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The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Workforce
Rapid Response Brief

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KEY FINDINGS

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) workforce represents only a portion of the home visiting workforce and most of the literature describes the home visiting workforce broadly.
We found that:

- The MIECHV home visiting workforce is relatively homogonous. Most home visitors are white and have a bachelor's degree; a small proportion speak Spanish fluently and another 5% speak a language other than English.
- The home visiting workforce, which includes those in MIECHV programs, is expected to possess a wide range of competencies to serve pregnant people, parents, and young children with variety of needs as well as risks. Increased opportunities for professional development are needed, particularly related to early childhood mental health, serving children and parents with disabilities, postpartum depression and perinatal mental health, and trauma-informed approaches.
- Retention is high; staff seem very committed to their work, but also have dissatisfaction due to lack of flexibility, low-quality supervision, lack of support to manage stresses experienced on the job, and lack of opportunities for advancement.

Impact of the COVID-19 pandemic:

- Home visitors quickly pivoted to providing services virtually. While not without challenges, there were also advantages to this approach to service delivery, including more flexibility in access for some families and increased schedule flexibility for staff. Further exploration is needed as to whether this could be permanently incorporated into home visiting services and how this may affect both workforce and home visiting outcomes.

Data availability:

- Two ongoing projects led by the Administration for Children and Families in collaboration with the Health Resources and Services Administration have resulted in multiple recent reports describing the MIECHV workforce including demographics as well as information on those who are entering and exiting the field. The reports are based on data collection that occurred in 2016.
- No other comprehensive dataset focused on the home visiting workforce exists.

Research gaps and opportunities:

- Ongoing research is needed to identify MIECHV workforce characteristics and information on retention and turnover; effective approaches to diversifying this workforce; skills as well as effective approaches for skill development; and needed competencies to develop a core set of competencies which can be shared across home visitors, regardless of the home visiting model they deliver.
- Other research gaps include developing high-quality supervisors, and to identify what additional components are needed to provide adequate support to this workforce to promote worker well-being (such as reflective supervision and trainings on dealing with stressful situations).

INTRODUCTION

Home visiting—a service delivery model provided to families in their home or location of choice—is considered a cost-effective approach for providing needed services and supports and has been shown to have positive short- and long-term infant, child, and family outcomes.[1] The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program supports evidence-based home visiting with the goal of improving outcomes for at-risk pregnant people, infants, children, and families.[2] Home visiting models funded and delivered through this program are associated with multiple positive health outcomes including improvements in birth spacing, breastfeeding, parent-child attachment, positive parenting practices, child development, and school readiness as well as reductions in perinatal depression, child maltreatment, and family violence.[3] While multiple home visiting models exist, there are currently 20 specific models which can be funded through the MIECHV program.[4] During the COVID-19 pandemic, these models received increased attention due to the ability to quickly adapt these services to a virtual format and minimize disruption; in addition, the trusted relationships home visitors have with families results in their having an important role in addressing the impacts COVID-19 had on pregnant people and families and resulted in increased enrollment.[5,6]

The focus of this rapid response brief is research published since March 2020 focused on the MIECHV and the broader home visiting workforce, the effect of the COVID-19 pandemic on this workforce, and available data. We begin with a brief overview of the MIECHV program to provide context for the recent research. We also highlight the complexities in summarizing or doing research on the workforce delivering programs supported by this funding, and discuss the opportunities, challenges, and future research needs related to this workforce.

WHAT IS THE MIECHV PROGRAM?

The MIECHV program provides support to pregnant individuals and families with young children who live in vulnerable and underserved communities and face barriers to achieving positive perinatal and child health outcomes.[4] Established in 2010 as part of the Affordable Care Act and operated through the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF), this program provides funding to states, territories, and tribal entities to develop and deliver home visiting services through approved evidence-based models.[7] This program was re-authorized in 2018 under the Bipartisan Budget Act of 2018 (H.R. 1892). In September 2021, $342 million was distributed to 56 states, territories, and non-profit organizations; an additional $121 million was distributed to awardees through the American Rescue Plan Act to support families affected by the COVID-19 pandemic.[4]

There are currently 20 home visiting programs that meet the benchmark for evidence, based on the Home Visiting Evidence of Effectiveness review, overseen by the ACF.[3] States, territories, and tribal entities can choose which models they want to implement. A majority of funded entities implement at least one of the following models: Nurse Family Partnership (NFP), Parents as Teachers (PAT), Early Head Start-Home Based, and Healthy Families America (HFA).[8] They are required to use 75% of their funds toward delivery of these models and are authorized to use up to 25% of their funds toward “innovative or promising” programs that lack sufficient evidence to be considered “evidence-based”, but whose preliminary evaluations show potential).[9] As part of continued funding requirements, states are monitored and evaluated by ACF and HRSA for improved outcomes in 19 areas across six categories: maternal and newborn health, child injuries, maltreatment, and reduction of emergency room visits, school readiness and achievement, crime or domestic violence, family economic self-sufficiency, and coordination and referrals.[9] Awardees are required to achieve improvements in at least 4 of the 6 categories; if these improvements are not made, technical assistance will be provided to support the awardee in developing an outcome improvement plan.[10]

COMPLEXITIES OF STUDYING THIS WORKFORCE AND DEFINING THE SCOPE OF THIS BRIEF

There are a couple key complexities to summarizing research and available data to describe the MIECHV workforce. First, MIECHV programs are not uniform. While each eligible model has certain commonalities—all are voluntary, delivered in the home or location of choice, involve a series of home visits, and are focused on families—each model uses a different approach and has different program requirements, including qualifications of those delivering the program, the intensity and frequency of visits, and the overall purpose of the program. Also, the composition of the workforce delivering MIECHV-supported services varies by state depending on which model each state chooses. The amount of training needed and required depends on the funded program, which limits the extent to which training can be standardized. For example, training for the Nurse Family Partnership program requires 20 hours of self-study modules, followed by a 4-day in-person training in Denver, 10 hours of additional professional development as well as 20-30 hours of distance learning focused on goal setting, mental health, and intimate partner violence.[11] Conversely, while the Early Head Start-Home Based Option program has education and competency requirements, there isn't a standardized approach for training.[12]

Second, the home visiting workforce encompasses a much larger workforce supply than the subset delivering MIECHV-funded programs. There are non-MIECHV home visiting models that may be delivered by the state or at the local level, often financed through Medicaid. For example, many states have a perinatal case management program, which may or may not involve home visiting, with visits that tend to be episodic based on the needs of the family (such as a medical need or postpartum support), rather than as part of a prescribed model.[13] States can choose to reimburse for home visits conducted through the local health department or other local providers; these visits can be provided by an array of professionals, including registered nurses, community health workers, parent educators, and lactation consultants.[13] Most studies discuss the home visiting workforce in general, without specifying MIECHV, or are focused on one MIECHV model. As such, the following provides an overview of what little is currently known about the MIECHV workforce, based on MIECHV-specific surveys and reports which were published from March 2020-August 2022. To provide as much information as possible, studies which are not specific to MIECHV, but which provide information on the workforce in programs which are eligible for MIECHV funding, are also included.

EXISTING PROJECTS EXAMINING THE MIECHV WORKFORCE

There are two ongoing projects, both led by ACF in collaboration with HRSA, that have contributed the most to the recent literature describing the MIECHV workforce and from which we summarize key findings below.

1. The Home Visiting Careers Trajectory project. Funded by ACF and HRSA and led by the Urban Institute, this project, specific to home visitors in MIECHV-funded programs, was launched in 2016 to address the gap in research regarding the perinatal and early childhood home visiting workforce. Data collection took place in 2018 in the form of a survey as well as through focus groups, with an aim toward understanding how people enter the field as well as their backgrounds, pathways for professional growth, tenure, and reasons for exiting the field.[14] The survey was sent to all 667 program managers in 633 funded agencies. 1,670 total staff were estimated to work as home visitors in these agencies in 2018. 369 program managers responded along with 926 staff. Multiple reports based on data as well as data itself from this project can be found here: https://www.acf.hhs.gov/opre/project/home-visiting-career-trajectories-2016-2021. It should be noted that a majority of the reports based on this survey were published in 2020, outside of the specified time frame for this brief; however, survey results provide the first known summary of the workforce to-date and are thus referenced throughout this brief. In addition, several reports were released in 2021 and 2022.
2. Supporting and Strengthening the Home Visiting Workforce (SAS-HV). This project focused on reviewing current research around and developing conceptual models focused on (1) perinatal and well child home visitor well-being and (2) reflective supervision.[15] There are currently two reports connected to this

project, each providing an overview of the literature regarding these two areas, which can be found here: https://www.acf.hhs.gov/opre/project/supporting-and-strengthening-home-visiting-workforce-sas-hv

WHO IS THE MIECHV WORKFORCE?

Demographics

The models funded through the MIECHV program are primarily delivered through home visits from a registered nurse, social worker, or an individual with a background in education (early childhood and/or special education).[16] Most with an educational background are either a Certified Parenting Educator or Certified Lactation Educator or have a state teaching certification in early childhood. The Home Visiting Careers Trajectories study found that a majority of the MIECHV home-visiting workforce were women, with 66% identifying as non-Hispanic white, 13% Black or African American, 16% Hispanic and 2% Asian. Seventeen percent were fluent in Spanish and 5% were fluent in a language other than English. A majority report being a nurse, social worker, or having a background in education. Where degree information was available, 73% reported having at least a bachelor's degree. Most (69%) had at least three years of related work experience prior to being a home visitor. Outside of this report, no other research has been done to explore demographics within this workforce.

Recruitment and training

Most home visitors report finding their job through online searches; other avenues include word of mouth, job shadowing, and professional networks. Home visitors within MIECHV-funded programs reported that job descriptions lacked accuracy and failed to fully encompass all responsibilities; in addition, supervisors in the program report having little control over the initial screening process, which can affect the qualifications of the candidate pool.[14] Perinatal and early childhood home visiting programs serve families with multiple risks and a wide range of needs, requiring knowledge on a large breadth of topics, including perinatal health (prenatal care, nutrition, labor and delivery, postpartum health, breastfeeding), mental health, child development, an ability to screen for issues such as intimate partner violence, depression, and developmental delays, safety in the home as well as the ability to assess and refer for appropriate resources. Home visitors often are also asked to assess parent-child interactions and provide coaching to parents. Some home visiting programs, including some MIECHV-funded programs, can also involve working with clients toward individual goals of furthering their education or achieving financial stability.[1] Overall, training tends to be on-the-job and involves agency onboarding procedures, required model-led training, and in-services offered by the MIECHV lead agency. However, a study by Hunter et al. done in 2020 focused on the “Mind the Baby” model noted that training can be fragmented and that core competencies across all models are needed.[17] Perinatal and early childhood home visitors, including those in MIECHV-funded programs, state there are gaps in current training and that they need more focus on early childhood mental health, serving children and parents with disabilities, postpartum depression and perinatal mental health, and trauma-informed approaches.[14,18] Cross-sector collaboration is an important part of success in these programs and home visitors require skill in this area, as detailed in research focused on the Nurse-Family Partnership program.[19,20]

Recent research regarding professional development for home visitors identified a need to incorporate reflective support to home visitors in their practice. Home visitors are often faced with the tension between needing to maintain model fidelity and adapting their practice to meet the diverse needs of families. This research, focused on home visitors in the Early Head Start Home-Based Option program, found that incorporating reflective practice, such as offering home visitors the opportunity to review videos of themselves in practice, can improve home visitors’ effectiveness overall as it both strengthens their own awareness of how they interact with families and offers tangible evidence of areas in need of improvement.[21]

Retention
The Home Visiting Career Trajectories report stated that only 5% of home visitors in MIECHV programs reported that they were likely to pursue a job outside of home visiting within the next two years. A majority stated they planned to stay.[14] Reasons for staying include flexibility, a supportive work environment, and work-life balance. Another report from this survey found that staff working in programs where they were given peer mentors, their performance reviews were used for salary and promotion decisions, and they had support in setting and achieving professional goals were more likely to report planning to stay in the job.[8,22] A study by Campbell et al. in 2020 focused on the Nurse-Family Partnership workforce in Canada also noted that nurses were more likely to stay in this role when given the opportunity to practice at the full scope of their license and when they experienced strong team connections.[23]

CHALLENGES EXPERIENCED BY THE MIECHV WORKFORCE

Lacking sufficient pay
The Home Visiting Career Trajectories reported noted that home visitors in MIECHV-funded programs tend to be mission-driven and motivated to do the work to help families but are overall dissatisfied with pay and opportunities for promotion.[14] While this alone does not seem to affect retention, retention may be affected by the level of stress that can be experienced on the job as well as the additional pressures due to the COVID-19 pandemic in combination with existing dissatisfaction with pay.

A need for professionalization
As found in the Home Visiting Career Trajectories survey and echoed in a study specific to Early Head Start home visitors, models vary in their training requirements and approach to service, creating a fragmented system for staff development and workforce support.[24] The National Home Visiting Resource Center issued a report in 2019 regarding core competency development work in Oregon and Pennsylvania as well as a larger project, the Institute for the Advancement of Family Support Professionals National Family Support Competency Framework, involving 21 states.[25] This report as well as the 2016 Career Trajectories survey highlighted the importance of core competency development work as part of further professionalizing the field; however, this work is still in process as each group of competencies is slightly different. As of now, there is still no set of shared competencies across the home visiting field.

Stress and anxiety on the job
Due to the stressors and complex needs of families they work with, home visitors report experiencing significant stress, anxiety, and secondary trauma.[26] This can lead to depression and burnout, affecting home visitors' relationship with families as well as retention.

Organizational climate and culture
Home visitors within MIECHV programs as well as in the wider home visiting community reported before the pandemic dissatisfaction due to rigid work environments (such as lack of flexibility around telecommuting), low-quality supervision, and lack of growth opportunities.[27]

IMPACT OF COVID-19

During the pandemic, all home visiting staff, including those in MIECHV-funded programs were required to move many of their services to being virtual, both telephone and video. Marshall et al. (2020) found that MIECHV home visitor staff overall felt supported in this transition and that the positive response of families helped them overcome some skepticism.[28] They also stated that having regular team check-ins was important as well as collaborating with other agencies. However, MIECHV staff also reported missing the in-person contact with families, complexities due to difficulties families had in accessing needed technology, and concern regarding program benchmarks and performance. Traube et al. (2022) reported that MIECHV staff who were home visitors

in Los Angeles County were able to transition quickly and that their transition was helped by strategies such as reflective supervision, training, and access to technology.[29] However, this study also reported that families had a more difficult time with this process and that screenings rates for depression and anxiety as well as referrals for support services decreased with virtual services, highlighting potential challenges.

While not specific to the MIECHV workforce, a Rapid Response Virtual Home Visiting collaborative (RR VHV) was developed in March of 2020 to ensure adequate support and training was available during home visitors' transition to virtual services. Multiple webinars, print materials and other resources from this collaborative were made available to all home visitors, including those in MIECHV-funded programs. This collaborative was led by representatives from the Institute for the Advancement of Family Health Professionals, Parents as Teachers National Center, and the National Alliance for Home Visiting Models.[30] The collaborative also conducted a survey to learn more about the transition to virtual home visiting. Findings align with other studies in that overall, home visitors reported high satisfaction with virtual home visiting, but experienced some challenges in engaging families during the visit, recruitment and parent-child interaction, including families forgetting appointments, limited internet access, families balancing multiple children, and difficulty supporting more positive parent-child interaction virtually; however, home visitors also reported learning skills to address these challenges.[30] Findings also show that longer tenure as a home visitor was associated with higher confidence in delivering services virtually.

RESEARCH GAPS AND OPPORTUNITIES

1. Repeat national survey to collect up-to-date information on this workforce. The most recent comprehensive data collection on the MIECHV workforce was done in 2018, and it is unclear whether there are plans to continue collecting these data in the future. Moving forward, a regular survey which collects demographic information as well as information on retention, turnover risk, job satisfaction, and staff psychological well-being is needed to better assess both staff characteristics and organizational factors which are important for recruitment, retention, and staff competencies. This should include reports on the findings and how these findings were applied to ensure that development of and support for this workforce is matched to current need. Other areas of focus could be staff perceptions of their roles and responsibilities, knowledge of content areas, as well as perceived skill in key areas of working with families to better assess workforce assets and needs.[27]
2. Research the core competencies needed for home visitors. Further research could help to develop core competencies across the home visiting workforce as well as effective training approaches. For example, while various home visiting models discuss the importance of the home visitor being able to establish a trusted relationship with the family, clear discussion about how to support development of this skill is lacking. Research is needed to clarify and quantify these various training approaches and to identify commonalities, opportunities for sharing effective procedures, and potential gaps in certain models.
3. Explore strategies for leadership development to support effective supervision. Lack of quality supervision is one area that can contribute to home visitor dissatisfaction, burnout, and turnover. Reflective supervision has been found to be an important tool in helping home visitors develop certain competencies and manage the complex experiences that are a part of their work. A clear understanding of the key elements, best practices, and effective training strategies for reflective supervision is needed.[31] Further, as reported by West and Dibble (2022), specialty skills, such as working with pregnant and parenting people with intellectual disabilities, require supervisors who can provide support and training in these areas.[18]
4. Increase opportunities for professional development. To address the need for professional development, researchers have suggested a certification process, in-service training, and population-specific training depending on program and geographic location.[32] However, there are concerns that certification could create barriers for entry and further homogenize this workforce, so such solutions must be approached with caution. Use of coaching strategies (such as partnership, ongoing action plans, role play, skill practice, and

performance feedback) have been researched in classroom settings, but less with home visiting. A literature review of the use of coaching as a strategy for home visitor professional development found that a majority of the research on this has been done in classroom settings; while shown to be effective, many studies lack a family-centered approach, focusing more on working with the child rather than supporting the parent-child relationship.[33] Thus, along with increasing professional development opportunities, research is needed to examine the best pathway forward, including use of coaching as an evidence-based approach and whether strategies such as reflective supervision are associated with improved home visit quality.[34]

5. Implement strategies to address home visitor well-being. Strategies such as reflective supervision, trainings to promote mental well-being practices such as mindfulness, coaching on how to address sensitive topics, and promotion of positive workplace cultures have all been shown to reduce burnout and job stress.[26] There are opportunities for those administering the MIECHV program to include requirements (and requisite support for meeting such requirements) for grantees to incorporate and/or participate in such strategies.
6. Research the wider home visiting workforce. Comparative research on the non-MIECHV home visiting workforce is needed as those outside of MIECHV-funded programs likely receive less funding, training, and technical support.[14] Such comparative research would provide information on how the MIECHV workforce might perform differently due to support they receive as well as identify areas where such support is less effective.
7. Explore continued provision of virtual home visiting. While virtual home visiting had its challenges, virtual visits also permitted more flexibility in access for some families and increased schedule flexibility for staff. Further exploration is needed as to whether this could be permanently incorporated into home visiting services and how this may affect both workforce and home visiting outcomes.
8. Develop more opportunities for collaboration across different types of home visiting programs. The RR VHV collaborative noted in their evaluation that the webinars offered opportunities for staff to collaborate and engage in strength-building across models and programs. This facilitated a more unified voice within the home visiting workforce, offering a stronger base from which to advocate for better support across the field. Such collaborative opportunities should be continued to reduce silos, support sharing of best practices, and ensure retention and growth of this workforce.

CONCLUSION

Existing studies and/or datasets which define or quantify the MIECHV workforce

Current literature on the MIECHV workforce is limited, with recent studies mainly focusing on worker well-being or training and competency development. The Home Visiting Career Trajectories survey, completed in 2018 and reported on in 2020, provides more comprehensive information on this workforce, finding that a majority were white, had at least a bachelor's degree and had home visiting experience prior to working in MIECHV-funded programs; however, it is unclear whether this will be continued. With respect to those entering and exiting this workforce, a majority of MIECHV-funded home visitors are registered nurses, social workers, or have a background in education. In the 2018 survey, home visitors reported being committed to their work and very few stated they plan to leave in the next two years; however, as there is no new data and with the added stress of the COVID-19 pandemic, it is possible these outcomes have changed.

COVID-19 impact on this workforce

The MIECHV workforce, similar to other home visitors, was required to pivot quickly to providing virtual services. Overall, MIECHV staff reported satisfaction with this transition, despite some challenges. In addition, the development of a virtual home visiting collaborative provided a platform for staff to connect across different MIECHV-funded programs and develop a more unified voice from which to advocate.

Next steps

There are several gaps with respect to research on and knowledge of this workforce, including workforce characteristics, best practices for training and competency development, strategies to support worker well-being, and approaches for leadership development in the field. This is a large workforce comprised of staff with a range of qualifications and educational backgrounds, who implement a variety of programs, and who see pregnant people, parents, and young children with multiple different needs. Such complexities need to be factored into any future research and workforce development, to ensure each home visitor receives the support they need to continue providing effective services.

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