Early Learning Council Home Visiting Systems Committee

MEETING AGENDA

October 6, 2022 12-2pm

Meeting Objectives

- Continue Building Relationships with Committee Members
- Review HVS Committee Working Agreements and Fist-to-Five Tool
- Overview Home visiting Programmatic and Funding "Cheat Sheets"
- Update on Working Team Progress/Process
- Consider Lessons Learned North Carolina's HVS, The Ford Family Foundation's HVS Project, and Researcher/Evaluator, Dr. Beth Green

AGENDA

12:00-1:00

- Welcome
- HVS Committee Working Agreements and Fist-to-Five Consensus Tool
- Small Group Discussions on Suggested Reading
- Oregon's Home Visiting Programming and Funding Streams
- Update on HVS Working Team
- Reflections and Discussion

1:00 – 2:00

- Home Visiting Systems Components – BUILD Tool
- Presentation: Rural Home Visiting System Coordination Project: Overview and Lessons Learned, Callie Lambarth, Portland State University and Robin Hill-Dunbar, The Ford Family Foundation
- Presentation: Lessons from the Field, Dr. Beth Green, Portland State University
- Reflections and Discussion
- Closing Comments

Materials Included in Packet (in order that they appear)

1. Agenda
2. PowerPoint
3. Committee Members Roster
4. Working Team Roster
5. Updated ELC HVS Committee Overview
6. Updated HVS Committee Charter
7. MIECHV 2020 Needs Assessment, Appendix C: Overview of Oregon's Home Visiting Program Models
8. DRAFT Oregon HV Program Matrix
9. BUILD Initiative Resource Tool: Essential Components of a Statewide Home Visiting System
10. TFFF HVSC Theory of Action
11. TFFF 2021 Cross-Region Systems Survey Summary
12. Region X Home Visiting Workforce Study

HOME VISITING SYSTEMS COMMITTEE

A Standing Committee of the Early Learning Council

12pm-2 pm

October 6, 2022

WELCOME – ELC HVS COMMITTEE

Hello and welcome!

The Hustle!

Enjoy a little music while you get settled in.

Can you name the group?

Chat Question: What was the first CD, tape, download, 8-track, or record that you bought with you own money?

WELCOME - OPENING REMARKS

From the HVS Committee Charter

- Our purpose is to advance the development of Oregon's statewide comprehensive home visiting service network by
  - Generating and sustaining momentum for coordinated, equitable system
  - Engaging responsible state agencies and their partners in the development and implementation
  - Ensuring effective collaboration on governance and administration across government entities, funders, and home visiting partners

WORKING AGREEMENTS

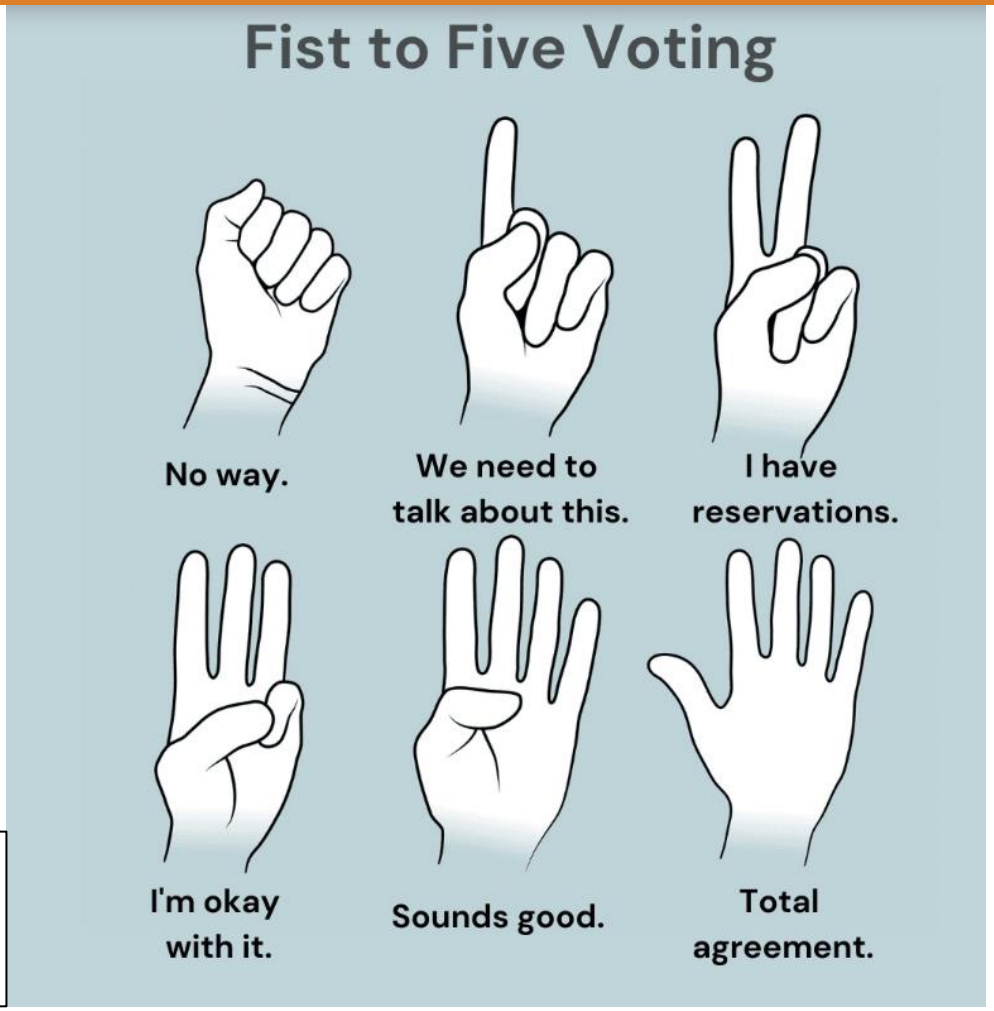
As a Committee of the Early Learning Council, we strive to

- Be fully present
- Listen to one person at a time
- Listen to learn
- Be curious
- Appreciate the value each of us brings to the table
- Use caring, respectful communication
- Be genuine
- Be playful and have fun (where appropriate)

FIST TO FIVE CONSENSUS BUILDING

- Fist: No way.
- 1 Finger: Hold on. We need to talk about this.
- 2 Fingers: I have reservations, but could be convinced.
- 3 Fingers: I guess I'm okay with it.
- 4 Fingers: Sounds good.
- 5 Fingers: I'm in total agreement

When we are trying to come to agreement anything 2 or below requires more discussion.

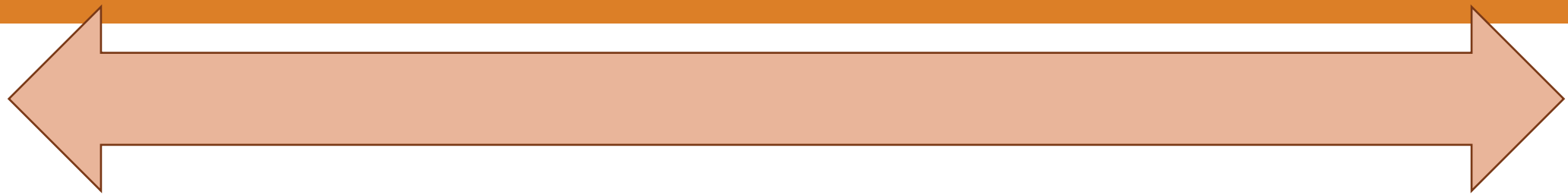


PAIR AND SHARE DISCUSSION

What came up for you from the suggested reading list…

- Ah-ha's or uh-oh's?
- Take aways that will help with your work in this Committee?

HOME VISITING PROGRAMMING



- Brief
- Primary
- Peer/Lived Experience
- Limited Reach
- More than One Stream

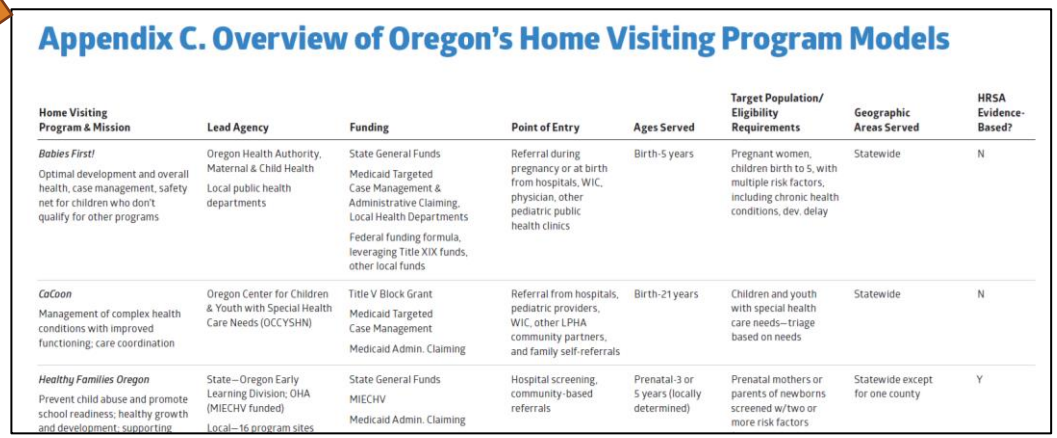
- Extended Duration
- Component
- Specific Training/Education
- Comprehensive Reach
- Many Streams

Voluntary – Relational – Family Health and Well-being

HOME VISITING PROGRAMMING

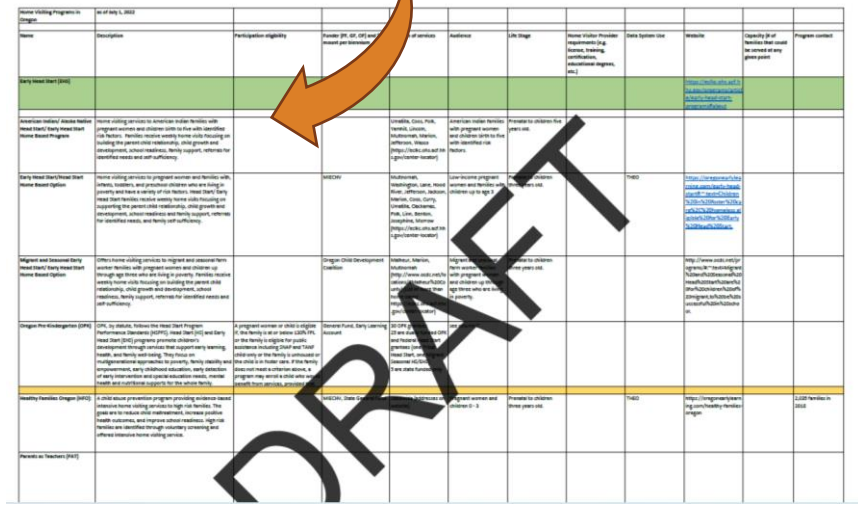
Programming “Cheat Sheets”

- MIECHV 2020 Needs Assessment (Appendix C)
- DRAFT Oregon Home Visiting Program Matrix



Appendix C. Overview of Oregon's Home Visiting Program Models

Home Visiting Program & Mission	Lead Agency	Funding	Point of Entry	Ages Served	Target Population/ Eligibility Requirements	Geographic Areas Served	HRSA Evidence-Based?
Babies First! Optimal development and overall health, case management, safety net for children who don't qualify for other programs	Oregon Health Authority, Maternal & Child Health Local public health departments	State General Funds Medicaid Targeted Case Management & Administrative Claiming, Local Health Departments Federal funding formula, leveraging Title XIX funds, other local funds	Referral during pregnancy or at birth from hospitals, WIC, physician, other pediatric public health clinics	Birth-5 years	Pregnant women, children birth to 5, with multiple risk factors, including chronic health conditions, dev. delay	Statewide	N
CaCoon Management of complex health conditions with improved functioning; care coordination	Oregon Center for Children & Youth with Special Health Care Needs (OCCYSHN)	Title V Block Grant Medicaid Targeted Case Management Medicaid Admin. Claiming	Referral from hospitals, pediatric providers, WIC, other LPHA community partners, and family self-referrals	Birth-21 years	Children and youth with special health care needs—triage based on needs	Statewide	N
Healthy Families Oregon Prevent child abuse and promote school readiness; healthy growth and development; supporting	State—Oregon Early Learning Division; OHA (MIECHV funded) Local—16 program sites	State General Funds MIECHV Medicaid Admin. Claiming	Hospital screening, community-based referrals	Prenatal-3 or 5 years (locally determined)	Prenatal mothers or parents of newborns screened w/two or more risk factors	Statewide except for one county	Y

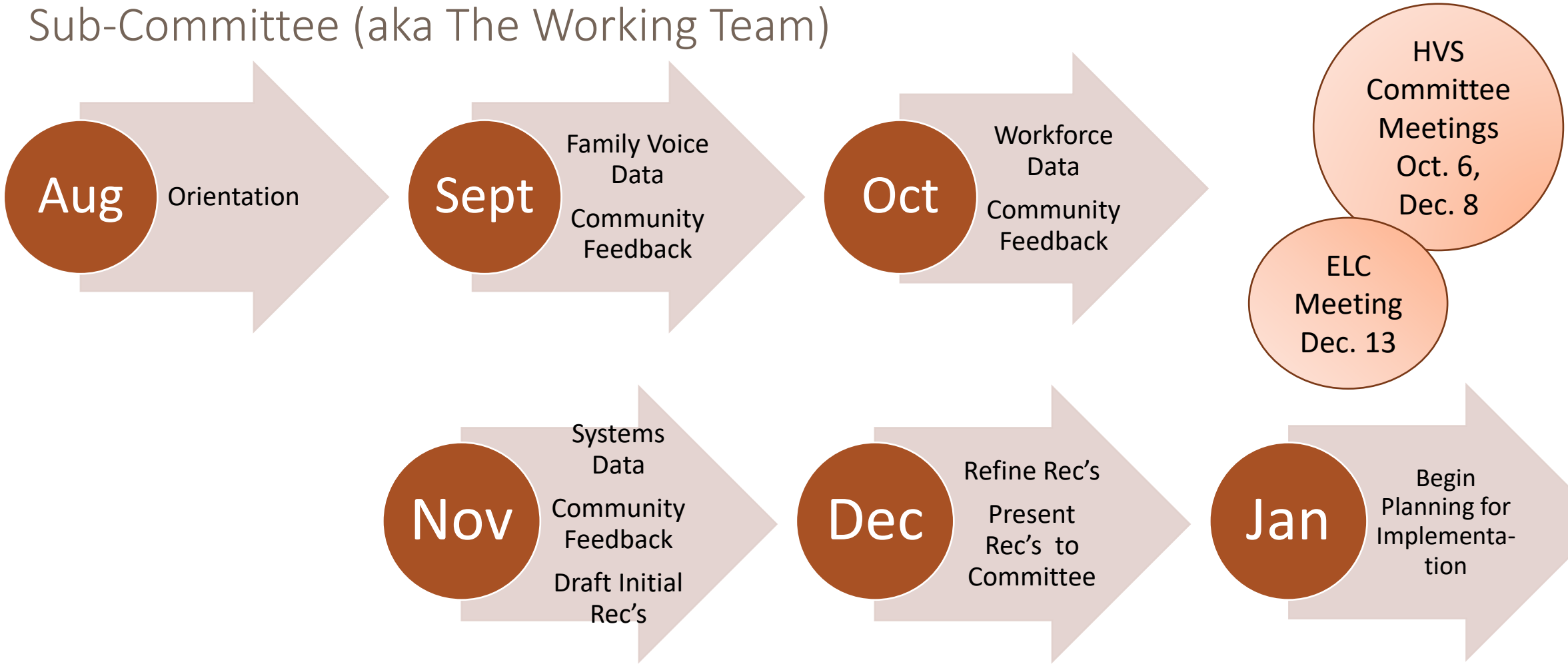


HOME VISITING FUNDING

- Programming Funding
- Systems Funding

HVS WORKING TEAM UPDATE

Sub-Committee (aka The Working Team)



PATHWAYS TO RECOMMENDATIONS

1. Analyze existing data about home visiting to find themes
2. Three data analysis phases
   - Phase 1: Parent/Family Experience September
   - Phase 2: Home Visiting Workforce October
   - Phase 3: Home Visiting Systems November
3. Share findings with community partners around the state for critique after each phase
4. Combine WT's findings and critical feedback to craft and prioritize recommendations for the HVS Committee

PHASE 1 DATA ANALYSIS: PARENT/FAMILY VOICE

EVERYONE READS THESE (aka Required Reading)

- Oregon Equity Lens
- Appendix D Parent Focus Groups (from Oregon 2020 MIECHV Needs Assessment)
- Listening to Parent Voices (Perigee Fund report)
- HVSC South Central and Siskiyou County, CA Parent Voice
- Multnomah County Parent Advisory Committee Listening Session Summary
- Multnomah County Highlights (focus on intake process)
- EI/ECSE parent/family experience data

EVERYONE CHOOSES AT LEAST 2-3 OF THESE TO ALSO READ (aka Choose Your Own Adventure - CYOA)

- Multnomah County Welcome Baby Parent/Community Input
- Health Care Needs, Access to Care, and Experiences of Racism: OCCYSHN 2020 Needs Assessment
  - Black Children/Youth and Families (Executive summary and recommendations)
  - Immigrant and Latinx Children/Youth and Families (Executive summary and recommendations)
- ELC Community Listening Sessions: Workgroup Analysis (pages 1-2; Sections B,C,F)
- Kindergarten Readiness Parent Focus Group Summary (slides 5-6; 74-100; 104)
- Millennial Connections: Findings from ZERO TO THREE's 2018 Parent Survey (Executive Summary)
- In their own words: Families' Biggest Challenges During the Pandemic (RAPID Report)

PHASE 1 DATA ANALYSIS: PARENT/FAMILY VOICE

Suggested Analysis Approach

1. Study the Required Readings and 2-3 more of your choosing

2. Capture your findings/themes in terms of +/-/0 from the readings

What's Working (+) **What's Not Working (-)** **What's Missing (0)**

3. Use the Oregon Equity Lens: Keep the questions on page 3 alongside you as you do your reading and +/-/0 analysis.

- What stands out to you about the themes you found in your parent/family voice reading when seen through this equity lens?

PHASE 1 COMMON THEMES

Types of Supports Families Desire

- Parents are looking for the following specific supports: **basic needs and community resources**, **mental health supports for caregivers and children**, **parental and prenatal supports**.
- Supports that help build parental resiliency: **emotional supports for caregivers** (including peer support), **leadership roles/opportunities**, **tools for self-advocacy**.
- Parents want **flexible programs that meet individual family needs**. Considerations include eligibility, frequency, duration, and availability (scheduling) of home visits.
- Issues around equitable physical access to programs were evident. **Telehealth/remote services** and **hybrid options** are desired, as is **increased access to programs in rural/frontier communities**.

PHASE 1 COMMON THEMES

Make it Easy for Families

- Families want **coordination between programs and services** with easy systems navigation.
- **Simplified screening, intake, and referral processes** that don't involve a massive amount of duplicative or intrusive paperwork for families or home visitors.
- **Warm hand-offs** for referrals and **support with transitions** between providers and programs.

PHASE 1 COMMON THEMES

What's Important to Families When Receiving Services

- Positive, supportive relationships make a difference. **Trusted relationships** with those making referrals and with home visitors are critical.
- **Cultural responsiveness** and **culturally specific programming** are needed to increase access and buy-in of home visiting services. The need for a **diverse workforce** is clear.
- Home visitors as **advocates and navigators**. Particularly when "the system" has previously failed the family.

PHASE 1 COMMON THEMES

Messaging and Outreach

- There appears to be a general lack of **understanding and awareness of home visiting** services by a variety of stakeholders.
- **Asset-based language** is desired when describing home visiting services (i.e., preventative and supportive), to help reduce stigma around receiving services.
- **Increase promotion and outreach** to families with cultural specificity in mind and include trusted community partners.

REFLECTIONS AND DISCUSSION

Write down any reflections on the info shared so far.

What comments or questions are coming up for you?

Share verbally or in the chat …

QUICK STRETCH BREAK

STATEWIDE HOME VISITING SYSTEM

North Carolina Home Visiting and Parent Education System Components*

- Governance and Administration
- Financing Strategies and Funding Mechanisms
- Assessment and Planning
- Monitoring and Accountability
- Continuous Quality Improvement, Implementation and Evaluation
- Professional Development, Training and Technical Assistance

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Governance and Administration

What?

Leadership, oversight, and management of home visiting at both the state and local levels, encompassing how the connection between state and local governance and administration occurs.

Why?

Establish and maintain the statewide vision for home visiting, along with the goals and activities that support that vision. Ensure the governance and administration of the vision, goals, activities, and programs is well coordinated within the broader early care and education system at both the state and local levels. Ensure that collaboration on governance and administration occurs across the government entities, funders and home visiting stakeholders. In developing and implementing governance and administration seek an approach that is adaptable and responsive to program needs.

Activities

- Administration of state funding for home visiting.
- Administration of federal Maternal, Infant and Early Childhood Home Visiting funding.
- Meet requirements of legislation related to home visiting (if legislation exists).
- Ensure adherence to funding requirements.
- Streamline administrative requirements of programs.

Considerations for Planning

1. Where are current investments in home visiting? Funding, quality supports, coordination resources, other?

2. What strategies and policies exist supporting home visiting program quality and improved child and family outcomes?

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Financing Strategies and Funding Mechanisms

What?

Financing and funding mechanisms to support home visiting are focused on diverse and stable sources implemented in an efficient and coordinated manner to best support local implementation.

Why?

The statewide home visiting system is in a position to advance the blending of multiple funding streams to support programming and systems supports. Blending funding streams, such as federal and state funding, is a way to ensure opportunities for expansion as needed. Additionally, accessing multiple funding streams may allow for implementing innovative models or enhancements to models driven by family and community needs.

Activities

- Track all federal, state, and local (public and private) funding for home visiting.
- Understand the funding needs of local programs and system-level supports.
- Coordinate funding streams in order to streamline administrative requirements.
- Advocate for funding needs of the programs and system.

Considerations for Planning

1. What are the current funding sources (type of funding and amount) supporting home visiting?

Source: North Carolina Home Visiting and Parenting Education System Action Plan, Updated February 2021

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Assessment and Planning

What?

Cross-system and interagency needs assessment and planning ensures all funders, programs, communities, and interests are captured in order to work toward a collaborative home visiting system made up of multiple models, funders, and community-based approaches to the work.

Why?

Assessment and planning are necessary to understand and implement a system that realizes the statewide vision for a continuum of home visiting services.

In a collaborative approach to a home visiting system, and with home visiting as a core piece of the broader early care and education system, planning that is built from an active needs assessment and data analysis approach is necessary to allow all partners to have a clear understanding of their roles and responsibilities and to detail out expectations, goals, and outcomes (at system, community, program, child, and family levels).

Activities

- Identify service gaps and plan for growth and expansion.
- Understand the role, and reality, of data systems collecting information on home visiting indicators and statistics. Seek to improve the data system functioning.
- Maintain access to data necessary for analysis and planning around home visiting.
- Ensure criteria related to who is served by the various home visiting models is understood and part of the planning process.
- Complete routine needs assessment and analysis of results.
- Maintain strategic and fiscal plans for home visiting.

Considerations for Planning

1. How has expansion of home visiting programs occurred in the recent past? What data or need informed the process?

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Monitoring and Accountability

What?

Monitoring and accountability activities are coordinated across agencies, funding, and models in order to have a shared understanding of program standards and model fidelity, and to streamline the administrative and reporting burden on programs.

Why?

Coordination of monitoring and accountability efforts will support implementation of multiple models within programs and communities, along with working to ensure each model includes all aspects necessary to support quality programming.

Activities

- Cross-walk standards of different models to understand similarities and differences, and the potential implications for a shared monitoring approach.
- Develop shared monitoring tools and reporting structures that are reflective of model needs and have minimal data management impact.
- Message the impact of model fidelity, and overall home visiting, in order to support home visiting as an effective support for children and families.

Considerations for Planning

1. What type of monitoring is done with home visiting programs? How does this monitoring relate to model fidelity?

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Continuous Quality Improvement, Implementation, and Evaluation

What?

Evaluation, quality assurance activities, and communication on results of evaluation and quality improvement activities are coordinated across models and funding, at the state and local levels, in order to improve programs and their support structures.

Why?

Program improvement should be driven by data and evaluation that considers both program strengths and weaknesses in working to improve program quality. Coordination at the state system level is necessary to achieve benefits of knowledge gained across different models and funders, and maximize opportunities to implement quality improvement strategies reaching all programs. Maintaining a statewide vision for quality and a quality assurance plan leads to coordinated data collection, analysis and monitoring, streamlining across models by shared metrics and evaluation points, and monitoring structures.

Activities

- Develop and maintain a quality assurance plan (cross-model and funding).
- Support models in understanding and applying an implementation science approach to their program-specific strategies. Ensure this approach is accounted for in state-level analysis of continuous quality improvement and evaluation, and communication of results.
- Identify outcomes and evaluation measures that are shared across models and support the statewide goals for the impact of home visiting.
- Maintain a dashboard tool that tracks the identified outcomes and evaluation measures, gathering data across models.
- Communicate with state and local partners on progress, including analysis of expected impact.

Considerations for Planning

1. How are home visiting program objectives and outcome measures currently understood by the early care and education system? What efforts exist to map or align objectives and outcomes across models?

BUILD INITIATIVE HOME VISITING SYSTEM RESOURCE TOOL

Component: Professional Development, Training and Technical Assistance

What?

The core value of a highly skilled and supported home visiting workforce is held by the system and maintained across agencies, funders, and models.

Why?

Professional development activities coordinated at the state level (training and technical assistance) have the ability to be responsive to the results of evaluation and continuous quality improvement efforts. Home visiting is a unique delivery model. Within the early care and education system, the training, supports, and supervision needed for high-quality home visiting must be reflective of this uniqueness, which the statewide system ensures.

Activities

- Assess for common training and professional development needs across programs and coordinate a response.
- Maintain an alignment and tracking chart which maps the training that all home visiting programs need, as well as model-specific trainings.
- Seek opportunities to deliver common trainings to models in collaboration settings.
- Understand the capacity of community level supports for cross-model training and professional development.

Considerations for Planning

1. What are the model-specific professional development supports in place?

REGIONAL HOME VISITING SYSTEM

Robin Hill-Dunbar, MS
Senior Program Officer
Department of Children, Youth and Families
The Ford Family Foundation

Callie H. Lambarth, MSW
Senior Research Associate
Center for Improvement of Child and Family Services
School of Social Work
Portland State University

Theory of Action (Phase 3)

Rural Home Visiting

System Coordination Project

Values

"Trusting relationships are vital to systems change

Family voice, engagement and choice are central to informing decision-making in system change

Data is essential to guide, inform, and assess progress toward goals

Home visiting systems are most effective when they align regional efforts to statewide early learning initiatives

Systems equitably address needs of all families, especially those historically underserved or marginalized"

Mission

To improve the system and coordination of accessible, culturally affirming, quality home visiting programs and family support services so that more children and families are served.

Vision

"Children are raised in healthy, stable, and attached families

The early learning system is aligned, coordinated, and family-centered"

If investments are made in these

RESOURCES

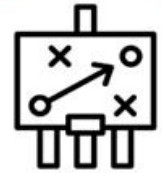
"Minimum, one full FTE per region for dedicated coordination and related activities

Consultants who provide:

- Project management
- Coaching
- Technical assistance
- Evaluation, data utilization support
- Facilitation

Training, consultation, and coaching for coordinators, home visitors, home visiting leaders, and system partners

Monetary and in-kind contributions from sponsoring/backbone organizations, philanthropic, and state/local partners"



So grantees with partners can implement these

STRATEGIES

Develop and utilize internal communication processes across home visiting models and system partners

Develop, and/or integrate, a coordinated home visiting and family support program intake/referral process

Create and maintain a shared professional development plan

Develop and share a unified external communication plan

Then local communities can build and sustain these

CAPACITIES

Leadership, governance, and/or advisory structures convene and engage system partners

System partners regularly participate in relationship-building and networking opportunities

HV and family support programs throughout the region use a shared intake/referral processes

A comprehensive inventory of the region's home visiting and supplemental family support services is maintained

HV and family support programs throughout the region jointly invest in home visiting professional development opportunities

HV Systems partners work together to implement an aligned home visiting and supplemental family support services awareness campaign

So that communities can realize these

RESULTS

System partners are engaged in and work collaboratively to shape and share a vision for HV system coordination

Trusting relationships exist between HV models and system partners

"Families experience improved access to home visiting and family support services

Ineligible families or those on wait lists are systematically referred to supplemental family support services"

Home visitors, home visiting leaders, and system partners equitably access and participate in shared, competency-based professional development

System partners and parents/caregivers are increasingly aware of availability, accessibility, and benefits of the array of home visiting and family support services in the region

Evaluation Overview

School of Social Work
PORTLAND STATE UNIVERSITY

Why Evaluate?

Inform the pathway

Support the steps

Describe the footprints

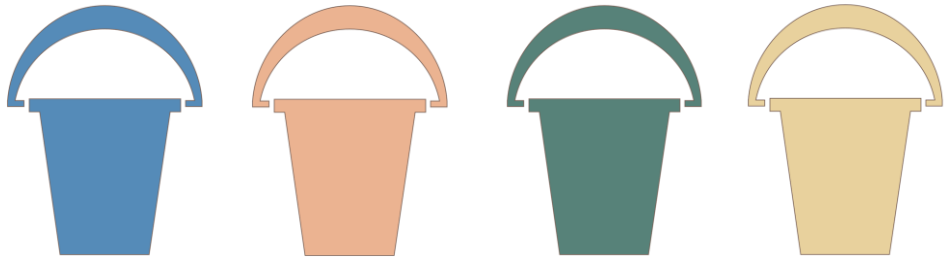
Tell the Story

Home Visiting System Coordination (HVSC) Project Cross-Region Evaluation Activities

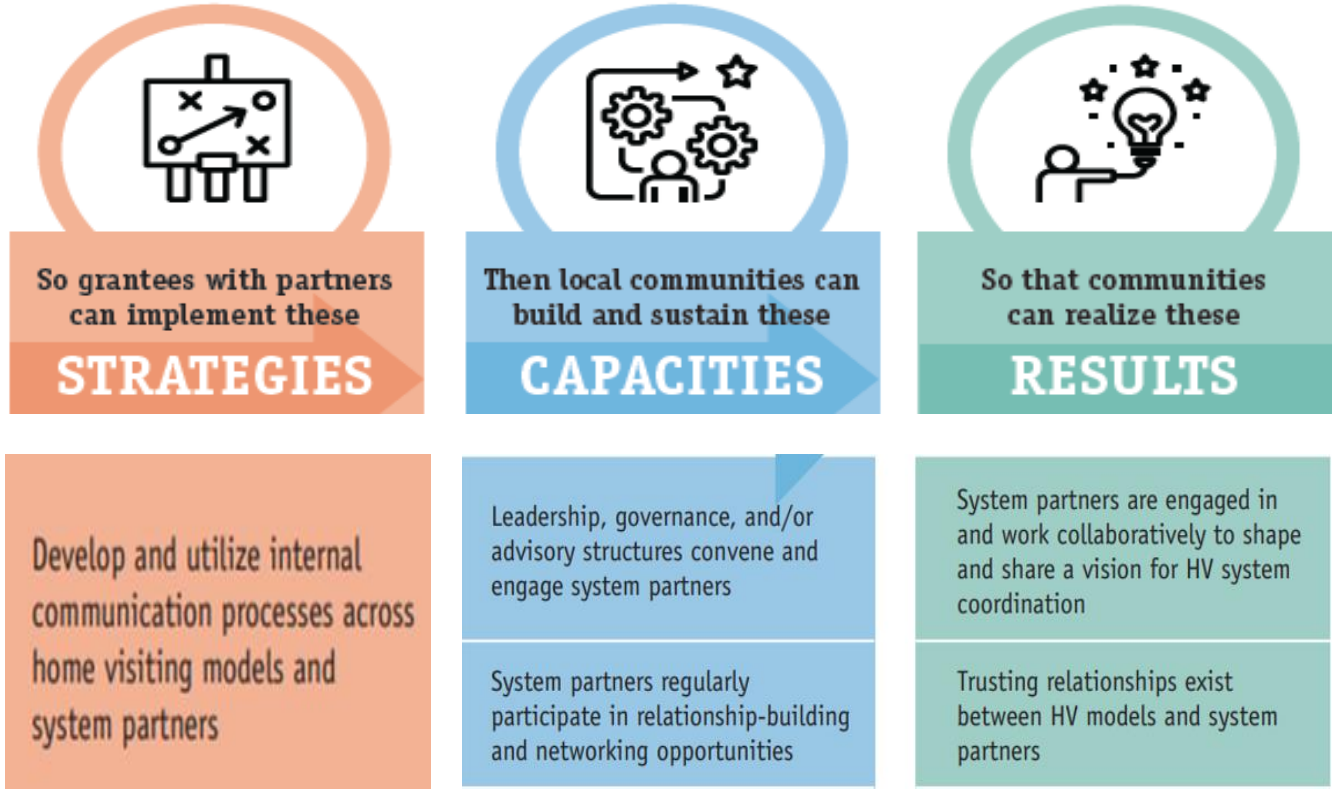
	Project Start 2016	2017	2018	2019	2020	2021	2022	Ad hoc / Ongoing
Stakeholder Interviews	X	X		X	X	X		
Stakeholder Systems Survey	X	X	X	X	X	X	X	
Stakeholder Focus groups	X	X	X	X				
Family Voice Journey Mapping						X		
PD Data Synthesis							X	
Provider & family stories								X
Plan-Do-Study-Act (PDSA) cycles								X
Professional Development Survey		X						
Community Awareness Survey				X				

The Four Buckets of Work

Our Focus & Our Journey



- ✓ Internal Communications
- ✓ Intake and Referral
- ✓ Professional Development
- ✓ External Communications



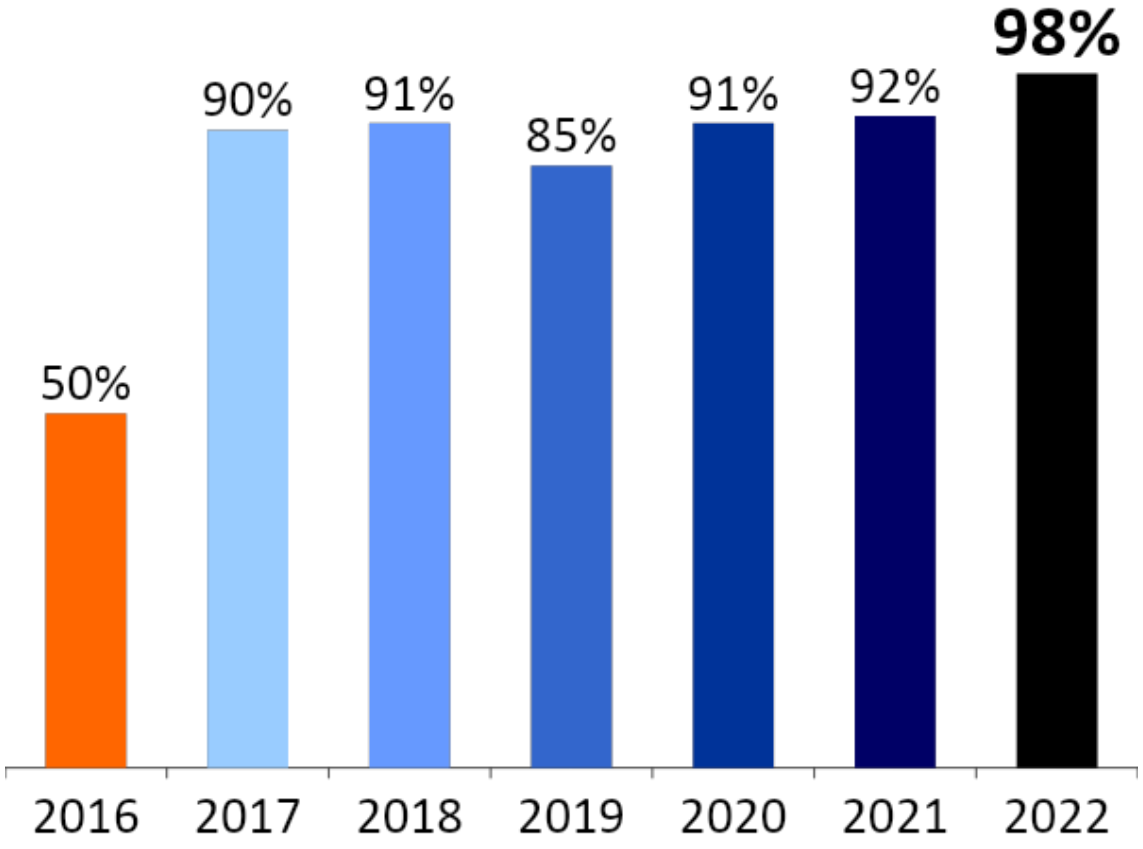
Internal Communications

Internal Communication Lessons

- Cross-sector stakeholder engagement plan and structure helps work take shape
- Time and space to cultivate trusting relationships is vital to collaborative work
- A dedicated position with a neutral convener helps bring stakeholders together and is needed to facilitate these processes

Shared Leadership & Collaboration

HV program leaders are effective at working together to improve the overall HV system

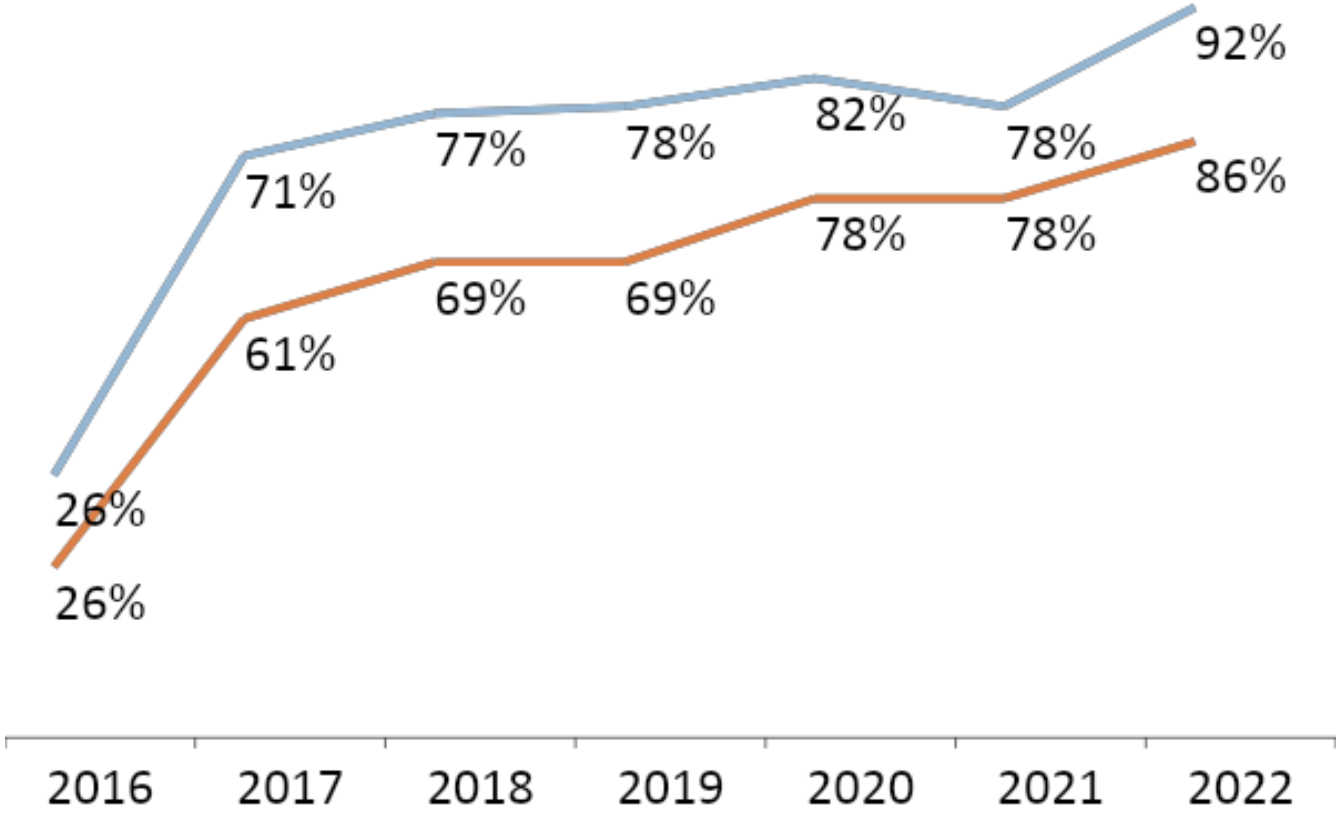


"We are incredibly lucky to work with all the HV partners – together everyone achieves more!"

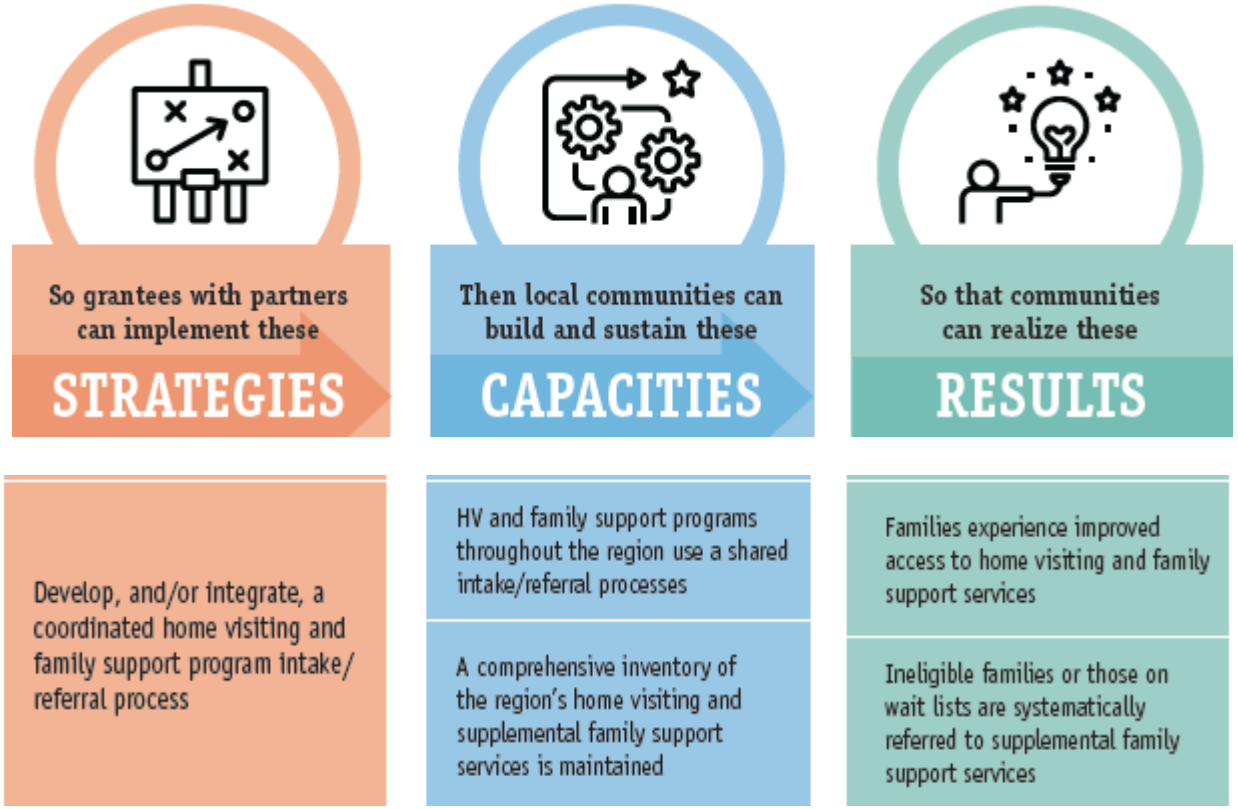
Internal Communication

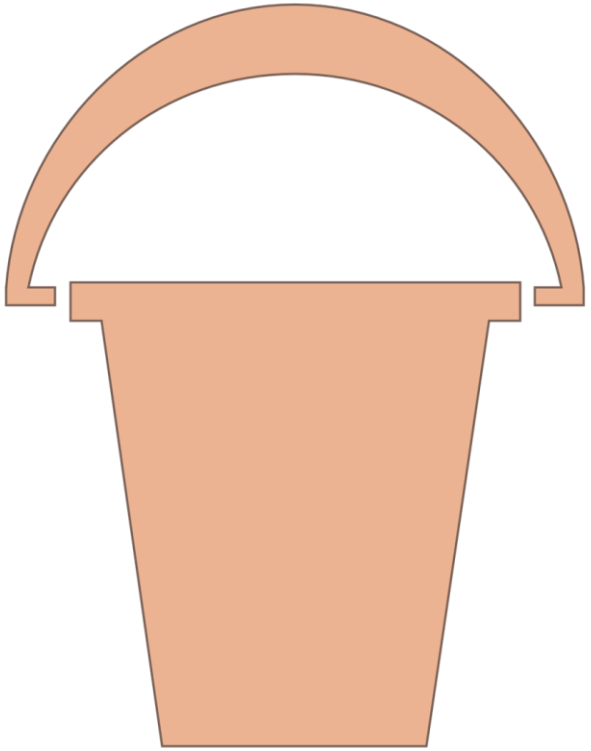
There is effective communication between HV program leadership in the region

There is effective communication between HV leaders and HVs in the region



"We have been working together and supporting each other in issues that we all are facing with the COVID restrictions, stress and dealing with families that are overwhelmed with the constant change to how services can be provided."





Coordinated Intake & Referral

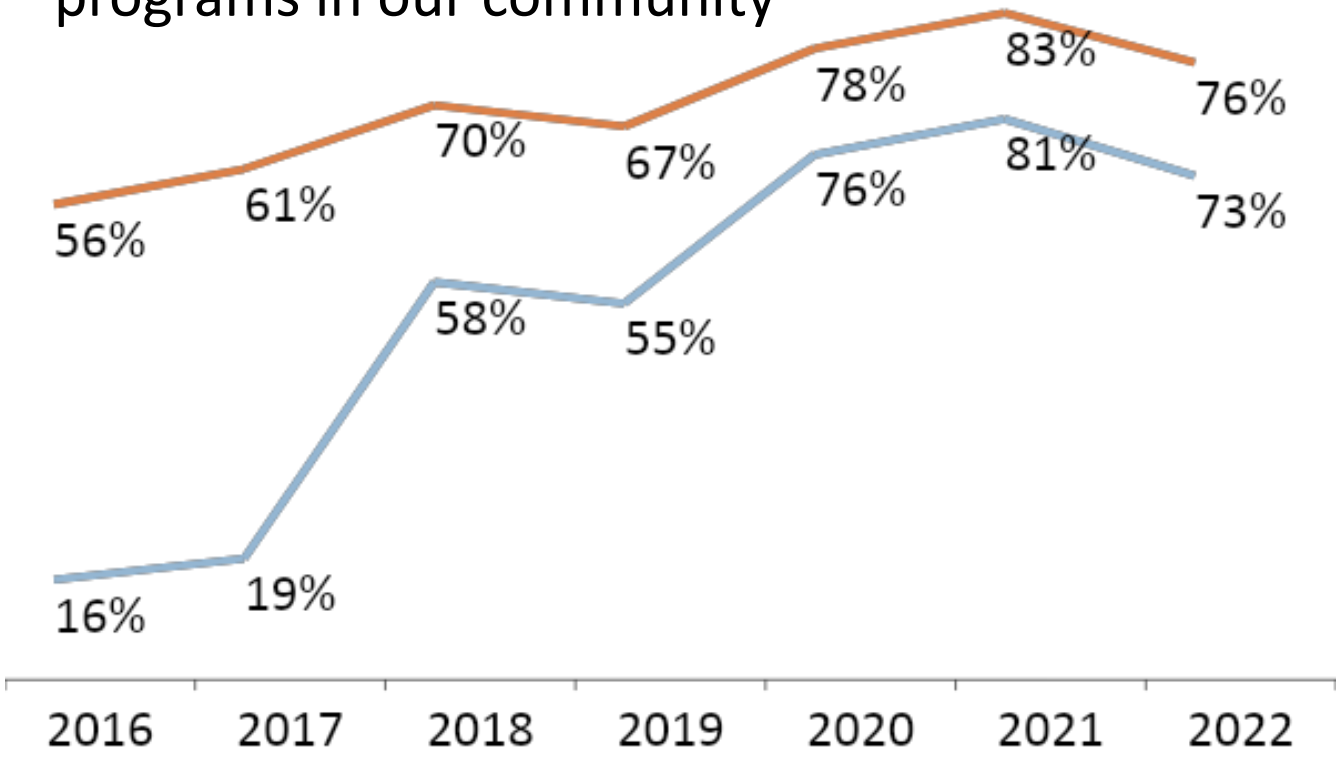
Coordinated Intake & Referral Lessons

- Foundational trusting relationships enable this work to unfold more effectively
- Start small with pilot processes then expand
- MOUs/MOAs can clarify expectations and investments of partners

Coordinated Referral

Our community uses a shared/common referral form to facilitate family access to HV services.

There are effective informal referral agreements between/among HV and other programs in our community

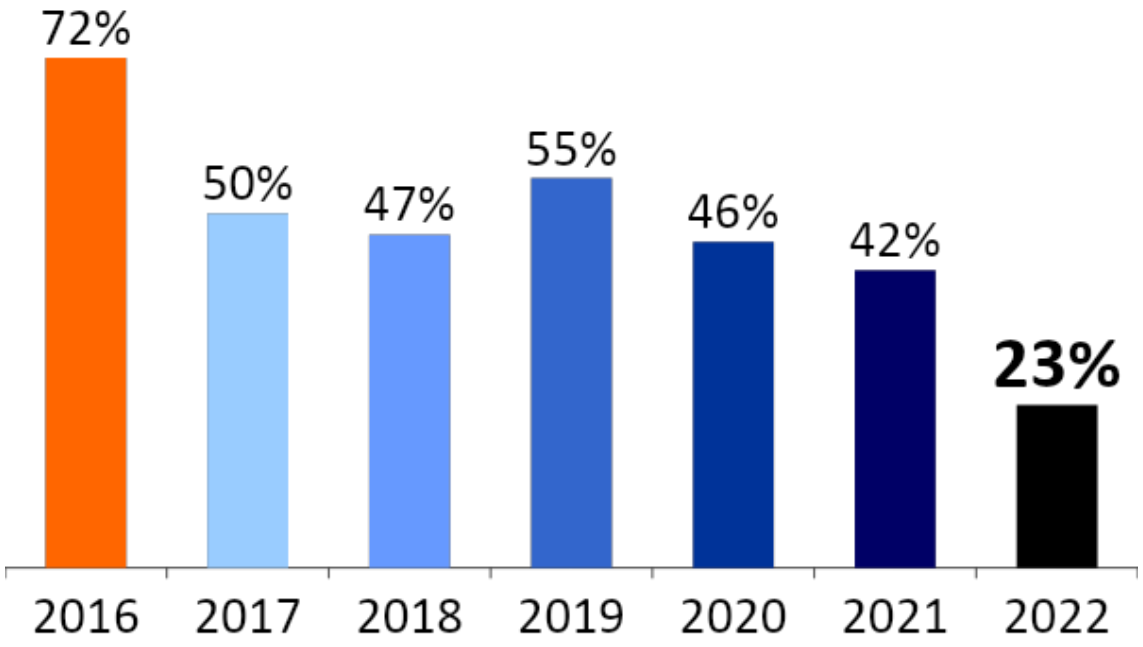


"I think it has helped that with the referral system, families have been able to be connected to services that they may not have been aware of."

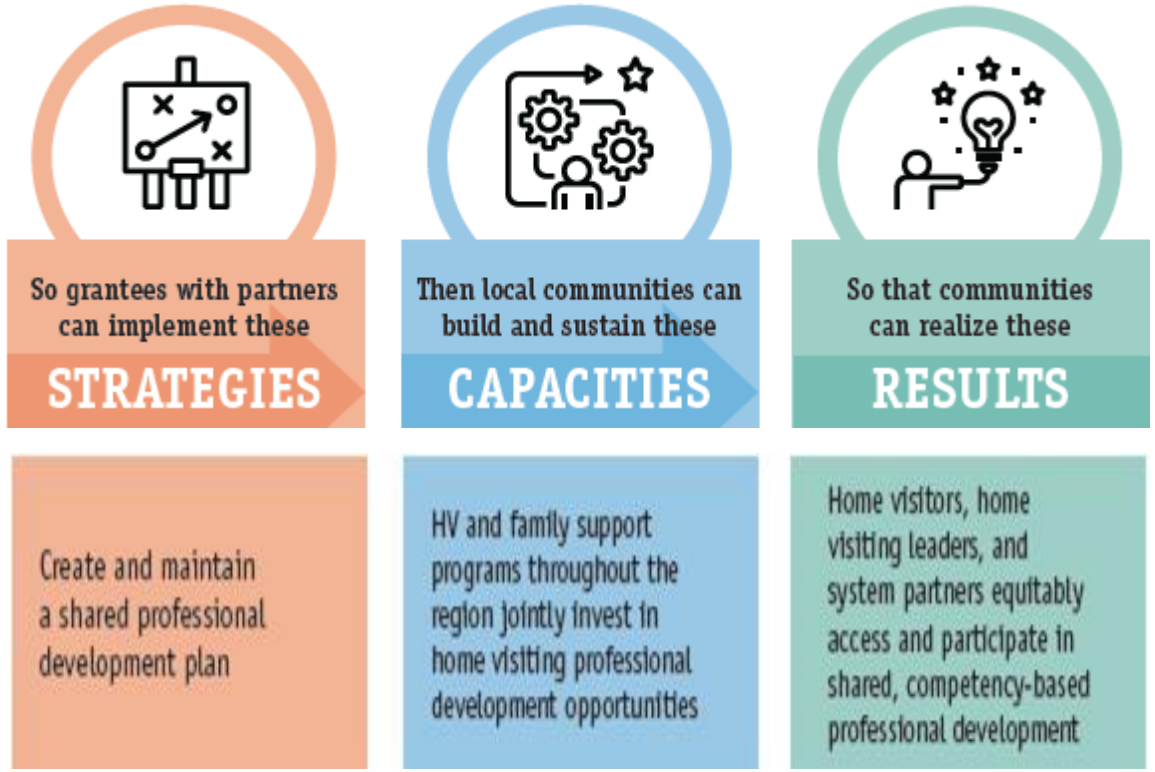
Coordinated Referral

Current HV program MOUs/MOAs need improvement.

(Lower % reflects improvement towards this goal)



"I appreciate the referrals we receive. I believe the system is a great relief to families who are connected."



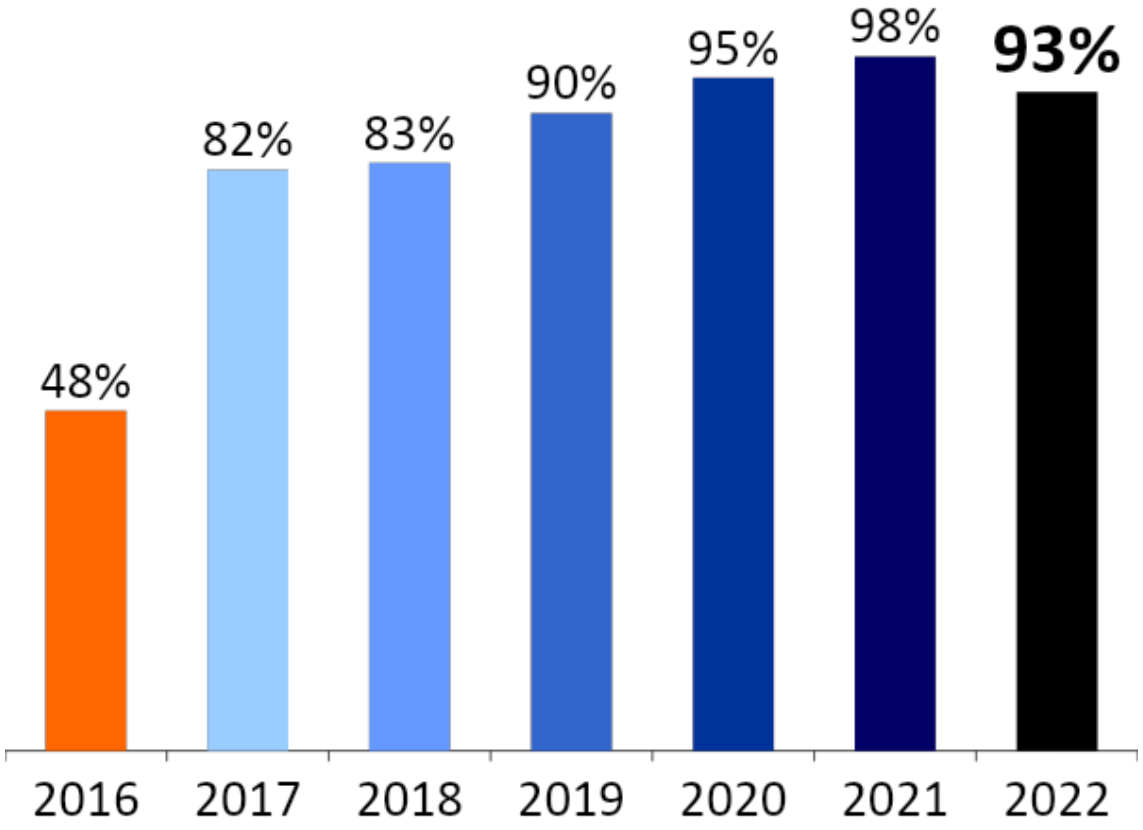
Shared Professional Development

Shared PD Lessons

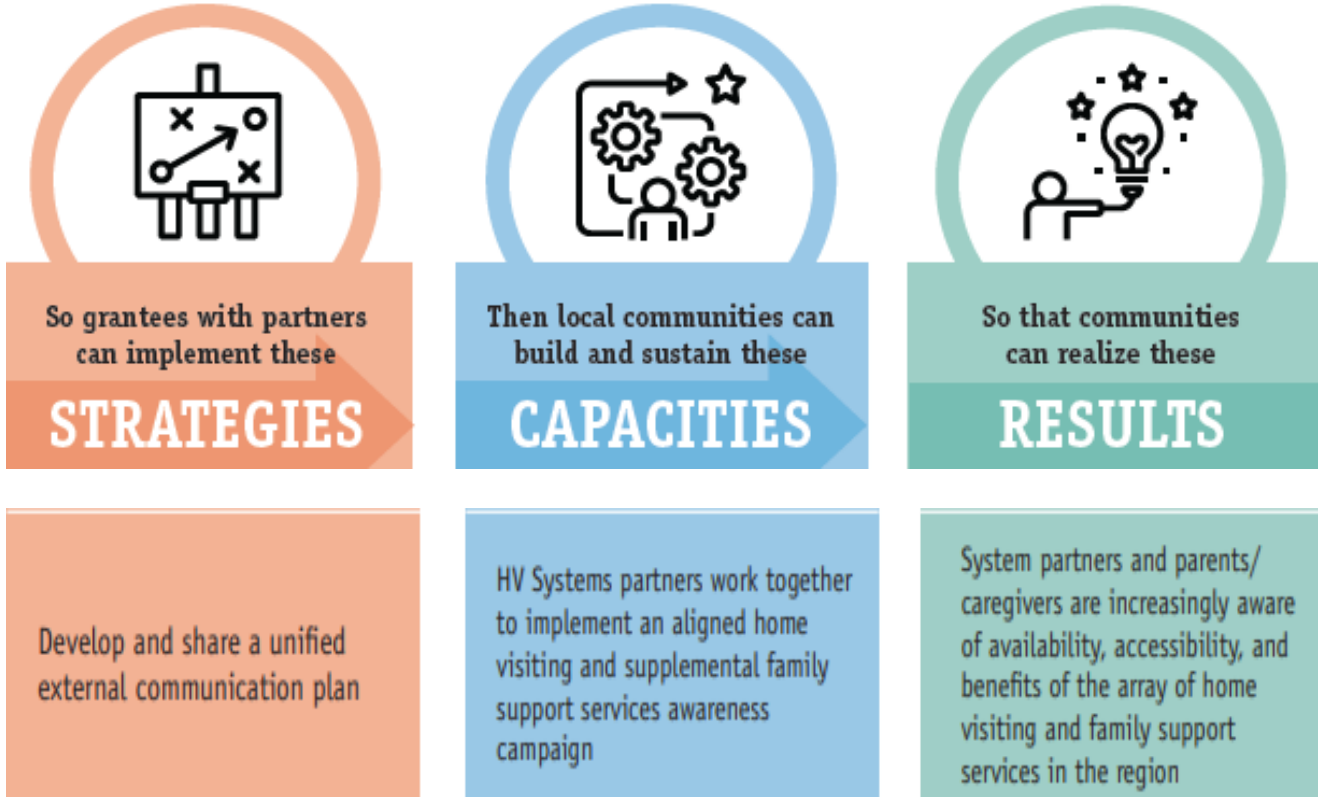
- Assessing workforce and community needs and strengths informs the planning process
- PD offered as series as through cohorts can have a deeper impact on practice
- Sharing PD resources creates more equitable access to opportunities across programs

Shared PD Plan

The HV system effectively shares professional development and training resources.



"I think that what we found in the beginning was everybody was doing their own thing. And now, people realize that we get more synergy by working together."



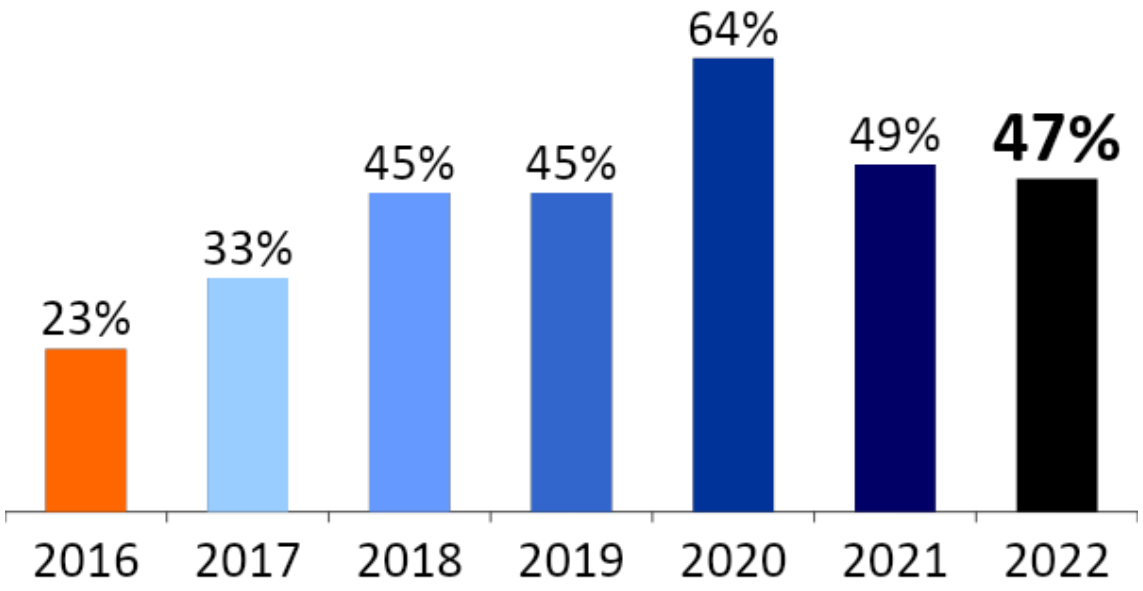
Unified External Communication

External Communication Lessons

- Parents/caregivers have unique insights about programs and their experiences are important to understand
- Unified messaging can benefit programs and families
- Many families and community partners still are not aware of HV supports available

Community Awareness

Families in our community know about HV programs and services.



"Extra effort has been focused on filling all available HV openings across the county and increasing awareness of the programs available to the community...given that HV program efforts were hindered by COVID for some time."

Theory of Action (Phase 3)

Rural Home Visiting System Coordination Project

Values

"Trusting relationships are vital to systems change

Family voice, engagement and choice are central to informing decision-making in system change

Data is essential to guide, inform, and assess progress toward goals

Home visiting systems are most effective when they align regional efforts to statewide early learning initiatives

Systems equitably address needs of all families, especially those historically underserved or marginalized"

Mission

To improve the system and coordination of accessible, culturally affirming, quality home visiting programs and family support services so that more children and families are served.

Vision

Children are raised in healthy, stable, and attached families

The early learning system is aligned, coordinated, and family-centered"

If investments are made in these

RESOURCES

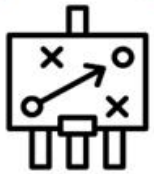
"Minimum, one full FTE per region for dedicated coordination and related activities

Consultants who provide:

- Project management
- Coaching
- Technical assistance
- Evaluation, data utilization support
- Facilitation

Training, consultation, and coaching for coordinators, home visitors, home visiting leaders, and system partners

Monetary and in-kind contributions from sponsoring/backbone organizations, philanthropic, and state/local partners"



So grantees with partners can implement these

STRATEGIES

Develop and utilize internal communication processes across home visiting models and system partners

Develop, and/or integrate, a coordinated home visiting and family support program intake/ referral process

Create and maintain a shared professional development plan

Develop and share a unified external communication plan

Then local communities can build and sustain these

CAPACITIES

Leadership, governance, and/or advisory structures convene and engage system partners

System partners regularly participate in relationship-building and networking opportunities

HV and family support programs throughout the region use a shared intake/referral processes

A comprehensive inventory of the region's home visiting and supplemental family support services is maintained

HV and family support programs throughout the region jointly invest in home visiting professional development opportunities

HV Systems partners work together to implement an aligned home visiting and supplemental family support services awareness campaign

So that communities can realize these

RESULTS

System partners are engaged in and work collaboratively to shape and share a vision for HV system coordination

Trusting relationships exist between HV models and system partners

"Families experience improved access to home visiting and family support services

Ineligible families or those on wait lists are systematically referred to supplemental family support services"

Home visitors, home visiting leaders, and system partners equitably access and participate in shared, competency-based professional development

System partners and parents/ caregivers are increasingly aware of availability, accessibility, and benefits of the array of home visiting and family support services in the region

Reflections & Questions

THE Ford Family FOUNDATION

School of Social Work
PORTLAND STATE UNIVERSITY

REFLECTIONS FROM…

Beth L. Green, Ph.D.

Research Professor
Director of Early Childhood & Family Support Research
Center for Improvement of Child and Family Services
School of Social Work
Portland State University

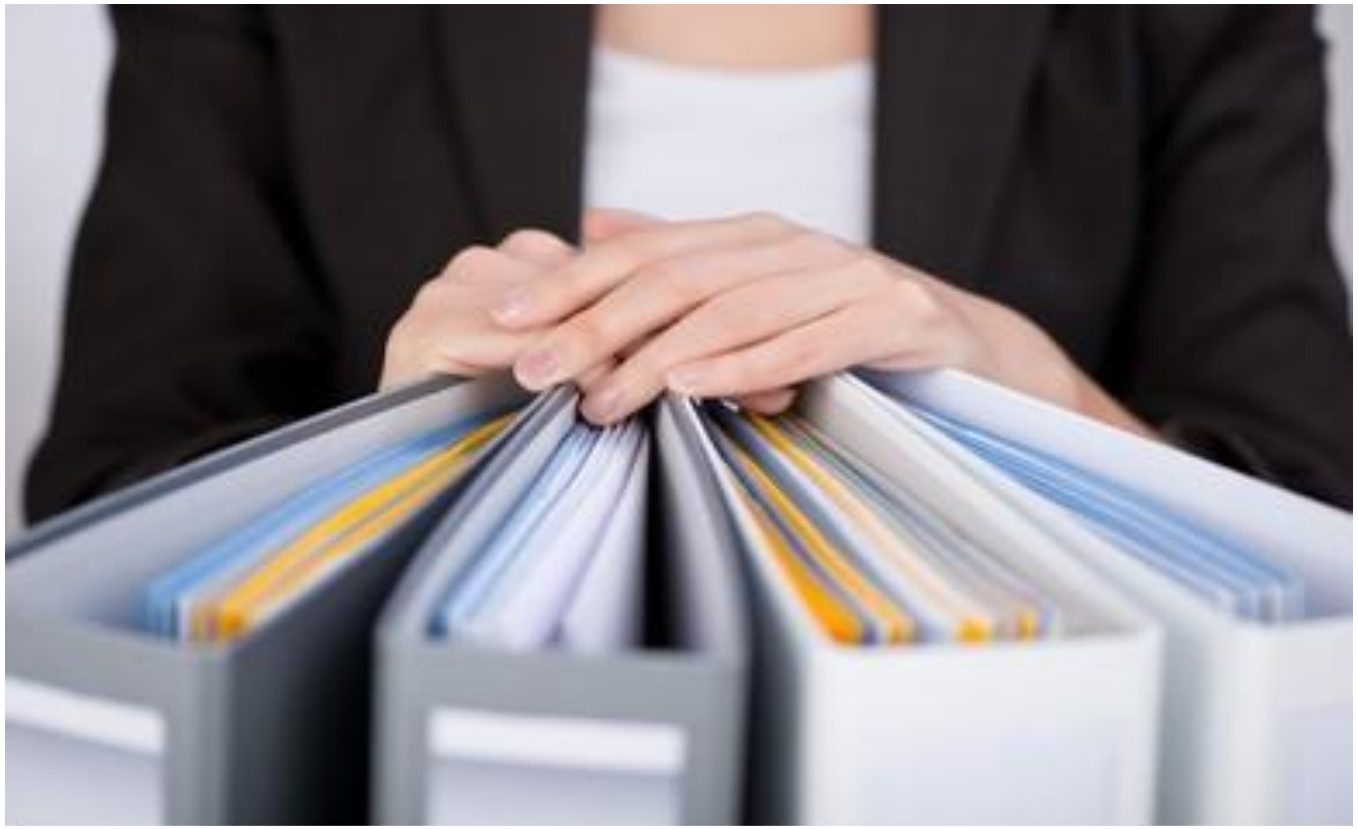
Reflections on the Role of State Leadership in Home Visiting Systems Change

Beth Green, Director of Early Childhood & Family Support Research
Portland State University

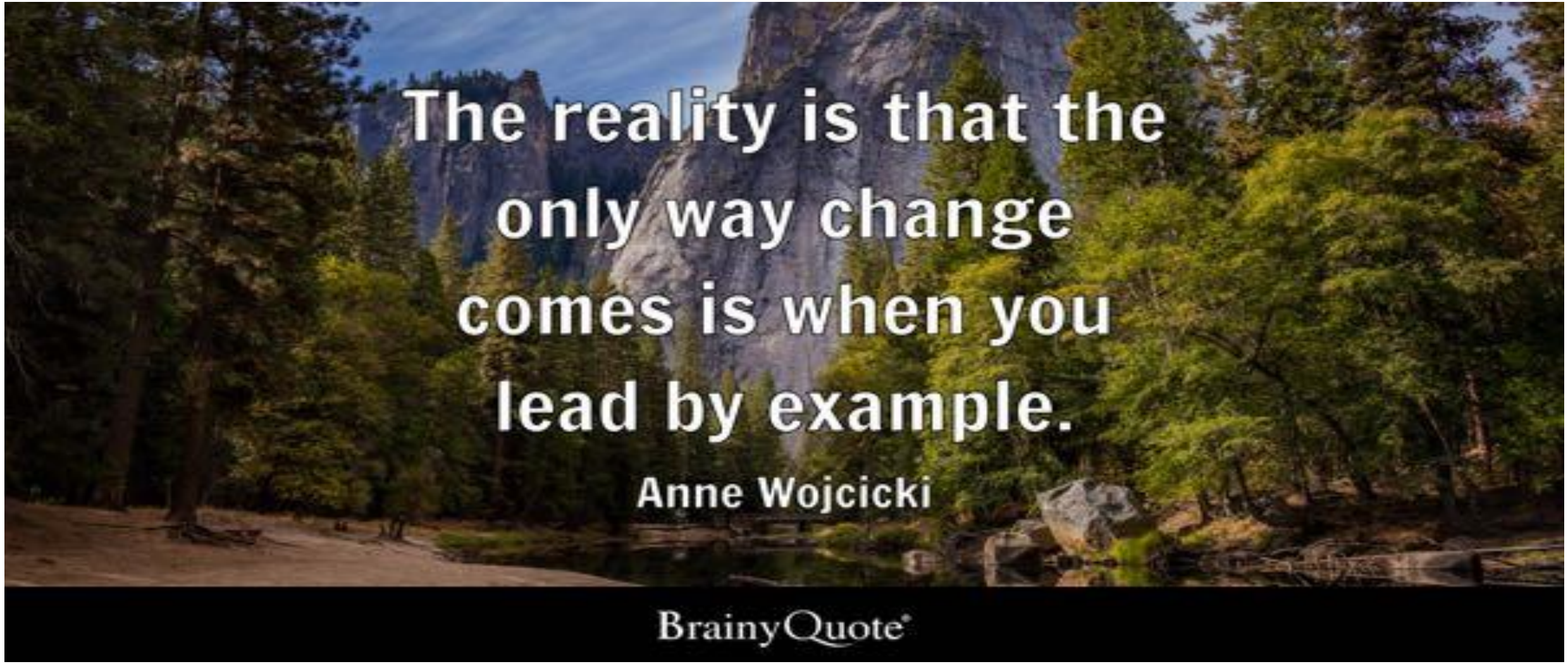
Untangling the knots takes time

What Matters to Families?

What Doesn’t Matter?



What Helps Local Leaders?



What Should We Let Go?

What Should We Embrace?

REFLECTIONS AND DISCUSSION

Would be great to hear from each of our Committee members.

Please, share one reflection and/or one question that's coming up for you from the presentations.

Share verbally or in the chat.

WRAP-UP - HOMEWORK

Suggested Homework

- Read
  - TFFF HVSC 2021 Cross-Region Summary (in packet)
  - **Key Findings** within the Region X Home Visiting Workforce Study (in packet)
  - Highlights from Home Visiting Systems Interviews (forthcoming)
  - Phase 1 and Phase 2 Working Team (forthcoming)
- Home Visiting State Systems 'Lessons Learned' (possible recording forthcoming)
- Respond to any surveys that come your way between now and Dec 8th

WRAP-UP – CLOSING REMARKS

ELC Home Visiting System Committee Membership
October 3, 2022

Peter Buckley, Co-chair
ELC Member
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Peg Miller, M.D., Co-chair
ELC Member
Pediatrician
Child abuse medical examiner, Juliette's House
Member, Yamhill Early Learning Hub
Board Member, Head Start of Yamhill County
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Director, Early Learning Hub of Central Oregon
Involved in MIECHV, Early Head Start, Healthy Families Oregon, Family Connects
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Benjamin Hazelton, HVS Working Team Co-chair
Home Visiting Policy & Systems Director, Center for Prevention and Health Promotion, Public Health Division
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Ruby Ramirez, HVS Working Team Co-chair
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Remember Watts
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Ruby Ramirez, Oregon Community Foundation, Program Officer Early Childhood	rramirez@oregoncf.org	Statewide	Team Lead
Shannon Armstrong, Immigrant and Refugee Community Organization, Manager	shannonA@irco.org	Malheur	
Abby Bush, Providence, Project Manager CORE	Abby.Bush@providence.org	Metro and Statewide	
Kerry Cassidy - Norton, OHA, HV Workforce Development Coordinator	KERRY.L.CASSIDYNORTON@dhsoha.state.or.us	Statewide	
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Coordinator for South Central ELH			
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Maria Weer, ED Building Healthy Families	mweer@oregonbhf.org	Wallowa Baker Malheur	
Kara Williams, ODE, EI/ECSE	kara.williams@ode.oregon.gov	Statewide	

Support People

Administrative Support: Kelli Taylor (they/them), Early Learning Division, kelli.taylor@ode.oregon.gov
Consultant: Christy Cox (she/her), media_noche7@hotmail.com

ELC Home Visiting System Committee Overview

September 29, 2022

ELC Home Visiting System Committee Statement of Purpose:

The ELC Home Visiting System Committee's (HVS Committee) purpose is to advance the development of Oregon's statewide comprehensive home visiting service network. This includes work to generate and sustain momentum for a coordinated and equitable system of home visiting; to engage responsible state agencies and their partners in the development and implementation of a coordinated and equitable system; and to ensure effective collaboration on governance and administration across government entities, funders and home visiting partners. The HVS Committee shall be a standing committee of the ELC.

The ELC HVS Committee will be supported by a subcommittee, the Home Visiting System (HVS) Working Team, which shall propose recommendations for system reform to the Committee. The Working Team shall proactively include the contribution of families through the engagement of existing local family committees as well as family voice reports as it moves its work forward. The HVS Committee will review, evaluate and may amend these recommendations and then forward those that they endorse to the Early Learning Council for adoption and advocacy. The Working Team shall have a limited duration of one year, and its members may independently support future implementation efforts.

Membership of HVS Committee:

Membership shall consist of: members of the Early Learning Council, as appointed by the chair and who will serve as chairs of the Committee; senior representatives of the Oregon Health Authority, the Early Learning Division, the Oregon Department of Education, the Oregon Department of Human Services, and Oregon Housing and Community Services; a representative of Oregon Early Learning Hubs; and representatives of nonprofit or philanthropic organization(s) and of the Oregon Tribes. Others may be appointed at the discretion of the ELC chair. The co-chairs of the HVS Working Team shall participate as ex officio members.

Responsibilities of HVS Committee:

The Committee shall advance the development of a comprehensive, coordinated, equitable home visiting service network for Oregon's pregnant women and people and families with young children. The Committee shall:

- evaluate recommendations for system development presented by the Home Visiting Working Team
- finalize recommendations for adoption and forward them to the Early Learning Council
- support implementation of recommendations adopted by the Early Learning Council

- keep the Early Learning Council, Health Advisory Board and Children's Cabinet apprised of the progress made by the Committee and Working Team, and provide support for implementation as appropriate
- meet as needed, approximately quarterly

The chair(s) of the HVS Committee shall appoint the co-chairs of the HVS Working Team in consultation with the ELC Chair.

Home Visiting System Working Team Statement of Purpose:

The purpose of the Home Visiting System Working Team is to achieve and promote a comprehensive continuum of voluntary, coordinated, equitable home visiting services. Its core work is to bring actionable recommendations to the ELC HVS Committee for discussion and consideration, and to support implementation of final recommendations adopted by the Early Learning Council.

Membership of the Working Team:

The Working Team shall consist of those who are leaders in the development of early learning systems with knowledge of home visiting for Oregon's pregnant families and families with young children. It will include representatives from public and private agencies, Oregon Tribes, providers of services, advocates, and funders who actively support the mission of the Working Team and the ELC HVS Committee.

Responsibilities of the Working Team:

The HVS Working Team shall work to identify elements of a comprehensive continuum of coordinated, equitable home visiting services and shall bring actionable recommendations to the HVS Committee for discussion and adoption.

The Home Visiting System Working Team shall:

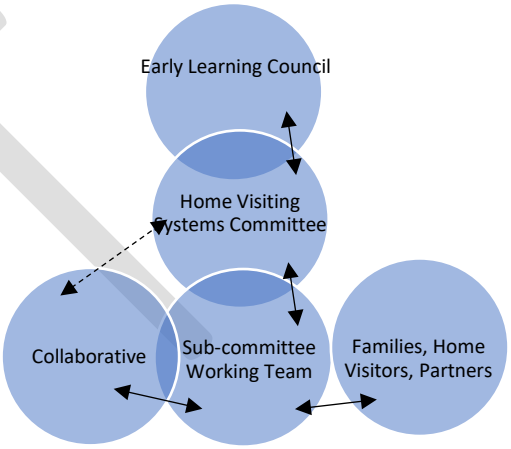
- identify and agree upon components of a comprehensive home visiting network
- describe the home visiting service network that currently exists in Oregon in order to integrate and promote a comprehensive continuum of home visiting services
- amplify family and community voices in co-creation and decision-making, emphasizing racial and ethnic voices that have been underrepresented
- identify barriers, along with solutions, to achieve a well-coordinated home visiting system that provides community- and family-centered, culturally appropriate, service delivery to pregnant families, families with young children
- prioritize strategies and recommendations for advancement to the HVS Committee - include staffing, communication strategies, funding and other resource needs to implement the recommendations
- work cooperatively with each other, the ELC Home Visiting System Committee, the Home Visiting Collaborative, and any consultants
- invest the time necessary to provide information and data in a timely manner to advance the work

- meet monthly for up to 12 months; this is a limited-duration group

Relationship Between the HVS Committee, Working Team, and the Collaborative*

There is overlapping membership among these 4 groups:

- Two members of the Early Learning Council co-chair the ELC HVS Committee.
- The co-chairs of the Working Team (WT) are ex officio members of the HVS Committee.
- A few members of the Working Team are members of the Collaborative and can act as a bridge/offer continuity between the two groups.
- Families, Home Visitors, and Home Visiting Partners are an important part of the work of all of these groups.



Communication: Information flows in many directions as denoted by double-headed arrows in the graphic on this page.

- The co-chairs of the Working Team ensure that information, resources, reports, updates are shared between families, home visitors, and community partners, the Working Team and the Committee AND between the Working Team and the Collaborative.
    - The Working Team will prioritize the use of as many *existing* primary data sources that include primary caregivers' and home visitors' experiences. The WT will also seek diverse feedback during the process from existing family/home visiting groups.
    - The Collaborative's members are home visiting program/model experts and are a critical part of the state's early learning sector because they have in-depth knowledge and experience about home visiting generally and their programs particularly. Their expertise is needed for the WT's successful creation of meaningful, actionable recommendations for the ELC HVS Committee to take to the ELC. And beyond!
        - Into the Future: As the WT sunsets, the Collaborative is in a position to help with implementation of the recommendations and to serve as a long-term partner to the state in offering ongoing expertise and guidance. Denoted by dash-line arrow in graphic above.

*The Collaborative was formed organically with leadership by the MIECHV State Lead. It is a long-term, informal group with representatives from agencies and associations across Oregon's home visiting service network. Members, like statewide home visiting model leads and associations, meet quarterly. The group is focused on building trusting relationships between state-level home visiting agency-leads and associations in order to strengthen Oregon's home visiting network.

ELC Home Visiting System Committee Charter

September 19, 2022

Committee Charge:

The ELC Home Visiting System Committee's (HVS Committee) purpose is to advance the development of Oregon's statewide comprehensive home visiting service network. This includes work to generate and sustain momentum for a coordinated and equitable system of home visiting; to engage responsible state agencies and their partners in the development and implementation of a coordinated and equitable system; and to ensure effective collaboration on governance and administration across government entities, funders and home visiting partners. The HVS Committee shall be a standing committee of the ELC.

The ELC HVS Committee will be supported by a subcommittee, the Home Visiting System (HVS) Working Team, which shall propose recommendations for system reform to the Committee. The Working Team shall proactively include the contribution of families through the engagement of existing local family committees as well as family voice reports as it moves its work forward. The HVS Committee will review, evaluate and may amend these recommendations and then forward those that they endorse to the Early Learning Council for adoption and advocacy. The Working Team shall have a limited duration of one year, and its members may independently support future implementation efforts.

Committee Composition:

Membership shall consist of:

- member(s) of the Early Learning Council, as appointed by the chair;
- senior representatives of the Oregon Health Authority, the Early Learning Division, the Oregon Department of Education, the Oregon Department of Human Services, and Oregon Housing and Community Services;
- a representative of Oregon Early Learning Hubs; and
- representative(s) of nonprofit or philanthropic organization(s).
- Oregon tribes will be invited to appoint a member.

Others may be appointed at the discretion of the ELC chair.

The chair (co-chairs) of the HVS Working Team shall participate as ex officio member(s).

Responsibilities of HVS Committee:

The Committee shall advance the development of a comprehensive, coordinated and equitable home visiting service network for Oregon's pregnant families with young children. The Committee shall:

- evaluate recommendations for system development presented by the Home Visiting System Working Team
- finalize recommendations for adoption and forward them to the Early Learning Council
- support implementation of recommendations adopted by the Early Learning Council
- keep the Early Learning Council, Health Advisory Board and Children's Cabinet apprised of the progress made by the Committee and Working Team, and provide support for implementation as appropriate

The chair(s) of the HVS Committee shall appoint the chair (co-chairs) of the HVS Working Team in consultation with the ELC Chair.

Frequency and Duration of Meetings:

The Committee will meet as needed, approximately quarterly.

Staff Support and Roles:

In the initial phases of the Committee's work, a Home Visiting Consultant shall provide substantive support to the Committee, working in collaboration with the BUILD Initiative team supporting Oregon.

The ELC Administrator shall provide notice of all meetings and ensure that public accountability and transparency provisions applicable to the Council are met.

Additional staff support will be provided by agency partners as needed.

Portland State UNIVERSITY

Oregon Health Authority

Oregon Statewide Maternal, Infant & Early Childhood Home Visiting Program 2020 Needs Assessment

Appendix C. Overview of Oregon's Home Visiting Program Models

Home Visiting Program & Mission	Lead Agency	Funding	Point of Entry	Ages Served	Target Population/ Eligibility Requirements	Geographic Areas Served	HRSA Evidence-Based?
Babies First! Optimal development and overall health, case management, safety net for children who don't qualify for other programs	Oregon Health Authority, Maternal & Child Health Local public health departments	State General Funds Medicaid Targeted Case Management & Administrative Claiming, Local Health Departments Federal funding formula, leveraging Title XIX funds, other local funds	Referral during pregnancy or at birth from hospitals, WIC, physician, other pediatric public health clinics	Birth-5 years	Pregnant women, children birth to 5, with multiple risk factors, including chronic health conditions, dev. delay	Statewide	N
CaCoon Management of complex health conditions with improved functioning; care coordination	Oregon Center for Children & Youth with Special Health Care Needs (OCCYSHN)	Title V Block Grant Medicaid Targeted Case Management Medicaid Admin. Claiming	Referral from hospitals, pediatric providers, WIC, other LPHA community partners, and family self-referrals	Birth-21 years	Children and youth with special health care needs—triage based on needs	Statewide	N
Healthy Families Oregon Prevent child abuse and promote school readiness; healthy growth and development; supporting positive parent-child attachments using an infant mental health lens	State—Oregon Early Learning Division; OHA (MIECHV funded) Local—16 program sites corresponding with each of the 16 Early Learning Hub regions	State General Funds MIECHV Medicaid Admin. Claiming Some county general funds/small grants	Hospital screening, community-based referrals	Prenatal-3 or 5 years (locally determined)	Prenatal mothers or parents of newborns screened w/two or more risk factors (demographic/ psychosocial); optional additional local criteria	Statewide except for one county	Y
Relief Nurseries Prevent child abuse and develop positive parent-child bonding and attachment; child development	State—Oregon Association of Relief Nurseries, Oregon Early Learning Division Local—Varies	State General Funds Title XX Early Learning Account (SSA) Local county and other grant funds Local fundraising	Various referral sources	Prenatal-6 years	Children at high risk for child welfare involvement, 5 risk factors for abuse and neglect, triaged for demographic/family/ psychosocial risk	Statewide: 20 counties (except Clatsop, Columbia, Tillamook, Wasco, Sherman, Gilliam, Wheelier, Morrow, Union, Wallowa, Coos, Curry, Lake, Harney)	N
Family Support & Connections Child abuse and neglect prevention; reduce families entering child welfare system; provide parenting education and support development of parental protective factors	State—Oregon Department of Human Services Self-sufficiency Programs Local—Central Office	Community-Based Child Abuse Prevention Funds Federal Funds State General Funds	DHS—ODHS Self-sufficiency local programs	Parents with children between 0-18	TANF families at-risk of child welfare intervention with 10% of slots for non-TANF families; all families must meet TANF eligibility	Statewide Variety of local community organizations	N

Overview of Oregon's Home Visiting Program Model CONT.

Home Visiting Program & Mission	Lead Agency	Funding	Point of Entry	Ages Served	Target Population/ Eligibility Requirements	Geographic Areas Served	HRSA Evidence-Based?
Nurse Family Partnership Child Health & Development and Self-Sufficiency	Oregon Health Authority, Maternal and Child Health Local public health departments	MIECHV Local county general funds and grants Medicaid, targeted case management Variety: county general, Medicaid, Targeted Case Mgt. Healthy Start prior to Healthy Families America	WIC, prenatal providers, health care providers	Prenatal-2 years	First births, < 28 weeks gestation, Low income, ? Teen mothers?	9 Counties: Washington, Multnomah, Yamhill, Lincoln, Lane, Jackson, Deschutes, Umatilla/Morrow	Y
Early Head Start, Oregon Prekindergarten Prenatal-3 years Home-Based Model Promote healthy prenatal outcomes, enhance development, healthy family functioning, parent-child bonding	State—Oregon Early Learning Division and Office of Head Start Region X Local—State and Federal Grantees	Federal with match (20% in-kind) State General Funds	Various community referrals, self-referral	Prenatal-3 years	<100% FPL, up to 10% over income; families who are homeless, foster children, families on public assistance automatically eligible; priority for children with special needs	Expansion currently with state funding 30 eligible grantees; in addition, migrant and tribal grantees	Y
Head Start, Oregon Prekindergarten Home-Based Model Mostly similar [to EHS] unless noted				3-5 years			
Parents As Teachers (PAT) Home-Based Model	Varies: county and other general funds, grants	Unknown/varies	Various referrals	Prenatal-5 years	Varies		Y

Home Visiting Programs in Oregon	as of July 1, 2022										
Name	**Description**	**Participation eligibility**	**Funder (FF, GF, OF) and $ mount per biennium**	**Location of services**	**Audience**	**Life Stage**	**Home Visitor Provider requirments (e.g. license, training, certification, educational degrees, etc.)**	**Data System Use**	**Website**	**Capacity (# of families that could be served at any given point**	**Program contact**
Early Head Start (EHS)									https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs#about		
American Indian/ Alaska Native Head Start/ Early Head Start Home Based Program	Home visiting services to American Indian families with pregnant women and children birth to five with identified risk factors. Families receive weekly home visits focusing on building the parent child relationship, child growth and development, school readiness, family support, referrals for identified needs and self-sufficiency.			Umatilla, Coos, Polk, Yamhill, Lincoln, Multnomah, Marion, Jefferson, Wasco (https://eclkc.ohs.acf.hhs.gov/center-locator)	American Indian families with pregnant women and children birth to five with identified risk factors.	Prenatal to children five years old.					
Early Head Start/Head Start Home Based Option	Home visiting services to pregnant women and families with, infants, toddlers, and preschool children who are living in poverty and have a variety of risk factors. Head Start/ Early Head Start families receive weekly home visits focusing on supporting the parent child relationship, child growth and development, school readiness and family support, referrals for identified needs, and family self-sufficiency.		MIECHV	Multnomah, Washington, Lane, Hood River, Jefferson, Jackson, Marion, Coos, Curry, Umatilla, Clackamas, Polk, Linn, Benton, Josephine, Morrow (https://eclkc.ohs.acf.hhs.gov/center-locator)	Low-income pregnant women and families with children up to age 3	Prenatal to children three years old.		THEO	https://oregonearlylearning.com/early-head-start#:~:text=Children%20in%20foster%20care%2C%20homeless,eligible%20for%20Early%20Head%20Start.		
Migrant and Seasonal Early Head Start/ Early Head Start Home Based Option	Offers home visiting services to migrant and seasonal farm worker families with pregnant women and children up through age three who are living in poverty. Families receive weekly home visits focusing on building the parent child relationship, child growth and development, school readiness, family support, referrals for identified needs and self-sufficiency.		Oregon Child Development Coalition	Malheur, Marion, Multnomah (http://www.ocdc.net/locations/#Malheur%20County%20(List of more than home sites https://eclkc.ohs.acf.hhs.gov/center-locator)	Migrant and seasonal farm worker families with pregnant women and children up through age three who are living in poverty.	Prenatal to children three years old.			http://www.ocdc.net/programs/#:~:text=Migrant%20and%20Seasonal%20Head%20Start%20are%20for%20children%20of%20migrant,to%20be%20successful%20in%20school.		
Oregon Pre-Kindergarten (OPK)	OPK, by statute, follows the Head Start Program Performance Standards (HSPPS). Head Start (HS) and Early Head Start (EHS) programs promote children's development through services that support early learning, health, and family well-being. They focus on multigenerational approaches to poverty, family stability and empowerment, early childhood education, early detection of early intervention and special education needs, mental health and nutritional supports for the whole family.	A pregnant woman or child is eligible if, the family is at or below 130% FPL or the family is eligible for public assistance including SNAP and TANF child-only or the family is unhoused or the child is in foster care. If the family does not meet a criterion above, a program may enroll a child who would benefit from services, provided that	General Fund, Early Learning Account	30 OPK grantees, 25 are dually funded OPK and federal Head Start grantees (one Tribal Head Start, one Migrant Seasonal HS/EHS). 5 are state funded only.	see column						
Healthy Families Oregon (HFO):	A child abuse prevention program providing evidence-based intensive home visiting services to high risk families. The goals are to reduce child maltreatment, increase positive health outcomes, and improve school readiness. High risk families are identified through voluntary screening and offered intensive home visiting service.		MIECHV, State General Fund	Statewide (addresses on website)	Pregnant women and children 0 - 3	Prenatal to children three years old.		THEO	https://oregonearlylearning.com/healthy-families-oregon		2,035 families in 2018
Parents as Teachers (PAT)											
Nurse Home Visiting											
Babies First!	A public health nurse home visiting program that serves pregnant people and children 0-5 at risk for poor health and development outcomes. The program includes public health nurse assessments and screenings, development of a care plan, health education, case management, and referrals. Family participation is voluntary.	At risk (as defined by OR TCM SPA) prenatal women and children age 0 - 5 (population served largely Medicaid eligible)	State General Fund, Title V, TCM, local funds	All Oregon counties except Curry, Josephine, Multnomah, Umatilla, Wallowa.	no additional characteristics	Pregnant women and children up to age 5	Registered Nurse	ORCHIDS; THEO (postponed until 2021)	https://www.oregon.gov/oha/PH/HealthyPeopleFamilies/BABIES/HEALTHSCREENING/BABIESFIRST/Pages/index.aspx	1,200	
CAre COordinatiON (CaCoon)	A statewide public health program that focuses on community based Care COordinatiON for children and youth with special health care needs, birth to 21 years old, through nurse home visiting. Family participation is voluntary. The goals of CaCoon are to promote the development of effective care teams which center on the child/family, increase family knowledge, skills, and confidence in caring for their children and youth with special health care needs, and promote effective and efficient use of the healthcare system.	Child Age Eligibility: CaCoon serves children and youth age's birth through age 20 (up to their 21st birthday). •Child Diagnostic Eligibility: Diagnostic eligibility is detailed in Targeted Case Management (TCM) OAR 410-138-0040 "Diagnosis" column of Table 2. Public Health Nurses may use their professional judgement if a client has a chronic health condition or disability that is not specifically identified on the list by assigning "Other chronic conditions not listed". •Parent/Caregiver Eligibility: CaCoon services may also be offered to a parent (primary caregiver) of the child or youth enrolled in the CaCoon Program. Eligibility is detailed in TCM OAR 410-138-0040 in Table 1 ("Parent of eligible child"). (See State Plan Amendment, Parental Eligibility Criteria). •Financial Eligibility: CaCoon is open to all regardless of insurance status or family income.	Title V, TCM, local funds	All Oregon counties except Curry, Malheur, Multnoma, Wallowa and Wheeler (LPHAs, https://www.ohsu.edu/sites/default/files/2020-01/CaCoon%20Program%20Contact%20Numbers%20for%20website%201.2020.pdf)	Birth to 21 years old with one or more diagnosis or very high risk factor	Newborn to 21 years old	Nurse	THEO	https://www.ohsu.edu/accyshn/cacoon-carecoordination		https://www.ohsu.edu/sites/default/files/2022-04/CaCoon%20Program%20Contact%20Numbers%20for%20website%204.2022.pdf
Family Connects Oregon	A unniversal, voluntary nurse newborn home visiting program. 1-3 nurse home visits will be offered to every family with a newborn in Oregon in order to support healthy child development and strengthen families. Family Connects core elements include nurse home visiting, population level data evaluation and community alignment activites coordinated by a designated Community Lead.	Child Diagnostic Eligibility: Diagnostic eligibility is detailed in Targeted Case Management (TCM) OAR 410-138-0040 "Diagnosis" column of Table 2. Public Health Nurses may use their professional judgement if a client has a chronic health condition or disability that is not specifically identified on the list by assigning "Other chronic conditions not listed".	State General Fund, TCM, Commercial health benefits plans (as of 1/1/23)	Benton, Crook, Deschutes, Jefferson, Lincoln, Linn, Marion, Polk, Washington	All parents of newborns in Oregon	Newborn until baby age 12 weeks	Registered Nurse	Salesforce	https://www.oregon.gov/OHA/PH/HEALTHYPEOPLEFAMILIES/BABIES/HOMEVISITING/Pages/family-Connects-Oregon.aspx - and - familyconnectsoregon.org		bobbie.bowman-meza@dhsoha.state.or.us
Healthy Birth Initiative (HBI)	A maternal and child health program offering home visiting services to African American pregnant women and their families in Multnomah County. The purpose of the HBI program is to reduce the premature birth and infant mortality rates of African American babies. The mission of HBI is to achieve healthy birth outcomes by improving the well-being of mothers, fathers and their children, before, during and in between pregnancies. Services begin prenatally and end when the child turns 2. Families receive home visits from nurses and community health specialists. The program includes in-home case management, transportation, respite care, incentives, mental health support, infant/child growth and development, health education, male involvement, leadership development, client focused goal planning, referrals and advocacy.	Parent/Caregiver Eligibility: CaCoon services may also be offered to a parent (primary caregiver) of the child or youth enrolled in the CaCoon Program. Eligibility is detailed in TCM OAR 410-138-0040 in Table 1 ("Parent of eligible child"). (See State Plan Amendment, Parental Eligibility Criteria)		Multnomah County (5329 Martin Luther King Jr Blvd Portland, Oregon 97211)	African American pregnant women and their families in Multnomah County.	Prenatal to child reaches two years old.	Nurses and community health specialists. "Has 4 NFP nurses who deliver the NFP program within the HBI umbrella (Cynthia Ikata, 7.16.2020)."		https://multco.us/children-and-family-health-services/healthy-birth-initiative		
Nurse-Family Partnership (NFP)	An evidenced-based nurse delivered home visiting program that works to improve pregnancy, child health and development (including child abuse and neglect prevention), and self-sufficiency outcomes for first-time parents utilizing a strength-based approach. Nurses deliver a curriculum based on the theories of self-efficacy, attachment and human ecology.	Financial Eligibility: CaCoon is open to all regardless of insurance status or family income.	State General Fund, MIECHV, Title V, local funds	Deschutes, Jackson, Lane, Lincoln, Morrow, Multnomah, Umatilla, Washington and Yamhill	Low-income, first time parents, enrolled before 28 weeks gestation. Jackson County has permission to serve multips via a national pilot program.	Prenatal before 28 weeks gestation to child's 2nd birthday.	Registerd Nurse	FLO	https://www.nursefamilypartnership.org/locations/oregon/	750	Cynthia.ikata@state.or.us
Home Visiting as a Component of their Service Array											

Early Intervention	Therapeutic services are provided to children 0-3 including occupational, hearing speech, vision, and communication augmentation. Home is the location for service delivery for the vast majority of children, but services can be provided in a variety of settings including child care, preschools, parent groups, and hospitals. Administered by 8 regional Educational Service Districts and 1 School District under contract with the Oregon Department of Education.	Children from birth to age 3 may qualify for services in a few different ways: 1) through standardized testing by demonstrating a developmental delay in one or more of the following developmental areas: cognitive, physical, communication, adaptive, and/or social/emotional; 2) on the basis of a medical diagnosis of a condition likely to result in a	Funded with federal (*Grants for Infants and Families program--Part C; Medicaid*) and state funds (General Fund; SSA)	Statewide https://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Documents/eiecsecontractorcontactsmap.pdf	Infants and toddlers with disabilities and developmental delays and their families.	Newborn to 3 years old	**EI/ECSE Specialists:** Teachers Standards and Practices (TSPC) license with an endorsement in Special Education: Early Intervention **or** Oregon Department of Education (ODE) Authorization in Early Intervention/Early	ecWeb https://ecweb.uoregon.edu/registry/	https://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Pages/default.aspx	Mandated by law to serve all children who qualify.	Kara Williams, Director of Inclusive Services, Oregon Department of Education Kara.Williams@ode.oregon.gov
Family Support and Connections (FS&C)	A primary/secondary child abuse prevention program with the goal of increasing parental protective factors and decreasing risks associated with child abuse. Contracted Community Based Organizations deliver voluntary services in all 16 ODHS Districts. Services are strength-based and tailored to meet family's individualized needs and include; home and community visits, strength needs assessments, connection to community resources, guidance	Households with income at or below 200% of FPL	Federal;Community Based Child Abuse Prevention (CBCAP) and Temporary Assistance for Needy Families (TANF); and a small amount of GF	Statewide in 16 ODHS Districts which includes all 36 counties in Oregon.	Direct service delivery: Low-income households with children 17 and younger; General population for prevention awareness activities	Caregivers and children 17 and younger	Provider organizations determine MQ's for Home Visitors.	Historically: ODHS TRACS (TANF case management system) and local Protective Factors Survey (PFS) database; Pending: PFS Statewide Database	https://www.oregon.gov/dhs/assistance/Pages/fsc.aspx	Just over 2,200 families annually. Program is in the process of expanding capacity to 7,400 annually	Tina Gorin; tina.m.gorin@dhsoha.state.or.us, 503-305-0154
Relief Nurseries	Child abuse and neglect prevention programs based in centers throughout the state. Currently, there are 14 main sites, and 12 satellite sites operating throughout the state with an additional 6 satellites to begin operation in 2016. Children 0-6 and their families are eligible for a wide range of services, including home visits, therapeutic classrooms, mental health services, Respite care, and parenting education.		General Funds, Early Learning Account, Federal Title XX, Asset Forfeiture, Grantee Match	Currently serving 16 counties/39 sites Yes: Baker, Klamath, Marion, Polk, Yamhill, Benton, Linn, Lincoln, Umatilla, Malheur, Jackson, Josephine, Douglas, Lane, Washington, Multnomah, Deschutes, Jefferson, Crook, Clackamas (20/36 counties are services areas. Coos and Tillamook are expected within the next 24 months) No: Clatsop, Columbia, Coos, Curry, Gilliam, Grant, Harney, Hood River, Lake, Morrow, Sherman, Tillamook, Union, Wallowa, Wasco, Wheeler	Families with children 0 - 6 years old	Newborn to 6 years old			https://www.oregonreliefnurseries.org/		

Essential Components of a Statewide Home Visiting System

RESOURCE TOOL

BUILD INITIATIVE
Strong Foundations For Our Youngest Children

INTRODUCTION: Each of these components exist in some manner within and across home visiting programs. Part of the discussion when we consider a home visiting system from the state perspective is how will this component be approached by the state? How should it be approached? The work on these questions for each component, aligned and integrated together, further refines the state home visiting system.

This resource tool supports discussion and decision-making on building and refining a statewide home visiting (HV) system by defining each component, outlining the impact and importance of the component and delineating common activities of the component. The tool includes questions to prompt discussion of key factors for the system approach to planning in your state and individual context.

Component: Governance and Administration

What?

Leadership, oversight, and management of home visiting at both the state and local levels, encompassing how the connection between state and local governance and administration occurs.

Why?

Establish and maintain the statewide vision for home visiting, along with the goals and activities that support that vision. Ensure the governance and administration of the vision, goals, activities, and programs is well coordinated within the broader early care and education system at both the state and local levels. Ensure that collaboration on governance and administration occurs across the government entities, funders and home visiting stakeholders. In developing and implementing governance and administration seek an approach that is adaptable and responsive to program needs.

Activities

- Administration of state funding for home visiting.
- Administration of federal Maternal, Infant and Early Childhood Home Visiting funding.
- Meet requirements of legislation related to home visiting (if legislation exists).
- Ensure adherence to funding requirements.
- Streamline administrative requirements of programs.

Considerations for Planning

1. Where are current investments in home visiting? Funding, quality supports, coordination resources, other?

2. What strategies and policies exist supporting home visiting program quality and improved child and family outcomes?

3. What are current mechanisms for interagency and cross-program coordination?

4. Who leads the state's work toward a comprehensive system of supports for children and families? Throughout this effort, consider the players and partners involved that demonstrate the collaborative nature. Consider home visiting's role as a part of this comprehensive system effort.

5. What structures exist to ensure that local programs and communities have a voice in governance and administration? How can these local structures function as part of the home visiting system to raise up and strategize in response to key local home visiting issues?

Component: Assessment and Planning

What?

Cross-system and interagency needs assessment and planning ensures all funders, programs, communities, and interests are captured in order to work toward a collaborative home visiting system made up of multiple models, funders, and community-based approaches to the work.

Why?

Assessment and planning are necessary to understand and implement a system that realizes the statewide vision for a continuum of home visiting services.

In a collaborative approach to a home visiting system, and with home visiting as a core piece of the broader early care and education system, planning that is built from an active needs assessment and data analysis approach is necessary to allow all partners to have a clear understanding of their roles and responsibilities and to detail out expectations, goals, and outcomes (at system, community, program, child, and family levels).

Activities

- Identify service gaps and plan for growth and expansion.
- Understand the role, and reality, of data systems collecting information on home visiting indicators and statistics. Seek to improve the data system functioning.
- Maintain access to data necessary for analysis and planning around home visiting.
- Ensure criteria related to who is served by the various home visiting models is understood and part of the planning process.
- Complete routine needs assessment and analysis of results.
- Maintain strategic and fiscal plans for home visiting.

Considerations for Planning

1. How has expansion of home visiting programs occurred in the recent past? What data or need informed the process?

2. What current processes are used by specific models in the areas of needs assessments and planning? How can these inform statewide system assessment and planning?

3. What cross-system coordination of assessment and planning is currently in place?

4. How will assessment and planning further the alignment between family needs and home visiting programs?

5. What other assessment and planning processes exist for the early care and education system? What role does home visiting have in these processes?

Component: Financing Strategies and Funding Mechanisms

What?

Financing and funding mechanisms to support home visiting are focused on diverse and stable sources implemented in an efficient and coordinated manner to best support local implementation.

Why?

The statewide home visiting system is in a position to advance the blending of multiple funding streams to support programming and systems supports. Blending funding streams, such as federal and state funding, is a way to ensure opportunities for expansion as needed. Additionally, accessing multiple funding streams may allow for implementing innovative models or enhancements to models driven by family and community needs.

Activities

- Track all federal, state, and local (public and private) funding for home visiting.
- Understand the funding needs of local programs and system-level supports.
- Coordinate funding streams in order to streamline administrative requirements.
- Advocate for funding needs of the programs and system.

Considerations for Planning

1. What are the current funding sources (type of funding and amount) supporting home visiting?

2. What examples of multiple funding sources supporting a continuum of funding in a local community exist to explore?

3. How are the costs of home visiting tracked and understood across models (the cost of quality and variance based on model intensity)?

4. What is the current understanding of the administrative requirements of models and funders?

5. Consider other states for examples of the impact of streamlining home visiting administrative requirements and the process to achieve the streamlining.

6. What messaging and advocacy tools exist to finance all aspects of the home visiting system and programming? How are these tools used?

Component: Continuous Quality Improvement, Implementation, and Evaluation

What?

Evaluation, quality assurance activities, and communication on results of evaluation and quality improvement activities are coordinated across models and funding, at the state and local levels, in order to improve programs and their support structures.

Why?

Program improvement should be driven by data and evaluation that considers both program strengths and weaknesses in working to improve program quality. Coordination at the state system level is necessary to achieve benefits of knowledge gained across different models and funders, and maximize opportunities to implement quality improvement strategies reaching all programs. Maintaining a statewide vision for quality and a quality assurance plan leads to coordinated data collection, analysis and monitoring, streamlining across models by shared metrics and evaluation points, and monitoring structures.

Activities

- Develop and maintain a quality assurance plan (cross-model and funding).
- Support models in understanding and applying an implementation science approach to their program-specific strategies. Ensure this approach is accounted for in state-level analysis of continuous quality improvement and evaluation, and communication of results.
- Identify outcomes and evaluation measures that are shared across models and support the statewide goals for the impact of home visiting.
- Maintain a dashboard tool that tracks the identified outcomes and evaluation measures, gathering data across models.
- Communicate with state and local partners on progress, including analysis of expected impact.

Considerations for Planning

1. How are home visiting program objectives and outcome measures currently understood by the early care and education system? What efforts exist to map or align objectives and outcomes across models?

2. What type of evaluation and quality assurance activities are in place by model, or at programs? How can these be integrated in to a state quality assurance plan?

3. What are potential funding sources to support statewide evaluation efforts? Consider how other states have developed and maintained evaluation across models? Quality assurance activities?

Component: Professional Development, Training and Technical Assistance

What?

The core value of a highly skilled and supported home visiting workforce is held by the system and maintained across agencies, funders, and models.

Why?

Professional development activities coordinated at the state level (training and technical assistance) have the ability to be responsive to the results of evaluation and continuous quality improvement efforts. Home visiting is a unique delivery model. Within the early care and education system, the training, supports, and supervision needed for high-quality home visiting must be reflective of this uniqueness, which the statewide system ensures.

Activities

- Assess for common training and professional development needs across programs and coordinate a response.
- Maintain an alignment and tracking chart which maps the training that all home visiting programs need, as well as model-specific trainings.
- Seek opportunities to deliver common trainings to models in collaboration settings.
- Understand the capacity of community level supports for cross-model training and professional development.

Considerations for Planning

1. What are the model-specific professional development supports in place?

2. How are training and technical assistance needs assessed and planned for at the state level (by model) and program level?

3. What examples of cross-model, cross-program professional development efforts exist? What has been the impact of these efforts?

4. Consider how other states have addressed the coordination of professional development with multiple models and funding sources directing the models.

Component: Monitoring and Accountability

What?

Monitoring and accountability activities are coordinated across agencies, funding, and models in order to have a shared understanding of program standards and model fidelity, and to streamline the administrative and reporting burden on programs.

Why?

Coordination of monitoring and accountability efforts will support implementation of multiple models within programs and communities, along with working to ensure each model includes all aspects necessary to support quality programming.

Activities

- Cross-walk standards of different models to understand similarities and differences, and the potential implications for a shared monitoring approach.
- Develop shared monitoring tools and reporting structures that are reflective of model needs and have minimal data management impact.
- Message the impact of model fidelity, and overall home visiting, in order to support home visiting as an effective support for children and families.

Considerations for Planning

1. What type of monitoring is done with home visiting programs? How does this monitoring relate to model fidelity?

2. Are programs nationally accredited (if applicable)?

3. How have variances in program standards been approached in other state home visiting systems? What role have state standards for home visiting played in quality assurance and accountability? How have states ensured these standards do not duplicate or conflict with model standards?

4. What reporting structures exist with models that can be used to build a common structure?

Theory of Action (Phase 3)

Rural Home Visiting

System Coordination Project

Values

Trusting relationships are vital to systems change

Family voice, engagement and choice are central to informing decision-making in system change

Data is essential to guide, inform, and assess progress toward goals

Home visiting systems are most effective when they align regional efforts to statewide early learning initiatives

Systems equitably address needs of all families, especially those historically underserved or marginalized

Mission

To improve the system and coordination of accessible, culturally affirming, quality home visiting programs and family support services so that more children and families are served.

Vision

Children are raised in healthy, stable, and attached families

The early learning system is aligned, coordinated, and family-centered

If investments are made in these

RESOURCES

Minimum, one full FTE per region for dedicated coordination and related activities

Consultants who provide:

- Project management
- Coaching
- Technical assistance
- Evaluation, data utilization support
- Facilitation

Training, consultation, and coaching for coordinators, home visitors, home visiting leaders, and system partners

Monetary and in-kind contributions from sponsoring/backbone organizations, philanthropic, and state/local partners

So grantees with partners can implement these

STRATEGIES

Develop and utilize internal communication processes across home visiting models and system partners

Develop, and/or integrate, a coordinated home visiting and family support program intake/referral process

Create and maintain a shared professional development plan

Develop and share a unified external communication plan

Then local communities can build and sustain these

CAPACITIES

Leadership, governance, and/or advisory structures convene and engage system partners

System partners regularly participate in relationship-building and networking opportunities

HV and family support programs throughout the region use a shared intake/referral processes

A comprehensive inventory of the region's home visiting and supplemental family support services is maintained

HV and family support programs throughout the region jointly invest in home visiting professional development opportunities

HV Systems partners work together to implement an aligned home visiting and supplemental family support services awareness campaign

So that communities can realize these

RESULTS

System partners are engaged in and work collaboratively to shape and share a vision for HV system coordination

Trusting relationships exist between HV models and system partners

Families experience improved access to home visiting and family support services

Ineligible families or those on wait lists are systematically referred to supplemental family support services

Home visitors, home visiting leaders, and system partners equitably access and participate in shared, competency-based professional development

System partners and parents/caregivers are increasingly aware of availability, accessibility, and benefits of the array of home visiting and family support services in the region

Portland State University · The Ford Family Foundation · School of Social Work, Portland State University · South Coast Early Learning · First 5 Siskiyou Children & Families Commission · South-Central Early Learning Hub · Community Uplift

Home Visiting Systems Coordination Systems Survey Summary Year 5 Cross-Region

Prepared by Callie Lambarth, Isabella Ginsberg, and Beth Green

Center for Improvement of Child & Family Services

Portland State University

November 16, 2021

The Center for Improvement of Child & Family Services (CCF) at Portland State University integrates research, education and training to advance the delivery of services to children and families. The CCF research team engages in equity-driven research, evaluation and consultation to promote social justice for children, youth, families and communities.

Introduction & Background

The Home Visiting Systems Coordination (HVSC) project aims to create a coordinated home visiting (HV) system that strengthens and benefits all home visiting models as part of each region's birth-to-five early childhood development system. Regions include counties served by First 5 Siskiyou, California; the South Central Early Learning Hub in Douglas, Klamath, and Lake counties in Oregon; and the South Coast Regional Early Learning Hub in Coos, Curry, and coastal Douglas counties in Oregon. The long-term goal for the project is to improve outcomes for families and expand each region's capacity to serve more families.

As part of the HVSC project evaluation, members of the Portland State University (PSU) evaluation team at the Center for Improvement of Child & Family Services (CCF) worked with coordinators in each of the project's three regions. The CCF evaluation team distributed the electronic survey to HV System Coordinators, who invited their stakeholders to participate. The survey was available in English and Spanish. The CCF evaluation team also invited survey participants to opt-in to a random electronic drawing for one of ten $40 Amazon e-gift cards as a thank you for their time.

The HV Systems Survey was developed to gather information about key aspects of the current HV systems, project governance, communication, and collaborative partnerships. The information summarized here shows survey results at baseline and annually at one, two, three, four, and five years after project start.

Survey Participants

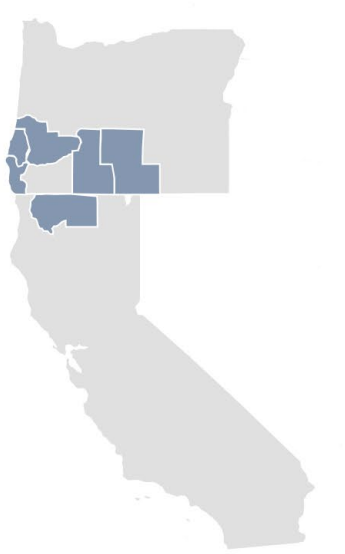
As shown in Table 1a, 52 stakeholders from the three regions participated in the Systems Survey in 2021. Each year, about half of the total number of survey participants across the project, are from the South Central, Oregon region.

Table 1a. Count of survey participants in each HVSC region

HVSC Region	Number of Respondents					
	2016 (Baseline)	2017 (Y1)	2018 (Y2)	2019 (Y3)	2020 (Y4)	2021 (Y5)
Siskiyou, CA	10	21	29	19	19	11
South Central, OR Lake, Klamath, Douglas Counties	27	32	42	38	33	28
South Coast, OR Curry, Coos, coastal Douglas Counties	20	12	17	17	14	13
Total	**57**	**65**	**88**	**74**	**66**	**52**

As shown in Table 1b, the project achieved an overall 50% response rate, based on the number of stakeholders who were invited to participate. This is somewhat lower compared to prior years, where the project consistently had achieved a 75% response rate or above.

HVSC Project Counties



Backbone Organizations

TALK, READ, SING, PLAY, EVERYDAY! FIRST 5 Siskiyou CHILDREN & FAMILIES COMMISSION

SOUTH-CENTRAL EARLY LEARNING HUB SERVING DOUGLAS, KLAMATH & LAKE COUNTIES

South Coast Early Learning Serving Coos, Curry, & Coastal Douglas Counties

Funding Organization

THE Ford Family FOUNDATION

Based on feedback from project partners, fewer respondents may have been able to participate in 2021 due to COVID-19 workload impacts.

Table 1b. Response Rates by Region

HVSC Region	Response Rate					
	2016 (Baseline)	2017 (Y1)	2018 (Y2)	2019 (Y3)	2020 (Y4)	2021 (Y5)
Siskiyou, CA	NR	NR	74%	68%	59%	37%
South Central, OR	NR	NR	81%	75%	87%	62%
South Coast, OR	NR	NR	81%	89%	82%	46%
Total	**NR**	**NR**	**79%**	**76%**	**76%**	**50%**

*"NR" indicates that Response Rate was not reported for 2016 and 2017.

Survey participants in 2021 worked in organizations with early childhood programs across sectors. Over a third of participants (35%) worked in organizations delivering early childhood home visiting supports, and nearly another third (31%) worked in organizations delivering early learning programming. Nearly one in five participants (19%) also worked in County, Hub, or regional organizations.

Table 1c. Type of Program or Organization Represented by Survey Respondents

Type of Program / Organization[1]	Number of Respondents	% of Respondents (n=52)
Early childhood home visiting program	18	35%
Early Learning Head Start, preschool, child care	16	31%
County, Hub, or regional organization	10	19%
Parenting education	6	12%
Additional types of organizations[2]: Human Services (self-sufficiency, child welfare); Public elementary school or district; parent/caregiver; Health care	13	25%

For more information about participants, find additional details in Appendix B.

"The collaborative was instrumental in building the networks we utilize today. [Home visiting programs] did not really speak to or refer families to each other [before the project]."

– Survey Respondent

Overall Home Visiting Systems Coordination

A total of 34 respondents (67%) reported that they participate in the HVSC project leadership, steering committee, or advisory group for their region, representing a similar rate compared to prior years.

Table 1d. Leadership & Governance Participation	Number of Respondents	% of Respondents
2016 Survey Participants (n=57)	37	65%
2017 Survey Participants (n=65)	49	75%
2018 Survey Participants (n=86)	62	72%
2019 Survey Participants (n=73)	44	60%
2020 Survey Participants (n=60)	39	65%
2021 Survey Participants (n=52)	34	67%

[1] Totals do not equal 100% because respondents can endorse more than one category.
[2] These types of organizations are combined because they had fewer than 5 respondents each.

Figure 1. in 2021, more survey participants (%) report being involved in home visiting systems coordination work for shorter periods.

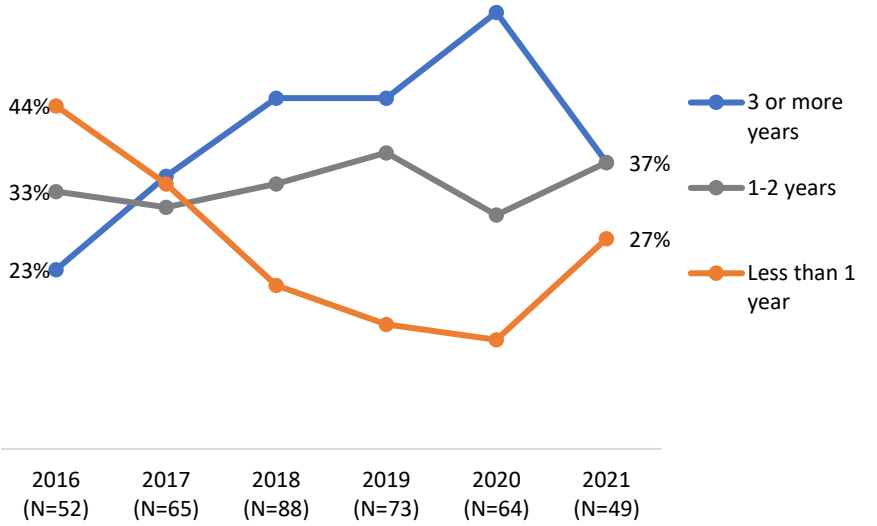
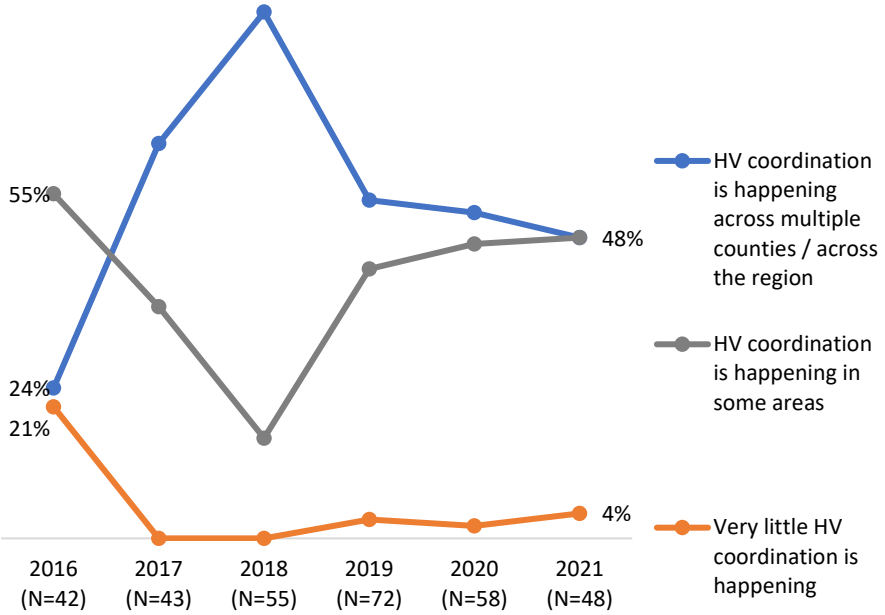


Figure 1 shows the percent of survey respondents who report being involved in home visiting systems coordination. At the start of the HVSC project, nearly half (44%) reported being involved for less than a year, while 23% reported being involved in systems coordination work for 3 or more years.

By 2021, 37% of survey respondents report being involved in home visiting systems coordination work for 1-2 and 3 or more years. At the same time, 27% of respondents newer to systems coordination work in 2021 were also involved.

In 2021, this suggests that more survey participants were newer to home visiting systems coordination work, compared to more recent, prior years. At the same time, over a third of survey respondents have also been involved in HVSC project goals for 3 more years.

Figure 2. Survey participants continue to report regional coordination, while change has occurred unevenly over the course of the project so far.



Compared to the first year of the project, when 24% of survey respondents reported that home visiting coordination was happening across multiple counties or their region overall, this has doubled, to 48% of survey respondents in 2021.

Similar rates of respondents report home visiting coordination happening within some areas within the region, while very few respondents reported only a little coordination happening regionally. These results suggest improved overall communication and home visiting coordination over the course of four years of the project.

Survey Domains

The following tables show the percent of respondents across regions who, on average, "Agree" or "Strongly Agree" with the items that make up each domain. Survey items are grouped into different domains that comprise effective HV collaborative groups and a coordinated HV system.

Although there were 52 total survey respondents in 2021, the number of valid responses for each region and domain may vary due to respondents skipping items or reporting they "Don't Know." For details on percent of respondents who Agree or Strongly Agree with each item by region, please refer to Appendix A.

Communication & Collaboration

Table 2. Communication & Collaboration Domain (% SA/A[3])	'16	'17	'18	'19	'20	'21
There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the ***county*** involved in the collaborative.	50%	84%	92%	88%	93%	83%
There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the ***region*** involved in the collaborative.	26%	71%	77%	78%	82%	78%
There is effective communication between HV leaders (e.g., HV supervisors, HV managers) and home visitors within the ***county*** involved in the collaborative.	50%	75%	82%	84%	90%	89%
There is effective communication between HV leaders (e.g., HV supervisors, HV managers) and home visitors within the ***region*** involved in the collaborative.	26%	61%	69%	69%	78%	78%
The current HV system provides sufficient networking opportunities between HV providers and programs.	34%	62%	76%	77%	79%	83%

Communication & Collaboration Highlights

A similar percentage of survey participants in 2021 agreed that **there is effective communication overall**, across each region, as well as between leadership and direct service providers.

"I'm proud of our ability to come together to problem-solve service delivery needs, provide support and share protocols, brainstorm and collaborate on initiatives."

– Survey Respondent

[3] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Table 2. Communication & Collaboration Domain (% SA/A[3])	'16	'17	'18	'19	'20	'21
There is a high level of mutual respect and understanding among people and programs involved in the HV systems-building work.	64%	92%	92%	90%	93%	92%

Governance & Planning

Table 3. Governance & Planning Domain (% SA/A[4])	'16	'17	'18	'19	'20	'21
HV program leaders are effective at working together to improve the overall HV system.	50%	90%	91%	85%	91%	92%
HV program leaders have the knowledge about each other's programs that is needed to collaborate successfully.	49%	79%	82%	78%	84%	90%
The group that is working on HV systems-building has a clear action plan that guides the steps for improving the HV system.	39%	93%	91%	74%	87%	89%
The HV collaborative has a shared, common vision.	56%	93%	96%	86%	93%	94%
The HV collaborative has identified early- to mid-term objectives that will set the stage for attainment of longer-term goals.	41%	90%	90%	83%	90%	94%

Governance & Planning Highlights

Survey participants largely agreed that those involved in governance and planning for HVSC work have **established and maintained a foundation for working together effectively.**

"There is a strong interconnectedness of all the care and help from organizations."
– Survey Respondent

[4] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Table 3. Governance & Planning Domain (% SA/A[4])	'16	'17	'18	'19	'20	'21
Members of the HV collaborative have a clear understanding of how system building supports better outcomes for children and families.	54%	90%	93%	86%	93%	96%
People and organizations that are critical to the success of the HV collaborative are actively engaged.	50%	81%	89%	86%	90%	78%

Roles & Responsibilities

Table 4. Roles & Responsibilities Domain (% SA/A[5])	'16	'17	'18	'19	'20	'21
All those involved in the HV systems work have a clear sense of their roles and responsibilities.	48%	79%	83%	76%	81%	84%
The HV collaborative group has ample knowledge of local needs and resources.	56%	81%	91%	87%	91%	94%

Roles & Responsibilities Highlights

Survey participants largely agreed that those involved in HVSC work have **clear roles and understand local needs and resources**.

Equity

Table 5. Equity Domain (% SA/A[6])	'16	'17	'18	'19	'20	'21
HV programs have effective ways to prioritize services to families.	60%	65%	85%	69%	80%	85%

[5] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.
[6] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Table 5. Equity Domain (% SA/A[6])	'16	'17	'18	'19	'20	'21
The HV system currently meets the needs of all families in our region who are interested in services, through HV or connecting to the other family support programs.*	NA	NA	NA	31%	62%	68%
HV programs currently have the capacity to meet the needs of culturally and linguistically diverse families in our community.	26%	43%	51%	33%	47%	48%
HV program staff currently reflect the diversity of families in the region.*	NA	NA	NA	48%	55%	50%

*"NA" indicates that the survey item was not included in prior years, so we report Not Applicable for those time points.

Equity Highlights

Despite improvements over time, there is still **room for growth in building a workforce that meets the needs of, and reflects, the diversity of families in their regions**.

Although more survey respondents agreed that programs are able to effectively prioritize services, there **is room for growth in outreach and engagement of families in the regions** as well, especially with continued COVID-19 conditions

"I hope that more families enroll in our programs."

– Survey Respondent

Continuous Program Improvement & Data Use

Table 6. Continuous Program Improvement & Data Use Domain (% SA/A[7])	'16	'17	'18	'19	'20	'21
The HV collaborative has sought out information from similar initiatives in other communities and continues to gather and share information about effective practices.	42%	89%	82%	80%	89%	90%
The HV collaborative takes time periodically to reflect on what we are learning, including the effectiveness of our collaborative structures and processes.	50%	91%	86%	86%	94%	96%
The HV collaborative has collected and assessed data about the needs and resources for children and families in our region.	51%	76%	90%	88%	90%	91%

CPI & Data Use Highlights

The vast majority of survey participants in 2021 agreed their HVSC work has included **ongoing gathering of and reflection on data**.

[7] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Systems Outcomes

Table 7. Systems Outcomes, Community Awareness Domain (% SA/A[8])	'16	'17	'18	'19	'20	'21
Families in our community know about HV programs and services.	23%	33%	45%	45%	64%	49%
Families in our community understand the benefits of home visiting.	26%	25%	31%	25%	44%	43%
Families in our community are skeptical about the idea of HV services. ***Lower means improvement***	57%	67%	69%	63%	50%	54%
Our community has effective ways of "getting the word out" to families about home visiting services.	25%	29%	47%	52%	62%	55%
Staff in other agencies know about HV programs and services.*	NA	NA	NA	57%	80%	69%

*"NA" indicates that the survey item was not included in prior years, so we report Not Applicable for those time points.

Community Awareness Highlights

Fewer survey participants in 2021 agreed that families and staff within other agencies are **aware of and understand the benefits of HV in their communities**, which could be related to challenges posed by changing COVID-19 conditions.

"We will need to continue to inform partners and the public about the benefits of home visiting."
– Survey Respondent

"We continue to meet families in creative ways to support them during this time. Letting them know that we are still concerned about their families' wellness and that they can still turn to their community for help and support to become stronger, healthier."
– Survey Respondent

[8] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Table 8. Systems Outcomes, Coordinated Referral Domain (% SA/A[9])	'16	'17	'18	'19	'20	'21
Our community uses a shared/common referral form to facilitate family access to HV services.	16%	19%	58%	55%	76%	81%
There are clear policies and procedures for obtaining family consent and releases for HV programs.	54%	59%	77%	77%	85%	86%
There are effective ***informal*** referral agreements between/among HV and other programs in our community.	56%	61%	70%	67%	78%	83%
There are effective ***formal*** referral agreements (i.e., MOU's, MOA's, contracts) between/among HV and other programs in our community.	34%	44%	57%	60%	80%	76%
Issues around family confidentiality are a barrier to a shared HV referral system. ***Lower means improvement***	41%	52%	39%	42%	31%	46%
Current HV program MOUs/MOAs need improvement. ***Lower means improvement***	72%	50%	47%	55%	46%	42%

Coordinated Referral Highlights

A higher percentage of survey participants in 2021 agreed that there have been **improvements across multiple dimensions of coordinated referral** in their regions. This varied by county or region, due to differences in when formal and/or informal referral processes had been established.

"We've had many referrals received and processed over the past year."
– Survey Respondent

"The most important accomplishment was getting our referral form out to different agencies so we can start coordinating with them to provide services to families."
– Survey Respondent

"We had many discussions about the best way to approach a warm handoff of families between agencies. We drafted, approved, and shared a best practices document between programs."
– Survey Respondent

[9] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Table 9. Systems Outcomes, Professional Development Domain (% SA/A[10])	'16	'17	'18	'19	'20	'21
The HV system effectively shares professional development and training resources.	48%	82%	83%	90%	95%	98%
The HV system has a cross-program professional development and training plan.	28%	25%	69%	80%	85%	91%
There are effective formal professional development and training agreements (i.e. MOU's, MOA's, contracts) between HV programs in our community.*	NA	NA	NA	51%	75%	67%

*"NA" indicates that the survey item was not included in prior years, so we report Not Applicable for those time points.

Professional Development Highlights

A higher percentage of survey participants in 2021 agreed that the HV system was effective at **sharing professional development resources, building from a training plan.**

"All of the professional development opportunities and our PLC sessions have been great."
– Survey Respondent

"Bringing virtual trainings to our region were well-attended by multiple agencies, not just home visiting." – Survey Respondent

Sustainability

Table 10. Sustainability Domain (% SA/A[11])	'16	'17	'18	'19	'20	'21
HV programs work together to increase funding and support all home visiting programs.	17%	39%	40%	46%	65%	65%
There are multiple sources (e.g., state, federal, private, foundation) of HV program funding in our community.	58%	65%	77%	77%	70%	85%
There is competition between HV programs for resources and funding. ***Lower means improvement***	69%	44%	39%	42%	25%	35%

Sustainability Highlights

A higher percentage of survey participants in 2021 agreed that programs have **improved their work together for increased funds.**

Although slightly fewer felt that **competition between programs has been reduced,** this is still much lower compared to that at project start.

"The potential for helping families is well worth the effort everyone in our county is putting in to HV."
– Survey Respondent

[10] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.
[11] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item.

Reflections on Year 5 of the Project

In addition to the series of scaled survey items, participants also shared their thoughts on key accomplishments from Year 5 of the HVSC project, hopes for the future, and challenges that will need to be addressed.

Key Accomplishments

- Building new and maintaining existing relationships among staff and between programs.
- Putting a warm handoff protocol into practice, in order to connect families with needed services.
- Maintaining and expanding referral data systems and processes.
- Sharing and accessing professional development opportunities in a virtual environment, and engaging new community partners through the process.
- Increasing awareness of families and community partners of the availability and benefits of HV programs.

Hopes for Coming Year

- Continuing working to engage new partners in the collaborative process on shared work.
- Continuing to build awareness with community partners and families to understand the availability and benefits of HV supports in the community.
- Using technology tools effectively to continue collaborative work, even through continuing COVID-19 conditions.
- Working on continuing to build, support, and retain an effective, skilled workforce as well as building back programs that had previously closed.
- Continuing to address workload, Zoom meeting fatigue, and staff health and wellness as the pandemic continues.

"We have been able to keep momentum going through the pandemic."
– Survey Respondent

"I'm grateful to have partners that care about this work and each other as a home visiting community."
– Survey Respondent

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Thank you to each survey participant for sharing your perspectives and your time.

Appendix A: % Agree/Strongly Agree for Items & Domains by Region, Year 5

Although there were 52 total respondents, the number of valid responses for each region and domain may vary due to respondents skipping items or reporting they "Don't Know"; these cases are omitted in the percent calculations.

Table 11. Communication & Collaboration Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the ***county*** involved in the collaborative.	73%	80%	100%	83%
There is effective communication between HV program leadership (e.g., HV supervisors, HV managers) within the ***region*** involved in the collaborative.	56%	77%	100%	78%
There is effective communication between HV leaders (e.g., HV supervisors, HV managers) and home visitors within the ***county*** involved in the collaborative.	80%	88%	100%	89%
There is effective communication between HV leaders (e.g., HV supervisors, HV managers) and home visitors within the ***region*** involved in the collaborative.	63%	74%	100%	78%
The current HV system provides sufficient networking opportunities between HV providers and programs.	91%	71%	100%	83%
There is a high level of mutual respect and understanding among people and programs involved in the HV systems-building work.	91%	89%	100%	92%
Communication & Collaboration Domain (% SA/A[12])	**82%**	**85%**	**100%**	**88%**

Table 12. Governance & Planning Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
HV program leaders are effective at working together to improve the overall HV system.	91%	89%	100%	92%
HV program leaders have the knowledge about each other's programs that is needed to collaborate successfully.	73%	96%	92%	90%
The group that is working on HV systems-building has a clear action plan that guides the steps for improving the HV system.	91%	83%	100%	89%
The HV collaborative has a shared, common vision.	100%	89%	100%	94%
The HV collaborative has identified early- to mid-term objectives that will set the stage for attainment of longer-term goals.	100%	89%	100%	94%
Members of the HV collaborative have a clear understanding of how system building supports better outcomes for children and families.	100%	92%	100%	96%
People and organizations that are critical to the success of the HV collaborative are actively engaged.	100%	73%	67%	78%
Governance & Planning Domain (% SA/A)	**100%**	**89%**	**100%**	**94%**

[12] "% SA/A" is the percent of respondents who reported they Agreed or Strongly Agreed with the item. Domain rates reflect the percent who on average, Agree/Strongly Agree for the items comprising that domain. Each item can be rated on a scale from 1 to 5. If the sum of the two items is a total of 3.5 or higher, the respondent is coded as "Agreeing/Strongly Agreeing" with the Domain. The percent reported for each Domain is the percent of respondents for whom this is true.

Table 13. Roles & Responsibilities Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
All those involved in the HV systems work have a clear sense of their roles and responsibilities.	70%	87%	90%	84%
The HV collaborative group has ample knowledge of local needs and resources.	90%	92%	100%	94%
Roles & Responsibilities Domain (% SA/A)	**90%**	**96%**	**100%**	**96%**

Table 14. Equity Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
HV programs have effective ways to prioritize services to families.	89%	77%	100%	85%
New Item for 2019-2020, not included in Domain calculation: The HV system currently meets the needs of all families in our region who are interested in services, through HV or connecting to the other family support programs.	50%	72%	73%	68%
HV programs currently have the capacity to meet the needs of culturally and linguistically diverse families in our community.	63%	48%	33%	48%
New Item for 2019-2020, not included in Domain calculation: HV program staff currently reflect the diversity of families in the region.	86%	50%	27%	50%
Equity Domain (% SA/A)	**67%**	**60%**	**56%**	**61%**

Table 15. Continuous Program Improvement & Data Use Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
The HV collaborative has sought out information from similar initiatives in other communities and continues to gather and share information about effective practices.	88%	91%	91%	90%
The HV collaborative takes time periodically to reflect on what we are learning, including the effectiveness of our collaborative structures and processes.	100%	92%	100%	96%
The HV collaborative has collected and assessed data about the needs and resources for children and families in our region.	100%	83%	100%	91%
Continuous Program Improvement & Data Use Domain (% SA/A)	**100%**	**92%**	**100%**	**96%**

Table 16. Systems Outcomes, Community Awareness Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
Families in our community know about HV programs and services.	44%	57%	36%	49%
Families in our community understand the benefits of home visiting.	56%	41%	36%	43%
Families in our community are skeptical about the idea of HV services.	63%	57%	40%	54%
Our community has effective ways of "getting the word out" to families about home visiting services.	67%	54%	46%	55%
New Item for 2019-2020, not included in Domain calculation: Staff in other agencies know about HV programs and services.	70%	71%	64%	69%
Systems Outcomes, Community Awareness Domain (% SA/A)	**50%**	**36%**	**42%**	**40%**

Table 17. Systems Outcomes, Coordinated Referral Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
Our community uses a shared/common referral form to facilitate family access to HV services.	100%	92%	25%	81%
There are clear policies and procedures for obtaining family consent and releases for HV programs.	90%	92%	67%	86%
There are effective ***informal*** referral agreements between/among HV and other programs in our community.	89%	80%	86%	83%
There are effective ***formal*** referral agreements (i.e., MOU's, MOA's, contracts) between/among HV and other programs in our community.	88%	82%	50%	76%
Issues around family confidentiality are a barrier to a shared HV referral system.	38%	39%	70%	46%
Current HV program MOUs/MOAs need improvement.	57%	29%	63%	42%
Systems Outcomes, Coordinated Referral Domain (% SA/A)	**70%**	**76%**	**20%**	**62%**

Table 18. Systems Outcomes, Professional Development Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
The HV system effectively shares professional development and training resources.	100%	96%	100%	98%
The HV system has a cross-program professional development and training plan.	100%	83%	100%	91%
New Item for 2019-2020, not included in Domain calculation: There are effective formal professional development and training agreements (i.e. MOU's, MOA's, contracts) between HV programs in our community	67%	58%	88%	67%
Systems Outcomes, Professional Development Domain (% SA/A)	**100%**	**96%**	**100%**	**98%**

Table 19. Sustainability Domain	Siskiyou CA (N=11)	South Central OR (N=28)	South Coast OR (N=13)	Cross-Region (N=52)
HV programs work together to increase funding and support all home visiting programs.	75%	53%	80%	65%
There are multiple sources (e.g., state, federal, private, foundation) of HV program funding in our community.	100%	79%	90%	85%
There is competition between HV programs for resources and funding.	40%	42%	20%	35%
Sustainability Domain (% SA/A)	**75%**	**44%**	**80%**	**58%**

Appendix B: Survey Participants, Year 5

Table 20. Type of Roles Represented by Survey Respondents	Number of Respondents	% of Respondents (n=52)
Direct service provider, home visitor, services coordinator, family advocate	20	38%
Program manager	13	25%
Program director	10	19%
Supervisor	9	17%
Additional types of roles[13]: Parent/caregiver or program consumer; Program coordinator; Outreach worker	7	13%

Table 21. HVSC Project Convenings Attended by Survey Respondents	Number of Respondents	% of Respondents (n=52)
2021 Family Voice Journey Mapping Event	13	25%
2020 Annual Leadership Gathering	22	42%
2019 Annual Leadership Gathering	14	27%
2018 Annual Leadership Gathering	13	25%
2017 Annual Leadership Gathering	7	14%
2016 Annual Leadership Gathering	7	14%
2016 Kick-Off Gathering	9	17%
All of the Leadership Gatherings, including Kick-Off	2	4%
2018 Regional professional development gatherings	13	25%
None of the gatherings listed	12	23%

[13] These types of roles are combined because they had fewer than 5 respondents each.

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

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Key Terms

Adverse Childhood Experiences (ACEs): Stressful or traumatic events that can have negative long-term effects on health and well-being into adult-hood.

Evidence-Based Home Visiting Model: To meet the U.S. Department of Health and Human Services' (DHHS) criteria for an "evidence-based early childhood home visiting service delivery model," models must meet at least one of the following criteria:

- At least one high- or moderate-quality evaluation study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains specified by DHHS;[1]
- At least two high- or moderate-quality evaluation studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain.

Home Visiting Administrator: The program director, manager, or administrator responsible for the overall operation and personnel of a home visitation program. For some programs, the home visiting administrator and home visiting supervisor may be dual roles.

Home Visitor: An individual who provides support to children and families in the participating family's home, or other community location, carrying out the program model, goals, or curriculum for their home visitation program.

Home Visiting Supervisor: Individual responsible for the assignment of children and families to home visitors, as well as the ongoing training, support, and supervision of the home visitor. For some programs, the home visiting administrator and home visiting supervisor may be dual roles. Some home visiting supervisors carry home visiting caseloads themselves.

Maternal Infant and Early Childhood Home Visiting (MIECHV) Program: A funding source administered through the U.S. Department of Health Resources and Services Administration (HRSA) that facilitates collaboration and partnership at the federal, state, and community levels to give pregnant women and families, particularly those considered at risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. The goals of all MIEHV home visiting programs are to improve maternal and child health,

[1] Please see the following website for a list of evidence-based home visiting models: https://homvee.acf.hhs.gov/document.aspx?rid=4&sid=19&mid=6 .

prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.

Program Model: The structure, style, and operational procedures that, together, make up a program type or that follow the standards outlined by a national organization or group.

Reflective Supervision: A form of ongoing intentional, scheduled professional development that focuses on enhancing the reflective practice skills of home visitors for purposes of program quality, including staff wellness and retention.[i]

Region X is the standard federal region as defined by the federal Office of Management and Budget Circular A-105, "*Standard Federal Regions.*" Region X includes the states of Alaska, Idaho, Oregon, and Washington.

[i] Region X Reflective Supervision/Consultation Collaborative. (2018). *Reflective supervision: A guide from Region X to enhance reflective practice among home visiting programs*. Washington State Department of Children, Youth, and Families: Olympia, WA.

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

INTRODUCTION

Overview and Background Information about the Region X Home Visiting Workforce Study

Background

Early childhood is a period characterized by rapid brain growth, development, and learning. It is also a time in which young children are most susceptible to risks to their development.[ii] Indeed, advances in neurobiological research over the past several decades have demonstrated how the quality of children's early experiences shape brain architecture that, in turn, influence children's social, cognitive, and emotional competence.[iii] Research also points to the critical role that families can play in buffering children from risk and promoting resilience in the face of adversity.[iv]

Based on this research, home visitation programs seek to support parenting capacities, particularly for families facing challenges such as living in poverty, parenting alone or as a teen, living with maternal depression, or having few social supports. In 2010, the U. S. Administration of Children and Families invested an initial $1.5 billion over five years in the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and in 2018, Congress renewed the legislation. This funding was designed to support states in delivering evidence-based home visiting services for pregnant women and families with children up to kindergarten entry who face a variety of risk factors. Currently, 3,019 children and their families across Region X, which includes Alaska, Idaho, Oregon, and Washington, have participated in a MIECHV-funded home visiting program.[v]

While there are important differences among home visiting programs, they share many common characteristics. Each offers regular visits to families from a nurse, child development, or social service professional. During home visits, these professionals support the parent-child relationship in order to build parenting skills, support children's early learning and language development, offer families guidance on child development, conduct screenings and assessments, and refer and connect families to resources to improve family health, social capital, and opportunities for children. Research across program models shows that home visiting can help support positive parenting, prevent child abuse and neglect, improve maternal and child health, and foster children's school readiness skills.[vi] In addition, cost-benefit analyses demonstrate a cost savings to society from investing in evidence-based home visiting programs, with savings realized from reductions in emergency room visits, special education services, and engagement in foster care and child protective service systems.[vii]

At the heart of any effective home visiting program is the home visitor. It is undeniable that home visitors have a complex job. In addition to implementing an evidence-based home visiting model with fidelity, home visitors must build positive

relationships with families grounded in mutual trust and respect. Home visitors must also be skilled in curriculum delivery, knowledgeable about assessments, able to help families navigate and access outside resources, and be sensitive and responsive to the cultural contexts in which they are delivering services. Often this work is done with families who are experiencing intimate partner violence, substance abuse, or mental health challenges, as well as with caregivers who have experienced their own adverse early experiences or significant trauma.

The complexity of a home visitor's job also requires a multifaceted set of knowledge and skills. Consequently, the professional preparation of home visitors is often described as a key ingredient to the successful implementation of a home visiting program.[viii] Yet home visitors come to their jobs with varying skills, levels of education, and backgrounds. The professional preparation required for the job also varies by home visiting model. For instance, some models may require a bachelor's degree in a particular subject area while others do not have any formal educational requirements. Understanding the qualifications of the workforce and their professional development needs is key to developing a responsive system of preparation and ongoing in-service learning for the range of professionals in the workforce.

Home visitors may also be particularly susceptible to job stress and burnout in their roles, which can affect their job satisfaction, the quality of their work, and their motivations to stay in or leave their jobs or the field.[ix] Home visitors often have to travel long distances and work with hard-to-engage families and families in crisis, all while balancing multiple job demands.[x] In turn, these factors may create job stress and burnout that can result in negative emotionality and less time spent with families, impacting their relationships with families and the effectiveness of the home visiting services they deliver.[xi] Working with families in crisis may also be particularly challenging for some home visitors who have experienced their own adverse early experiences.

Work environments and working conditions can help home visitors navigate job stressors or can add additional stress that may limit the effectiveness of their service delivery, well-being, and ultimate retention in the field.[xii] For example, home visitors who are provided with ongoing reflective supervision may have opportunities to explore the range of emotions associated with their work to help mitigate the stresses associated with the job, which can facilitate more effective relationships with families.[xiii] Alternatively, home visitors who work in organizations with high caseloads, with few supportive and collegial relationships, and who are challenged by a lack of autonomy and with role conflict within their organizations may experience greater burnout and stress, leading to high turnover among home visitors and reduced program effects.[xiv]

To date, however, few studies have taken a comprehensive look at the work lives of home visitors. Such a study is necessary to understand their professional needs so that a comprehensive set of policies and supports can be developed to ensure a thriving workforce.

Purpose of Current Study

Recognizing the importance of the home visiting workforce to effective service delivery and improved child and family outcomes, the MIECHV programs within the Alaska Division of Public Health, the Idaho Department of Health and Welfare, the Oregon Health Authority, and the Washington Department of Children, Youth, and Families, which together comprise Region X, received an innovation grant from the HRSA. The purpose of this grant was to develop, implement, and evaluate innovations to strengthen and improve the delivery of coordinated and comprehensive high-quality home visitation services to eligible families.

As a part of the *Region X Innovation grant*, this study seeks to identify the current strengths, gaps, and unmet needs in the home visitor workforce in Region X. In particular, it has been designed to help inform workforce recruitment, retention, and professional development needs to help ensure the well-being and effectiveness of home visitors in the region. Consequently, this study addresses the following overarching research questions:

1. What are the demographic and educational characteristics of the Region X workforce? (Brief 1)
2. What are the job characteristics of the workforce? (Brief 2)
3. What professional development opportunities are available to the workforce, and how do they rate the quality of their workplace and their intent to stay? (Brief 3)
4. What is the health and well-being of the workforce? (Brief 4)
5. What predicts job role, pay, intent to stay, and health status within the Region X home visiting workforce? (Brief 5)

Procedures

Recruitment. To address these research questions, we obtained the email addresses of 196 home visiting program administrators in Alaska, Idaho, Oregon, and Washington (Region X). Emails were sent to these administrators informing them of the study and requesting the email addresses of the home visitors and home visiting supervisors employed by their organization, or with whom they contracted, so that electronic surveys could be sent to them individually. For home visitors and supervisors to be eligible to participate in the study, they had to be employed by (or contracted with) an organization that used an evidence-based home visiting model approved by MIECHV (see https://homvee.acf.hhs.gov/ for a complete list) or work for an organization that used "promising practices" or evidence-informed models as defined by criteria defined by the states comprising Region X. Administrators who returned their email lists were given a $50 gift card for their program.

In total, we sent emails to 98% of eligible home visiting administrators in the region.[2] Of the 196 administrators we requested emails from, 147 (75%) replied. In total, we received emails for 1,208 home visitors and home visiting supervisors. We then sent an electronic survey to each email address. Home visiting program administrators were given a $25 gift card for their program if between 1% and 49% of their staff completed the survey, a $50 gift card if between 50% and 74% of their staff completed the survey, or a $100 gift card if 75% or more of their staff completed the survey. In total, 635 (52.6%) home visitors and supervisors completed the survey.

We followed up with each of the 635 survey respondents via email two times, at the three-month mark and at the six-month mark, after completing the initial survey to see if they had left their job. If they had left their job, we asked them to take an online exit survey. Respondents who took the exit survey were given a $25 gift card. In total, 21 exit surveys were completed.

Each of the 635 home visitors and home visiting supervisors who responded to the initial survey were also asked if they would be interested in participating in a telephone interview with the research team about their work lives. The 571 (90.8%) respondents who indicated that they would participate in a phone interview were stratified by their job roles (home visitors and supervisors). For home visitors, we then stratified by state and, within states, by their Adverse Childhood Experiences (ACEs) scores to represent two groups, those scoring over four ACEs and those scoring under four, which represents the cut point at which individuals might

[2] We did not attempt to recruit four Nurse Family Partnership programs funded by MIECHV in Alaska because it had a separate IRB process that would have extended the study timeline.

experience challenges to their well-being.[xv] Within these groups, we stratified again by home visiting model, selecting from the five most prevalent models. We randomly selected 14 home visitors to interview. We then stratified supervisors by state and randomly selected six supervisors who worked in the most prevalent home visiting model in their state. This sampling strategy was designed to draw an interview sample reflective of a range of ACEs scores, home visiting approaches, and geographical service provision areas. Interviewees were given a $40 gift card as a thank you for their participation.

Instruments

All instruments used for this study were created in collaboration with a regional workgroup of home visiting and early childhood professionals. For a full list of working group members, see Appendix A.

Home Visiting Workforce Survey. Home visitors and home visiting supervisors were administered an electronic survey that focused on their personal characteristics, the nature of their work, the quality of their work environment, and on their health and well-being.

> ***Personal Characteristics.*** This section of the survey asked respondents about their background characteristics, education, perceptions of their professional development needs, and years of experience in their jobs and in the field. It asked respondents about their financial well-being, including their compensation, receipt of public assistance, and whether they have a second job. It also included questions from the *Financial Strain* scale from the *Family Economic Pressure Survey.*[xvi]
>
> ***Nature of the Work.*** The next section of the survey focused on the nature of the work and included items about respondents' employment status, the home visiting model(s) in use by their organization, whether their organization receives MIECHV funding, how they spend their time at work, their caseload, and about the characteristics of the families that they serve. It also asked respondents about the effects of their work and included items from the *Maslach Burnout Inventory-Educational Survey*,[xvii] the *Secondary Traumatic Stress Scale* drawn from the *Parker Psychological Climate Scale*,[xviii] and the *Self-Efficacy Scale* adapted from the *Texas Christian University Organizational Readiness to Change Scale.*[xix]
>
> ***Quality of Work Environment.*** The next section of the survey concentrated on the quality of the organizations within which home visitors and home visiting supervisors work. It included items drawn from the *Comprehensive Organizational Health Assessment*[xx] that measured role clarity, job

satisfaction, supervision support, time pressure, leadership, collegiality, and professional learning cultures. This section also asked respondents about their job frustrations, job motivations, and job intentions and asked supervisors to provide information about job turnover by job role within their organizations

Well-Being. The final section of the survey focused on respondents' health and well-being, including the abbreviated *Connor-Davidson Resilience Scale*[xxi] and items drawn from the *Patient Health Questionnaire-9th Edition*[xxii] that asked respondents about their physical health, access to and use of health care, and the frequency with which they exhibited healthy behaviors. The survey concluded with a 10-item *Adverse Childhood Experiences* questionnaire[xxiii] that asked participants to provide a count of particular traumatic events in childhood that they experienced.

Exit Survey. All survey respondents who left their job after completing the *Home Visiting Workforce Survey* were asked to complete a 12-item electronic exit survey. This survey queried individuals about why they left their job, factors that would have motivated them to stay in their job, the nature of their relationship with their former supervisor, and their current job status.

Interviews. Twenty respondents who completed the *Home Visiting Workforce Survey* were also administered a semi-structured, open-ended, telephone interview tailored to either home visitors or home visiting supervisors. Questions asked interviewees to trace their career and educational trajectories and how they entered into the home visiting field. They were also asked to assess the hardest parts of their job and how their education and professional development prepared them for the work. Interviewees then were asked about strategies they employ for working with challenging families, how their early experiences shape the services they provide, and the strategies they use to manage the stress of the job. The interview concluded by asking interviewees to consider the types of supervision that they receive, how supervision could be improved, their job frustrations and motivations, and career intentions.

Methods

Descriptive statistics. Descriptive statistics were calculated to provide an overview of the characteristics of the sample, the nature of their work, the quality of their work environment, and a description of aspects of their well-being. In instances where key differences among states or job roles are highlighted, the differences are statistically significant at the 0.05 level. For items where home visitors who work in

the same organization are expected to give similar responses (e.g., items relating to wages or benefits), statistical tests accounted for the clustering of responses from home visitors within the same organization.

Regressions. A series of regression analyses were used to examine factors that predict job role, intent to stay, and health status/well-being. All models accounted for the clustering of home visitors and supervisors within programs. Logistic regressions were used for dichotomous outcomes. Categorical predictors with more than two groups were entered into the models using reference groups, which allow direct comparison between the reference variable and each category. In instances with more than 10% missing data, full information maximum likelihood was used to account for missing data. A p-value of 0.05 or less was used to determine whether predictors were significant.

Interview Themes. Researchers analyzed the qualitative data using a two-step process involving a combination of *a priori* codes drawn from literature as well as codes that emerged from the interviews. Initially, analysts coded the data according to broad thematic categories (e.g., Motivation, Job Challenges). This resulted in a list of themes and excerpts from interviews that corresponded with each theme. Next, the research team proceeded with a second, more fine-grained analysis in which the data were assigned to sub-themes (e.g., Organizational Culture, Self-Care). Two lead researchers read 15% of the interviews, identified themes generated from responses, and then met to compare themes and settle disagreements by consensus. The full research team then coded the remaining interviews, adding new sub-themes where relevant.

Sample

In total, 635 home visitors and home visiting supervisors completed the *Home Visiting Workforce Survey.* Of the surveys completed, 468 were completed by home visitors who provide direct services to families, 120 were completed by supervisors, and 41 were completed by professionals who provide both home visiting services and act as a supervisor. For the purposes of this report, professionals who serve both roles are included in the supervisor sample. Table i displays the respondents by job role and by state. Across states, approximately two-thirds of respondents who have a caseload of families work in urban environments while approximately one-third serve families in rural or remote areas of their state.

GEOGRAPHY AND JOB ROLE

Table i. Respondents by Job Role and State

	AK		ID		OR		WA		All States	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Home Visitor	60	76.9%	30	73.2%	186	74.7%	192	73.6%	468	73.7%
Supervisor	18	23.1%	11	26.8%	63	25.3%	69	26.4%	161	25.4%
No Job Role Selected	--	--	--	--	--	--	--	--	6	0.9%
Total	78	100%	41	100%	249	100%	261	100%	635	100%

Note: Six respondents did not provide a job role and are not included in the analytic sample moving forward.

FUNDING STATUS

Of the sample, 202 (44.2%) home visitors and 76 (48.7%) home visiting supervisors worked in home visiting programs that received MIECHV funding. Table ii displays response rates by state, job role, and MIECHV funding status.

Table ii. Response Rate by Job Role, State, and MIECHV Status

		AK		ID		OR		WA		All States	
		N	%	N	%	N	%	N	%	N	%
Home Visitors	MIECHV	--	--	18	60	85	48.6	94	49.0	202	44.2
	Non-MIECHV	50	100	12	40	82	46.9	72	37.5	216	47.3
	Missing	--	--	--	--	8	4.6	26	13.5	39	8.5
	Total	50	100	30	100	175	100	192	100	457	100
Supervisors	MIECHV	--	--	7	100	32	52.50	36	53.7	76	48.7
	Non-MIECHV	16	100	--	--	29	47.50	31	46.3	80	51.3
	Missing	--	--	--	--	--	--	--	--	--	--
	Total	16	100	7	100	61	100	67	100	156	100

HOME-VISITING MODEL

For the purposes of this study, state agency partners from Region X identified criteria for including programs in the study recruitment. In particular, they identified home visiting programs that are:

- Voluntary for families to join
- Providing regular home visits for 6 months or longer
- Evidence-based or based on promising practices
- Serving prenatal/birth through early childhood populations
- Using a home visiting model or curriculum

In addition, Alaska included programs that provide home visiting services in the context of other specialized services, such as Part C early intervention.

Across the region, the study sample reported using a variety of home visiting models. Table iii shows that home visitors and supervisors in the sample are using eighteen different home visiting models across the four states. Home visitors and supervisors in Idaho and Washington identified Parents as Teachers most frequently, while the samples in Alaska and Oregon most frequently identified Infant Learning Programs and Healthy Families America, respectively. For the region as a whole, Parents as Teachers was the most frequently reported model (37.4%). Three models are used in all four states within Region X: Early Head Start,

Nurse Family Partnership, and Parents as Teachers. Of the programs receiving MIECHV funding, all models present in Table iii are represented except for Infant Learning Programs.

Table iii. HV Model Use by State

Model	AK n = 6–37	ID n = 10–23	OR n = 9–97	WA n = 12–118	Region X n = 16–235
Babies First!	--	--	8.4%	--	3.3%
CaCoon	--	--	6.4%	--	2.5%
Early Head Start: Home-based	23.1%	24.4%	22.5%	23.8%	23.2%
Growing Great Kids	--	--	9.2%	--	3.7%
Healthy Families America	--	--	39.0%	--	15.9%
Infant Learning Programs*	47.4%	--	--	--	7.2%
Nurse Family Partnership	9.0%	24.4%	11.2%	30.3%	19.7%
Parent-Child Home Program	--	--	4.8%	12.3%	7.3%
Parents as Teachers	28.2%	56.1%	28.9%	45.2%	37.4%
Play and Learning Strategies	7.7%	--	3.6%	4.6%	4.3%
Other Models**	7.7%	--	13.3%	7.3%	9.4%

-- Missing, suppressed, or 0.0 value cells.
*Infant Learning Programs (ILP) do not adhere to a home visiting model and provide services under Part C. In Alaska, ILPs provide the majority of home visiting services statewide.
**Other Models represents models with fewer than 5 cases in each state. These include Child Parent Psychotherapy, Early Steps to School Success, Family Spirit, and Parent Child Home Program.
***HV models are not mutually exclusive and column totals may exceed 100%.

While 75.1% of home visitors and supervisors reported using a single home visiting model in their practice, approximately one-quarter of the sample (24.9%) reported using two or more home visiting models (Table iv). Across the region, most respondents delivering more than one model reported using two models (18.8%), although a small percentage (6.2%) reported using three or more.

Table iv. Percent of Home Visitors and Supervisors Delivering Multiple Models

Number of HV Models Delivered	AK n = 74	ID n = 41	OR n = 235	WA n = 249	Region X n = 599
1	79.7%	95.1%	63.8%	81.1%	75.1%
2 or more	20.3%	4.9%	36.2%	18.9%	24.9%

In instances where home visitors and supervisors reported using multiple home visiting models in their work, the most common combinations of models included:

- Parents as Teachers, Early Head Start: Home Visiting
- Parents as Teachers, Healthy Families America

EXIT SURVEY

Of the 635 respondents to the *Home Visiting Workforce Survey*, 27 home visitors and 7 supervisors/administrators participated in the supplementary online exit survey. See the text box for demographic details about the exit survey participants.

Exit Survey Demographics *

STATE DISTRIBUTION
- Alaska: 23.5%
- Idaho: 0.0%
- Oregon: 35.3%
- Washington: 41.2%

RACE/ETHNICITY
- People of color: 32.4%
- White: 67.6%

LANGUAGE
- English: 79.4%
- Spanish/Other: 20.5%

AGE
- 20–29: 17.6%
- 30–49: 67.6%
- 50+: 14.7%

EDUCATION
- Bachelor's or less: 58.8%
- Some graduate school: 20.6%
- Master's degree: 20.6%

WORKER EXPERIENCE (AVERAGE # OF YEARS)
- Most recent position: 3.5
- Direct home visiting: 6.3
- Early childhood field: 9.4

WAGES
- Average hourly wage: $21.76
- Time since last pay increase: 1.7 years

* To protect anonymity, some data categories have been merged due to small cell sizes.

Study Limitations

It is important to note that the sample of 635 home visitors and home visiting supervisors drawn for this study may not be representative of the population of home visitors and supervisors in the region. While we made sizable efforts to include 100% of the population of home visitors and supervisors employing evidence-based models, or that met evidence informed criteria, in Region X in the study, we have no way of knowing whether there are differences between home visitors and supervisors who elected to respond to the survey and those who did not. Similarly, we have no way of knowing whether there are important differences in home visitors whose program administrators passed along their email addresses to the research team and those who did not. Thus, we cannot control for non-response bias in this study. Consequently, caution should be taken when generalizing study findings to the population of home visitors and supervisors in the region.

Organization of Report

The following sections of this report provide an overview of the characteristics of a sample of the home visiting workforce in Region X and the settings in which they work. The report also explores personal and workplace factors associated with job turnover and retention among home visitors and home visiting supervisors and examines factors that predict job role, pay, job intentions, and dimensions of their health and well-being. The report is organized into a series of topical research briefs that can be read and disseminated separately or can be read and disseminated as a whole.

Research Brief 1 explores the background characteristics of the sample, including their educational preparation, and explores how prepared they feel to meet the demands of their jobs. *Research Brief 2* reports on the nature of the sample's work experience, including their employment characteristics, caseloads, and how they spend their time at work, and concludes with an examination of their compensation. *Research Brief 3* examines the quality of the sample's work environments, as well as their job frustrations, motivations, and intentions. It concludes by reporting on the turnover rates among home visitors and home visiting supervisors within the organizations in which they work. *Research Brief 4* describes the financial, emotional, and physical well-being of the sample, including the adverse early experiences they reported. *Research Brief 5* investigates the personal and workplace factors that predict job role, pay, and job intentions, as well as dimensions of the

sample's health and well-being. Each brief ends with a set of policy and practice recommendations for strengthening the system of supports needed for a thriving and skilled home visiting workforce in the region.

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Appendix A

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*** Regional Governance Committee Member**
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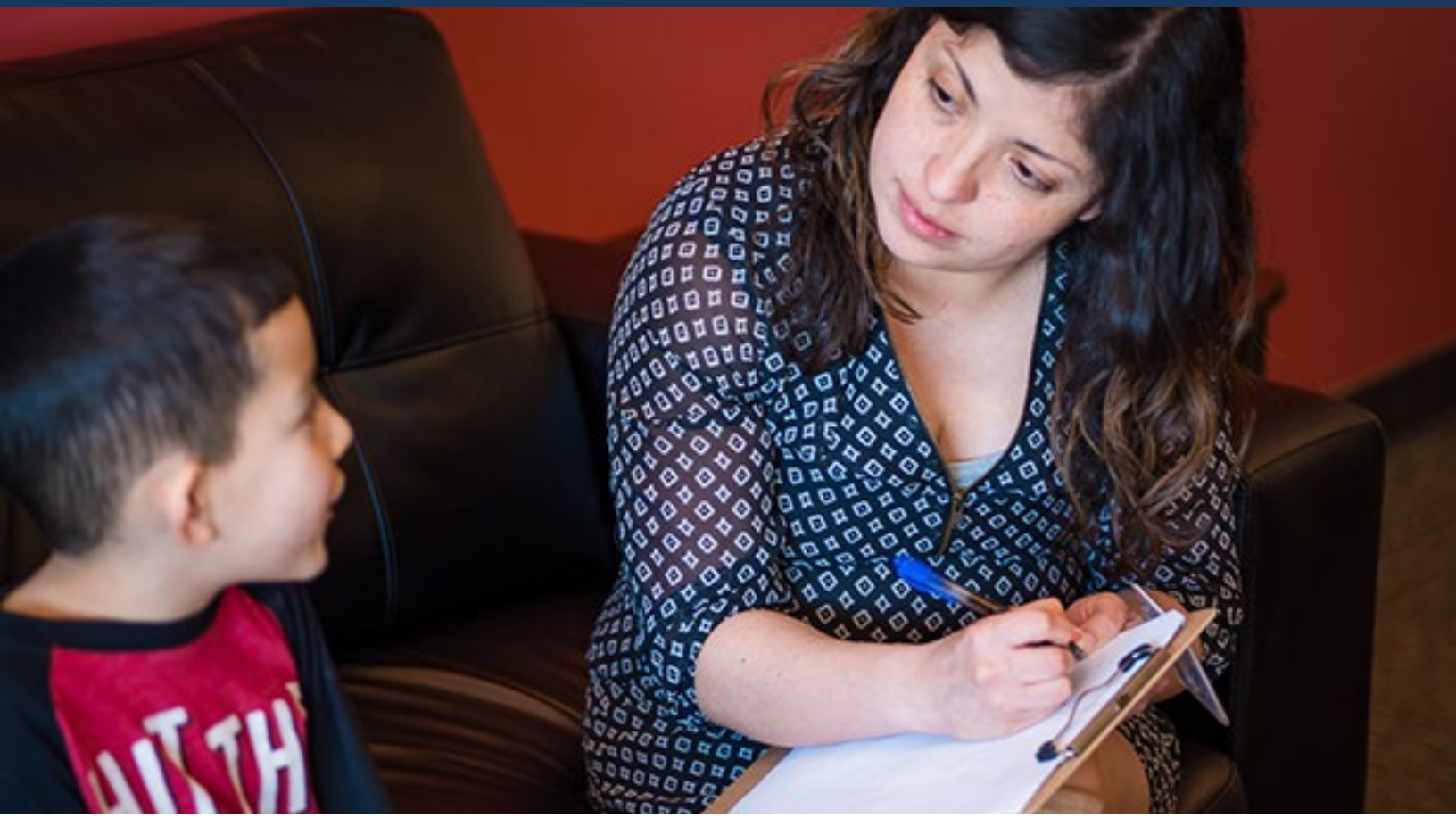
Region X Innovation Grant

AK • ID • OR • WA

Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study



RESEARCH BRIEF #1

Demographic and Educational Characteristics of the Region X Home Visiting Workforce

This research brief is the first in a series that is part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with the Alaska Division of Public Health, the Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[vi]

Key Findings

Many home visitors and home visiting supervisors in the region are new to the profession.

- A third of home visitors and almost a quarter of supervisors have been in the home visiting profession less than two years.
- Almost half of home visitors and slightly over a third of supervisors have been in their current job less than two years.

A quarter of home visitors and about 40% of supervisors are approaching retirement age.

Fifteen percent of home visitors and 9% of supervisors speak a home language other than English. The most common home language other than English is Spanish.

Home visitors and supervisors most commonly identified as white and of European origin; supervisors were more likely to be white than were home visitors (78% vs. 62%, respectively).

The majority of home visitors (70%) and supervisors (90%) hold bachelor's degrees or higher, with supervisors more likely to have a graduate degree than home visitors. However, many home visitors (40%) and supervisors (45%) hold degrees in fields unrelated to the profession.

Home visitors and supervisors rated themselves most confident in their knowledge of child and social-emotional development and least confident in supporting families with children with special needs and in culturally and linguistically responsive home visiting practices.

Introduction

Over the past decade, home visiting has received an unprecedented amount of policy attention. This attention stems from several decades of research documenting the potential role that home visiting programs can play in addressing many of society's most pressing problems, including child abuse, neglect, and failure to succeed in school.[xxiv] Indeed, evidence-based home visiting can lead to increased parenting capacity and support for children, improved school readiness and health outcomes for children,[xxv] and reductions in family involvement in juvenile justice and social service systems.[xxvi] Consequently, the federal government has invested $1.85 billion in home visiting programs since 2010, and the numbers of families receiving home visiting services across the country has quadrupled.[xxvii] This federal investment, as well as additional state and private investments in home visitation programs, has resulted in a need to substantially increase the numbers of home visitors across the country (including in Region X) and to ensure a skilled and thriving current and future workforce.

Evidence-based home visiting can lead to increased parenting capacity and support for children and improved school readiness and health outcomes for children.

Home visitors are widely viewed as the most important ingredient for ensuring the effectiveness of the services programs deliver. Their knowledge and skills are paramount to administering an evidence-based home visiting model to fidelity.[xxviii] They are also

important for appropriately implementing and using assessments, for the dyadic work of supporting the parent-child relationship and building parent capacity to support their child's development, for helping families to access and navigate resources, for fostering collaborative relationships with families, and for being culturally sensitive and responsive to the family systems in which they work. Therefore, a number of efforts are underway in Region X to enhance the knowledge, competencies, and skills of the home visiting workforce.

Yet very little is currently known about the home visiting workforce collectively across Region X, including their strengths, gaps, and unmet needs. Thus, efforts to best support them are often challenged by the lack of detailed information that describes their basic characteristics, including their demographic information, education, and their professional development needs. Such information is needed to help decision-makers create a strong system of professional preparation and ongoing, in-service professional development to help ensure an effective home visiting workforce.

> Home visitors are widely viewed as the most important ingredient for ensuring the effectiveness of the services programs deliver.

Detailed information about the current gaps in the workforce is also needed to understand where recruitment efforts could best be targeted to build a workforce pipeline that is reflective of the diversity of families in the region and well positioned to meet the needs of the families who experience persistent challenges to their well-being.

Research Questions

The purpose of this research brief is to address the following research questions:

1. What are the demographic characteristics of a sample of home visitors and home visiting supervisors in Region X?

2. What are the educational levels and educational backgrounds of the sample of home visitors and supervisors?

3. What are home visitors' and supervisors' perceptions of their professional knowledge and professional development needs?

Sample

The sample used for this research brief includes 468 home visitors who provide home visiting services directly to families, and 161 home visiting supervisors, 29% of whom have a caseload of families they serve. These home visitors and supervisors were drawn from Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Of the sample, 44.2% of home visitors and 47.8% of supervisors worked in home visiting programs that received Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) funding. The sample also worked in organizations that employed a variety of different home visiting models, including Babies First, Child Parent Psychotherapy, Early Head Start, Early Steps to School Success, Family Spirit, Healthy Families America, Infant Learning Program, The Nurse Family Partnership, The Outreach Doula, The Parent Child Home Program, and Parents as Teachers. For more information about how the sample was drawn and the measures used for this study, please see *The Region X Home Visiting Workforce Study: Introduction.*[xxix] Throughout this brief, we have merged data categories in cases where a single cell has fewer than five respondents. This protects the anonymity of respondents and minimizes the suppression of data. In the few instances where merging categories is not possible, we have suppressed data in an effort to preserve anonymity of survey respondents.

Results

Research Question 1: What are the demographic characteristics of a sample of home visitors and home visiting supervisors in Region X?

In this section, descriptive information on the ages, experience levels, home languages, and the racial/ethnic backgrounds of the sample of home visitors and home visiting supervisors in Region X are provided.

AGE

Across the region, there were statistically significant differences found in the ages of the sample based on job role,[3] with home visiting supervisors[4] being approximately 5.8 years older, on average, than home visitors. As a region, home visitors averaged approximately 41 years of age, with a median age of 38, and ranged in age from 20 to 71 years old. Supervisors averaged approximately 46 years of age, with a median age of 45 years of age, and ranged from 26 to 73 years old. In addition, 24.4% of home visitors and 41.2% of supervisors across the region reported being 50 years of age or older. ***This suggests that within the next decade a sizable proportion of the workforce may be retiring and leaving the field.*** Table 1.1 displays the ages of the sample by job role for each state and for the region as a whole.

Within the next decade, a sizeable proportion of the workforce *may be retiring and leaving the field.*

[3] (t = −5.434, p<.001)

[4] For all analyses, we combined supervisors who do and do not carry a caseload into one group labeled as "supervisor."

Table 1.1. Ages of Home Visitors and Supervisors

Age	Alaska	Idaho	Oregon	Washington	Region X
Home Visitors					
20–29	18.6%	20.7%	19.1%	20.3%	19.7%
30–39	33.9%	31.0%	33.3%	36.4%	34.5%
40–49	30.5%	24.1%	20.8%	18.7%	21.4%
50–59	17.0%	24.1%	15.8%	16.6%	14.8%
60 or older			10.9%	8.0%	9.6%
Supervisors					
20–29	44.5%	45.5%	37.1%	30.4%	4.4%
30–39					26.3%
40–49			29.0%	27.5%	28.1%
50–59	55.5%	54.5%	14.5%	23.2%	23.1%
60 or older			19.4%	18.8%	18.1%

EXPERIENCE

Table 1.2 focuses on home visitors and their professional experience. The table displays their average years of experience in the early childhood field, defined as paid work experience with children birth to five years of age or their families, which could include work in other early childhood service sectors. The table also displays their average years of experience in the home visitation profession providing direct services and their years of experience in their current position.

When considering the professional background of home visitors, it appears that many did not begin their careers in home visiting. Approximately 62% worked in other early childhood sectors, with an average of about 3.6 years in the early childhood field prior to becoming a home visitor. On the other hand, approximately 38% of home visitors' first jobs in early childhood were in home visitation.

As a region, home visitors averaged more than 10 years of experience working with young children or their families and averaged approximately 6.8 years in the home visiting service sector. The average home visitor reported being in their current job slightly more than four years. However, the large standard deviations suggest wide variation in home visitors' experience levels, with a sizable group new to the profession and another group having more than 10 years of experience in home visiting.

Home visitors averaged more than 10 years' experience working with young children or their families and averaged approximately 6.8 years in the home visiting service sector.

For example, across the region, 33.3% have been in the home visiting sector less than two years, and 49.8% have been in their current jobs less than two years. These trends are similar within individual states, with 30% of home visitors in Alaska and Idaho, 34.1% in Oregon, and 34.1% in Washington in the home visiting sector less than two years. Similarly, 40.7% of home visitors in Alaska, 66.7% in Idaho, 50.3% in Oregon, and 49.5% in Washington have been in their jobs less than two years. **When taken together, these figures suggest a degree of occupational stability in the field working in early childhood, but less job longevity as a home visitor specifically.** In contrast, across Region X, 26.7% of home visitors have been in the home visiting profession more than 10 years and 13.2% have been in their current position more than 10 years. These trends too are similar within each of the four states, with 23.3% of home visitors in Alaska, 33.3% in Idaho, 27.0% in Oregon, and 26.5% in Washington having been in the home visitation sector more than 10 years. Similarly, 15.4% of home visitors in Alaska, 14.6% in Idaho, 12.4% in Oregon, and 15.1% in Washington have been in their jobs more than 10 years.

Across Region X, 26.7% of home visitors have been in the home visiting profession more than 10 years and 13.2% have been in their current position more than 10 years.

Table 1.2. Experience Levels: Home Visitors

	Mean	Std. Dev.	Min.	Max.
Years in Early Childhood Field				
Alaska	11.45	8.97	1	40
Idaho	10.00	8.42	0	30
Oregon	10.19	8.99	0	43
Washington	10.30	8.39	0	38
Region X	10.39	8.70	0	43
Years in Home Visiting Sector				
Alaska	7.32	8.08	0	39
Idaho	5.97	5.46	0	17
Oregon	6.72	7.15	0	40
Washington	6.87	7.24	0	30
Region X	6.81	7.20	0	40
Years in Current Position				
Alaska	4.53	4.51	0	20
Idaho	3.57	4.60	0	17
Oregon	4.08	5.12	0	31
Washington	4.08	4.57	0	28
Region X	4.10	4.78	0	31

Typically, supervisors spent approximately 8.3 years as a home visitor prior to becoming a supervisor.

Table 1.3 turns to home visiting supervisors. Similar to home visitors, the typical supervisor began their career in other early childhood service sectors, averaging approximately 7.9 years in other sectors before entering the home visiting profession. Only a small percentage of supervisors across the region, 11.4%, had no experience as a home visitor prior to becoming supervisor. Typically, supervisors spent approximately 8.3 years as a home visitor prior to becoming a supervisor. These figures varied somewhat by state, with the average number of years spent as a home visitor prior to becoming a supervisor calculated at 7.1 in Alaska, 5.6 in Idaho, and 8.7 in Oregon and Washington. [5] ***This suggests both a degree of occupation stability for supervisors and that a transition may occur for many home visitors approximately six to eight years into the profession, when some move into leadership positions.***

Table 1.3 shows that the average home visiting supervisor across the region has considerable experience in the early childhood field, yet the large standard deviations also suggest wide variation in experience levels. Like home visitors, many are new to the home visiting profession and to their jobs. Almost a quarter (22.8%) have been in the home visiting sector less than two years, and slightly over a third (36.5%) have been in their

[5] Figures for supervisors in Alaska and Idaho should be interpreted with caution due to the small sample size.

current jobs less than two years. These trends vary somewhat across states, with 27.8% of supervisors in Alaska, 36.4% in Idaho, 27% in Oregon, and 15.2% in Washington reporting having been in the service sector less than two years. In Alaska and Washington, 27.8% and 29.4% of supervisors, respectively, reported being in their jobs less than two years. These figures were higher in Idaho and Oregon, where 54.5% and 43.5% of supervisors, respectively, reported being in their jobs less than two years.

When comparing the experience levels of home visitors and home visiting supervisors, supervisors had slightly more experience in the home visiting profession[6] and in their current position[7] than home visitors. Differences between the two groups were statistically significant for both—on average, supervisors had approximately 1.52 years more experience in home visitation and approximately 1.81 more years of experience in their current jobs than home visitors.

Table 1.3. Experience Levels: Home Visiting Supervisors

	Mean	Std. Dev.	Min.	Max.
Years in Early Childhood Field				
Alaska	17.56	10.23	4	36
Idaho	15.27	9.12	1	30
Oregon	16.21	11.59	1	45
Washington	16.09	9.00	0	35
Region X	16.25	10.14	0	45
Years in Home Visiting				
Alaska	7.11	7.34	0	23
Idaho	5.64	5.16	0	15
Oregon	8.73	8.43	0	32
Washington	8.73	7.44	0	28
Region X	8.33	7.70	0	32
Years in Current Position				
Alaska	8.00	7.48	0	25
Idaho	3.36	2.91	1	10
Oregon	5.24	6.30	0	37
Washington	6.37	6.86	0	33
Region X	5.91	6.56	0	37

[6] ($t = -2.25$, $p<.05$)
[7] ($t = -3.19$, $p<.01$)

PRIMARY LANGUAGES

Table 1.4 displays the languages that home visitors and home visiting supervisors reported speaking as their primary language at home. The first column under each state displays the percentage of home visitors (HV) who reported speaking the language at home, the second column displays the percentage of supervisors (Sup.) who reported speaking the language at home, and the third column (State) displays the percentage of the population in the state that primarily speaks the language at home.[8] In some cases, there were fewer than five respondents within job roles in individual states that responded to speaking a primary language other than English or Spanish. In these cases, we merged the Spanish and "Other" primary language responses to protect anonymity.

Less than 0.05% of home visitors and supervisors combined reported speaking a primary language other than English or Spanish.

Across the region, 15% of home visitors and 11.1% of home visiting supervisors indicated speaking a primary language other than English. These figures varied across states and ranged from no home visitors in Idaho speaking a primary language other than English to 18.3% in Washington. Similar variations were noted in supervisors' primary languages, which ranged from no supervisors in Alaska speaking a primary language other than English to 11.1% in Oregon.

As can be seen in Table 1.4, English is by far the most common primary language for home visitors and for home visiting supervisors, followed by Spanish. Less than 0.05% of home visitors and supervisors combined reported speaking a primary language other than English or Spanish.[9] The table also shows that there may be a need to recruit more Spanish-speaking home visitors and supervisors in Idaho to reflect the primary languages spoken in the state.[10]

In Alaska and Washington, according to US census estimates, 16.2% and 19.0% of their respective population speak a primary language other than English or Spanish, commonly an Asian or Pacific Island language. According to 2016 census estimates, 5.5% of the population in Alaska and 5.7% in Washington speak an Asian or Pacific Island language.

[8]It is important to note that this study collected information on home languages, not on all of the languages that home visitors and home visiting supervisors speak.

[9] Across states and job roles, less than 5% of the sample combined reported speaking Mandarin, Cantonese, French, Arabic, Russian, Somali, Vietnamese, Farsi, Inupiat, Lingala, Samoan, Swahili, Thai, and Mien as their primary language.

[10] It is important to note that the population of families participating in home visitation programs may not match the home language demographics of the state as a whole and may be more likely to speak non-English home languages. Thus, there may be a greater need to develop bilingual home visitors than the population language parameters may indicate.

Thus, efforts may also be needed to recruit home visitors and supervisors who speak Cantonese, Mandarin, Tagalog, and Thai, among other Asian and Pacific Island languages, in these states. [xxx]

Table 1.4. Languages Spoken

	Alaska			Idaho			Oregon			Washington		
Language	HV	Sup.	State	HV	Sup.	State	HV	Sup.	State	HV	Sup.	State
English	91.5%	100%	83.8%	100%	90.9%	89.4%	83.9%	88.9%	84.9%	81.8%	89.9%	81.0%
Spanish	8.5%	--	3.5%	--	9.1%	7.9%	13.4%	11.1%	8.9%	14.1%	10.1%	8.4%
Other		--	12.7%	--	0.0%	2.7%	2.7%		6.2%	4.2%		10.6%

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ETHNICITY

Table 1.5 displays the racial/ethnic backgrounds of the sample of home visitors in each state. For comparative purposes, Table 1.6 displays the racial/ethnic makeup of the population in each state based on 2016 census estimates.

Across the region, 38.2% of home visitors identified as people of color. These figures varied somewhat by state, with 31.7% of home visitors in Alaska, 23.3% in Idaho, 38.7% in Oregon, and 42.7% in Washington identifying as people of color. The most common racial/ethnic background, other than white, across states also varied somewhat, with 16.7% of home visitors in Alaska identifying as Indigenous Americans / Alaska Natives, and almost one quarter of home visitors in Oregon (24.7%) and Washington (22.9%) identifying as Hispanic/Latina.

Table 1.5. Racial/Ethnic Backgrounds Home Visitors

	AK	ID	OR	WA
African American	--	--	--	4.2%
Indigenous Americans / Native Alaskans	16.7%	--	--	--
Asian / Pacific Islander	--	--	--	4.1%
Hispanic/Latina	--	--	24.7%	22.9%
White	68.3%	76.7%	61.3%	57.3%
Multi-racial	--	--	5.4%	5.7%

-- Missing, suppressed, or 0.0 value cells.

For home visiting supervisors, 21.7% identified as people of color. Across individual states, 11.1% of supervisors in Alaska, 27.3% in Idaho, 25.4% in Oregon, and 20.3% in Washington did not report being white. In Oregon, 12.7% of supervisors identified as Hispanic/Latina, and in Washington, 8.7% reported being Hispanic/Latina.

When comparing the ethnicities of the sample across job roles, home visiting supervisors were more likely to be of white, European origin than were home visitors.[11] When examining whether supervisors were more likely to be white than home visitors within individual states, results showed that in Alaska, Oregon, and Washington, a higher percentage of supervisors were white, but the only statistically significant difference was found in Washington.[12]

Table 1.6. Racial/Ethnic Backgrounds of State Population

	AK	ID	OR	WA
African American	3.3%	< 1%	1.9%	3.6%
Indigenous Americans / Native Alaskans	14.1%	1.3%	1.1%	1.3%
Asian / Pacific Islander	7.2%	1.4%	4.4%	8.4%
Hispanic	7.1%	11.2%	13.1%	12.7%
White	65.6%	91.3%	85.1%	77.3%
Multi-racial	8.5%	2.6%	4.4%	5.3%

Research Question 2: What are the educational levels and educational backgrounds of the sample?

This section explores the educational levels and backgrounds of home visitors and home visiting supervisors in the sample.

EDUCATIONAL LEVELS

Table 1.7 displays the highest educational attainment of home visitors and home visiting supervisors by state and as a region. In cases where there were fewer than five respondents, we merged response categories to protect anonymity.

As can be seen in the Table 1.7, a high percentage of home visitors in the region are degreed (84.7%)—having attained at least an associate's (A.A.)[13] degree or higher. High percentages of degreed home visitors are also observed within individual states, with 85% of home visitors in Alaska, 96.6% in Idaho, 79.5% in Oregon, and 88% in Washington holding an A.A.

[11] ($X^2 = 14.45$, $p < .001$)

[12] ($X^2 = 10.694$, $p > .001$)

[13] For the ease of the reader, we refer to all associate's degrees, including associate's of arts, science, and transfer degrees, as an A.A. Similarly, we refer to both bachelor's of arts and of science as B.A. degrees.

degree or higher. When considering bachelor's degree attainment (B.A.), 70% of home visitors in Alaska, 83.3% in Idaho, 63.2% in Oregon, 80.1% in Washington, and 72.3% across the region have a B.A. degree or higher.

Table 1.7. Highest Degree Attainment

	Alaska		Idaho		Oregon		Washington		Region	
	HV	Sup.	HV	Sup.	HV	Sup.	HV	Sup.	HV	Sup.
H.S. / Some College	15.0%	--	--	--	20.5%	--	12.0%	--	15.2%	5.0%
A.A.	15.0%				16.2%		7.9%		12.4%	8.1%
B.A.	30.0%	88.9%	96.6%	100%	56.8%	60.3%	65.4%	58.8	57.7%	46.9%
Graduate	40.0%				6.5%	34.9%	14.7%	36.8%	14.6%	40.0%

-- Missing, suppressed, or 0.0 value cells.

Similar to home visitors, a high percentage of home visiting supervisors are also degreed. Across the region, 86.9% have a B.A. degree or higher, with similar figures found in Oregon (87.3%) and Washington (89.7%) and with slightly lower figures found in Alaska and Idaho—although Alaska has a noticeably higher percentage of supervisors with graduate degrees. When considering differences in educational levels between home visitors and supervisors, supervisors were approximately 20% more likely to have a graduate degree than were home visitors.[14]

A high percentage of home visitors in the region have attained at least an associate's (A.A.) degree or higher.

DEGREE CONTENT

Home visitors and home visiting supervisors who had completed at least one degree were also asked to report on their major or concentration area for their highest degree. Degree majors were then classified into four categories. The first category, *Education and Development*, includes majors such as human development and family relations, early childhood education / special education, and child development. The second category, *Social Services*, includes majors such as social work and human services. The third category, *Clinical*, includes majors such as nursing, speech pathology, and early intervention. The final category, *Unrelated*, includes all other majors, such as biology and economics. Table 1.8 displays the percentage of home visitors and supervisors for each state, and for the region as a whole, who hold degrees in different majors.

[14] ($X^2 = 50.86$, $p < .001$)

As can be seen in Table 1.8, home visitors come to their jobs with a range of educational backgrounds. When considering the region as a whole, approximately 22.8% have degrees focused on education or development, 17.2% have social service–focused degrees, 20% have clinically focused degrees, and the remaining 40% hold degrees in unrelated fields. Some differences in degree focus emerged across states, with Alaska having a higher percentage of home visitors holding educationally focused degrees and degrees in related fields and a lower percentage of home visitors holding clinically focused degrees than home visitors in the region. Similarly, Idaho and Washington had more clinically focused degree holders than did the region.

Table 1.8. Highest Degree Major

	Alaska		Idaho		Oregon		Washington		Region	
	HV	Sup.	HV	Sup	HV	Sup.	HV	Sup.	HV	Sup.
Education & Development										
A.A.	11.8%	--	25.0%	--	4.1%	13.5%	2.4%	3.1%	4.6%	5.9%
B.A.	9.8%	--		--	14.3%		16.7%	9.2%	14.9%	7.2%
Graduate	17.6%	--	--	--	2.7%		--	10.8%	3.3%	7.2%
Total	39.2%	--	25.0%	--	21.2%	13.5%	19.2%	23.3%	22.8%	20.3%
Social Service										
A.A.	--	--	--	--	1.4%	1.7%	--	--	0.5%	0.7%
B.A.	19.6%	--	--	--	12.9%	10.0%	13.1%	15.4%	11.1%	11.2%
Graduate		--	--	--	1.4%	13.3%	6.5%	12.3%	5.6%	13.2%
Total	19.6%	--	--	--	15.6%	25.0%	19.6%	27.7%	17.2%	25.1%
Clinical										
A.A.	--	--	24.1%	--	4.1%	--	21.4%	--	2.3%	--
B.A.	--	--		--	13.6%	13.3%		16.9%	15.4%	11.2%
Graduate	--	--		--			3.6%		2.3%	4.6%
Total	--	--	24.1%	--	17.7%	13.3%	25.0%	16.9%	20.0%	15.8%
Unrelated										
A.A.	19.6%	--	44.8%	--	10.9%	30.0%	6.0%	20.0%	7.3%	8.6%
B.A.		37.5%		--	34.7%		23.8%		26.2%	19.7%
Graduate	13.7%			--		18.3%	6.5%	12.3%	6.1%	17.1%
Total	**33.3%**	**37.5%**	**44.8%**	**--**	**45.6%**	**48.3%**	**36.3%**	**32.3%**	**40.0%**	**45.4%**

-- Missing, suppressed, or 0.0 value cells.

Home visiting supervisors also appear to come to their jobs with varying educational backgrounds. Across the region, 20.3% have degrees focused on education or development, 25.1% have social service–focused degrees, 15.8% have clinically focused degrees, and the remaining 45.4% hold degrees in unrelated fields. Some differences in degree focus emerged across states, with Idaho having a higher percentage of supervisors holding

educationally and clinically focused degrees and a lower percentage holding social service related degrees compared to the region as a whole. Alaska, Idaho, and Washington also have fewer supervisors with unrelated degrees than in Oregon and the region as a whole.

When comparing home visitors and home visiting supervisors, no differences were found in their educational backgrounds with respect to holding a degree in a related field.[15] Home visitors were no more or less likely to hold a degree in an unrelated field than were supervisors.

SPECIALIZED COURSE WORK

Home visitors and home visiting supervisors also reported on whether their preparatory experiences included course work that fostered specialized knowledge considered critical to being effective in their job roles. Figure 1.1 shows the percentage of home visitors (indicated by the green bars) and supervisors (indicated by the blue bars) across the region that have completed formal college course work that addressed core knowledge domains. For more information about the percentage of home visitors and supervisors in each individual state that have completed course work in the core knowledge domains, please see Appendix A.

[15] (X^2= 0.453, p = .459)

Figure 1.1. Percent Who Have Completed Course Work in Core Knowledge Areas

Across the region, for the most part, home visitors and home visiting supervisors have completed course work focused on child development, including their social-emotional development, and to a slightly lesser extent have completed course work that focused on fostering family health, well-being, and positive parent-child relationships. However, less than half have completed course work related to supporting families with children with special needs, effective home visiting practices, family resources and support, and reflective practices. There were no significant differences in the percentages of home visitors and supervisors that completed course work in each knowledge domain.[16]

SPECIALIZED CREDENTIALS

Home visitors and home visiting supervisors also reported on whether they had earned any specialized credentials related to supporting families, including the *Child Development*

[16] Significance testing ranged from $X^2 = 2.75$, $p = .10$ to $X^2 = 0.03$, $p = .88$.

Associate – Home Visiting Credential (CDA) and the *Infant Mental Health Credential*. Across the region, only 9.5% of home visitors and 7.0% of supervisors have obtained a *CDA Home Visiting Credential*. Only 7.5% of home visitors and 5.6% of supervisors have completed an *Infant Mental Health Credential*. These figures are similar across states, except within Alaska, where 13.3% of home visitors have earned an *Infant Mental Health Credential* and 39.9% of supervisors hold either a *CDA Home Visiting Credential* or an *Infant Mental Health Credential*.

Research Question 3: What are home visitors' and supervisors' perceptions of their professional knowledge?

To better understand the areas of the work where home visitors and home visiting supervisors feel confident and where they might need more professional development, they were asked to reflect on their professional knowledge and skills. Specifically, they were asked to rate on a scale of 1 to 5, with 5 meaning very knowledgeable, how knowledgeable they felt in the key professional knowledge domains described in Figure 1.2.

Figure 1.2. Home Visitor Perceptions of Professional Knowledge

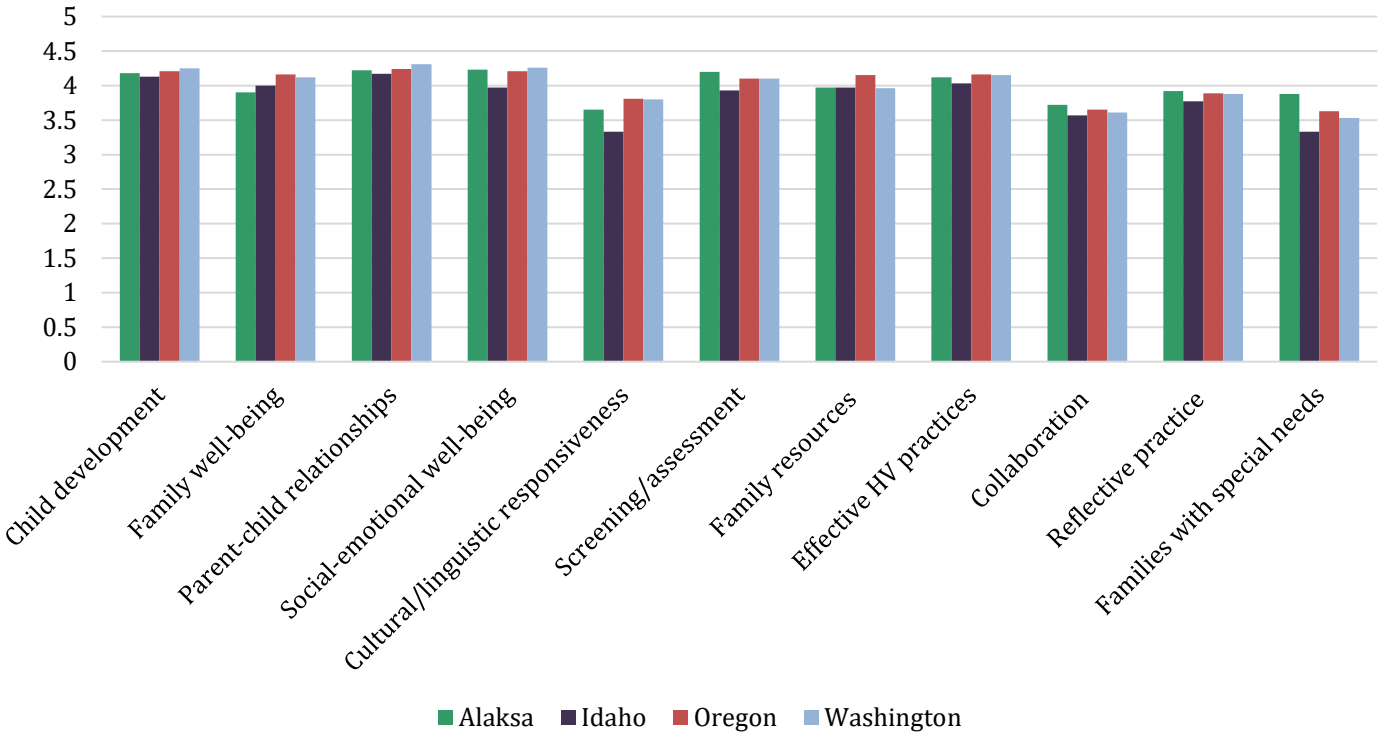


Figure 1.2 shows that home visitors rated themselves most knowledgeable in their understanding of child development, family health and well-being, and parent-child relationship processes. They rated themselves as the least confident in their knowledge and skills related to culturally and linguistically responsive home visiting practices, supporting

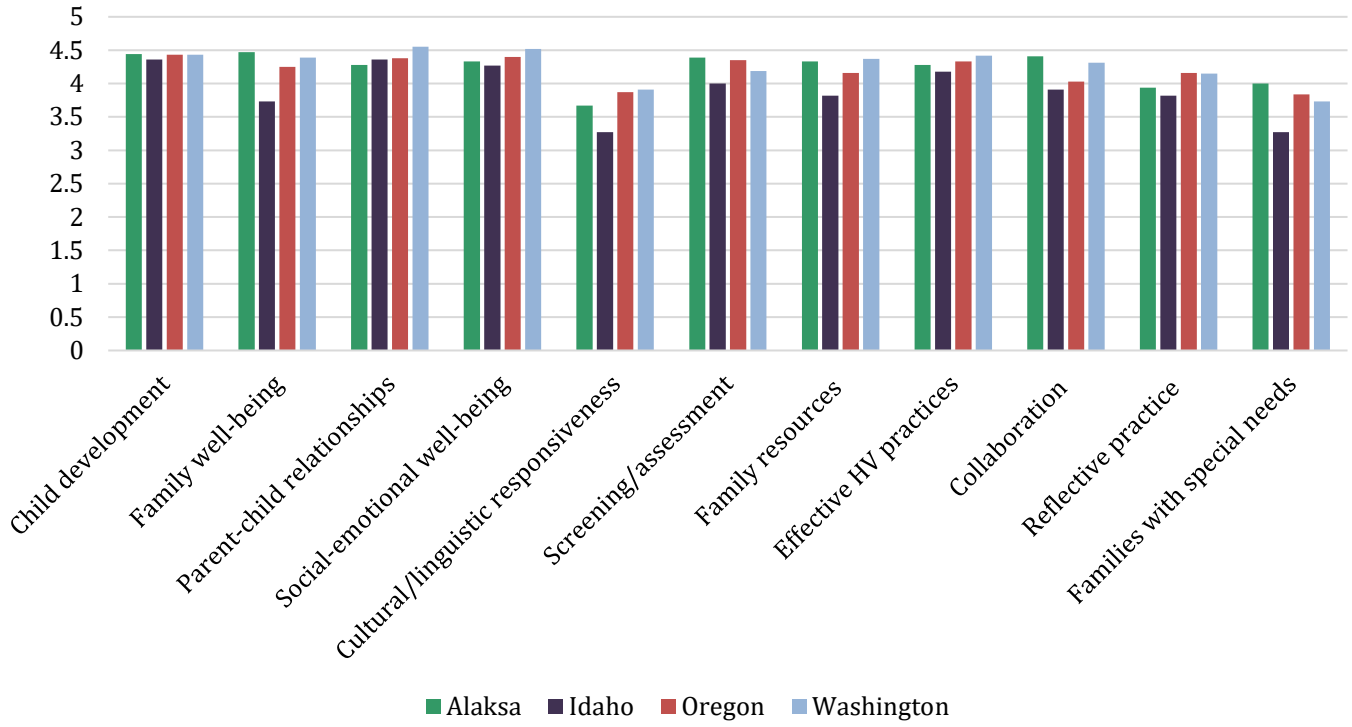
families with children with special needs, reflective supervision practices, and fostering collaboration.

Figure 1.3 displays home visiting supervisors' ratings of their professional knowledge. Similar to home visitors, supervisors rated themselves as the least confident in their knowledge and skills related to supporting families with children with special needs and home visiting practices that are responsive to the cultural and linguistic diversity of the families that they serve. Across the region, however, supervisors reported feeling more confident in culturally and linguistically responsive home visiting practices, supporting families with children with special needs, and fostering collaborations than did home visitors.[17]

Home visitors rated themselves most knowledgeable in their understanding of child development, family health and well-being, and parent-child relationship processes.

[17] The significance values of T-tests ranged from <.001 to .86.

Figure 1.3. Home Visiting Supervisor Perceptions of Professional Knowledge



Policy Considerations

This research brief points to several important policy considerations to support the home visiting workforce in Region X.

Recruiting a Home Visiting Supervisor Pipeline

Region X might consider strategic efforts for developing a diverse pipeline of home visiting supervisors. The results of this brief suggest that over the next 10 years, the region may lose about 20% of the supervisor workforce to retirement. Results also point to the important period in a home visitor's career trajectory in which some home visitors transition into leadership roles—between six and eight years into the profession. This time period may represent an important period in which home visitors may be mentored toward leadership roles and provided with additional professional development. This professional development might focus on developing reflective supervision skills and collaborations, areas that home visitors report feeling less confident in their knowledge and skills than do supervisors. Strategic efforts might also be made to expand their leadership competencies in other areas, including, for example, human resources, organizational development and fiscal management, and developing home visiting professionals. Targeting leadership

development and mentoring toward home visitors of color will be an important strategy for ensuring that leaders better represent the diversity of the profession, as currently supervisors are more likely to be white and of European origin than are home visitors.

Over the next 10 years, the region may lose about 20% of the supervisor workforce to retirement.

Recruiting and Developing Home Visitors

Strategic efforts are also needed to develop a pipeline of well-qualified home visitors. This brief finds that about a quarter of the home visitors in this study will also be approaching retirement in the next decade, creating a need to recruit and induct new home visitors into the profession. This brief also finds that many home visitors come to the profession after completing degrees that are educationally focused and after gaining experience in other early childhood service sectors, such as early learning settings. Home visiting leaders might consider working with early childhood education and/or child and adolescent development departments within local colleges and universities to offer course work that will deepen the understanding of family support, home visiting practices, infant mental health, and reflective supervision, and will promote the home visiting career pathway through advisement[18] as many students may not know about home visiting as a career trajectory.

Developing Scholarship Pools

The results of this brief also suggest that while this workforce appears to be highly educated in comparison to other early childhood service sectors, such as early learning,[xxxi] there are still opportunities to advance the formal education of home visitors in the region. Efforts might focus on developing a scholarship pool targeted toward supporting home visitors in articulating their A.A. degree to a B.A. degree in a relevant field and working with colleges and universities to foster articulation agreements. Fairly high proportions of home visitors and supervisors also hold degrees unrelated to children and families. Thus, certification or endorsement programs may be an important strategy for attaining specialized training and for supporting the cross-section of the profession with unrelated degrees. Home visiting leaders might consider collaborations with local workforce development offices to identify potential funding to support greater educational attainment for the workforce.

[18] See San Diego State University for an example of a bachelor's degree program that specifically embeds a home visiting credential and specialized course work within a Child and Family Development degree.

Enhancing Professional Development to Ensure a Workforce That Can Address the Needs of the Range of Families in the Region

Home visitors and home visiting supervisors across the region also indicate that they feel less confident in their knowledge and skills for supporting families with children with special needs and in culturally and linguistically responsive home visiting practices. These responses represent key areas in which home visiting leaders might develop comprehensive professional development to address these needs and where they might work with local colleges and universities to enhance their offerings in these areas.

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Appendix A

Percent of Home Visitors and Home Visiting Supervisors in Each State That Have Completed Course Work in Core Knowledge Domains

	Alaska		Idaho		Oregon		Washington	
Specialized Course Work	HV	Sup.	HV	Sup.	HV	Sup.	HV	Sup.
Child development	93.2%	94.1%	92.9%	100.0%	73.5%	87.3%	83.9%	83.1%
Family health & well-being	69.5%	81.3%	67.9%	63.6%	66.5%	77.4%	75.1%	77.3%
Parent-child relationships	71.2%	81.3%	57.1%	63.6%	55.9%	74.6%	65.2%	66.7%
Social-emotional well-being	78.0%	81.3%	67.9%	72.7%	69.2%	87.3%	80.0%	76.9%
Cultural/linguistic responsiveness	71.2%	56.3%	42.9%	54.5%	59.9%	72.6%	66.3%	65.2%
Screening & assessment	71.2%	68.8%	60.7%	54.5%	42.5%	69.8%	58.4%	62.1%
Family resources & support	50.8%	52.9%	21.4%	27.3%	29.1%	38.1%	32.3%	34.3%
Effective home visiting practices	36.2%	41.2%	11.1%	9.1%	24.4%	25.4%	32.4%	26.9%
Collaboration	34.5%	52.9%	22.2%	36.4%	24.4%	34.9%	28.6%	36.4%
Reflective practice	39.0%	41.2%	25.0%	18.2%	34.3%	33.3%	28.3%	22.4%
Families/ children with special needs	67.8%	82.4%	28.6%	9.1%	34.8%	44.4%	37.1%	43.3%

Region X Innovation Grant

AK • ID • OR • WA

Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

RESEARCH BRIEF #2

Job Characteristics of the Region X Home Visiting Workforce

This research brief is the second in a series that is part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with the Alaska Division of Public Health, the Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[vii]

Key Findings

Across Region X, home visitors report using eighteen different home visiting models; approximately one-quarter of home visitors in the region regularly deliver services using two or more home visiting models.

As a region, median home visitors' wages were $19.22 per hour, while supervisors' were $26.08 per hour.

Over one-quarter of home visitors who have at least one year of experience have not received a raise in over a year.

On average, home visitors and supervisors in Region X are offered approximately nine benefit options as part of their employment. The most common benefits offered include: health insurance, paid vacation days, dental insurance, paid sick days, mileage reimbursement, vision insurance, and employer-contributed retirement savings. One of the least common benefit offerings is tuition reimbursement.

Regionally, 23.4% of home visitors and 17.4% of supervisors receive public assistance, and use an average of 2.2 and 1.6 public assistance services, respectively. The most common public assistance services received are child health subsidies, Medicare/Medicaid, and free and reduced lunch.

Approximately one-third of Region X home visitors and over half of Region X supervisors report working longer hours than their paid hours suggest. Nearly half of the regional sample conducts home visits in the evenings (after 5:00pm).

Across the region, home visitors carry an average caseload of 16.0 families, and home visiting supervisors carry an average caseload of 10.5 families, of which they visit approximately 8.9 and 4.0 families, respectively, each week. Over 80% of home visits last longer than 60 minutes.

Home visitors across the region spend the largest amount of time each week delivering face-to-face home visitation services (12.9 hours on average). They also report spending 10.1 hours each week completing paperwork.

Families on Region X home visitors' caseloads are under stress: two-thirds are low-income, one-third experience family health / mental health issues, and one in five has a special needs child and/or has experience domestic violence.

Home visitors share common racial, ethnic, or cultural traits with fewer than half of the families they serve; approximately one-third of families speak a different language than their home visitors.

Introduction

Evidence shows that home visiting can support positive outcomes for parents and children.[xxxii] The effectiveness of home visiting programs depends, in part, on the home visitor. Home visitors must be knowledgeable in the content and delivery of the home visiting model, and they must effectively communicate with multiple families in their caseload, build and sustain relationships, and adhere to professional requirements and policies. Given how integral home visitors are to the success of home visiting programs, it is important to understand the characteristics of the home visiting workforce, including the home visiting models they use, their compensation and work schedules, their caseloads and responsibilities, and the characteristics of the families they serve, all of which can vary across and within regions.

There are a variety of home visiting models that programs and individuals can implement. In a recent review, 45 home visiting models were identified.[xxxiii] These models vary in the training and experience required, screening and assessment tools used, scope and sequence of topics addressed with families, and overall duration of the home visiting program. Furthermore, individual home visitors may implement elements of multiple home visiting models. Given this complexity, it is necessary to understand the home visiting model(s) used because the model can determine the scope, sequence, and requirements of the home visitor's work, as well as how and how often home visitors engage with families.

Understanding home visitors' compensation, along with their utilization of public assistance, can determine the extent to which the home visiting workforce is receiving living wages and what further supports are needed.

Relatedly, home visitors can experience different pay structures, wages, and employer-sponsored benefits based on location, employer, training, experience, and program models. The low wages of the early childhood field, which includes home visitors, has been well-documented.[xxxiv] Understanding home visitors' compensation, along with their utilization of public assistance, can determine the extent to which the home visiting workforce is receiving living wages and what further supports are needed. Further, it is important to understand home visitors' work schedules, responsibilities, and caseloads, including the number and characteristics of families served, which may relate to compensation and, ultimately, financial stability, personal health and well-being, job satisfaction, and work-life balance.

Families are at the heart of home visiting. Families may experience stressors, such as poverty, domestic violence, substance abuse, or health issues.[xxxv] On the part of the home visitor, the opportunity to work with these families may be a source of fulfillment or "compassion satisfaction," but it may also be a source of stress or "compassion fatigue."[xxxvi] Additionally, past research has shown that families were more engaged in home visiting when programs matched a greater proportion of home visitors to families in terms of sociodemographic characteristics (e.g., race or ethnicity).[xxxvii] In sum, the characteristics of the families served, including life experiences and sociodemographic characteristics, provides greater insight into the experience of home visitors.

Research Questions

The purpose of this research brief is to address the following questions based on a sample of home visitors and home visiting supervisors in Region X:

1. What home visiting models are used?
2. What are the compensation structures and work schedules?
3. What are the caseloads and job responsibilities?
4. What are the characteristics of families?

Sample

The sample used for this research brief includes 468 home visitors who provide home visiting services directly to families, and 161 home visiting supervisors, 29% of whom have a caseload of families they serve. These home visitors and supervisors were drawn from 148 programs in Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Within the sample, 202 (43.2%) home visitors and 76 (47.2%) home visiting supervisors work in home visiting programs that receive MIECHV funding. Thirty-eight percent of programs in the sample reported receiving MIECHV funding. For more information about the sample and the measures used for this study, please see *The Region X Home Visiting Workforce Study.*[xxxviii]

Results

Research Question 1: What Home Visiting Models Are Used?

For the purposes of this study, state agency partners from Region X identified criteria for including programs in the study recruitment. In particular, they identified home visiting programs that are:

- Voluntary for families to join
- High-dosage/long-term
- Evidence-based or based on promising practices
- Serving prenatal/birth through early childhood populations
- Using a home visiting model or curriculum

In addition, Alaska included programs that provide home visiting services in the context of other specialized services, such as Part C early intervention.

Across the region, the study sample reported using a variety of home visiting models. Table 2.1 shows that home visitors and supervisors in the sample are using eighteen different home visiting models across the four states. The most frequently reported model in each state and for the region as a whole is highlighted. Home visitors and supervisors in Idaho and Washington identified Parents as Teachers most frequently, while the samples in Alaska and Oregon most frequently identified Infant Learning Programs and Healthy Families America, respectively. For the region as a whole, Parents as Teachers was the most frequently reported model (37.4%). Three models are used in all four states within Region X: Early Head Start, Nurse Family Partnership, and Parents as Teachers. Of the programs receiving MIECHV funding all models present in Table 2.1 are represented except for Infant Learning Programs.

Table 2.1. HV Model Use by State

Model	AK n = 6-37	ID n = 10-23	OR n = 9-97	WA n = 12-118	Region X n = 16-235
Babies First	--	--	8.4%	--	3.3%
CaCoon	--	--	6.4%	--	2.5%
Early Head Start: Home Visiting	23.1%	24.4%	22.5%	23.8%	23.2%
Growing Great Kids	--	--	9.2%	--	3.7%
Healthy Families America	--	--	39.0%	--	15.9%
Infant Learning Programs*	47.4%	--	--	--	7.2%
Nurse Family Partnership	9.0%	24.4%	11.2%	30.3%	19.7%
Parent-Child Home Program	--	--	4.8%	12.3%	7.3%
Parents as Teachers	28.2%	56.1%	28.9%	45.2%	37.4%
Play and Learning Strategies	7.7%	--	3.6%	4.6%	4.3%
Other Models**	7.7%	--	13.3%	7.3%	9.4%

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*Infant Learning Programs (ILP) do not adhere to a home visiting model and provide services under Part C. In Alaska, ILPs provide the majority of home visiting services statewide.
**Other Models represents models with fewer than 5 cases in each state. These include Child Parent Psychotherapy, Early Steps to School Success, Family Spirit, and Parent Child Home Program.
***HV models are not mutually exclusive and column totals may exceed 100%.

While 75.1% of home visitors and supervisors reported using a single home visiting model in their practice, approximately one-quarter of the sample (24.9%) reported using two or more home visiting models (Table 2.2). Across the region, most respondents delivering more than one model reported using two models (18.8%), although a small percentage (6.2%) reported using three or more.

Table 2.2. Percent of Home Visitors and Supervisors Delivering Multiple Models

Number of HV Models Delivered	**AK** n = 74	**ID** n = 41	**OR** n = 235	**WA** n = 249	**Region X** n = 599
1	79.7%	95.1%	63.8%	81.1%	75.1%
2 or more	20.3%	4.9%	36.2%	18.9%	24.9%

In instances where home visitors and supervisors reported using multiple home visiting models in their work, the most common combinations of models included:

- Parents as Teachers, Early Head Start: Home Visiting
- Parents as Teachers, Healthy Families America

Research Question 2: What Are Home Visitors' and Supervisors' Compensation Structures and Work Schedules?

In this section, we provide descriptive information on pay, benefits, employment status, and work hours of the sample of home visitors and home visiting supervisors in Region X.

PAY

Figure 2.1 displays the average hourly pay for home visitors and supervisors, respectively; data are displayed for each state and for the region as a whole. There were significant differences found in the average hourly pay of the sample based on job role (t = −7.26, p<.001), with home visiting supervisors earning approximately $5.75 more per hour, on average, than home visitors. As a region, home visitors averaged $22.65 per hour, while supervisors averaged $28.40 hourly. Median wages were $19.22 per hour and $26.08 respectively.

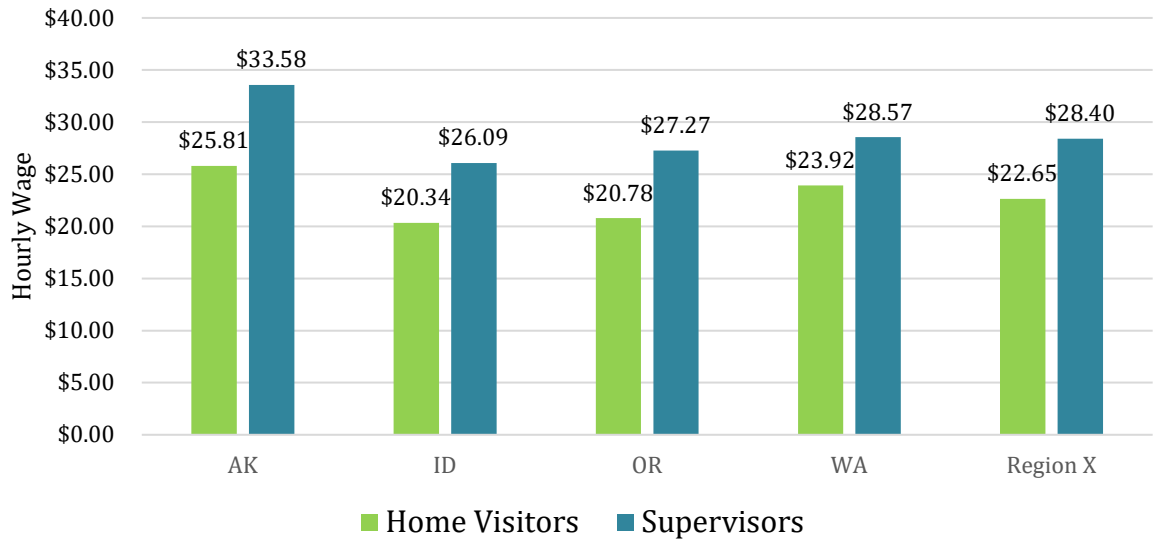

Figure 2.1. Average Hourly Pay

Most home visitors in the region (62.1%) earn between $15.00 and $25.00 per hour, although a small percentage (8.1%) earn less than $15.00/hour and over a third (29.7%) earn more than $25.00/hour. Salaries for supervisors trend higher, with 41.9% of supervisors reporting wages of $30.00/hour or more. Table 2.3 shows the distribution of pay across wage categories, broken down by state and job role. On average, supervisors earned between $5.00 and $8.00 per hour more. Differences in pay between home visitors and supervisors were significant in each state.[19] Across states in the region, differences in pay were statistically significant for home visitors ($F(3, 450) = 9.00$, $p < .001$) but not for supervisors ($F(3, 140) = 2.31$, $p < .08$). Home

[19] AK: t(70) = 3.2 p = 0.002; ID: t(39) = 3.2 p = 0.003; OR: t(238) = 5.8 p<0.001; WA: t(243) = 3.5 p<0.001

visitor salaries in Alaska were significantly higher than in Idaho and Oregon (p = 0.012, and p<0.001) and HV salaries in Washington were significantly higher than those in Oregon (p<0.001). [20]

Table 2.3. Home Visitors' Reported Hourly Wages

Hourly Wage	**Alaska n = 57**	**Idaho n = 30**	**Oregon n = 184**	**Washington n = 183**	**Region X n = 454**
Home Visitors					
Under $15.00	--	20.0%	12.4%	4.8%	8.1%
$15.00–$19.99	34.5%	24.0%	55.6%	44.0%	46.3%
$20.00–$24.99	21.8%	36.0%	13.0%	13.7%	15.8%
$25.00–$29.99	16.4%	20.0%	5.3%	8.9%	9.1%
$30.00–$34.99	10.9%	--	4.7%	14.3%	9.1%
Over $35.00	16.4%	--	8.9%	14.2%	11.5%
	Alaska n = 15	**Idaho** n = 11	**Oregon** n = 56	**Washington** n = 62	**Region X** n = 144
Under $30.00	--	--	62.3%	59.4%	58.0%
$30.00 and over	--	--	37.7%	40.7%	41.9%

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[20] Based on results of Tukey post-hoc tests

WAGE INCREASES

Within each state and across the region, over half of all home visitors and supervisors (58.7%) have received a wage increase within the past year. Table 2.4 shows that 28.2% of home visitors and supervisors regionally have not received a raise in more than a year, although this proportion varies by state. Across the region, some respondents (13.1%) also reported never having received a wage increase. Over three-quarters (79.0%) of those who have never received a wage increase have been in their jobs one year or less, indicating that approximately 17 home visitors / supervisors in Region X have worked longer than one year in their jobs without a wage increase.

Table 2.4. Time since Last Wage Increase

Time Since Last Wage Increase	**Alaska** n = 76	**Idaho** n = 41	**Oregon** n = 243	**Washington** n = 253	**Region X** n = 613
Less than one year	64.5	61.0	56.8	58.5	58.7
1+ years	28.9	17.1	30.0	28.1	28.2
No wage increase	6.6	22.0	13.2	13.4	13.1

* This table combines home visitor and supervisor data, since some cell sizes were too small to display results broken out by job role.

BENEFITS

Across Region X, home visitors and supervisors are offered an average of 9 benefit options from their employers (Tables 2.5 and 2.6). The most common benefits offered include health insurance, paid vacation and sick days, and dental insurance, with over 90% of home visitors and supervisors regionally reporting these benefits as available through their organizations. Other common benefits offered to home visitors and supervisors include mileage reimbursement, vision insurance, and employer-contribution retirement savings, with more than 75% of home visitors and supervisors reporting having these options available. Between 50–75% of home visitors and supervisors in the sample have access to employer-sponsored life insurance, paid professional development, and disability insurance. Less common benefit options for both home visitors and supervisors across the region include paid family leave, long-term care insurance, and tuition reimbursement. These options are offered to approximately 20–40% of home visitors and supervisors regionally. Notably, home visitors and supervisors in Alaska have relatively more access to tuition reimbursement (46.7% and 55.6% respectively) than home visitors and supervisors across the region as a whole (22.4% and 19.9%) respectively. Differences across states varied significantly for both home visitors ($\chi^2(3, N = 468) = 28.50, p = <.001$) and supervisors ($\chi^2(3, N = 161) = 18.02, p = <.001$).

> "And then when I came to the new organization . . . they had some opportunities where they would be able to pay for some of my classes. . . . I'd try to take as many classes as I could take that they were willing to pay for."
>
> —Supervisor

Table 2.5. Benefits Offered to Home Visitors

Benefits Offered	AK n = 60	ID n = 30	OR n = 186	WA n = 192	Region X n = 468
Home Visitors					
Mean # of Benefits Offered	***9.5***	***8.7***	***9.3***	***9.1***	***9.2***
Health Insurance	91.7%	90.0%	95.7%	91.7%	93.2%
Paid Vacation Days	95.0%	96.7%	96.2%	86.5%	92.1%
Dental Insurance	91.7%	83.3%	93.0%	89.1%	90.6%
Paid Sick Days	75.0%	96.7%	94.1%	89.6%	90.0%
Mileage Reimbursement	93.3%	73.3%	85.5%	86.5%	86.1%
Vision Insurance	83.3%	83.3%	80.1%	83.3%	82.1%
Retirement Savings *(Employer contributed)*	81.7%	83.3%	78.5%	76.0%	78.2%
Life Insurance	73.3%	66.7%	74.7%	72.4%	73.1%
Paid Professional Development	78.3%	63.3%	61.3%	64.6%	65.0%
Disability Insurance	58.3%	43.3%	54.8%	49.0%	52.1%
Paid Family Leave	31.7%	40.0%	44.6%	40.6%	41.0%
Long-Term Care Insurance	35.0%	--	37.1%	26.0%	30.8%
Tuition Reimbursement	46.7%	--	22.0%	18.2%	22.4%

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Table 2.6. Benefits Offered to Supervisors

Benefits Offered	AK n = 18	ID n = 11	OR n = 63	WA n = 69	Region X n = 161
Supervisors					
Mean # of Benefits Offered	***10.2***	***9.4***	***9.0***	***9.0***	***9.1***
Paid Vacation Days	100.0%	100.0%	92.1%	94.2%	94.4%
Health Insurance	100.0%	100.0%	90.5%	94.2%	93.8%
Paid Sick Days	83.3%	100.0%	92.1%	95.7%	93.2%
Dental Insurance	100.0%	100.0%	88.9%	88.4%	90.7%
Mileage Reimbursement	100.0%	81.8%	87.3%	88.4%	88.8%
Vision Insurance	77.8%	100.0%	73.0%	81.2%	78.9%
Retirement Savings *(Employer contributed)*	83.3%	100.0%	77.8%	72.5%	77.6%
Life Insurance	88.9%	90.9%	69.8%	65.2%	71.4%
Paid Professional Development	88.9%	63.6%	60.3%	68.1%	67.1%
Disability Insurance	66.7%	45.5%	60.3%	52.2%	56.5%
Paid Family Leave	27.8%	--	27.0%	31.9%	29.8%
Long-Term Care Insurance	44.4%	--	27.0%	21.7%	26.1%
Tuition Reimbursement	55.6%	--	17.5%	15.9%	19.9%

-- Missing, suppressed, or 0.0 value cells

PUBLIC ASSISTANCE

According to the Massachusetts Institute of Technology (MIT) Living Wage Calculator,[xxxix] an adult with one child needs to earn between approximately $23–$27 hourly in Region X to make a living wage (defined as a wage necessary to meet very basic living needs, such as food, housing, and child care). Table 2.7 shows the median income reported by home visitors and supervisors along with the estimated hourly living wages in the four states that make up Region X, based on different family configurations.

Table 2.7. Median Wage of Survey Respondents and MIT Living Wage Estimates

	Alaska	Idaho	Oregon	Washington
Median Wage of Home Visitors	**$ 23.56**	**$ 22.20**	**$ 18.00**	**$ 20.12**
Median Wage of Supervisors	**$ 33.00**	**$ 26.11**	**$ 25.06**	**$ 25.20**
MIT Living Wage Estimates				
Single Adult	$ 12.48	$ 10.64	$ 12.48	$ 12.28
1 Adult 1 Child	$ 27.34	$ 23.57	$ 25.49	$ 26.53
1 Adult 2 Children	$ 32.39	$ 28.03	$ 30.92	$ 30.87
1 Adult 3 Children	$ 42.18	$ 36.13	$ 41.12	$ 40.08
2 Adults (1 Working)	$ 19.56	$ 18.30	$ 20.23	$ 19.81
2 Adults (1 Working) 1 Child	$ 23.64	$ 21.99	$ 23.53	$ 23.59
2 Adults (1 Working) 2 Children	$ 26.68	$ 25.23	$ 26.82	$ 26.63
2 Adults (1 Working) 3 Children	$ 30.82	$ 28.23	$ 30.93	$ 30.91
2 Adults (1 Working Part Time) 1 Child	$ 18.85	$ 16.67	$ 17.93	$ 18.40
2 Adults	$ 9.78	$ 9.15	$ 10.11	$ 9.91
2 Adults 1 Child	$ 14.62	$ 12.80	$ 13.77	$ 14.21
2 Adults 2 Children	$ 17.78	$ 15.70	$ 17.17	$ 17.02
2 Adults 3 Children	$ 21.49	$ 18.49	$ 20.99	$ 20.44

Given the average hourly wage for home visitors ($22.65) and supervisors ($28.40) in the region, this study examined home visitors' and supervisors' use of public assistance programs to make ends meet. Some respondents indicated that they receive public assistance (23.4% of home visitors and 17.4% of supervisors). Of those who did indicate that they receive public assistance, results show that home visitors and supervisors use an average of 2.2 and 1.6 public assistance services, respectively (Figure 2.2). Receipt of public assistance varied, by state; however, these differences were not statistically significant.

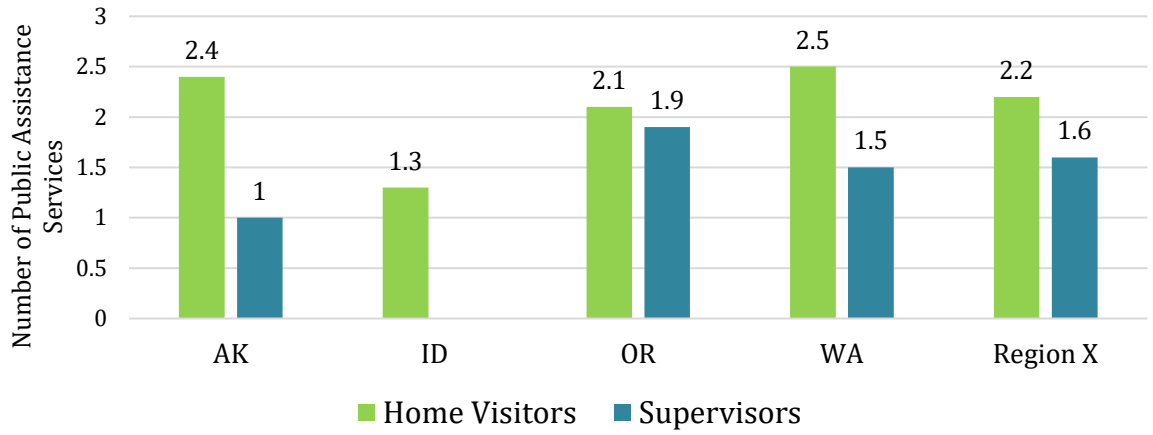

Figure 2.2. Average Number of Public Assistance Supports Received Per Person

Across Region X, the public assistance services most commonly accessed by home visitors and supervisors were children's Medicaid or other health subsidy (12.1%), free or reduced lunch (10.3%), and Medicare or Medicaid for the home visitor / supervisor (7.6%). The Medicaid and CHIP Payment and Access Commission (MACPAC) estimates that between 19% and 24% of the US population utilized Medicaid or children's subsidized health insurance programs in 2016.

Table 2.8 shows the percentage of home visitors and supervisors accessing various public assistance services by state and regionally.

Table 2.8. Public Assistance

Public Assistance Received	**AK**	**ID**	**OR**	**WA**	**Region X**
Home Visitors and Supervisors	**n = 5-9**		**n = 10-31**	**n = 9-35**	**n = 9-76**
Children's Medicaid or subsidized health insurance	10.3%	--	12.4%	13.4%	12.1%
Free or reduced lunches	11.5%	--	10.0%	10.3%	10.3%
Medicaid or Medicare (for HV/supervisor)	9.0%	--	6.4%	9.6%	7.6%
Food Stamps (SNAP)	--	--	6.0%	3.4%	4.3%
WIC (supplemental nutrition)	6.4%	--	4.0%	5.4%	4.6%
Other public assistance**	--	--	5.6%	3.4%	4.1%
Child care subsidies or vouchers	--	--	--	--	1.7%
Section 8 housing / public housing	--	--	--	--	1.4%

-- Missing, suppressed, or 0.0 value data.
** Respondents reported that other public assistance includes energy assistance, food pantry support, and help with gifts around the holidays. Temporary Assistance for Needy Families (TANF) was also included in this category due to small cell sizes in all states.

JOB STRUCTURE

Across Region X, home visitors and supervisors within the sample were almost universally employees rather than contractors (98.2% and 98.7% respectively). This was consistent within individual states as well as for the region as a whole. Similarly, 87.7% of home visitors and 80.6% of supervisors regionally reported that their jobs are full time (defined here as 30 hours or more per week). Some variations to this exist within the supervisor samples in Alaska and Idaho, where 66.7% and 72.7% of supervisors, respectively, reported working full time. These differences are not statistically significant.

On average, the sample of home visitors across the region are paid to work a 36.6 hour work week; supervisors' average paid work week is slightly lower at 33.9 hours per week. Figure 2.3 shows the average paid hours/week for home visitors and supervisors by state and for the region as a whole. Seventy-three percent of home visitors and 70% of supervisors reported a paid work week of 40 hours per week.

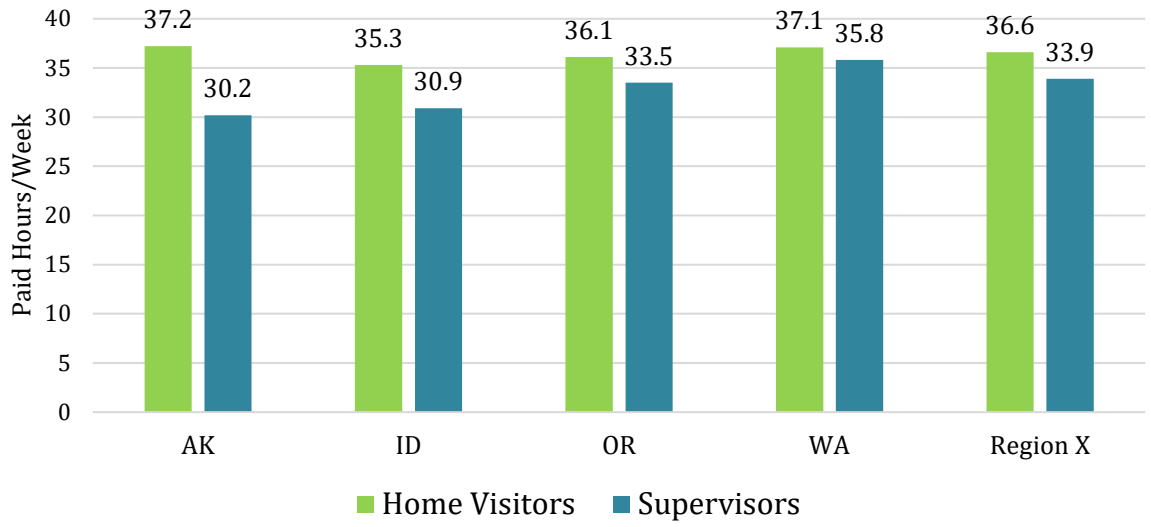

Figure 2.3. Average Paid Hours per Week

The sample of home visitors in Region X work approximately the same number of hours on average (36.2) as they are paid to work (36.6), while the sample of supervisors work 2.8 more hours on average (36.7) than they are paid to work (33.9). All differences between hours paid and hours actually worked are not statistically significant. Regionally, 32.0% of home visitors and 52.9% of supervisors report working longer hours than their paid hours suggest. Within Oregon and Washington, in particular, there was a statistically significant difference between the amount of overtime work supervisors experience, as compared to home visitors. When considering turnover and retention of the home visiting workforce, working long hours can be an important factor to consider.

Table 2.9. Actual Hours Worked per Week

	AK n = 58	ID n = 30	OR n = 174	WA n = 184	Region X n = 446
Home Visitors					
Mean Actual Hours/Week	**35.4**	**35.2**	**35.4**	**37.3**	**36.2**
Percent working over paid hours/week	34.5%	26.7%	28.9%	35.0%	32.0%
	AK n = 18	**ID n = 11**	**OR n = 60**	**WA n = 64**	**Region X n = 153**
Supervisors					
Mean Actual Hours/Week	**33.4**	**31.8**	**36.0**	**39.2**	**36.7**
Percent working over paid hours/week	44.4%	36.4%	48.3%	62.5%	52.9%

Table 2.10 shows that most home visitors and supervisors in the Region X sample (68.3% and 69.3%, respectively) work five days per week. Another 22.6% of home visitors work four days per week, while 6.8% work three or fewer days each week. A very small proportion of home visitors (2.3%) work more than five days per week, yet this figure is higher for supervisors in the sample, 9.2% of whom work more than five days a week. Of the supervisor sample in the region, 21.6% work four or fewer days per week. On average, home visitors in Region X work 4.7 days per week, compared to 5.0 days per week for the supervisor sample. Differences across states and by job role were not statistically significant.

Table 2.10. Average Days Worked per Week

	AK n = 54	ID n = 30	OR n = 174	WA n = 181	Region X n = 439
Mean Days Worked/Week	***4.9***	***4.6***	***4.7***	***4.7***	***4.7***
More than 5 days/week	--	--	--	--	2.3%
5 days/week	75.9%	63.3%	68.4%	66.9%	68.3%
4 days/week	14.8%	26.7%	21.3%	25.4%	22.6%
3 or fewer days/week	--	--	--	--	6.8%
Mean Days Worked/Week	***5.2***	***4.6***	***5.1***	***4.8***	***5.0***
More than 5 days/week	--	--	7.9%	10.1%	9.2%
5 days/week	72.2%	72.7%	63.5%	65.2%	69.3%
4 days/week	--	--	12.7%	8.7%	10.5%
3 or fewer days/week	--	--	12.7%	8.7%	11.1%

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Figure 2.4 reflects the percentage of home visitors (and supervisors who have a home visiting caseload) who conduct home visits in the evenings (after 5:00 pm) and on the weekends.

Evening home visits are common across the region (48.3%), although this varies somewhat by state. Differences by state are statistically significant ($\chi^2(3, N = 497) = 9.71, p = .021$).[21] Weekend home visits are rarer. Only 5.0% of the Region X sample report delivering home visits on the weekends; this ranges from 2.1% in Oregon to 9.1% in Idaho.

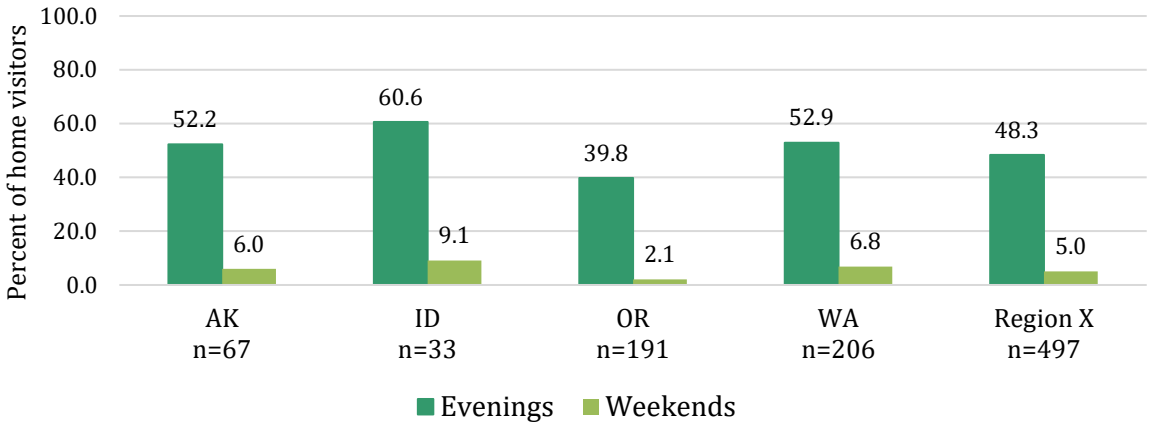

Figure 2.4. Evening and Weekend Home Visiting

Research Question 3: What Are Home Visitors' and Supervisors' Caseloads and Job Responsibilities?

This section explores the workloads and job responsibilities of home visitors and home visiting supervisors in the sample.

CASELOADS AND VISIT FREQUENCY

Across Region X, home visitors report an average caseload of 15.0 families and home visiting supervisors carry a caseload average of 10.5 families (Figure 2.5). Across the states, caseloads for home visitors were pretty similar, with caseloads ranging from 14.1 families in Washington to 15.9 families in Oregon. For supervisors, there was a larger range across states, from 6.1 families in Alaska to 17.0 families in Oregon. Differences between caseload sizes were not statistically significant. The home visitors reported visiting a little more than half of the families on their caseload each week, seeing an average of 8.9 families, while home visiting supervisors visit a little under half their caseload, seeing an average of 4.0 families weekly. The average number of visits per week ranged from 8.0 in Idaho to 10.5 in Alaska for home visitors and from 3.4 in Oregon to 4.6 in Washington for supervisors (Figure 2.6). Differences between states in the number of weekly visits were statistically significant for home visitors only (F (3, 438) = 6.69, p < .001). Follow-up tests showed that these statistically significant differences existed between home visitors in Alaska and Idaho (p=0.006), and between home visitors in Alaska and Oregon (p=<0.001), with Alaska home visitors meeting with more of their families each week.

[21] Chi-square adjusted residuals show the statistically significant difference is between Oregon and the other states.

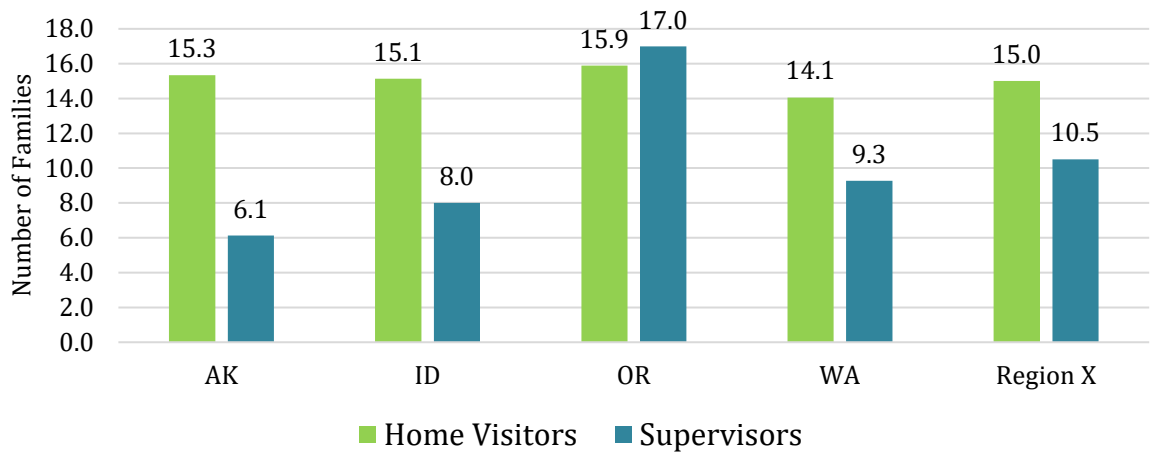

Figure 2.5. Average Caseloads

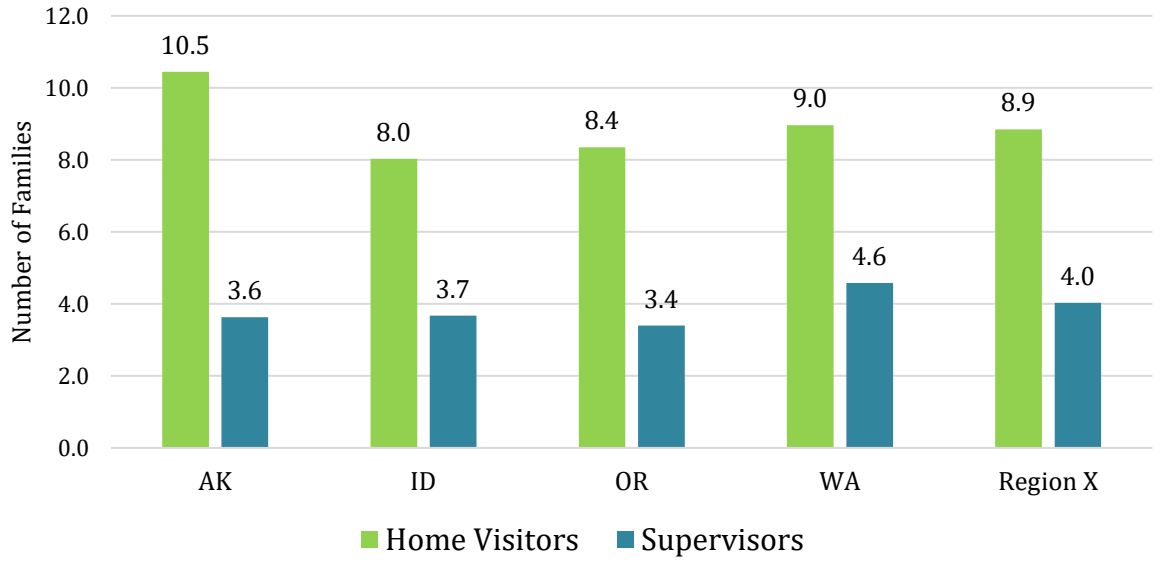

Figure 2.6 Average Home Visits Each Week

Table 2.10 shows that the largest proportion of home visitors in the regional sample (47.7%) carry a caseload of 10–15 families. 20.4% have a caseload of under ten families, while 16.2% have caseloads of sixteen or more families. Over half of the regional sample (51.8%) visits fewer than ten of the families on their caseload each week (Table 2.11), and 49.6% of them spend between 60–74 minutes with families per visit (Table 2.12). More than three quarters of supervisors (76.9%) of supervisors carry a caseload of fewer than 10 families. Time spent with each family is similar to home visitors with 43.9% of supervisors spending 60-74 minutes with families per visit. Time spent in home visits is typically driven by requirements of specific home visiting models.

Table 2.9. Home Visiting Caseloads

Number of families in caseload	**AK**	**ID**	**OR**	**WA**	**Region X**
Home Visitors	*n = 59*	*n = 30*	*n = 176*	*n = 186*	*n = 451*
Under 10	11.9%	30.0%	21.0%	21.0%	20.4%
10-15	55.9%	16.7%	50.0%	47.8%	47.7%
16-20	16.9%	33.3%	10.8%	18.3%	16.2%
Over 20	15.3%	20.0%	18.2%	12.9%	15.7%
Supervisors	*n = 8*	*n = 3*	*n = 10*	*n = 18*	*n = 39*
Under 10	87.5%	--	70.0%	77.8%	76.9%
Over 10	--	--	--	--	23.1%

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Table 2.10. Weekly Home Visits

Number of visits per week	AK	ID	OR	WA	Region X
Home Visitors	n = 56	n = 29	n = 172	n = 185	n = 442
Under 10	35.7%	55.2%	58.1%	50.3%	51.8%
10 and over	64.3%	44.8%	41.9%	49.7%	48.2%
Supervisors	n = 8	n = 3	n = 10	n = 19	n = 40
Under 10	100.0%	--	100.0%	89.5%	99.6%
10 and over	--	--	--	--	--

-- Missing, suppressed, or 0.0 value data.

Table 2.11. Home Visit Durations

Time per home visit	AK	ID	OR	WA	Region X
Home Visitors	n = 60	n = 30	n = 177	n = 187	n = 454
Less than 60 minutes	28.3%	13.3%	14.2%	14.0%	15.8%
60–74 minutes	43.3%	33.3%	56.5%	47.6%	49.6%
75 or more minutes	28.3%	53.3%	28.3%	38.5%	34.1%
Supervisors	n = 8	n = 3	n = 11	n = 19	n = 41
Less than 60 minutes	--	--	--	42.2%	36.5%
60–74 minutes	--	--	54.5%	31.6%	43.9%
75 or more minutes	--	--	--	--	--

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JOB RESPONSIBILITIES

The work of a home visitor is complex. It involves not only the direct delivery of home visiting services, but also requires researching and providing families with referrals to other services, completing paperwork and tracking activities to document work done with families, and traveling, sometimes long distances. In addition, to keep skills up to date, home visitors also spend time in training and reflective supervision activities. Figure 2.7 shows that home visitors in the Region X study sample reported that the greatest amount of their time each week is dedicated to providing direct, face-to-face home visiting services, followed by completing paperwork (10.1 hours, on average).

Other job functions that make up home visitors' typical work weeks include traveling to visit families (5.7 hours), researching and making service referrals (3.0 hours), conducting family follow-ups (2.5 hours), and participating in administrative meetings (2.4 hours). Interestingly, home visitors and supervisors across the region report spending about the same amount of time completing paperwork, at about 10 hours for each group. Supervisors also reported spending their week in administrative meetings (7.8 hours), in reflective supervision (4.9 hours), and providing direct face-to-face home visiting services (2.4 hours).

"Paperwork. Too much. We now have a new rule for Medicaid, that all of our paperwork has to be done within three days. Not three business days; 72 hours. So if we do something on a Friday, it has to be done by Monday. None of us can follow this rule, because it's impossible. I have 37 kids on my caseload. There's no way."

—Home Visitor

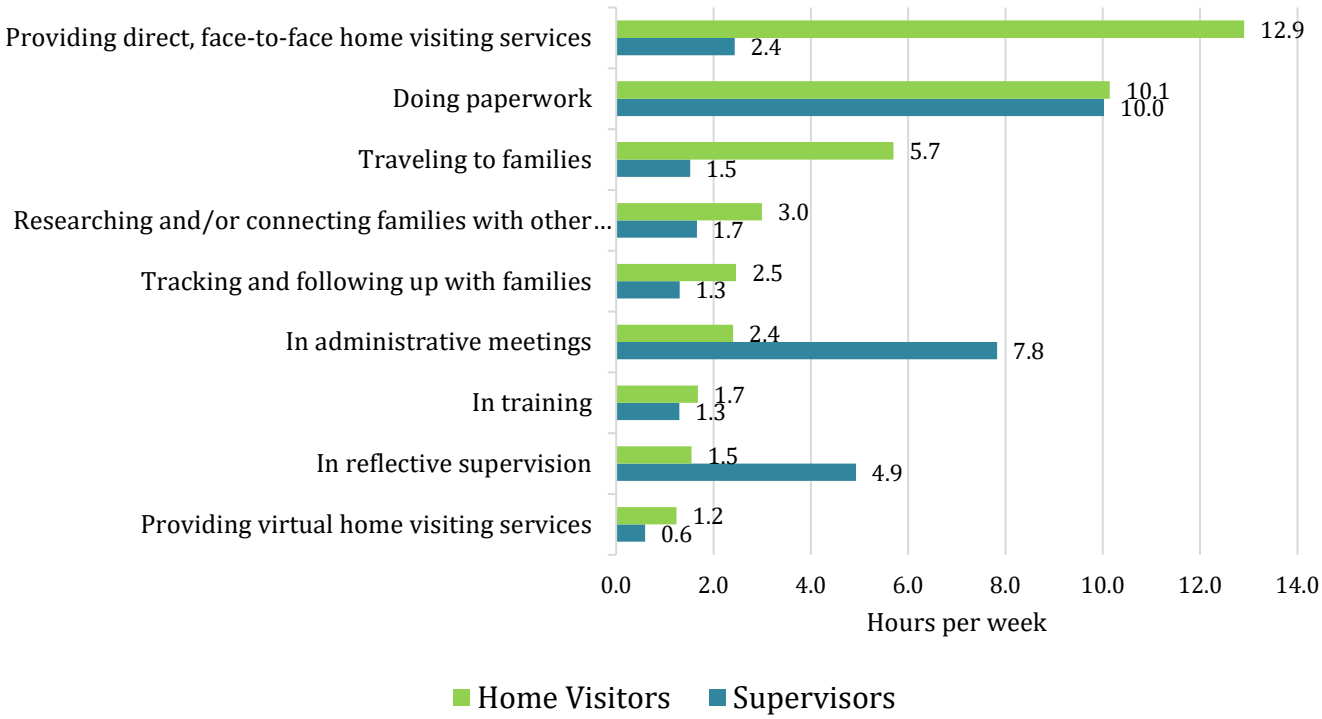

Figure 2.6. Time Distribution by Job Responsibility

Table 2.12. Average Time Spent by Job Responsibility (Hours per Week)

Job Responsibility	AK	ID	OR	WA	Region X
Home Visitors	n = 59-60	n = 29–30	n = 172–176	n = 183–186	n = 154–157
Providing direct, face-to-face home visiting services	12.6	13.3	11.9	13.8	12.9
Doing paperwork	8.3	19.1	9.4	10	10.1
Traveling to families	5.3	6.4	5.2	6.2	5.7
Researching and/or connecting families with other resources	3.1	3.1	3.2	2.7	3
Tracking and following up with families	2.4	2.7	2.7	2.2	2.5
In administrative meetings	1.8	6.3	1.9	2.4	2.4
In training	1.3	5.1	1.5	1.4	1.7
In reflective supervision	0.9	1.9	1.7	1.5	1.5
Providing virtual home visiting services	1.3	0.4	1.2	1.4	1.2
Supervisors	n = 18	n = 11	n = 61	n = 64–67	n = 154–157
Doing paperwork	8.3	9.2	10.0	10.6	10.0
In administrative meetings	9.8	4.9	8.6	7.1	7.8
In reflective supervision	3.1	4.5	5.6	4.9	4.9
Providing direct, face-to-face home visiting services	3.4	2.4	1.4	3.1	2.4
Researching and/or connecting families with other resources	2.1	1.3	1.5	1.7	1.7
Traveling to families	2.4	1.6	0.9	1.8	1.5
In training	0.7	1.1	1.8	1.1	1.3
Tracking and following up with families	1.4	1.1	1.1	1.5	1.3
Providing virtual home visiting services	1.6	0.2	0.6	0.4	0.6

Research Question 4: What Are the Characteristics of Families Served by Home Visitors and Home Visiting Supervisors in Region X?

This section describes the characteristics of families served by the study's sample of home visitors. In particular, we examined the geographic breakdown of families in home visitors' caseloads, looking at the proportion of families who reside in urban, suburban, rural, and remote areas. These categories were defined as:

- Urban: Cities
- Suburban: Residential areas outside of cities
- Rural: In the country, but accessible by road
- Remote: Not accessible by road

Working with families experiencing stressful life circumstances can potentially add job stress to the home visiting workforce, so we also looked at the percent of families within the sample's caseload who are experiencing challenges such as substance use, domestic abuse or intimate partner violence, raising a child with special needs, low-income, or refugee status. Similarly, parenting and co-parenting arrangements of families within a caseload can also affect the nature of the work of the home visitor; as such, we asked study participants to estimate the number of families in their caseloads with various parenting situations. Finally, we were interested in the extent to which home visitors share race, ethnicity, culture, and language traits with the families they serve, since research indicates that families are more likely to engage in services when home visitors share and understand their own cultures and languages.[xl]

FAMILY GEOGRAPHY

Table 2.14 shows that, within Region X, almost 60% of families on home visitors' caseloads live in urban or suburban areas. Home visitors in the sample indicate that approximately one in six families on their caseloads live in rural areas, and a very small proportion (1.4%) live in remote areas that can't easily be accessed by road. Alaska home visitors indicate a higher percentage of their caseloads live in remote areas (8.1%) reflecting the unique geography of the state.

Table 2.13. Family Geography*

Family Geographic Location	AK n = 67	ID n = 41	OR n = 233	WA n = 244	Region X n = 585
Urban	49.3%	26.7%	34.7%	39.0%	37.6%
Suburban	12.2%	34.8%	21.9%	22.1%	21.8%
Rural	10.3%	15.5%	16.6%	18.6%	16.6%
Remote	8.1%	1.3%	0.5%	0.4%	1.4%

* Columns do not sum to 100% based on some instances of home visitor–reported geographic allocations of families on their caseloads that were less than their total reported caseloads.

FAMILY CHARACTERISTICS

Some home visitors in the sample reported that the families on their caseloads are experiencing a variety of challenging circumstances within their family lives. In particular, across the region, 68.5% of the families in the sample's caseloads are low-income, although this ranges from a low of 48.8% in Alaska to a high of 76.0% of families in Washington. Approximately one-third (33.0%) of families served by the sample of home visitors in the region have a health or mental health challenge, while 20.7% have a child with special needs. There are more families with children with special needs in Alaska (38.7%), likely reflecting the fact that the primary home visiting model in that state (Infant Learning Program) is specifically geared toward children with special needs. Within Region X, the sample also reported serving families who are experiencing domestic violence (20.4%), substance abuse (14.7%), and child welfare involvement (10.9%). The average proportion of families within the regional sample's caseload that are refugees was 3.5%. Table 2.15 shows specific percentages by state.

> "It's when you have a community that has a lot of at-risk factors with DHS, with just mental health issues, drug addictions, just different things—that can be hard on a home visitor, because you will have to tend to spend more time with this, a lot more problem-solving, a lot more kind of taming the fires, I guess you could say, so that the family can function for this child, and I think that can be hard on a home visitor."
>
> —Supervisor

Table 2.14. Family Characteristics*

Family Characteristic	AK n = 78–74	ID n = 41	OR n = 243–249	WA n = 255–261	Region X n = 616–629
Low income	48.8%	72.6%	66.2%	76.0%	68.5%
Family health / mental health challenge	27.0%	38.9%	32.2%	34.8%	33.0%
Child with special needs	38.7%	18.6%	17.8%	18.7%	20.7%
Domestic violence	21.1%	17.6%	19.9%	21.0%	20.4%
Substance abuse	18.4%	10.1%	14.8%	14.1%	14.7%
Child welfare involvement	19.7%	9.3%	10.3%	9.1%	10.9%
Refugee status	1.2%	2.4%	4.0%	3.8%	3.5%

* Response options were not mutually exclusive, so columns do not sum to 100%.

SHARED TRAITS

Research has shown that families were more engaged in home visiting when programs matched a greater proportion of home visitors to families in terms of sociodemographic characteristics, including race or ethnicity.[xli] Across Region X, home visitors reported sharing a common language with approximately two-thirds (68.0%) of the families they serve, while they share common race, ethnicity, or cultural traits with less than half (46.7%) of the families on their caseloads. These figures are relatively consistent within individual states as well (Table 2.17).

> "Recently, a complicated and difficult part of my job has been recognizing the systemic racism that's built into healthcare and education programs, including mine, and trying to think of how I name that, work with that, try to work to undo it within myself and others."
>
> —Home Visitor

Table 2.15. Home Visitor Share Traits with Families*

Home Visitor Shared Traits with Families	AK n = 73–78	ID n = 41	OR n = 243–246	WA n = 257–260	Region X n = 614–625
Common race, ethnicity, or culture	46.1%	50.3%	46.1%	46.9%	46.7%
Common language	74.3%	71.0%	62.7%	70.7%	68.0%

* Common trait options are not mutually exclusive, so columns do not sum to 100%.

Home visitors in the region reported that English is the most common language spoken by families on their caseload (74.1%). For three states, the second most common language spoken by families on the sample's caseload is Spanish (56.2%–62.1%); however, for Alaskan home visitors, Native American languages (42.3%) are more common within their caseloads than Spanish (33.3%).

Across the four states, there appears to be a wide diversity of languages spoken by the families served by home visitors, with 16.9% and 16.7% of families speaking Native American and Asian/Pacific Island languages, respectively. Similarly, nearly one-third (30.6%) of home visitors' families in the region speak either a language other than those already noted or American Sign Language.

Table 2.16. Languages Spoken by Families in Home Visitors' Caseloads*

Languages Spoken by Families in Home Visitors' Caseloads	AK n = 15–62	ID n = 9–33	OR n = 16–177	WA n = 21–194	Region X n = 40–466
English	79.5%	80.5%	71.1%	74.3%	74.1%
Spanish	33.3%	61.0%	56.2%	62.1%	56.1%
Native languages of the Americas	42.3%	22.0%	10.4%	14.6%	16.9%
Asian and Pacific Island language (e.g., Mandarin, Japanese, Korean)	26.9%	--	14.1%	17.2%	16.7%
American Sign Language	--	--	6.4%	8.0%	6.4%
All other languages**	19.2%	44.0%	20.9%	30.7%	26.2%

-- Missing or suppressed data

* Language options are not mutually exclusive, so columns do not sum to 100%.

** Other languages include, but are not limited to, Arabic, Hebrew, Hindu, Urdu, French, Russian, and Swahili.

Policy Considerations

This research brief points to several important policy considerations to support the home visiting workforce in Region X.

Increase Home Visitor Compensation

While the average pay for home visitors in Region X hovers near the living wage of $23–$27/hour for one adult and one child, as calculated by the MIT study,[xlii] over half of home visitors in the region earn below this amount. Since home visitors make significantly less than supervisors, Region X states might consider ways to ensure that home visitors, in particular, are appropriately compensated for the important work they do. Considering that the living wage calculation is an estimate of very basic living requirements, without room for extras or emergencies, this suggests that many home visitors may not be able to financially sustain a long-term career in the field. Because some states in the region have significantly higher salaries for home visitors than others, particularly Alaska and Washington, these higher-paying states may serve as a model for how to raise pay for home visitors across the region. Some of these pay differences may reflect different costs of living within each state; however, they may also reflect differences in compensation models (for instance, hourly, annual, or per visit) or funding structures inherent in predominantly used home visiting models within the state.

Reduce Paperwork

Home visitors in Region X report spending more time on paperwork than in conducting direct, face-to-face home visiting services. The average time spent on paperwork and in administrative meetings amounts to 1.5 work days per week. This is time that home visitors could spend serving families and/or improving their own skills through training, professional development, or reflective supervision. While paperwork and administrative functions are inevitable and necessary, states and home visiting organizations may want to explore ways to reduce the administrative burden of the job through efficiencies such as computerized/tablet-based reporting tools, centralizing administrative functions, and reducing redundant reporting requirements to free up home visitors to work more directly with families.

Increase Access to Training and Professional Development

Home visiting is a highly skilled profession that requires specialized knowledge and skills on various topics. Ongoing training and professional development allow home visitors and supervisors to engage in a process of continuous learning and improvement, which not only benefits the individual staff member, but also the children and families served. It is especially important, then, to ensure training and professional development are financially accessible.

Across Region X, only about one in five staff receive tuition reimbursement. Although paid professional development time is more consistently provided, with 65% of home visitors across the region reporting this benefit, there are still approximately one in three home visitors who

do not have paid professional development time. Without tuition reimbursement and paid professional development, the cost of training and coursework may deter interested staff from advancing their education.

Given the wide variation in educational attainment, from high school diplomas to graduate degrees (see Brief 1), it is important that staff who are interested in advancing their education can afford to do so. As the field constantly grows and new knowledge and practices emerge, it is important for staff, regardless of educational attainment, to access training and professional development. In Region X, Alaska is the exception, with approximately half of sampled staff receiving tuition reimbursement in the state. Perhaps this may explain why 40% of home visitors and 72% of supervisors in Alaska hold graduate degrees (compared to 15% of home visitors and 40% for the entire region; Brief 1.) Other states may be able to learn from Alaska's model to provide this benefit more ubiquitously across the region.

Support Training to Serve Families Under Stress

The data presented in this brief indicate that many families served by Region X home visitors are experiencing high levels of stress, including poverty, health / mental health issues, and substance and domestic abuse. These are uniquely difficult family circumstances that home visitors face as a regular part of their work with families on their caseloads. Ongoing supports and training to support home visitors with this aspect of their work may help to increase retention of skilled workers in the field. Additionally, states in Region X may want to explore compensation structures that incentivize home visitors for working with families experiencing life circumstances that increase the challenge and stress of the home visiting job. This strategy could support both the need to increase home visiting compensation, while encouraging work with high-need families.

> "I love what I do. [laughs] I like the fact that I get to help families, I get to help the community, I get to help the children. I don't ever feel like I'm burnt out. They've given me such great opportunities, so I was able to finish my education because of them. It's just a great overall place and a great organization to work for, and I think it's more of a passion than it is a career."
>
> —Supervisor

Increase Access to Paid Family Leave

Paid family leave is an important benefit to consider, especially related to the realities of life outside of work and maintaining work-life balance. This benefit allows workers to care for very ill family members, recover from serious health problems, or bond with newborns. Across the region, only about two in five home visitors receive paid family leave. Fortunately, this number

is likely to go up in future years as Washington will become the fifth state in the nation to offer paid family leave to all workers, which will take effect in 2020. To attract and retain a highly qualified home visiting workforce, policy makers in Region X might explore options for supporting paid family leave for home visitors and their supervisors.

Recruit and Retain a More Diverse Workforce

Data presented in this brief indicate that home visitors in the Region X sample share a common language with approximately two-thirds of the families on their caseloads and that they share common racial, ethnic, and cultural characteristics with a little less than half of their families. Since research indicates increased retention when families and home visitors share similar racial/ethnic identities,[xliii] home visiting programs across Region X may consider options for ensuring the workforce reflects the families they serve. This may take the form of recruitment and retention strategies aimed at attracting and keeping a workforce that matches the racial and ethnic diversity of the families served and/or caseload assignment strategies that maximize the extent to which home visitors serve families with common language, race, ethnic, and cultural traits. Efforts to recruit a diverse student body into educational majors that tend to feed into a home visiting profession are one place to start, as is considering opportunities to create apprenticeship programs that may give a more diverse population an alternative route into the field.

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Region X Innovation Grant

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

RESEARCH BRIEF #3

Professional Development, Workplace Quality, and Retention within the Region X Home Visiting Workforce

This research brief is the third in a series that are part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with The Alaska Division of Public Health, The Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce[1] in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[x]

Key Findings

The majority of Region X home visitors and supervisors report participation in reflective supervision training and practices that support their work, such as opportunities to reflect on the emotional impact of the work.

Across the region, both home visitors and supervisors report strong learning cultures that include staff collaboration and opportunities for peer-to-peer reflections about the work.

Home visitors and supervisors across Region X feel that their safety is supported; home visitors in Oregon have a particularly strong sense of value and support for their personal safety.

Supervisors and home visitors generally reported a strong sense of autonomy, importance, justice, support, role clarity, and opportunities for taking on challenges and innovations in their workplace. Supervisors, especially, rated the presence of some of these workplace factors highly.

Reported average annual turnover rates for home visitors and supervisors in Region X were 23% and 20%, respectively.

Eighty-seven percent of home visitors and 91% of supervisors plan to stay in their jobs for at least the next two years. Primary reasons for staying include a desire to help children and families and work schedules that meet personal needs.

Of the 12% of home visiting professionals who plan to leave their jobs in the next two years, the most common reasons are low pay, a lack of promotion opportunities, excess paperwork, and inadequate supervisory support.

Introduction

Home visitors tend to experience a reduction in job satisfaction and high emotional exhaustion and burnout over time,[xliv] both of which are associated with increased intentions of leaving and higher turnover rates.[xlv,xlvi] Burnout can also result from high workloads and too many demands on home visitors' time. However, strong factors that reduce burnout for home visitors include satisfaction with supervisors, feelings of empowerment or control over work, and organizational task–orientation or an emphasis on planning and efficacy.[xlvii] Other contributing factors to high retention rates include limited alternative employment opportunities and higher wages or benefits.[xlviii]

Similarly, training, staff support, and supervision have been shown to provide home visitors with the skills needed to feel effective and confident in their jobs, regardless of their educational or training background.[xlix] Additionally, reflective supervision provides supplementary support by providing home visitors with reflective thinking skills and coping mechanisms and contributes to a supportive work climate.[l] Reflective supervision refers to a supportive relationship-based practice between supervisors and

Reflective Supervision Definition:

Reflective supervision is a form of ongoing intentional, scheduled professional development that focuses on enhancing the reflective practice skills of home visitors for purposes of program quality, including staff wellness & retention.

Source: Region X Reflective Supervision/Consultation Collaborative. (2018). *Reflective supervision: A guide from Region X to enhance reflective practice among home visiting programs*. Olympia, WA: Washington State Department of Children, Youth, and Families.

supervisees that emphasizes reflection, collaboration, and regular, consistent meetings, and that supports home visitors in exploring the experiences and emotions they bring to their work with families. Because home visiting professionals can experience substantial work-related stress, a positive work climate that includes supervisory support can mitigate burnout and combat high turnover rates in the field.[li]

Recent evidence has found several benefits of reflective supervision for the home visiting workforce, including benefits to program implementation, feelings of self-efficacy, and an overall increased knowledge of reflective practices. In particular, home visitors have reported a sense that reflective supervision benefits their coping abilities related to work stress, ability to manage emotional responses to family conflict, relationships with coworkers, overall professional development, and overall job satisfaction.[lii]

Research Questions

The purpose of this research brief is to address the following questions based on a sample of home visitors and home visiting supervisors in Region X:

1. How do home visitors and supervisors experience training and reflective supervision?

2. How do home visitors and supervisors perceive the quality of their work environments?

3. What factors are driving turnover among home visitors and supervisors?

4. What are the future job intentions of the sample of home visitors and supervisors?

Sample

The sample used for this research brief includes 468 home visitors who provide home visiting services directly to families and 161 home visiting supervisors, 29% of whom conduct home visits with the families they serve. These home visitors and supervisors were drawn from 148 programs in Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Within the sample, 202 (43.2%) home visitors and 76 (47.2%) home visiting supervisors work in home visiting programs that receive MIECHV funding. Thirty-eight percent of programs in the sample reported receiving MIECHV funding. This brief also

includes data from a sub-group of 27 home visitors and 6 supervisors who left their jobs within six months of taking the original survey. For more information about the measures used for this study, please see *The Region X Home Visiting Workforce Study: Introduction.*[liii]

Results

Research Question 1: How do home visitors and supervisors experience reflective supervision?

Training and reflective supervision are important components of professional development within the home visiting profession. This section describes the questions the Region X Home Visiting Workforce Survey asked about these topics and presents the results by state and job role.

REFLECTIVE SUPERVISION

The workforce survey included seven items about the presence of various aspects of reflective supervision (Figure 3.1). For all items, the majority of home visitors responded that they "agreed" or "strongly agreed," indicating a trusting relationship with their supervisor, a consistent supervision schedule, and opportunities to reflect upon their work and how it relates to their emotions. Most home visitors also reported that their supervisor helps them explore cultural considerations in their work, though the endorsement of this item was slightly lower.

Home visitors from Alaska typically endorsed the reflective supervision items at the highest rates. Notably, 91% of Alaska's home visitors reported a trusting relationship with their supervisor, versus 70–80% of respondents from other states. Alaska's home visitors were also more likely to indicate that their supervisor improves their ability to be reflective compared with those from other Region X states.

TRAINING

Three survey questions asked about home visitors' perceptions of training they receive as part of their job. As shown in Figure 3.2, about two-thirds (or more) of home visitors agreed or strongly agreed that training prepared them for the job, that they received observation and coaching, and that they have support to help families with challenging issues. Idaho had the highest rate of home visitors who reported that their training prepares them well for the job (87%), while Alaska had the greatest proportion reporting having tools and training to help families with challenging issues (87%). Responses pertaining to observation and coaching were fairly similar across states, with about 65–75% of home visitors reporting that their agency used these strategies to help them improve their practice.

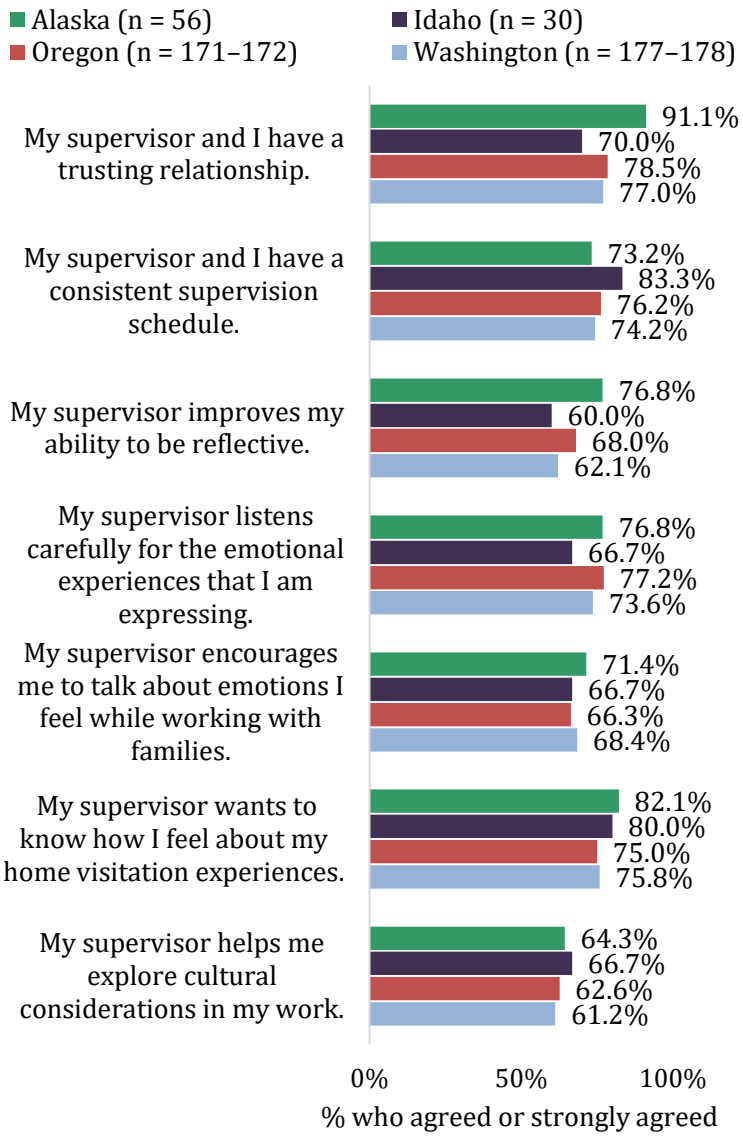


Figure 3.1. Home visitors' perceptions of reflective supervision: Item endorsement by state

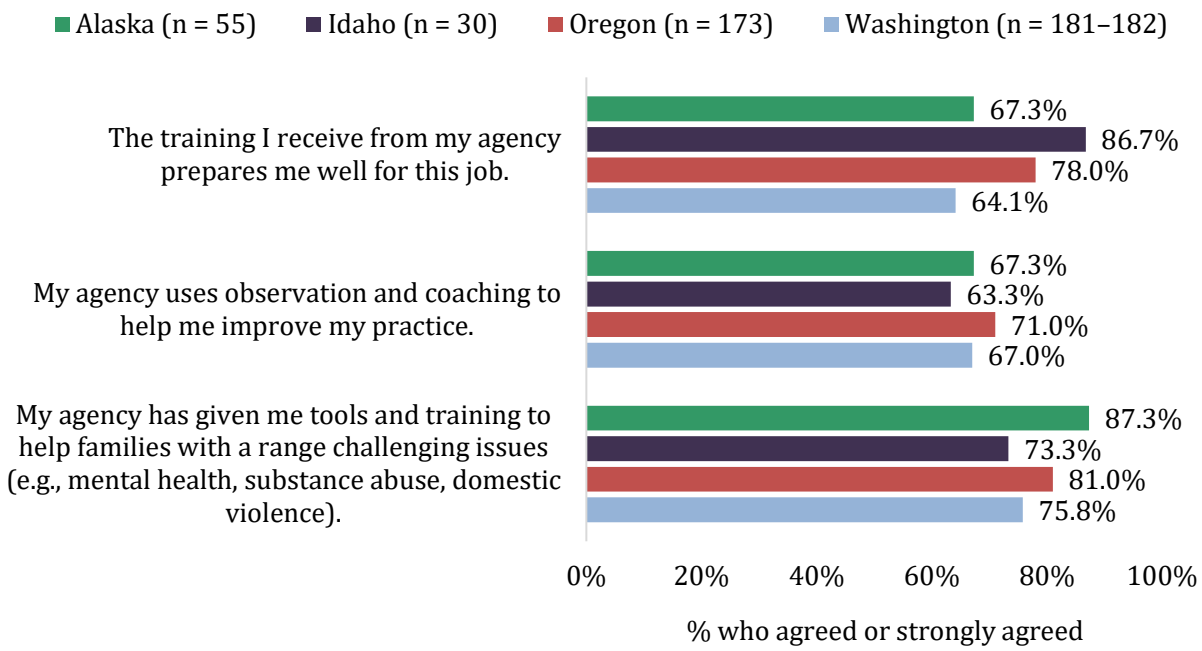


Figure 3.2. Home visitors' perceptions of training: Item endorsement by state

Analyses of reflective supervision and training scales showed no significant differences between Region X states.

GROUP DIFFERENCES IN REFLECTIVE SUPERVISION AND TRAINING

To examine differences by state in participants' overall ratings of reflective supervision and training, we computed scale scores, which represent the averages across the individual items. Results of statistical analyses showed no statistically significant differences between states.

In summary, the majority of home visitors across Region X reported having a trusting relationship with a supervisor who helped them to reflect upon the emotional aspects of their work. Most home visitors also felt that they received the necessary training to do their job and help families with a range of challenging issues. However, it is important to note that about one-quarter to one-third of home visitors did not endorse the relfective supervision and training items, suggesting some variation in the implementation of professional development supports such as reflective supervision and training across the region.

> "[We have been] learning and getting a little more education on reflective supervision and that process. I understand more now that it's a time for [home visitors] to come in and talk about what's happening, what's on their mind."
>
> - Home visiting supervisor

Research Question 2: How do home visitors and supervisors perceive the quality of their work environments?

Across all work sectors, the quality of employees' work environment and culture can play a strong role in workforce retention.[liv] This is also true for the home visiting profession, where the emotional toll of the work with children and families makes a supportive organizational climate especially important. This section explores how home visitors and supervisors perceive the quality of their work environments, with a focus on perceptions of organizations' learning cultures, emphasis on home visitor safety, and provision of a psychologically supportive environment.

LEARNING CULTURE

Three learning culture items assessed the extent to which staff collaborate, reflect about the work together, and seek support from one another. Home visitors and supervisors in Region X reported strong learning cultures within their work environments, with mean scores of 4.17 and 4.37, respectively, on a scale of 1–5. Scores did not differ significantly by state; however, there were significant differences by job role,[22] with supervisors rating the learning culture more positively than home visitors.

Table 3.1. Learning culture scale scores by state and job role

Measure	Items	Scale means by job role and state				
Learning Culture	Home visiting staff . . .	**Home visitors**				
		AK n = 56	**ID** n = 30	**OR** n = 174	**WA** n = 182	**Region X** n = 442
	Work together to find new and better ways to meet the needs of families.	4.32	4.32	4.19	4.08	4.17
	Take time together to reflect about the work.	**Supervisors**				
		AK n = 15	**ID** n = 11	**OR** n = 57	**WA** n = 65	**Region X** n =148
	Feel comfortable seeking support from colleagues.	4.64	4.51	4.29	4.36	4.37

[a] Rating scale: 1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

SAFETY

By nature, home visiting is a profession that requires professionals to enter the homes of the families they serve. This study explored whether home visitors feel that their organizations support their personal safety during home visits by giving them adequate training in personal safety and by communicating an organizational value for personal safety.

As shown in Figure 3.3, ratings of safety were high for Region X home visitors and supervisors, with means for the two-item scale of 4.0 and 4.1, respectively. While scores were high overall, there was a statistically significant difference between states' overall mean ratings of safety,[23] with home visitors in Oregon having a particularly strong sense of value and support for their personal safety.

[22] $F(1, 355.32) = 12.45$, $p < .001$

[23] Tukey HSD post-hoc follow-up to ANOVA, $p = .03$.

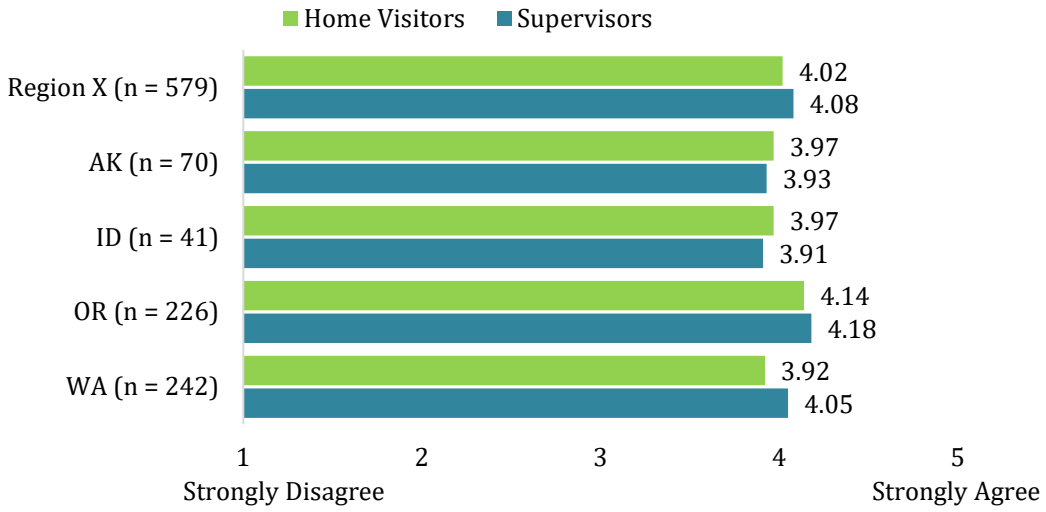


Figure 3.3. Average scores for safety scale, by state and job role

PSYCHOLOGICAL CLIMATE

Psychological climate refers to employees' individual perceptions of their work environment.[lv] This study included items adapted from the Parker Psychological Climate scale, which measure eight components, including their sense of autonomy, importance, justice, support, role clarity, interpersonal conflict, and opportunities for taking on challenges and innovations. See Table 3.2 for the overall scales and subscales related to psychological climate.

Results indicate that ratings of psychological climate were relatively high across positions for overall scale scores and for most subscales, as mean scores of about 4.0 roughly correspond with the "agree" category. (Note: for the conflict subscale, lower scores are preferable). Overall, the highest-rated aspects of climate included importance (e.g., making a meaningful contribution) and challenge. Home visitors tended to rate role clarity highly (M = 4.11), while supervisors generally endorsed autonomy highly (M = 4.21).

Analyses revealed several statistically significant differences in views of climate across job roles and states. As shown in Table 3.2, supervisors had more favorable perceptions of their psychological climate overall, and their sense of autonomy, challenge, importance, innovation, and justice, than did home visitors. So, although scores for psychological climate and its subscales were relatively high for both supervisors and home visitors, they were especially high for supervisors.

There were also statistically significant differences between states for the innovation and support psychological climate subscales, with Alaska home visitors and supervisors endorsing these factors more highly, on average, than other states in the region (see text box below).[24,25]

Psychological climate ratings: differences by state

Innovation: Alaska (*M* = 4.13) had significantly higher ratings than did Oregon (M = 3.83) and Washington (*M* = 3.71).

Support: Alaska (*M* = 4.11) had significantly higher ratings than did Washington (*M* = 3.71).

[24] Innovation: Mann-Whitney nonparametric tests: Alaska vs. Oregon (Z = -2.73, p = .01); Alaska vs. Washington (Z = -3.87, p < .001)

[25] Support: Tukey post-hoc follow-up to ANOVA, Alaska vs. Washington, p = .01.

Table 3.2. Mean scores for psychological climate scale and subscales, by job role[a]

Measure Items	Home visitors (n = 439–442)	Supervisors (n = 145–147)	Significant differences by job role?
Psychological Climate – Overall Scale	3.94	4.10	**Yes** [26]
Autonomy I have a great deal of freedom to decide how to do my job.	3.89	4.21	**Yes**[27]
Challenge I am able to make full use of my knowledge and skills in my job.	4.10	4.27	**Yes** [28]
Clarity My job responsibilities are clearly defined. I know what is expected of me in my organization.	4.11	4.06	**No**
Conflict* I have to do things for my job that are against my better judgment. I am held responsible for things over which I have no control.	2.24	2.18	**No**
Importance I feel that my job is important to the functioning of my team. I feel that my work makes a meaningful contribution.	4.29	4.57	**Yes** [29]
Innovation My agency encourages me to find new ways around old problems.	3.76	4.03	**Yes** [30]
Justice Decisions about my job are made in a fair manner.	3.67	3.88	**Yes** [31]
Support My agency really cares about my well-being. My agency cares about my general satisfaction at work.	3.77	3.93	**No**

[a] Rating scale: 1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree
* A lower score on conflict subscale is preferable.

[26] $F(1, 585) = 8.52$, $p = .001$
[27] $Z = -4.06$, $p < .001$ (Mann-Whitney nonparametric test)
[28] $Z = -2.27$, $p = .02$ (Mann-Whitney nonparametric test)
[29] $F(1, 583) = 29.71$, $p < .001$
[30] $Z = -3.17$, $p = .002$ (Mann-Whitney nonparametric test)
[31] $Z = -2.79$, $p = .01$ (Mann-Whitney nonparametric test)

Research Question 3: What factors are driving turnover among home visitors and supervisors?

One of the most pressing problems across early childhood and family support professions, including home visiting, is how to retain a highly qualified workforce. This section describes the average turnover rate for Region X home visiting programs whose administrators participated in this study. In addition, we provide results of an exit survey that was administered to 27 home visitors and 7 supervisors/administrators across the region who left their jobs within the six months following administration of the full home visiting workforce study (March–July 2018).

TURNOVER

For this study, program administrators were asked to report their total number of home visitors and supervisors on staff and the number of home visitors and supervisors who had left their jobs in the previous twelve months. We used these data to calculate turnover rates by position and state. As shown in Table 3.3, average turnover rates varied by state, but these differences were not statistically significant (this may be because of small response rates that tend to make statistically significant differences hard to detect). Differences between the average turnover rates for home visitors and supervisors in Region X (23% and 20% respectively) also were not statistically significant. For Alaska, however, turnover differences between job roles were statistically significant (p = .05).

"I, right now, would say the hardest part [of my job] is figuring out a way to make the work environment more—I'm trying to figure out the word to say here—a little more cohesive . . . [or] collaborative when it comes to leadership and [other home visitors]."

- Home visiting supervisor

Table 3.3. Average 12-month turnover rates

	Alaska n = 10	Idaho n = 9	Oregon n = 39–41	Washington n = 43–46	Region X n = 101–106
Home visitors	40.2%	21.9%	24.2%	17.6%	23%
Supervisors	13.4%	22.2%	26.7%	15.3%	20%

Within the broader early childhood workforce, turnover rates of 30% or higher are typical.[lvi] Similarly, a recent study of the home visiting workforce turnover in Illinois identified average turnover rates between 27–31%.[lvii] Average turnover rates from this study are similar or slightly lower; however, small sample sizes and use of administrator reporting mean that results should be interpreted with caution.

EXIT SURVEYS

All respondents to the Region X Home Visiting Workforce Survey who left their jobs within six months of completing the original survey were invited to participate in an exit survey. Twenty-seven home visitors and 7 supervisors/administrators participated. See the text box for demographic details about the exit survey participants.

Twenty-eight home visitors and supervisors who left their jobs did so by choice. Six were laid off or asked to leave. All of those who were laid off said they would have stayed in their jobs if they could have. Of the full sample of exited home visitors and supervisors, 77% identified home visiting as their preferred profession.

Home visitors and supervisors had similar reasons for leaving the profession. For both, the top reason for leaving was personal and unrelated to home visitation work. Both also identified low pay and excessive paperwork as primary drivers for exiting their jobs.

In addition to these common reasons for leaving, home visitors specifically identified wanting more promotion opportunities and the drain of travel and work with families as top reasons for leaving their positions. For supervisors, turnover among home visitors, feelings of ineffectiveness, and unsupportive work environments were top drivers of their decisions to leave (see Table 3.4). More than half of exiters (60.7%) reported that they felt comfortable sharing their job concerns with supervisors or leadership.

Exit Survey Demographics *

STATE DISTRIBUTION
- Alaska: 23.5%
- Idaho: 0.0%
- Oregon: 35.3%
- Washington: 41.2%

RACE/ETHNICITY
- People of color: 32.4%
- White: 67.6%

LANGUAGE
- English: 79.4%
- Spanish/Other: 20.5%

AGE
- 20–29: 17.6%
- 30–49: 67.6%
- 50+: 14.7%

EDUCATION
- Bachelor's or less: 58.8%
- Some graduate school: 20.6%
- Master's degree: 20.6%

WORKER EXPERIENCE (AVERAGE # OF YEARS)
- Most recent position: 3.5
- Direct home visiting: 6.3
- Early childhood field: 9.4

WAGES
- Average hourly wage: $21.76
- Time since last pay increase: 1.7 years

* To protect anonymity, some data categories have been merged due to small cell sizes.

Table 3.4. Top reasons for leaving home visiting job (ranked by most common)

Home Visitors	Supervisors
1. Personal reasons not specific to home visitation work	1. Personal reasons not specific to home visitation work
2. The low pay	2. The instability/turnover among home visitors in my program was draining
3. There was excessive paperwork and reporting	3. I was not feeling effective in the job
4. I wanted a job with greater responsibility/promotion	4. The low pay
5. The travel was draining	5. There was excessive paperwork and reporting
6. The work with families was draining	6. There was a punitive/unsupportive work environment

Home visitors and supervisors most frequently reported the following as changes to their jobs or work environments that they would have needed to stay in their jobs:

- Higher pay
- More supportive leadership/supervisor
- Better communication in the organization
- More promotion opportunities
- Less paperwork
- Better relationships with coworkers
- Reduced caseloads

Exit survey respondents employed in new positions: 62%

Of these…

24% were re-employed in the home visiting field

43% were working in early childhood or with older children, but not in home visitation

33% had changed fields altogether

Exit survey respondents who took new employment (see sidebar) most frequently reported that their new jobs offer higher pay, less travel and paperwork, better schedules, increased promotion opportunities, and more supportive leadership. Respondents had the following suggestions for what their supervisors might have done to be more supportive:

1. Clarify job roles, responsibilities, and expectations
2. Be more consistent and effective in providing reflective/clinical supervision
3. Understand supervisee's job duties and challenges better

Of respondents who had not yet taken new positions, nearly half (46%) did not intend to stay within the home visiting or broader early childhood field.

Research Question 4: What are the job intentions of home visitors and supervisors within Region X?

To better understand the future professional plans of the current home visiting workforce in Region X, this section explores the job intentions of home visitors and home visiting supervisors in the survey sample. In particular, participating home visitors and supervisors answered questions about their intent to either stay in or leave their current positions and identified factors driving their anticipated plans.

"The only thing that is a little frustrating about this particular job is that there's not much room for advancement because home visiting, it's like you're a home visitor. We have a program lead, we have a program director. . . . You kind of have to be a lead or some sort of other supervisory role before you can be the program director. You know what I mean? So, there's not a ton of room for advancement."

- Home visitor

INTENT TO STAY

Overall, 87.2% of surveyed home visitors and 91.2% of supervisors in Region X plan to stay in their jobs for at least the next two years (Table 3.5). There were no statistically significant differences in intent to stay by state or by position.

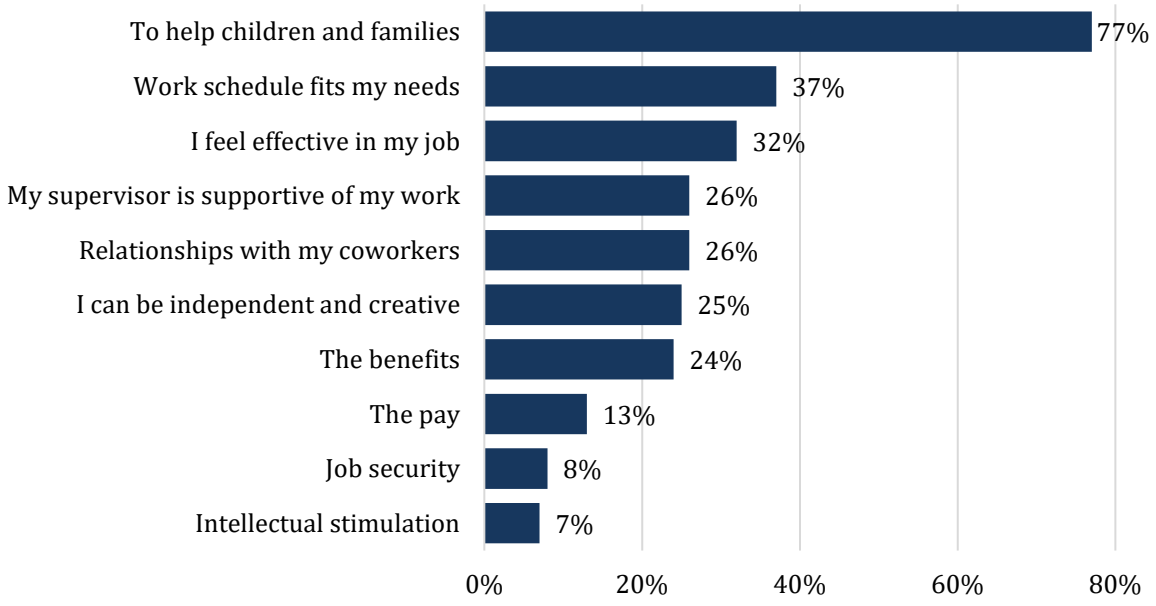
Table 3.5. Percent of home visiting professionals who intend to stay for at least the next two years

	Alaska	Idaho	Oregon	Washington	Region X
Home visitors	n = 55	n = 30	n = 175	n = 184	n = 444
	90.9%	93.3%	86.3%	85.9%	87.2%
Supervisors	n = 16	n = 11	n = 56	n = 65	n = 148
	100.0%	100.0%	89.3%	89.2%	91.2%

Among those who plan to stay in their jobs, the most frequently cited reason is to help children and families. Following this, home visiting professionals indicate that the work schedule fits their needs and they feel effective, have a supportive supervisor and/or

positive working relationships with coworkers, and can be independent/creative. Figure 3.4 lists the top ten reasons home visiting professionals provided for staying in their jobs.[32]

Figure 3.4. Top 10 reasons Region X home visiting professionals stay in their jobs



Across states and job roles, there were some variations in the most frequently reported reasons home visiting professionals had for staying in their positions (Table 3.6). Bolded text indicates a response other than the top 3 reasons indicated for the full sample. These variations largely reflect positive supervisor or coworker relationships that contribute to workers' desire to stay in their positions.

[32] Additional reasons for staying included: It would be too hard to change jobs (6%); no other jobs in my area are appealing to me (4%); there are no other jobs as good in my community (4%); I've been here too long to leave (2%); advancement or promotion opportunities (2%); I don't feel qualified for any other job (1%). Twenty respondents wrote in an "other" response not captured by the provided response options; examples include: "*I love my job*," "*personal growth*," "*mak[ing] a partnership between agencies*," and "*the philosophy of my agency inspires me.*"

Table 3.6. Top 3 reasons for intent to stay by state and position

	Alaska	Idaho	Oregon	Washington	Region X
Home visitors	n = 55	n = 30	n = 175	n = 184	n = 444
	1. To help children & families (70%)	1. To help children & families (96%)	1. To help children & families (83%)	1. To help children & families (78%)	1. To help children & families (80%)
	2. Work schedule fits my needs (50%)	2. Work schedule fits my needs (46%)	2. Work schedule fits my needs (35%)	2. Work schedule fits my needs (42%)	2. Work schedule fits my needs (41%)
	3. (tie) I feel effective in my job (30%) **(tie) My supervisor is supportive of my work (30%)**	3. **The benefits (36%)**	3. **My supervisor is supportive of my work (30%)**	3. I feel effective in my job (31%)	3. I feel effective in my job (29%)
Supervisors	n = 16	n = 11	n = 56	n = 65	n = 148
	1. To help children & families (63%)	1. I feel effective in my job (82%)	1. To help children & families (70%)	1. To help children & families (71%)	1. To help children & families (69%)
	2. (tie) Relationships with my co-workers (44%) (tie) I feel effective in my job (44%)	2. To help children & families (64%)	2. I feel effective in my job (40%)	2. I feel effective in my job (34%)	2. I feel effective in my job (42%)
		3. Work schedule fits my needs (45%)	3. Relationships with my co-workers (36%)	**3. Work schedule fits my needs (29%)**	3. Relationships with my co-workers (32%)

INTENT TO LEAVE

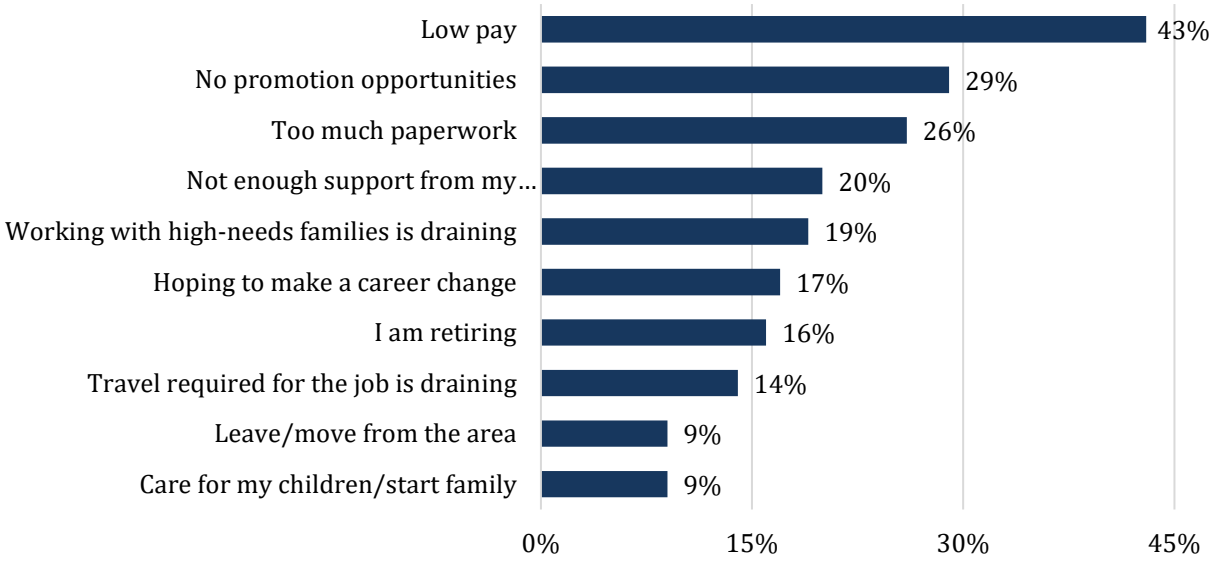
Across Region X, 12% of home visiting professionals in the sample indicated that they plan to leave their jobs within the next two years. The most common reason provided for wanting to leave was low pay, followed by the lack of promotion opportunities, excess paperwork, and inadequate supervisory support. Figure 3.5 shows the top ten reasons home

"I'm just saying it—they don't pay us enough. They really don't. But I have such an amazing team, and we do the best we can."

- Home visitor

visiting professionals in Region X provided for intending to leave their jobs.[33]

Figure 3.5. Top 10 reasons for intending to leave job (n = 70)



Of the 70 home visiting professionals who plan to leave their jobs . . .

only **24%** plan to keep working in the home visiting field.

[33] Additional reasons for intending to leave were reported by fewer than 5 respondents; these included: lack of/poor benefits; it is challenging to follow a home-visiting model; conflict among coworkers; not enough autonomy or independence in the job; for my spouse's or partner's job; to care of sick or aging relatives; to care for my own health; I do not feel effective in my job; I do not feel physically safe doing my job; I do not like working evenings and/or weekends; funding for my job is ending. Also, 12 respondents wrote in an "other" response not captured by the provided response options; examples include*: "workload is too high," "got a promotion at current job,"* and *"pursuing a graduate degree."*

Policy Considerations

This brief has explored perceptions of home visiting professionals across Alaska, Idaho, Oregon, and Washington regarding their opportunities for professional development, the quality of the home visiting work environment, and workforce turnover and retention.

Results suggest generally positive perceptions of professional support and organizational practices. Nevertheless, turnover in the home visiting workforce remains relatively high. This section provides some policy considerations for maintaining and even growing some of the positive components of the home visiting profession, while improving factors that may increase workforce retention and reduce turnover.

Reflective Supervision

Reflective supervision practices emphasize reflection, collaboration, and regular, consistent meetings between home visitors and their supervisors and encourage home visitors to explore the experiences and emotions they bring to their work with families. Survey data and interviews with home visiting professionals suggested that many organizations are incorporating elements of these supervision practices into the home visitor–supervisor relationship and that home visitors generally find the support to be beneficial.

Because poor supervision is a leading reason that home visitors and supervisors give for leaving their jobs or the field, agencies can help mitigate this problem by providing, financially supporting, and/or instituting guidance around reflective supervision training for home visiting supervisors in the field. Higher education programs that prepare professionals for home visiting careers and similar human service professions might also consider adding endorsements or courses for students that focus on the core elements of reflective supervision.

Organizational Practices

Home visiting professionals who participated in the current study identified a number of strong organizational factors that support their work, including an attention to home visitor safety as well as work cultures that promote learning, autonomy, innovation, and role clarity and minimize interpersonal conflict.

Developers of specific home visiting models and the government agencies that either fund or support home visiting programs can play a role in promoting these practices by building in selection or continuation criteria related to the presence of these organizational factors and by developing organizational support and training offerings that help home visiting organizations build work cultures that foster these characteristics.

Turnover

One of the most pressing problems within the home visiting sector is the prevalence of workforce turnover. While lower than some other early childhood fields, the turnover rates of 23% and 20% for home visitors and supervisors in Region X, respectively, are still too high. Results from this study identify pay, promotional opportunities, excessive paperwork, and lack of support from supervisors as key factors driving turnover.

Governmental programs that have been successful for other workforce sectors, such as teachers, might be considered to improve the financial status of home visitors. These might include programs that provide student loan forgiveness for professionals who enter and stay within the home visiting profession for at least three to five years, housing purchase programs that lower interest rates or provide down payments for home visiting professionals, or priority health insurance rates on the open market for home visiting organizations.

Similarly, home organizations within the sector might consider staffing structures that build in a career ladder with more growth opportunities and positions that take on some leadership roles to provide a bridge between home visitors and the program lead or director. With an aging workforce among current supervisors (results from this study indicate 40% of supervisors nearing retirement; see *Brief 1: Demographic and Educational Characteristics of the Region X Home Visiting Workforce*), this strategy provides for succession planning to keep qualified home visitors in the workforce while growing their management and leadership skills.

To combat turnover resulting from excessive paperwork, home visiting organizations should explore opportunities for streamlining reporting and utilizing technology to reduce paperwork burden. Investing in tablets can be an effective strategy to reduce data entry that can otherwise be necessary when using paper forms.

Finally, because poor supervision can be a key factor in driving home visitors out of the field, a continuation or expansion of leadership and management trainings for supervisors may be warranted. In addition to existing opportunities for reflective supervision training, leadership and management training and coaching may help many home visiting program leads or directors learn the skills that are needed to develop the kind of positive work culture that has already been emphasized here.

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Region X Innovation Grant

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

RESEARCH BRIEF #4

The Health and Well-Being of the Region X Home Visiting Workforce

This research brief is the fourth in a series that is part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with The Alaska Division of Public Health, The Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[xvi]

Key Findings

On average, home visitors and supervisors rated their overall health as "good" or "very good." Supervisors rated their health significantly higher than home visitors.

Healthy eating (52%) was more common than regular exercise (25%), and more than half (51%) of the workforce was dissatisfied with their body weight.

Tobacco use was lower among the home visiting workforce (7%) than the general population (16%).

Approximately one in ten (9%) home visitors and supervisors screened positively for depression. Rates of depression were significantly higher in Alaska (14%) and Washington (12%) than Oregon (5%).

More than half (63%) of the workforce reported at least some difficulty paying bills during the year; home visitors reported greater difficulty than supervisors.

Leadership and coworker support, reflective supervision, and self-care were commonly identified stress management techniques.

Most of the workforce reported having a primary care doctor (81%) and access to mental health support (80%) and attending regular check-ups (66%). However, 17% reported health care barriers, which were more common among home visitors than supervisors.

Most of the workforce (81%) reported at least one Adverse Childhood Experience (ACE). One-third (33%) of home visitors and supervisors experienced four or more ACEs. In comparison, recent population estimates in Alaska,[lviii] Oregon,[lix] and Washington[lx] indicate 15–17% of residents have four or more ACEs.

Introduction

A thriving workforce is key to achieving the goals of home visiting. Home visitors work with families to help them accomplish their goals, foster healthy parent-child relationships, and support children's development.[lxi] In order for home visitors to successfully support the health and well-being of families, they themselves must also be healthy and well.[lxii]

There are various facets of an individual's health and well-being, including physical, mental, and economic.[lxiii] A past study of the Head Start and Early Head Start workforce in Pennsylvania revealed several pressing health concerns, including high prevalence of depressive symptoms, obesity, and other adverse health indicators.[lxiv] Furthermore, the lack of economic well-being among the early childhood workforce is well-documented, with many professionals experiencing economic insecurity.[lxv] Although there is some indication that the health and well-being of the early childhood workforce, broadly, are cause for concern, less is known about the status of the home visiting workforce specifically.

Aside from understanding the well-being status of home visitors, it is also helpful to know what healthy practices they engage in and what health care services they access. There is clear consensus on the benefits of a healthy diet, regular exercise, avoiding tobacco, and receiving preventive health care services.[lxvi] Furthermore, stress management and self-care are important in high-stress occupations, like home visiting, because stress can lead to occupational burnout.[lxvii] One type of stress that is important to consider in the context of home visiting is secondary traumatic stress which results from helping or wanting to help a traumatized or suffering person.[lxviii]

Finally, it is important to understand the extent to which home visitors may have experienced trauma during their own childhood, known Adverse Childhood Experiences (ACEs), because past trauma can be reactivated in the context of home visiting. [lxix] ACEs include child abuse or household dysfunction (e.g., exposure to substance abuse, mental illness, household violence, etc.), and have been linked to increased risk of several chronic health conditions later in life.[lxx] Recent studies of ACEs among human service providers, which includes home visitors, found 70% experienced at least one ACE,[lxxi] and individuals with higher ACE scores may be more likely to pursue human service careers.[lxxii] To avoid reactivating past trauma, restorative cultures can be created within workplaces, which promote positive relationships, reflection, shared values, and self-care.[lxxiii]

Research Questions

The purpose of this research brief is to address the following questions based on a sample of home visitors and home visiting supervisors ("the workforce") in Region X:

1. How do home visitors and supervisors rate their personal health and well-being, including economic well-being?

2. What healthy practices does the workforce engage in?

3. To what extent do home visitors and supervisors access health care services?

4. To what extent has the workforce experienced Adverse Childhood Experiences?

Sample

The sample used for this research brief includes 468 home visitors who provide home visiting services directly to families and 161 home visiting supervisors, 29% of whom have a caseload of families they serve. These home visitors and supervisors were drawn from 148

programs in Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Within the sample, 202 (43.2%) home visitors and 76 (47.2%) home visiting supervisors work in home visiting programs that receive MIECHV funding. Thirty-eight percent of programs in the sample reported receiving MIECHV funding. This brief also includes data from a sub-group of 12 home visitors and 7 supervisors who participated in follow-up interviews. For more information about the sample and the measures used for this study, please see *The Region X Home Visiting Workforce Study: Introduction.*[lxxiv]

Results

Research Question 1: How do home visitors and supervisors rate their personal health and well-being, including economic well-being?

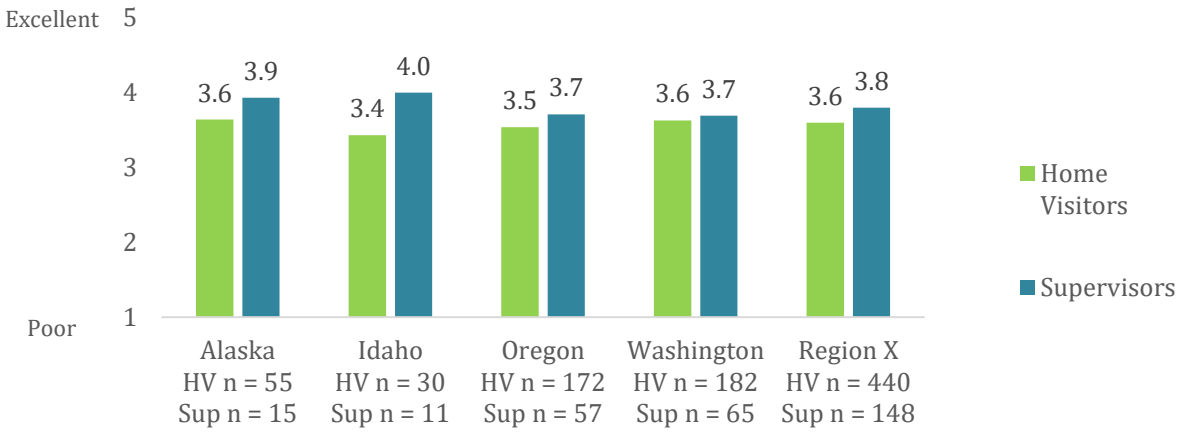
As described in the introduction to this brief, health and well-being includes physical health, mental health, and economic well-being. This section describes how home visitors and supervisors rate various aspects of their own health and well-being.

OVERALL HEALTH

When home visitors and supervisors were asked to rate their overall health, more than half (57.7%) indicated their health was "very good" or "excellent." An additional 34.4% rated their overall health as "good," while the remaining 7.9% rated their health as "fair" or "poor." Figure 4.1 shows the overall health ratings of home visitors and supervisors, respectively, by state. Means ranged from 3–4, indicating average ratings of "good" to "very good." Home visiting supervisors rated their health significantly higher than home visitors.[34] Specifically, 65.5% of supervisors rated their health as "very good" or "excellent" compared to 55.0% of home visitors. There were no significant differences in overall health ratings by state.

[34] $t(586) = 2.09$, $p = .04$

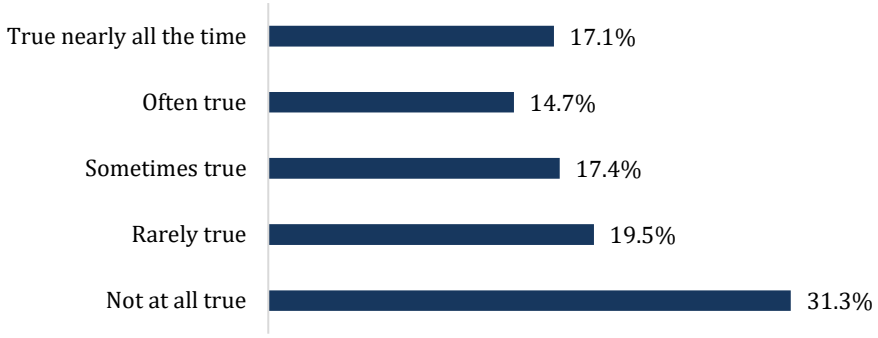
Figure 4.1. Mean scores of "overall health" by role and state



BODY WEIGHT

Although the workforce tended to rate their overall health favorably, they expressed dissatisfaction with their body weight. Half (50.8%) of the workforce disagreed with the statement "I am at my ideal body weight (plus or minus 5 lbs)." Specifically, 31.3% felt this statement was "not at all true" and an additional 19.5% felt this statement was "rarely true." The overall distribution of responses can be found in Figure 4.2. No significant differences were found by position or by state.

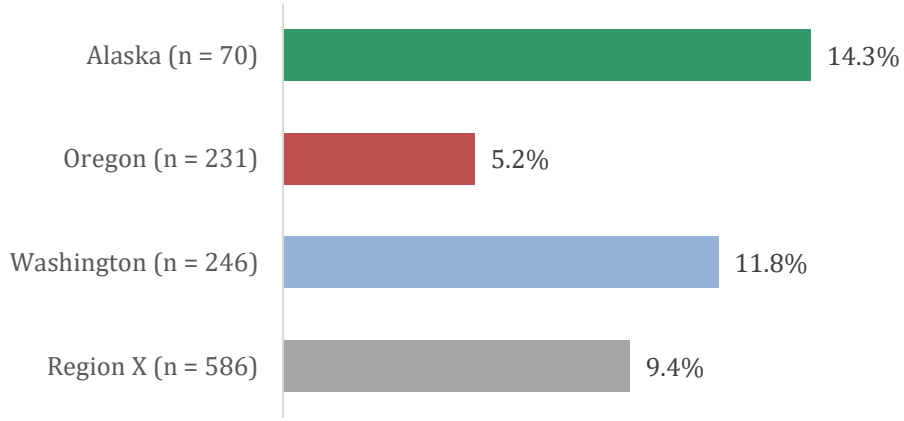
Figure 4.2. Home visitor and supervisor responses to the statement "I am at my ideal body weight" (n = 585)



MENTAL HEALTH: DEPRESSION

Overall, 9% of the workforce screened positively for depression based on the Patient Health Questionnaire-2 (PHQ-2) scale.[lxxv] Note, a positive screen for depression on the PHQ-2 does not necessarily indicate clinical depression, which is a diagnosis that must be made by a clinician. Figure 4.3 shows the percentage of home visitors and supervisors, collectively, who screened positively for depression by state. Data from Idaho were suppressed due to sample size. There were statistically significant differences by state,[35] but not by job role. Rates of depression were significantly higher in Alaska[36] (14.3%) and Washington[37] (11.8%) than Oregon (5.2%.)

Figure 4.3. Proportion of home visitors and supervisors screening positively for depression by state



Past work (from 1980 to 2012) estimates clinical depression among the early childhood workforce ranging from 6–27%;[lxxvi] a study of home visitors found roughly 20% had clinically significant symptoms.[lxxvii] Although stigma and bias make it difficult to estimate the true incidence of depression among the workforce, depression rates in the present study are consistent with rates observed in past work.

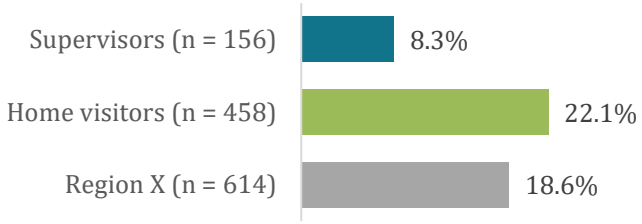
ECONOMIC WELL-BEING

Two items were used to assess economic well-being: not having enough money left at the end of the month and difficulty paying bills in the past year. Overall, 18.6% of home visitors and supervisors reported "not having enough money left at the end of the month to make

[35] χ^2 (3) = 8.45, p = .04
[36] χ^2 (1) = 6.55, p = .01
[37] χ^2 (1) = 6.59, p = .01

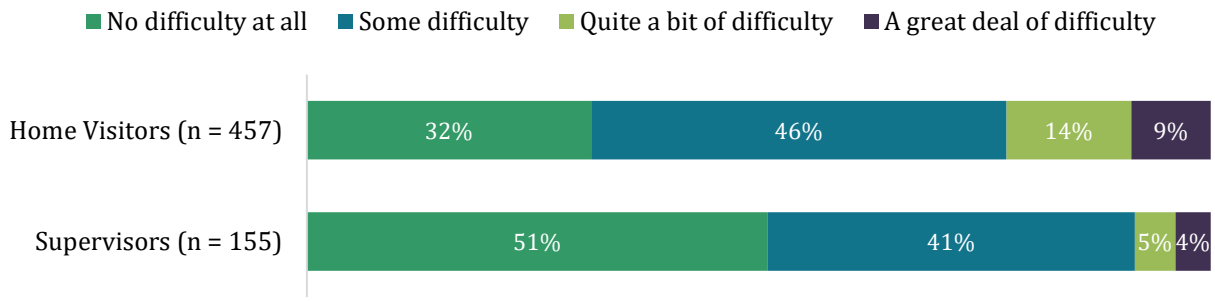
ends meet." As shown in Figure 4.4, home visitors were significantly more likely to report not having enough money to make ends meet compared to supervisors.[38] There were no significant differences by state.

Figure 4.4. Percent of respondents who have difficulty making ends meet by job role



In terms of the second indicator of economic well-being, 63.6% of home visitors and supervisors reported at least some difficulty paying bills in the past year. Specifically, 7.5% reported "a great deal of difficulty," 11.4% reported "quite a bit of difficulty," 44.6% reported "some difficulty," while 36.4% reported "no difficulty at all." Again, there were statistically significant group differences by job role, with home visitors having greater difficulty paying bills compared to supervisors.[39] There were no significant differences among state comparisons. Figure 4.5 shows the distribution of responses among home visitors and supervisors for Region X, respectively.

Figure 4.5. Home Visitors' responses regrading "difficulty paying bills in the past year"



In sum, this suggests much of the workforce has at least some difficulty maintaining their economic well-being, especially home visitors.

[38] χ^2 (1) = 14.48, $p < .001$
[39] t (610) = -4.80, $p < .001$

Research Question 2: What healthy practices does the workforce engage in?

This section describes the healthy practices of home visitors and supervisors, specifically, eating well, exercising, not using tobacco, and managing stress.

EATING WELL

About half (51.7%) of the workforce reports eating a healthy diet "often" or "nearly all the time." Of the remaining half, 31.6% report "sometimes," 10.4% report "rarely," and 6.3% report "never" eating a healthy diet. There were no statistically significant differences by state or role.

EXERCISING

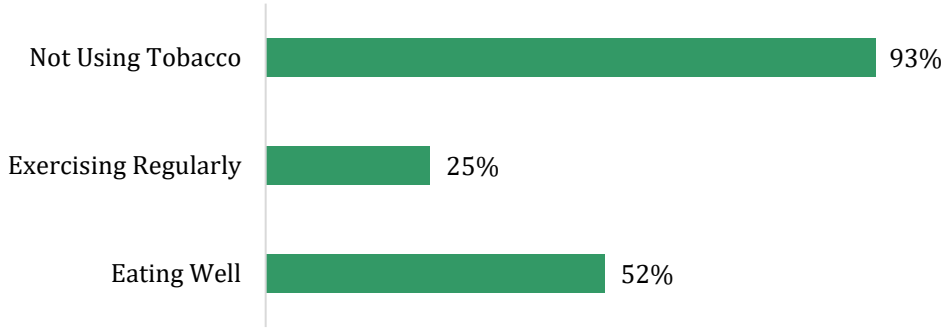
Regular exercise (at least 30 minutes most days) was less common than healthy eating. One quarter (25.1%) of the workforce reported regularly exercising "often" or "nearly all the time," followed by 30.2% reporting "sometimes," 29.2% "rarely," and 15.5% "not" exercising regularly. There were no statistically significant differences in exercise by state or role. Interestingly, more experienced home visitors and supervisors exercised more regularly than less experienced staff.[40] Exercise habits did not vary significantly by age.

NOT USING TOBACCO

Nearly all of the workforce (93%) report not using any form of tobacco. Additionally, 86% report not living with anyone who uses tobacco. Tobacco use is lower among the home visiting workforce (6.8%) than the general population (15.5%).[lxxviii] There were no statistically significant differences in tobacco use by state or role.

[40] $t(216.03) = -2.24$, $p = .03$

Figure 4.6. Proportion of home visitors and supervisors engaging in healthy behaviors



MANAGING STRESS

During interviews, home visitors and supervisors were asked to reflect on how they manage the stress of their profession. Several strategies were often discussed, including reflective supervision, coworker support, and various self-care practices. More detail, including specific examples, are shown below.

Reflective supervision. Of the 19 interviews conducted, 16 (84%) mentioned leadership support and/or reflective supervision as a means of managing stress. As discussed in *Brief 3*, reflective supervision refers to an ongoing, scheduled professional development process that enhances the reflective practice skills of home visitors. Reflective supervision, specifically, was discussed as a stress management technique in 13 (68%) interviews. As demonstrated in the corresponding excerpts, reflective supervision was a stress management technique used by both home visitors and supervisors.

In the excerpt to the right, the home visitor mentioned how reflective supervision allows her to regulate her emotions, "think clearly," and "be present" with families, which are characteristic of mindfulness, a state of being attentive, present, non-judgmental, and accepting.[lxxix] Similarly, the supervisor discusses how she has chosen to receive reflective supervision, even though it is not required, because it allows her to process difficult situations.

Coworker support. Talking with coworkers is another stress management technique. In fact, 14 (73.7%) interviews discussed coworker support as a stress management strategy. Similar to reflective supervision and leadership support, coworker support offers an opportunity to be heard while maintaining the confidentiality of the clients.

> I have to process that stuff with my coworkers, because I literally can't talk about it with anyone else, because of the confidentiality. . . . My team is really good about checking in. . . . We all know each other well enough to check in, "Do you need anything? What can I do?" and then [be] really respectful, whatever the answer is, about maintaining that boundary or helping with whatever.
>
> –Home Visitor

Self-care practices were also commonly discussed as strategies for coping with stressful situations. All but one (94.7%) interview mentioned self-care practices, which include exercise, taking time off, practicing mindfulness, journaling, having hobbies outside of work, and spending time with family and friends. One supervisor shares examples of self-care practices she does both in and outside of work:

> I make sure that I build in self-care on a regular basis. So I have a lot of things that I do outside of work. But, also, when I'm at work I'm really intentional about making sure that I take time for a lunch. That if I'm in my office all day that I'm getting up and that I'm moving around and that

"I have reflective supervision, and that's probably the main way I [deal with emotional aspects of the work.] I've learned—four years now of reflective supervision—I've really learned how to control my emotions or deal with what's happening inside me at the moment of a visit that a crisis happens so that I can think clearly and be present to the family and then be able to later process it. It's usually talking to a coworker or talking to my supervisor or my regular supervisor. Just talking to someone really helps."

- Home visitor

"Hearing about trauma and these really, really sad stories that can, also, be really hard. But I think I found enough strategies that I've built in to keep that balance for myself because I also make sure that I receive reflective supervision as well. . . . It's not required. But it is recommended. So I know that that's also helped me as a supervisor to be able to continue to have that not only as a home visitor, being able to have reflective supervision but, also then, as a supervisor receiving it as well. So it kind of counters some of those challenges, having a place to be able to process it."

- Supervisor

> I'm going outside. . . . And I build in exercise on a regular basis outside of work. . . . I have noticed throughout the years of doing this program that there are times when I didn't have that built in as much and I could definitely see the impact. And having it built-in allows for having more emotional availability for others to be able to be present and be with them when we're talking about really difficult things.
>
> –Supervisor

Consistent with past excerpts, the above supervisor discusses how her work is positively impacted by her self-care / stress management. Namely, she is more emotionally available and "present" for others. She specifically addresses times when self-care was not a part of her routine and how she "could definitely see the impact."

"[Handling the emotional aspects of the job] is a learning curve. I don't always handle it well. I have been learning to practice more—to do more mindfulness practices and meditation practices. My team has been working collectively on the ways to kind of just regulate our own hearts and systems and quiet ourselves when things kind of tend to get emotional or triggered. . . . I've been trying to develop routines at home as well. That's a practice, right? It's learning. Sometimes, I'm really messy."

- Home visitor

Some home visitors acknowledged the difficulty of building a regular self-care practice, especially with some of the challenges of the profession. One home visitor shared how difficult and "messy" it is to establish self-care routines, such as practicing mindfulness or art, to "quiet ourselves" and "regulate our own hearts."

Although the majority of self-care strategies that were shared during the interviews were healthy behaviors, a few home visitors also mentioned strategies that may not be healthy if practiced in excess, such as drinking, spending money (i.e., "retail therapy"), or emotional eating.

In sum, home visitors and supervisors face various emotionally challenging situations in their work, and they employ a variety of strategies to cope with

stress. Many report utilizing healthy strategies, including leadership and coworker support, reflective supervision, and self-care. However, it is important to acknowledge that self-care and stress management are not always easy to do, and some professionals use less healthy coping strategies.

> "I probably gained about 40 pounds since I took this job. Now, I'm losing it, so emotional eating, I think, is one way [I deal with stress]."
>
> - Home visitor

Research Question 3: To what extent do home visitors and supervisors access health care services?

This section describes the extent to which home visitors and supervisors access health care services, including primary care and mental health services, as well as the extent to which they experience barriers to access.

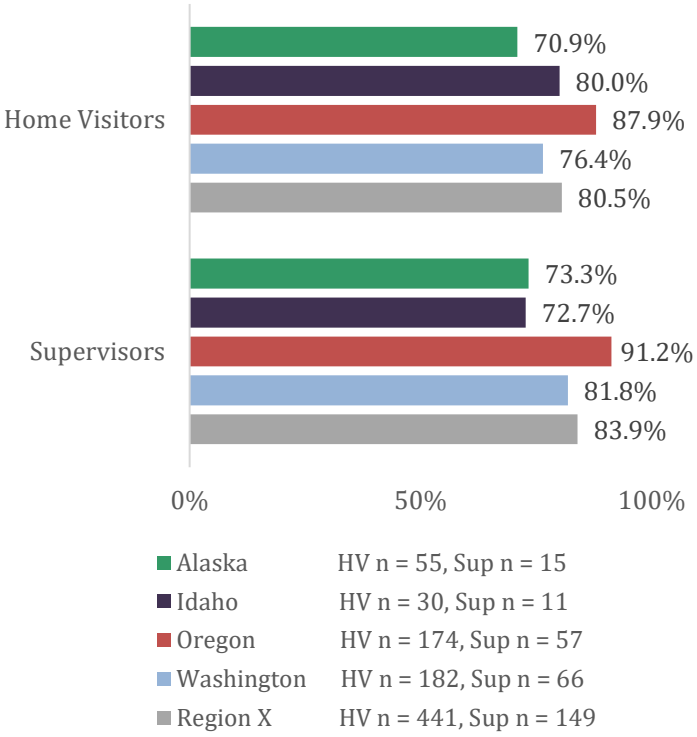
ACCESSING PRIMARY CARE

Most (81%) of the workforce reports having a primary doctor or health care provider. There were no statistically significant differences by job role; however, there were statistically significant differences by state. Figure 4.7 shows the percent of home visitors and supervisors, respectively, who report having at least one primary care doctor. Accessing primary care was more common in Oregon than in Alaska[41] and Washington.[42]

[41] χ^2 (1) = 12.44, $p < .001$
[42] χ^2 (1) = 10.15, $p = .001$

Across Region X, 65.7% of the workforce reports visiting a doctor within the past year for a routine checkup. There were no statistically significant differences by job role or state.

Figure 4.7. Percent of respondents who have a primary care doctor



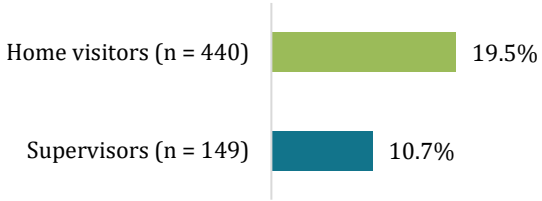
MENTAL HEALTH SERVICES

Similar to primary care, most (80%) of the workforce reported having easy access to a behavioral or mental health specialist. There were no statistically significant differences by job role and state.

BARRIERS TO ACCESS

Despite the majority of professionals reporting access to primary care and mental health services, 17% of the workforce said they needed to see a doctor in the last year but could not because of cost or distance. There were statistically significant differences by job role, but not by state. As shown in Figure 4.8, home visitors experienced health care barriers to a greater extent than supervisors.

Figure 4.8. Percent of respondents who experience barriers to health care access by job role



Access to Health Care

81% have at least one primary doctor / health care provider

80% have easy access to a behavioral or mental health specialist

17% needed to see a doctor in the last year but could not because of the cost or distance

n = 589–590

Research Question 4: To what extent has the workforce experienced Adverse Childhood Experiences?

ADVERSE CHILDHOOD EXPERIENCES

Survey respondents were given the option to report their ACE scores. Approximately three quarters of the workforce (75.7%) reported ACE scores (74.8% of home visitors and 78.3% of supervisors). Of those who responded, the majority (81.1%) experienced at least one Adverse Childhood Experience (ACE) prior to age 18, which could have included abuse, neglect, poverty, substance abuse, divorce or separation, domestic violence, mental illness, or parent incarceration. The distribution of ACE scores can be found in Table 4.1. There were no statistically significant differences by job role and state.

Table 4.1. **Distribution of ACE scores by job role**

# of ACES	Total Workforce	Home Visitors	Supervisors
0	18.9%	17.1%	23.8%
1	16.8%	16.3%	18.3%
2	16.0%	16.6%	14.3%
3	14.9%	14.3%	16.7%
4+	33.4%	35.7%	26.9%

As shown in Table 4.1, one-third of the workforce had four ACEs or more, which, based on data from the original ACE study, substantially increases risk of chronic health problems.[lxxx] Table 4.2 shows, by state, the average ACE scores, as well as the percent of respondents reporting ACE scores of four or more. Please note, select cells are suppressed due to sample size. Among the general population surveyed in the original study, approximately half (52%) of respondents experienced at least one ACE, and fewer than one in ten (6%) reported four or more ACEs.[lxxxi] More recent population estimates in Alaska,[lxxxii] Oregon,[lxxxiii] and Washington[lxxxiv] indicate 15–17% of residents have four or more ACEs.

Table 4.2. **Average ACE scores and ACE scores of 4+ by state and job role**

	Alaska			**Idaho**			**Oregon**			**Washington**		
	Home Visitor n = 43	Sup. n = 14	State n = 57	Home Visitor n = 28	Sup. n = 9	State n = 37	Home Visitor n = 132	Sup. n = 46	State n = 178	Home Visitor n = 147	Sup. n = 57	State n = 204
Average	3.1	2.8	3.0	2.5	1.6	2.3	3.2	2.8	3.1	3.0	2.4	2.9
% with 4+ ACEs	39.5%	--	35.1%	28.6%	--	27.0%	36.4%	30.4%	34.8%	35.4%	26.3%	32.8%

During interviews, the workforce reflected on how their childhood experiences influence their current work with families. Often, home visitors and supervisors reflected on how their own adverse childhood experiences allow them to have empathy and compassion for some of the challenging situations facing families, and how it motivates them to help families who are experiencing similar situations.

To summarize, the majority of the home visiting workforce in Region X experienced Adverse Childhood Experiences, and roughly 33% of the workforce experienced 4 or more ACEs. Based on interviews, these experiences motivated career decisions and a desire to help families, and inspired empathy and compassion among home visitation professionals.

"[Reflecting on abuse she experienced as a child]…*that was part of an awful piece of my childhood, but it was also a place from which a lot of compassion for people's stories came from.*"

- Home visitor

SECONDARY TRAUMATIC STRESS

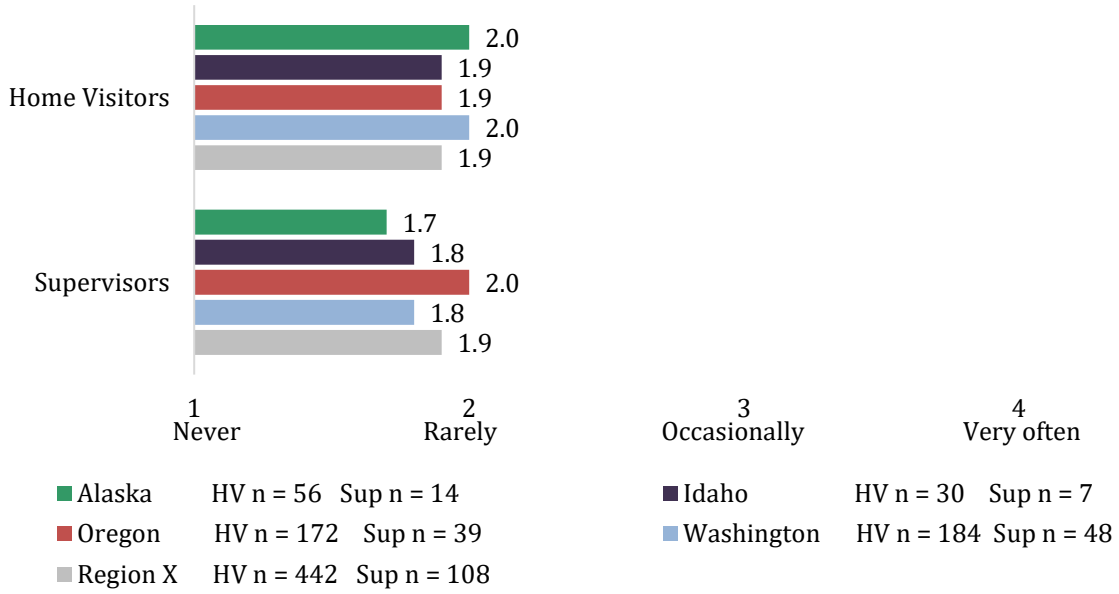
Given how common ACEs are among the home visiting workforce in Region X, it is important to understand secondary traumatic stress. Four items from the Secondary Traumatic Stress Scale (STSS)[lxxxv] were administered ($\alpha = .68$), specifically:

- It seems as if I am reliving the trauma(s) experienced by my families
- When I think about my work with some of my families or are reminded of them, it upsets me
- I avoid people, places, or things that remind me of my work with families
- I want to avoid working with some of my families

Overall, the mean for home visitors and supervisors was 1.92, which coincides with "rarely" experiencing secondary traumatic stress. For home visitors, scores ranged from 1.00 to 3.25, and supervisors' scores ranged from 1.00 to 4.00. Figure 4.9 shows the mean secondary traumatic stress scores by role and state. Note, there were no significant differences by role or state. In sum, the workforce does not report experiencing high levels of secondary traumatic stress.

> "I did have a brother that did partake in drugs, and so I saw what that can do to a family . . . how it took a toll on the community. . . . I kind of wanted to do something that gave back. . . . Everybody makes mistakes. . . . How do we fix it instead of punishing? And I think that's kind of where I wanted to come into home visiting, is I know that most of our families in our caseload are at-risk families, and so I knew there had to be someone that's out there that would understand and not be judging and just kind of give them that support that they need just to get over the hump and be successful in the long run."
>
> - Supervisor

Figure 4.9. Mean scores of secondary traumatic stress scale by role and state



Policy Considerations

This brief broadly explored Region X home visiting professionals' perceptions of their own health and well-being. Based on these findings, the following policy considerations are proposed.

Cultivate Supportive Workplaces

Restorative cultures that promote relationships, reflection, shared values, and self-care are particularly important for individuals who have experienced trauma.[lxxxvi] In the Region X sample, eight in ten workers reported experiencing at least one Adverse Childhood Experience, and one in three workers reported significant trauma (4 or more ACEs.) In order to avoid reactivating past trauma, the workforce needs opportunities to reflect, process emotions, cultivate mindfulness, and take care of themselves. During interviews, many home visitors and supervisors discussed using reflective supervision to process emotions and, ultimately, be more mindful in their interactions with families. In fact, past work has shown that home visitors who were more mindful had higher quality relationships with families.[lxxxvii] Additionally, self-care was identified as a stress management technique during interviews and must be supported in the workplace.[lxxxviii] Self-care at work can include taking periodic breaks, taking vacations, seeking out supportive colleagues, and reserving work tasks for designated hours. Workplace cultures that support self-care could encourage staff to engage in healthy activities and set and monitor self-care goals, and

supervisors can model positive practices (i.e., limit e-mails to working hours, take vacations themselves, etc.). It is apparent through past Region X work, such as *NEAR@Home: Addressing ACEs in Home Visiting by Asking, Listening, and Accepting*, that understanding ACEs is recognized as important, especially in supporting families.[lxxxix] We recommend this work continue with special attention to creating restorative cultures that support the home visiting workforce.

Support and Incentivize Health and Wellness

Consistent with the previous recommendation, health and wellness should be supported and incentivized. Region X should continue to provide opportunities for physical and mental health care and support, which was received by most of the workforce. It is important to note that approximately one in five workers experienced barriers to health care related to cost and/or distance. More information is needed to determine possible solutions, such as creating or contributing to health savings accounts (for financial barriers) or promoting tele-health options (for geographic barriers). Interestingly, the home visiting workforce in Oregon reported significantly higher rates of primary care access and also reported significantly lower rates of depression. Given that depression is highly treatable,[xc] it is possible that access to primary care increases the likelihood that a variety of health conditions, including depression, will be detected and treated. Furthermore, exercise appears to be an area in need of improvement among the Region X workforce. Only one in four workers engage in regular exercise, and over half are not pleased with their body weight. To the extent possible, efforts should be made to incentivize exercise (e.g., set self-care goals related to exercise, provide gym memberships, hold walking meetings, host fitness classes, share information, etc.).

Foster Financial Well-Being

Finally, much of the workforce indicated at least some degree of difficulty maintaining their economic well-being. To increase financial stability, efforts should be made to increase wages, especially among home visitors, who experience the most economic instability. In fact, wages were identified as the second most common reason for turnover (see *Brief 3*), suggesting that increasing wages may promote retention. In addition, it may also be beneficial to share information and resources related to financial well-being on topics such as strategies for saving money, paying off or avoiding debt, retirement planning, and the like. Integrating financial counseling into human service professions, like home visiting, may not only benefit the workforce, but also the families they serve.[xci]

In conclusion, the home visiting workforce must be supported in order to be supportive of families. This report indicates that there are many great things already happening in Region X to support the workforce, including reflective supervision and access to health care services; nevertheless, there is still much to be done to ensure all workers are thriving across domains of health and well-being.

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Growing Together to Support Our Home Visiting Workforce

Region X Home Visiting Workforce Study

RESEARCH BRIEF #5

Predicting Job Role, Pay, Intent to Stay, and Health Status

This research brief is the fifth and final in a series that is part of the *Region X Home Visiting Workforce Study* funded by the *Region X Innovation Grant* at the Washington Department of Children, Youth, and Families, in partnership with the Alaska Division of Public Health, the Idaho Department of Health and Welfare, and the Oregon Health Authority. The study was designed to identify the current strengths, gaps, and unmet needs in the home visiting workforce in Region X to inform workforce recruitment, retention, and professional development efforts. For more information about the study, please see *The Region X Home Visiting Workforce Study: Introduction.*[ii]

Key Findings

Regression analyses were conducted to determine what characteristics significantly predict job role, pay, intent to stay, depression, and overall health, respectively.

- ***Job Role.*** Having a master's degree, having more early childhood experience, and having less direct home visiting experience were associated with being a home visiting supervisor.

- ***Pay.*** Having more education, having a degree in a clinical field, having more experience, being a supervisor, and being white were associated with higher pay.

- ***Intent to Stay.*** Working in more supportive workplaces and being a person of color were associated with intent to stay in their current jobs.

- ***Depression.*** Having fewer ACEs, greater access to behavioral health services, more supportive reflective supervision, and more employer-sponsored benefits were associated with the absence of depression.

- ***Overall Health Rating.*** Having fewer ACEs, working in more supportive workplaces, having more employer-sponsored benefits, and working fewer hours were associated with better overall health.

Introduction

This brief seeks to identify personal and contextual predictors of home visiting professionals' job roles, pay, intent to stay in their current job, and health status. Identifying the characteristics that relate to job role, for instance, provides insight into who tends to hold supervisory positions (e.g., those with more education or experience). We also explore the extent to which race relates to supervisory status, which may suggest systemic racial inequities in promotional opportunities.

Similarly, we look at the extent to which race, among other characteristics, relates to pay. Wage gaps exist among U.S. workers, especially among women and individuals of color. Specifically, median hourly earnings among white men were $21 in 2015, whereas white women earned $17 and black and Hispanic women earned $13 and $12, respectively.[xcii] Exploring the extent to which racial wage gaps exist among the Region X home visiting workforce is an important area of investigation.

Furthermore, understanding the characteristics that relate to intent to stay and health status may suggest ways to promote retention and health. For both outcomes, we take a broad, exploratory approach by considering a variety of characteristics, including opportunities for reflective supervision, the psychological climate of the workplace, Adverse Childhood Experiences (ACEs), hours worked per week, and so on. These results are expected to have implications for both practice and policy.

Research Questions

Based on a sample of home visitors and home visiting supervisors in Region X, this research brief seeks to answer the following questions:

1. What predicts job role?
2. What predicts pay?
3. What predicts intent to stay in one's current job?
4. What predicts health status?

Sample

The sample used for this research brief included 468 home visitors who provide home visiting services directly to families, and 161 home visiting supervisors, 29% of whom have a caseload of families they serve. These home visitors and supervisors were drawn from 148 programs in Alaska, Idaho, Oregon, and Washington, collectively known as Region X. Within the sample, 202 (43.2%) home visitors and 76 (47.2%) home visiting supervisors work in home visiting programs that receive MIECHV funding. Thirty-eight percent of programs in the sample reported receiving MIECHV funding. This brief also includes data from a sub-group of 12 home visitors and 7 supervisors who participated in follow-up interviews. For more information about the sample and the measures used for this study, please see *The Region X Home Visiting Workforce Study: Introduction*.[xciii]

Analytic Approach

The research team conducted a series of regression analyses to examine factors that predict job role classification, pay, intent to stay, and health status. All models accounted for the clustering of home visitors and supervisors within programs. For dichotomous outcomes, such as job role (home visitor vs. supervisor) and intent to stay (yes vs. no), we used logistic regression models.[43] We entered categorical predictors with more than two groups (e.g., education) into the models using reference groups, which allow direct comparison between the reference variable and each other category. Please note that we did not include state in the model because the large differences between samples sizes across the states are likely to

[43] For these models, odds ratios (ORs) and probabilities are presented, which refer to the likelihood of membership in particular category based on a one-unit increase in the predictor variable.

yield unreliable results. We used models that account for missing data in instances with more than 10% missing data. The team used a p-value of .05 or less to determine whether predictors were significant.

When interpreting these results, please keep in mind:

The results of the regression analyses show the relationships between each predictor and outcome while controlling for the effects of all other variables in the model.

Results do not establish cause-and-effect relationships between variables.

Results

Research Question 1: What predicts job role?

Researchers explored whether the following factors predict job role[44] (home visitor or supervisor):

- Educational attainment[45]
- Area of study[46]
- Years of experience
  - In the early childhood field
  - As a home visitor
- Race

Predictors of being a supervisor:

- Having a master's degree
- More experience in ECE
- *Less* experience in home visiting

Results show that level of education, experience in the early childhood education (ECE) field,[47] and experience as a home visitor were statistically significant predictors of job role. Those with a master's degree were nearly five times more likely to be a supervisor than

[44] Classified as home visitor = 0; supervisor (or both) = 1

[45] Classified as less than a bachelor's degree, bachelor's degree, or master's degree

[46] Majors were classified into four categories: education and development, social services, clinical, or unrelated; see *Brief 1* for more information

[47] Defined as years worked, for pay, with pregnant women, children birth to five, and/or their families

those with less than a bachelor's degree, and nearly three times more likely to be a supervisor than those with a bachelor's degree (or some graduate school).

The likelihood of being a supervisor increased slightly as ECE experience increased; for every year worked in ECE, the odds of being a supervisor increased by 8%. In contrast, after controlling for all other variables, each year of home visiting experience yielded a slight (4%) decrease in the odds of being a supervisor. It is possible that direct home visiting experience is less of a consideration when deciding who is hired or promoted into supervisor positions. However, having advanced education and broader early childhood experience may be more important considerations, especially since many home visiting programs have recently experienced rapid growth (i.e., creating new positions and needing to fill vacancies from a broader applicant pool). Notably, race and degree focus did not predict likelihood of being a supervisor after accounting for education and work experience.

Those with a master's degrees were nearly 3 times more likely to be a supervisor than those with a bachelor's degree

Home visiting professionals with:

- A master's degree
- More early childhood education experience
- Less direct home visiting experience

Are **more likely** to be a supervisor

This analytic model accounts for educational attainment, area of study, years of experience in early childhood education and as a home visitor, and race

Research Question 2: What predicts pay?

The research team analyzed the following variables as potential predictors of home visiting professionals' self-reported hourly pay:

- Educational attainment
- Area of study
- Years of experience
- Job role
- Race

All predictors were statistically significant. Specifically, having more education, a degree in a clinical content area (e.g., nursing, speech pathology, early intervention, etc.), more years of direct home visiting experience, more years in the ECE field, being a supervisor, and being white predicted higher pay. Conversely, being a home visitor, having less experience and education, having a degree related to social services or education (as compared to unrelated fields), and identifying as a person of color predicted lower pay.

PREDICTORS OF HIGHER PAY:

- Higher educational attainment
- A degree in a clinical content area
- More years of ECE experience
- More years of home visiting experience
- Being a supervisor
- Being white

Pay:

Significant predictors of hourly pay

This analytic model accounts for: educational attainment, area of study, years of experience, job role, and race.

More specifically, supervisors make $4.77 more per hour than home visitors. Those with master's degrees make $1.90 more per hour than those with less education. For each year of ECE experience, home visiting professionals make $0.07 more per hour, and for each year of home visiting experience, professionals make $0.14 more per hour.

Importantly, the association between race and pay was found after controlling for educational attainment, area of study, years of experience, and job role. In other words, all else being equal, individuals of color make $1.35 less per hour than white individuals, a difference of nearly $3,000 per year. Overall, this suggests racial pay disparities among this sample.

Research Question 3: What predicts intent to stay?

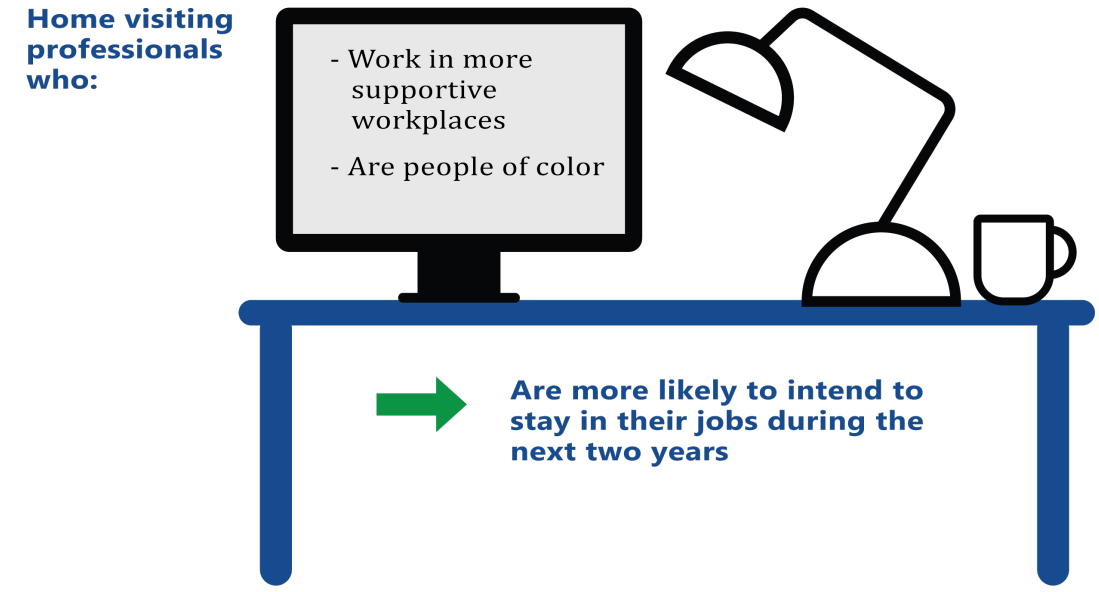
We considered the following variables as predictors of whether or not home visiting professionals reported intending to stay in their jobs during the next two years:

- Adverse Childhood Experiences (ACEs)
- Reflective supervision
- Psychological climate of the workplace
- Pay
- Hours worked per week
- Hours spent doing paperwork per week
- Job role
- Caseload
- Age
- Race

For each one point increase in participants' ratings of their program's psychological climate, they were 2 times more likely to report intention to stay in their job.

Of all the variables included in the model, two variables significantly predict intent to stay: the psychological climate of the workplace and the race of the staff member. Psychological climate refers to employees' perceptions of their work environments,[xciv] including their sense of autonomy, importance, fairness, support, role clarity, interpersonal conflict, and opportunities for taking on challenges and innovations. The psychological climate scale included 12 items, rated on a scale of strongly disagree = 1 to strongly agree = 5. Those who rated the psychological climates of their workplaces more favorably were more likely to report intention to stay in their jobs.

Intent to Stay:



This analytic model accounts for adverse childhood experiences (ACEs), reflective supervision, psychological climate, pay, hours work per week, hours spent doing paperwork, caseload, age, job role, and race

Also, home visitors and supervisors who identified as a person of color were 86% more likely to report intention to stay in their jobs, which could suggest greater job satisfaction—or less job mobility. Although low pay and paperwork were among the most common reasons home visitors and supervisors intended to leave their jobs (*Brief 3*), these variables did not predict job intentions in this sample.

Research Question 4: What predicts health status?

To examine potential predictors of depression[48] and respondents' ratings of their overall health,[49] the team analyzed the following variables:

- Adverse Childhood Experiences (ACEs)
- Access to behavioral health services
- Reflective Supervision
- Psychological climate of the workplace

[48] Based on the Patient Health Questionnaire-2

[49] Rated on a scale of *Poor* = 1 to *Excellent* = 5

- Pay
- Hours per week
- Number of employer-provided benefits
- Age
- Years of ECE experience
- Years of Home Visiting Experience
- Race

Individuals lacking access to behavioral health support are 3 times more likely to report symptoms consistent with depression.

Depression

ACEs, access to behavioral health services, reflective supervision, and employer-sponsored benefits all predicted home visitors' and supervisors' depression.

Specifically, home visiting professionals who had fewer ACEs, greater access to behavioral health support, more supportive reflective supervision, and more employer-sponsored benefits were *less* likely to be depressed. In fact, individuals who report *not* having access to behavioral health support are over three times more likely to report symptoms consistent

Depression:

Home visiting professionals who:

- Have more ACEs
- Lack access to behavioral health services
- Have less supportive reflective supervision
- Have fewer employer-sponsored benefits

Are more likely to report symptoms of depression

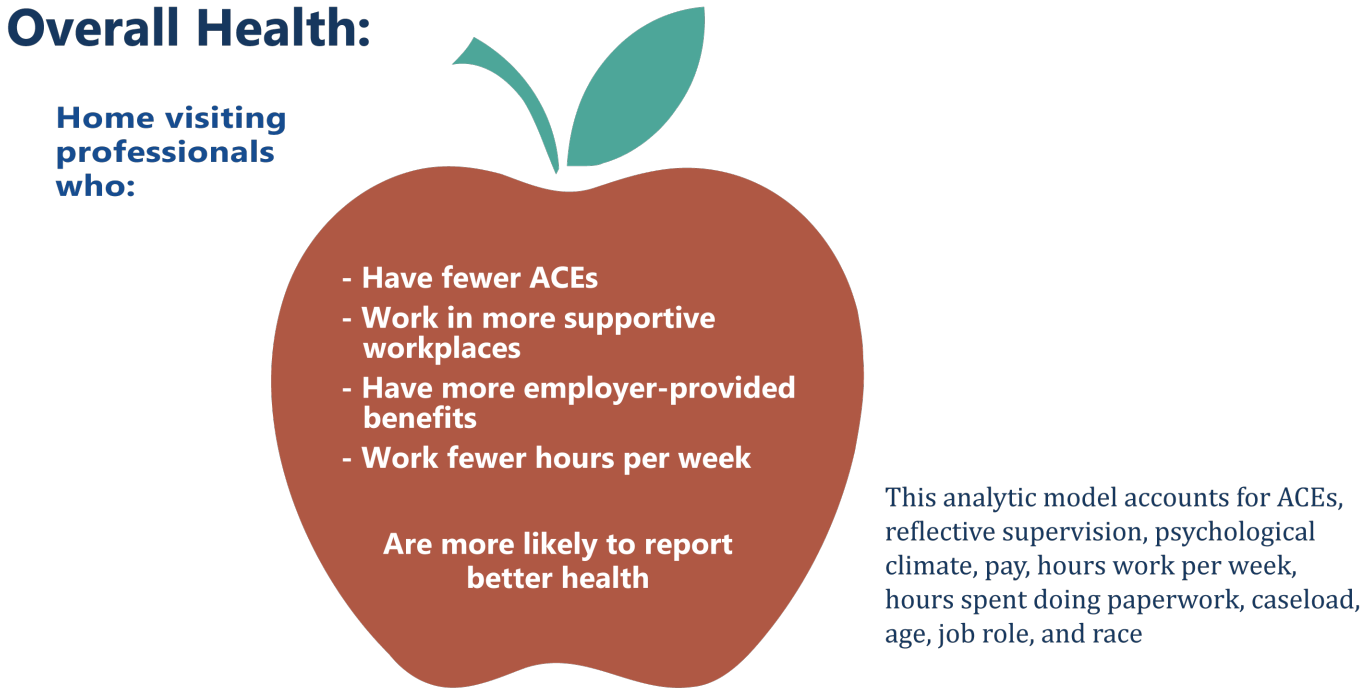
This analytic model accounts for ACEs, reflective supervision, psychological climate, pay, hours work per week, hours spent doing paperwork, caseload, age, job role, and race

with depression. For every one-point increase in the supportiveness of reflective supervision, respondents were 34% less likely to be depressed. For each additional ACE, respondents were 17% more likely to report symptoms of depression. Variables that did not predict depression include psychological climate, pay, hours worked, job role, age, experience, and race.

Overall Health

A survey item asked home visiting professionals to "please rate your overall health" on a scale of *poor* = 1 to *excellent* = 5. Significant predictors of overall health included ACEs, the psychological climate of the workplace, hours worked per week, and benefits. Similar to depression, fewer ACEs were related to better health. Working in more psychologically supportive climates, having more employer-provided benefits, and working fewer hours per week were also associated with better health.

Access to behavioral health support, reflective supervision, pay, job role, age, experience, and race did not relate to overall health in this sample.



For all analytic models, significant predictors are not listed in any particular order.

Policy Considerations

This research brief points to several important policy considerations to support the home visiting workforce in Region X.

Create pathways for home visitors to advance their education

Having a master's degree appears to be an especially important criterion for being a supervisor. In this sample, individuals with master's degrees were nearly 3 times more likely to be supervisors than those with only bachelor's degrees. As such, it is important to ensure higher education is accessible to home visitors who are interested in gaining valuable learning opportunities and advancing to supervisory roles. The transition from home visitor to supervisor is an important promotion opportunity. *Brief 3* of this series reported that the second most common reason staff intend to leave their home visiting jobs is the lack of promotional opportunities. Therefore, increasing access to higher education (via scholarships, advising, or tuition reimbursement) may increase the number of staff who are qualified for supervisor roles and possibly increase staff retention. Notably, as reported in *Brief 2*, one in five home visiting staff receive tuition reimbursement, suggesting this is an area with opportunities for replication and expansion.

Ensure home visitors and supervisors are paid equitably for their expertise

After accounting for relevant characteristics such as education, experience, and job role, race significantly predicted pay, suggesting that racial pay disparities exist in this sample. Internal pay audits must be conducted to determine if, in fact, individuals of color are paid less than their white counterparts in this workforce. If pay disparities are identified, as these preliminary analyses suggest, steps must be taken to assure equitable pay. As previously noted, racial and gender pay disparities have been documented among U.S. workers.[xcv] Creating formal compensation structures, promoting greater pay transparency, incentivizing managers to fix pay disparities, and conducting implicit bias training are a few possible solutions. Overall, remedying pay disparities requires concerted efforts across sectors and institutions.

Ensure workplaces are psychologically supportive and include reflective supervision

More psychologically supportive workplaces, characterized by greater autonomy, role clarity, and fairness, predicted intentions to stay as well as overall health. These findings are consistent with social determination theory, which states that individuals are motivated by conditions that promote autonomy, competence, and relatedness.[xcvi] Workplaces must allow home visitors and supervisors to contribute to their jobs with some level of independence and to feel connected, supported, and, ultimately, competent and effective in their work. Reflective supervision appears to be a particularly important component of the supportive workplace, based on results showing that more supportive reflective supervision predicted a decreased likelihood of having a positive screen for depression. Those who felt they had more supportive supervision, characterized by consistency, trust, active listening, and reflecting on emotions, were less depressed than those who received less supportive supervision. Although we cannot determine if less supportive reflective supervision *causes*

depression, this association suggests reflective supervision may be one way to support workplace well-being. We recommend Region X continue to build on their past work focused on reflective supervision, including recently published guidelines for administrators, supervisors, and home visitors.[xcvii]

Provide benefits and promote access to mental health services

The number of employer-sponsored benefits provided to home visitors and supervisors predicted both depression and overall health, such that more benefits predicted less depression and better health. As noted in *Brief 2*, home visitors and supervisors received an average of 9 employer-sponsored benefits. Although most of the workforce received health insurance, paid vacation, dental insurance, and paid sick leave, there were still approximately one in ten workers who reported not receiving these important benefits. Less commonly received benefits included retirement savings, paid family leave, and tuition reimbursement, which may also be important for promoting health and well-being (see *Brief 3*). Similarly, those who reported greater access to mental health services reported less depression. As discussed in *Brief 4*, although most of the workforce reported access, two in ten workers did not have access to behavioral or mental health specialists. Efforts should be made to remove barriers to mental health support, especially given the high incidence of ACEs among this workforce (33% experienced four or more ACEs) and the potentially stressful nature of the work.

Promote work-life balance and self-care

Number of hours worked was a significant predictor of home visitors' and supervisors' ratings of their overall health, such that more hours worked related to poorer health. Given that 32% of home visitors and 53% of supervisors report working longer hours than their paid hours suggest (*Brief 2*), efforts to create more realistic workloads that are conducive to work-life balance and self-care must be undertaken. Follow-up interviews and focus groups could be used to understand how workloads can be shifted or reorganized to better meet the needs of home visitors and supervisors. Promoting the practice of self-care, both inside and outside of the workplace, may help support a healthier workforce.

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