Since the start of the pandemic, home visitors

have become a vital resource to mitigate the disruption and consequences of the pandemic on the lives of home visiting clients and their families. Their ability to provide individualized support with linkages to community resources is critical more than ever during the pandemic as clients weather the pandemic's social and economic impact. The overarching umbrella of CHWs involves this work with the main goal of improving health outcomes and providing underserved communities with the tools to overcome social stressors. While CHWs' roles and responsibilities may vary, home visitors along with other CHWs are well-suited to address the health inequities that often plague low-resourced communities. Thus, as the pandemic's end continues to be unknown, home visitors remain a beacon for home visiting clients.

Strengths and Limitations

This project has a number of limitations. First, home visiting programs included in the study are those managed by the Georgia Department of Public Health, so other home visiting programs that do not have formal oversight from GDPH are not included. Therefore, findings from this project are not generalizable to other local implementing agencies outside of the Georgia Home Visiting Program. Second, while the results from the staff survey encompass findings from all employed HV staff across the 21 program sites, the results from the client survey are not representative of all enrolled HV clients in Georgia. Clients were not randomly selected to participate as a sampling frame was not feasibly developed due to lack of human resource capacity. Therefore, HV staff were instructed to share the client survey to as many of their clients as possible to obtain responses from 25% of the client population. This presents an issue of selection bias in terms of which clients received the invitation to complete the survey. Weighting was also not employed in survey participant recruitment to take into account the potential differences between HV programs with regards to program size and curriculum. Third,

due to time constraints with data analysis, this project was solely able to include a select number of HV staff and client interviews. Thus, identified themes in this project may not address other trends or nuances that are shared in other interviews not included in this project. Issues of social desirability bias may also have impacted clients' responses to topics on resource needs and satisfaction with home visiting services during the pandemic. Finally, this project does not include the perspectives of community organizations with regards to their experiences during the pandemic. Therefore, future studies should attempt to reveal their experiences as resource providers during a time where these resources are needed more than ever.

Despite these limitations, this project displayed several strengths. The first strength is that this study used a mixed methods research design. By collecting both quantitative and qualitative data, survey responses were able to be further elaborated on during interviews. This generated robust findings as in-depth interviews provided the context for the survey responses and provided an opportunity to explore survey responses in more detail. By collecting both types of data across home visiting staff and clients, the project was able to display a more complete picture of the landscape of home visiting programs since the start of the pandemic. Including both perspectives from the referral and receipt standpoints allowed a clear representation of where the facilitators and barriers are along the resource coordination process. Another strength of this project can be attributed to the collaborative nature of this project between Emory researchers and the Georgia DPH. Dr. Katrina Brantley of GDPH was instrumental in facilitating the communication to home visiting staff regarding the project as well as during study recruitment. Her leadership within the home visiting program provided substantial engagement from staff and subsequently from clients to participate in the project's data collection activities.

This project largely shines the light on the crucial role home visiting programs play in supporting Georgia families through the ongoing challenges presented by the pandemic. As one of the key services provided by home visitors, the coordination of resources is essential during the pandemic with the increased stressors families face. The findings in this project begin to illustrate how home visiting programs manage to continually address the unique needs of their clients especially during a time of crisis where some resources have become more limited than before. Describing the experiences of home visitors in making referrals for clients during a public health and economic crisis also reveals the program and community adaptations to responding to the immediate needs among under-resourced communities. This project also uniquely presents the voices of clients regarding their experiences accessing resources including difficulties obtaining them and how they may have had to adjust to the challenges when they are not able to get the assistance they need.

Recommendations

This study features the heightened needs of clients as well as the facilitators and barriers of resource coordination during the COVID-19 pandemic. From both survey and interview data, home visiting staff reported the adversities impacting the lives of clients due to the pandemic. Clients also confirmed these exacerbated needs through both surveys and interviews. It was evident that home visiting staff are experiencing difficulties meeting the needs of clients and clients are experiencing difficulty accessing the referred resources as the pandemic has thrown the community resource delivery system into a state of limbo.

There has been plenty of confusion among home visiting staff and clients regarding whether resources in the community have been able to transition their services to virtual or if they are continuing services during the pandemic. Improvement in information sharing regarding the available community resources between home visiting programs and community organizations would benefit home visitors in addressing their clients' needs both during the pandemic and beyond. One home visitor offered a way to address this through the development of a "community agency network" where home visiting programs and community resource providers share information on new and ongoing resources. A formal collaboration through a recurring gathering would also further develop and strengthen relationships among programs that serve expectant mothers and families with young children. Increased communication between agencies that potentially interface with the same families can improve timeliness of referrals and receipt of resources for clients as well as reduce any inefficiencies with the referral-making process. However, involvement and guidance from leadership of both home visiting programs and the local organizations are needed to ensure that these partnerships are sustainable and continue long-term. As described with the MIECHV program evaluation, improving these

collaborations can be achieved through memoranda or formal agreements between the programs and local agencies as well as establishment of a clear point of contact among other agencies to ensure an entry point for communication (HRSA & ACF, 2016).

Another recommendation expressed by home visiting staff and clients is the need to improve the accessibility of resources. One home visitor working particularly with Spanish-speaking families conveyed the lack of community resources that are offered in various languages including Spanish. Improving the inclusivity of resources especially for mental health care services would increase the receipt of resources among clients. Access to on-site translators or a language line can begin to address this access barrier. Obtaining resources during a time where most services transitioned virtually can be overwhelming as new processes were perceived to be disjointed and unclear by both home visitors and clients. Thus, improved partnerships and collaborations can mitigate this issue by establishing a clear flow of information where home visitors are aware of these processes and can then share with their clients. This would prevent discouraging clients from following up on referrals as well as reduce the obstacles clients face while getting the assistance they need.

The various referrals to resources needed by clients uncovers the importance of adopting a formal system between home visiting programs and the local agencies to track these referrals and the receipt of the resources. This would streamline the process of making referrals as well as provide timely feedback to home visitors whether clients are indeed able to obtain the resource that they made a referral for. It would also further allow for the identification of gaps and challenges in navigating the community resource and social service delivery systems. This added structural support may reduce unmet needs of clients as well as improve the clients' satisfaction with the resource connection. There is also little information on what the process of resource

coordination is like from referrals to the receipt of the resources within home visiting programs. Therefore, a system in place to capture these activities related to resource coordination will assist in not only shedding light on the complexity of this process but also inform both home visiting programs and community agencies on how to jointly serve clients efficiently.

Some home visitors expressed minor frustrations with making referrals for their clients, but their clients not following through with them. From the client interviews, some voiced that while they appreciate their home visitor for sharing resources with them, sometimes they do not necessarily need it at the time. Therefore, it would be a more efficient use of time and effort for home visitors to not only have a good understanding of their clients' immediate needs but also tailor the referrals such that clients there are no outstanding barriers that need to be addressed for clients to access the resource. For example, a client needing access to food pantries may follow up on a referral to them if they are able to conveniently access the location. Therefore, it is key for home visitors to have a holistic picture of what potential barriers may arise for clients in following up on their referrals. This would prevent home visitors from making extra referrals that may not be acted on by clients. Conducting routine follow-ups soon after making the referral would also further facilitate the receipt of resources as most clients are overburdened already and may simply forget to follow up.

Some home visitors also recognize that while they may be aware of their clients' needs, there are sometimes no viable resources to connect them with that specifically addresses those needs. This is an opportunity for cross-collaborations among maternal and child health programs housed within the Georgia Department of Public Health and the social service sector. Some communities are more fortunate than others in having local organizations that address needs observed among home visiting clients. However, for those communities such as in rural areas

with limited resource agencies, investing in partnerships and long-term integration between siloed sectors to develop new approaches has the potential to address clients' needs holistically especially in under-resourced communities. Established partnerships between the Georgia Home Visiting Program and social service agencies would further promote seamless resource coordination and increased capacity to address the needs of home visiting clients especially during the COVID-19 pandemic coupled with an economic crisis.

Conclusion

Home visitors are vital in mitigating the far-reaching consequences of the COVID-19 pandemic on home visiting clients who are already facing social and economic challenges. The Georgia Home Visiting Program has proven its ability to respond to the needs of clients despite an unprecedented pandemic demonstrating their flexibility and commitment to serving vulnerable families throughout the state of Georgia. The community and social service needs driven by the pandemic have significantly impacted the lives of home visiting clients and may continue to do so with the aftermath of COVID-19. Future research needs to examine how this public health emergency has also impacted the community organizations directly providing essential resources to communities. Understanding their challenges is critical in strengthening coordination efforts and subsequently addressing emerging community needs. Their perspective would provide the missing piece to the full picture of resource coordination, which would be beneficial in developing successful strategies and solutions to effectively serving communities.

The new stressors and challenges families are facing around the country during the pandemic and beyond demonstrate how much home visiting programs are an asset to communities that have them available. With their proven track record, Georgia needs to expand their home visiting services by leveraging MIECHV funds to reach more at-risk communities and guide families in navigating extreme difficulties during times of crises. Connections to community resources only represent a part of the whole host of services home visitors provide their clients, yet it has been highlighted as a much needed service, if not, the most needed during the pandemic. Recognizing the factors impacting the delivery of community resources by home visiting programs in Georgia to clients and the subsequent accessibility of the resources will contribute to future efforts to plan and prepare a concerted community response in the event of a

public health and economic crisis. Ultimately, it will guide the needed improvements to resource coordination now and beyond the pandemic to meet the essential needs of clients. Low-income and disadvantaged families have been in crisis mode since the start of the pandemic and with improvements to resource coordination and expansion of home visiting services, they may receive the opportunity to realize the full benefits of home visiting.

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APPENDIX A: SURVEYS

Home visiting staff survey

INTRODUCTION Thank you for your interest in participating in the AICHV- Georgia Study – Assessing the Impact of the COVID-Pandemic on Home Visiting in Georgia. This study is a collaboration between the Georgia Department of Public Health (GDPH) and Emory University. The purpose is to learn more about the delivery of home visiting services since the start of the COVID 19 pandemic in Georgia, which officially began on March 14, 2020.

You have been asked to participate in this study because you serve as a home visitor or home visiting program supervisor in Georgia. The information gathered from this project will help DPH know how to improve home visiting services for their clients. This survey will take about 15 minutes and will ask you to answer questions about yourself, your well-being, the kinds of home visiting services you provide, and how these services may have changed since the start of the COVID-19 pandemic. All responses are confidential, and you will not be identified by name. You will be offered a $15 Walmart electronic gift card at the end of this survey. To receive it, you must provide your contact information (including telephone number and email address). If you have any difficulties with this survey, please contact Dr. Sarah Blake at Emory University at scblake@emory.edu. By continuing forward with this survey, you are providing consent to participate in this study. Thank you for your time. Let's begin!

Section A: Staff Information
The first set of questions focuses on your background information.

A1. Name the home visiting program you work for:

A2. For which of the following home visiting programs do you currently work? (Choose one only).
- Parents as Teachers (PAT)
- Healthy Families
- Nurse-Family Partnership (NFP)

A3. Please indicate your position in your home visiting program.
- Supervisor
- Home visiting staff
- Other: _____

A4. How long have you held this position?
- <1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

A5. What is the highest level of education you have received?
- Some high school
- High school diploma
- Some college
- College degree
- Some graduate school
- Graduate degree (Master's)
- Graduate degree (Doctoral)
- Other: _____

A6. Please indicate your clinical background.
- Registered nurse
- Nurse practitioner
- Certified nursing assistant
- Licensed clinical social worker
- Doula
- Lactation consultant/counselor
- Other: _____
- No clinical background

A7. What is your ethnicity?
- Hispanic or Latinx
- Not Hispanic or Latinx
- Other: _____
- Prefer not to answer

A8. What is your race? (Check all that apply).
- American Indian or Alaskan Native
- Asian
- Black/African American
- Native Hawaiian or Pacific Islander
- White/Caucasian
- Other: _____
- Prefer not to answer

Section B: Services Delivered
The following questions refer to the program you currently support.

B1. Before the COVID-19 pandemic, what was the average number of families you served monthly?
- <10 families
- 11-20 families
- 21-30 families

- 31-40 families
- >40 families

B2. **Since the start** of the COVID-19 pandemic, what is the average number of families you currently serve monthly?

- <10 families
- 11-20 families
- 21-30 families
- 31-40 families
- >40 families

B3. What percentage of your current caseload includes pregnant women?

- 1-25%
- 26-50%
- 51-75%
- 76-100%

B4. What percentage of your current caseload continued receiving home visiting services after switching to virtual visits?

- 1-25%
- 26-50%
- 51-75%
- 76-100%

B5. What methods are you using to share available resources with your clients? Please indicate an answer for every option below that apply.

	Yes	No
Mailing before a visit	○	○
Dropping off handouts before a visit	○	○
Emailing/texting activity sheets	○	○
Posting on Facebook or other social media/digital platform	○	○
Describing over phone	○	○
Sharing my screen via Cisco WebEx during a visit	○	○
Using materials the family already has in their home	○	○
Creating a video or reading a book or doing an activity	○	○
Pre-existing online formats such as YouTube	○	○

Other:	○	○

Section C: Service Provision since COVID-19

We now would like to ask you some questions about your experiences with providing services since the start of the pandemic.

C1. What is the overall level of difficulty you have experienced with providing home visiting services since the start of the pandemic?

- Not difficult
- Somewhat difficult
- Difficult
- Very difficult

C2. Have you been tested for COVID-19?

- Yes
- No
- Prefer not to answer

C3. If yes, have you tested positive for COVID-19?

- Yes
- No
- Prefer not to answer

C4. If yes, did that affect your ability to do your job?

- Yes
- No
- Prefer not to answer

C5. If you tested positive for COVID-19 and it affected your ability to do your job, please indicate why? (Check all that apply).

- I was on medical leave and did not work while recovering
- I was too sick and unable to complete home visits for some of my clients
- I was too sick and unable to complete home visits for most of my clients
- Other: _____
- Prefer not to answer

C6. Have any of your clients tested positive for COVID-19?

- Yes
- No
- Don't know
- Prefer not to answer

C7. If yes, which of the following support services did you provide? (Select all that apply).

- Phone visits
- Video visits

- Referrals for medical assistance
- Referrals for assistance with social services
- Emotional support
- Other: _____

C8. Please indicate how difficult it has been to make referrals for your clients to the following community or clinical services since COVID. Make a selection for every option below.

	Not difficult	Somewhat difficult	Difficult	Very difficult	N/A or Unsure
Bill assistance (SNAP)	○	○	○	○	○
Childcare	○	○	○	○	○
Food/formula (WIC)	○	○	○	○	○
Diapers and wipes	○	○	○	○	○
Essential household items including disinfecting products	○	○	○	○	○
Housing/rent assistance	○	○	○	○	○
Transportation	○	○	○	○	○
Mental health services	○	○	○	○	○
Well-child doctor visits	○	○	○	○	○
Unemployment services	○	○	○	○	○
Job assistance	○	○	○	○	○
Legal services	○	○	○	○	○
Medicaid or other public health care program	○	○	○	○	○
Child and family services	○	○	○	○	○
Referrals for early intervention	○	○	○	○	○
Childbirth classes	○	○	○	○	○
Breastfeeding classes	○	○	○	○	○

Doula services	○	○	○	○	○
OBGYN services	○	○	○	○	○
Shelter services	○	○	○	○	○
Other public health services	○	○	○	○	○
Virtual Learning EBT cards	○	○	○	○	○
Other:	○	○	○	○	○

C9. Please indicate how difficult it has been for you to provide the following home visiting services to your clients since the start of the COVID-19 pandemic. Make a selection for every option below.

	Not difficult	Somewhat difficult	Difficult	Very difficult	N/A or Unsure
Well baby checks	○	○	○	○	○
Administering or completing assessments	○	○	○	○	○
Linking to other services	○	○	○	○	○
Facilitating support groups (e.g. Group Connections)	○	○	○	○	○
Lactation support	○	○	○	○	○
Prenatal education	○	○	○	○	○
Prenatal health checks (e.g. weight, blood pressure, glucose)	○	○	○	○	○
Prenatal development checks (e.g. fundal height)	○	○	○	○	○
Parenting education	○	○	○	○	○
Delivering the curriculum with fidelity	○	○	○	○	○
Delivering education information and activities to client homes	○	○	○	○	○
Other:	○	○	○	○	○

C10. Please indicate how difficult it has been to conduct the following home visitor communication strategies below since the COVID-19 pandemic. Make a selection for every option below.

	Not difficult	Somewhat difficult	Difficult	Very difficult	N/A or Unsure
Connecting with newly enrolled clients	○	○	○	○	○
Maintaining contact with already enrolled clients	○	○	○	○	○
Text messaging	○	○	○	○	○
Video visits	○	○	○	○	○
Phone calls	○	○	○	○	○
Mailing education information and activities	○	○	○	○	○
Emailing education information and activities	○	○	○	○	○
Texting links to information and curriculum materials	○	○	○	○	○
Other:	○	○	○	○	○

C11. Should certain aspects of virtual home visiting continue, even after the pandemic is over?

- Yes
- No
- Unsure

C12. What aspects of virtual home visiting services stay in effect, even after the pandemic is over? Please describe below.

Section D: Barriers

We now would like to ask you some questions about any barriers you may have encountered while conducting virtual home visits with your clients since the start of the pandemic.

D1. Which of the following are barriers to receiving home visiting services for your clients? Make a selection for every option below.

	Yes	No
Confidentiality/HIPAA concerns	○	○
Families in crisis and cannot commit to a specific time	○	○
Families with limited phone plans or data plans	○	○
Families not comfortable with doing a virtual visit	○	○
Family has children at home and hard to focus without interruption	○	○
Family uncomfortable doing visit due to limitations of work-at-home set-up	○	○
Limited time available due to other demands at home	○	○
No access to a printer for activities or handouts	○	○
Challenging to find a time with families with essential workers	○	○
Some families are overwhelmed	○	○
Families may not be able to use the same technology as a home visitor	○	○
Other:	○	○

D2. Which of the following are barriers that you encounter while trying to provide home visiting services to your clients? Make a selection for every option below.

	Yes	No
Families not interested	○	○
No response from some families	○	○
Lack of guidance on how to complete a visit virtually	○	○
Lack of home visitor confidence on how to complete visit virtually	○	○
Limited time available due to other demands at home	○	○

D3. Please indicate the percentage of your families who currently experience any of the following barriers since the start of the COVID-19 pandemic. Make a selection for every option below.

	1-25%	26-50%	51-75%	76-100%	Don't know
Sufficient minutes for phone visits	○	○	○	○	○
Access to computer	○	○	○	○	○
Access to tablet	○	○	○	○	○
Access to smartphone	○	○	○	○	○
Access to internet	○	○	○	○	○
Loss of employment	○	○	○	○	○
Reduced working hours	○	○	○	○	○
Reduced pay	○	○	○	○	○
Housing insecurity	○	○	○	○	○
Food insecurity	○	○	○	○	○
Transportation	○	○	○	○	○
Other:	○	○	○	○	○

Section E: Mental Health, Social Support, and Coping Behaviors
Now, we would like to know more about how the COVID-19 pandemic has affected you and your mental wellbeing.

E1. Choose only one statement below that best fits how you feel currently.

- I enjoy my work and I have no symptoms of burnout.
- Occasionally, I am under stress, but I don’t feel burned out.
- I am burning out and have one or more burnout symptoms, such as physical and emotional exhaustion.
- The symptoms of burnout that I’m experiencing won’t go away, and I am frustrated at work a lot.
- I feel completely burned out and I am at the point where I may need to seek some sort of help.

E2. How are you coping with the stress related to the COVID-10 pandemic? Make a selection for every option below.

	Yes	No	N/A or Unsure
Improve sleep (e.g. get to bed earlier, nap)	○	○	○
Practice meditation and/or mindfulness practice	○	○	○
Talk/consult with friends and family	○	○	○
Talk/consult with my coworkers and supervisor(s)	○	○	○
Talk/consult with my health provider	○	○	○
Talk/consult with my health care provider	○	○	○
Talk/consult with my counselor or mental health provider	○	○	○
Engage in more family activities (e.g. games, sports)	○	○	○
Increase phone or TV time	○	○	○
Decrease phone or TV time	○	○	○
Read books or newspapers	○	○	○
Eat comfort foods	○	○	○
Eat healthier foods	○	○	○
Practice self-care (e.g. taking baths, giving self a facial)	○	○	○
Exercise	○	○	○
Attend prayer/worship services	○	○	○
Drink alcohol	○	○	○
Use drugs (prescription or illegal drugs)	○	○	○
Nothing	○	○	○
Prefer not to answer	○	○	○
Other, please list	○	○	○

Section F: Support for Home Visitors

F1. Please indicate how supported you have felt in your work since the beginning of the pandemic from your direct supervisor, your local agency, and the state DPH. Make a selection for every option below.

	Not supported	Somewhat supported	Supported	Very supported	N/A or Unsure
Supervisor	○	○	○	○	○
Agency	○	○	○	○	○
State DPH	○	○	○	○	○

F2. Please indicate whether or not you have received the following types of support for your work. Make a selection for every option below.

	Yes	No
Information about how to provide HV services virtually	○	○
Received guidance on how to provide service to pregnant clients	○	○
COVID webinar	○	○
Individual supervision/debriefs	○	○
Reflective Supervision	○	○
Timely responsiveness to needs	○	○
Information about how I can keep safe from COVID	○	○
Information about how my clients can keep safe from COVID	○	○
Adjusted/flexible schedule	○	○
Received PPE	○	○
Received masks	○	○
Received printer	○	○
Received headset with microphone	○	○
Received Internet hot spot	○	○
Received work laptop or tablet	○	○
Received work cell phone	○	○
Received webcam	○	○
Was offered mental health support	○	○
Received mental health support	○	○
Other	○	○

Section G: Perceived Risks for COVID

G1. How likely do you think it is that the following events will happen in light of the current COVID-19 pandemic? Make a selection for every option below.

	Not at all likely	Not likely	Unsure	Likely	Very likely
You will be infected with COVID.	○	○	○	○	○
Someone in your immediate environment (family, friends, colleagues) will be infected with COVID.	○	○	○	○	○
You will have to go to the hospital if you get infected COVID.	○	○	○	○	○
You will have to go into quarantine if you have been exposed to or have been infected with COVID.	○	○	○	○	○
You will get infected with COVID, and you will infect someone else.	○	○	○	○	○
Someone in your immediate environment (family, friends, colleagues) will die from COVID	○	○	○	○	○

Section H: Readiness to Return to In-Person Services

H1. Please indicate your level of agreement with the following statements. Make a selection for every option below.

	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	N/A or Unsure
I would feel safe conducting an in-person home visit while wearing a mask and PPE.	○	○	○	○	○	
I would prefer to conduct an in-person home visit during the COVID-19 pandemic, despite the risks.	○	○	○	○	○	
I would feel safe conducting in-person home visits once there is a vaccine.	○	○	○	○	○	
I would feel safe conducting in-person home visits if clients had regular COVID-19 tests.	○	○	○	○	○	

I would feel safe conducting weekly COVID-19 testing for myself.	○	○	○	○	○
I prefer to continue virtual home visits until the COVID-19 pandemic is over.	○	○	○	○	○

H2. Do you plan to get the COVID-19 vaccine once it becomes readily available?

- Yes
- No
- Unsure

H3. If you do not plan to get the COVID-19 vaccine, please indicate why not. Check all that apply.

- I do not think the vaccine will be safe.
- I do not think the vaccine will be effective for preventing coronavirus.
- I do not need the vaccine, because I already tested positive for coronavirus.
- I do not think the vaccine will be covered by my insurance.
- I will not be able to afford the vaccine.

END OF SURVEY. Thank you so much for your participation. To receive a $15 Walmart electronic card for your participation, please provide your email address and telephone number. We will first email you the electronic gift card and may text or call you to confirm receipt.
Email Address _____
Telephone Number _____

Home visiting client survey

Thank you for your interest in participating in the **AICHV Georgia Study – Assessing the Impact of the COVID-19 Pandemic on Home Visiting in Georgia.** This study is a collaboration between the Georgia Department of Public Health (GDPH) and Emory University. The purpose is to learn more about the delivery of home visiting services since the start of the COVID 19 pandemic in Georgia, **which officially began on March 14, 2020**.

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If you have any questions about this survey, please contact Dr. Sarah Blake at Emory University at scblake@emory.edu. By continuing forward with this survey, you are providing consent to participate in this study.

Thank you for your time. Let's begin!

SECTION A: DEMOGRAPHICS
In this section, we will ask you a few questions about yourself and your household. As a reminder, please refer to the start of the COVID-19 pandemic in Georgia as March 14, 2020.

A1. How old are you?

A2. What is your ethnicity?
- Hispanic or Latinx
- Not Hispanic or Latinx
- Other _____
- Prefer not to answer

A3. What is your race? Check all that apply.
- American Indian or Alaskan Native
- Asian
- Black/African American
- Native Hawaiian or Pacific Islander
- White/Caucasian
- Other _____
- Prefer not to answer

A4. Which relationship status best describes you?
- Single/never married
- Married/partnered
- Separated
- Divorced
- Widowed
- Prefer not to answer

A5. What is your county of residence?

A6. Are you currently pregnant?
- Yes
- No
- Unsure
- Does not apply

A7. If not currently pregnant, have you delivered a baby since the start of the COVID-19 pandemic?
- Yes
- No

A8. What type of health insurance coverage do you currently have?
- Medicaid
- Tricare/Military
- Private/Commercial/Employer
- Uninsured
- Self-Pay
- I don't know
- Other _____

A9. Please describe the current employment status of yourself and your spouse/partner (if applicable). Please indicate an answer for each option.

	Self	Spouse/Partner	Not applicable
Full-time	○	○	○
Part-time	○	○	○
Paid sick leave or family leave	○	○	○
Unpaid leave	○	○	○
Working from home	○	○	○
Working in-person	○	○	○
Laid off or lost job due to COVID-19	○	○	○

Unemployed and looking for a job	○	○	○
Staying at home and not looking for a job	○	○	○
Enrolled in school/college/university	○	○	○
Other	○	○	○

A10. Which of the following employment **changes** occurred for you **and** your spouse/partner (if applicable) since the start of the COVID-19 pandemic? Please indicate an answer for each option.

	Self	Spouse/Partner	Not applicable
Started a new full-time/part-time job	○	○	○
Received flexible work hours (either total hours per week of timing of work schedule)	○	○	○
Needed to work additional jobs	○	○	○
Had to purchase or change internet access to work from home	○	○	○
Accessed unemployment benefits	○	○	○
Left job to take care of family at home	○	○	○
No changes	○	○	○
Other	○	○	○

A11. Have you been tested for COVID-19?
- Yes
- No
- Prefer not to answer

A12. Have you tested **positive** for COVID-19?
- Yes
- No
- Pending results
- Prefer not to answer

SECTION B: FAMILY ENVIRONMENT

The following questions ask you about your home environment. As a reminder, please refer to the start of the COVID-19 pandemic in Georgia as March 14, 2020.

B1. Including yourself, how many people live in your home? Please indicate a number for each option below, even if zero.
Number of adults (people aged 18 years or older) _____
Number of babies, children, or teenagers (people aged 17 years or younger) _____

B2. Are you the primary caregiver for anyone in your family other than your children?
- Yes
- No
- Prefer not to answer

B3. Is there another adult in your household besides yourself who usually helps with caregiving responsibilities?
- Yes
- No
- Prefer not to answer

B4. Do you have school-age (K-12) children that are currently attending school virtually due to the COVID-19 pandemic?
- Yes
- No
- Not applicable (No school-age children)

B5. Does your child have access to technology and other resources (such as a laptop or computer) needed for virtual learning at home?
- Yes
- No
- Prefer not to answer

B6. Is your role caring for your child or other dependents conflicting with your work responsibilities since the start of the COVID-19 pandemic?
- A great deal
- Some
- None
- Not applicable (i.e., unemployed or stay-at-home mother)

SECTION C: HOME VISITS RECEIVED
The following questions refer to your experience with receiving home visiting services since the start of the COVID-19 pandemic. As a reminder, please refer to the start of the COVID-19 pandemic in Georgia as March 14, 2020.

C1. What is the name of the home visiting program you participate in? (Example: "BabyLuv")
We will not associate your survey answers with your participation in this program.

C2. How long have you been receiving services from this program?
Please enter a response for both years and months.
Months _____
Years _____

C3. Since the start of the COVID-19 pandemic, have your visits been conducted through any of the following methods? Please indicate an answer for each option.

	Yes	No
Virtual visits by telephone	○	○
Virtual visits by computer	○	○
In-person only	○	○
Mix of virtual and in-person visits	○	○
Text messaging	○	○
Phone Calls	○	○
Other	○	○

C4. Have you encountered any of the following challenges with virtual visits?
Please indicate an answer for each option.

	Yes	No
Unstable/No internet access	○	○
No access to tablets, webcams or computers	○	○
No access to software for video conferencing	○	○
Phone coverage is limited/limited phone data plan	○	○
Uncomfortable doing virtual visits	○	○
Lack of privacy at home (specific about school/homeschooling kids at home)	○	○
No quiet space at home	○	○
Not interested in doing virtual visits	○	○
Lack of time	○	○

C5. Which of the following are benefits of having virtual visits? Check all that apply.

- It takes less time to complete the visit
- I do not have to clean my house/get my house prepared for the home visitor
- I am more comfortable with a virtual visit
- It's easier to set up visit times
- None/no benefits
- Other _____

C6. In general, thinking back to your most recent **VIRTUAL** home visit, how satisfied were you with the visit?

- Not at all satisfied
- Not very satisfied
- Neutral
- Somewhat satisfied
- Very satisfied

C7. Please indicate how helpful the following support services provided by home visiting has been for you and your family since the start of the COVID-19 pandemic. Please indicate an answer for each option.

	Not at all helpful	Slightly helpful	Somewh at helpful	Very helpful	Extreme ly helpful	Not applicable /Did not receive
Emotional/social support	○	○	○	○	○	○
Medicaid enrollment/support	○	○	○	○	○	○
WIC/Food Stamps	○	○	○	○	○	○
Pandemic EBT/Virtual learning EBT	○	○	○	○	○	○
Transportation	○	○	○	○	○	○
Housing support	○	○	○	○	○	○
Unemployment benefits	○	○	○	○	○	○
Health care assistance, including pediatrician suggestion	○	○	○	○	○	○
Employment search/finding a job	○	○	○	○	○	○

Information on GED classes/ESL classes	○	○	○	○	○	○
Parenting skills	○	○	○	○	○	○
Prenatal support/scheduling appointments	○	○	○	○	○	○
Child development resources and education	○	○	○	○	○	○
Information about COVID-19	○	○	○	○	○	○
Public safety and legal service referrals	○	○	○	○	○	○
Other	○	○	○	○	○	○

C8. Since the start of the COVID-19 pandemic, how has the frequency of your visits changed?

- Less frequent
- No change
- More frequent
- Not applicable (enrolled after the start of the COVID-19 pandemic)

C9. Since the start of the COVID-19 pandemic, how has the number of home visits been for you?

- More than I would like
- About right
- Less than I would like

C10. Please indicate whether or not you are satisfied with the following support services provided during your virtual home visits.

	Yes	No	Not applicable
Child development information	○	○	○
Games/activities	○	○	○
Having another adult to talk to	○	○	○
Working on goals for my child and myself	○	○	○
Prenatal care support	○	○	○
Well-baby care	○	○	○
Breastfeeding support	○	○	○
Referrals to community resources	○	○	○

Other	○	○	○

C11. What suggestions do you have to improve your home visiting program's response to the COVID-19 pandemic?

C12. What changes that have been made to the format of your home visiting program should stay in effect, even after the COVID-19 pandemic is over?

_____

SECTION D: HEALTH AND SOCIAL SERVICE NEEDS

The following questions will help measure the impact of COVID-19 on social service needs. As a reminder, please refer to the start of the COVID-19 pandemic in Georgia as March 14, 2020.

D1. Please indicate if the COVID-19 pandemic affected your overall healthcare.
Please indicate an answer for each option.

	Yes	No
I did not go to healthcare appointments because I was concerned about entering my healthcare provider's office	○	○
I delayed getting medical care	○	○
My healthcare provider cancelled appointments	○	○
My healthcare provider changed to phone or virtual visits	○	○
My healthcare provider told me to self-isolate or quarantine	○	○
Other	○	○

D2. Please indicate if the COVID-19 pandemic has affected your child(ren) or other family members' overall healthcare. Please indicate an answer for each option.

	Yes	No
Did not go to healthcare appointments because of concern about entering a healthcare provider's office	○	○
Delayed getting medical care	○	○
Healthcare provider cancelled appointments	○	○

Healthcare provider changed to phone or virtual visits	○	○
Healthcare provider advised to self-isolate or quarantine	○	○
Other	○	○

D3. Since the start of the COVID-19 pandemic, how confident are you that your household will be able to pay your next rent or mortgage payment on time?

- No confidence
- Slight confidence
- Moderate confidence
- High confidence
- Payment is/will be deferred
- Prefer not to answer

D4. How often is this statement true? "*Since the start of the COVID-19 pandemic, I do not have enough money to pay for the food my household needs."*

- Never
- Almost never
- Sometimes
- Fairly often
- Very often
- Prefer not to answer

D5. In the past month, has the lack of reliable transportation been harder to obtain for any needed appointments/work/activities?

- Yes
- No
- Prefer not to answer

D6. Since the start of the COVID-19 pandemic, have you experienced any physical, sexual or emotional aggression by a spouse or partner?

- Yes
- No
- Not applicable
- Prefer not to answer

SECTION E. MENTAL HEALTH

This last section seeks to learn about your mental health experiences with regards to the COVID 19 pandemic. As a reminder, please refer to the start of the COVID-19 pandemic in Georgia as March 14, 2020.

E1. How likely do you believe that the following events will happen due to the COVID-19 pandemic? Please indicate an answer for each option.

	No chance	Very small chance	Medium chance	High chance	Very high chance	Absolutely sure	This has already happened
You will be infected with COVID.	○	○	○	○	○	○	○
Someone in your direct environment (family, friends, colleagues) will be infected with COVID.	○	○	○	○	○	○	○
You will have to go to the hospital if you get COVID.	○	○	○	○	○	○	○
You will have to go into quarantine if you have been exposed to or have been infected with COVID.	○	○	○	○	○	○	○
You will get infected and you will infect someone else with COVID.	○	○	○	○	○	○	○
Someone in your direct environment (family, friends, colleagues) will die from COVID.	○	○	○	○	○	○	○

E2. Since the start of the COVID-19 pandemic, have you avoided any of the following activities? Please indicate an answer for each option.

	Yes	No
Going to in-person health visits	○	○
Shopping in-person at a grocery store	○	○
Visiting family/friends	○	○
Eating in restaurants	○	○
Shopping in-person at retail stores/malls	○	○

Going on personal travel	○	○
Attending in-person religious services	○	○
Exercising in a gym	○	○
Going to work in person	○	○
Leaving my child/children in daycare or a babysitter	○	○
Going to hair/nail or other beauty appointments	○	○
Going to the park or playground	○	○
Volunteering in person	○	○
Other	○	○

E3. Since the start of the COVID-19 pandemic, have any of the following been a source of major stress for you? Please indicate an answer for each option.

	Yes	No
Health concerns	○	○
Lack of stable housing or rent assistance	○	○
Financial concerns	○	○
Impact on work	○	○
Impact on your child(ren)	○	○
Impact on your community	○	○
Impact on your family members	○	○
Access to food	○	○
Access to baby supplies (e.g., formula, diapers, wipes)	○	○
Access to personal care products or household supplies	○	○
Access to medical care, including mental health care	○	○
Social distancing or being quarantined	○	○
I am not stressed about the COVID-19 pandemic	○	○
Other	○	○

E4. How has the COVID-19 pandemic changed your stress levels or mental health?

- Worsened it significantly
- Worsened it moderately
- No change
- Improved it moderately
- Improved it significantly

E5. Have you used any of the following to cope with your stress related to the COVID-19 pandemic? Please indicate an answer for each option.

	Yes	No
Improved sleep	○	○
Practiced meditation and/or mindfulness practices	○	○
Talked/consulted with friends and family	○	○
Talked/consulted with health care provider	○	○
Talked/consulted with counselor or mental health provider	○	○
Engaged in more family activities (e.g., games, sports)	○	○
Increased phone or TV time	○	○
Decreased phone or TV time	○	○
Read books or newspapers	○	○
Ate comfort foods	○	○
Ate healthier foods	○	○
Practiced self-care (e.g., taking baths, giving self a facial)	○	○
Exercised	○	○
Attended prayer/worship services	○	○
Drank alcohol	○	○
Used drugs (prescription or illegal drugs)	○	○
Nothing	○	○
I have not felt stressed due to the COVID-19 pandemic	○	○
Prefer not to answer	○	○
Other	○	○

E6. Have you received or sought information regarding COVID-19 from any of the following sources? Please indicate an answer for each option.

	Yes	No
Centers for Disease Control and Prevention (CDC)	○	○
World Health Organization (WHO)	○	○
Georgia Department of Public Health website	○	○
Local health departments	○	○
Federal government	○	○
Local government	○	○
Healthcare provider	○	○

Home visitor	○	○
Media news outlet (e.g., CBS, CNN, Fox, MSNBC, etc.)	○	○
Social media (e.g., Facebook, Twitter	○	○
Other pregnant women/new moms	○	○
Pregnancy websites or blogs	○	○
Word of mouth or friends/family	○	○
Employer	○	○
Newspaper or radio	○	○
Other	○	○

E7. How likely are you to get the COVID-19 vaccine when it becomes publicly available?

- ○ Very unlikely
- ○ Not likely
- ○ Likely
- ○ Very likely
- ○ Unsure/undecided

E8. If you do not plan to get the COVID-19 vaccine, please indicate why not. Check all that apply.

I do not think the vaccine will be safe.
I do not think the vaccine will be effective for preventing coronavirus.
I do not need the vaccine, because I already tested positive for coronavirus.
I do not think the vaccine will be covered by my insurance.
I will not be able to afford the vaccine.

Thank you so much for your participation. To receive a $15 Walmart electronic card for your participation, please provide your email address and telephone number. We will first email you the electronic gift card and may text or call you to confirm receipt.

- Email _____
- Phone number _____

APPENDIX B: IN-DEPTH INTERVIEW GUIDES

Home visiting staff /supervisor interview guide

Date: _____
Name of Interviewer: _____
Interviewee ID: _____
Time Started: _____ Time Ended: _____

Introduction

Thank you for taking the time to participate in this interview today.

My name is ---------. I am a researcher at -----. I am joined by my colleagues [and]. The main focus of the interview will be to learn about your experience as a home visitor in Georgia during the COVID-19 pandemic. We will refer to the pandemic as starting March 14, 2020, as this was the date that Georgia Governor Brian Kemp declared a statewide emergency.

The questions I will be asking you today will focus on your experience as a home visitor or supervisor during the COVID-19 pandemic. We are trying to understand how COVID-19 has affected the delivery of home visiting services in Georgia both from the perspectives of home visitors and their clients. We will also ask you to identify any challenges that your home visiting program has experienced as well as any innovative strategies to adapt home visiting services during the pandemic.

Before we get started, I want to assure you that your participation in this interview is completely voluntary and you are not obligated to answer any question you don't feel comfortable with or ask to stop the interview at any time. Our discussion today is completely confidential, and anyone not associated with the project will not hear the recording or know of anything we have discussed today. We really want you to speak freely and share any thoughts and feelings you have.

I would like to record our discussion to make sure we don't miss any of your comments. Every comment or concern you have is important to us and don't want to miss any important points. The recording is only for our records and we won't share it with anyone. We will transcribe only the audio file from this interview. The transcript is not shared outside of the research team and will be deleted once the project is complete.

I am now going to hit the record button to ask for your permission to record. [HIT RECORD]

Do I have your permission to record this interview?

A. Background information – Warm Up Questions (5-10 minutes)

We'll first start with you telling me a bit about yourself and your work as a home visitor or Supervisor.

1. **Describe for us the position you hold in your home visiting program**.
   PROBES: What is the title of your position? How long have you held this position?
   PROBE: Have you held other positions in this or another home visiting program in Georgia?
   PROBES: What is your educational background? Do you have a clinical background?
   PROBE: What are your major responsibilities in your position as a home visitor or Supervisor?
   PROBE: **If a supervisor**, how many staff do you supervise?
   PROBE: **If a supervisor**, are you also conducting home visits?

2. **Please describe your home visiting program.**
   PROBE: What is the program most commonly known as?
   PROBE: What home visiting curriculum (curricula) does your program use? [If already known, just confirm]
   PROBE: With this curriculum, what are your major responsibilities as a home visitor?
   PROBE: Who are your clients?
   PROBE: How many other staff work for this home visiting program?
   PROBE: What is a typical monthly caseload for you (or your staff-if a Supervisor)?

3. **Please describe your work with pregnant and/or postpartum clients.**
   PROBE: What are the typical services you provide to pregnant clients?
   PROBE: What are the typical services you provide to clients who recently delivered? How long do you work with them after delivery?

B. Home Visits during the COVID-19 pandemic (10-15 minutes)

In this next set of questions, we would like to discuss your current experience with conducting home visits since the COVID-19 pandemic.

1. **How has home visiting changed since COVID?**
   PROBE: How has it changed the way you do home visiting?
   PROBE: What adjustments have you had to make in order to have successful home visits?
   PROBE: Do you follow any specific COVID home visiting guidelines?
   PROBE: Where are you working? From home or at the office?

2. **What changes to your clientele have occurred since COVID?**
   PROBE: How did it change your case load?
   PROBES: Are you seeing an increase in a specific type of client, like pregnant clients, high need clients)? If so, how has that changed your workload or how your delivery of home visiting?
   PROBE: Were new families still being enrolled?

3. **What technologies have you started using to do your home visiting work with families?**
   PROBE: Text, Video conferencing such as WebEx, telephone?
   PROBE: Have you experienced any challenges with these technologies? If so, please describe the challenges.
   PROBE: If you have experienced challenges with the technologies what do you need to make it easier to conduct home visiting services?

4. **What have been the most significant challenges families have experienced with remote visits?**
   PROBE: Technology, activities hard, Internet connectivity
   PROBE: What are the consequences of these challenges?
   PROBE: Quantity and quality of engagement? Ability to implement activities?

5. **What have been the most significant benefits that families have experienced with remote visits?**
   PROBE: Do they find it more convenient? Less stressful?
   PROBE: Has the level of engagement changed with families? If so, how?

6. **Do you prefer virtual visits or in-person visits during the COVID-19 pandemic?**
   PROBE: How safe would you feel now if home visits were to be in-person again?
   PROBE: What resources or support would you need from your program or the Department of Public Health if you were to return to conducting visits in-person?

7. **How important do you believe home visiting programs are during the COVID- 19 pandemic? Why or why not?**

8. **What recommendations do you have for other home visiting program to provide home visiting services to families during COVID?**

9. **How has your program leadership supported you when the COVID-19 pandemic was declared?**
   PROBE: What about the Department of Public Health? How have they supported you during the COVID-19 pandemic?
   PROBE: Did you receive the appropriate information to be able to continue home visits virtually?
   PROBE: Looking back, what other support would have been helpful?

C. Continuity of Services during COVID-19 (15 minutes)

Now we will move into questions about the continuity of home visiting services provided during COVID-19.

1. **How were the services you provided to families prior to the pandemic different from the services you currently provide?**
   PROBE: Which services stayed the same and were not affected?
   PROBE: Which ones changed or ended?

PROBE: How have services changed for pregnant women/recently delivered/post-partum/working with toddlers?

2. **What are some of the resources that most families have needed <u>since the COVID-19 pandemic</u> started?**
   PROBE: Food/SNAP, housing, WIC, employment assistance, transportation, childcare?
   PROBE: How easy or difficult was it to provide these resources to families at this time?
   PROBE: Are there barriers preventing you from providing resources?
   PROBE: What are resources missing from the community and/or your program?
   PROBE: What resources have ended since the start of COVID-19?

3. **What has your experience been like coordinating with other community agencies to support families during the pandemic?**
   PROBE: Have you collaborated with other community organizations to provide resources?
   PROBE: Is there another staff person in your program whose main responsibilities are to provide community referrals or coordination?
   PROBE: Have you and/or the program developed new partnerships within the community since the start of the COVID-19 pandemic?

4. **How likely are you to get the COVID-19 vaccine when it becomes widely available to the public?**
   PROBE: If unlikely, what are your concerns
   PROBE: If likely, how do you think having this vaccine will affect your work?
   PROBE: Has your opinion about the vaccine changed over time? What has influenced you?

D. Managing stress and well-being as a Home Visitor (15 minutes)

The next set of questions asks about your experiences with managing stress and your well-being during the COVID-19 pandemic.

1. **How has the COVID-19 pandemic affected you personally?**
   PROBE: Has it affected your home life, such as taking care of your family?
   PROBE: Has it affected you in any other way (e.g., financially)?
   PROBE: What are some stressors in your life brought on by the pandemic?
   PROBE: Have there been any positive outcomes or upsides to the pandemic in your life?

2. **How has your work as a home visitor during COVID affected your well-being?**
   PROBE: How has it affected your mental health in particular?
   PROBE: What has been particularly stressful about doing your work during the COVID-19 pandemic?

3. **How have you been taking care of your well-being during the COVID-19 pandemic? [If already mentioned certain strategies for taking care of herself, ask if there are other ways, she is taking care of her well-being]**
   PROBE: Have you sought support from friends and family?
   PROBE: Have you sought any support from your co-workers/supervisor?
   PROBE: Have you seen a mental health provider, like a therapist or counselor?

4. **What are some ways your home visiting program can support your well-being during the COVID-19 pandemic?**
   PROBES: More time off? More mental health/emotional support or resources? A reduced caseload?

5. **What else do you need to be successful in your job as a home visitor at this time?**
   PROBE: How can your programs help support you?
   PROBE: How can DPH help support you?
   PROBE: What other sources of support do you need? Can area ObGYNs help you? Mental health providers?

E. Closing Questions and Recommendations (5 minutes)

Thank you so much for your input today. We would like to end with a few general questions including some final thoughts and suggestions about improving the home visiting program during this pandemic and beyond.

1. Is there anything else you would like to share with us regarding your experiences as a home visitor in Georgia during the COVID-19 pandemic?

Thank you. Before we finish today, I want to ask my colleagues if they have any additional questions.

Thank you so much for your time today. I appreciated the chance to learn more about your experiences as a home visitor during the COVID-19 pandemic. Your responses were very insightful.

Home visiting client interview guide

Date: _____
Name of Informant: _____
Name of Interviewer: _____
Name of Note-Taker: _____
Time Started: _____ Time Ended: _____

Introduction
Thank you for taking the time to participate in this interview today.
My name is ---------. I am a researcher at Emory University. My colleague ---------. is also here today to take notes. We are members of a research study that seeks to understand how home visiting services in Georgia have been affected since the start of the COVID-19 pandemic. We are conducting interviews with other home visiting clients. We have also completed interviews with home visiting staff and their supervisors.

The purpose of our interview is to learn more about your experience with home visiting since the start of the COVID-19 pandemic in Georgia, which officially began on March 14, 2020. We hope that the information gathered from this research will help improve home visiting services. Before we get started, I want to assure you that your participation in this interview is voluntary and you are not obligated to answer any question you do not feel comfortable with. You can ask to skip questions you do not feel comfortable with or even ask to stop the interview at any time. Our discussion today is completely confidential. We do not identify your name with anything you share with us today. We really want you to speak freely and share any thoughts and feelings you have.

In addition, with your permission, we would like to record just the audio portion of our interview. The recording is only for our records, and we will not share it with anyone outside the research team. This recording will be made into a transcript that we will then de-identify so you are not named in any of the data we analyze.
Do you have any questions about any of the information we have provided regarding the study or about the purpose of the interview?
Do you agree to participate in this interview? And do I have your permission to record this interview? [START RECORDING]

A. Background information – Warm Up Questions

First, we'd like to ask a few questions about you and your family. Then I will ask about your experiences with home visiting.

1. **Tell me about yourself.**
   PROBE: Are you currently pregnant?
   PROBE: Did you recently deliver?
   PROBES: Do you have any children? If so, what ages?
   PROBES: Do you work outside your home? If so, what kind of work do you do?

2. **Tell me about your family.**
   PROBE: How many people do you have living with you?
   PROBE: How many children?
   PROBE: Do you have others that you care for in your household?

3. **Now, tell me about getting connected with your home visiting program. [insert HV program]**
   PROBE: What is the name of the home visiting program you are a part of?
   PROBE: How long have you been enrolled in the program? ***[Interviewer, note whether informant has been enrolled before COVID. Will need to reference for section below]***
   PROBE: How did you first learn about this program?
   PROBES: What made you want to be a part of the program? What appealed to you about participating in home visiting?

4. **Tell me about the services you receive in [insert HV program].**
   PROBE: If currently pregnant, what services do you receive?
   PROBE: If recently delivered, what services do you receive?
   PROBE: If not pregnant and have a young child at home, what services do you AND your child receive?

B. COVID-19 Experiences and Information

In this section I would like to discuss how you have been doing since the start of the COVID-19 pandemic.

1. **How has COVID-19 pandemic affected your family?**
   PROBES: How has your daily routine changed since the start of the COVID pandemic? What changes have occurred at home (quarantine, kids home from school)?
   PROBES: How has the COVID pandemic affected your family's financial wellbeing? Has it caused any of your family members (including you) to change jobs, lose jobs, experience reduced income?
   PROBES: What other ways has the COVID pandemic affected your family life? (difficulty paying rent/mortgage, or paying for food)

2. **How has the COVID-19 pandemic affected your health?**
   PROBES: Have you tested positive for COVID?
   PROBE: What have been your experiences getting tested for COVID-19?

3. **How has the COVID-19 pandemic affected the health of your family?**
   PROBE: How has COVID affected the health of your family?
   PROBES: Has any member tested positive for COVID? If you or someone in your family tested positive for COVID, how did this affect you? How did it affect your home life?

4. **How has the COVID-19 pandemic affected your ability to seek healthcare?**
   PROBES: Were you able to get the healthcare you needed? If not, what were some barriers to accessing healthcare?

PROBE: [IF PREGNANT] How has COVID-19 Pandemic impacted your pre-natal care?
PROBE: [IF POSTPARTUM] How has the COVID-19 Pandemic impacted your post-partum care?
PROBES: How did COVID-19 impact any other healthcare? Well-visits? Immunizations? Dental care?

5. **How has the COVID-19 pandemic affected your mental health or stress level?**
   PROBE: What about COVID-19 has been most stressful?
   PROBES: What has helped you manage or cope during this time? Have you sought care from a professional mental health provider such as a counselor, psychologist, or psychiatrist?

Now, I want to know a little about the information you have received regarding the COVID-19 pandemic and what you may be doing to protect yourself against the virus.

6. **How have you gotten information about the risks of and prevention of COVID-19?**
   PROBE: Where do you get this information (From TV, friends, CDC)
   PROBE: How do you decide which information you trust?
   PROBE: What information is difficult to understand about COVID 19? Is it difficult to understand how widespread the pandemic is? Difficult to understand the best ways to protect yourself?
   PROBE: How has home visiting helped you understand information about COVID-19?

7. **What have you done to protect yourself against COVID-19?**
   PROBES: Have you changed the way you interact or socialize with others? If so, how has that affected you/your well-being?
   PROBE: Have you changed certain behaviors, such as handwashing (more) or using masks?

C. Home Visiting during COVID-19

Now I would like to discuss your experiences with home visiting services since the start of the COVID-19 pandemic.
[INTERVIEWER NOTE SOME OF THIS MAY HAVE BEEN DISCUSSED DURING DISCUSSION ON HOME VISITING IN FIRST SECTION]

1. **Describe what it has been like to receive home visiting services since the start of the COVID pandemic.**
   [Interviewer, if informant has been enrolled in HV since before the start of the pandemic, ask specific probes below. Some of these probes may have been answered above in question A4 above. If so, skip those that are repetitive]
   PROBES: If you were enrolled in the program prior to the start of COVID, what was home visiting like then? What specific services did you receive and how?]
   PROBE: Since COVID started, how do you receive home visits? (Phone calls, Video, text)
   PROBES: How have any visits changed since the start of COVID? For instance, are you having visits in public places, like a park or library, etc.? Have you participated in any hybrid visits (drive by baby showers/diaper days)? Are the visits shorter in length?

PROBES: How has the interaction been with your home visitor in this virtual environment? Has this changed since the pandemic has gone on? [*INTERVIEWER: Trying to assess changes in engagement – not sure what language clients will use]*
PROBE: What is MOST important to you about home visiting?

2. **What have been the challenges of virtual home visiting?**
   PROBES: Has having kids at home been particularly challenging to conduct these visits? Has having to work (inside or outside the home) been challenging for you to schedule or conduct these visits?
   PROBE: Do you have any issues with the technology needed to conduct these visits (not enough data on your phone, no computer/internet problems)?
   PROBES: What's the hardest part about going "virtual" with home visiting? Has this changed as the pandemic has gone on?

3. **What have been the benefits of virtual home visiting? (or alternative home visiting, if applicable)**
   PROBE: What have you liked? (scheduling is easier, no tidying up,)
   PROBE: What is the best part about going "virtual" with home visiting?
   PROBE: What parts of virtual home visiting do you think might be best to keep even after the pandemic is over?

4. **What other ways has your home visitor helped you during the COVID pandemic?**
   PROBE: Getting information about COVID transmission, rates, and other information?
   PROBE: Getting resources to help to deal with unemployment/employment
   PROBE: Getting resources to deal with your health/mental health
   PROBE: Getting resources to help your family with technology

5. **How has your home visitor connected you to community resources, such as housing, food banks, WIC, employment assistance?**
   PROBE: Which resources did you need access to the most?
   PROBES: What has it been like accessing those resources? Were they available to you?
   PROBE: Did you experience any difficulties accessing them?

6. **What type of support do you receive from your home visitor with regard to caring for your child(ren) during the pandemic?** *[Interviewer asks if client is not pregnant and has a young child under 3]*
   PROBE: Does your home visitor provide you support on topics related to well-baby/infant care, such as breastfeeding or information about child development?
   PROBE: Does your home visitor help you get social service support for your child (e.g., WIC, Medicaid)?
   PROBE: Do you wish you received more or different support for your child from your home visitor?

PROBES: How would you describe the interaction your home visitor has with your child during visits? Do you feel this interaction is sufficient/not sufficient? What do you wish could be done differently to make this interaction better?
PROBE: What other support do you wish you had from your home visitor to care for your child during the pandemic?

7. **How satisfied are you with home visiting services during the COVID-19 pandemic?**
   PROBE: Do you feel the current frequency of home visits is appropriate/enough?
   PROBES: Do you like the activities you are taking part of during these home visits? Do you feel like you can engage well with your home visitor?
   PROBE: What about the time allocated during your visits?
   PROBE: Were the resources or information shared with you useful?

D. Home Visiting Going Forward

Now, we would like to discuss your future home visiting needs.

1. **When things get back to a more normal environment and home visitors are allowed to come into the home, would you prefer in-person or virtual visits?**
   PROBE: Tell me more about why you prefer in-person or virtual visits.
   PROBE: How safe would you feel if home visits were to be in-person again?
   PROBE: Would you be comfortable with participating in visits in-person now?
   PROBES: What resources or support would you need from your program or DPH if you were to return to participating in visits in-person? What resources or support would you need to remain virtual?

2. **How can home visiting programs make virtual visits better?**
   PROBE: Should they schedule home visits differently, such as making them shorter or schedule them at different times?
   PROBE: Can programs help you with the technology challenges?
   PROBE: Should the home visiting visits be different in terms of the content?
   PROBE: Do you wish you had some privacy or more space to conduct these visits?

E. Closing Questions and Recommendations

Thank you so much for your input today. We would like to end with a few general questions including some final thoughts and suggestions about improving the home visiting program during this pandemic and beyond. *[Interviewer to summarize what she heard so far from the interviews and to review any recommendations made so far from the informant]*

1. **What other recommendations do you have to improve the home visiting services that families in Georgia receive during the pandemic?**

2. **What else would be important for us to know about your experience with your home visiting program?**

3. **What other resources or information do you wish are available to you during the pandemic?**

Thanks so much for all your feedback. We have one more question that we want your perspective on. As you know, the COVID-19 vaccine will be slowly rolling out to the general public over the next few months. We would like to know your thoughts about it.

4. **How likely are you to get the vaccine once it becomes more widely available to you?**
   PROBE: If you are likely to get the vaccine, why do you think it is important to get it?
   PROBE: If you are NOT likely to get the vaccine, why not? Is it a matter of trust? Safety concerns? Affordability? What has influenced your thinking?
   PROBE: Have your thoughts about the vaccine changed since you first heard that a vaccine would become available?

Before we finish let me ask my colleague if they have any other questions. [Ask colleague]

Closing
Thank you so much for your time. That ends this interview. Thank you again for helping me understand your perspective I really appreciate it. For participating in this interview, we will provide you with a $25 gift card.

Can we use the email we have on file for you to send this gift card? Please know that it takes about a week to process the gift card. When you do receive your gift card, please respond to us that you have received it.

Thank you and have a good rest of the day.