MUSE

REPORT | August 2026

Implementing Home Visiting in Native Communities

A Report from the Multi-Site Implementation Evaluation of Tribal Home Visiting

OPRE Report 2026-026



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Office of Planning, Research, and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services
Contract Number: HHS 75ACF121F80025

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Acknowledgments

We would like to begin by thanking the 17 Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant recipients whose partnership made this study possible. Although they are not named to protect confidentiality, we are deeply grateful for their guidance throughout the study design and implementation and for their essential contributions to data collection. Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) would not have been possible without the generosity of the participating programs, staff members, and caregivers who shared their time and insights.

We thank our federal partners for their commitment to this study and contribution to the report, most notably our OPRE project officers, Aleta Meyer and Nicole Denmark, who provided thoughtful guidance throughout. We also deeply appreciate the input of our Tribal MIECHV Program office partners—Moushumi Beltangady, Carrie Peake, Anne Bergan, Farha Marfani (formerly at Administration for Children and Families [ACF]), and Jesse LaSarte. Laura Sherman (Health Resources and Services Administration [HRSA]), Kerry Cassidy Norton (formerly at HRSA), and Alicia Heim (formerly at HRSA) further shaped the study and report. We are grateful to Maria Wolverton (Office of Planning, Research, and Evaluation [OPRE]), Soohyun Kim (HRSA), and Katie Pahigiannis (OPRE), whose reviews ensured the report would be meaningful to a wider audience.

We are grateful to the many team members whose expertise contributed to the project over the years: Tess Abraham-Richardson, Patrice Cachat, Melanie Estarziau, Alva Gachupin, Minh Ha, Alex Joraanstad, Kristen Keene, Doreen Major Ryan, Loren Masters, Natalie Moyer, Matt Poes, Kerry Ryan, Michelle Sarche, Amy Stiffarm, and Ziyun Wang. Ongoing support from Joelle Ruben and Kristine Neurauter from the James Bell Associates Communications Department helped to improve this report.

We would also like to thank all members of the MUSE Technical Workgroup for their input throughout the study. Finally, we are grateful to the members of the MUSE Dissemination Review and Data Approval Committee for reviewing and approving the use of their program's data in this report.

Overview

The Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) Program provides funding to Tribes and Tribal organizations to develop, implement, and evaluate evidence-based home visiting services that promote the health and well-being of American Indian and Alaska Native (AIAN) families, strengthen early childhood systems, and expand the evidence base for home visiting in AIAN communities. While home visiting implementation has been the focus of prior studies (Boller et al., 2014; Duggan et al., 2018; Sandstrom et al., 2020), little is known about how evidence-based home visiting models are implemented in Native communities. The Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) was funded to describe how Tribal MIECHV grant recipients implemented their programs across varied Native community contexts and to identify factors leading to successful program implementation. MUSE, the first multi-site, multi-model study of home visiting in Native communities, was designed to be a mixed-methods community engaged study. MUSE is also unique in that most of its data were collected during the COVID-19 pandemic, a period that significantly shaped the study context.

Primary Research Questions

This report primarily addresses the following research questions:

- How are Tribal MIECHV programs staffed and what are the characteristics of those staff?
- What services are provided to families?
- What are caregivers' experiences with services?
- What happens during home visits?
- What training, support, and supervision do staff receive?
- What are the characteristics of families served and do those characteristics change over time?

Purpose

This report shares results and implications from MUSE. Specifically, it addresses how programs are implemented by Tribal MIECHV grant recipients and to a lesser extent, related supports and challenges. The pandemic complicated data collection, analyses, and the ability to fully address the research questions. Consequently, this report primarily reflects implementation during the pandemic. While many of the findings can likely be generalized to post-COVID contexts, care should be taken to consider the extent to which the pandemic impacted implementation of home visiting and to recognize that some findings may be less generalizable to current home visiting environments.

Key Findings

- During the MUSE data collection period of June 2019 to December 2021, Tribal MIECHV programs were successfully reaching AIAN caregivers. Half of those caregivers were pregnant at enrollment. Four-fifths had one or more children, with an average of 2.3 children under age 5. Most lived with a partner and/or other family members. Overall, caregivers entered the program with high levels of social support and felt they had the skills necessary to be good parents, especially with support from their families and communities.
- Caregivers were generally satisfied with how often visits happened (i.e., frequency) and how long they lasted (i.e., duration). They reported positive experiences participating in Tribal MIECHV programs and especially valued support directly related to parenting.
- Home visitors tailored how they delivered home visits in meaningful and impactful ways. They spent the most time providing emotional support and delivering curriculum content. Child development, parent-child interaction, and caregiver stress and well-being were frequent topics.
- Shared background and knowledge of cultural norms, language, and context benefited home visitor-caregiver relationships. Their shared experience as parents also fostered mutual respect.
- Home visitors reported high levels of confidence in their ability to carry out many different activities during home visits and to address a wide range of topics with families. They viewed their work within the community as valuable and meaningful. This commitment to serving one's community can help guard against burnout.

Methods

MUSE employed a mixed-methods approach, collecting survey, interview, and administrative data from caregivers receiving services and staff at 17 Tribal MIECHV programs. Data were collected over a 2.5-year period (June 2019 to December 2021), including a 5-month pause in data collection at the start of the COVID-19 pandemic. When data collection resumed, several adjustments to the protocol were made to ensure data collection was safe and feasible and could include data on the impact of COVID-19. The study team partnered with the MUSE Technical Workgroup, participating programs, and other partners to design the study; develop, select, and modify data collection instruments; collect data; and develop an analysis plan. Multiple data sources supported gathering information at various time points and with different modalities. This allowed us to expand and elaborate on data collected at one time point through subsequent data collection. Qualitative and quantitative data were integrated during both analysis and interpretation, supporting triangulation and comparison of data across sources.

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Executive Summary





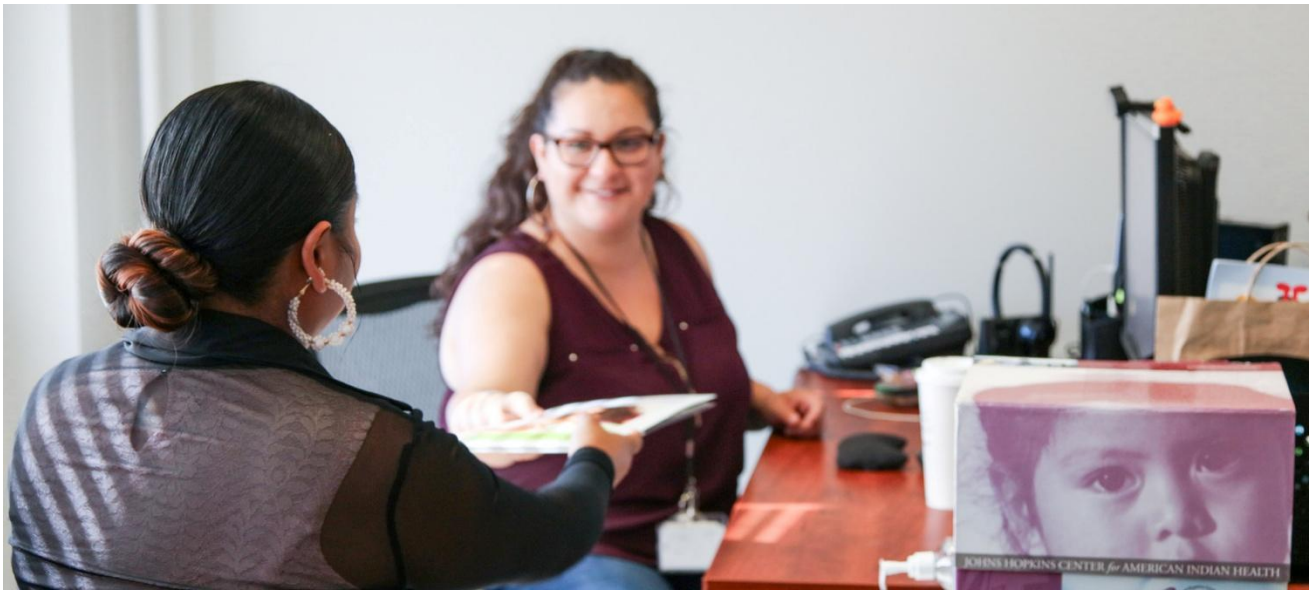
Home visiting is a service delivery strategy that connects expectant parents and caregivers of young children with a designated support person—typically a nurse, social worker, or early childhood specialist—who guides them through the early stages of raising a family (National Home Visiting Resource Center, 2018). The Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program provides funding to Tribes and Tribal organizations to develop, implement, and evaluate evidence-based home visiting services that promote the health and well-being of American Indian and Alaska Native (AIAN) families, strengthen early childhood systems, and expand the evidence base for home visiting in AIAN communities. While home visiting implementation has been the focus of prior studies (Boller et al., 2014; Duggan et al., 2018; Sandstrom et al., 2020), little is known about how home visiting models are implemented in Native communities and how evidence-based models are translated in these contexts. The Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) was funded to describe how Tribal MIECHV grant recipients implemented their programs across varied Native community contexts and to identify factors leading to successful program implementation. MUSE, the first multi-site, multi-model study of home visiting in Native communities, was designed to be a mixed-methods community engaged study. MUSE is also unique in that most of its data were collected during the COVID-19 pandemic, a period that saw a substantial increase in virtual service delivery which significantly shaped the study context. The pandemic complicated data collection, analyses, and the ability to fully address the research questions. Consequently, this report primarily reflects implementation during the pandemic. While many of the findings are likely generalizable to post-COVID contexts, care should be taken to consider the extent to which the pandemic impacted implementation and to recognize that some findings may be less generalizable to current home visiting environments. For more information on how COVID-19 impacted Tribal MIECHV programs please see *Continuing Home Visiting Services During COVID-19: A Brief From the Multi-Site Implementation Evaluation of Tribal Home Visiting*.

Tribal MIECHV

Through the Tribal MIECHV Program, the Administration for Children and Families (ACF) provides funding to Tribes; consortia of Tribes; Tribal organizations; and urban Indian organizations to develop, implement, and evaluate home visiting programs in AIAN communities. The program was designed to support Tribes and Tribal organizations in promoting the health and well-being of AIAN families through evidence-based home visiting provided to pregnant women and caregivers of children from birth to kindergarten entry; expand the evidence base on home visiting in AIAN communities; and contribute to coordinated, comprehensive early childhood systems.

The Tribal MIECHV Program was established in the MIECHV authorizing legislation and initially funded with a 3 percent set-aside of the program budget. The set-aside was increased to 6 percent in fiscal year 2023. The legislation indicated that Tribal MIECHV programs should be consistent with the requirements of MIECHV awards to states and jurisdictions to the greatest extent practicable. This provision left flexibility for ACF to tailor Tribal MIECHV program requirements to the varied community contexts in which the grant program operates.

Tribal MIECHV grant recipients serve Native communities ranging from rural reservations to urban areas to remote Alaska villages. They represent the richness of AIAN populations, their unique cultural contexts, and varied geographic locations and service areas. Between 2010 and 2025, ACF awarded Tribal MIECHV grants to 53 Tribal entities.





MUSE

In 2016, the Office of Planning, Research, and Evaluation (OPRE) in ACF funded James Bell Associates (JBA), in partnership with the Centers for American Indian and Alaska Native Health (CAIANH) at the University of Colorado Anschutz, to conduct a multi-site implementation study of the Tribal MIECHV Program. MUSE is the first multi-site, multi-model study to systematically explore how home visiting programs operate across varied Native community contexts. To fulfill a grant requirement, one cohort of Tribal MIECHV programs (consisting of 17 grant recipients) participated in the study. The study team (i.e., JBA and CAIANH with oversight from OPRE) employed a community-engaged approach to collaboratively design and implement the study with participating programs and other study partners (Salvador et al., 2024a). Ongoing engagement was achieved mainly through in-person and virtual meetings with study partners, monthly meetings between programs and MUSE liaisons, and periodic meetings with a Technical Workgroup that included representatives from all partner groups. MUSE was primarily funded to inform the federal government's efforts to support home visiting initiatives in Native communities and similar populations. It was also funded and designed to identify successful implementation strategies that can be used by Tribal MIECHV programs to improve service delivery for children and families.

Study Aims and Questions

Aim 1: Identify and describe primary influences shaping Tribal MIECHV program planning. What is the local context that informs planning? How are implementation science principles reflected in local program planning? What is the degree of alignment between local context and implementation science principles? How are differences addressed in planning? How do home visiting model requirements inform program planning? What adaptations, enhancements, and supplements are planned? Why?

Aim 2: Identify and describe how Tribal MIECHV programs are implemented. How are Tribal MIECHV programs staffed and what are the characteristics of those staff? What services are provided to families? What are caregivers' experiences with services? What happens during home visits? What training, support, and supervision do staff receive? What are the characteristics of families served, and do those characteristics change over time?

Aim 3: Explore supports and challenges to home visiting implementation in Native communities. What influences relationships between home visitors and families? What influences what happens during home visits? What influences the amount of home visiting families receive? What influences staff self-efficacy and job satisfaction? What influences Tribal MIECHV programs' ability to implement their programs as intended?



This report presents findings related to Aim 2 and, to the extent possible, Aim 3; data collection disruptions related to the COVID-19 pandemic limited exploration of Aim 3. MUSE findings related to Aim 1 were described in the report *Understanding Planning for Tribal Home Visiting* (Salvador et al., 2024b).

Methods

MUSE employed a mixed-methods approach, collecting survey, interview, and administrative data from caregivers participating in home visiting and staff. Data were collected over a 2.5-year period (June 2019 to December 2021), including a 5-month pause in data collection at the start of the COVID-19 pandemic. The study team partnered with the MUSE Technical Workgroup and programs participating in the study to develop, select, and modify data collection instruments and develop an analysis plan. MUSE data sources included—

- Interviews conducted with program leadership (program directors or managers) and selected home visitors and caregivers from each participating program
- One-time staff surveys administered to program directors, program managers, home visitors, and evaluators
- Caregiver Surveys administered to program participants who were newly enrolled in home visiting at three time points: program enrollment (i.e., baseline), 6 months, and 12 months; 12-month Caregiver Surveys were discontinued during the pandemic
- Rapid Reflect Surveys completed by home visitors and caregivers after a sampling of home visits and designed to gather data on the range of content, structure, adjustments, and approaches used during visits; Caregiver Rapid Reflects were discontinued during the pandemic



- Implementation logs that tracked program staffing, training, supervision, and family group events submitted by program staff
- A one-time survey focused on program implementation activities completed by program managers in consultation with program directors or other staff as needed
- Administrative data on caregiver demographics, service utilization, and screenings submitted by program staff

Multiple data sources supported gathering information at various time points and with different modalities. For example, the Rapid Reflect Surveys facilitated quick reporting and quantitative information on a particular home visit, and qualitative interviews elicited global feedback across months of service provision. Data collected across multiple time points allowed us to expand and elaborate on data collected at one time point (e.g., surveys of caregivers when they

enrolled in home visiting) through subsequent data collection (e.g., interviews with caregivers who were participating in home visiting). Qualitative and quantitative data were integrated during both analysis and interpretation, supporting triangulation and comparison of data across sources. Additionally, findings from Aim 1 informed analysis and interpretation of results for this report (see Salvador et al., 2024b for more information).

Key Findings



It's important to note that findings reported here are high level summaries across programs that do not fully capture the considerable variability in models, program size, community context, response to the COVID-19 pandemic, and other characteristics. As a result, certain findings may not fully resonate with every program's experience.

Caregiver Characteristics

- Most caregivers (88 percent) who participated in MUSE were AIAN women. At program enrollment, almost half were pregnant, and 20 percent of those were expecting their first child. Eighty percent had 1 or more children, with an average of 2.3 children under age 5. Almost two thirds lived with a partner, 38 percent lived with other family members, and ten percent lived with only their children.[1]
- Nearly all caregivers had a place to live (94 percent) and access to health insurance or Indian Health Services (97 percent). However, household income was generally low, and most experienced economic strain in at least one area.
- Caregivers entered the program with significant strengths. They reported strong social support and felt they had the skills necessary to be good parents, especially with support from their families and communities. Caregivers also reported relatively high levels of attention regulation and the ability to focus attention on their children.

[1] Data on caregiver pregnancy status and number of children are drawn from a subsample of caregivers who completed the Baseline Caregiver Survey.



Caregiver Enrollment, Participation, and Experience

- Caregivers who participated in MUSE learned about Tribal MIECHV programs through their personal networks or service providers. They enrolled in the program to strengthen their parenting, support their child's development, and connect with cultural practices.
- Caregivers took part in one to two visits per month, each lasting around an hour. Between visits, they stayed in touch with their home visitor by text, email, and phone. They also participated in other activities that built connections with other families, often focused on parent-child interaction, child development, and connecting to community and culture.
- Caregivers were generally satisfied with how often visits happened (i.e., frequency) and how long they lasted (i.e., duration). They reported positive experiences participating in Tribal MIECHV programs, and especially valued support directly related to parenting.
- On average, caregivers stayed in the program for about 13.5 months, with higher retention than seen in some studies with other populations. Visit frequency was adjusted to meet caregiver needs, and retention was likely supported by the consistency, flexibility, and responsiveness of home visitors.

Inside Tribal MIECHV Home Visits



- The primary caregiver and index child were the main participants in home visits, with other family members participating less often. When asked about the approximate amount of time spent on six key activities during visits, home visitors reported spending the most time providing emotional support and delivering curriculum content/educational information, which often focused on child development, parent-child interaction, and caregiver stress and well-being. Collaborative goal setting took place during most visits. Caregivers were satisfied with the process, and home visitors found it valuable to set goals with families.
- Home visitors used model guidance and curriculum, and sometimes additional materials, to plan home visits. When tailoring plans, they considered what they knew about each family and the connections they had built with them. They also modified plans during visits to manage time, respond to caregiver needs and preferences, and adjust to evolving issues ranging from a child's mood to emerging crises.
- Caregivers felt home visitors responded to their needs, feelings, and interests with warmth and care and worked with them to tailor visits to fit their own families. Nearly all caregivers found visits interesting, useful, and a good use of their time. They especially valued the practical support and social connection they received.

Home Visitor-Caregiver Relationships

- Caregivers felt cared for and understood by their home visitors. They valued being able to discuss sensitive topics with someone they trusted and often described their home visitors as more like friends or family members
- Home visiting staff described boundary setting as a protective strategy to help prevent burnout. They found boundaries worked best when they were flexible, responsive, and grounded in mutual respect.
- Shared background and knowledge of cultural norms, language, and context benefited home visitor-caregiver relationships. Their shared experience as parents also fostered mutual respect.
- Some home visitors shared that self-disclosure—or the sharing of personal information and experiences—helped to establish common ground with caregivers and normalize caregiver

experiences. It also encouraged open and honest communication, helping to overcome caregivers' negative associations with social services.

Staff Characteristics

- A majority of home visitors and nearly half of program managers participating in MUSE identified as AIAN. Many staff shared the same community and cultural backgrounds as the families they served. Almost all program staff had some education beyond high school. About half of the home visitors and nearly all program managers had a bachelor's degree. Only a third of home visitors had prior professional experience working with children and families before their current role, compared to more than two thirds of program managers.

- Overall, programs reported staffing was stable. However, they had difficulty hiring staff with the qualifications they wanted. These included strong interpersonal skills, experience working with children and families, and a cultural background similar to the families served.

Training, Supervision, and Peer Support for Staff

- On average, staff participated in training once a month. Topics included data collection and entry, administrative tasks, and content specific to supporting children and families. About three quarters of staff said training was helpful, engaging, and relevant to their day-to-day work with families.



- Home visitors received about two one-on-one supervision sessions each month and one to two group supervision sessions. These sessions focused on their emotional well-being and reflective practice. One-on-one sessions also frequently covered managing caseloads. Home visitors said they received reflective supervision as intended—meaning they had time to discuss their thoughts, feelings, actions, and reactions when working with young children and families (Early Childhood Technical Assistance Center, 2022). They also valued the mentoring and trusting relationships they had with their supervisors.

- Home visitors said they most often turned to their peers with questions about working well with team members (such as collaborating on activities and roles), problem solving for specific families, and building skills to better support and provide information to families.

- Both home visitors and program managers agreed that almost all of the strategies used to support home visitors were important. However, program managers were more likely to place a higher value on reflective supervision and home visitors were more likely to value continuing education opportunities.

Staff Experiences

- On average, home visitors reported working 40 hours per week. The number of families they served varied widely—from as few as 3 to as many as 38—but the average was 13 families. Two-thirds felt their current caseload was "about right." Program managers worked an average of 43 hours per week and felt their supervisory and caseload responsibilities were "about right." Overall, home visitors reported a positive workplace culture and climate in their organizations.

- Home visitors reported high levels of confidence in their ability to carry out many different activities during home visits and to address a wide range of topics with families. They felt especially confident in building and maintaining trusting relationships with caregivers based on mutual care and respect; tailoring visits while still delivering curricula as intended; collecting data; and addressing topics like child health and development, maternal health, and family well-being.



- Home visitors reported the lowest levels of confidence working with fathers, uninterested or fussy children, and caregivers who seemed uninterested or distracted. They also felt less confident addressing topics such as coparenting, past trauma, and the legal system and services, although still more than half reported confidence in these areas.

- Home visitors reported high job satisfaction and low frustration overall, even though they were not satisfied with their pay and opportunities for promotion. Most said they were very likely to remain in their jobs for the next 6 months. They also reported high levels of compassion satisfaction and low levels of burnout and secondary trauma. Overall, home visitors remained committed to working with families and making a positive difference in their communities.

Implications for Tribal MIECHV Implementation

Just as key findings represent high level summaries that apply to a varying extent to different programs, the implications will be more relevant to some community and program contexts than others. Also, some may remain relevant to the post-COVID environment while others less so. Decisions on actionable implications will need to be informed by careful consideration of local program context.



Exploring opportunities to strategically engage additional household or family members in home visits could potentially extend and amplify the benefits of home visiting beyond the caregiver and child. MUSE findings show that most caregivers lived with partners or other family members, yet other household members rarely participated in home visits. The strong support networks and collective parenting practices of Native communities could present an opportunity to extend home visiting's benefits to other family members. While other studies have identified a range of strategies for increasing father engagement (Kleinman et al., 2023; Sandstrom et al., 2015; Stolz & LaGraff, 2025), less is known about ways of engaging extended family or other household members. Learning from related research and exploring the views of home visiting staff, caregivers, and models on the benefits, challenges, and constraints related to engaging additional family and household members in Tribal MIECHV home visits could be an important next step.

Ensuring adequate supports for home visitors to tailor home visit content is critical. Because home visiting programs serve families with varied experiences, resources, and needs, home visitors must be able to tailor their visits to the unique circumstances of the families they serve. Home visitors described tailoring as continually considering caregivers' goals, needs, and interests when developing home visit plans and then listening to and observing caregiver cues to respond in the moment with appropriate adjustments to their plans. They drew on their in-depth understanding of wide-ranging topics and deep connections with caregivers to effectively tailor visits, often incorporating cultural knowledge and practice. MUSE findings demonstrate that tailoring is a strength of Tribal MIECHV home visitors; and that responsive tailoring of home visit content is likely central to successful caregiver engagement, satisfaction, and retention. The importance of tailoring suggests that training and supervision to support home visitors in customizing and adapting visits while also attending to model requirements is fundamental. Identifying the critical components of tailoring and amplifying these could support programs and new home visitors in this important practice.

Staff recruitment strategies that emphasize serving one's community may help attract and retain home visitors. Home visitors who participated in MUSE viewed their work within the community as valuable and meaningful. In interviews, they reflected on the reciprocal nature of providing services to members of one's own Native community and highlighted the nuanced way they relate to their work and programs and to the families they serve. For some, a deeply relational approach to home visiting and the commitment to serving one's community may be protective factors against some common issues impacting home visitor retention, including burnout. Hiring qualified home visitors remains a challenge, particularly when seeking individuals with strong interpersonal skills, experience working with children and families, and similar cultural backgrounds as the communities served. Staff recruitment strategies emphasizing cultural relevance, relational skills, and commitment to serving one's community may help attract and retain staff who are both well-qualified and deeply invested in serving their community.

Workforce supports can be optimized by strategically leveraging the relative strengths of supervision, training, and peer support while also exploring ways to streamline training for data collection and enhance reflective supervision. Tribal MIECHV programs provided a robust system of workforce supports to ensure home visitors were equipped to carry out the many activities required of them. While training was provided on a wide variety of topics, data collection and entry was the most frequent training topic; it was also frequently discussed in supervision. Home visitors found training, supervision, and peer support to be helpful across a broad range of topics, but the sources of support seen as most helpful varied somewhat by topic. A multi-pronged approach, drawing on the distinct strengths of supervision, training, and peer collaboration, appears to be effective. Understanding these strengths can help programs tailor the delivery of supports and prioritize the efficient and effective use of resources. Future efforts could also focus on finding ways to both streamline data demands and create more efficient approaches to equipping home visitors with the necessary skills to collect vital data.



Professional development opportunities and career pathways can strengthen the Tribal MIECHV workforce and may improve home visitor job satisfaction and retention. Home visitors participating in MUSE consistently valued professional development opportunities and wanted more pathways to advancement. When asked how satisfied they were with different aspects of their jobs, they were least satisfied with their chances for promotion. In response to home visitor concerns, programs might consider adopting a more structured approach to professional development with dedicated time and resources. Strategies like employer-sponsored continuing education, support for obtaining early childhood credentials, technical assistance focused on skill building, and model training beyond required courses may help prepare individuals who share cultural backgrounds with families served (including former home visiting participants). This could strengthen the home visiting workforce for Native community contexts. Similarly, support for Tribal MIECHV programs to define professional growth pathways, provide leadership training, and develop competency frameworks could result in more opportunities for advancement (Sparr et al., 2022).

Investing in better pay, benefits, and other incentives can help retain experienced staff who are deeply committed to serving their communities. Consistent with what has been reported by studies of other home visiting contexts (Sandstrom et al., 2020), MUSE found that low wages are a concern among staff and likely a barrier to retention. When asked how satisfied they were with various aspects of their jobs, pay ranked next to last, and less than a fifth of home visitors reported that their salaries were enough to live comfortably. Among home visitors who reported being less committed to remaining in their position, 50 percent reported salary as a factor, indicating compensation's direct impact on retention. While funding constraints can make increasing pay difficult, addressing compensation remains a high priority. Compensation assessments examining pay and benefits by role, exploring fairness in pay and promotion practices, and benchmarking compensation to industry standards could be useful for Tribal MIECHV programs. Beyond pay, other incentives could include longevity pay, enhanced health and retirement benefits, paid parental leave, and increased vacation accrual.

Implications for Future Research

Considerations for Future Research Goals and Approaches

More research is needed on Tribal MIECHV programs in post COVID-19 contexts. While some MUSE study data were collected before COVID-19, most were collected between July 2020 and December 2021 and were thus deeply influenced by the impact of COVID-19 on caregivers and staff and the shift to virtual home visiting. We learned a lot about how home visiting is implemented by Tribal MIECHV programs, but additional research is needed to better understand the extent to which implementation practices observed during the study period have been sustained or changed post COVID.



The MUSE community-engaged approach is an important foundation to expand upon in future studies of home visiting in Native communities. The study invested time and resources in a deeply community-engaged approach. The engagement ensured that it was feasible to implement, scientifically rigorous, and culturally and contextually relevant. It is important for future research to include deep conversations about focus, feasibility, and scope with community partners as studies are conceptualized and launched. Future viable and rigorous research with Native communities depends on similar community engagement.

Further exploring the values that lead Native communities to engage in home visiting and the priority outcomes they hope to achieve is an important precursor to examining the effectiveness of these programs. MUSE partners expressed the importance of defining successful and effective home visiting services within the context of Native worldviews and local values and priorities for children and families. Additional research could articulate key intended outcomes across programs in Native communities and explore options for studying those outcomes in ways that are both rigorous and relevant.



Studies that examine the impact of Tribal MIECHV programs on outcomes important to Native communities can fill critical gaps in the knowledge base and inform Native communities' decision making and planning processes. After meaningful attempts to identify key, relevant outcomes with and for Native communities and develop measures to accurately assess those outcomes, effectiveness research that integrates Western and Native research paradigms is an important next step. Native paradigms emphasize the value of engaging communities in the research that is anchored in relationality, respect, reciprocity, relational accountability, and place (Moyer et al., 2024). Applying these principles can ensure the optimal use of Western scientific methods within Native community contexts. Engaging in relationships with communities to identify appropriate research methods ensures the most rigorous science. These methods support the identification of priority questions and salient outcomes, the use of feasible and effective methods, the collection of reliable and valid data, and the accurate and meaningful interpretation of findings. Results of such studies can increase our understanding of how well home visiting achieves outcomes of importance to Native communities and can ultimately support informed community decision making about model selection and implementation.

Incremental research that answers discrete questions, such as those that use rapid-cycle methods, can provide timely, useful information and reduce burden. MUSE was an ambitious study at the outset and expanded to address key questions raised by community partners. This resulted in a complex data collection protocol with multiple data sources and instruments that left some participating sites feeling overwhelmed. The variety of data collected also contributed to lengthy analysis and report writing timelines. Future studies examining more focused and specific questions could produce actionable findings more quickly.

Topics for Future Research

Better understanding the facilitators and barriers to caregiver recruitment and retention could extend Tribal MIECHV's reach to even more families. Future studies could explore how elements of community context (e.g., existence of/collaboration with other home visiting or early childhood programs in the service area) and the service and policy environment (e.g., supportiveness of Tribal/organizational leadership) influence recruitment efforts. Findings could inform efforts to reach families served by Tribal MIECHV programs, including different types of caregivers and communities that could benefit from participating.

Assessing the effects of economic strain on caregiver participation and outcomes can help programs tailor services to meet the needs of families within the economic contexts of their communities. Other research on family economic well-being in Native communities suggests that unique factors—including subsistence living, cultural capital, and collective responsibility—impact experiences of economic strain in Native community contexts (Raj et al., 2023). A better understanding of how to measure family economic well-being and its relationship to family stress could help programs tailor services to better support families.

Examining practices that facilitate relationship-building in Tribal MIECHV could inform training, supervision, and peer support strategies that enhance these practices. MUSE established that home visitors are successfully building relationships with caregivers, which provides multiple benefits. An in-depth study of how relationships are formed and sustained could support new Tribal MIECHV grant recipients as they build their programs and enhance efforts of existing ones. Formative research designed to develop a conceptual model of relationship building and identify core skills, model components, and institutional practices could inform both implementation and evaluation efforts.

Understanding how home visitors tailor their visits to families, and the impact of that tailoring, is essential for ensuring that adequate time, resources, and organizational supports are in place for this critical work. Home visitors draw on detailed knowledge of family needs, preferences, and circumstances, as well as curriculum requirements and broader home visiting practices, to tailor visits effectively. This is a task that is both time-intensive and skill-based. Descriptive studies examining the information considered while tailoring, the kinds of adjustments made during visits, the amount of time spent adjusting plans and activities, and how staff are empowered and supported in tailoring can clarify the effort and burden involved. Examining how successful tailoring contributes to family engagement and outcomes can help clarify the mechanisms through which home visiting benefits families. Gaining an understanding of what successful tailoring looks like and what best facilitates the process can help programs better plan for implementation; establish realistic caseload expectations; and encourage and gain sufficient ongoing resources, training, and support from programs, models, and funders.

Exploring how integrating cultural practices into home visiting affects caregiver engagement and outcomes can shed light on a critical element of Tribal MIECHV programs. Better understanding of the benefits of integrating cultural practice and the impacts of culturally enhanced services on caregiver engagement, satisfaction, and outcomes, as well as practices supporting integration could lead to additional resources and support. Robust community-engaged approaches will be especially critical for pursuing these questions, given the importance of honoring and respecting cultural protocols and protected cultural information while at the same time understanding the impact of culture in effective home visiting practices.

Identifying primary influences of home visitor recruitment and retention can inform efforts to retain the Tribal MIECHV workforce and support consistent implementation. MUSE demonstrated that commitment to serving one's community was a major factor as to why home visitors continue in their jobs. Given the challenges to recruiting qualified candidates and the large investment in model training, a better understanding of how to retain home visitors, especially those from the community served, could be beneficial.

Chapter 1: Background and Approach for a Multi-Site Implementation Evaluation of Tribal MIECHV



Introduction to MUSE

In 2016, the Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF) funded James Bell Associates, in partnership with the Centers for American Indian and Alaska Native Health at the University of Colorado Anschutz Medical Center, to conduct a multi-site implementation study of the Tribal Maternal Infant and Early Childhood Home Visiting (MIECHV) Program. The Multi-Site Implementation Evaluation of Tribal Home Visiting (MUSE) is the first multi-site, multi-model study to systematically explore how home visiting programs operate across varied Native community contexts and to identify factors that lead to successful program implementation. To fulfill a grant requirement, 17 Tribal MIECHV programs participated in the study. The MUSE study team employed a community-engaged approach to collaboratively design and implement the study with participating programs and other study partners. MUSE employed a mixed-methods approach, collecting survey, interview, and administrative data from home visiting participants (referred to as caregivers) and staff over a two-year period. MUSE was primarily funded to inform the federal government's efforts to support home visiting initiatives in Native communities and similar populations. MUSE was also funded and designed to identify successful implementation strategies that can be used by Tribal MIECHV programs to improve service delivery for children and families.

Tribal MIECHV Program

Congress initially authorized the MIECHV Program via Section 2951 of The Patient Protection and Affordable Care Act, 2010 (P.L 111–148), which greatly expanded federal funding for voluntary, evidence-based home visiting programs. The legislation described the following goals of the MIECHV program: (1) Identify and provide comprehensive home visiting services to improve outcomes for eligible families living in at-risk communities; (2) Improve coordination of services within at-risk communities; and (3) Strengthen and improve programs and activities that address preventive and primary care services for pregnant women, infants, and children under Title V of the Social Security Act.

The Tribal MIECHV Program was established in the MIECHV authorizing legislation and initially funded with a 3 percent set-aside of the total program budget; the set-aside was increased to 6 percent in fiscal year 2023. Through Tribal MIECHV, ACF awards funding to Tribes, consortia of Tribes, Tribal organizations, and urban Indian organizations to develop, implement, and evaluate home visiting programs in American Indian and Alaska Native (AIAN) communities.

The MIECHV legislation indicated Tribal MIECHV programs should be consistent with the requirements of the MIECHV awards to states and jurisdictions to the greatest extent practicable. This provision left flexibility for ACF to tailor program requirements to the varied community contexts in which the grant program operates.

The goals of the Tribal MIECHV Program are to—

- Support the development of happy, healthy, and successful AIAN children and families through a coordinated home visiting strategy that addresses critical maternal and child health, development, early learning, family support, and child abuse and neglect prevention needs
- Implement high-quality, culturally relevant evidence-based home visiting programs in AIAN communities
- Expand the evidence base around home visiting interventions with Native populations
- Support and strengthen cooperation and coordination and promote linkages among various programs that serve expectant families, young children, and families, resulting in coordinated, comprehensive early childhood systems in grant recipient communities

Tribal MIECHV grant recipients serve Native communities ranging from rural reservations to urban areas to remote Alaska villages. Grant recipients represent the richness of AIAN populations, their unique cultural contexts, and varied geographic locations and service areas. Between 2010 and 2025, ACF has awarded Tribal MIECHV grants to 53 Tribal entities.

In addition to providing home visiting services, the statute requires MIECHV to implement a continuous program of research and evaluation activities to increase knowledge about the implementation and effectiveness of home visiting programs. In response, the Health Resources and Services Administration (HRSA) and ACF created the MIECHV Learning Agenda, which includes performance measurement; continuous quality improvement efforts; descriptive, implementation, and impact evaluation and research studies; and rigorous local evaluation led by state and Tribal grant recipients to improve home visiting services and ultimately family outcomes (Health Resources and Services Administration, n.d.).

Tribal MIECHV's emphasis on expanding the evidence base is critical because most home visiting models, meeting the criteria established by HHS through the Home Visiting Evidence of Effectiveness (HomVEE) review for being evidence based, were not created for and have not been tested with Native communities. Tribal MIECHV grant recipients funded in 2010 through 2012 conducted local evaluations during their 5-year awards that were designed to strengthen

the evidence base for home visiting in Native communities and to answer locally relevant questions. The evaluations combined scientific and cultural rigor to ensure results were valid for both researchers and communities (Meyer & Denmark, 2020). With the award of new grants in 2016, OPRE also funded a multi-site study (i.e., MUSE) to build on the valuable, yet locally specific, Tribal MIECHV evaluations. MUSE provided an opportunity to pool data from Native communities to answer important research questions about home visiting implementation across varied community contexts.

Rationale for a Descriptive Implementation Study of Tribal MIECHV

While MUSE is the first multi-site, multi-model study focused on home visiting implementation in Native communities, several initiatives have sought to understand implementation more broadly. The Mother and Infant Home Visiting Program Evaluation (MIHOPE) implementation study described the actual services the families received and examined how they varied, depending on the characteristics of families, home visitors, local programs, evidence-based models, and communities (Duggan et al., 2018). The Supporting Evidence Based Home Visiting to Prevent Child Maltreatment study examined intervention implementation, fidelity to the evidence-based model, costs of the programs, family and child outcomes, and systems change (Boller et al., 2014). Although these studies generally provided important insights into home visiting implementation, there was a need to better understand program implementation in Native communities because they were not well represented in prior implementation or effectiveness studies.

Although less structured forms of home visiting have existed in Native communities for generations, questions remain about the use of home visiting models that were created and tested with the general population. These questions include whether the resource requirements of federal programs and evidence-based models align with the contexts of communities that have long been underresourced. Additionally, Native communities advocate strongly for autonomy to make cultural and contextual adaptations to evidence-based models. Furthermore, compelling research suggests family-centered interventions rooted in Native cultural values and practices are most likely to be implemented with fidelity and sustained over time in AIAN communities (Spicer et al., 2012). Given all these considerations, OPRE partnered with the Tribal MIECHV Program office within ACF to envision a study to help understand whether models developed for non-Native families can be implemented with fidelity in Native communities, what intentional support may be necessary for translating evidence-based models

for Native community contexts to promote quality, and how Tribal MIECHV grant recipients adapt and enhance home visiting models.

In the scope of work for the MUSE contract, OPRE detailed its initial vision of a mixed-methods, community-engaged, multi-site implementation evaluation. Within the contract, OPRE required the selected contractor to develop and implement an engagement plan that would entail consulting with Tribal leaders, Tribal MIECHV grant recipients, and other local community members and convening a Technical Workgroup to provide specific input into all major study activities. MUSE was the first OPRE-funded project to require a formal and comprehensive plan for incorporating community engagement into project implementation. OPRE's commitment to community-engaged evaluation, codified in the engagement plan task, would set the stage for ongoing and iterative feedback to inform study methods, instruments, and processes and substantially shift the focus away from model fidelity, quality, and adaptation to a broader focus on describing implementation in Native communities. More about this community engaged approach and the resultant shift is described below and in Salvador et al. (2024a).

Following the Guidance in the Roadmap for Collaborative and Effective Evaluation in Tribal Communities

From the outset, the MUSE study was designed to follow *A Roadmap for Collaborative and Effective Evaluation in Tribal Communities* (*Roadmap*; Tribal Evaluation Workgroup, 2013), for example through the requirements OPRE set for community engagement as described above. This *Roadmap,* published in 2013, was developed by a workgroup convened by the Children's Bureau in ACF with the goal of improving evaluation of child welfare programs in Native communities. The workgroup included representatives from Tribal child welfare programs, evaluators, university researchers, technical assistance providers, and Federal program partners. Their work resulted in a vision for transforming how evaluation is conducted, advancing a new narrative in which evaluators and communities work in partnership to make evaluation more effective.

Fundamental to the development of the *Roadmap* was the recognition of how the historical context of evaluation in Native communities had shaped perspectives on evaluation. Invasive, imposed, and judgmental evaluation by outside entities engendered deep distrust of the evaluation process in many Native communities. Equally essential was the emphasis on values that underpin a more effective approach to evaluation. These included valuing Native ways of knowing, respect for Tribal sovereignty, focus on strengths, recognition of the equal importance

of both cultural and scientific rigor, commitment to ethical practices, and engagement of the community in evaluation, and knowledge sharing.

Within this context, the developers of the *Roadmap* identified two important tasks for improving evaluation in Native communities. First was Relationship Building to create trust and partnership and to address the fears of evaluation resulting from past approaches. Several key strategies were articulated to accomplish this, including commitment to dialogue among partners and transparency in expectations. Second was Knowledge and Skill Building, emphasizing bi-directional opportunities for learning to improve capacity among partners in both communities and outside entities (e.g., universities) to conduct more effective evaluation. Critical to both tasks was the importance of engaging relevant partners—including program staff, evaluation partners, Tribal leaders, university researchers, and policy makers—at all phases, from development of research questions through dissemination of findings.

The *Roadmap* laid a critical foundation for the MUSE study. Its principles were woven into the MUSE contract developed by OPRE, and they remained a guiding force throughout all study phases. Following the vision articulated in the *Roadmap,* MUSE study team brought the participating programs together for both virtual and in-person meetings soon after the contract was awarded. This engagement continued throughout the design, data collection, interpretation, and dissemination phases.

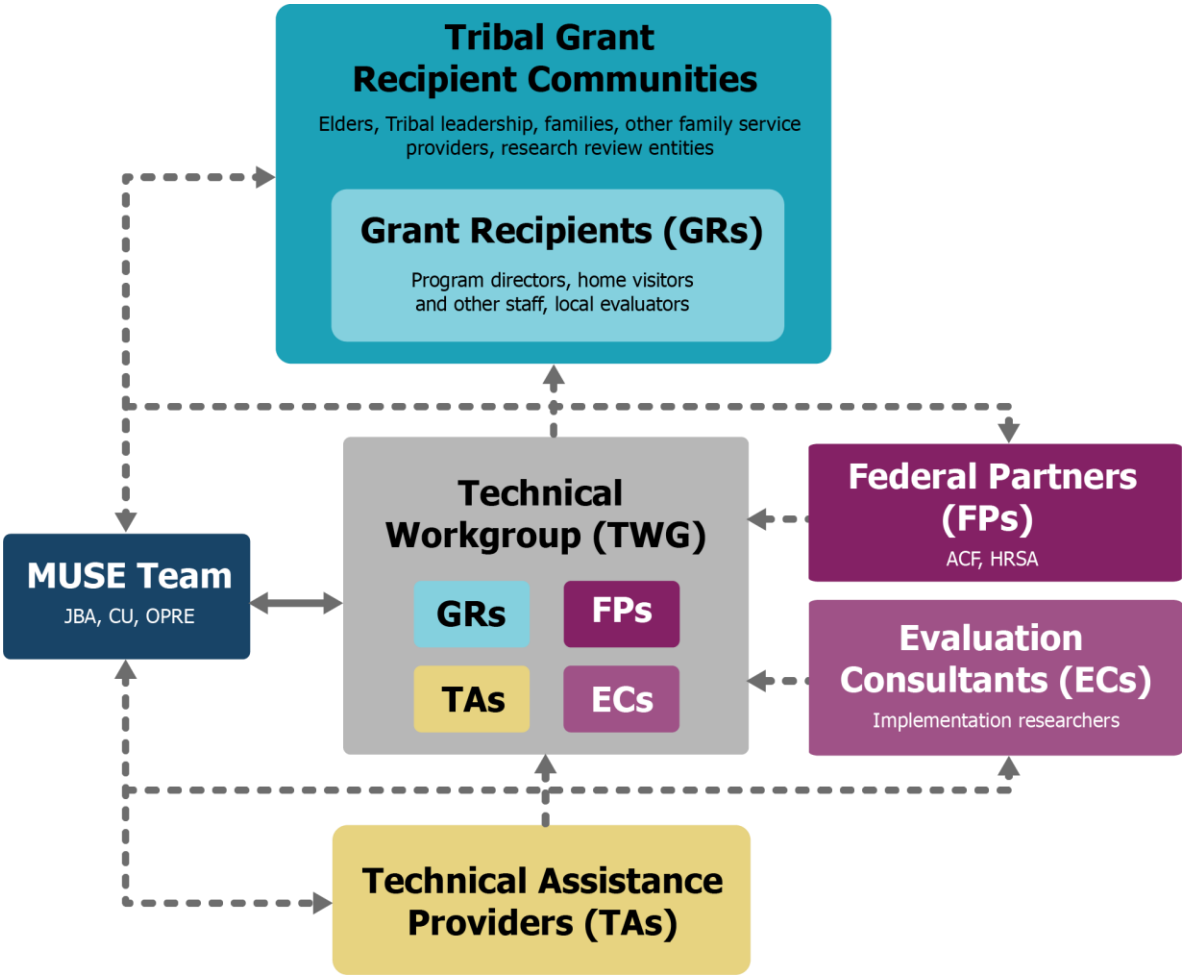
The Community-Engaged Approach to MUSE

Tribal sovereignty necessitates that Tribal communities maintain authority over and have a significant voice in how research is designed and conducted within their communities. MUSE was established as a community engaged study in adherence to Tribal sovereignty, to enhance the contextual rigor of the study and ensure it would generate meaningful and relevant findings for Native communities. Additionally, community engagement is a demonstrated way to integrate Native and Western research approaches (Rink et al., 2020). The community-engaged approach can be characterized by intensive and iterative engagement of partner groups, most notably the 17 Tribal MIECHV programs that elected to participate in the study to fulfill the rigorous research requirement of the grant.

Guided by the *Roadmap*, the MUSE study team established a shared vision for the community-engaged approach, including a set of partnership principles. At the same time, the team developed an engagement plan that identified partner groups to engage, established a

structure and timeline for engaging study partners, and outlined the goals of engagement for each study phase. Exhibit 1.1 depicts the MUSE study partners and engagement structure. Tribal MIECHV grant recipients (one of the partner groups), featured below in light blue, were heavily involved in study planning, execution, data interpretation, and dissemination. Other partner groups supported MUSE as members of the Technical Workgroup (TWG) as depicted in the gray box. They are federal partners from ACF (Tribal MIECHV) and HRSA (depicted in the dark purple box), Tribal MIECHV technical assistance providers (depicted in the yellow box), and evaluation consultants who specialize in Tribal sovereignty and data governance and/or implementation and evaluation of evidence-based practices (depicted in the light purple box).

Exhibit 1.1. MUSE Study Partners and Engagement Structure



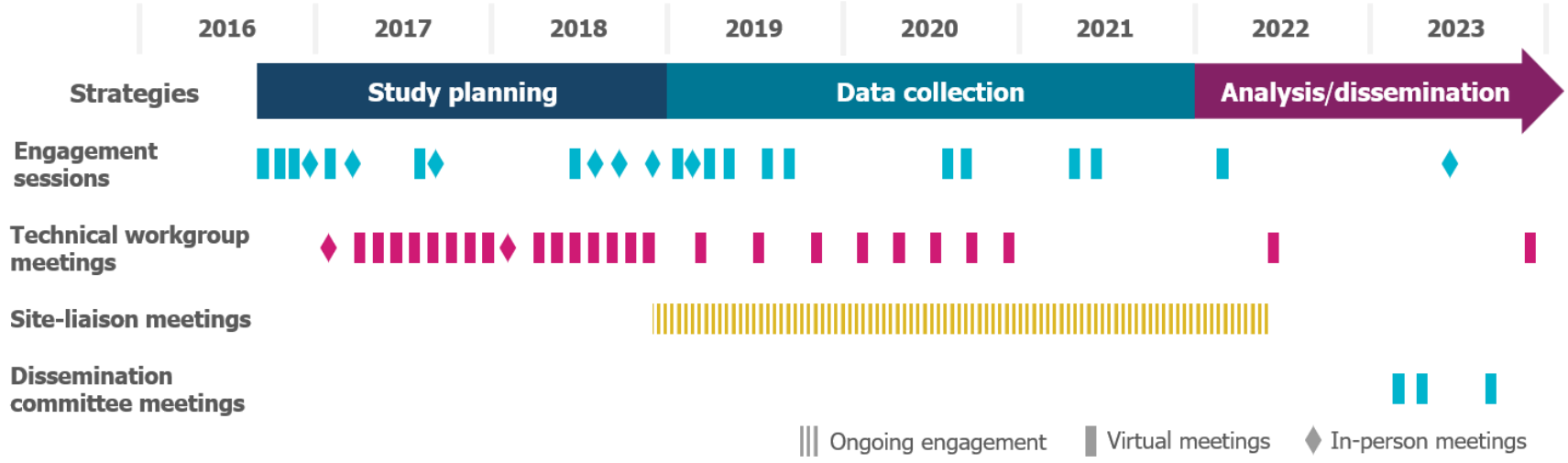
The MUSE study team used four primary engagement strategies: (1) in-person meetings with partner groups, (2) periodic virtual meetings with partner groups, (3) meetings between grant recipients and liaisons who supported grant recipients throughout data collection, and (4)

meetings with the TWG members (both in-person and virtual). Team members also used one-on-one consultation, public comment, and formal Tribal review processes to obtain input and memorandums of understanding (MOUs) to document study commitments.

During meetings with grant recipients and with the TWG, the MUSE study team used a variety of strategies to encourage all partners to provide input. The engagement strategies were tailored to the phase of the study and the partner groups attending. They included a variety of interactive activities (e.g., small groups to develop the conceptual model, world café- style discussions to identify study priorities, pilot testing data collection instruments).

Exhibit 1.2 depicts MUSE engagement activities as they occurred throughout the study timeline, including the creation of the conceptual model; the development of research aims, questions, instruments, and data collection protocols; gaining study approval from Tribal research oversight entities (e.g., Tribal Councils, Tribal Research Review Boards, Urban Indian Organization leaderships); the interpretation of findings; and review of reports (Salvador et al., 2024b). Throughout the study, partners collaboratively developed and modified (sometimes significantly) study timelines to accommodate all partner timeframes. The MUSE study is a culmination of this community-engaged process.

Exhibit 1.2. Community Engaged Activities Timeline



Engagement topics

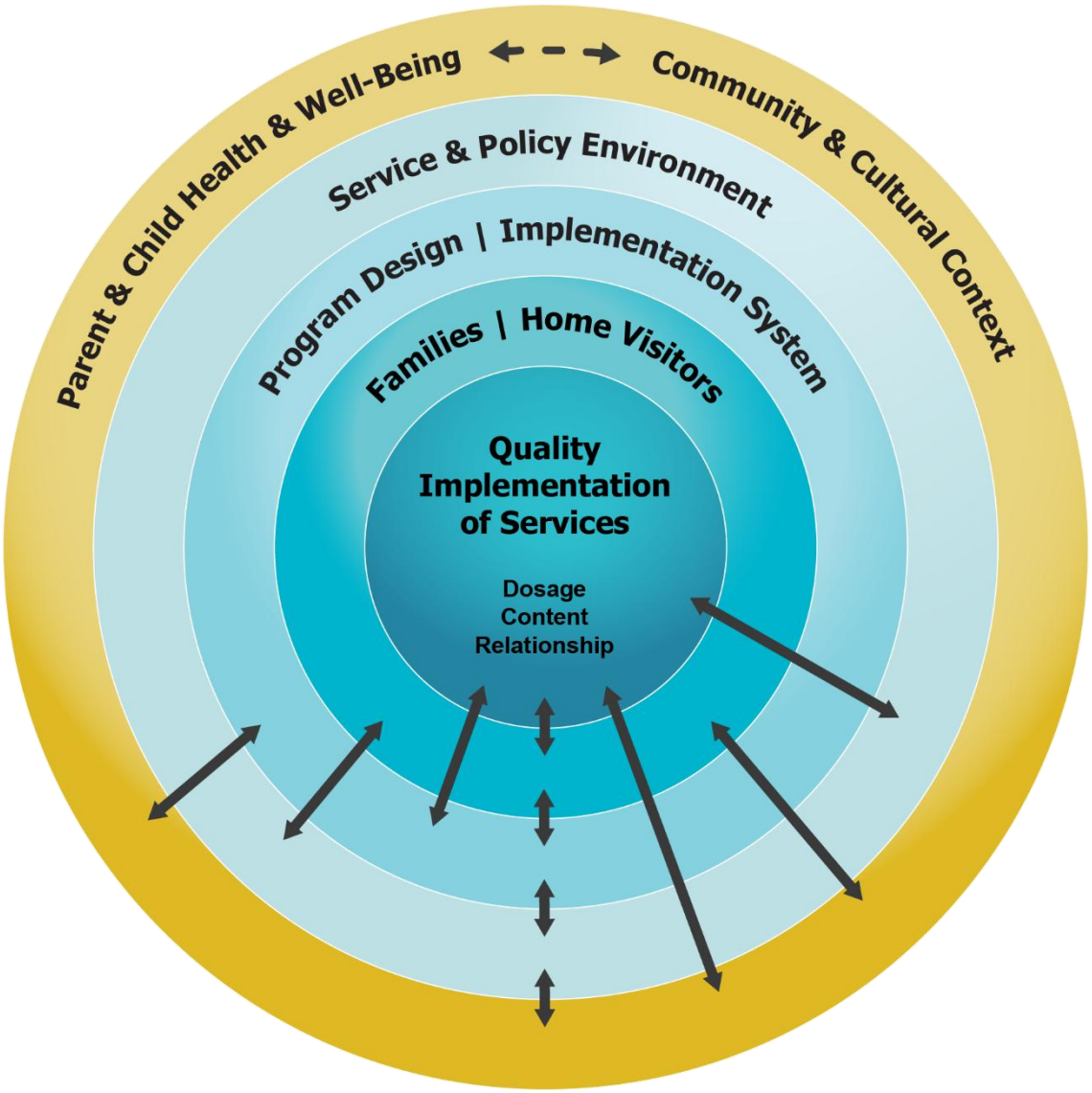
- Cocreating the MUSE conceptual model
- Developing MUSE study design and research questions
- Developing and pilot testing instruments
- Research approvals
- Developing local data collection protocols
- Developing training and support for data collection
- *Getting Ready to MUSE* video orientation series for home visitors
- Training on human subjects protection and MUSE data collection methods
- Training and ongoing support for data collection coaches (i.e., train the trainer)
- Changes to the MUSE data collection plan in response to COVID-19
- Input on mixed-methods analysis plan
- Feedback on analyses of data to address Aim 1
- Developing processes for MUSE Dissemination Review and Data Approval Committee
- Planning for MUSE products
- Participatory data interpretation

The MUSE Conceptual Model

The first step in planning MUSE was to develop a conceptual model of the implementation of Tribal MIECHV. OPRE directed the study team to build on the MIHOPE conceptual model and articulate a model of how implementation fidelity and cultural and contextual adaptation of home visiting programs relate to quality of services and outcomes in Native communities. In response, the study team initially developed a revision of the MIHOPE model that was informed by background literature and prior experience with Tribal MIECHV and resembled a linear logic model. The draft model was shared with MUSE partnering programs and Tribal MIECHV federal partners and was substantially revised following multiple virtual and in-person engagement sessions. See Salvador et al. (2024a) for more information on the process of codeveloping the conceptual model with study partners.

The resulting conceptual model shown in exhibit 1.3 features eight domains embedded in five mutually influencing systems or levels. The Parent and Child Health and Well-Being domain highlights the overarching commitment of Tribal MIECHV toward increasing parent and child health and well-being. Within this same level is Community and Cultural Context, which is a broad Native community-level domain that influences how services are designed and implemented to support parent and child well-being. Nested within this level is the Service and Policy Environment, which includes the organization or agency that houses the Tribal MIECHV Program, the MIECHV legislation and federal program office, home visiting models, referral networks, and more. The Program Design domain refers to local program-level Tribal MIECHV design elements, including the selected model; any adaptations, enhancements, or supplements; and other features described in grant recipient implementation plans. The Implementation System domain refers to the administrative features, resources, supports, and priorities of the service agency operating the program, including training and supervision of home visitors and clinical and administrative supports. The Families and Home Visitor domains refer to the home visitor–family dyads at the heart of home visiting, including the families that participate in Tribal MIECHV programs and the staff who provide services. Home visitors are staff with varying backgrounds and credentials, including parent educators, parent advocates, and nurses. Finally, at the center of the MUSE Conceptual Model is Quality Implementation of Services, which includes the services delivered (amount and content) and the relational work that contributes to services being effective and valued.

Exhibit 1.3 MUSE Conceptual Model



Through community engagement, the model shifted from one of linear inputs, outputs, and outcomes to a circular ecological structure with multi-directional influences between and among elements. It maintained a vision of Tribal MIECHV in which service delivery, conceptualized here as implementation quality (outputs/services), is embedded in layers of influencing domains that drive implementation. All layers are held within the context of the broader Native community, where parental and child health and wellness are cultivated.

This conceptual model, codeveloped with MUSE study partners, informed the development of the research questions which are discussed below.

MUSE Study Aims and Questions

MUSE had three study aims that were developed in collaboration with the 17 participating programs and other partners.

Aim 1: Identify and describe primary influences shaping Tribal MIECHV program planning.

- What is the local context that informs planning?
- How are implementation science principles reflected in local program planning?
- What is the degree of alignment between local context and implementation science principles? How are differences addressed in planning?
- How do home visiting model requirements inform program planning?
- What adaptations, enhancements, and supplements are planned? Why?

Aim 2: Identify and describe how Tribal MIECHV programs are implemented.

- How are Tribal MIECHV programs staffed and what are the characteristics of those staff?
- What services are provided to families?
- What are caregivers' experiences with services?
- What happens during home visits?
- What training, support, and supervision do staff receive?
- What are the characteristics of families served, and do those characteristics change over time?

Aim 3: Explore supports and challenges to home visiting implementation in Native communities.

- What influences relationships between home visitors and families?
- What influences what happens during home visits?
- What influences the amount of home visiting families receive?
- What influences staff self-efficacy and job satisfaction?
- What influences Tribal MIECHV programs' ability to implement their programs as intended?

Aim 1—to identify and describe primary influences shaping Tribal MIECHV Program planning—was addressed in the report *Understanding Planning for Tribal Home Visiting* (Salvador et al., 2024b). This report primarily presents findings related to Aim 2—to identify and describe how

Tribal MIECHV programs are implemented. Where possible, we present findings related to Aim 3—to explore supports and challenges to home visiting implementation. However, we were unable to directly answer many of the Aim 3 research questions due to data collection limitations resulting from COVID-19.

The research questions drove the study design, measure development, and analytic approach. Next, we describe the report structure that organizes findings around domains tied to the conceptual model and research questions.

Report Organization

The next chapter (Chapter 2) provides details on data collection methods, sample sizes, and analytic approaches. Subsequent chapters present results organized around four domains rooted in the levels of the conceptual model (see exhibit 1.3): caregivers (chapter 3), services (chapters 4 and 5), caregiver-home visitor relationships (chapter 6), and staff (chapters 7 to 9).

Chapter 3. Characteristics of Caregivers Who Enrolled in Tribal MIECHV describes the characteristics of families upon enrollment in the program including caregiver, child, and household demographics. This chapter also presents caregiver perceptions of their social support networks and parenting abilities.

Chapter 4. Caregiver Enrollment, Participation, and Experience in Tribal MIECHV Programs describes caregiver enrollment, amount and types of services caregivers participated in, length of their participation, and their experiences with home visiting programs.

Chapter 5. Inside Tribal MIECHV Home Visits: Activities, Adjustments, and Experiences describes what happened during home visits, including topics addressed, activities involved, and who participated. We present data on how visits were planned and how home visitors adjusted their plans during visits. This chapter also describes caregiver experiences with visits and highlights what they found valuable.

Chapter 6. Relationships Between Home Visitors and Caregivers in Tribal MIECHV describes perceptions of caregiver-home visitor relationships and discusses the importance of shared experience and open and honest communication in forming and sustaining these relationships.

Chapter 7. Characteristics of Tribal MIECHV Program Staff presents demographic data on Tribal MIECHV program staff and describes how they are connected to the communities they serve. We describe staff educational and professional backgrounds and personal experiences raising children. The chapter concludes with a description of program staffing, including staffing levels, staff recruitment, and hiring priorities.

Chapter 8. Training, Supervision, and Peer Support for Tribal MIECHV Staff describes the availability and use of training, supervision, and peer support. Findings on staff experiences with these supports and their perceived quality, helpfulness, and effectiveness are also described.

Chapter 9. Staff Experiences in Tribal MIECHV describes the experiences of staff as they implement home visiting, including workload, perceptions of their work environment, self-efficacy (i.e., how they feel about their abilities to do their jobs well), and reflections on job satisfaction and their professional quality of life. The important contributions home visitors make to their communities through this work are also examined.

Chapter 10. Discussion of Study Findings and Implications for Tribal MIECHV Implementation and Future Research synthesizes study results to inform Tribal MIECHV implementation strategies and suggest areas for continued investigation.

Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV



Descriptive Mixed-Methods Study Design

MUSE addressed the aims described in chapter 1 by using a rigorous, mixed-methods approach. This allowed the MUSE study team to integrate multiple theoretical approaches and worldviews into the study design and application. Using a mixed method approach increased study relevance, reduced limitations of strictly qualitative (e.g., reduced generalizability) or quantitative studies (e.g., limitations associated with statistical power), and enhanced our ability to pursue a study that was responsive to multiple partners and had a high level of scientific rigor and cultural relevance. The theoretical orientation of this study was informed by multiple domains including child development, implementation science, and community-engaged research.

Both primary and secondary data were used. We used secondary data to address Aim 1 by reviewing existing grant recipient implementation plans. Aims 2 and 3 were addressed through extensive primary data collection using interviews and surveys and collecting secondary data via administrative data submissions. Multiple data sources supported gathering information at various time points and with different modalities (i.e., quantitative surveys for quick reporting on a particular home visit and qualitative interviews eliciting more global feedback across months of service provision). Collecting data across multiple time points allowed us to expand on, and elaborate data collected at one time point (e.g., surveys of caregivers when they enrolled in home visiting) by refining subsequent data collection (e.g., refining interview protocols for caregivers). Qualitative and quantitative data were integrated during both analysis and interpretation, supporting triangulation and comparison of data across sources.

Study Participants

Study participants were from 17 home visiting programs funded through Tribal MIECHV that partnered with the MUSE study team to design and conduct the study. They included both program staff and caregivers receiving services. A description of the programs and the staff and caregiver participants is provided below.

Tribal MIECHV Programs

The participating Tribal MIECHV programs included Tribal Nations, consortia of Tribes, and Urban Indian Organizations across the country. When the study began, all had been implementing home visiting programs for at least 5 years. They varied in size, with some

programs serving fewer than 30 families at a time and others serving up to 170.[2] They implemented a variety of home visiting models, including Parents as Teachers (PAT) (n = 12), Nurse Family Partnership (NFP) (n = 3), Family Spirit (n = 2), and Parent Child Assistance Program (PCAP) (n = 1).[3] Since most caregivers (74 percent) received the PAT model, examining differences by model was not possible. To protect confidentiality at the program level, the specific programs are not named in this report.

Program Staff

Within each participating Tribal MIECHV program, staff were involved in the study in two key ways—as collaborators and participants.

Collaborators

As part of their job duties for the Tribal MIECHV grants, home visitors, program managers, program directors, and local evaluators were involved as study collaborators. In this role, staff engaged caregivers in the consent process and administered Caregiver Surveys and Rapid Reflects (described below) to those who provided consent. Some staff from each program were also involved in reporting program-level data (implementation logs and administrative data). A total of 121 staff across 17 programs were involved as collaborators.

Participants

Staff were also invited to be study participants.[4] All were invited to complete staff surveys with a total of 100 completions across the 17 programs. A member of program leadership (program manager or program director) and a small group of home visitors at each site were invited to participate in interviews about their experiences; a total of 51 staff members across 17 programs were interviewed. Both surveys and interviews (described below) were tailored to specific staff roles. Being a study participant was optional; staff were asked to complete an informed consent process and those who provided consent were sent surveys or scheduled for interviews.

[2] Number of families served reflect the maximum service capacity of the grant recipients. The actual numbers of families served may be lower due to a range of factors.

[3] One program implemented two models.

[4] Many of the 100 staff who were MUSE study participants supported data collection as study collaborators. However, some staff who were trained to collect data may not have answered the staff survey and vice versa.

Caregivers Receiving Home Visiting Services

All caregivers receiving home visiting services from the 17 participating programs were eligible to participate in the study. However, their participation in data collection varied depending on whether caregivers were already enrolled in home visiting at the time MUSE began (Existing Caregivers, *N* = 287) or enrolled while the study was underway (New Caregivers, *N* = 209). For example, only New Caregivers were invited to complete Caregiver Surveys (described below) because these included a baseline time point, when caregivers began receiving services. All other types of data in the next section were collected from both types. Data Collection Instruments and Processes

As described in chapter 1, OPRE intended MUSE to build from the MIHOPE implementation study. When developing the study design, we reviewed data collection instruments from MIHOPE, Home Visiting Career Trajectories, and other recent home visiting studies and incorporated and adapted instruments and questions from these studies that addressed MUSE research questions. All data collection instruments were selected, adapted, and/or developed by the study team in partnership with participating programs and with the Technical Workgroup. These partners reviewed existing measures relevant to the study questions; helped to adapt these measures, develop new ones as needed, and pilot test them; and helped determine the data collection schedule across instruments and participants.

This section provides an overview of the MUSE data collection instruments and the data collection processes. It also includes a description of the changes that were made to both instruments and processes because of the disruption caused by the COVID-19 pandemic.

Data Collection Instruments

The study incorporated a total of 14 data collection instruments, including 11 quantitative instruments and 3 qualitative interview guides.

Quantitative Data

Administrative Data

Programs provided administrative data for both New and Existing Caregivers receiving Tribal MIECHV services who had consented to participate in MUSE. Most of these data were collected as part of ongoing program data collection and reporting requirements for Tribal MIECHV and reported to the MUSE study twice during the study period.

Four types of administrative program data were collected on caregiver demographics, screenings (including screening for developmental delays, economic strain, substance use, and intimate partner violence), home visit participation, and group activity participation. A more extensive set of administrative data was collected for New Caregivers, as compared to a more limited one for Existing Caregivers (i.e., demographics only).

Implementation Logs

Program managers were asked to submit logs each month that included information about staff changes, training, individual and group supervision, and family group events. Logs completed for trainings, supervision, and group events included details about frequency, topics, and attendance.

Caregiver Surveys

Caregiver Surveys were created for three time points—upon enrollment into the study (baseline), again approximately 6 months later, and finally approximately 12 months after baseline. As noted above, only New Caregivers—those who enrolled during the course of MUSE—were invited to complete Caregiver Surveys. These surveys gathered information about five key constructs: household composition, social support, parenting emotion regulation, parenting self-efficacy and communal-efficacy, and caregiver experiences with home visiting.

Rapid Reflect Surveys

Rapid Reflect Surveys (Rapid Reflects) were brief surveys designed to gather data on the range of content, structure, adjustments, and approaches used in home visits. To reduce data collection burden, Rapid Reflects were only collected for a sample of home visits that occurred during one week out of each month that was randomly selected. The MUSE study team worked with program partners at the participating sites to develop these surveys—one version for caregivers and another for home visitors—to capture real-time reflections on what happened in a particular visit.

The Caregiver Rapid Reflect consisted of five questions about caregiver satisfaction with the home visit and their home visitor.

The Home Visitor Rapid Reflect included 11 questions about the visit including travel time, length and location, people participating, content covered, responsiveness of the home visitor to emerging needs and interests, challenges encountered during the visit, and engagement of the participating caregiver.

Staff Surveys

All program directors, program managers, home visitors, and local program evaluators were asked to complete a one-time staff survey on their experiences with the home visiting program.

Staff surveys contained common domains across staff roles, including professional background, role within the program, organizational culture and climate, job satisfaction, professional quality of life, perceived program effectiveness, connection to community served, and demographics. Other survey elements were tailored by staff roles, as described below.

The Program Director Survey included questions about prioritized outcomes, the program's ability to prepare home visitors, expectations of home visitors, self-efficacy in the program director role, leadership style, and perceptions of training received related to the program director role.

The Program Manager Survey asked about alignment with model prioritized outcomes, setting goals with staff, expectations of home visitors, self-efficacy in program management and supervisory role, leadership style, perceptions of their training related to program management and supervision, and experience providing supervision and home visit observations.

The Home Visitor Survey included questions about the service environment, home visit planning and resources, perceptions of and self-efficacy in the home visitor role, perceptions of training, supervision and peer support received, and reflective supervision.

The Program Evaluator Survey asked about the level of evaluator involvement with the program, frequency of communication with program staff, the data system, performance measurement and continuous quality improvement, and organizational culture and climate. Data from the Program Evaluator Survey are not presented in this report due to resource limitations.

Program Implementation Surveys

Program managers, in coordination with project directors or other staff if needed, were asked to complete a short survey on program implementation activities. This survey asked about services available in the community: funding sources, program eligibility criteria, use of incentives, staffing levels, caseloads, and home visitor recruitment and hiring.

Qualitative Data

Members of the MUSE study team conducted interviews with participating program managers, home visitors, and caregivers. They were originally planned to be conducted during site visits with each of the 17 programs. Interviews with one Tribal MIECHV partner program were completed in person prior to the onset of COVID-19. Due to COVID-19 travel restrictions, all others were conducted virtually using Zoom.[5]

Qualitative interviews were used to examine four primary areas: (1) real-world implementation, (2) home visitor support and supervision, (3) home visitor-family relationship, and (4) home visits. The interviews followed a semistructured format, allowing some questions to be consistently asked across grant recipients while also enabling grant recipient- and interviewee-specific questions to be tailored when necessary.

Program leadership interview protocols included questions about staffing; services provided; program planning; model selection and fit; adaptations, enhancements, and supplements; technical assistance; home visitor support and supervision; why families enroll; successful parenting; program impact; program manager role; and role of the community in program decisions.

Home visitor interviews included questions about home visitor support and supervision, model fit, reasons families enroll, successful parenting, family experiences, perceived program effectiveness, relationships with caregivers, what happens during a typical home visit, and a description of a great home visit.

Caregiver interviews included questions about expectations around home visiting, home visitor-family relationships, what happened during typical visits, description of a great home visit, screenings, visit preferences, support from home visitor, skills gained, and changes and benefits experienced.

Additionally, the study team added questions about COVID-19 and its impacts on services to all interview guides prior to implementing virtual interviews.

[5] After the only in-person interview with a program evaluator -, the study team decided to discontinue interviews with local program evaluators as part of the effort to decrease burden during the pandemic. Therefore, data from the single interview were not used in analysis.

Data Collection Process

The data collection plan was developed in collaboration with study partners from the 17 Tribal MIECHV programs who guided key decisions about how and when to collect data. Below we describe the data collection plan and processes.

Consent and Data Collection

Caregivers

In early planning meetings, we discussed with partners two options for collecting data from caregivers: (1) staff from the MUSE study team could interact with caregivers to obtain consent and administer surveys or (2) local program staff could be trained in human subjects protections and be the ones to obtain consent and administer surveys. Program partners preferred the second option for quantitative measures. Extensive training prepared staff at each program for the quantitative data collection activities. These are described below.

MUSE study team members recruited and consented caregivers for interviews. Tribal MIECHV program staff identified interested caregivers and provided a brief introduction to the interviews. Caregivers who were interested in participating provided permission for their contact information to be shared with the MUSE study team. Email and phone calls were also used to recruit. Informed consent was administered prior to each interview.

Home Visiting Program Staff

Informed consent, survey administration, and interviews with home visiting program staff were all conducted by the MUSE study team. Team members sent invitations to participate in surveys via email and obtained consent via REDCap.[6] For staff who provided consent for surveys, survey links were sent via email. Study team members recruited and obtained consent from program staff interview participants by email and phone. The study team scheduled interviews directly with staff who indicated interest and obtained consent before interviews began.

Data Collection Training

We engaged in a tiered approach to training and support for data collection. First, in September 2018, program staff from all 17 programs gathered on Tribal land outside of Seattle, WA, for a 3-day training. On the first day, program staff completed human subjects training using the Research Ethics Training for Health in Indigenous Communities (rEthics) curriculum (Parker et

[6] https://projectredcap.org/

al., 2019) and received their certification at the end of the day. On the second day, the study team provided an overview of data collection procedures and staff roles and trained all program staff in MUSE processes for obtaining consent from caregivers and administering Caregiver Rapid Reflects and Caregiver Surveys. On the final day, select program staff (mostly program managers and directors) received training on data collection procedures related to completing implementation logs and sharing administrative data and on use of REDCap software.

Second, in December 2018, we convened a smaller group of program staff to be trained as data collection coaches. Coaches were selected by each program and included local program evaluators, program managers, and home visitors. Coaches received more extensive training in data collection procedures, including training on use of iPads for survey data collection and received support and guidance for tailoring data collection procedures by site, as needed. Coaches were also provided with resources (e.g., data collection handbook, training slides) to assist them in further supporting local staff.

Third, we assigned a liaison from the MUSE study team to each of the 17 Tribal MIECHV programs. Liaisons met with their assigned programs monthly during the data collection period to provide additional support, monitor progress, and identify solutions to data collection challenges.

Data Collection Schedule

Quantitative and qualitative data were collected over approximately 2.5 years. Most sites (14) began collecting data in June 2019; three sites were still awaiting approval from Tribal research oversight agencies and were unable to begin data collection at that time. Data collection activities were paused in March 2020, with the onset of the COVID-19 pandemic. During this pause, the MUSE study team worked with partners at the 17 sites to make adjustments to protocols (e.g., retooling for online data collection, virtual interviews) and to obtain Institutional Review Board and local Tribal Review Board approvals for these modifications (see section on changes to study design in response to COVID-19 below for details). Data collection resumed in August 2020, with each site resuming data collection activities as they were able and as additional local approvals were in place. The three sites that were unable to begin collecting data before the pandemic received Tribal approval and were able to begin collecting data by October 2020. All data collection activities were completed by the end of December 2021. The frequency and timing of each type of data collection are shown in exhibit 2.1.

Exhibit 2.1. Data Collection Frequency by Instrument

Data collection method	Respondent	Frequency
Administrative data	Program managers, program directors, and/or evaluators (providing data on New and Existing Caregivers)	Data file submitted up to twice
Caregiver Survey	New Caregivers	Baseline, 6 months*
Home Visitor Rapid Reflect Survey	Home visitors	All home visits during one sampled week each month**
Caregiver Rapid Reflect Survey	New and Existing Caregivers	Up to once a month**
Staff surveys	Program managers, program directors, home visitors, and evaluators	Once
Program Implementation Survey	Program managers (with other program leadership as needed)	Once
Interviews	Program managers or directors and selected New and Existing Caregivers and home visitors	Once
Implementation logs	Program managers and/or evaluators (providing data on activities of home visitors and program managers)	Monthly, for up to 12 months

Note: *12-month surveys were discontinued due to the pandemic. **Rapid Reflects were collected on all home visits conducted during 1 sampled week per month, with the selected weeks varying across the months. The number and frequency of Rapid Reflects completed by individual caregivers and home visitors depend on the number of visits scheduled during sampled weeks.

Changes to Data Collection Instruments and Methods in Response to COVID-19

In March 2020, the MUSE study paused data collection until July 2020 due to the inherent risks and stressors of COVID-19. When data collection resumed, several adjustments to the protocol were made to ensure data collection was safe and feasible and could include data on the impact of COVID-19. Exhibit 2.2 describes modifications made to instruments and protocols.

Exhibit 2.2. Changes to MUSE Data Collection After COVID-19

Instrument	Change	Rationale
12-month Caregiver Survey	Discontinued survey	Reduce burden
Interviews	Conducted virtual interviews instead of in-person site visits	Ensure safety
Interviews	Discontinued local evaluator interviews	Reduce burden
Interviews	Incorporated COVID-19-specific questions reflecting on the pandemic, the public health measures undertaken to mitigate risk, and the impacts of these measures	Obtain data on the impact of COVID-19
Caregiver Rapid Reflect Survey	Discontinued survey	Ensure safety
Home Visitor Rapid Reflect Survey	Modified guidance on completing the home visit location question to indicate virtual visits by selecting "other location" and typing in virtual	Obtain data on the impact of COVID-19
Implementation logs	Reduced the number of months programs were asked to submit data	Reduce burden
Administrative data	Added home visit mode (virtual or in person) to data elements submitted	Obtain data on the impact of COVID-19

Small sample sizes, often a result of pandemic restrictions, limited what could be done with many analyses. For example, we intended to examine change over time in caregiver characteristics using the baseline, 6-month, and 12-month Caregiver Surveys, but the sample size was insufficient. Additionally, small sample sizes precluded examining most relationships between variables (e.g., supervision and home visitor job satisfaction) as originally envisioned in the analysis plan for Aim 3. Therefore, this report primarily addresses the descriptive research questions under Aim 2, with data relevant to Aim 3 presented only when rigorous conclusions could be drawn.

Final Sample by Data Collection Instrument

The MUSE study had relatively high participation rates across all data collection types. At the program level, all sites participated in administrative data collection and Program Implementation Surveys. On average, two caregivers, two home visitors, and one program manager or director from each site participated in the interviews. Most staff who were invited to participate consented and completed the process (only two declined). Staff survey response rates ranged from 63 percent for home visitors to 95 percent for local evaluators. More than half (54 percent) of new caregivers responded to the baseline survey. Each of the 17 participating sites was responsible for recruiting and consenting caregivers to complete surveys. To reduce burden on sites, tracking and reporting the number of invited caregivers was not required; thus, we are unable to provide an accurate response rate for Caregiver Surveys. Exhibit 2.3 displays the final sample sizes by data type that were used in analyses by data source.

Exhibit 2.3 Study Samples

Sample	*N*	Unit
Participants		
New Caregivers consented	209	Individual
New Caregivers withdrew	3	Individual
Existing Caregivers consented	287	Individual
Existing Caregivers withdrew	2	Individual
Staff consented	86	Individual
Administrative Data	17	Site/program
Program Implementation Survey	17	Site/program
New Caregiver Surveys*		
Baseline	112	Individual
6-month	54	Individual
Interviews		
New and Existing Caregivers	30	Individual
Home visitors	34	Individual
Program managers/directors	17	Individual
Rapid Reflect		
New and Existing Caregivers	394	Home visit

Home visitor	1,018	Home visit
Staff Surveys		
Home visitor	55	Individual
Program manager	16	Individual
Program director	10	Individual
Local evaluator	19	Individual
Implementation Logs		
Training	2,064	Session
Individual Supervision	806	Session
Group Supervision	1,501	Session
Family Group Event	253	Session

Note: The exhibit displays the maximum *N* for each data type. When survey questions were not answered, we excluded data from analyses. *The *N* for 12-month Caregiver Surveys is not included because the surveys were discontinued.

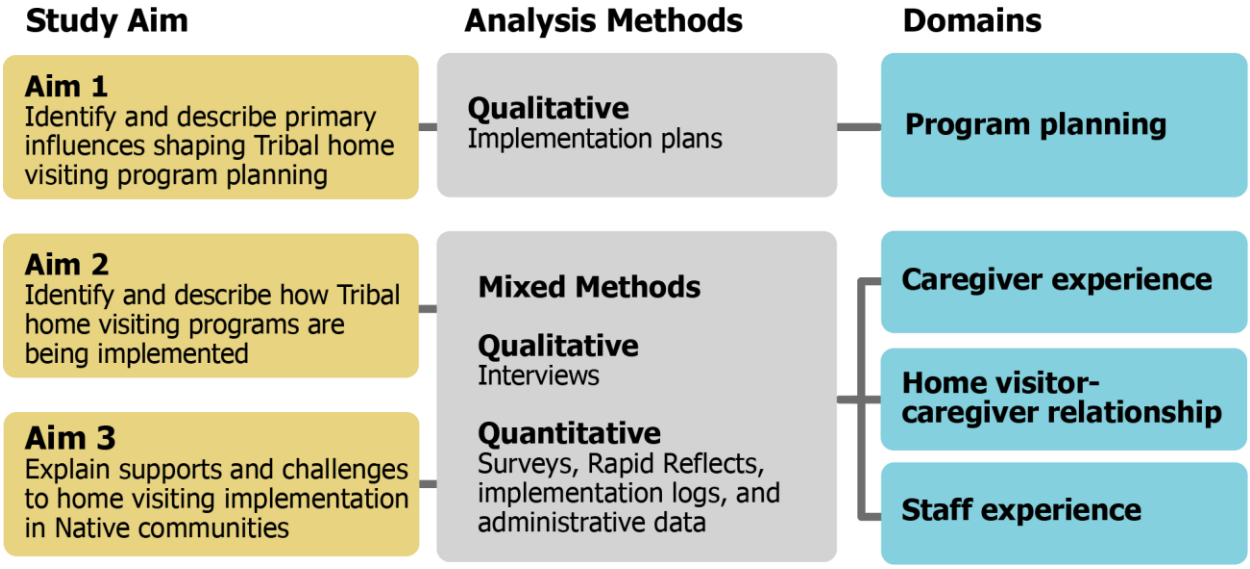
Among the 112 caregivers who completed a baseline survey, 32 (28.6 percent) also completed a follow-up survey 6 months later; 80 (71.4 percent) did not. This high rate of attrition is partially attributable to the disruption in data collection caused by the COVID pandemic.[7] Twenty-two caregivers who did not complete a baseline survey completed a 6-month survey. Thus, a total of 54 caregivers completed follow-up surveys.

Analytic Methods

In 2019 and 2020, we engaged in an intensive process to create and refine a data analysis plan to address each of the three study aims. We engaged the MUSE Technical Workgroup in several rounds of iterative review of the plan to identify the best approaches to address the study questions. Exhibit 2.4 provides an overview of how we envisioned the mixed-methods analytic process delineated through the planning process to address all three study aims.

[7] We assessed response bias for caregivers completing one survey (baseline only) compared to those who completed two surveys (baseline and 6-month) and found that the groups were sufficiently similar, so the study team was not concerned about response bias in the sample.

Exhibit 2.4. Mixed-Methods Analytic Process



To optimize integration between quantitative and qualitative methods, we used the taxonomy described by Palinkas et al. (2011) delineate the structure of analysis for each aim. As shown in exhibit 2.4, one approach addressed Aim 1 and a second approach addressed Aims 2 and 3.

The structure for addressing Aim 1 was QUAL (qualitative) and involved secondary analysis of written program implementation plans prepared by Tribal MIECHV programs at the start of their funding. The process resulted in a report published earlier (Salvador et al., 2024b).

This report focuses on Aims 2 and 3. For these, the mixed-methods structure was QUANT + QUAL (quantitative and qualitative data were collected contemporaneously, analyzed in tandem, and given equal weight), the function was convergence (to obtain different perspectives on the same questions, capitalizing on the strengths of both approaches to obtain relevant and valid information), and the process of combining data was merging (through ongoing communication and collaboration among members of the MUSE study team).

While Aim 1 and Aims 2 and 3 analyses were distinct, analysis across all three was strategically connected. Emergent concepts identified in Aim 1 analysis informed analysis of interview data (e.g., concept included as code). Aim 1 findings established a baseline description of implementation planning which was triangulated and extended through interview data to identify changes or adjustments made to implementation planning and to assess the perception of the implementation planning process.

Quantitative analysis for Aim 2 relies on basic descriptive statistics, such as measures of central tendency and distribution (e.g., average/mean [*M*], standard deviation [*SD*], percentiles) and simple associations (e.g., crosstabs, correlations). Quantitative analytic team members met weekly during the analytic period to interpret analyses.

Qualitative interview data were analyzed using content analysis, primarily through open coding (i.e., categorize material by type) and axial (i.e., establish relationships between codes/constructs). Codes included apriori codes (those established in advance of analysis to capture what was expected) and codes developed during analysis (to capture unanticipated concepts emerging in the data). The qualitative analysis team met weekly to interpret coding.

Mixing was ensured by regular meetings (approximately monthly) of the combined quantitative and qualitative analytic teams to ensure timely communication about emergent findings, integration of results across data sources, flexible analytic approaches, and optimal interpretation of findings. Team members populated Excel spreadsheets with key quantitative and qualitative findings and discussed how these data were related. In some cases, after reviewing findings across data sources, we identified additional quantitative or qualitative analyses.

The most significant, anticipated challenge to the analytic plan was collecting sufficient quantitative data from grant recipients, most notably getting a reasonable sample from each of the participating sites. MUSE relied on participating site staff to recruit caregiver participants and to also participate as staff in the data collection. The challenges to data collection on top of the other demands of delivering home visiting services in Native communities were steep and were exacerbated tremendously by the COVID-19 pandemic, which began a few months into quantitative data collection and 1 month into qualitative data collection. As a result of the pause in data collection from March to July 2020, we collected less data than projected and, as a result, scaled back the planned analyses. In addition to reduced numbers, the nature of data being collected reflected a different kind of service delivery than was underway before the pandemic forced programs to shift course. There were nuances within each data source as to what constituted a reasonable sample and what analyses were possible.

The psychometric structure and integrity of all such scales included on quantitative instruments were carefully evaluated, including reliability and exploratory/confirmatory factor analyses as appropriate. Scales were revised as warranted for these data.

Study Strengths and Limitations

MUSE was the first multi-site, multi-model study of home visiting in Native communities. The study's strengths are rooted in its community-engaged approach are described below.

- The MUSE team committed to practicing extensive community engagement from the beginning, and thus study partners were engaged early and at all phases of the study.
- The study design and data collection instruments were deeply informed by community partners. In some cases, study components were codesigned with partners including the conceptual model, Family Resources Check-In, and Rapid Reflect Surveys.
- Data collection protocols were developed in collaboration with participating sites, and program partners worked with liaisons from the MUSE team to tailor protocols to local contexts.
- Partner sites were supported through a multi-step, in-person, and virtual data collection training process; on-demand technical support; and liaisons who met with participating sites regularly to answer questions and troubleshoot issues.
- MUSE built on previous home visiting research (e.g., MIHOPE) and was able to draw from lessons learned and prior approaches.
- Despite the disruptions of COVID-19, all 17 partners remained engaged in the study and continued participating once data collection approaches and measures were adapted.

MUSE also has several limitations that should be considered when interpreting findings.

- The MUSE study was designed to be a descriptive study and was not designed to examine causal relationships between implementation factors or determine family-level outcomes.
- This MUSE study was not designed to be a nationally representative sample of all Tribal MIECHV programs; programs were not randomly selected to participate. Programs participating were from one cohort of programs that were funded in 2016 and had a grant requirement to conduct rigorous research. All Tribal MIECHV programs in the cohort opted to participate to fulfill the requirements. Within this one cohort, however, the sample included programs from across the country—from reservation, rural, and urban settings and from Tribes, consortia of Tribes, and Urban Indian Organizations. Thus, findings can be reasonably generalized to Tribal MIECHV.
- Despite the ability to continue during COVID-19, the study resulted in a smaller sample than planned, and some of the planned longitudinal data collection was discontinued. As mentioned above, this resulted in being unable to examine change over time or associations between different data elements that could explore correlations between implementation components.

- The amount and timing of data collected across sites varied considerably. Response rates for each data source and the resulting sample sizes varied by site. The timing of data collection differed by site, including whether data were collected before the start of the pandemic, during, or both. These differences constrained our ability to identify and understand variability across sites.
- While some data were collected before the pandemic hit, the ability to examine the impacts of the COVID-19 pandemic on most of the data is limited. Salvador et al. (2025) highlights some of the impacts of COVID-19 on Tribal MIECHV implementation, but most of the findings in this report—except where COVID-19 differences are noted—have to be interpreted in light of COVID-19. While many of the findings are likely generalizable to post-COVID contexts, care should be taken to consider the extent to which the pandemic impacted implementation of home visiting and to recognize that some findings may be less generalizable to current home visiting environments.

Chapter 3: Characteristics of Caregivers Who Enrolled in Tribal MIECHV

Chapter 3 at a glance

Most caregivers served by Tribal MIECHV programs were American Indian and Alaska Native (AIAN) women. At program enrollment, almost half were pregnant. Eighty percent had one or more children, with an average of 2.3 children under age 5. Household income was generally low, and most experienced economic strain. Caregivers reported strong support from family and their community. They also felt confident in themselves and their parenting. More than a third of households included other family members in addition to the caregiver's children and partner, which illustrates the family and community setting in which home visiting occurs.

Introduction

Home visiting models are designed to serve a wide range of families. Therefore, many provide services and offer curricula that cover an extensive list of topics from prenatal care and child development to attaining educational goals and accessing critical services. Understanding the characteristics of the families served is critical for home visiting programs, as it can inform all aspects of implementation, including recruitment and engagement strategies, training and support, and tailoring home visits to meet family needs.

This chapter focuses on the characteristics of caregivers and their families at the time of enrollment including caregiver and child demographics, household composition, and economic strain. This chapter also describes caregiver perceptions of their social networks and parenting abilities when they enrolled in the program. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

Caregiver Characteristics

- Most caregivers participating in the MUSE study identified as AIAN women and nearly half were pregnant at enrollment.
- Most caregivers lived with their partners, many in combination with other family members, primarily parents and siblings.
- Most caregivers had a place to live and access to health insurance or Indian Health Services. However, household income was generally low, and most experienced economic strain in at least one area.

Caregiver Perceptions of Social Support and Parenting

- Caregivers reported high levels of support within their social networks.
- Caregivers reported high levels of parenting self-efficacy and even higher levels of parenting collective-efficacy, reflecting shared caregiving among extended family and community members.
- Caregivers reported relatively high levels of attention regulation and the ability to focus attention on their children.

Family Characteristics

This section describes the caregivers and their children including demographic and household characteristics and family economic resources. We present data collected at program enrollment (i.e., baseline) from caregiver surveys and administrative program data.

Demographics of Caregivers and Their Children

Most caregivers participating in the MUSE study identified as AIAN women and nearly half were pregnant at enrollment.

Almost all caregivers (97 percent) were female, and 88 percent were AIAN, either alone or in combination with other races. Most caregivers were single, although almost a third were married. Most completed high school, and almost half (48 percent) reported at least some secondary education. The average age at the time of enrollment was 28 with considerable variability in age (14–64 years). About half of caregivers were employed, most full time. Demographic data collected by programs are shown in exhibit 3.1.

Exhibit 3.1. Caregiver Demographics

Characteristic	Caregivers *n*	Caregivers %
Sex		
Female	471	97%
Male	17	3%
Age at enrollment		
19 years or younger	46	9%
20 to 24 years	124	25%
25 to 29 years	142	29%
30 to 34 years	99	20%
35 to 45 years	71	14%
Over 45 years	11	3%
Race		
AIAN	395	81%
Black	5	1%
White	42	9%
More than one race, including AIAN	33	7%

Characteristic	Caregivers *n*	Caregivers %
More than one race, not including AIAN	7	1%
Other race	3	1%
Ethnicity		
Non-Hispanic	409	86%
Hispanic	69	14%
Marital status		
Single/Never married	299	65%
Married	133	29%
Separated/Divorced/Widowed	26	6%
Educational attainment		
Less than HS diploma	58	13%
HS diploma/GED	168	38%
Some college/Training/Technical training/Certification	134	30%
Associate's degree	41	9%
Bachelor's degree or higher	42	9%
Employment status		
Not employed	224	51%
Employed part time	55	12%
Employed full time	162	37%

Note: Data are from administrative program data (N = 493). Sample excludes data where the question was not answered. Percentages may not add up to 100 due to rounding.

Forty-seven percent of all caregivers were pregnant when they enrolled. For caregivers who were not pregnant when they began services, most (63 percent) enrolled with a child[8]—known as the index child— under 1 year of age, whereas 37 percent of caregivers enrolled an index child older than 1 year of age. The average age of a child enrolled in home visiting was 6.5 months. Boys and girls were enrolled in roughly equal numbers.

The subset of caregivers who enrolled in home visiting after the study began were invited to complete a baseline survey shortly after they enrolled. Eighty percent of caregivers who completed a survey, including those who were pregnant at the time of enrollment, said they

[8] MUSE only collected data on the index child (i.e., child enrolled in home visiting). We did not collect data on other children in the family who may have benefitted from home visiting services.

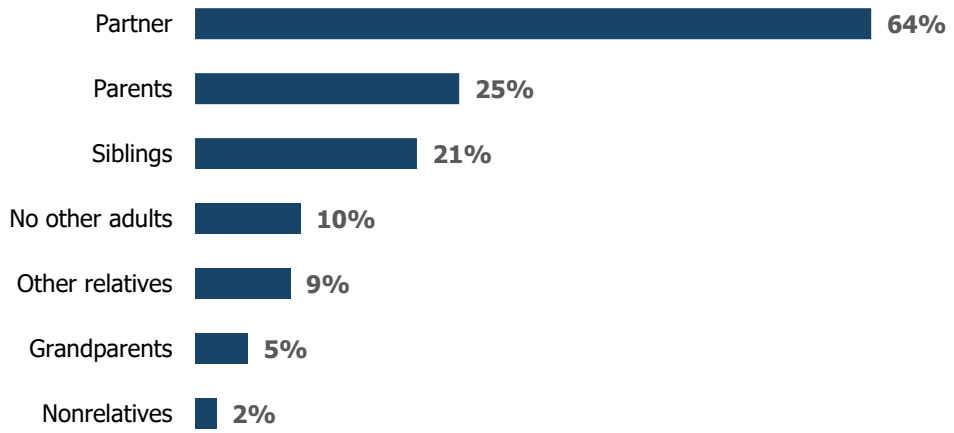
had one or more children (average 2.3 children). Nearly all the children in these families (99 percent) were under the age of 5. Thirty-three percent of caregivers had received services from the local Tribal MIECHV program prior to their current enrollment (i.e., they had participated with one or more of their older children).

Household Characteristics

Most caregivers lived with their partners, many in combination with other family members, primarily parents and siblings.

The subset of caregivers that enrolled in home visiting during the MUSE study reported a mix of housing arrangements at baseline (exhibit 3.2). Sixty-four percent reported living with their partners, 38 percent with at least one family member (e.g., parents, siblings, grandparents, other relatives), and 10 percent reported living with only their children.

Exhibit 3.2. Household Composition



Note: Data are from the baseline Caregiver Survey (*N* = 112). Percentages do not add up to 100 because multiple responses were allowed for this question.

All households spoke English as the primary language. Ten percent of caregivers reported speaking a secondary language at home, including Spanish, Native languages, and other languages.

Family Economic Resources

Most caregivers had a place to live and access to health insurance or Indian Health Services. However, household income was generally low, and most experienced economic strain in at least one area.

Nearly all caregivers had a place to live and either health insurance or access to health care through Indian Health Services. About half of the households had an annual income of $12,000 or less.[9] For caregivers that completed the baseline survey, 80 percent reported they would be able to cover basic expenses (e.g., housing, food, car) for less than 2 months if their income were to stop suddenly. Information about caregiver household resources, taken from administrative data on all caregivers enrolled in MUSE, is shown in exhibit 3.3.

Exhibit 3.3. Household Resources

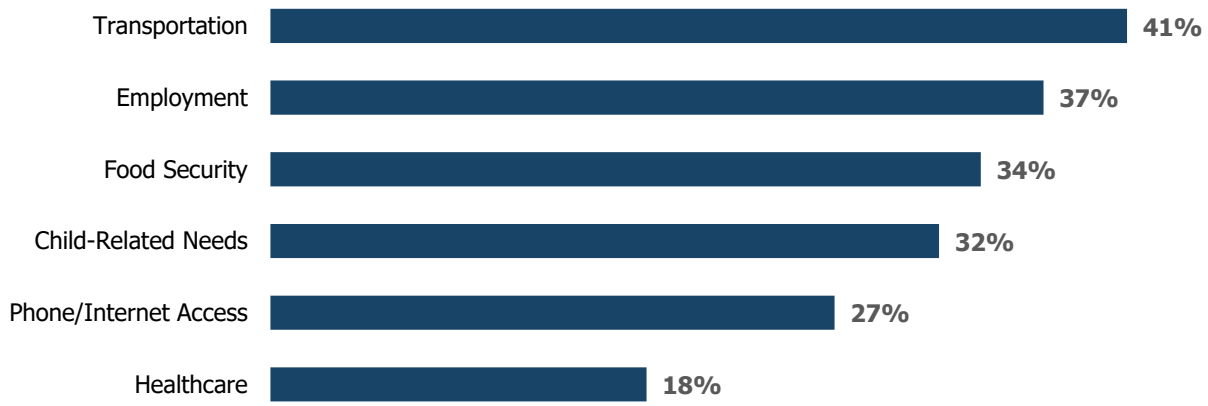
Characteristic	Caregivers *n*	Caregivers %
Household annual income		
Less than or equal to $6,000	137	33%
$6,001 to $12,000	56	14%
$12,001 to $30,000	129	31%
Over $30,000	90	22%
Housing status		
Housed	405	94%
Unhoused	25	6%
Caregiver health insurance		
Medicaid or Children's Health Insurance Plan (CHIP)	314	70%
Private insurance	89	20%
Not insured but has access to Indian Health Service (IHS)	28	6%
Not insured and does not have access to Indian Health Service (IHS)	12	3%
Other insurance	5	1%

Note: Data are from administrative program data ($N = 493$). Sample excludes data where the question was not answered.

[9] In 2020, the federal poverty level for a single individual was $12,760. https://www.federalregister.gov/documents/2020/01/17/2020-00858/annual-update-of-the-hhs-poverty-guidelines

A subset of caregivers who enrolled in home visiting after the MUSE study began completed the Family Resources Check-in (FRC). This measure was codesigned by MUSE researchers and home visiting programs to assess family economic resources. Details about the FRC and its psychometric properties in this sample are included in appendix A. Exhibit 3.4 shows that more than 30 percent of caregivers reported difficulty in four FRC domains including transportation, employment, food security, and child-related needs (i.e., money to buy things for child or lack of child care). Reports of economic strain were slightly lower for phone or internet access and lowest for healthcare needs. Fifty-nine percent of caregivers reported difficulty with at least one economic resource.

Exhibit 3.4. Families That Reported Economic Strain by Domain



Note: Data are from the Family Resource Check In assessment, submitted with administrative program data (*N* = 165). Caregivers could select more than one domain, so percentages do not add up to 100.

Caregiver Perceptions of Social Support and Parenting Abilities

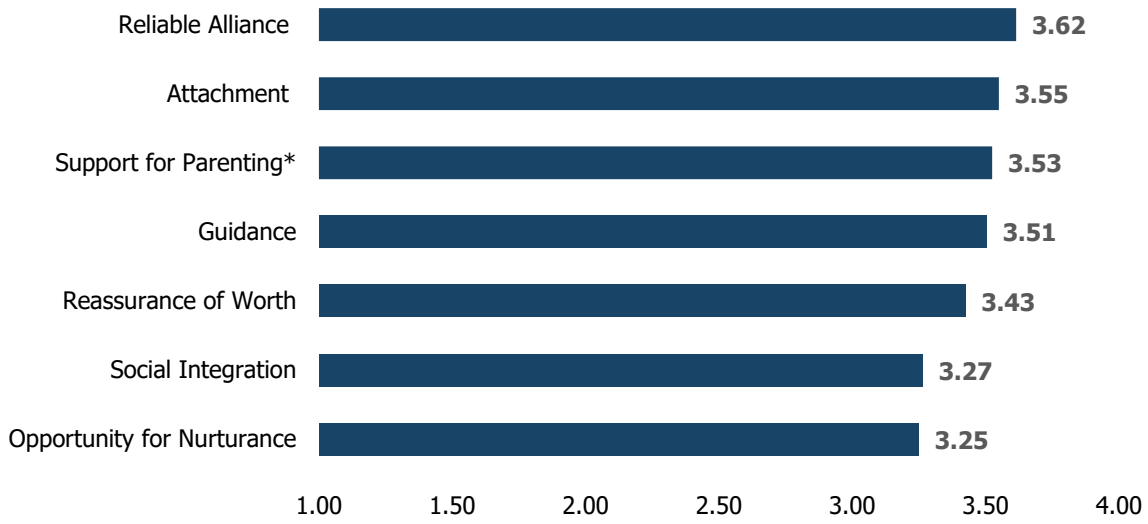
This section presents data on three domains related to caregiver and child well-being: (1) Social Support, (2) Parenting Self-efficacy, and (3) Mindful Parenting, as assessed on the baseline survey by measures listed in appendix A.

Caregiver Self-Assessment of Social Support

Caregivers reported high levels of support within their social networks. The extent and type of social support caregivers report receiving has long been associated with positive outcomes for their children (e.g., Byrnes & Miller, 2012; Cochran & Niegro, 2002; Marroquín, 2011; Sehmi et al., 2020; Taylor et al., 2012).

To assess social support, caregivers completed an adapted and abbreviated version of the Social Provisions Scale (Cutrona & Russell, 1987) when they enrolled in home visiting. The measure assessed social support across seven dimensions expected to be particularly relevant to early parenting: Attachment (close relationships), Guidance (someone to go to for advice), Opportunity for Nurturance (people who rely on you), Reassurance of Worth (people who value your skills and talents), Reliable Alliance (people you can count on), Social Integration (people who share activities and beliefs), and Support for Parenting (someone to help with parenting). Specific items for each dimension are shown in appendix A. As shown in exhibit 3.5, caregivers reported high levels of support across all seven dimensions.

Exhibit 3.5. Caregiver Perceptions of Social Support



Note: Data are from the baseline Caregiver Survey ($N = 112$). Subscale scores were calculated for each of the social provision dimensions. Response options from 1 (strongly disagree) to 4 (strongly agree); higher scores reflect greater perceived social support. *The Support for Parenting dimension was developed specifically for the MUSE study.

Interview data also addresses how caregivers experience social support. Although the enrolled primary caregivers tended to be mothers, interviews reinforced how support from others helping to care for the enrolled children was essential to their parenting. For instance, when asked who takes care of her child when she is at work, one caregiver commented:

> My dad does. He's retired, and he does a really good job taking care of them. I just have to get them ready, really because he says he can't bathe the baby. He's too small, and I understand that. My dad is super scared when it comes to bathing him, but he's pretty good at watching them. He's calmer. He's not too good when it comes to the educational piece, but when it comes to the traditional side of it, the [Native] language, all of that, he's really good at it.

Offering a similar example of family support, another caregiver described how her grandma takes care of her kids, making it possible for her to take online courses with fewer distractions: "She does an amazing job. They love their nana!"

Recognizing the importance of social support, some programs have expanded services to include other family members. As one program manager worded it, programs included "everyone that surrounds mom." Another commented:

> It's not just the caregiver that we're working with, but indirectly we're kind of touching the child's grandparents; we're touching the aunts and uncles. And so when we do our home visits, it was typical for not only the mom or dad or primary caregiver to sit with the home visitor—everyone would. You know, we had everyone coming to the table and listening to what the home visitor had to say.

Such commentary by program managers signals there is value in increasing attention on how programs may best support caregivers by recognizing and drawing upon their existing support networks.

Caregiver Self-Assessment of Parenting Self- and Collective-Efficacy

Caregivers reported high levels of parenting self-efficacy and even higher levels of parenting collective-efficacy, reflecting shared caregiving among extended family and community members.

Parenting self-efficacy is defined as a parent's belief that they can parent effectively: they have the skills and capacity to do the things needed to support their child's healthy development (Jones & Prinz, 2005; Wittkowski et al., 2017). A significant body of research has shown higher parenting self-efficacy to be associated with more successful developmental outcomes among children in the general population (Albanese et al., 2019; Jones & Prinz, 2005), but little is known about parenting self-efficacy among Native caregivers.

To assess parenting self-efficacy among caregivers participating in MUSE, we used a modified version of the Efficacy subscale of the Parenting Sense of Competency Scale-Revised (PSOC; Gilmore & Cuskelly, 2024) which is commonly used in other home visiting research. The version used had been adapted slightly by the Home Visiting Applied Research Collaborative. Details on items included are in appendix A.

Measures of parenting self-efficacy, such as the PSOC, focus narrowly on individual parenting and on a parent's belief that they can handle parenting themselves (e.g., "I have all the skills necessary to be a good parent to my child" [Gilmore & Cuskelly, 2024, p. 11]). But in Native communities parenting often involves a more collectivist approach (Allison-Burbank & Collins, 2020; Cross & Cross-Hemmer, 2014; McWilliams et al., 2011; Muir & Bohr, 2019), including extended family caregiving. Thus, we worked collaboratively with MUSE study partners to develop an additional measure of parenting self-efficacy that incorporated this collective approach and to assess caregiver beliefs about whether they can handle parenting with the help of their families and communities (e.g., "Working together with family and friends, I can solve many of the problems of caring for my child" [Gilmore & Cuskelly, 2024, p. 11]). This measure is referred to as parenting collective-efficacy. Details about this four-item measure and its development are included in appendix A.

At the time of enrollment, we measured both parenting self-efficacy using the PSOC efficacy subscale and parenting collective-efficacy among the 89 caregivers who had children. Average/Mean (*M*) levels of parenting self-efficacy across these caregivers were high ($M = 3.25$, $SD = 0.47$), with response options from 1 (strongly disagree) to 4 (strongly agree), indicating that they felt competent in their parenting abilities. Average/Mean levels of parenting collective-efficacy were even higher ($M = 3.63$, $SD = 0.50$). These findings are consistent with Native traditions of shared caregiving among extended family and community members (Coser et al., 2020) and suggest that parenting self-efficacy may be enhanced by additional resources available through collective caregiving approaches.

Caregiver Self-Assessment of Mindful Parenting

Caregivers reported relatively high levels of attention regulation and the ability to focus attention on their children.

Research into mindful parenting, including both attention and emotion regulation, has increasingly pointed to the critical role it plays in a caregiver's ability to support their children's growth and development (Coatsworth et al., 2015; Duncan et al., 2009; Shorey & Ng, 2021; Townshend et al., 2016).

Eighty-nine caregivers, who had children at the time of enrollment, completed a baseline measure of mindful parenting, including both attention and emotion regulation. The MUSE study team developed the measure to use with parents of young children by adapting several

mindfulness measures from other research (see appendix A for details on the development of the measure and items included).

Only the Attention Regulation dimension proved sufficiently reliable and is reported here. This dimension assessed the extent to which parents were able to focus on their children 'in the moment' (e.g., "I am often so busy thinking about other things that I am not really listening to my child"). Levels of attention regulation were moderately high in this sample (M = 3.85, SD = 1.04) with response options from 1 (never true) to 5 (always true), meaning parents were able to focus on their children 'in the moment.'[10]

Conclusion

This chapter described caregiver demographic and household characteristics, family economic resources, and caregiver social support and parenting confidence before receiving home visiting services. Findings show Tribal MIECHV programs are successfully recruiting AIAN caregivers, many of whom experience one or more forms of economic strain. The data also show that services are often delivered in multi-generational environments which has implications for how home visitors plan and conduct home visits. We learned that caregivers enrolled with already high levels of social support and parenting efficacy, providing an important foundation from which home visiting could build. Together, the findings presented in this chapter illuminate the environmental and relational context in which Tribal MIECHV programs operate. Chapter 3 explores how caregivers learned about Tribal MIECHV programs, their reasons for engaging in program services, and how long they participated in the program.

[10] Attention Regulation was reverse scored based on how the questions were worded (i.e., higher score indicates more attention regulation).

Chapter 4: Caregiver Enrollment, Participation, and Experience in Tribal MIECHV Programs

Chapter 4 at a glance

Caregivers learned about Tribal MIECHV programs through their personal networks or service providers. They enrolled in the program to support their parenting, promote their children's development, and engage with culturally rooted practices. Caregivers participated in 1 to 2 visits per month, each lasting around an hour. Between visits, they stayed in touch with their home visitors by text, email, and phone. On average, caregivers stayed in the program for about 13.5 months, with higher retention than seen in some studies with other populations. Caregivers reported positive experiences participating in Tribal MIECHV programs, and especially valued support directly related to parenting.

Introduction

Caregiver recruitment and retention are key program metrics that can indicate successful implementation of home visiting programs. Effective recruitment ensures that families who can benefit the most are identified and enrolled. Retention is critical because sustained participation ensures caregivers and their families receive the amount and types of services intended by the model to achieve desired outcomes.

Tribal MIECHV programs developed Implementation Plans that described how they would recruit, enroll, and engage families served by their programs (Salvador et al., 2024b). This chapter describes caregiver enrollment, the amount and types of services caregivers participated in, length of participation, and caregiver experiences with home visiting programs. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

Caregiver Enrollment

- Caregivers learned about Tribal MIECHV programs on their own or were referred by family members, friends, or service providers.
- Caregivers enrolled for many reasons including learning parenting strategies, fostering family health and child development, cultivating a parenting support system, and connecting with cultural practices.

Amount and Types of Services

- Caregivers participated in one to two home visits per month, each lasting around an hour. They were generally satisfied with how often visits happened and how long they lasted.
- Home visiting programs tailored the frequency of home visits in meaningful ways.
- Between visits, caregivers stayed in touch with their home visitors by text, email, and phone.
- Tribal MIECHV programs also offered other activities to build connections between families, often with a focus on parent-child interaction, child development, and connecting to community and culture.

Length of Caregiver Participation

- On average, caregivers stayed in the program for 13.5 months, which is longer than participation periods reported in some studies with other populations.
- Caregiver retention in Tribal MIECHV programs was higher than seen in some studies with other populations.
- Home visitor consistency, flexibility, and adaptability were likely critical to caregiver retention.

Caregiver Experience with Services

- Overall, caregivers reported positive experiences with their home visiting programs.

Caregiver Enrollment

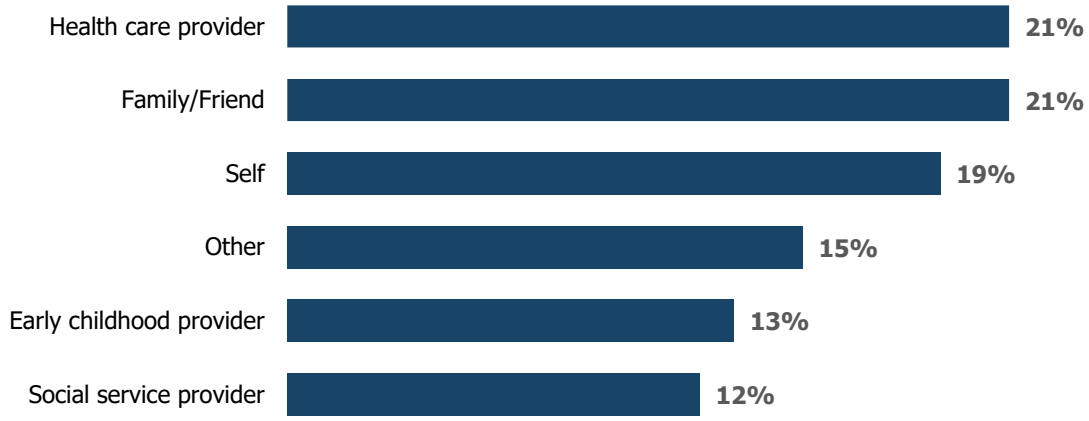
This section describes how caregivers learned about Tribal MIECHV programs and examines the wide-ranging reasons they had for enrolling in home visiting services, as reported in administrative data, caregiver interviews, and surveys.

How Caregivers Learned About Tribal MIECHV Programs

Caregivers learned about Tribal MIECHV programs on their own or were referred by family members, friends, or service providers.

Programs typically work with community service providers—health care, social services, and early childhood programs—to reach potential participants. Forty-six percent of caregivers reported they learned about home visiting through service providers, with health care providers being the most common among these referral sources (exhibit 4.1). They also frequently learned about the program from their family members or friends, many of whom had participated in home visiting and shared their positive experiences. It was also common for caregivers to report they learned about the program on their own (i.e., self-referral).

Exhibit 4.1. How Caregivers Learned About Home Visiting Programs (i.e., Referral Sources)



Note: Data are from administrative program data (N = 384). Percentages do not add up to 100 due to rounding. Examples of early childhood providers include early intervention; other home visiting programs; child care; and child development, health, and education initiatives. Examples of social service providers include Temporary Assistance for Needy Families and Women, Infants, and Children. Examples of other types of referral sources include social media, Tribal organizations, community events, community agencies, and external agencies.

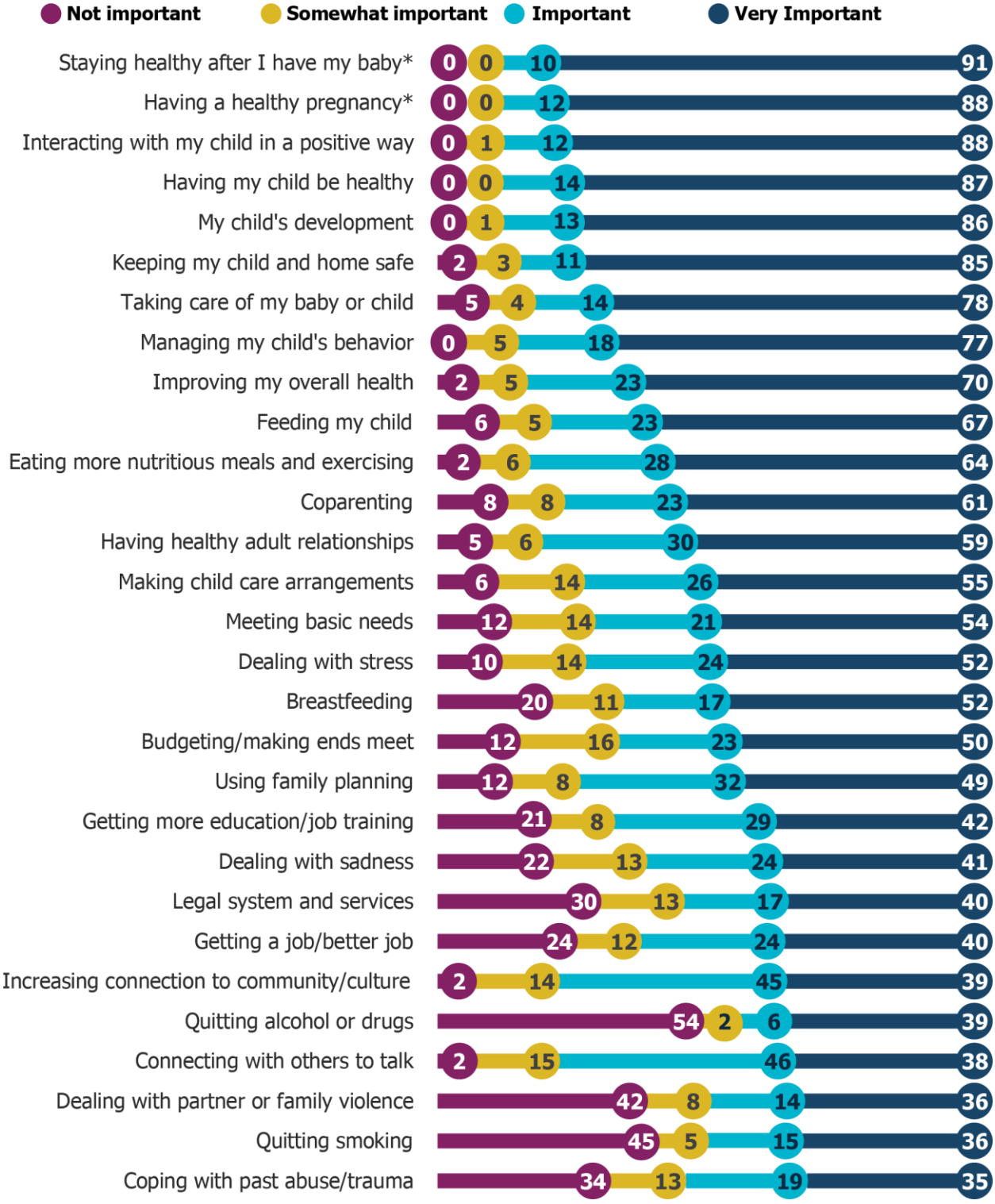
Reasons for Enrolling

Caregivers enrolled in home visiting for many reasons including learning parenting strategies, fostering family health and child development, cultivating a parenting support system, and connecting with cultural practices.

In general caregivers, who were interviewed, described enrolling in Tribal MIECHV programs to be, as one stated, "the best parent they could be." Critical to this caregiver's goal was a recognition, also shared by others, that becoming the best parent 'one can be' often necessitates self-reflection, learning, and change. Caregivers saw Tribal MIECHV programs as potentially helpful in this effort. They described enrolling in home visiting services to learn about their children's development, to fill gaps in parenting knowledge, or to find other alternatives to the parenting approaches they experienced as children.

Caregiver Survey data provide additional insights. The survey presented a list of 29 common reasons why families might enroll in home visiting. This list was aligned with the goals of the models being used by programs participating in MUSE and included broad goals for better child and parent health and well-being. Caregivers rated how important each reason was in their decisions to enroll. Exhibit 4.2 shows the percentage who endorsed each of these reasons.

Exhibit 4.2. Caregiver Reasons for Enrollment



Note: Data are from the baseline Caregiver Survey (N = 112). *Only caregivers who were pregnant at baseline were asked about these items (N = 42). Access the data in a table in appendix B.

These data align with qualitative findings and highlight caregiver interest in focusing on child development and parenting. Nearly all caregivers reported that enrolling in home visiting was important or very important to support their children's development (99 percent), interact with their children in a positive way (99 percent), keep their children and homes safe (96 percent), and manage their children's behavior (95 percent). Other top-rated reasons related to fostering their own health—either generally (93 percent) or during pregnancy (100 percent) and the postpartum period (100 percent)—and their children's health (100 percent).

As the exhibit demonstrates, caregivers rated many wide-ranging and potentially interrelated reasons for enrolling. They reported that most of the reasons presented were reasons they enrolled in home visiting; in fact, on average, caregivers rated 22 of 29 reasons (*SD* = 5.9, range = 3–29) as important or very important. These data suggest caregivers enrolled seeking services to address multiple needs and goals across different domains, with the most frequently endorsed reasons directly related to child health and well-being.

The lowest rated reasons for enrolling were areas related to caregivers themselves; these included getting a job/better job, quitting smoking, dealing with trauma and violence, or substance use. It is notable, however, that substantial numbers of caregivers cited these as important reasons for enrolling. This may reflect a desire to address their own challenges as part of achieving broader goals of supporting their children and improving their parenting. These caregivers may have been looking for home visiting programs to help bridge a gap in accessing services in these areas. While most program managers (80 to 100 percent) reported some services addressing these issues were available in their communities, accessibility was often an issue cited by caregivers.

Interview data show how first-time parents and parents without support systems, in particular, valued learning about parenting strategies. While discussing why they enrolled in a Tribal MIECHV program, one caregiver described doing so to learn "tips and tricks" related to topics like bathing, nutrition, play, and discipline. A first-time parent commented on approaching parenting as a "blank slate" and seeking essential parenting information. Another commented:

> This was my first pregnancy. I didn't have a lot of support. I had so many questions, so much fear. It was the biggest thing that happened in my life, and I didn't feel prepared for it. So, I was kind of open and happy to have as much help and resources as possible … Most importantly, what I was looking for was just like the overall basics, basic infant care and safety. I had no idea. I had never been around babies before. So, I really didn't know. You know what I

> mean? So, I was really looking forward to talking to them about just overall safety and care, what to expect when I bring the baby home. How do I safely feed it? How do I make sure they're not too hot or too cold? And how do I give them a bath? How do I check their diaper and put their diaper on?

This experience of feeling alone as a parent and looking to home visiting programs to fill that void was not uncommon. Although many caregivers described robust parenting social support, others described fewer opportunities for learning how to parent. When asked about enrolling, one stated plainly, "I didn't have nobody to teach me about kids."

Several caregivers remarked on enrolling in home visiting to learn how to parent differently than they had been parented themselves. One recounted how she and her husband experienced a "rough time growing up" and expressed their shared wish to "give our kids a better life than what we had." Together with other examples, these reflections show that caregivers often enroll curious about how to support their children to learn and grow while avoiding patterns that caused harm in the past.

In particular, caregivers described enrolling as an opportunity to connect with Native culture and community. In interviews, they talked about culture as central to parenting and child development, a benefit to parents and children alike. One caregiver who was adopted by non-Native parents commented on reconnecting to their culture:

> I lost a lot of my culture, like cultural upbringing … I wanted to teach the children what I knew, and if I didn't know, then I can't teach them. So, you know, [my home visiting program] teaches tradition and different positive parenting ways that are within Native tradition.

Another caregiver described her desire for "her and her son to stay in touch" with Native culture. Yet another emphasized "anything that has to do with our culture, I will immediately jump on it because I wasn't raised on the reservation, and I barely learned about me being Native." Likewise, another caregiver envisioned home visiting as a way out of urban cultural isolation and a way to connect with "Natives that you can talk with" in the city.

Amount and Types of Services

This section presents information on the frequency and length of home visits, family participation in family and community events, and how long families received services as reported in administrative data and implementation logs. All caregivers included in these findings had at least one home visit.[11]

Frequency and Length of Home Visits

Caregivers participated in one to two home visits per month, each lasting around an hour. They were generally satisfied with how often visits happened (i.e., frequency) and how long they lasted (i.e., duration).

Home visit frequency varies by model and is based on several factors including the model, number of family stressors, gestational age, and child age. Home visit frequency can change over time according to family circumstances. However, in their Implementation Plans, Tribal MIECHV programs established a standard expected visit frequency of two visits per month, regardless of the family length of participation or the model being implemented. On average, caregivers participated in 1.7 (*SD* = 0.7, range = less than one to 3 or more) visits per month, just under the expected visit frequency, and this frequency stayed consistent throughout caregiver participation. One quarter of caregivers received two or more visits per month (i.e., met or exceeded the expected visit frequency), whereas two-thirds of caregivers received an average of one visit per month, and less than one tenth received fewer than one visit per month.

Home visiting models have minimum requirements for visit length. Most MUSE programs (71 percent) implemented the Parents as Teachers (PAT) model, which requires visits to last at least 60 minutes ("Home Visiting Evidence of Effectiveness," n.d.). In the MUSE study, an average visit lasted

During COVID-19, families participated in fewer home visits than they had before the pandemic and visits were shorter.

On average, visits were 18 minutes shorter, regardless of mode (e.g., in person, virtual). Specifically, visits before COVID-19 averaged 64 minutes and visits during COVID-19 averaged 46 minutes. Further, prior to COVID-19, families participated in an average of 2.1 visits per month, while during the pandemic they averaged 1.7 visits per month (Salvador et al., 2025, p.4).

[11] All home visiting models that were represented in the MUSE study consider the date of program enrollment to be the same as the first home visit.

about 1 hour (54 minutes) and ranged from 25 to 150 minutes. Despite the impacts of COVID-19 on visit length (see sidebar on previous page), the average visit length was just under the average reported in the MIHOPE study (i.e., 60 minutes) which included PAT, Nurse Family Partnership, and other models not implemented by programs participating in MUSE (Duggan et al., 2018).

Caregivers were generally satisfied with the frequency and length of visits. When surveyed, 85 percent reported visits occurred exactly as often as they would like, and 96 percent said the length was exactly as long as they would like. When they were asked about how decisions were made regarding visit frequency, 26 percent reported they made the decision mostly or totally on their own, 68 percent reported they made the decision equally with their home visitor, and 6 percent reported that it was mostly or totally the home visitor's decision. When caregivers were asked about how decisions were made regarding the length of home visits, 13 percent reported they mostly or totally made the decision on their own, 74 percent reported they made the decision equally with their home visitor, and 13 percent reported that it was mostly or totally the home visitor's decision.

Home visiting programs tailored the frequency of home visits in meaningful ways.

Often, tailoring visit frequency to caregiver needs and context meant departing from model standards, as model recommendations may not fit all families or fit given families at all times. For instance, one program manager explained that model guidance determined visit frequency based on family stressors ("the curriculum says if they have this many stressors, you have to do this many visits"). But the program found these guidelines to be unhelpful. Rather, they suggested family needs may not equate directly with stressors as indicated on scored assessments of life stressors and family characteristics:

> How do you know what this family needs? How do you know? You don't know. So why are you putting that pressure? Like, because this family has that many stressors and characteristics, they have to have this many visits?

Beyond "need," parental availability was also a consideration for tailoring. One home visitor noted, while "some parents are available every week," others "are single parents, and they work, and they also have their kids" and may be unable to meet as frequently. In other words, a single parent may "need" (or benefit from) more frequent visits yet be unable to add them to the many other demands of 'getting by,' This reinforced the importance of weighing a wide assortment of factors when assessing visit frequency.

Interviewees described such tailoring as a way to enhance convenience and empowerment. One home visitor suggested using the benefits of empowering caregivers to determine visit frequency rather than determining frequency based on model guidance (such as guidance about "need"):

> I feel like when we just say "Hey, how often do you want visits and when do you want me to come see you again?" it works a lot better—when they're in control of that and it's not us that is saying, "No, I need to see you every week for 6 weeks or whatever kind of thing."

This home visitor identified putting caregivers "in control" of how often home visits happen as a facilitator of program participation. One caregiver described how being empowered to make decisions about home visit frequency supported her to continue to go to school:

> There was a point where I was doing them, I think once every 2 weeks. But I decided once a month is better for me at this time because I'm in school and everything is so busy. So, I think they really work with you too. So, if you wanted to see them on a certain day or so many times a month, they're more than willing to do that.

This quote highlights how the 'right' frequency may not be static or generalizable but depends on the circumstances of everyday life. Data suggest the importance of tailoring visit frequency as decisions about how often home visits occur are both personal and dynamic, requiring on-going flexibility.

Between visits, caregivers stayed in touch with their home visitors by text, email, and phone.

In some cases, there was significant contact between home visitors and caregivers outside of the home visit. For example, interviewees described checking in via texting. One stated:

> One family comes to mind, and I know she's struggling. I tell her weekly, I'm like, "You're doing a good job. The kids are in school. They're learning. You take some self-care time now." And she's like, "I just can't, I worry about them." I'm like, "They're in school. You know, they're safe in school, and now you're at home. You need to take a nap." I'll text her, I'll be like, "Are you taking a nap? Are you laying down?" I go and see her tomorrow, so she's so excited for me to come out. I had sent her a YouTube link to a song and I said, "I need you to sit down, and I need you to listen to this." She's like, "Okay." She texts me back and she goes, "Thank you. You made me cry, but you made me really think I am doing a good job."

In this example, texting enabled the home visitor to reinforce this caregiver's confidence between visits. Texting practices varied significantly across programs and home visitors, depending on agency protocols and personal boundary settings. Not all home visitors text with their caregivers, and others described texting within certain hours or only on business days. Such forms of contact were especially critical during the COVID pandemic. The text box to the right features findings discussed in the *Continuing Home Visiting Services During COVID-19* brief, which traces Tribal MIECHV home visiting service delivery during the pandemic.

> During COVID, "Tribal MIECHV programs used multiple modalities to continue home visiting services, including videoconferencing (Zoom, Skype, FaceTime), voice-only phone calls, text messages, and social media platforms (e.g., Facebook)." (Salvador et al., 2025, p.3)

Family and Community Events

Tribal MIECHV programs offered other activities to build connections between families, often with a focus on parent-child interaction, child development, and connecting to community and culture.

Caregivers described events hosted by their home visiting programs that brought groups of families together for shared learning about topics that aligned with the model curriculum, including parent-child interaction, child development, child safety, and breastfeeding.[12]

Caregivers also recounted participating in events (virtual and in person) in which they learned cultural practices, including how to make cradle boards, drums, and dresses and how to prepare traditional recipes with supplies provided by the program.

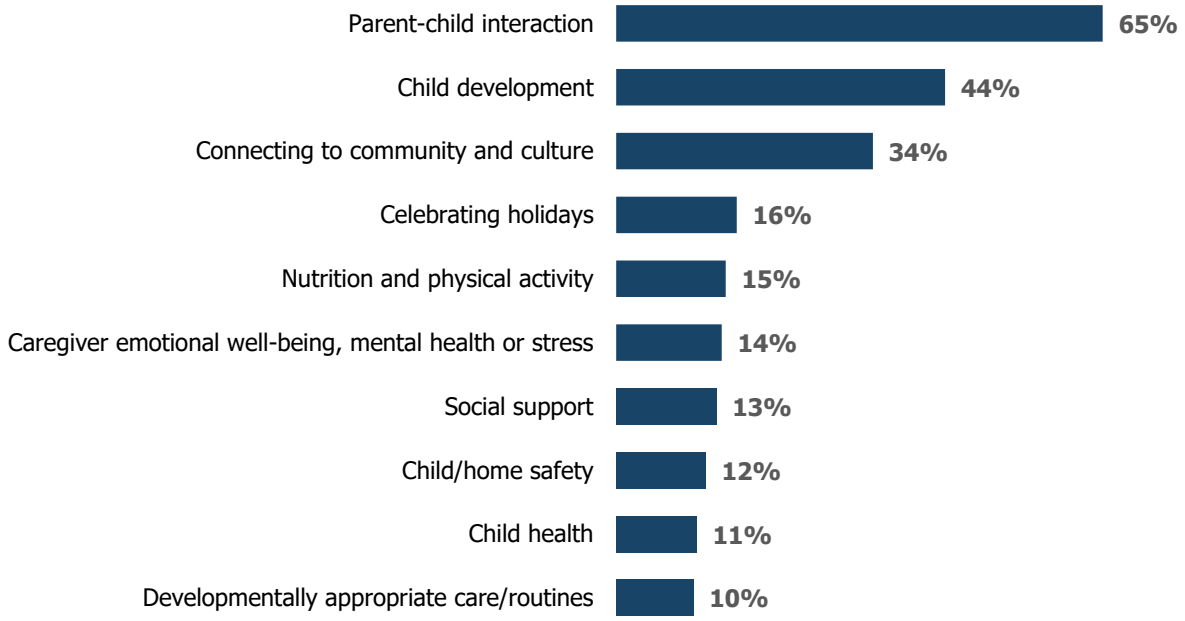
On average, programs held family group events about 1.4 times per month (*SD* = 1.0, range = 0–18) and provided an average of 2.5 hours of event time (*SD* = 2.1, range = 0.5–8) during the month. Attendance at family group events ranged from 1 to 51 participants with an average attendance of 10 (*SD* = 9.7) and median of 7.0, indicating most events were small, with a few large ones. Eighty-six percent of the events were focused on both caregivers and children; the remaining 14 percent focused on caregivers only or children only. The average number of topics covered at each event was 2.9 (*SD* = 1.7, range = 1–12). Parent-child interaction[13] was the

[12] Not all models implemented by Tribal MIECHV programs require group events.

[13] Parent-child interaction included discussions of communication (e.g., speaking, reading, singing to the child), responsiveness (e.g., paying attention to each other, adhering to needs), sensitivity (e.g., feelings, positive regard), and parent and child attachment. It also included observation of parent-child interactions and reflections on observations.

most frequently covered topic (65 percent). Exhibit 4.3 displays the frequency of topics covered during family group events.

Exhibit 4.3. Topics Covered During Family Group Events



Note: Data are from the implementation logs. Sample includes 12 programs that provided family group event data (*N* = 195). Percentages exceed 100 because each group event may cover multiple topic areas.

One caregiver noted that the program motivated them to live a healthier life:

> This program has given me the motivation to seek out things—like better healthier options for me, like emotionally, mentally, healthier—not just for me but for the environment too. Like they are the best. They recycle. They fish and they berry pick!

Another emphasized how the program facilitated a nonjudgmental (re)entry into Native culture for them and their children:

> It's really important to me because I lost that as a kid. It makes it awkward trying to re-enter it because you go to a pow wow and you want to dance, but you don't know how to. And as an adult, it's a lot harder … It's like you're kind of an outsider if you didn't grow up on the rez. So, for programs to teach you how to enter it in a positive way, for your kids, is kind of rare.

Caregivers described how deeply they valued the programs' support of cultural reengagement efforts.

Caregiver Retention

This section describes caregiver retention or length of participation in the program. MUSE explored two measures of retention: the average number of months caregivers participated and retention rates. For both measures, we examine the amount of time between program enrollment (i.e., start of services) and the last home visit or the program exit date.

Length of Caregiver Participation

On average, caregivers stayed in the program for 13.5 months, which is longer than participation periods reported in some studies with other populations.

Length of participation in Tribal MIECHV programs across all models averaged 13.5 months following the first visit. Previous studies, including MIHOPE and EBHV, reported that families continued receiving home visits, on average across models,[14] for about 8 months (Daro et al., 2012; Daro et al., 2014; Duggan et al., 2018). Thus, on average, Tribal MIECHV caregivers participated 5.5 months longer than past studies with other populations reported. The range of caregiver participation in Tribal MIECHV was less than 1 month and up to 26 months.[15] Even though participation in Tribal MIECHV programs was longer than previous studies, it was still significantly less time than the evidence-based models recommended. For all models implemented by Tribal MIECHV programs, the recommended length of participation is at least 2 years.[16]

[14] MIHOPE models included Early Head Start, Healthy Families America (HFA), NFP, PAT. EBHV models included HFA, NFP, PAT, SafeCare, and Triple P.

[15] Caregiver participation was limited to caregivers who enrolled in home visiting after MUSE began. The longest time caregivers could remain in Home Visiting was 26 months, which was the duration of MUSE data collection.

[16] For NFP, a participant must enroll prenatally before the 28th week and can be served until the child turns 2 years old (Home Visiting Evidence of Effectiveness, n.d.). For Family Spirit, a participant must enroll prenatally before the 28th week and can be served until the child turns 36 months (Home Visiting Evidence of Effectiveness, n.d.). For PAT, families can enroll anytime between pregnancy and kindergarten entry. (Home Visiting Evidence of Effectiveness, n.d.). For PCAP, participants can enroll during pregnancy or up to 24 months postpartum (Parent-Child Assistance Program, n.d.).

Caregiver Retention

Caregiver retention in Tribal MIECHV programs was higher than seen in some studies with other populations.

Ongoing caregiver participation in home visiting services was examined by using retention rates.[17] A retention rate is a calculation indicating what percentage of caregivers were still participating in the program or receiving visits at key time points (e.g., 6 or 12 months post program enrollment). In this study, we calculated retention rates using administrative data (i.e., start date, date of last home visit) provided by grant recipients and examined them across the entire study period (exhibit 4.4). Over 80 percent of caregivers were still receiving home visits 6 months after their first visit, 52 percent at 12 months (compared to 46 percent retention at 12 months reported in the MIHOPE study) (Duggan et al., 2018), and 10 percent at 24 months. When we examined retention by month, the biggest reductions (around 8 percent) were at 6, 12, and 22 months. In contrast, the MIHOPE study found the steepest drop in retention occurred between 1 to 2 months of services, which suggests that Tribal MIECHV programs may be using strategies that are effective in retaining families past the 2-month mark (see below for strategies supporting retention). A subgroup analysis[18] showed that caregivers who were pregnant at study entry (61 percent) had a higher retention rate at 12 months compared with caregivers who were not pregnant at study entry (45 percent).

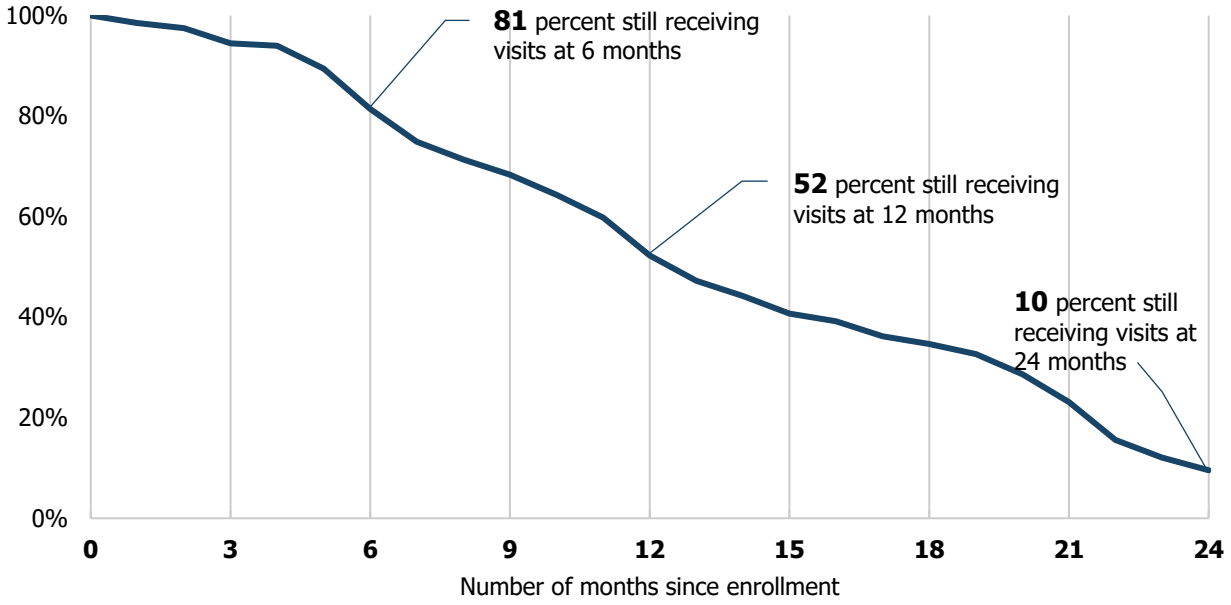
Retention rates were lower for families that enrolled during COVID-19 compared to families that enrolled before.

Caregivers who enrolled in Tribal MIECHV programs before COVID-19 had higher retention rates at both 6 and 12 months compared to caregivers who enrolled during the pandemic (Salvador et al., 2025, p.11).

[17] The retention period for caregivers with at least one home visit is calculated from the date of the first home visit or enrollment date (whichever is later) and ending with either the last visit date or the end of data collection (whichever is earlier).

[18] Of new caregivers that enrolled in home visiting after the MUSE study began.

Exhibit 4.4. Caregiver Retention Rates Through 24 months



Note: Data are from administrative program data ($N = 199$). The retention rate for each caregiver is calculated from the date of the first home visit or program enrollment date (whichever is later) and ends with either the last visit date or the end of data collection (August 31, 2021), whichever is earlier. A caregiver is considered still enrolled for the month if they received a home visit in the following month.

Strategies That Supported Caregiver Retention

Home visitor consistency, flexibility, and adaptability were likely critical to caregiver retention.

Throughout interviews, program staff and caregivers reiterated that consistent check-ins during and outside of the home visit had a positive impact on retention. As a program manager commented, quick check-ins with families "just to say like hey, how are you doing, do you need anything ..." can go a long way to support caregiver engagement and retention. Such efforts, via text, phone calls, and social media check-ins, were described as especially important for families whose engagement was sporadic. When asked about caregiver retention, one program manager referenced "just staying in contact with that family" and "just checking in." These descriptions suggest that check-ins helped home visitors keep in touch and provide important resources to families. One program manager reflected on what kept families in the program:

> ... being like, "Hey, I found this great resource that's happening over the weekend." You know, maybe it's a food box drive or a back-to-school backpack drive or something that would benefit the family. I think those can go really a long way with the families too and so that continues to help build that rapport between the home visitor and the family and the family can be like, "Oh okay,

> I'm glad my home visitor was able to provide this resource even though I didn't request for it. It just shows that my home visitor is keeping me in mind when it comes to resources and if it benefits me then I will go attend that resource but just little things like that."

In addition to consistency, interviewees described flexibility, such as meeting families "after hours," as critical to ongoing caregiver engagement and retention. Flexibility in frequency of home visits was also mentioned as a way to enhance length of participation. For example, one program increased the frequency of home visits for families who were newly enrolled after finding that families stayed longer in the program if they made it to the 3-month threshold. This approach helped the home visitor and family establish a critical rapport by getting "a little bit deeper, sooner" and is an example of a strategy that may have positively impacted retention rates at 6 months (see previous section).

In interviews, home visitors reflected on how consistently checking in with families and providing the flexibility to support robust and enduring participation required them to be highly adaptable. In one example, a home visitor talked about becoming frustrated when "families are constantly rescheduling ... not really keeping their schedules." When this happened, she described reminding herself that caregivers are not only caregivers in home visiting. Mothers are more than mothers. As women in Native communities, they have responsibilities extending beyond the program and their role as parents. As a mother herself, another home visitor empathized,

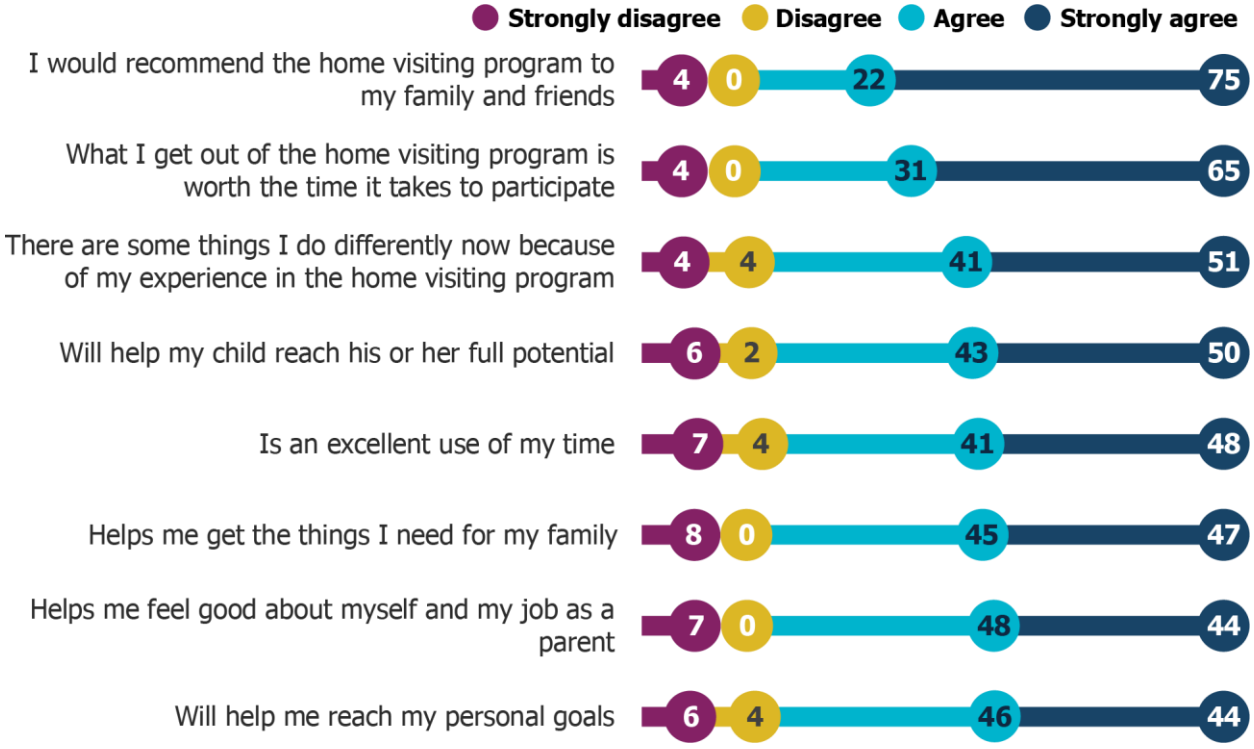
> I've been in their situation. I have been in their shoes. As a mother, I know there's a lot of responsibilities. And, as a Tribal member, we come with a lot of responsibilities too because we're women. We not only carry the mother role model or the title, we carry everything that involves our community. We are a daughter. We are a granddaughter. We are a sister. And, being a female role model takes a lot of commitment to not just our children but to others … I'm just very patient with them. So, I think when families see that, how I'm not so pushy, I'm not so forceful with services, they come back on their own.

According to this home visitor, personally knowing this reality for mothers enrolled in the program, and being able to adapt was part of what brought them back to the program time and again. This reflection also highlighted the balance between consistency, flexibility, and adaptability.

Caregiver Experience With Home Visiting Programs

Overall, caregivers reported positive experiences with their home visiting programs. On the 6-month survey caregivers responded to statements about their experiences including their beliefs, thoughts, feelings, and overall satisfaction. Exhibit 4.5 displays the statements and the percentage of caregivers that responded in each category. Across all statements, more than 91 percent of caregivers agreed or strongly agreed, indicating their positive experiences with Tribal MIECHV programs.

Exhibit 4.5 Caregiver Experience With Home Visiting Programs



Note: Data are from the 6-month Caregiver Survey (*N* = 54). Access the data in a table in appendix B.

In interviews, caregivers reflected on their participation in Tribal MIECHV programs. Recognizing that parenting is a difficult endeavor, one caregiver emphasized the impact of new information, "The program definitely gave me more knowledge. I mean, raising kids ain't easy, but it's making it a little bit easier from all the information that I've been given."

Another described how they benefited from the program and continued to apply what they learned:

> Everything with the program has been amazing. It's been great. You know the stuff that they provide, the resources, the pamphlets, the understanding of how

> child's brains work—all that stuff is very informational. So, we continue to use everything that they provide for us … The only change that we would like to see is if they would keep it until 10 … or higher.

This sentiment, that home visiting should continue longer, even into adolescence, came up in multiple interviews. For one caregiver, the support she received from her home visitor helped her feel accompanied in parenthood:

> I am a single mother, I guess, technically by the book ... [but] I don't feel like a single mom because when I have questions about parenting—am I feeding them too much or am I spoiling her or boundaries anything like that—when I need feedback or reinforcement for good parenting strategies, [the home visitor] is right there.

As this quote suggests, feedback and positive reinforcement from home visitors may make caregivers feel they are not alone as parents. Overwhelmingly, MUSE data show that caregivers were satisfied with Tribal MIECHV services, especially the parenting support provided.

Conclusion

This chapter described caregiver enrollment, participation, and experiences with Tribal MIECHV programs. Findings show that home visitor flexibility, family and community events, and positive caregiver experiences helped to bolster program participation. Home visitor strategies, including flexibility with visit schedules, communicating between visits to check in, and engaging in more frequent visits soon after enrollment, may have contributed to the higher retention rates seen in Tribal MIECHV programs compared to previous studies with other populations. But we weren't able to directly assess the influence of these factors. Moreover, program offerings like family and community events aligned with caregiver reasons for enrolling in the program (e.g., parent-child interaction, child development, cultural practices) which may have also contributed to positive retention rates. Caregivers participating in Tribal MIECHV programs were satisfied with the services received. Clearly their positive reflections were being shared with family members and friends in the community, resulting in new caregivers learning about Tribal MIECHV programs. The findings in this chapter highlighted the successes of Tribal MIECHV programs in serving families in ways that help them feel supported in their parenting and effective program implementation strategies for recruitment and retention efforts. In the next chapter we take a look inside Tribal MIECHV home visits, including how home visitors plan for visits, topics and activities covered, types of adjustments made during visits, and caregiver experiences with home visits.

Chapter 5: Inside Tribal MIECHV Home Visits

Chapter 5 at a glance

Home visits typically focused on child development, parent-child interaction, and goal setting, with the primary caregiver and child as the main participants. Home visitors drew on their relationships with caregivers to plan visits and adjust in real time based on the families' emerging needs and preferences. Home visitors demonstrated flexibility by adjusting visit timing, activities, and data collection processes to keep caregivers and children engaged and maintain trusting relationships with families. Caregivers felt that home visitors responded with warmth and care and valued the practical and social aspects of home visits the most.

Introduction

Chapter 4 described participation in the broader Tribal MIECHV program which included home visits, family group activities, and community events. This chapter explores what happens within home visits specifically, the core service provided by Tribal MIECHV programs. Visits can address many topics and involve different activities guided by the model curriculum. What happens in home visits depends on the child's age, length of time in the program, and a family's goals, interests, and needs. While home visitors create plans that provide a framework for topics and activities for each visit, what happens during visits is also determined by recent family experiences, needs, and preferences that are shared during the visit and home visitor responses in the moment. Understanding what happens during visits and how home visitors adapt to emerging issues can inform efforts to strengthen implementation, including guidance for tailoring visits to individual families, family recruitment and engagement, staff training, and reflective supervision.

This chapter describes what happened during home visits, including topics addressed, activities involved, and who participated during home visits. We present data on how visits were planned and how home visitors adjusted their plans during visits. Finally, this chapter describes caregiver experiences with visits and highlights what they found valuable. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

What Happens During Home Visits

- Caregivers described home visits as typically including check-ins, information sharing, developmental assessments and activities, and connections to resources.
- The primary caregiver and index child were the main participants in home visits, with other family members participating less often.
- When asked about the approximate amount of time spent on six key activities during visits, home visitors reported spending the most time providing emotional support and educational information/curriculum content.
- Child development, parent-child interaction, and caregiver emotional well-being and stress were the topics most frequently discussed during home visits.
- Collaborative goal setting took place during most visits. Caregivers were satisfied with this process, and home visitors found setting goals with families valuable.

Home Visit Plans and Adjustments

- Home visitors used model guidance and curriculum and sometimes supplemental materials to plan home visits. When tailoring their plans, home visitors considered what they knew about each family and the connections they had built with them.
- Home visitors modified plans during visits to manage time, respond to caregiver needs and preferences, and adjust to evolving issues ranging from a child's mood to emerging crises.

Challenges Experienced During Home Visits

- Home visitors reported challenges with caregiver or child engagement in about one-third of visits. They responded by adjusting visit plans or rescheduling visits.
- Home visitors reported that data collection hindered relationship building and limited time with families. To address these concerns, they delayed, spread out, or integrated data collection throughout the visits to reduce burden and maintain rapport.

Caregiver Experiences During Home Visits

- Home visitors displayed warmth and responsiveness to caregiver needs, feelings, and interests.
- Caregivers felt home visitors worked with them to plan and carry out home visits based on their family needs and preferences.
- Nearly all caregivers found home visits interesting, useful, and a good use of time.
- Caregivers said they especially valued the practical support and social connection they received during home visits.

What Happens During Home Visits

This section presents data on what happens during home visits. We present interview and survey data to describe typical home visits, including participants, use of time, topics discussed, and the goal setting process.

Inside a Typical Home Visit

Caregivers described home visits as typically including check-ins, information sharing, developmental assessments and activities, and connections to resources.

One caregiver described a typical home visit:

> We sit down. We talk and we catch up. We weigh my daughter. We check her length, the circumference of her head, and kind of see where she's at. … She brings—each month that she comes and corresponding with whatever age she is—she'll bring a paper that shows different activities that you can do with the child or what they should or could be doing right now. Yeah, that's about it, but most of it is just talking and catching up. If I have any questions about what's going on, she's answering them. Yeah, that's pretty much a visit.

While this example focuses on physical indicators of child development, another example highlighted how home visits focused on a child's developmental skills relative to a norm or standard but also to parental expectations:

> [My home visitor] talks about what are new things that I have noticed since the last time we spoke about a week ago ... about my son. What are new things that he's doing, new developments? How, based on my expectations, how well is he coming along and so on and so forth? What am I doing to support it and so on. We talk about his eating habits, his sleeping habits. We talk about the routines of activities that a child his age needs and then we talk about, is he reaching that? What am I doing to support that? And, if there's anything that isn't working out and I would like to talk about, how can she support to make sure that he is able to get the time that he needs ... stuff that he needs throughout the day.

Learning Activities in the Home Visit

It's a coordination and aiming activity. So, it's just bringing out any kind of basket whether it's a laundry basket, a tote box, anything that you can aim a ball into. The other example, using something in the home, is water bottles. So, using empty water bottles and putting a little bit of water or sand in it to make a bowling set…And then, with babies, using the tissue box and having babies go into the tissue box and kind of grab [things] and talking about the texture and the color of it and different things like that.

—Program Manager

In the following description, another caregiver described a typical home visit as starting off with an activity led by a beloved visitor:

> Well, my [home visitor] will come in, and she always has like an activity to do. A lot of time, we start with that, just because my kids love my [home visitor]. So, when she walks in, they want her attention. So, a lot of times we start with the activity; and then while we're doing the activity, you know she's going over with me on what motor skills it helps with, things like that and then as the kids are ... Once we have them going and doing the activity, and they're more independent on it or doing it—that's when her and I will get to talk … So, that's normally when we get into the mom advice, or even like the resource advice. That's a really big one for me with my [home visitor]. She knows what resources [the community] has to offer, and she is my go-to.

In these descriptions, home visits include a similar pattern of assessing how each family is doing at the time of the visit, providing information or education on child development through pamphlets or activities (example provided in text box to the right), and connecting families to resources beyond the visit.

Family Members That Participated

The primary caregiver and index child were the main participants in home visits, with other family members participating less often.

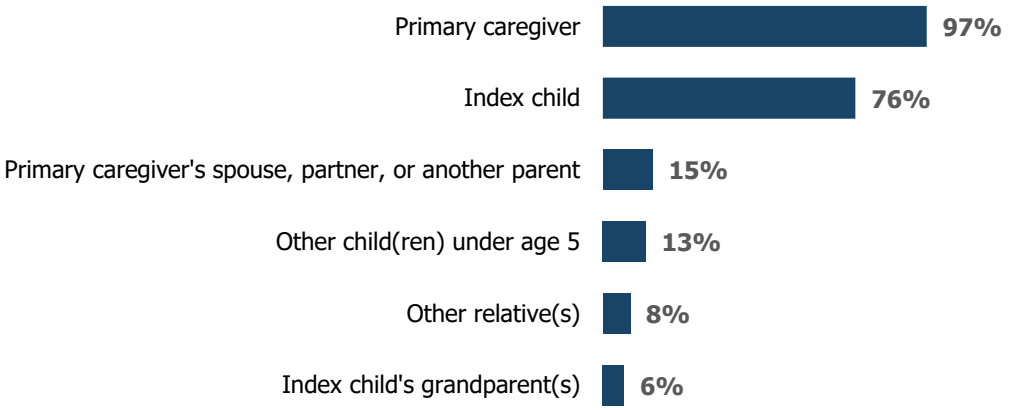
Data from the Home Visitor Rapid Reflect (exhibit 5.1) showed that primary caregivers participated in nearly all home visits and that the index child participated in three-fourths of the visits.[19] Other family members actively participated in some visits, including the primary caregiver's spouse or partner, other children under age 5, grandparents, and other relatives. On the 6-month Caregiver Survey, more than 85 percent indicated their home visitor spent most of the time talking with both the caregiver and the index child. Among visits attended by other family members, 42 percent of the time the home visitor talked with all family members but mainly focused on the caregiver and index child, 39 percent of the time all the family members were included, and 18 percent of the time the home visitor only focused on the caregiver and index child.

Interview data described how, while less common, participation of family members other than the caregiver and index child could enhance the home visit. In one example, a home visitor was using bubbles as a developmental activity with a baby. When the baby was too afraid of the bubbles to participate, her older sister saved the day by demonstrating how much fun playing

[19] Home visiting models included in the MUSE study may require the parent and the child (if born) to be present for a visit to be counted as a completed home visit. If the parent is not present, the encounter may not meet model criteria for a completed visit.

with bubbles could be, which resulted in the baby joining them. This example showed how siblings can be wonderful and uniquely effective teachers too.

Exhibit 5.1. Visit Participants



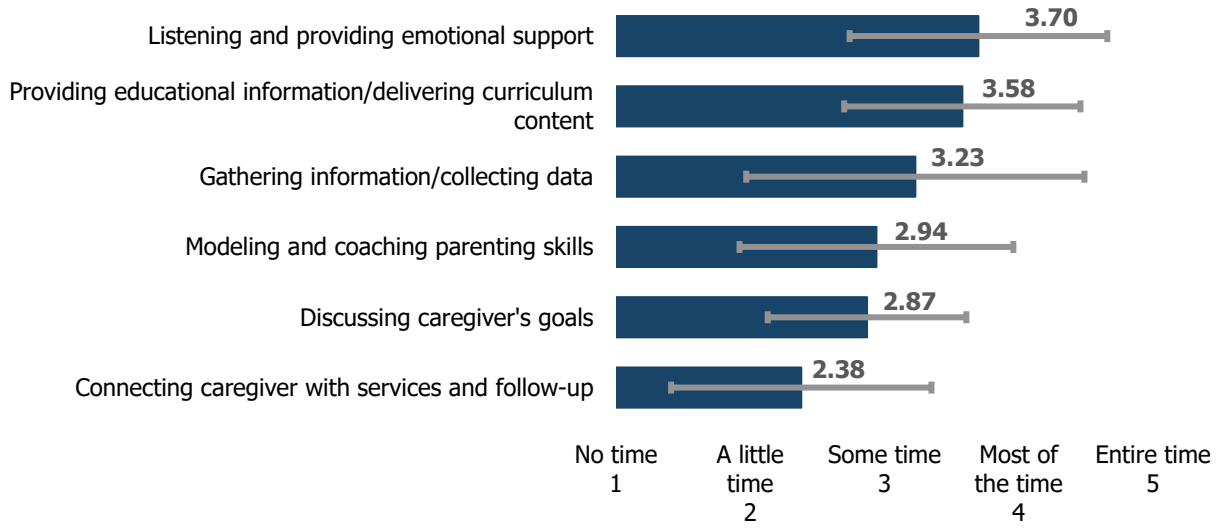
Note: Data are from the Home Visitor Rapid Reflect Survey (*N* = 1,017 home visits for 288 caregivers). Data are aggregated and weighted by caregivers. Percentages do not add up to 100 because multiple responses were allowed for this question. Some caregivers may have been pregnant at the time of the Rapid Reflect, and thus the index child may not have been recorded as present at the visit.

How Time Was Spent During Home Visits

When asked about the approximate amount of time spent on six key activities during visits, home visitors reported spending the most time providing emotional support and educational information/curriculum content.

The Home Visitor Rapid Reflect Survey asked home visitors to report the approximate amount of time spent on six key activities commonly carried out during home visits. For each activity, home visitors noted about how much time they spent, on a scale from 1 (no time) to 5 (entire time). Exhibit 5.2 displays responses collected across the sampled visits indicating the average time spent on each activity. Home visitors spent the most time listening and providing emotional support, followed by providing educational information/delivering curriculum content. Given this study was conducted during the COVID-19 pandemic, it's not surprising that home visitors prioritized listening and providing emotional support. They spent the least amount of time during visits connecting caregivers with services and following-up.

Exhibit 5.2. Average Time Spent on Key Activities During Home Visits



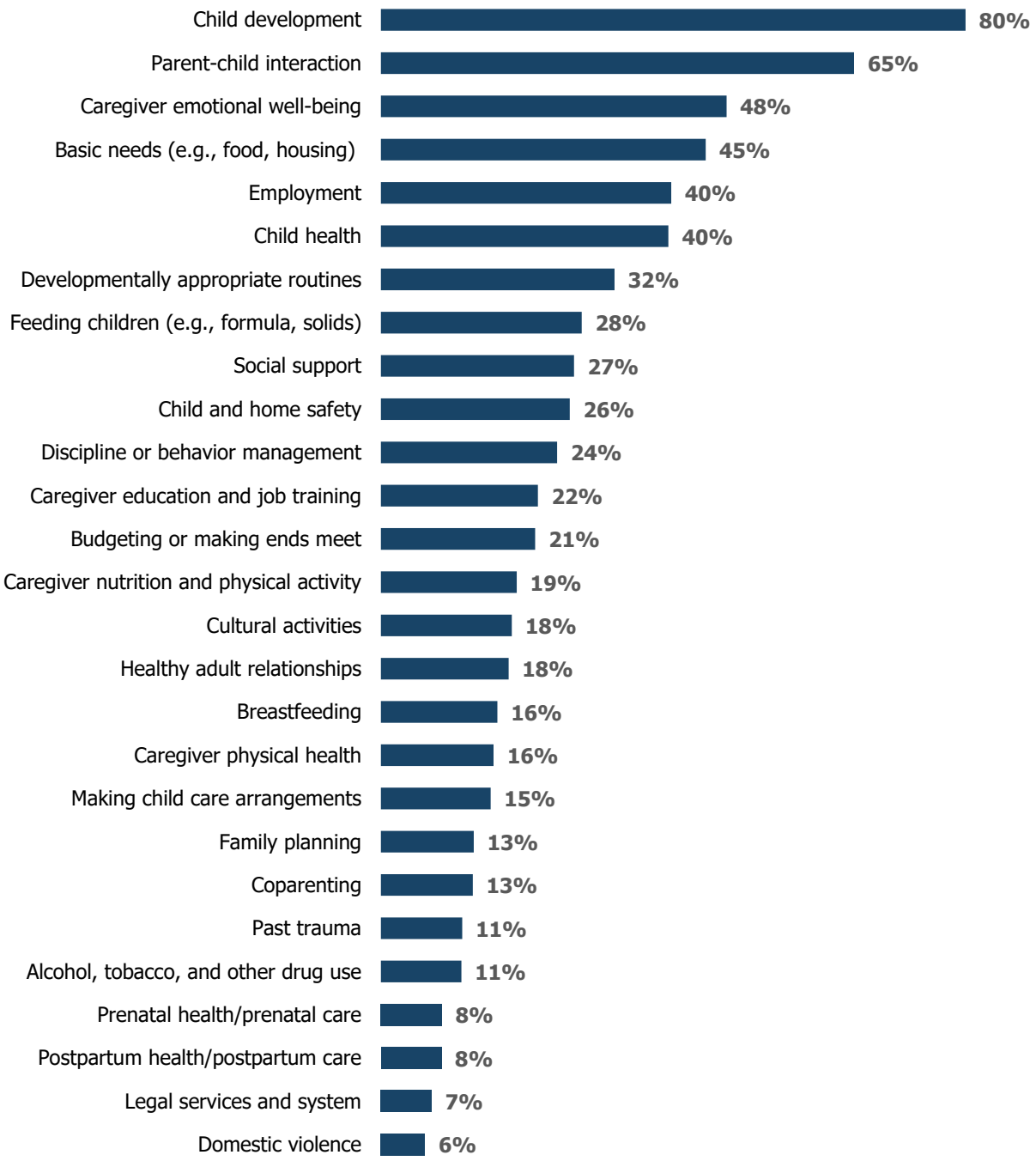
Note: Data are from the Home Visitor Rapid Reflect Survey (*N* = 1,017 home visits for 288 caregivers). Data are aggregated and weighted by caregivers. The chart displays the average time spent on these activities during sampled home visits. The bars represent the average score, and the lines represent the standard deviation of the average score.

Topics Discussed

Child development, parent-child interaction, and caregiver emotional well-being and stress were the topics most frequently discussed during home visits.

A wide range of child and caregiver topics were discussed during visits. On average, 6.4 (*SD* = 3.4, range = 1–27) topics were discussed during a typical home visit. The frequency of topics discussed was likely driven by two sources: home visiting model curriculum and caregiver needs and interests. Most model curricula focus on parent-child interaction and child development. So we would expect to see these topics discussed frequently and reinforced during home visits (see exhibit 5.2). Further, the topics discussed most frequently, as shown in exhibit 5.3 below, closely mirror the reasons caregivers cited for enrolling in Tribal MIECHV programs in chapter 4 (e.g., child health and development, parent-child interaction). Likewise, the topics discussed least often during home visits (e.g., legal services, domestic violence, and smoking cessation) correspond to the least common reasons caregivers enrolled in the programs.

Exhibit 5.3. Frequency of Topics Discussed During Home Visits



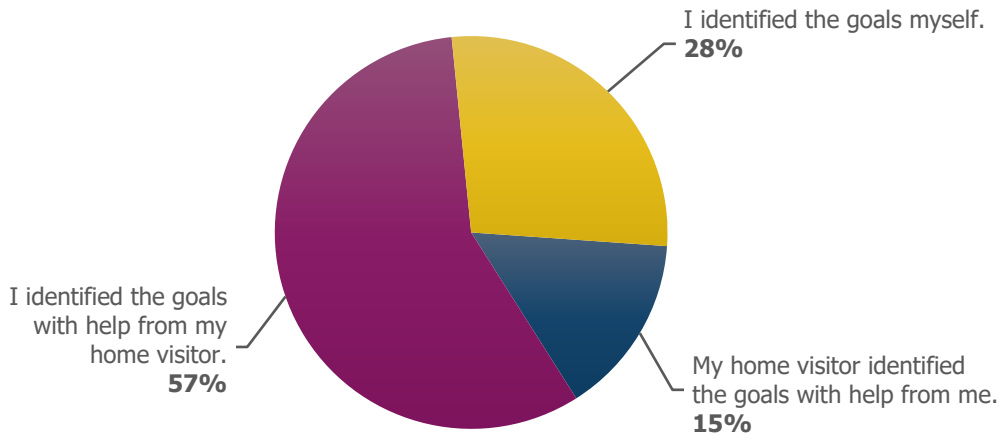
Note: Data are from the Home Visitor Rapid Reflect Survey (*N* = 1,017 home visits for 288 caregivers). The percentage of visits where each topic was discussed was calculated by dividing the number of visits where the topic was discussed by the total number of visits.

Collaborative Goal Setting

Collaborative goal setting took place during most visits. Caregivers were satisfied with this process, and home visitors found setting goals with families valuable.

On the 6-month Caregiver Survey, 87 percent of caregivers reported they had talked with their home visitor about goals and goal planning within the first 6 months of services. Of those caregivers, 70 percent talked about goals on most or all visits and 28 percent on some visits, even though relatively less time was spent on goal setting than other activities (exhibit 5.2). Caregivers who reported talking with their home visitors about goals were also asked about the goal setting process. They responded to questions about how they identified their goals, their role in the goal setting process, and satisfaction with their goals. A majority of caregivers said they identified goals with help from their home visitor (exhibit 5.4). A majority also reported their role in goal setting was "just right." Overall, 98 percent of caregivers were satisfied with the goals they set, and 91 percent reported their goals were similar to what they had hoped for when they started home visiting.

Exhibit 5.4. Process for Identifying Caregiver Goals



Note: Data are from the 6-month Caregiver Survey. Sample includes caregivers who talked about goals and goal planning with their home visitor (*N* = 47).

Nearly all home visitors (94 percent) reported working with families to develop a goal plan was valuable. A majority (77 percent) also reported they thought families found developing a goal plan useful. Less than one-third (29 percent) of home visitors reported believing that families felt home visitors were "being pushy" when they brought up goal plans. Further, home visitors reported their program expected every family to have a goal plan (94 percent), families took

the lead in developing those plans (98 percent), and families and home visitors collaborated to regularly review progress and update the plan (96 percent). These data reflect program emphasis on the importance of goal setting and the process by which home visitors help families identify and review progress on their goals.

Planning and Adjusting Home Visits

This section describes what home visitors considered when planning home visits and how they adjusted those plans during visits to respond to caregiver needs, time constraints, and emerging issues.

Home Visit Planning

Home visitors used model guidance and curriculum and sometimes supplemental materials to plan home visits. When tailoring their plans, home visitors considered what they knew about each family and the connections they had built with them.

On the staff survey, 84 percent of home visitors reported their program provided all the materials needed to cover the topics they wanted to cover during home visits. These materials included both model curricula and supplemental materials. During interviews, they described the content as mostly curriculum driven with supplemental materials including books, musical instruments, and arts and crafts intended to keep children and families engaged. Additionally, 35 percent made efforts to independently find materials beyond the home visiting model and supplemental program resources to use during most or every home visit. Home visitors reported spending an average of 1 hour planning for individual visits and about 7 hours planning for a week of visits.

The depth of their relationships also appeared to affect planning as home visitors became more familiar with caregiver goals. As one home visitor commented:

> When it got to a point where I did know the families really well, I was able to just kind of wing it a lot. I mean I would still write up a plan, but I was able to think about, "Okay, well what did we talk about at our last visit? And what were their goals?"

Another home visitor reinforced how their personalized connections with caregivers impacted planning:

> Every home visit with every family is going to look different depending on the connection that you have with the family, the way they're comfortable communicating. It's going to be different. It doesn't work if you have it standard, like a cookie cutter for every family. So, every visit is tailored specifically to that family.

In other words, getting to know families helped home visitors effectively plan visits.

Other home visitors reinforced the importance of "going with the flow," suggesting that fluidity should be built into home visiting planning. According to one home visitor, "You have to have a P-L-A, the N comes later, it's like the rest of that plan you know isn't there." They continued:

> Our whole program is about meeting people where they are … I'm always just a little bit ready for whatever. I try not to just have one thing in my notebook for them … I have other handouts in my bag. I should weigh my bag and tell you how much it weighs. It's just resources and things and ideas and stuff you know and crafts because sometimes they were sad last time and they're so happy today.

Although, as these data suggest, home visitors considered each caregiver's specific context when planning visits, data also suggested they made in-visit adjustments based on where families were during the home visit itself.

Adjusting Plans During Visits

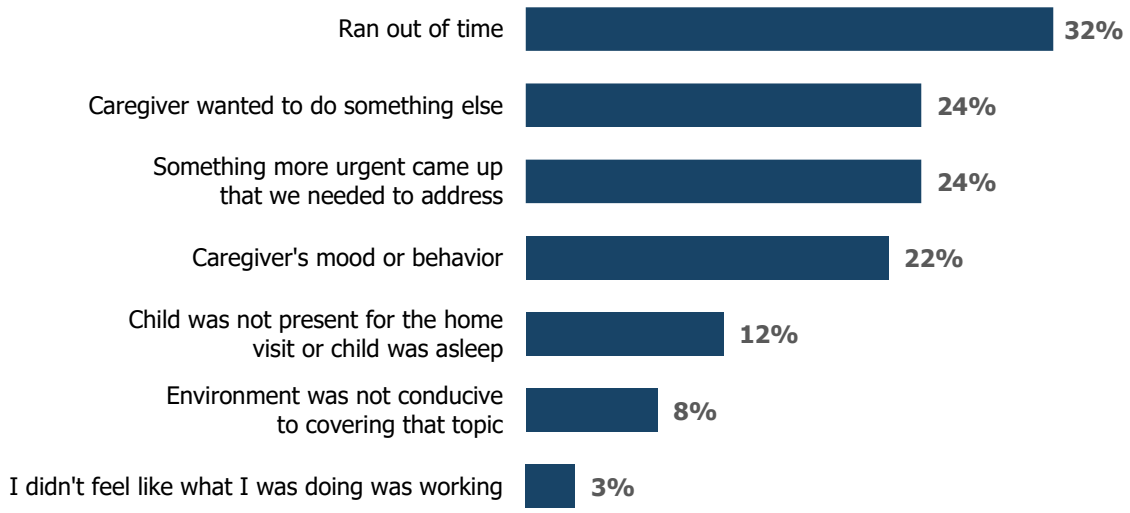
Home visitors modified plans during visits to manage time, respond to caregiver needs and preferences, and adjust to evolving issues ranging from a child's mood to emerging crises.

According to quantitative data, 70 percent of home visits were completed according to the plan. For about one-third of visits, home visitors reported they were not able to cover everything they planned, mostly due to timing or caregiver needs. Exhibit 5.5 displays reasons home visitors adjusted their plans, the most common reason being that they ran out of time.

When describing running out of time during visits, one home visitor explained they prioritized immediate caregiver needs above preplanned activities:

> I usually cover what I need to cover eventually and cover what they need me to do first and foremost before I get to what I have to do or whatever. And if we run out of time before what I have to do, that's better than if we run out of time before what they need.

Exhibit 5.5. Reasons for Adjusting the Home Visit Plan



Note: Data are from the Home Visitor Rapid Reflect Survey. Sample includes home visitors who indicated they adjusted their plan for the visit (*N* = 283 home visits for 137 caregivers). Data are aggregated and weighted by caregivers. Percentages will not add up to 100 because multiple responses were allowed.

As exhibit 5.5 shows, home visitors adjusted visits in response to explicitly stated caregiver needs (e.g., caregiver wanted to do something else) or instinctually (e.g., caregiver's mood or behavior). Findings from the Caregiver Survey show that when the caregiver was not interested in a topic or activity, 46 percent reported the home visitor would suggest another topic or activity, and 31 percent reported they would ask what the caregiver would prefer to do. Qualitative data also suggests home visitors respond to caregiver cues. For instance, one home visitor described pivoting from planned lessons and activities after recognizing the caregiver needed "to just vent out":

> If that happens, then I push [planned lessons and activities] aside. I listen to the family. I listen to the mom, and then when it's appropriate, I'll bring in those kinds of activities. If not, you know I'll schedule another time to do those activities. So, basically, … I try to pay attention to the families' cues … When you check in with the mom, they express so much and then that's where you have to really do critical thinking for yourself. How does the mom need this kind of support, or can we go on with the lesson. So it's just knowing your family. You have to know your family to know when it's appropriate to give the lesson or activities.

Interview data also showed that child moods and behaviors (i.e., uninterested, fussy) were a common reason plans were adapted. Addressing the range of child moods and behaviors that constrained home visits, a home visitor added:

> Sometimes a child is fussy or sleepy. So if they're asleep during the visit, you gotta let the child sleep. So, you can't always expect a visit where the child is going to be in the best mood or awake.

Another caregiver elaborated on the importance of adapting to changing child temperaments. They described how home visitors must "read the cues of the room":

> We don't know what we're going to get from them, and they're just going to be organically who they are in that moment. And so, if someone is having a bad crying tantrum filled day, they're going to do that whether or not—so if the visitor sees, "Hmm, we might not accomplish this activity right now in a way that's going to benefit anybody, let's pause, let's distract." I remember my visitor would do that really well. She would try to ask questions to help the kids. It wasn't always mayhem. But in those moments where it was, you appreciate your visitor realizing like, let's not force this activity.

A home visitor must consider more than only a child's mood. One program manager reflected on how keeping families engaged in home visits required "adapting to their current mood or mindset":

> So, if the family is pretty stressed out, then the [home visitor] is going to get to the bottom of why they're stressed out. And probably that day's agenda will go out the window and they're going to deal with whatever is causing the stress first.

While survey data showed home visitors experienced few challenges arising from family crises, during interviews they often reflected on the importance of adjusting home visits to family crises when necessary. For instance, one home visitor remarked on tailoring visit plans to accommodate acute caregiver needs, and another recalled postponing visits for families in response to emergent crises. Another home visitor described preparing "prescripted things that I would say in a tough situation" to be the "calm person in the face of crisis."

As data in this section show, home visitors made visits work for families by proactively tailoring them during the planning phase and by making in visit adjustments in response to time constraints, caregiver needs, or various challenges to home visit plans.

Challenges Experienced

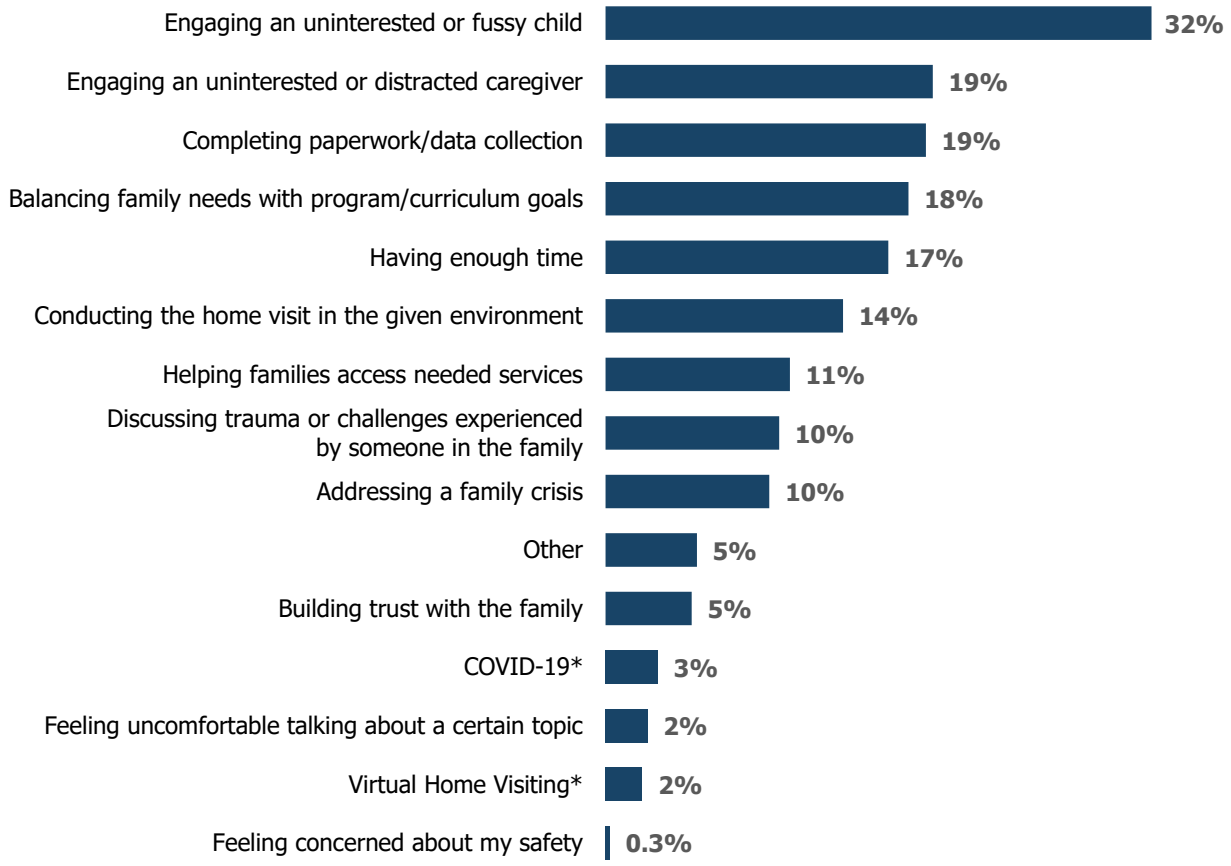
Below are descriptions of the common challenges experienced during home visits and how home visitors overcame those associated with data collection.

Common Challenges Reported

Home visitors reported challenges with caregiver or child engagement in about one-third of visits. They responded by adjusting visit plans or rescheduling visits.

In addition to asking home visitors why they adjusted their plans, the Rapid Reflect asked them to report any challenges they experienced during the visit. Challenges were defined as situations the home visitor struggled with and would likely talk about with a coworker or supervisor. These were not challenges the family was experiencing. No challenges were reported on 67 percent of the sampled visits, and the average number of challenges reported per visit was 1.7 (*SD* = 1.0, range = 0–6). The three most common challenges reported were engaging an uninterested or fussy child (32 percent), engaging an uninterested or distracted caregiver (19 percent), and completing paperwork/data collection (19 percent). Exhibit 5.6 displays the types of challenges experienced.

Exhibit 5.6 Types of Challenges Experienced During Home Visits



Note: Data are from Home Visitor Rapid Reflect Survey. Sample includes home visitors who indicated they experienced challenges (*N* = 300 home visits for 150 caregivers). Data are aggregated and weighted by caregivers.

Percentages will not add up to 100 because multiple responses were allowed. *This challenge was identified by re-coding open-ended responses.

Home visitor experiences with paperwork and data collection are described in more detail in the next section.

Strategies to Overcome Data Collection Challenges

Home visitors reported that data collection hindered relationship building and limited time with families. To address these concerns, they delayed, spread out, or integrated data collection throughout the visits to reduce burden and maintain rapport.

It has been widely acknowledged that MIECHV's extensive data reporting requirements place a significant share of the program's data collection responsibilities on home visitors (Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022, U.S. Department of Health and Human Services, 2024). Home visitors participating in MUSE consistently described how paperwork, including screenings, data collection, and charting, posed several challenges. First, administering required paperwork was identified as a potential barrier to building strong relationships, especially early on. Second, they described completing paperwork as impacting service delivery by creating competing demands on time spent with families. Third, some described paperwork, particularly data collection, as important for quality assurance and funding but could feel at odds with the relational nature of home visiting.

Home visitors were acutely aware of the potential for paperwork to overwhelm or annoy caregivers when administered as part of an initial visit, describing it as overwhelming, frustrating, or "off putting" for caregivers, with Ages and Stages Questionnaires® (ASQ) occasionally being mentioned as an exception. When asked to identify a challenge in home visits, one home visitor remarked:

> I think the paperwork, trying to get families to do paperwork, like the screenings and assessments that we are required to do … it is a lot of paperwork. I try and spread it out over a couple [of] visits, so it's not so much right away.

Many home visitors described developing similar strategies for reducing the burden of paperwork for families. Three common practices were delaying the administration of paperwork until after a relationship had been established, spacing out paperwork across several visits, and integrating questions required on paperwork (e.g., health questions) throughout the home visit rather than as a discrete task. Many described how large amounts of paperwork required at

certain time periods produced compounding challenges, including interfering with rapport building and compromising a sense of authenticity in their work.

> I understand, and I really see the value and the importance of data collection because it tells a story. But I just feel like sometimes the deadlines that we have to follow are very hard when you're trying to build rapport with the family. At the same time, you're asking about alcohol and drug use and domestic violence. These are very important, and sometimes very sensitive topics, that will come out even if they're not comfortable in the beginning. They will eventually talk about them. This isn't a job for just anybody to do because you have to be personable, be able to build the trust and the rapport with your families, but also being very administratively mindful of all the paperwork and the data end of the job too. So, there's really two ends of the spectrum, there's some days honestly where I feel like I'm more of a data collector than I am a home visitor.

These data illustrate how home visitors navigate the tension between fulfilling program data collection requirements and fostering relationships with families.

Caregiver Experience With Home Visits

This section summarizes caregiver experiences with home visits. We present data on caregiver impressions of home visitor warmth and responsiveness and their ability to plan and adjust visits according to their needs. This section concludes with caregiver reflections on the value of home visits and what they liked best about visits. Data reported here are from the 6-month caregiver survey, the Caregiver Rapid Reflect survey, and caregiver interviews.

Home visitor warmth and responsiveness

Home visitors displayed warmth and responsiveness to caregiver needs, feelings, and interests.

On the caregiver survey we asked caregivers how they felt about their home visitor using questions adapted from a survey[20] developed by the Home Visiting Research Collaborative (Filene et al., 2018). Caregivers responded to "My home visitor … (1) gives me positive feedback; (2) shows warmth, respect, and appreciation to my family; (3) shows that she/he wants to understand my perspective, concerns, and feelings; (4) makes sure that visit activities match my interests, concerns, and preferences; and (5) balances my interests with those of the home visiting program". Response options ranged from 1 (never) to 5 (every visit). The internal

[20] Email harc@hvresearch.org for copies of the instruments.

consistency reliability among these questions was high (Cronbach's alpha = 0.85), so they were averaged to create a single score. The average across home visitors was 4.80 (*SD* = 0.36), indicating that caregivers generally thought their home visitors displayed warmth and responsiveness to their needs, feelings, and interests.

Tailoring home visits to caregivers and their families

Caregivers felt home visitors worked with them to plan and carry out home visits based on their family needs and preferences.

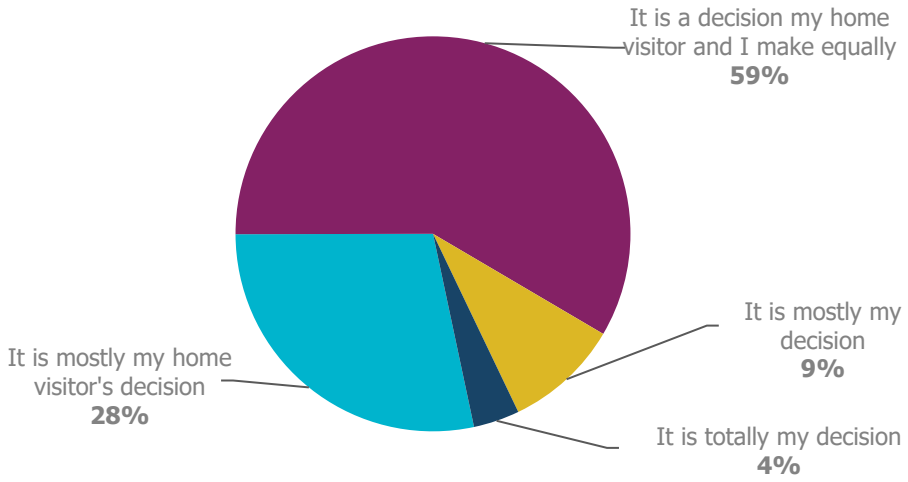
We asked four questions to understand caregiver perceptions of how home visit were planned and carried out: "My home visitor … (1) plans visits according to what I prefer; (2) asks me about and addresses family concerns, even if this means changing planned activities: (3) makes sure I understand what we're talking about before moving on; and (4) focuses on conversations and activities to fit my interest". Response options ranged from 1 (strongly disagree) to 4 (strongly agree). The internal consistency reliability of these questions was high (Cronbach's alpha = 0.92), so they were averaged to create a single score. The average across home visitors was 3.39 (*SD* = 0.67), indicating that caregivers generally thought their home visitors planned and adjusted visits according to their needs and preferences.

We asked caregivers who made decisions about topics and activities covered during visits, and most (59 percent) reported that they worked together with their home visitor (exhibit 5.7). However, when asked how much they agree or disagree with the statement "I prefer for the home visitor to lead the visit. She or he can decide what we talk about and do," most (85 percent) said they agreed or strongly agreed that their home visitor lead the visit and decide what to talk about and do.

Interview data from home visitors corroborated the survey data about caregiver perspectives on whether home visits were designed to meet caregiver needs. One home visitor described visit planning as a parent-driven process, explaining that they:

> ... usually ask the parents, "What's an area that you would like to work on? What's an area you would like to focus on?" So, that's pretty much how I would schedule the visit and if you know they didn't have a preference, then you just kind of go with the flow.

Exhibit 5.7. Decisions About Home Visit Topics and Activities



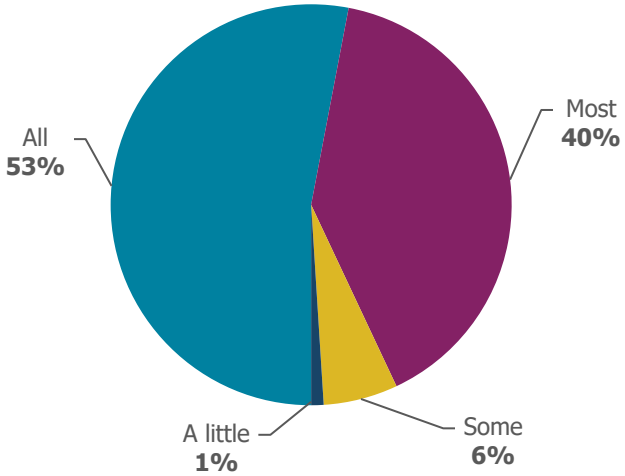
Note: Data are from the 6-month Caregiver Survey (*N* = 54).

Home visit usefulness

Nearly all caregivers found home visits interesting, useful, and a good use of time.

On the Home Visitor Rapid Reflect, 98 percent of home visitors reported that the caregiver was interested in what they did during the home visit. Similarly, on the Caregiver Rapid Reflect, 99 percent of caregivers said they were glad they made time for the home visit. Overall, 93 percent of caregivers thought that all or most home visits were useful in their everyday lives (exhibit 5.8).

Exhibit 5.8. How Much of the Home Visit Was Useful in Everyday Life



Note: Data are from the Caregiver Rapid Reflect Survey (*N* = 212). Of the caregivers who responded, none of them answered "none," so that option was not included in the pie chart.

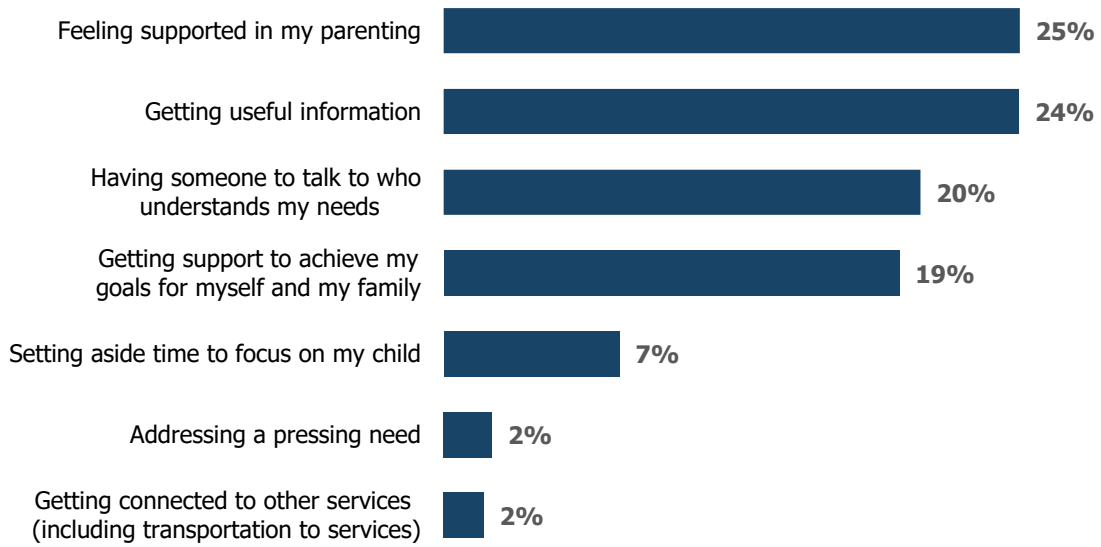
In interviews, caregivers underscored how home visits made parenting easier by helping them navigate the ever-growing list of things parents need to pay attention to including 'to do' lists, checklists, strategies, milestones, and techniques. One caregiver remarked that she found the "constant reminders of just keeping things on track with your child" most useful.

Value of a home visit

Caregivers said they especially valued the practical support and social connection they received during home visits.

After a sample of home visits, caregivers were asked to identify the one thing they liked most about their home visit. Most rated feeling supported in my parenting and getting useful information as the things they liked most about their visit (exhibit 5.9).

Exhibit 5.9. What Caregivers Liked Most About the Home Visit



Note: Data are from the Caregiver Rapid Reflect Survey (*N* = 212).

Interviews echoed caregiver perceptions depicted in exhibits 5.8 and 5.9. Caregivers appreciated the parenting support they received from home visits. In particular, they liked receiving information about child rearing and developmental milestones, learning strategies for moderating stressors associated with parenting (e.g., journaling, coloring, breathing techniques), and having a trusted person with whom to discuss sensitive topics.

One caregiver attributed an increase in parenting confidence to their experience in home visits:

> I think it's made a huge impact on my ability to feel confident that I'm doing the right things and that I'm on the right track. I just feel better prepared for parenthood after I do those visits and I have that information. I just feel like I'm more prepared.

Another noted how home visits helped them to handle stress, particularly at a time when they "had all my kids home and everything was just nonstop." They recalled how the home visitor normalized the feeling of stress and provided strategies for coping:

> She told me everyone goes through stress. You're not the only one who goes through stress. She just told me like you need to recognize your warning signs and what's making you feel stressed out. Take care of yourself and remember to eat well. Spend time with your loved ones, accept how some people [are] ...— and you know she just gave me those kinds of things to help me with it ...things to do with it.

As shown in these quotes, home visits play a critical role in shaping caregiver experiences as parents by encouraging them to be self-assured and not feel alone in their parenting.

Conclusion

This chapter described what happens during home visits, how visits were planned and adjusted in response to family preferences and needs, and how caregivers experienced them. Findings showed that home visitors used both model curricula and caregiver preferences to plan and conduct visits focused on child development and parent-child interaction while also providing emotional support. While not among the top reasons caregivers reported for enrolling in home visiting (see chapter 4), caregiver emotional well-being and stress were among the most common topics discussed. This may reflect the period in which most data were collected (i.e., during the COVID pandemic), or it may indicate that attending to caregiver emotional well-being is central to supporting parenting and child well-being. Home visitors drew on their deep connections with caregivers to respond to family needs and emerging issues by adjusting visits in real time. These in-the-moment adjustments suggest the importance of training and supervision to prepare home visitors to modify visits responsively. Together, the findings illuminate what happens before and during home visits and the various ways in which home visitors respond with warmth and care to caregivers' practical and emotional needs. In the next chapter, we explore the relationship between caregivers and home visitors to understand how shared experiences and open and honest communication strengthen relationships and build trust, allowing for opportunities to discuss sensitive topics.

Chapter 6: Home Visitor-Caregiver Relationships in Tribal MIECHV

Chapter 6 at a glance

Caregivers described positive relationships with their home visitors, likening them to friends and family. These relationships benefitted from shared experience as parents and shared cultural backgrounds. For home visitors, maintaining these close relationships required thoughtful and nuanced boundary setting, which served as a protective strategy against burnout. Home visitors worked to establish open and honest communication, which was sometimes compromised by negative associations with social services.

Introduction

Relationships between program staff and caregivers are a foundational component of home visiting. These relationships develop over time through ongoing interactions and have an important role in how caregivers participate in services. Positive relationships are critical to effective service delivery, as they support caregiver engagement in the program (Korfmacher et al., 2007) and are associated with improved outcomes such as increased parenting self-efficacy, emotional well-being, and better use of available resources (Olds et al., 2007; Duggan et al., 2000). These relationships also play a key role in retention as families are more likely to remain in the program when they feel connected and respected (Daro & Harding, 1999; Gill et al., 2007; Lee et al., 2023). Understanding how these relationships are built and what both caregivers and home visitors value about them can inform home visitor training, supervision, and caregiver engagement strategies.

This chapter describes caregiver perceptions of relationships with home visitors and discusses the importance of shared experience and open and honest communication in forming and sustaining these relationships. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

- Caregivers felt cared for and understood by their home visitors. They valued being able to discuss sensitive topics with someone they trusted.
- Caregivers described their relationships with home visitors as more than professional, likening them to friends and family.
- Home visiting staff described boundary setting as a protective strategy to help prevent burnout. They found boundaries worked best when they were flexible, responsive, and grounded in mutual respect.
- Shared experience as parents fostered mutual respect between home visitors and caregivers.
- Shared background and knowledge of cultural norms, language, and context benefited home visitor-caregiver relationships.
- Some home visitors shared that self-disclosures—or the sharing of personal information and experiences—helped to establish common ground with caregivers, normalize caregiver experiences, and facilitate communication.

- Building open and honest communication can be compromised by negative associations with social services.

Perceptions of Relationships

This section presents data from interviews and the 6-month Caregiver Survey on caregiver perceptions of their relationships with home visitors. We also describe one way that home visitors navigated relationships by setting boundaries as shared in interviews.

Caregivers Felt Supported and Understood

Caregivers felt cared for and understood by their home visitors. They valued being able to discuss sensitive topics with someone they trusted.

When caregivers who completed the 6-month survey were asked about their relationships with their home visitors, nearly all reported their home visitors engaged in supportive behaviors on most or every visit, including (1) giving positive feedback; (2) showing warmth, respect, and appreciation to the family; (3) making an effort to understand their perspectives, concerns, and feelings; (4) ensuring the visit activities match the caregiver's interests, concerns, and preferences; and (5) balancing their interests with those of the home visitor.

Likewise, all or nearly all caregivers reported that, on most or every visit, their home visitor (1) really listens to their concerns or requests, (2) sees their family in a positive way, (3) provides information that helps them make good choices, (4) responds to requests for information or guidance, (5) tries hard to understand the their perspective, (6) recognizes the strengths of their family, (7) empowers them to get the resources and support they need, and (8) is flexible when family situations change.

Nearly all caregivers who completed a 6-month survey felt their home visitors were motivated by care and concern for them and their families, with 96 percent agreeing or strongly agreeing with—"If my home visitor raises a concern about my parenting, it shows that she or he cares for and respects my family," and "If my home visitor asks about my mental health, substance use, or relationship with my partner, it is because she or he cares about me and my family."

Further, 90 percent of caregivers reported they appreciated opportunities to talk about sensitive topics (e.g., mental health, substance use, partner violence) during the visit, and 96 percent believed that home visitors brought up sensitive topics because they cared about them and their families.

Qualitative data similarly show that caregivers value opportunities to discuss sensitive topics with trusted home visitors. In one example a caregiver shared:

> So, when I've had moments, very depressed moments and anxiety filled moments … we took the time to talk about it. I was able to talk about a lot of different things. And for them to understand where I'm coming from, and my strength, and my not so strong point, I think it was really good. Because where they have heard, and I guess seen, my strength, they nurture me there. They focus a lot there. And where they have seen me struggle, and I need support, they have found me help and they have tried to support me there.

Critical here is the open and empathetic nature of the relationship with her home visitor. Their enduring relationship, through various moments of mental distress, leads to what is "really good" about home visiting—the ability to nurture strengths and provide much valued support.

Home Visitors as Friends and Family

Caregivers described their relationship with home visitors as more than professional, likening them to friends and family.

Many caregivers used "family" and "friendship" as ways to describe the relationship they had with their home visitors. For instance, one caregiver described their home visitor as "more of a family member … than just somebody that comes and helps or teaches." Another caregiver described the entire home visiting program as "like real blood family."

While attempting the tricky task of characterizing the home visitor's place within their life, one caregiver said:

> It feels like they're part of the family, but I don't know, a little bit like a part of the family but an outsider who's not like an outsider … I know they're not a part of the home, but they're a part of it because they know my family. ... I don't know how to really say it specifically, but they do feel like a part of the family.

One home visitor described that caregivers refer to her as "auntie" and "grandma." Another reinforced the family-like dynamic that exists between caregivers and home visitors, commenting, "I've had people tell me, 'Okay, we're family now.' They're like, "I'm telling you things I wouldn't tell anybody else.'" These data suggest not only a closeness in home visitor-caregiver relationships, but also a high degree of confidence and trust, typically reserved for family members.

Caregivers also used "friendship" to describe home visiting relationships. They characterized home visitors as "like a really good friend," compared talking with them to "talking to a friend," and commented that they talk with them "more regular than my best friend sometimes." Home visitors shared this perspective. One shared the following about a caregiver: "If I wasn't her home visitor, she would be my friend." Friendship, another suggested, is an inherent part of home visiting: "You build that bond with families even if you don't mean to, especially if they're active in their visits and doing what they should. You build a friendship." For some caregivers, closeness at the level of friendship meant sending flowers when their home visitor was ill or making them earrings to express gratitude.

For many caregivers, the characterization of home visitors as being like a close friend meant they were "more comfortable" with them than other health care professionals and service providers. When invited to compare the home visitor to their doctor, dentist, or day-care provider, one caregiver commented:

> She's honestly become like one of my best friends just because she is a listening ear, and she truly listens to me before she gives suggestions. I mean she's honest with me.

In other words, for caregivers, being able to speak openly and confidentially with home visitors and being listened to, as one would with a friend, were essential to establishing and sustaining valued relationships.

Boundary Setting as a Protective Strategy

Home visiting staff described boundary setting as a protective strategy to help prevent burnout. They found boundaries worked best when they were flexible, responsive, and grounded in mutual respect.

While framing home visitor-caregiver relationships as family was common and appreciated across home visitor and caregiver interviews, it was not true for everyone. One home visitor reflected on how setting professional boundaries supports her work, especially when the families are in crisis. She explained how her reflective supervisor

> always tells me, "Make sure you maintain that professional boundary. Because sometimes it's really easy to go over that boundary. And you're not their friend. You're actually a home visitor. So, make sure that you know, you don't open yourself to something that you don't want to get into."

In these comments, reflective supervision was an opportunity to discuss establishing a distinction between the role of home visitor and being a friend or family member. The home visitor experienced maintaining this distinction as protective and supportive.

Home visitor training and reflective supervision emphasize maintaining personal (physical, emotional) and professional (legal, ethical) boundaries, as these are not always clear-cut (U.S. Department of Health & Human Services et al., 2022; Tomlin et al., 2016). Home visitors described setting boundaries as an important strategy to prevent 'burnout'[21] by establishing shared expectations around their personal availability (e.g., available to answer phone) and professional limitations (e.g., restrictions on giving rides). One home visitor described boundary setting as helping her regulate when the families she was serving were having a difficult time. She explained that boundaries around her role help her mirror regulated behavior. She explained:

> I have to shift my perception and not put in my own personal bias or feelings. It's always having that professional boundary of knowing what my role is and why I'm in this position in the first place. That really helps me to know how to help the family.

The boundaries home visitors described as helpful were typically set around them being available only during certain times of the day or being unable to do certain types of things (e.g., not paying for a ticket). Such boundaries created space for home visitors outside their relationships with caregivers. When asked about compassion fatigue, one explained how she sets boundaries that are responsive to her own needs and to the circumstances of the family:

> If they called and honestly didn't have diapers, and they needed them, I could probably go get them a diaper or something. But, I do set boundaries. I do. Don't come to my house. Just don't come to my house, unless it's an emergency. And most of them are pretty good about that; they are.

This description highlights the dynamic nature of boundary setting to situations (e.g., emergencies) and in contexts where home visitors are well known in the community, especially in small communities where people are likely to know where everyone lives.

[21] Home visitor burnout refers to a state of physical, emotional, and mental exhaustion resulting from chronic work-related stress, often associated with high caseloads, exposure to family trauma, and organizational demands in home visiting programs (Sandstrom et al., 2020; West et al., 2018). While documented as an issue for the home visiting field more broadly, burnout can be exacerbated by the long-term underresourcing and historical demands experienced within Native communities.

Many home visitors expressed concern about how certain approaches to boundary setting (e.g., too rigid, too many) could compromise their relationships with the families they served. While talking about the complexity of boundary setting, one home visitor reflected, "I don't know how you can have so many boundaries and have a good relationship with people." Interestingly, at least two home visitors discussed helpful boundary setting as a product of healthy relationships. In one instance, they likened learning to set boundaries to teaching mothers to take care of themselves, suggesting boundary setting as a more generalized form of self-care that happens within professional and personal relationships. Across interviews, boundary setting seemed most helpful when applied through a reflective practice that considered changing demands, specific settings, and relationships rather than through more rigid rules.

The Role of Shared Experiences in Building Relationships

This section presents data from interviews with caregivers, home visitors, and program managers on how shared experiences, especially in parenting and being Native, are central to fostering mutual respect between home visitors and caregivers.

Shared Parenting Experience

Shared experience as parents fostered mutual respect between home visitors and caregivers.

Emphasizing the importance of a shared experience of parenting with her home visitor, one caregiver remarked:

> I did appreciate the fact that she had experience. She had children. She had her own kids. She had her own grandkids. And so, I knew she wasn't coming from left field and had no idea what an overwhelmed mama was. She was in it at one point!

Having a home visitor who had been "in it" mattered to this caregiver both in terms of establishing mutual respect (putting them on the same 'playing field') and how it facilitated empathy between them (had an idea of "an overwhelmed mama"). During a virtual visit, another caregiver recalled hearing "all [the home visitor's] kids in the background and her grandkids." According to this caregiver, being able to hear the family made them seem like "more of a peer." Such reflections suggest a benefit when home visitors can bring themselves as parents into the relationship. "It makes me feel less alone," added another caregiver. "You're talking to someone who is like you, like another parent like you." Explaining that home visitors

need not be parents to have impacts "because you can still be an awesome teacher or mentor or whatever," one caregiver explained that shared parenting experience does facilitate a special bond. Home visitors commented on the benefits of this shared experience, highlighting how it supports rapport building, helps with destigmatization, and balances power dynamics. This commentary supports previous studies that suggest shared experiences of parenting are a facilitator of home visitor-caregiver relationships (Lee et al., 2023; Jack et al., 2002).

Shared Background and Knowledge of Culture

Shared background and knowledge of cultural norms, language, and context benefited home visitor-caregiver relationships.

Across interviews, caregivers described the wide-ranging benefits of working with home visitors who shared their same cultural background and had similar cultural knowledge (e.g., being able to speak a shared Native language). Caregivers explained that shared knowledge and understanding was more likely with Native home visitors. One home visitor reflected on how introducing herself in her Native language helped to build a bridge with caregivers:

> Yes, and I like introducing myself in my language. I believe it opens another door sooner than most for Native American families. Because some of them are more like, "We don't know you" (laughter). They're kind of stand-offish. But once you introduce yourself in [Native language] and ask questions about their family—getting to know them, getting to know what the kids' favorite animal is, even or what mom or dad likes to do—I think that's a connection there. And, just asking them how they're feeling or what things they like to do. It helps build that relationship.

Similarly, a caregiver described how receiving home visiting services from a Tribal program,

> ... kind of eases stuff because, they're Tribal. So, they know. They just know how Tribal houses are … It's a lot easier to deal with somebody who knows what's going on, like culturally, and the way we do stuff. Than [it is] to have a non-Tribal, like an outsider, come in and go "Well, why do you guys do that?"

These data demonstrate the significant value of Tribal MIECHV programs and distinguish them from programs not rooted in Native communities. One program manager referred to her staff as "heroes"—as unconditionally loving and compassionate—and attributed their successes, at least partially, to the home visitors being community members:

> ... the ladies that I work with manage to figure out how to get families connected and do it in a loving and compassionate way, not expecting anything

> in return … My staff are always saying, "It's not just home visits, ... I go to bed thinking about this." As much as you try to shut it off, you can't. And I don't know that they would want to anyway because that's just—they're those people that really want to help and really want to put their community in a better place. That heart just really comes from being from that place where you see it, and you experience it, and you just want better for your people.

Here, what makes home visits "not just home visits" is a commitment to putting one's own community in a better place. It is both what cannot be "shut off" and what gives these services "heart." Such common experiences were seen as deeply valued throughout the interviews, but especially for caregivers.

Open and Honest Communication

This section presents data from caregiver, home visitor, and program manager interviews on how reciprocal sharing facilitates open and honest communication and can help overcome negative associations between home visiting and child welfare services.

Reciprocal Sharing

Some home visitors shared that self-disclosures—or the sharing of personal information and experiences—helped to establish common ground with caregivers, normalize caregiver experiences, and facilitate communication.

One home visitor described "reciprocal sharing," a process wherein,

> [You] can kind of share your own experiences as a home visitor and as a parent or in any other capacity regarding a conversation that you're having to kind of let them know, "Hey, I can relate."

Both home visitors and caregivers reflected on the many benefits of home visitors openly discussing their own personal experiences as parents. These benefits included modeling empathy with self and others, demonstrating credibility, normalizing mistakes in parenting, incorporating a strengths-based framework, and motivating change. Namely, caregivers described how knowing home visitors as parents helped establish open and honest communication. One caregiver noted:

> We're open and honest with each other, and I don't keep nothing from her, and she definitely doesn't keep anything from me. She's an open book just as much as I am an open book, and I can really trust her.

In interviews, open and honest communication seemed to be facilitated through home visitor parenting self-disclosures, or the intentional sharing of information and experiences:

> I don't like the [home visitors] that try to keep it just about work and try to keep their life private because that doesn't make me feel good. Honestly, it makes me feel like people are judgmental when they're like that.

Similarly, another caregiver expressed preference for home visitors who do not erect a "professional barrier that makes you feel like I shouldn't say these things, or I shouldn't tell this person."

For caregivers, such displays of professionalism seemed to create distance when mutuality was more advantageous. As one explained, it is "important to see yourself in your provider." Caregivers described establishing such commonality in multiple ways, including in how a home visitor dresses. One mom described feeling more comfortable when her home visitor arrived dressed "like I am," not "in a suit and tie and heels." Such efforts were acknowledged as demonstrations that the home visitor can "walk in my path." A home visitor reinforced this perspective, stressing, "You've got to let [caregivers] know that you've walked in their shoes." For many home visitors, such efforts are an almost 'taken-for-granted' part of relationship building. "Sharing a little bit" about oneself can make a home visitor seem like "not a complete stranger" to caregivers.

When caregiver experiences are normalized through reciprocal sharing, caregivers may feel accepted rather than judged and perceive home visitors as more trustworthy. Relatability rooted in reciprocal sharing may help break down, or soften, barriers to trust that exist at first. Such findings complicate assumptions around the importance of professional boundaries. They illustrate that while certain boundaries may be important for professional well-being, as has been established in home visiting and related fields (e.g., social work; Bradmiller, 1978; Marino et al., 2015), there is also a benefit to sharing personal parenting experience. This evidence suggests that supporting home visitors in bringing this knowledge to home visits may enhance relationships. These data also raise important questions about self-disclosures, including when they are most impactful, how they can be incorporated into home visits, and what home visitors need to feel safe and confident to make disclosures.

Overcoming Negative Associations Between Home Visting and Child Welfare

Building open and honest communication can be compromised by negative associations with social services.

Home visitors explained that establishing trusting relationships with caregivers who had negative experiences with or carry negative associations about other health and social service programs can be more complicated. While describing the complex and sometimes harmful experiences[22] faced by caregivers, one program manager explained:

> I feel like [engaging families in programs requires] decoding all of the bad coding that has happened along the way with other agencies or services that have presented in one way and actually done the exact opposite of what they promised.

In these instances, mistrust of certain agencies may remain, and trust building must begin by addressing it. Relationship building with caregivers in these situations may become especially important even as it is particularly challenging.

Concerns about the connection between home visiting and child welfare programs were identified as a particular challenge. One mother attributed her wariness of social services to having "grown up in the system":

> I've been distrusting or worried about certain institutions or organizations, you know? Just growing up, I sometimes experienced that things that are supposed to help, don't always help … My family was on welfare, and you know all those types of assistance, and I think sometimes just going through that and having Child Protective Services involved in my childhood, I feel like made me kind of distrusting of certain organizations.

By further reflecting on the lasting effects of her childhood experiences, this caregiver described the difficulty of exposing more vulnerable aspects of her parenting to a stranger. She framed her underlying fear as being reported to social services and having her child taken:

> The home visitor, they're coming into your home. They're seeing the good, the bad, and the ugly. And, especially with parenting, being a new parent—it's probably one of the most stressful times. So, it's kind of scary to invite, you know at first, they're strangers. So, it's kind of scary to invite a stranger in and be like, "Here's my most vulnerable, most stressful time," you know? And, "you're going to see all of it." It's that kind of fear, I think, of mandated reporting even though you may not be doing anything wrong. Just, it's a scary kind of thing.

[22] Failures in health and social services are well-documented in Native communities and often lead to serious harm, including the forced separation of Native families. (Goodkind et al., 2010; Newland, 2024; Ullrich, 2020; Brockie et al., 2024; National Indian Child Welfare Association, 2022; Waubanascum & Sarche, 2023).

Even in the absence of "doing anything wrong," such fear perseveres and impacts the caregiver's trust in program staff and comfort with services. Fear of "the system" makes her question herself, her home, and her chances for success. The harm reaches far beyond the bounds of any specific child welfare concern and involves more widely held distrust of the social service system.

For these parents, child welfare represents historical and ongoing state and federal interference in Native life and Native self-determination. One home visitor recognized such impacts and distinguished her work from child welfare to facilitate trust building with families:

> A lot of [caregivers] feel intimidated. They think that we are child welfare, which we ain't. So, I specifically state that to them. I do not work with child welfare. I am here to help your family stay together and better your skills. I'm not here to judge you. I'm not here to take away your family. I'm here to partner with you to build those skills.

Although, as in this quote, home visitors generally characterized home visiting as unaffiliated with child welfare or child protective services, interview data shows that caregivers may not perceive distinctions between child welfare or child protective services and home visiting programs. Also, in many communities, mandated reporting can further blur the distinction between home visiting with these programs which can complicate relationship building.

Conclusion

This chapter described how caregivers and home visitors cultivated open and honest communication and used strengths-based approaches rooted in shared experiences to build positive relationships. The data show how caregivers experienced deep and meaningful relationships with their home visitors. Data suggests that home visitors' openness to sharing personal parenting experiences helps to reduce feelings of judgement and advances a strength-based foundation to the work caregivers and home visitors do together. In chapter 7 we focus on describing Tribal MIECHV program staff to enhance our understanding of who these staff are and the critical skills and experience they bring to their work.

Chapter 7: Characteristics of Tribal MIECHV Program Staff

Chapter 7 at a glance

A majority of home visitors and nearly half of program managers identified as American Indian or Alaska Native (AIAN). Many staff shared the same community and cultural backgrounds as the families they served. About half of home visitors and nearly all program managers had a bachelor's degree. Typically, home visitors did not have prior professional experience working with children and families before their current role, while most program managers did. Overall, programs reported that staffing was stable. However, they had difficulty hiring staff with the qualifications they wanted. These included strong interpersonal skills, experience working with children and families, and cultural backgrounds similar to the families served.

Introduction

The success of home visiting programs relies heavily on the staff that provide critical services and supports to families. Understanding who home visitors and program managers are, including their personal and professional background and connection to the local community, offers insights into the strengths they bring to their roles serving families. Programs can use these insights to build and strengthen the home visiting workforce by focusing on effective hiring practices.

This chapter presents demographic data on Tribal MIECHV program staff, their connections to the communities they serve, staff professional backgrounds, and experiences hiring home visitors. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

Staff Characteristics

- A majority of home visitors and nearly half of program managers identified as AIAN.
- Many staff were from the same communities they served and shared similar cultural backgrounds with the families.

Staff Backgrounds

- Almost all program staff had some education beyond high school. About half of home visitors and nearly all program managers had a bachelor's degree.
- Only one-third of home visitors had prior professional experience working with children and families before their current role, compared to more than two-thirds of program managers.

Hiring Home Visitors

- Programs reported staffing was relatively stable. However, they had difficulty hiring staff with the qualifications they wanted.
- Program managers prioritized hiring home visitors with cultural backgrounds similar to the families served by their programs.
- Program managers also prioritized hiring home visitors with interpersonal skills and experience working with children and families.

Staff Characteristics

This section provides demographic information about Tribal MIECHV home visitors and program managers including race, ethnicity, age, and language fluency. This section also describes findings from staff surveys (Home Visitor and Program Manager Surveys) about the ways they are connected to the communities they serve.

Staff Demographics

A majority of home visitors and nearly half of program managers identified as AIAN. Nearly a third of home visitors and nearly half of program managers identified as White. Both primarily identified as non-Hispanic. Program managers were older than home visitors. Exhibit 7.1 displays demographic characteristics of Tribal MIECHV home visitors and program managers who participated in the MUSE study.

Exhibit 7.1. Staff Demographic Characteristics by Role

Characteristic	Home Visitors *n*	Home visitors %	Program managers *n*	Program managers %
Race				
AIAN	27	60%	5	46%
Asian	2	4%	1	9%
Black	1	2%	0	0%
Hawaiian	1	2%	0	0%
White	14	31%	5	46%
Ethnicity				
Non-Hispanic	41	91%	9	82%
Hispanic	4	9%	2	18%
Age (years)				
25 or <	3	7%	0	0%
26 to 29	8	17%	1	9%
30 to 39	15	33%	3	27%
40 to 49	10	22%	4	36%
50 to 59	6	13%	3	27%
60+	4	9%	0	0%

Characteristic	Home Visitors *n*	Home visitors %	Program managers *n*	Program managers %
Language Fluency*				
English	55	100%		
Local	4	7%		
Spanish	2	4%		
Other	0	0%		

Note: Data are from the Home Visitor Survey (*N* = 55) and Program Manager Survey (*N* = 16). Percentages may not add up to 100 due to rounding. *Language fluency data was not collected for program managers. Percentages do not add up to 100 because home visitors were able to select more than one language.

Relationship to Community

Many staff were from the same communities they served and shared similar cultural backgrounds with families.

As shown in exhibit 7.2, a majority of home visitors and program managers reported living in the same community as the families served by their home visiting program, considered themselves a community member, at least to a certain extent, and felt they shared a cultural background with at least some of the families served. Although a higher percentage of program managers reported living in the service community compared to home visitors, a higher percentage also reported they did not consider themselves community members. These findings demonstrate that living in a community, considering oneself a community member, and sharing a cultural background are unique yet related concepts.[23]

Exhibit 7.2. Staff Member Relationships to Community Served

Characteristic	Home visitors *n*	Home visitors %	Program managers *n*	Program managers %
Lived in service community				
No	15	33%	3	27%
Yes	31	67%	8	73%
Consider yourself a community member				
No	18	39%	5	46%
Somewhat	8	17%	1	9%

[23] Chapter 9 presents data on home visitor perceptions about how they contribute to the communities they serve.

Characteristic	Home visitors *n*	Home visitors %	Program managers *n*	Program managers %
Yes	20	44%	5	46%
Feel you share a similar cultural background				
No	8	17%	1	9%
Yes, with a few families	10	22%	1	9%
Yes, with some families	14	30%	3	27%
Yes, with most families	14	30%	6	55%

Note: Data are from the Home Visitor Survey (*N* = 55) and Program Manager Survey (*N* = 16). Percentages may not add to 100 due to rounding.

Staff Background

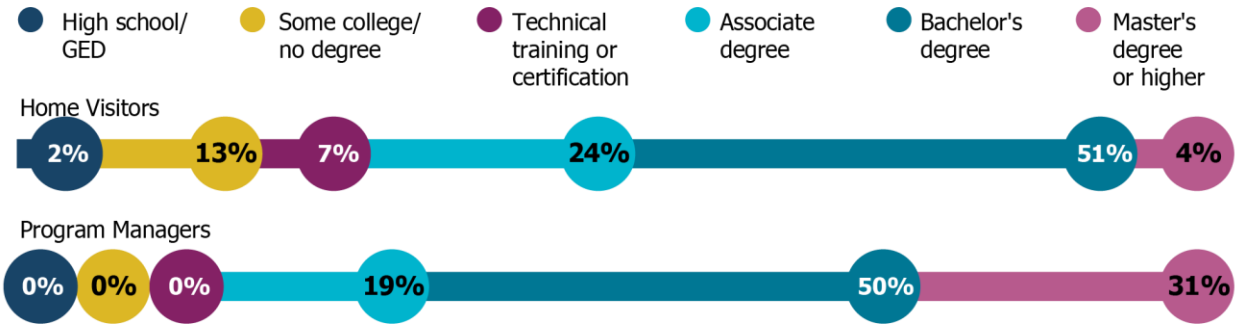
This section describes the educational backgrounds of home visitors and program managers. We also present information on staff professional experiences in home visiting and other jobs working with children and families, as well as nonprofessional experience raising children.

Staff Education

Almost all program staff had some education beyond high school. About half of home visitors and nearly all program managers had a bachelor's degree.

As shown in exhibit 7.3, nearly all home visitors (98 percent) received at least some post-secondary training, with 24 percent having an associate degree, over half holding a bachelor's degree, and 4 percent with a master's degree or higher.

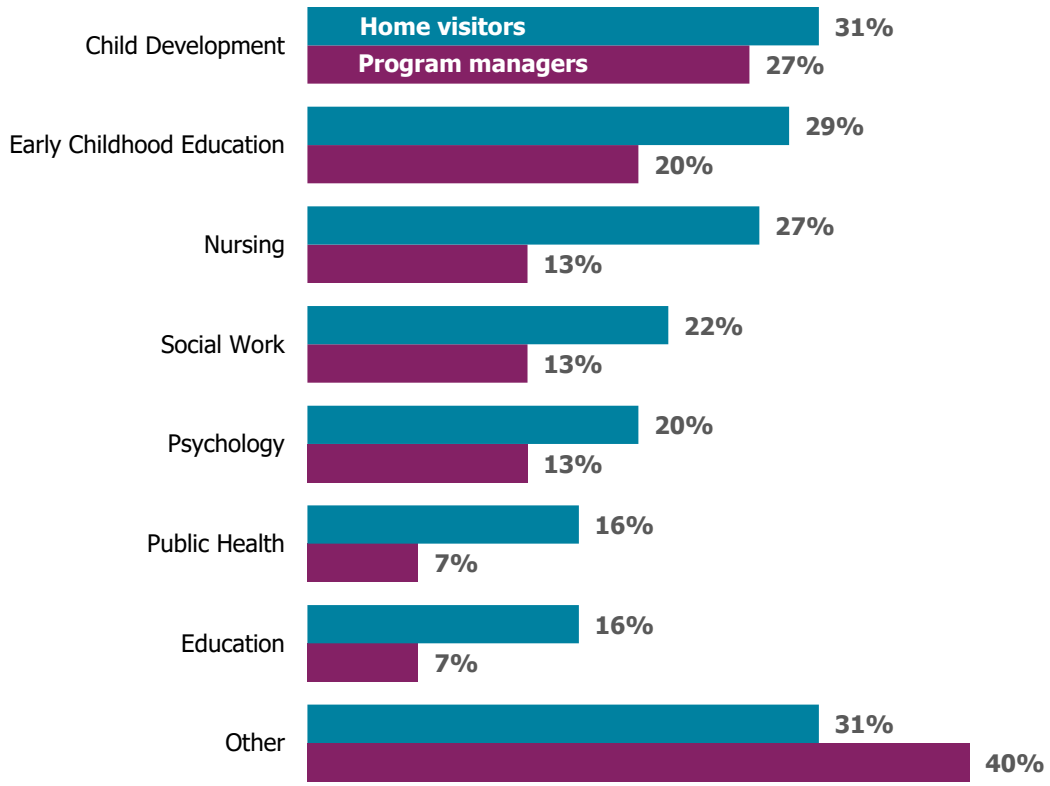
Exhibit 7.3. Education Attainment by Staff Role



Note: Data are from the Home Visitor Survey (*N* = 55) and Program Manager Survey (*N* = 16).

Program managers also reported high levels of education with 19 percent having an associate degree, 50 percent a bachelor's degree, and 31 percent a master's degree or higher. Exhibit 7.4 displays the different fields of study reported by home visitors and program managers. For all staff combined, the field of child development was most common followed by early childhood education and nursing. However, the "other" fields of study were selected as frequently as child development by home visitors and more frequently by program managers. The other category includes a wide variety of study fields (e.g., business, allied health, accounting) that could not be collapsed into existing categories or combined to create new ones.

Exhibit 7.4. Fields of Study by Staff Role



Note: Data are from the Home Visitor Survey (N = 55) and Program Manager Survey (N = 16). Percentages do not add up to 100 because staff were able to select more than one field of study.

Staff Experience

Only one-third of home visitors had prior professional experience working with children and families before their current role, compared to more than two-thirds of program managers.

Twenty-six percent of home visitors and 50 percent of program managers had worked at their current program for 6 or more years. Sixty-seven percent of home visitors and 88 percent of program managers had 6 or more years of experience working with children and families. The greater professional experience among program managers is expected, given that home visitors tend to be younger and earlier in their career. While home visitors had less professional experience working with children and families, 62 percent had more than 10 years of experience raising children and likely started their positions with some of this experience. On average, home visitors reported 15.6 years (*SD* = 10.2, range = 0–37) of experience raising children, and program managers reported 18.9 years (*SD* = 10.9, range = 0–42). Exhibit 7.5 displays staff professional experiences in home visiting and other jobs working with children and families, as well as nonprofessional experience raising children.

Exhibit 7.5. Staff Experiences by Role

Experience	Home visitors *n*	Home visitors %	Program managers *n*	Program managers %
Experienced in home visiting or other jobs working with children/families prior to current position				
No	37	67%	6	38%
Yes	18	33%	10	63%
Total years of home visiting experience prior to current position*				
< 1 year	0	0%	0	0%
1 to 2 years	1	6%	3	30%
3 to 5 years	6	33%	2	20%
6 to 10 years	4	22%	3	30%
10+ years	7	39%	2	20%
Years worked for current home visiting program				
< 1 year	12	22%	0	0%
1 to 2 years	16	29%	5	31%
3 to 5 years	13	24%	3	19%
6 to 10 years	11	20%	8	50%
10+ years	3	6%	0	0%

Experience	Home visitors *n*	Home visitors %	Program managers *n*	Program managers %
Total years of professional experience working with families and young children				
< 1 year	4	7%	0	0%
1 to 2 years	5	9%	1	6%
3 to 5 years	9	16%	1	6%
6 to 10 years	20	36%	4	25%
10+ years	17	31%	10	63%
Total years of nonprofessional experience with raising children				
No experience	6	12%	1	6%
1 to 10 years	14	27%	2	13%
11 to 20 years	16	31%	6	38%
21 to 30 years	12	23%	5	31%
30+ years	4	8%	2	13%

Note: Data are from the Home Visitor Survey ($N = 55$) and Program Manager Survey ($N = 16$). Percentages may not add to 100 due to rounding. *Only includes home visitors who answered yes to the question about whether they were experienced in home visiting or other jobs working with children/families prior to their current positions. Thus, the results exclude home visitors that did not have experience working with children and families in home visiting or other jobs prior to their current position.

Hiring Home Visitors

This section presents data on program staffing and hiring priorities as reported by program managers on the Program Implementation Survey, staff surveys, and interviews.

Program Staffing

Programs reported staffing was relatively stable. However, they had difficulty hiring staff with the qualifications they wanted.

On the Program Implementation Survey, most programs (60 percent) indicated they were fully staffed for the last 10 months or longer as reported by the program manager. Of the 17 Tribal MIECHV programs, seven reported hiring one or more home visitors in the past year. Of these seven programs, five reported that it took an average of 4 months or more to identify and select a candidate. Six programs reported it was hard or very hard to recruit qualified candidates. Six programs also reported difficulty finding candidates with experience in three

areas: home visiting, working in the community, and the education or degree required by the model or organization. Three programs reported difficulties recruiting home visitors with their own transportation that would allow them to make home visits.

Although MUSE did not have sufficient data to report on staff turnover, we asked program managers about strategies used to ensure continuity of care when there is a vacancy. They could select multiple strategies but most frequently reported strategies were to shift families to other home visitors' caseloads (93 percent) or supervisors (80 percent). In fewer cases, 40 percent of programs decreased the frequency of visits to families affected by the vacancy. Due to their size, smaller programs (e.g.., one to two home visitors and one supervisor) are more likely to be impacted by staff turnover than larger ones where more staff may be available to fill gaps until a new staff member is recruited, trained, and ready to take on a caseload. The impact of staff turnover on small programs is particularly relevant in Tribal MIECHV, as programs participating ranged in size from 2 to 10 home visitors with most having between 2 to 4 home visitors.

Hiring Priorities

Program managers prioritized hiring home visitors with cultural backgrounds similar to the families served by their programs.

As detailed in chapter 6, hiring home visitors with similar backgrounds and knowledge as caregivers was valued in multiple ways including how they facilitate relationship building with incoming families and enable services to be delivered in Native languages and culturally enriched ways.

As one program manager commented:

> That's one of the first questions when you walk in the house, "Oh, are you Native?" "Yeah." "Well, where are you from?" Like, "Oh, I say I'm from somewhere else," and "Oh, you're not from here, but come on, go ahead sit down."

In this example, shared Native heritage, regardless of specific Tribal affiliation, helped to establish the relationship. Interviewees, including the program manager quoted in the text box below, reflected on how employing community members as home visitors in Tribal MIECHV programs can increase access to services for Native language speakers, reinforce caregiver-home visitor relationships, and enhance service delivery by increasing the facility with which cultural practice can be integrated into visits.

Hiring Priorities Described By a Tribal MIECHV Program Manager

"For us, they **need to be a community member**, because we deliver the lessons in both English and [Native language]. We have some families that strictly want it in [Native language] or, you know, for the most part, having it delivered that way. So, we need staff that are **knowledgeable with the language** and know how to communicate in that way.

"It's also important for us to have **experience in working in early childhood**, with early childhood programs or having some sort of background with child development. And people that are **nonjudgmental**. That's a big piece. People that can **communicate, that can uphold confidentiality**. I think for us, those are like the biggest character type of things that we look for. It's important to us for our families to be able to trust that we're there for the right reasons, and that we really want the best for them….

"Also, being **open minded**, because our program goes through these series of changes and adaptations, and I think we need to have team members that are **willing or want to work with other**s and have that open mindedness to want to be better and to be able to change.

"That's another thing, like **willingness to learn** and support—**be a team member** and be a supportive person to other team members. We provide training and we provide the supports to help staff kind of become confident in areas of delivering lessons and also delivering home visits. It's not too much of a big deal if they don't come in with that, because we provide them with adequate training to get there."

Program managers also prioritized hiring home visitors with interpersonal skills and experience working with children and families.

Even though a majority of home visitors did not have experience in home visiting or similar jobs prior to starting their positions, early childhood experience was described as a common hiring priority for program managers.

Program managers described this priority as a desirable qualification in expansive and varied ways. It exceeded education or direct work experience, including "mother–baby type of experience," such as having experience with labor and delivery, a degree in nursing, and training in child development. One program manager emphasized that a background in "early childhood development is one of the first things that I look for when I look at resumes."

Another suggested that early childhood education "should be a pre-req for any kind of person that comes into home visiting," adding:

> ... We have actually had the experience with a couple of the people that came through that didn't have that background and it's hard to try to get all that information about what's appropriate for early childhood, what's appropriate for being in a home.

But program leadership also prioritized interpersonal skills such as initiative, being a team player, or, as one program manager described, being able to do "heart work" which they explained characterized home visiting. Another suggested, "There's a human element, right, to being a home visitor, being in this type of field at all, and so I don't think that you have to have any educational background to be able to do this work." Yet another reinforced the importance of this unteachable, intangible human element, saying home visitors need to "have a heart": "I can teach anybody how to do a home visit. I can teach them about child development … but I can't teach you to care about or to like people …". Similarly, one interviewee described deprioritizing certain professional duties relative to others saying, they do not look to hire someone "capable of the data entry and stuff" because "that's not as important to me," but rather to hire "somebody who is within this community, somebody who we know will engage with families, be respectful of families, and be supportive."

Conclusion

This chapter described home visitor and program manager characteristics, their personal and professional backgrounds, and program experiences in hiring qualified staff. These findings indicate Tribal MIECHV programs are successfully hiring staff who identify as AIAN and share cultural and community ties with the families they serve. Nearly all Tribal MIECHV staff have some post-secondary education or training and have brought valuable experiences working with children and families or raising children to their work. Tribal MIECHV programs reported stable staffing patterns; however, program managers expressed difficulties in hiring staff with the education, background, and interpersonal skills to excel as home visitors. These findings underscore the importance of retaining highly qualified and skilled home visitors and program managers within Tribal MIECHV programs. Together, the findings presented in this chapter illuminate how staff contribute to the community and cultural context which is crucial to successful program implementation. Chapter 8 explores staff training topics and experiences, supervision types and frequency, peer support, and the importance of these various support strategies.

Chapter 8: Training, Supervision, and Peer Support for Tribal MIECHV Staff

Chapter 8 at a glance

Staff had access to several supports to help deliver home visiting services and support their well-being. These supports included training, supervision, and peer support. Most staff reported the training was helpful, engaging, and related to their day-to-day work with families. Home visitors received two to four supervision sessions per month which included time to reflect on their work with families and discuss their well-being. Reflective supervision helped build trust and provided mentoring, while peer support encouraged teamwork and problem-solving. Overall, staff agreed that almost all of the strategies used to support home visitors were valuable. However, program managers were more likely to place a higher value on reflective supervision, and home visitors were more likely to value continuing education opportunities.

Introduction

Home visiting requires a robust system of training, supervision, and supports to ensure home visitors are equipped to carry out the many activities required in their job. Home visitors receive training and support focused on providing services in accordance with the home visiting model, effectively engaging and supporting families from the community, addressing a wide range of topics—from fostering child development to navigating local services, data collection and entry, and other administrative tasks. This chapter describes three types of support strategies available to Tribal MIECHV staff—training, supervision, and peer support—and examines staff perceptions of their value. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

Training

- On average, staff participated in training once a month. Topics included data collection and entry, administrative tasks, and content specific to supporting children and families.
- About three quarters of staff said training was helpful, engaging, and relevant to their day-to-day work with families.

Supervision

- Home visitors received about two one-on-one supervision sessions each month that frequently covered managing caseloads and the emotional well-being of home visitors.
- Home visitors also received from one to two group supervision sessions a month that lasted about two hours. These most often covered home visitors' emotional well-being and included discussions about their thoughts, feelings, actions, and reactions when working with families.
- Most program managers conducted in-person observations of home visits and said they were essential for assessing home visitors.
- Home visitors were satisfied with the amount and quality of the different types of supervision they received.
- Home visitors said they received reflective supervision as intended—meaning they had time to discuss their thoughts, feelings, actions, and reactions when working with young children and families. They rated supervisors very highly in mentoring and providing trusting relationships.

Peer Support

- Home visitors said they most often turned to their peers with questions about working with team members (such as collaborating on activities and roles), problem solving for specific families, and building skills to better support and provide information to families.

Relative Importance of Support Strategies

- Both home visitors and program managers agreed that almost all of the strategies used to support home visitors were important. However, program managers were more likely to place a higher value on reflective supervision, and home visitors were more likely to value continuing education opportunities.

Staff Training

When staff are first hired, home visiting models provide extensive initial training and onboarding for home visitors focused on the model's curriculum and processes for delivering services. In general, extensive foundational training must be completed before home visitors can begin providing visits to families. Continued training, coaching, and shadowing are provided while they are slowly building their caseloads (i.e., number of families assigned to them). Models also provide training for program managers that include strategies for supervising and supporting home visitors. Ongoing training throughout a home visitor's tenure is often provided by the model, the agency housing the home visiting program, community partners, and Tribal MIECHV technical assistance providers.

This section presents data on staff training including time spent, topics covered, and the value of training, as reported by home visitors and program managers on implementation logs and staff surveys.

Frequency and Focus of Training

On average, staff participated in training once a month. Topics included data collection and entry, administrative tasks, and content specific to supporting children and families.

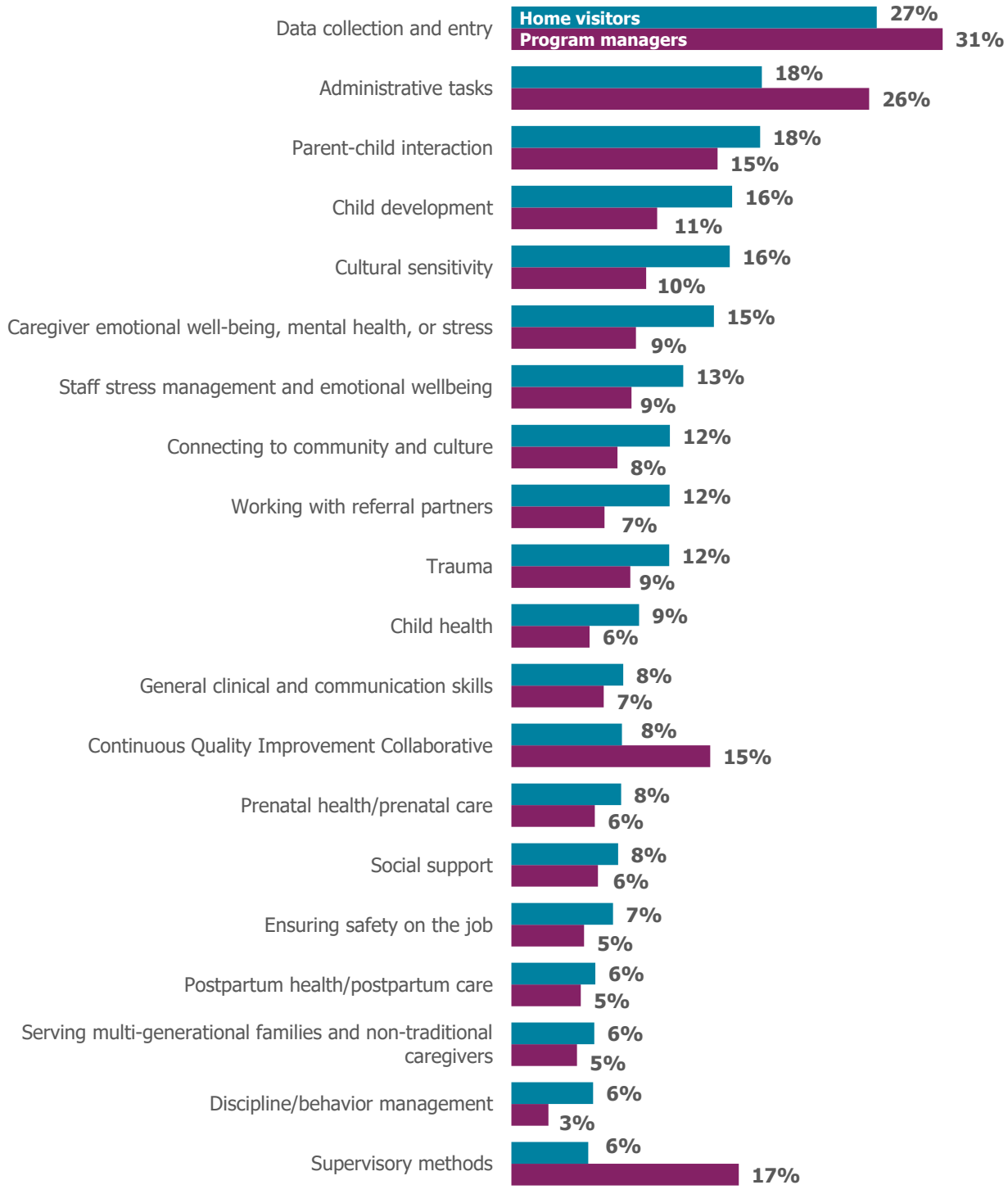
On average, staff attended one training per month, which was similar for home visitors and program managers. Home visitors spent an average of 3.6 hours each month in training, while program managers spent about an hour more, an average of 4.5 hours a month. About 80

percent of staff training was delivered virtually[24], with the remaining 20 percent in person. Most home visitors (61 percent) and program managers (64 percent) reported they could attend training in areas relevant to their professional needs and goals if they asked. Regarding initial model training described in the introduction to this section, all program managers attended model training for home visitors, and 64 percent attended model training for supervisors and training on staff management.

Within the Implementation Logs, we collected data on a range of training topics. We developed a comprehensive list of topics by drawing from previous home visiting implementation studies, model requirements, and conversations with grant recipients. As shown in exhibit 8.1, home visitors and program managers attended trainings about a lengthy list of topics. The most frequent—for both home visitors and program managers—was data collection and entry, reflecting the emphasis Tribal MIECHV and the models place on performance measurement and data-informed service delivery. Additionally, home visitors frequently attended trainings on administrative tasks and a range of topics related to working with children and families (e.g., parent-child interaction, child development, caregiver emotional well-being) and working within the community (e.g., cultural sensitivity, connecting to community and culture, referral partners). Program managers received more frequent training on administrative tasks, supervisory methods, and continuous quality improvement collaboratives which were sponsored by ACF during the MUSE data collection period. However, program managers also received training in all the same topics as home visitors, just less frequently. For both home visitors and program managers, 29 percent of trainings were delivered by the program's Tribe or organization, 27 percent by federal technical assistance providers, 25 percent by other consultants or organizations, 10 percent by models and 9 percent by states. Home visitors attended more training delivered by the program's Tribe or organization compared to program managers (31 versus 22 percent). Program Managers attended more training delivered by federal technical assistance providers than did home visitors (42 versus 22 percent).

[24] The high percentage of staff training delivered virtually was likely due to MUSE occurring during COVID-19.

Exhibit 8.1. Percentage of Trainings Where Topic Was Addressed by Staff Role



Note: Data are from the implementation logs. Sample includes 1,011 Training Logs, with 66 home visitors and 22 program managers attending recorded trainings. More than one topic could be discussed during training sessions. Topics were excluded from chart if addressed in less than 5 percent of training sessions for both home visitors and program managers.

Perceptions of the Value of Training

About three quarters of staff said training was helpful, engaging, and relevant to their day-to-day work with families.

When asked about the value of the training they received, most home visitors and program managers regarded them as directly related to their work, helpful and engaging, and relevant for the families and the community they served (exhibit 8.2). When asked whether trainings were individualized to meet their needs, program managers were much more likely to agree (73 percent) than home visitors (53 percent).

Exhibit 8.2. Perceived Value of Trainings by Staff Role



Note: Data are from the Home Visitor Survey (*N* = 55) and Program Manager Survey (*N* = 16).

Supervision

Several different types of supervision strategies are used by Tribal MIECHV programs including one-on-one, group, and observation of home visits. Reflective supervision—or supervision focused on examining the thoughts, feelings, actions, and reactions evoked in the course of working closely with young children and their families (Early Childhood Technical Assistance Center, 2022)—is typically a component of one-on-one and group supervision. It is seen as an important support to help home visitors develop critical competencies and manage complex relationships and emotions encountered in their work with families (West et al., 2022). As such, Tribal MIECHV programs were required to incorporate into their Implementations Plans, plans

to ensure administrative, clinical, and reflective supervision (as well as general reflective practice) for all home visitors and supervisors.

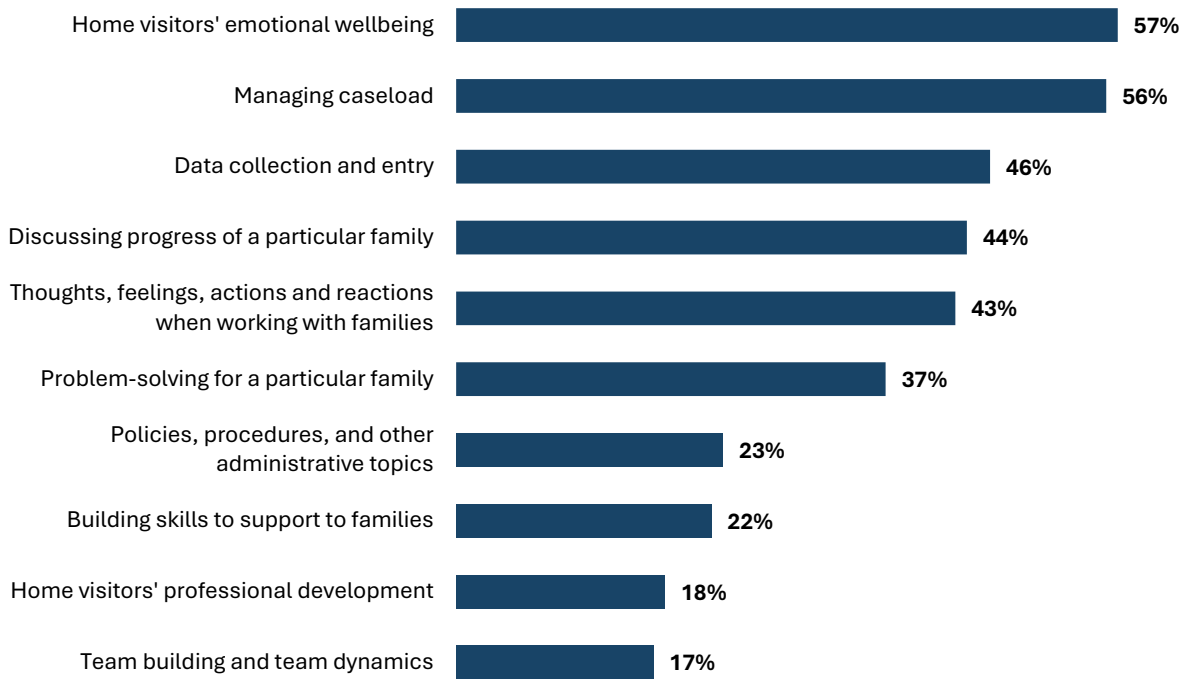
This section presents implementation log data on the types of supervision home visitors received (e.g., one-on-one, group, observation) and data on the quality of supervision as reported by home visitors and program managers on staff surveys.

One-on-One Supervision Sessions

Home visitors received about two one-on-one supervision sessions each month that frequently covered managing caseloads and the emotional well-being of home visitors.

On average, home visitors received 2.2 individual supervision sessions with their direct supervisor each month (*SD* = 1.2, range = 1–6). Most supervision sessions (89 percent) were led by Tribal MIECHV staff members, with the remaining 11 percent provided by external consultants. On average, 4.3 topics were discussed per session. Home visitors' emotional wellbeing and managing caseload were the most frequently discussed topics and were addressed in over half of all sessions. Forty-three percent of supervision sessions incorporated reflective practice (i.e., addressed the home visitor's thoughts, feelings, actions, and reactions when working with families). Exhibit 8.3 displays the percentage of one-on-one supervision sessions where the topics were covered.

Exhibit 8.3. Percentage of One-on-One Supervision Sessions Where Specific Topics Were Covered



Note: Data are from implementation logs. Sample includes 880 One-on-One Supervision Logs for each session held with 59 home visitors. Percentages do not add up to 100 because staff had the option to choose more than one topic per one-on-one supervision session.

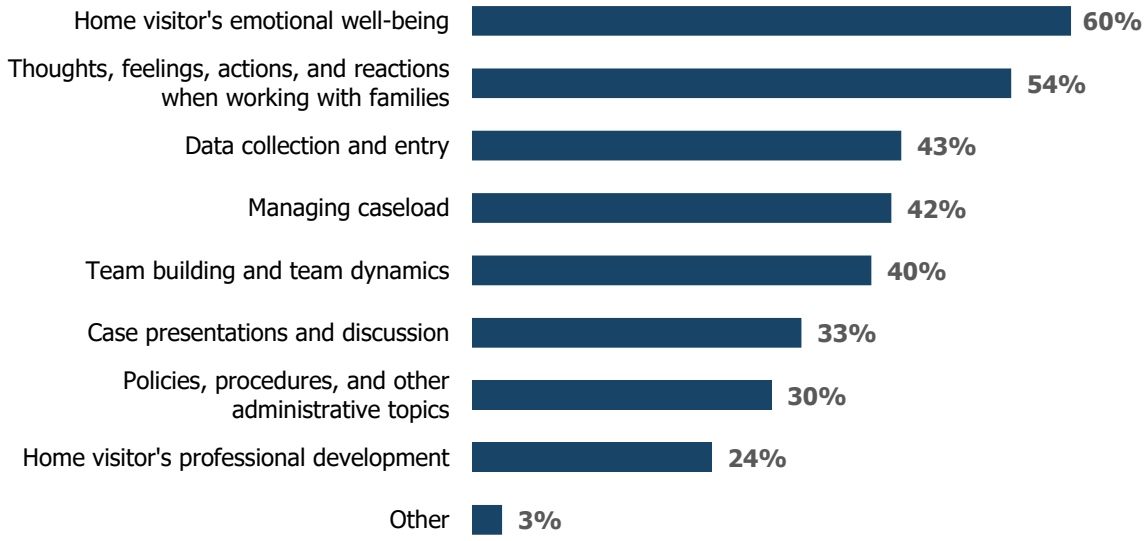
Group Supervision Sessions

Home visitors also received from one to two group supervision sessions a month that lasted about two hours. These most often covered home visitors' emotional wellbeing and included discussions of their thoughts, feelings, actions, and reactions when working with families.

In addition to receiving one-on-one supervision, home visitors participated in an average of 1.5 group supervision sessions per month (*SD* = 1.1, range = 0–4) that lasted an average of 2 hours and 20 minutes (*SD* = 1.6, range = 0–5). Group supervision was mostly led by Tribal MIECHV staff members (67 percent), followed by an external consultant (23 percent), with the remaining sessions (10 percent) led by a combination of Tribal MIECHV staff and external consultants or some other arrangement. As with one-on-one supervision, the most frequent topic of group supervision sessions was home visitor emotional well-being. However, group supervision focused less frequently than one-on-one supervision on managing caseload and data collection and entry and more often on thoughts, feelings, actions, and reactions when

working with families (i.e., reflective practice). Exhibit 8.4 displays the percentage of group supervision sessions where a specific topic was covered.

Exhibit 8.4. Percentage of Group Supervision Sessions Where the Specific Topics Were Covered



Note: Data are from implementation logs. Sample includes 495 logs, one for each group supervision session held with a total of 65 home visitors. Percentages will not add up to 100 because staff could choose more than one topic per group supervision session.

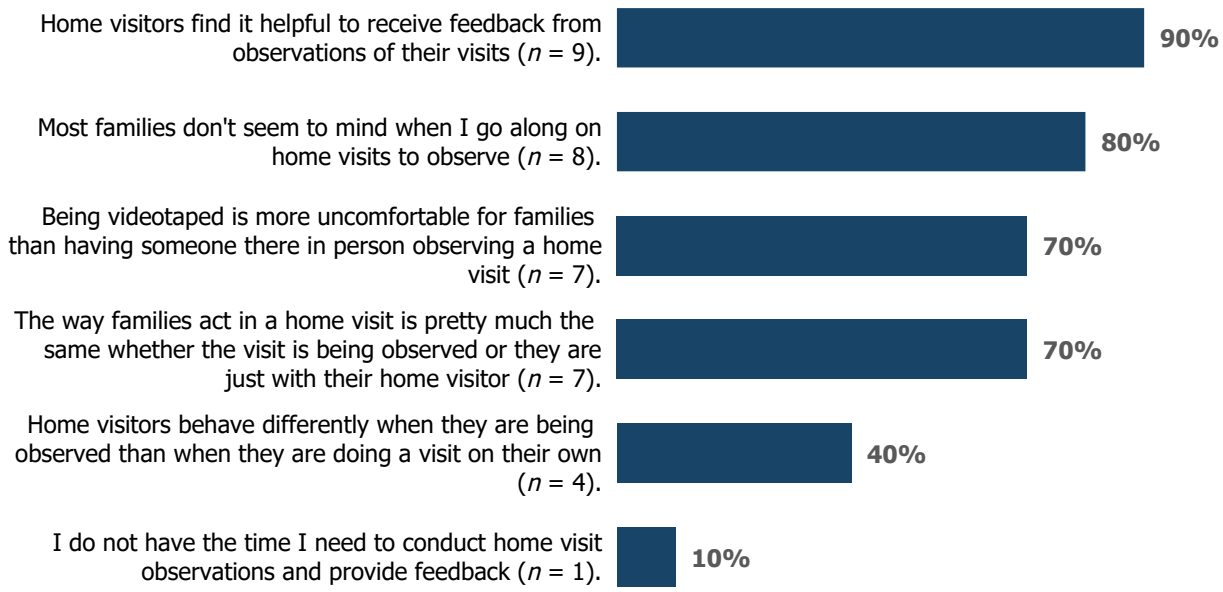
Observations of Home Visits

Most program managers conducted in-person observations of home visits and said they were essential for assessing home visitors.

Of the 12 program managers who responded to questions about observations on the Program Manager Survey, 10 (83 percent) reported they conducted in-person observations during some visits. Of the 10 who conducted observations, most (n = 8) did so for all their home visitors, while some only observed new home visitors (n = 2), home visitors who requested to be observed (n =1), or those who needed extra help (n = 1). Most of these program managers observed home visitors two or more times per year (n = 9), all (n = 10) used a specific tool or form for observations (a variety of tools were used across programs); and six received training on that tool. Six program managers felt they could use additional training on the observation tool they used. Most reported being satisfied or very satisfied with the rating areas on the tool (n = 9) and all (n = 10) found it to be either somewhat or extremely useful for guiding their observations.

Program managers generally regarded observation as valuable and feasible. Of those who used observation, eight described it as one of several essential tools for assessing home visitors, and two described it as the most important tool. As shown in exhibit 8.5, most program managers believed that home visitors found observation-based feedback helpful, reported that most families didn't mind being observed and did not act differently when being observed, and most also reported that in-person observation was more acceptable to families than videotaping visits.

Exhibit 8.5. Program Manager Perceptions of the Value of Observation



Note: Data are from the Program Manager Survey. The sample includes 10 program managers who answered the questions. The numbers reported above are the percentages of program managers who reported agree or strongly agree with these reflections on observation.

Satisfaction With Supervision

Home visitors were satisfied with the amount and quality of the different types of supervision they received.

Home visitors responded to a series of questions about the frequency and adequacy of supervision in particular areas. Eighty-one percent reported getting "just the right amount" of one-on-one reflective supervision and 72 percent reported getting "just the right amount'" of group reflective supervision. They were also asked whether they would like to discuss 10 particular topics with their one-on-one direct supervisor more often, about the same, or less

frequently than they currently did. They generally reported that the frequency of supervision was about what they wanted across topics (exhibit 8.6).

Exhibit 8.6. Home Visitor Preferences for Amount of Supervision, by Topic

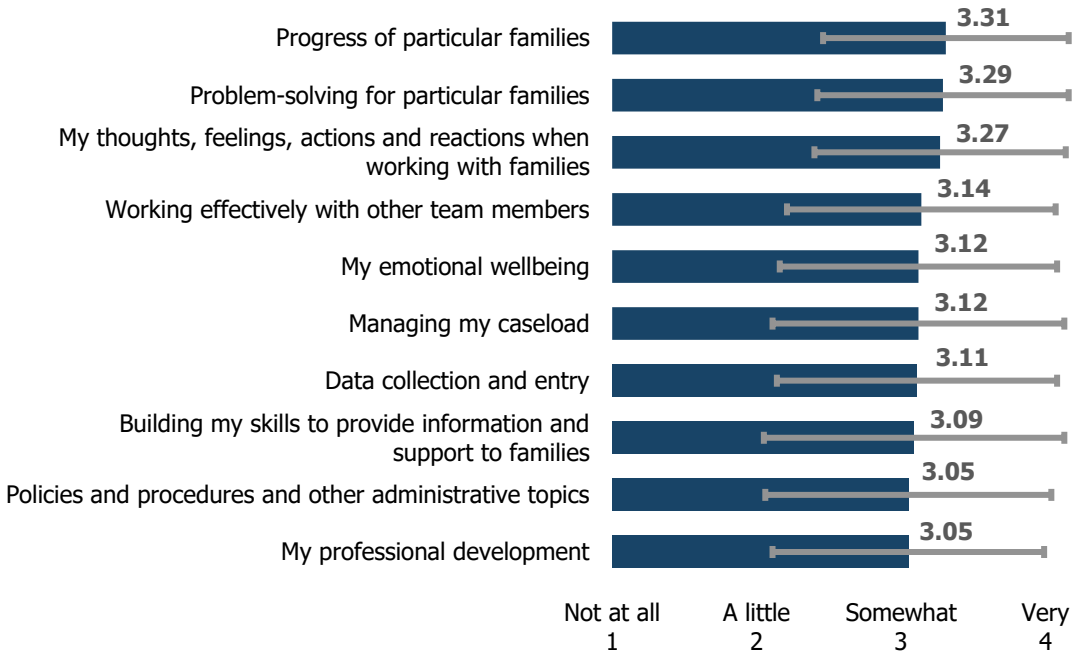


Note: Data are from the Home Visitor Survey (*N* = 55). Response options ranged from 1 (less) to 3 (more); higher scores reflect a desire for more supervision on the topic. The response option "Not sure" was excluded. The bars represent the mean score and the lines represent the standard deviation of the mean score.

Home visitors were also asked to reflect on how helpful supervision was for each of these 10 topics. On average, they reported that direct supervisors were "somewhat" to "very helpful" across all topics (exhibit 8.7). The top three most helpful topics focused on working directly with families.

We were also interested in the effectiveness of supervision from the perspective of program managers, so we asked them to report how confidently they could support home visitors in each of these areas during one-on-one or group supervision. They reported high confidence across all areas, with average scores ranging from 4.27 to 4.45 with scores mostly falling between 4 (mostly) and 5 (completely confident).

Exhibit 8.7. Home Visitor Perceptions of the Helpfulness of Supervision



Note: Data are from the Home Visitor Survey (*N* = 55). Response options ranged from 1 (not at all helpful) to 4 (very helpful). Higher scores reflect more perceived helpfulness. The bar represents the mean score, and the lines represent the standard deviation of the mean score.

Home visitors were asked to reflect on the supervisory and leadership support they received. Eighty-five percent reported having a supervisor or someone in a leadership position they could go to for support in their job every month over the past 12 months; 19 percent reported some months with no support. Likewise, when asked about reflective supervision, 81 percent reported they were able to receive reflective supervision to explore thoughts, feelings, actions, and reactions every month over the past 12 months; 19 percent reported some months with no support. The final question asked about having a trusting relationship (regardless of role) with someone in their program. Ninety-two percent of home visitors reported they had this support every month in the past 12 months, whereas 8 percent reported some months with no support.

Twelve program managers responded to questions about the supervisory and leadership support they received. Ten program managers reported having a supervisor or someone in a leadership position they could go to for support in their job every month over the past 12 months; 2 reported some months with no support. Likewise, when asked about supervision, 9 reported they were able to receive reflective supervision to explore thoughts, feelings, actions, and reactions every month over the past 12 months; 3 reported some months with no support. The final question asked about having a trusting relationship (regardless of role) with someone

in their program. Nine program managers reported they had this support every month in the past 12 months, whereas 3 reported some months with no support.

Experiences with Reflective Supervision

Home visitors said they received reflective supervision as intended—meaning they had time to discuss their thoughts, feelings, actions, and reactions when working with young children and families. They rated supervisors very highly in mentoring and providing trusting relationships.

To gain a deeper understanding of home visitor experiences with reflective supervision, we integrated the Reflective Supervision Rating Scale (Gallen et al., 2016) into the Home Visitor Survey. This measure utilizes supervisee ratings of different aspects of supervision sessions to assess the degree to which reflective supervision is being provided as intended. It assesses four key domains of reflective supervision: reflective processes and skills, mentoring, supervision structure, and mentalization. Short descriptions of each domain are included in exhibit 8.8, and specific items assessing each domain are included in appendix A. As shown in exhibit 8.8, mean scores in each domain were high, indicating home visitors were receiving reflective supervision that aligned with best practices.

Exhibit 8.8. Home Visitor Reflective Supervision Ratings

Domain	Number of items	Cronbach's alpha	Mean*	Standard deviation
Reflective Processes and Skills Encouraging growth and skill development	6	0.95	3.95	1.04
Mentoring Providing a trusting, attentive, and collaborative learning relationship	6	0.91	4.29	0.77
Supervision Structure Providing consistent and engaged supervision	3	0.81	4.09	0.88
Mentalization Understanding emotional, situational, and cultural influences on behavior	5	0.93	4.17	0.92

Note: Data are from the Home Visitor Survey ($N = 55$). *Response options ranged from 1 (never) to 5 (always); higher scores reflect greater frequency.

During qualitative interviews, most home visitors described the support they received through reflective supervision favorably, especially as it went beyond other forms of supervision focused

on performance indicators and paperwork. One underscored the value of one-on-one time to discuss caseload challenges and family resources and feeling "better heard" because of it. Another highlighted that reflective supervision focused not only on work-related challenges but also on personal ones, as well as on successes:

> If we're having some problems at home, you know we're in an environment where we can talk about anything, you know. Just any problems that we have or anything going on. I've had a grandbaby, ... just anything positive, you know whatever our celebrations are.

This home visitor also commented on reflective supervision as an opportunity for goal setting and for receiving support toward achieving these goals. And another stated that feedback received during reflective supervision made them feel good about their work, along with their relationship with families.

While describing reflective supervision as "incredibly valuable" in theory, one home visitor commented that when supervisors are not prepared and supported to provide the reflective part, reflective supervision can be less impactful, reverting back to "them going over our numbers."

In the absence of supportive reflective supervision, this same home visitor described how their peers picked up the slack. They characterized coworkers as

> ... who we go to, when there's ... a tricky case, or I had this really stressful visit, or what do you recommend for this type of diaper rash. Anything, whatever it is. We all help each other and so that's a huge resource.

This quote highlights the value of multiple sources of support, including support from peers, discussed next.

Peer Support

Peers can also play an important role in supporting the work of home visitors. Peer support can be informal or built into program processes and can be a critical source of information, guidance, and encouragement. This section presents data from surveys and interviews with home visitors on the use of peer support and its helpfulness.

Home visitors said they most often turned to their peers with questions about working with team members (such as collaborating on activities and roles), problem solving for specific families, and building skills to better support and provide information to families.

Home visitors rated how often they turned to peers for support in the same areas examined for supervision. They were asked to indicate, for each area, if they looked to other home visitors for support. Response options ranged from 1 (never) to 5 (always), with higher scores reflecting more frequent use. As shown in exhibit 8.9, average ratings across domains were in the middle of the response scale, indicating they sometimes looked to peers for support. The area where they sought peer support most often was in working effectively with other team members (e.g., collaborating on activities and roles and responsibilities of team members), followed by problem solving for specific families and building my skills to provide information and support to families. In contrast, peer support was used least often for managing caseloads, supporting emotional well-being, and professional development.

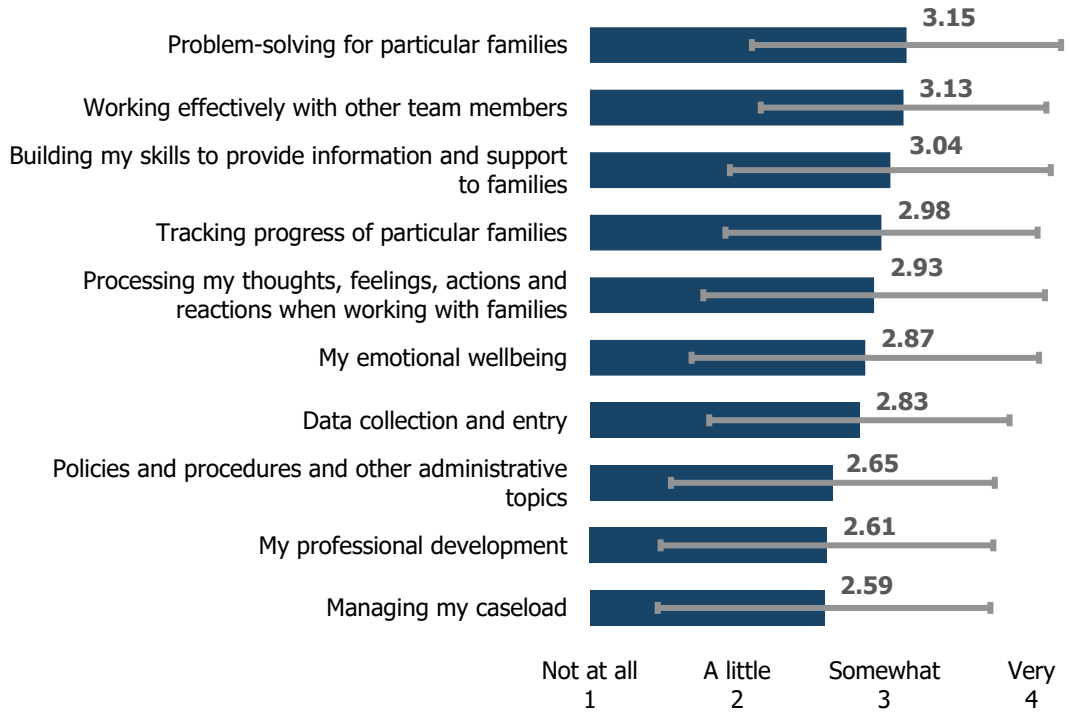
Exhibit 8.9. Frequency of Peer Support Among Home Visitors



Note: Data are from the Home Visitor Survey ($N = 55$). Response options ranged from 1 (never) to 5 (always); higher scores reflect more frequent use of peer support. The bar represents the mean score, and the lines represent the standard deviation of the mean score.

Next, we looked at ratings of its perceived helpfulness. Home visitors rated peer support as the most helpful in the same areas in which they turned to peers most often (exhibit 8.10). Peer support was perceived as the least helpful in areas where home visitors saw supervisor support as more helpful (e.g., managing caseloads, policies and procedures and other administrative topics, and professional development; see exhibit 8.7).

Exhibit 8.10. Perceived Helpfulness of Peer Support Among Home Visitors



Note: Data are from the Home Visitor Survey ($N = 55$). Response options ranged from 1 (not at all helpful) to 4 (very helpful). Higher scores reflect more perceived helpfulness. The bar represents the mean score, and the lines represent the standard deviation of the mean score.

In qualitative interviews, home visitors described the role of peer support, including peer feedback. One noted:

> Sometimes I'll dwell on those tough cases where I feel like I'm not getting through … but we're always with each other here. Our team, we're always practicing like positive affirmations with each other. So, sometimes when I get that feedback from my coworkers or even sometimes the clients are like wow that really, you did this ... it really helped.

These findings show how home visitors use peer support and supervision for different purposes. Below, we examine perspectives on these and additional specific support strategies.

Relative Importance of Support Strategies

The findings above show that home visitors accessed a variety of support to do their jobs well, including training, supervision, and peer support. We wanted to learn how staff felt about many of the specific support strategies commonly used by programs to prepare and support home visitors in their work. The staff survey, we presented both home visitors and program managers with a list of strategies and asked them to rate the importance of each. This section summarizes those ratings.

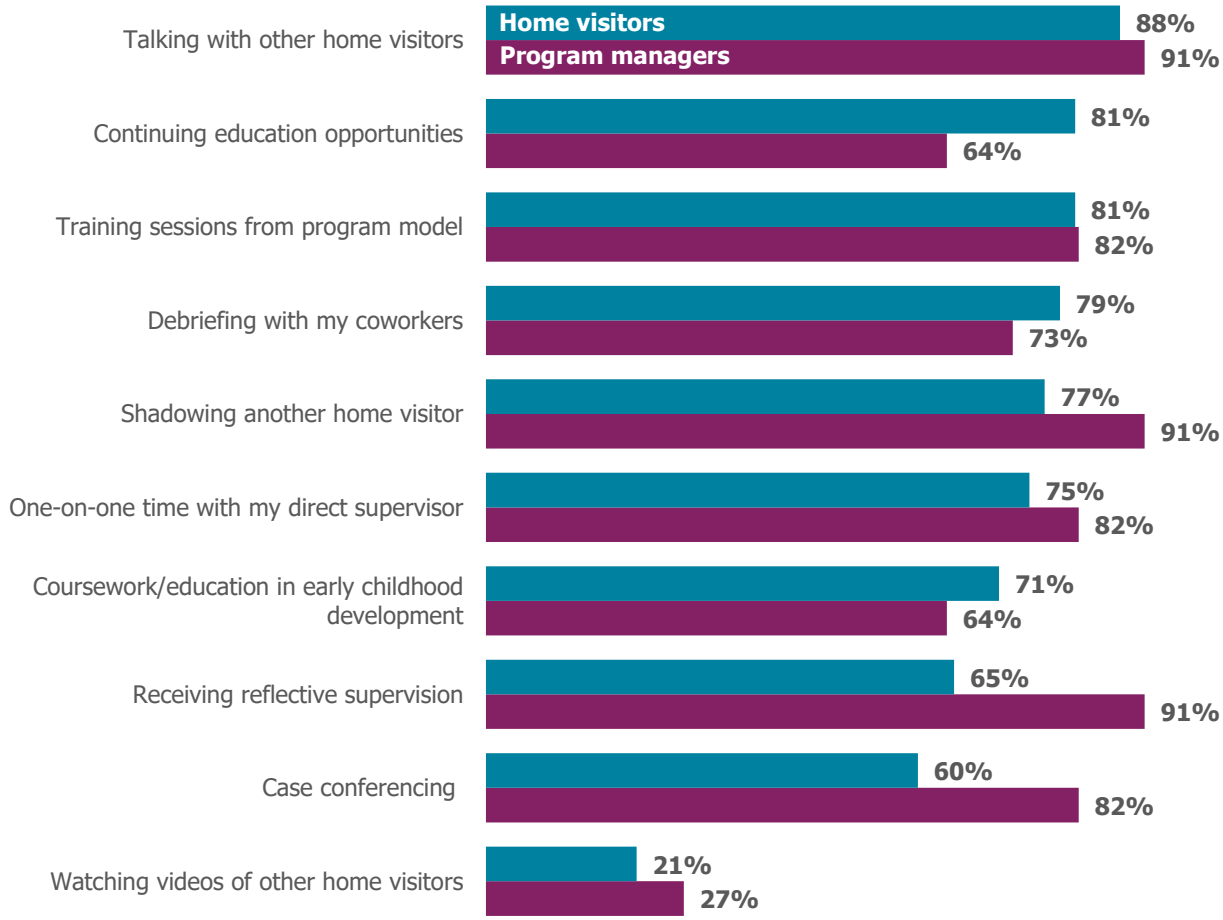
Both home visitors and program managers agreed that almost all of the strategies used to support home visitors were important. However, program managers were more likely to place a higher value on reflective supervision, and home visitors were more likely to value continuing education opportunities.

Exhibit 8.11 shows the percentages of home visitors and program managers who reported that each strategy was very important. Many of the strategies deemed very important by most home visitors were supports from peers—talking with other home visitors, debriefing with coworkers, and shadowing other home visitors. One-on-one time with direct supervisors was also seen as very important, as were continuing education opportunities, coursework in early childhood development, and training sessions from the program model.[25] Reflective supervision and case conferencing were rated as important less often but still seen as important by the majority. Only a minority of home visitors rated watching videos of other home visitors as very important.

Program managers, on average, rated more strategies as very important than did home visitors. The three strategies they rated as most important by program managers were talking with other home visitors, shadowing other home visitors, and reflective supervision (91 percent rated each of these as very important). Talking with other home visitors was also rated as very important by most (88 percent) but shadowing other home visitors and reflective supervision were rated as very important by a smaller percentage (77 percent and 65 percent, respectively). In contrast, continuing education was rated as very important by 81 percent of home visitors but by only 64 percent of program managers.

[25] Case conferences are meetings where home visitors and program managers gather to review a family's care plans, reflect referrals and services, and discuss challenges.

Exhibit 8.11. Staff Rating of the Importance of Support Strategies for Home Visitors



Note: Data are from the Home Visitor Survey (*N* = 55) and Program Manager Survey (*N* = 16). The numbers reported above are the percentages of staff who rated these support strategies as "very important."

Conclusion

This chapter described the kinds of support received by Tribal MIECHV staff—namely training, supervision, and peer support—and examined staff perceptions of the value of different supports. Home visitors received ongoing supports, including monthly training, bimonthly one-on-one supervision, and at least monthly group supervision. While training was provided on a wide variety of topics, data collection and entry was the most frequent training topic reported by both home visitors and program managers. These topics were also regularly discussed in both one-on-one and group supervision (46 and 43 percent of sessions, respectively). The extent of data-related support reported by program staff reflects efforts to be responsive to Tribal MIECHV's emphasis on data-informed services and an emerging expectation that direct

service providers within the home visiting field possess skill sets beyond those focused on child and family development. Future efforts could focus on finding ways to both streamline data demands and create more efficient approaches to equipping home visitors with the necessary skills to collect vital data.

Home visitors were generally satisfied with the amount and quality of supervision received. They reported that supervision was often focused on their emotional well-being and involved reflective practice, facilitated in accordance with best practices for reflective supervision. They were less satisfied with how often professional development was discussed during supervision and found those discussions less helpful. Findings suggest Tribal MIECHV programs have appropriate structures in place to support home visitors to be successful in their demanding and complex jobs, but they also point to some opportunities for greater investment in the development of this workforce.

This chapter showed home visitors found training, supervision, and peer support to be helpful across a broad range of topics, but the sources of support seen as most helpful varied somewhat by topic. Supervision appeared to be especially helpful in areas like managing caseloads, tracking progress of families, and following policies and procedures. Peer support, in contrast, was especially helpful in areas like working effectively with team members and problem solving for specific families. These findings underscore the value of multi-pronged strategies that utilize the strengths of different home visiting team members and support structures. Understanding these patterns can help programs tailor delivery of supports and prioritize utilization of resources efficiently and effectively. Chapter 9 explores the experiences of Tribal MIECHV staff members including workload, the work environment, self-efficacy, and job satisfaction.

Chapter 9: Staff Experiences in Tribal MIECHV

Chapter 9 at a glance

Tribal MIECHV home visitors had confidence in their ability to do their jobs well. They also had a positive outlook on their workload and working environment. Despite the challenges of working with families that have multiple stressors in their lives and dissatisfaction with compensation, home visitors reported high levels of compassion satisfaction and low levels of compassion fatigue. Overall, home visitors remained committed to working with families and making a difference in their community.

Introduction

Home visiting is a deeply meaningful but demanding multi-faceted job. Home visitors take on many roles including educators, counselors, advocates, and sometimes crisis responders. They build trust and relationships with caregivers and experience complex family dynamics which can take an emotional toll. By examining the work experiences of staff, including their professional well-being, we can identify the supports and investments that are critical to retaining and strengthening the home visiting workforce.

This chapter describes the experiences of Tribal MIECHV staff as they implement home visiting, including workload, perceptions of their work environment, self-efficacy (i.e., how they feel about their abilities to do their jobs well), and reflections on job satisfaction and their professional quality of life. We also examine the important contributions home visitors make to their communities through this work. For more information on data sources and sample sizes for the MUSE study, please visit Chapter 2: Mixed-Methods Approach to Studying Implementation of Tribal MIECHV.

Key Findings

- On average, home visitors worked 40 hours per week. The number of families they served varied widely—from as few as 3 to as many as 38—but the average was 13. Two thirds of home visitors felt their caseloads were "about right."
- Program managers worked an average of 43 hours a week and felt their supervisory and caseload responsibilities were "about right."
- Overall, home visitors reported a positive workplace culture and climate in their organizations.
- Home visitors reported high levels of confidence in their ability to carry out many different activities during home visits, most notably engaging caregivers, tailoring visits while still delivering curricula as intended, and collecting data.
- Home visitors reported high levels of confidence addressing a wide range of topics with families during home visits, including child health and development, maternal health and development, and family well-being.
- Home visitors reported high job satisfaction and low frustration overall, even though they were not satisfied with their pay and opportunities for promotion. Most said they were very likely to remain in their jobs for the next 6 months.

- Home visitors reported high levels of compassion satisfaction and low levels of burnout and secondary trauma.
- Home visitors reported that their role and work within the community was valuable and meaningful.

Workload and Perceptions of the Work Environment

This section presents data on workload and organizational culture and climate as reported by home visitors and program managers on staff surveys.

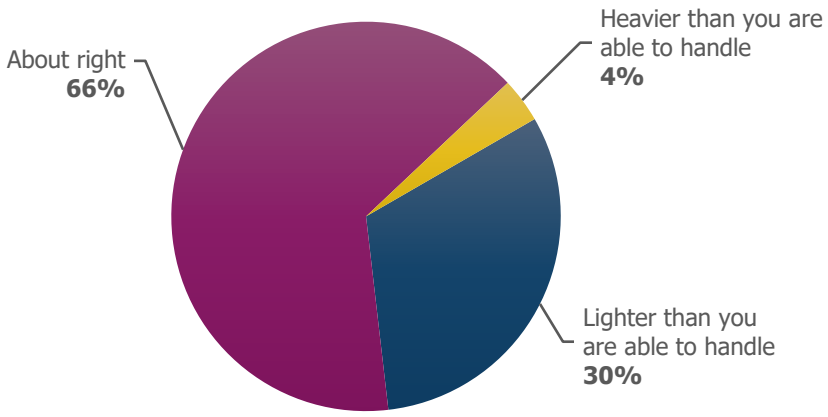
Perceptions of Workload

On average, home visitors worked 40 hours per week. The number of families they served varied widely—from as few as 3 to as many as 38—but the average was 13. Two thirds of home visitors felt their caseload was "about right."

We asked home visitors about indicators of workload including hours worked in a typical week, the number of families they served, and how they felt about the size of their current caseloads.[26] Home visitors worked an average of 40 hours in a typical week (*SD* = 1.09, range = 38–45). While the number of families they reported serving varied (*SD* = 6.41, range = 3–28), the average number served was 13 families. Two-thirds of home visitors reported the size of their current caseloads (i.e., the number of families assigned to a home visitor) was about right, and just under one-third reported they were lighter than they could handle (exhibit 9.1). Sixty-eight percent reported they never had a "heavy" caseload in the past 6 months. Eighty percent of program managers reported that home visitors did not have caseloads exceeding the limits outlined by program policy, currently or in the past 12 months.

[26] Most home visiting models have requirements around the size of home visitor caseloads. These requirements are intended to support manageable workloads for home visitors and quality services for families. In addition to model requirements, programs may have their own policies on caseload size. We did not examine whether these reported caseload counts were outside the range of model or program requirements.

Exhibit 9.1. Home Visitor Reflections on the Size of Their Caseload



Note: Data are from the Home Visitor Survey. Sample includes home visitors who reported working full time (i.e., 35+ hours per week) and carried a caseload (*N* = 50).

Program managers worked an average of 43 hours a week and felt their supervisory and caseload responsibilities were "about right."

Program manager roles vary across Tribal MIECHV programs. Some managers oversee multiple programs and dedicate a portion of their time to the Tribal MIECHV program including staff supervision. In other situations, program managers maintain a family caseload in addition to their supervision responsibilities. To better understand this variability, the Program Manager Survey included several questions about indicators of workload including hours worked in a typical week, size of their caseload (if they had one), and how they felt about the size of their caseload and supervisory responsibilities. Twenty-five percent (*n* = 4) of program managers reported they also carried a caseload, and the number of families on their caseloads ranged from 2 to 8 families. Overall, program managers reported working an average of 43 hours in a typical week (*SD* = 11.3, range = 20–75). Eighty-five percent (*n* = 14) program managers reported working full time or more than 35 hours per week. Nearly all (92 percent) program managers described the number they supervised as "about right," and 92 percent reported they never had a supervisor-to-home visitor ratio that was more than they could handle in the past 6 months. Program managers that also carried a caseload reported that the size of their caseload was "about right" given their other responsibilities as a program manager.

Perceptions of Workplace Culture and Climate

Overall, home visitors reported a positive workplace culture and climate in their organizations.

Research has demonstrated the importance of the work environment, specifically organizational culture and climate, for the implementation of evidence-based practices like home visiting (Glisson & Hemmelgarn, 1998; Aarons et al., 2014). To understand home visitor perceptions of the cultures and climates of their programs, teams, organizations, and leadership, we used an adapted version[27] of a measure published by Edmondson (1999). We selected seven scales from this measure identified by study partners as most relevant to the home visiting context Supportiveness of the Organization Context, Clear Direction, Team Psychological Safety, Team Efficacy, Team Composition, Team Learning Behavior, and Team Leader Coaching. More details on each of these dimensions and items used to measure them can be found in appendix A.

Reliability analyses showed these scales to be sufficiently internally consistent in the MUSE sample of home visitors, so mean scores were calculated for each scale (exhibit 9.2). Home visitors generally rated the culture and climate of their workplaces positively, averaging around 3 on a 4-point scale (i.e., agreeing, but not strongly agreeing with positive statements on the measure). When averaged across programs, there was little difference across the dimensions assessed, although ratings about Team Leader Coaching were the highest.[28]

Exhibit 9.2. Organizational Culture and Climate

Dimension	Number of items	Cronbach's alpha	Mean*	Standard deviation
Supportiveness of Organization Context	5	0.78	2.97	0.57
Clear Direction	3	0.87	2.97	0.71
Team Psychological Safety	7	0.67	3.04	0.44
Team Efficacy	3	0.88	3.13	0.60
Team Composition	3	0.67	3.05	0.62
Team Learning Behavior	12	0.89	3.08	0.52
Team Leader Coaching	10	0.96	3.21	0.72

Note: Data are from the Home Visitor Survey ($N = 46$ except for Team Leader Coaching, where $N = 45$). *Response options ranged from 1 (strongly disagree) to 4 (strongly agree). Higher scores reflect more perceived positive climate.

[27] The study team made very minor changes to the wording of most items (i.e., changing "this team" to "our team" or "this company" to "this organization"). We also made wording changes in response to feedback from MUSE program partners, added three items to the Team Learning Behavior scale, and expanded the Team Leader Coaching scale by adding seven items. All items used as a part of the MUSE measure of organizational culture and climate are included in appendix A, along with descriptions of specific changes from the original Edmondson measure.

[28] We examined ratings for variability across programs and found them to be similar for most, although home visitors from one program consistently reported the highest ratings on all dimensions and home visitors at another consistently reported the lowest ratings.

Home Visitor Self-Efficacy

This section presents data on home visitor self-efficacy or home visitors' confidence in their ability to do their jobs, as reported in staff surveys and interviews. The training and support home visitors receive (see chapter 8) is essential in preparing them to provide services and cultivating their self-efficacy or confidence in their ability to deliver those services to caregivers. To assess their sense of confidence in a number of areas, home visitors reflected on how prepared they felt for the wide variety of activities and topics they often address with caregivers with the response ranging from 1 (not at all confident) to 5 (completely confident).

Home visitors reported high levels of confidence in their ability to carry out many different activities during home visits, most notably engaging caregivers, tailoring visits while still delivering curricula as intended, and collecting data.

Home visitors expressed high levels of confidence (i.e., completely or mostly confident) that they could manage most of the activities required in their jobs (see exhibit 9.3). More than 80 percent said they were mostly or completely confident in their abilities to carry out over two thirds of the activities. One hundred percent were either completely or mostly confident in their abilities to communicate warmth, appreciation, and respect with families, and related activities showed similarly high levels of confidence (e.g., build relationships and trust with caregivers and their families, identify and communicating strengths to caregivers). Home visitors were also confident in their abilities to deliver curriculum in a way that meets individual family needs and to carry out associated activities like planning home visits, modeling and coaching parenting skills, helping families access needed services, and developing and using family goal plans. They expressed high levels of confidence doing activities requiring a different skill set than those described above. Between 86 and 96 percent were completely or somewhat confident in their abilities to collect data from families, enter those data into data systems, document what happens during the home visit, and conduct required screenings. The fewest number of home visitors expressed high levels of confidence in their abilities to engage fathers, fussy children, or distracted caregivers during visits (although still more than 65 percent reported high levels of confidence in these areas).

Home visitors reported high levels of confidence addressing a wide range of topics with families during home visits, including child health and development, maternal health and development, and family well-being.

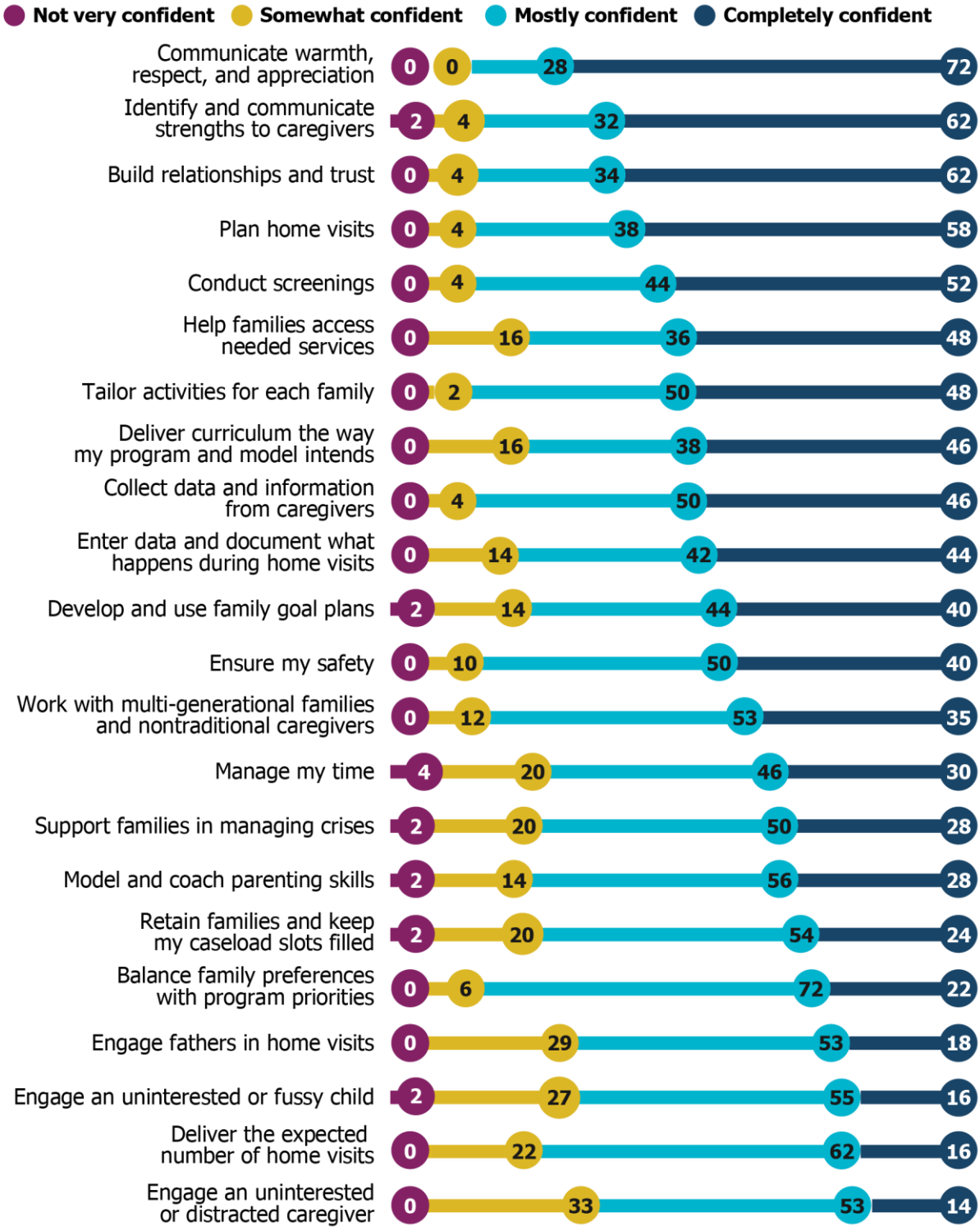
When it came to addressing particular topics with caregivers, home visitors expressed very high levels of confidence when addressing most of the topics presented (see exhibit 9.4). In fact, 20 out of 27 topics were rated as completely or mostly confident by more than 80 percent of home visitors. The topics that were rated the highest were related to child and family health, parenting and child development, and social and emotional support. The topics where home visitors expressed the lowest levels of confidence (although still more than half reported high levels of confidence) were those beyond the primary focus of most home visiting models, including substance use, domestic violence, dealing with trauma, and involvement with the legal system. Coparenting was also rated low with 31 percent saying they were somewhat confident. The two topic areas where most home visitors reported being not very confident were legal systems and services and breastfeeding.

As these findings demonstrate, home visiting requires a broad skillset and an ability to engage with families on many different topics. While Tribal MIECHV home visitors were highly confident in most areas, there were variations across topics and activities, and many factors likely contributed to this variation. Due to data collection disruptions related to the COVID-19 pandemic that limited the sample size, MUSE was unable to directly explore what drove this variation but factors could include home visitor background and experience, training, supervision, the degree to which the model focuses on the topic/activity, and the availability of services in the community.

Professional Well-Being

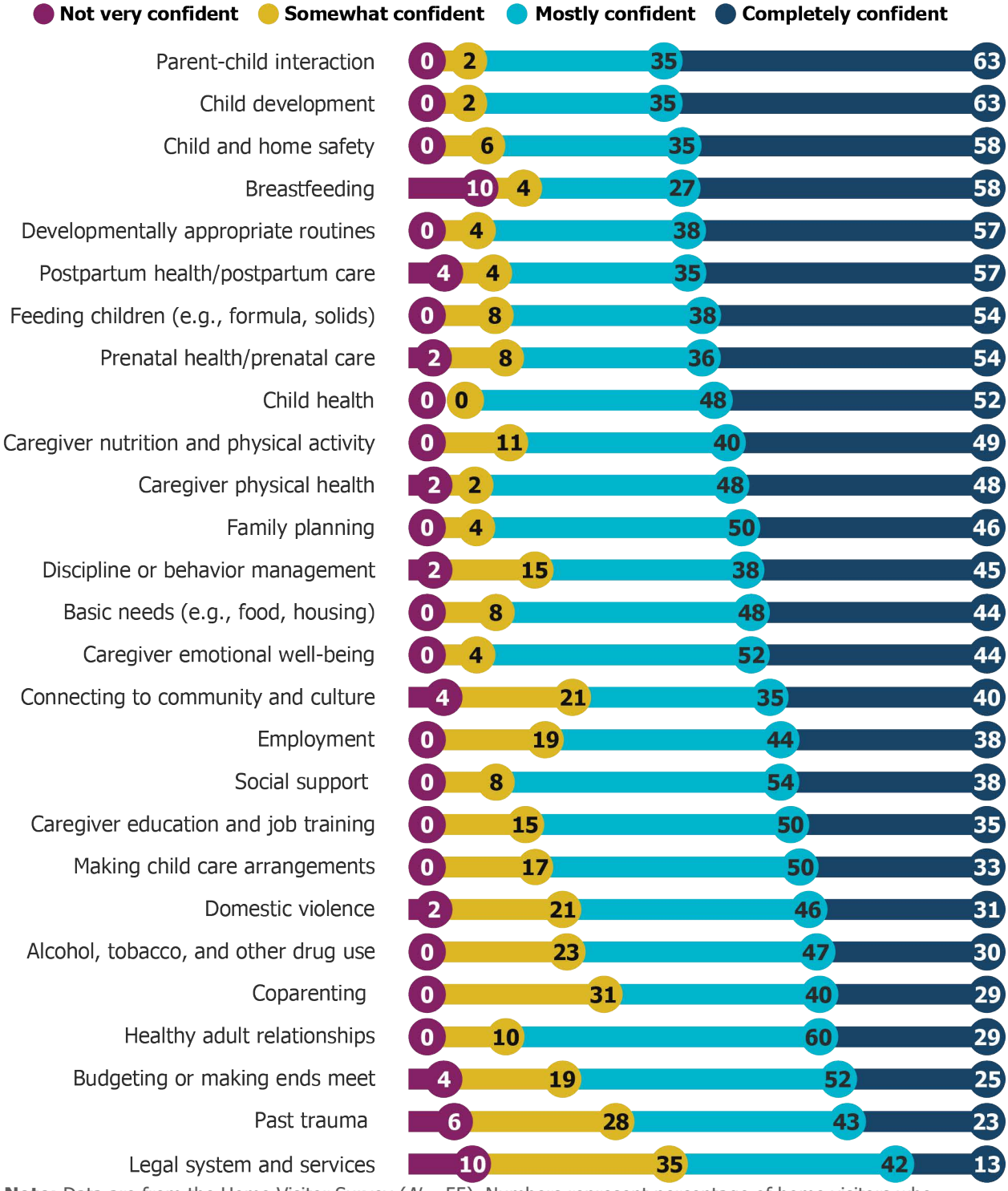
This section presents data on staff job satisfaction, professional quality of life, and contribution to community, as reported by home visitors and program managers in staff surveys and interviews. The surveys focused on two domains identified in the literature as related to the well-being of home visiting staff. These are Job Satisfaction and Professional Quality of Life (the latter includes Compassion Satisfaction, Burnout, and Secondary Trauma) (Sparr et al., 2022; Ross et al., 2023; Lee et al., 2013) and Contribution to Community. Measures and findings related to each of these domains are described in the following sections.

Exhibit 9.3. Home Visitors That Reported Confidence in Carrying Out Home Visit Activities



Note: Data are from the Home Visitor Survey ($N = 55$). Numbers represent percentage of home visitors who responded to each category. Of the home visitors that responded, none answered "not at all confident," so that option was not included in the bar chart. Access the data in a table in appendix B.

Exhibit 9.4. Home Visitors That Reported Confidence in Addressing Topics



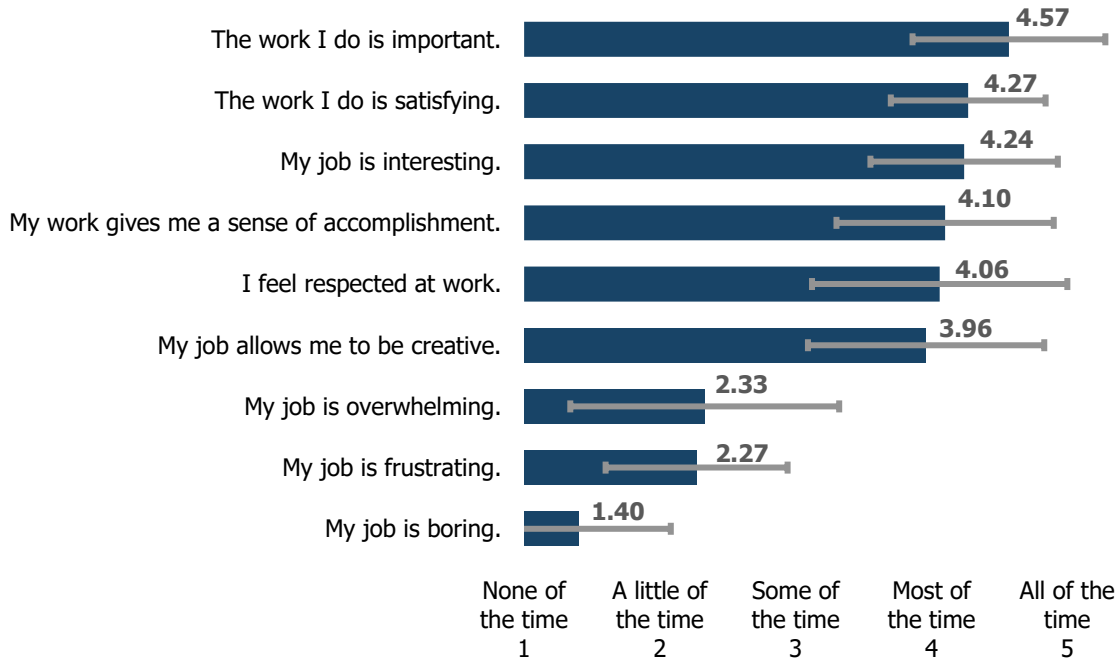
Note: Data are from the Home Visitor Survey ($N = 55$). Numbers represent percentage of home visitors who responded to each category. Of the home visitors that responded, none answered "not at all confident," so that option was not included in the bar chart. Access the data in a table in appendix B.

Job Satisfaction

Home visitors reported high job satisfaction and low frustration overall, even though they were not satisfied with their pay and opportunities for promotion. Most said they were very likely to remain in their jobs for the next 6 months.

On the staff survey, home visitors responded to a series of questions about their overall satisfaction with their jobs as well as with a range of specific aspects, including pay, hours, flexibility, support, and relationships with coworkers. They were asked, "How often do you feel this way…" and then were presented with a series of statements about their job. On average, home visitors reported high levels of overall job satisfaction and low levels of job frustration, as shown in exhibit 9.5.

Exhibit 9.5. Average Scores for Home Visitor Overall Job Satisfaction



Note: Staff Surveys completed by home visitors (*N* = 55). The top of each blue bar represents the mean score and the grey lines represent the standard deviation of the mean score.

As shown in exhibit 9.6, home visitors reported high levels of satisfaction (e.g., satisfied, very satisfied) with specific aspects of their jobs, including training and professional development opportunities, work-life balance, flexible work schedules, job security, and relationships with coworkers and supervisors. Fifty percent reported they were very satisfied with their relationships with their immediate supervisors, and 90 percent were satisfied or very satisfied.

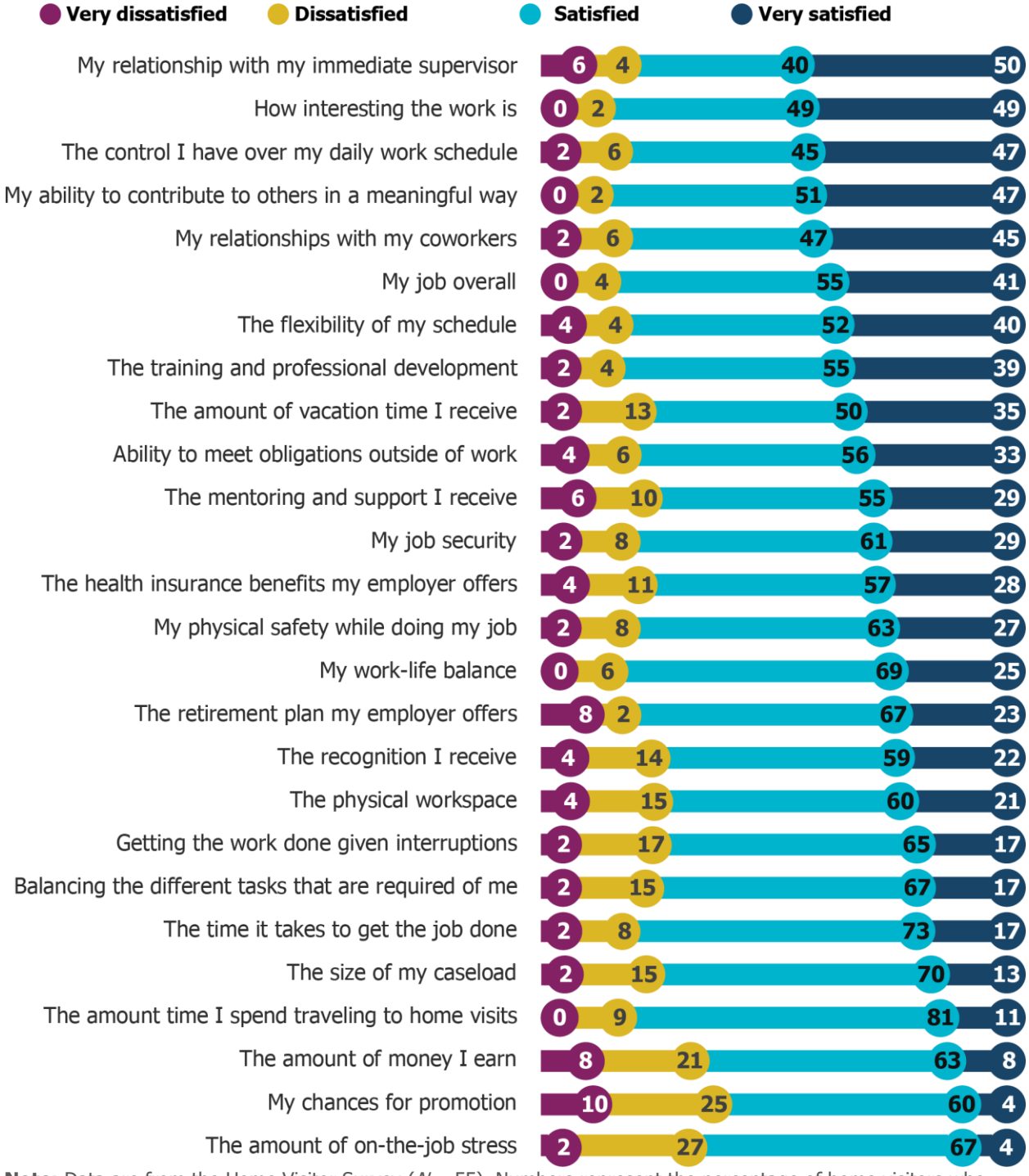
The highest satisfaction ratings (98 percent) were related to how interesting the work is and the ability to contribute to others in a meaningful way. Job-related stress, compensation, and prospects for advancement received the lowest satisfaction ratings. These findings are generally consistent with findings from the Home Visiting Career Trajectories Study (HVCT) which examined the factors influencing home visitors' career paths and workforce experiences (Sandstrom et al., 2020). In both studies, home visitors reported the highest levels of satisfaction in comparable areas (e.g., meaningful work, relationships with coworkers and supervisors, schedule flexibility) and also the lowest (e.g., job stress, pay, and chances for promotion). Notably, however, those who participated in the MUSE study reported higher levels of satisfaction overall, across nearly all aspects of their jobs. Higher satisfaction ratings by MUSE home visitors were particularly notable for job stress, pay, and chances for promotion; two-thirds or more reported satisfaction in these areas compared to less than half of those in the HVCT. The differences in job satisfaction between these two studies appear notable, but we cannot make direct comparisons because they vary on the populations studied (i.e., state versus Tribal MIECHV), data collection timing (i.e., before/during COVID), wording of the questions, models implemented, and sample size.

As mentioned above, pay was a particular area of concern. In a separate series of questions focusing specifically on pay, 36 percent of home visitors said their pay was less than what they deserved for their work and only 18 percent reported it was enough to live comfortably. Sixty-nine percent, however, reported their compensation was fair for their qualifications.

In interviews, home visiting was described as rewarding and demanding work. One home visitor expressed her love for the job many times including when she explained, "I love it, I love it; and if I can make a difference in one family's life like, ... then I know I've done my job."

Previous research has shown a connection between job satisfaction and home visitors' intentions to continue working as a home visitor (Lou et al., 2021). We asked home visitors about these intentions and their reasons for considering leaving. On the staff survey, nearly all home visitors (86 percent) reported that they were very likely to be in their current position in 6 months. Among home visitors who reported being less committed to remaining in their position, the most common factors influencing their expectations were the amount of data collection/paperwork involved in the position (63 percent), salary (50 percent), opportunities for advancement (50 percent), and a challenging work environment (50 percent).

Exhibit 9.6. Home Visitor Job Satisfaction With Specific Aspects of Their Jobs



Note: Data are from the Home Visitor Survey ($N = 55$). Numbers represent the percentage of home visitors who responded to each category. Access the data in a table in appendix B.

Professional Quality of Life

Home visitors reported high levels of compassion satisfaction and low levels of burnout and secondary trauma.

Home visitors completed a modified version of the Professional Quality of Life Scale (ProQOL), Version 5 (Stamm, 2009)[29] which measures compassion satisfaction, secondary trauma, and burnout.

Compassion satisfaction reflects the pleasure a home visitor feels from doing their job well. Questions asked about the extent to which they like their work; believe they can make a difference; and feel satisfied, invigorated, and proud of their work. Home visitors reported experiencing compassion satisfaction often, with an average rating of 4.12 (*SD* = 0.52) on a scale of 1 (never) to 5 (always).

Burnout reflects a sense of hopelessness and difficulty with the work and was measured by asking how often in the past month home visitors experienced feeling overwhelmed by their caseload, bogged down by the system, or worn out by their work. They reported experiencing burnout "rarely," with an average rating of 1.81 (*SD* = 0.50) on a scale of 1 (never) to 5 (always).

Secondary trauma concerns negative experiences resulting from providing services to people who have suffered significant stressors in their lives. Home visitors were asked about feeling depressed because of the traumatic experiences shared by caregivers, avoiding certain activities or situations because they are reminders of frightening experiences shared by clients, or having intrusive frightening thoughts related to home visiting experiences. Home visitors reported infrequent experiences of secondary trauma, with an average rating of just 1.74 (*SD* = 0.50) on a scale of 1 (never) to 5 (always).

Interview data show how these findings may be related to how home visitors approach their jobs as much as what these jobs entail. For example, they consistently described supporting families through traumatizing experiences. Therefore, the low levels of secondary trauma are not likely due to lack of exposure to traumatic stories and events. Instead, as one home visitor

[29] The instrument was modified to include specific wording for the home visiting context. For example, "I get satisfaction from being able to help people" was changed to "I get satisfaction from being able to provide home visits to people." The internal consistency of all three ProQOL scales was high in this sample, with Cronbach's alphas ranging from .71 to .87. More details on measures are included in appendix A.

described, being deeply committed to their work—putting their "whole heart" into it—may help them provide better care to families. This level of dedication might also help protect them from feeling overwhelmed or burned out by the challenges of the job. One home visitor explained that to sustain her love for her job and to do a good job at it, her "whole heart has to be into it. You can't be here just to go through the motions." She explained she could not do her job whole heartedly without making herself available to families around the clock, whenever they needed her. Her wholehearted approach places a lot of responsibility and makes many demands on the home visitor. When asked how she takes care of herself while expecting so much, she responded:

> It's very hard. It's very hard because like I said, with my clients, I'm there round the clock if they need me. But, I also know if it's just something that's not of the utmost importance at the time, I just tell them you know what, why don't we take care of this on Monday. I think it will be okay on Monday. And just knowing that, I told them that and they understood it. So yeah, I guess I really, I don't know. I really don't know how to answer that because I'm here for my clients (laughter). I mean I'm always; it's like being on-call 24/7. And I wouldn't want it any other way.

It is neither the absence of difficulty nor the use of boundaries around her availability to clients—a common strategy for preventing burnout—that reinforces her love for her work. Such observations were particularly true for home visitors who worked in Native communities with which they are affiliated. These home visitors powerfully reflected on the reciprocal care of providing services to members of one's own community. Such reflections highlight the nuanced way home visitors in Tribal MIECHV programs relate to their work, programs, and clients; and how, for some, a deeply relational approach may be a protective factor against some common issues facing home visitor retention. In the following section, we continue to explore Tribal MIECHV home visitors' connections to the communities they served.

Contributing to One's Community

Home visitors reported that their role and work within the community was valuable and meaningful.

In planning for MUSE, study partners conveyed that making a difference in the community is an essential part of home visitor well-being and encouraged us to explore how home visiting staff saw their jobs as contributing to their communities. Together we created four questions for the staff survey that assessed the degree to which staff felt their work made a contribution to their community: "My job … (1) is contributing to a brighter future for the local community, (2)

makes a positive difference in the local community, (3) is meaningful to the local community, (4) makes me feel more connected to the community." Response options ranged from 1 (strongly disagree) to 4 (strongly agree). The reliability of this scale was high (Cronbach's alpha = .897), so they were averaged to create a single score. The average across home visitors on this measure of Contribution to Community was 3.33 (*SD* = .51), indicating that home visitors generally saw their work as meaningful to their communities.

Using the same response options described above, two broader questions asked about the connection between home visitors' work and their communities: "The local community is very involved in shaping the home visiting services your home visiting program provides," and "I worry that my job has negatively impacted how I'm perceived in the local community."

The average rating of the item about the local community shaping home visiting services was 2.70 (*SD* = .77), falling between disagree and agree on the scale. This item was positively correlated ($r = .49$, $p = .001$) with the overall Contribution to Community scale, meaning that home visitors who generally felt their work was contributing to their communities also tended to see the community as shaping that work.

Most home visitors disagreed when asked if they worried that their job negatively impacted how they were perceived in the community (*M* = 1.57, *SD* = .58). This item was negatively and significantly correlated ($r = -.40$, $p = .006$) with Contribution to Community, meaning home visitors who generally felt their work was contributing to their communities were unlikely to see it negatively impacting how they were perceived.

Conclusion

The role of the home visitor is complex and demanding, requiring a broad skill set to effectively engage families in a range of activities. This chapter described the multi-faceted experiences of Tribal MIECHV staff as they implemented services, focused on their workload, work environment, self-efficacy, job satisfaction, professional quality of life, and meaningful contributions to their communities.

Findings suggest home visitors are highly skilled, deeply motivated, and confident in their abilities, even while managing job demands and stress. High levels of job satisfaction and professional quality of life suggest supportive structures are effective (see chapter 8), although we could not directly examine these relationships due to sample size limitations. Protective factors such as effective supervision, organizational and peer support, and a shared

commitment to serving Native communities likely played a role in buffering against burnout and promoting resilience.

Despite these strengths, and consistent with what has been reported by studies of other home visiting contexts (Sandstrom et al., 2020), home visitors in the MUSE study reported concerns over low compensation and limited opportunities for advancement. Addressing these issues will be important for retaining staff and ensuring the long-term sustainability of Tribal MIECHV programs. More research is needed to explore the conditions that most effectively support home visitors, including how factors such as professional development, supervision, and service to the community may influence workforce experiences.

Overall, the findings highlight that Tribal MIECHV home visitors are navigating a challenging and demanding role with professionalism, resilience, and purpose. The study findings suggest a connection between the ability of Tribal MIECHV home visitors to find meaning in their work—even under stress—and professional well-being. In the next chapter, we conclude this report with a discussion of key findings and implications for Tribal MIECHV implementation and future research.

Chapter 10: Discussion of Key Findings and Implications for Tribal MIECHV Implementation and Future Research



In recognition of the unique context of Native communities, the Tribal MIECHV Program was developed to provide funding to Tribes, consortia of Tribes, Tribal organizations, and urban Indian organizations to develop, implement, and evaluate evidence-based[30] home visiting programs in AIAN communities. While home visiting implementation has been the focus of prior studies (Boller et al., 2014; Duggan et al., 2018; Sandstrom et al., 2020), little is known about how home visiting models are implemented in Native communities and how evidence-based models are translated in these contexts. MUSE was funded to describe how Tribal MIECHV grant recipients implemented their programs across varied community contexts and to identify factors that lead to successful program implementation. MUSE, the first multi-site, multi-model study of home visiting in Native communities, was designed to be a mixed-method, community engaged study. MUSE is also unique in that most of its data were collected during the COVID-19 pandemic, which significantly shaped the study's context. The pandemic complicated data collection, analyses, and our ability to fully address the research questions. Consequently, this report primarily reflects implementation during the pandemic. While many of the findings are likely generalizable to post-COVID contexts, care should be taken to consider the extent to which the pandemic impacted implementation and to recognize that some findings may be less generalizable to current home visiting environments. For more information on how COVID-19 impacted Tribal MIECHV programs, please see *Continuing Home Visiting Services During COVID-19: A Brief From the Multi-Site Implementation Evaluation of Tribal Home Visiting*.

The MUSE community engaged approach (Salvador et al., 2024a) was guided by the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities* (Tribal Evaluation Workgroup, 2013) and can be characterized by intensive and iterative engagement of partner groups, most notably the 17 Tribal MIECHV programs that participated in the study. Throughout the study, partners collaboratively developed and modified (sometimes significantly) the study design, methods, and timelines; this engaged approach was particularly important in responding to the changing landscape of the COVID pandemic. The MUSE study, including the following three study aims, is a culmination of this community-engaged process:

1. Identify and describe primary influences shaping Tribal MIECHV program planning
2. Identify and describe how Tribal MIECHV programs are implemented
3. Explore supports and challenges to home visiting implementation in Native communities

[30] Evidence-based models used by Tribal MIECHV programs that participated in MUSE were studied and determined to be evidence-based with non-Native populations, with the exception of Family Spirit which was determined to be evidence-based for Native people and communities (Home Visiting Evidence of Effectiveness, n.d.).

MUSE findings related to Aim 1 were described in the report *Understanding Planning for Tribal Home Visiting* (Salvador et al., 2024b). The current report presents findings related to Aim 2 and, to the extent possible, to Aim 3; data collection disruptions related to the COVID-19 pandemic limited exploration of Aim 3. This chapter summarizes Aim 2 and 3 findings and the implications of those findings for future implementation and research.

Summary of Key Findings by Chapter

The MUSE study identified key findings across the primary domains examined throughout this report—caregivers participating in services, home visiting program staff, the services provided, and the relationships between caregivers and home visitors.[31] These findings are presented in detail in previous chapters; here we highlight key findings distilled from each chapter.

It's important to note that findings reported are high level summaries across programs that do not fully capture the considerable variability in models, program size, community context, response to the COVID-19 pandemic, and other characteristics. As a result, certain findings may not fully resonate with every program's experience.

Caregiver Characteristics

- Most caregivers (88 percent) who participated in MUSE were AIAN women. At program enrollment, almost half were pregnant, and 20 percent of those were expecting their first child. Eighty percent had one or more children, with an average of 2.3 children under age 5. Almost two thirds lived with a partner, 38 percent lived with other family members, and ten percent lived only with their children.[32]
- Nearly all caregivers had a place to live (94 percent) and access to health insurance or Indian Health Services (97 percent). However, household income was generally low, and most experienced economic strain in at least one area.
- Caregivers entered the program with significant strengths. They reported strong social support and felt that they had the skills necessary to be good parents, especially with support from their families and communities. Caregivers also reported relatively high levels of attention regulation and ability to focus attention on their child.

[31] We were not able to fully address all of the factors depicted in the conceptual model, most notably structural influences related to funding, the availability of services in the community, and other aspects of the service and policy environment.

[32] Data on caregivers' pregnancy status and number of children are drawn from a subsample of caregivers who completed the Baseline Caregiver Survey.

Caregiver Enrollment, Participation, and Experience

- Caregivers who participated in MUSE learned about Tribal MIECHV programs through their personal networks or service providers. They enrolled in the program to strengthen their parenting, support their child's development, and connect with cultural practices.
- Caregivers took part in about one to two visits per month, each lasting around an hour. Between visits, they stayed in touch with their home visitor by text, email, and phone. They also participated in other activities that built connections with other families, often focused on parent-child interaction, child development, and connecting to community and culture.
- Caregivers were generally satisfied with how often visits happened (i.e., frequency) and how long they lasted (i.e., duration). They reported positive experiences participating in Tribal MIECHV programs, and especially valued support directly related to parenting.
- On average, caregivers stayed in the program for about 13.5 months, with higher retention than seen in some studies with other populations. Visit frequency was adjusted to meet caregiver needs and retention was likely supported by the consistency, flexibility, and responsiveness of home visitors.

Inside Tribal MIECHV Home Visits

- The primary caregiver and index child were the main participants in home visits, with other family members participating less often. When asked about the approximate amount of time spent on six key activities during visits, home visitors reported spending the most time providing emotional support and delivering curriculum content/educational information, which often focused on child development, parent-child interaction, and caregiver stress and wellbeing. Collaborative goal setting took place during most visits. Caregivers were satisfied with the process and home visitors found it valuable to set goals with families.
- Home visitors used model guidance and curriculum, and sometimes additional materials, to plan home visits. When tailoring plans, they considered what they knew about each family and the connections they had built with them. They also modified plans during visits to manage time, respond to caregiver needs and preferences, and adjust to evolving issues ranging from a child's mood to emerging crises.
- Caregivers felt that home visitors responded to their needs, feelings, and interests with warmth and care and worked with them to tailor visits to fit their own families. Nearly all caregivers found visits interesting, useful, and a good use of their time. They especially valued the practical support and social connection they received.

Home Visitor-Caregiver Relationships

- Caregivers felt cared for and understood by their home visitors. They valued being able to discuss sensitive topics with someone they trusted and often described their home visitors as more like friends or family members.

- Home visiting staff described boundary setting as a protective strategy that helped to prevent burnout. They found boundaries worked best when they were flexible, responsive, and grounded in mutual respect.
- Shared background and knowledge of cultural norms, language, and context benefited home visitor-caregiver relationships. Their shared experience as parents also fostered mutual respect.
- Some home visitors shared that self-disclosure—or the sharing of personal information and experiences—helped to establish common ground with caregivers and normalize caregiver experiences. It also encouraged open and honest communication, helping to overcome caregivers' negative associations with social services.

Staff Characteristics

- A majority of home visitors and nearly half of program managers that participated in MUSE identified as AIAN. Many staff shared the same community and cultural backgrounds as the families they served. Almost all program staff had some education beyond high school. About half of home visitors and nearly all program managers had a bachelor's degree. Only a third of home visitors had prior professional experience working with children and families before their current role, compared to more than two thirds of program managers.
- Overall, programs reported that staffing was stable. However, they had difficulty hiring staff with the qualifications they wanted. These included strong interpersonal skills, experience working with children and families, and a cultural background similar to the families served.

Training, Supervision, and Peer Support for Staff

- On average, staff participated in training once a month. Topics included data collection and entry, administrative tasks, and content specific to supporting children and families. About three quarters of staff said training was helpful, engaging, and relevant to their day-to-day work with families.
- Home visitors received about two one-on-one supervision sessions each month and one to two group supervision sessions. These sessions focused on their emotional well-being and reflective practice. One-on-one sessions also frequently covered managing caseloads. Home visitors said they received reflective supervision as intended—meaning they had time to discuss their thoughts, feelings, actions, and reactions when working with young children and families (Early Childhood Technical Assistance Center, 2022). They also valued the mentoring and trusting relationships they had with their supervisors.
- Home visitors said they most often turned to their peers with questions about working well with team members (such as collaborating on activities and roles), problem solving for specific families, and building skills to better support and provide information to families.

- Both home visitors and program managers agreed that almost all of the strategies used to support home visitors were important. However, program managers were more likely to place a higher value on reflective supervision and home visitors were more likely to value continuing education opportunities.

Staff Experiences

- On average, home visitors reported working 40 hours per week. The number of families they served varied widely—from as few as 3 to as many as 38—but the average was 13 families. Two-thirds of home visitors felt their current caseload was "about right." Program managers worked an average of 43 hours a week and also felt that their supervisory and caseload responsibilities were "about right." Overall, home visitors reported a positive workplace culture and climate in their organizations.

- Home visitors reported high levels of confidence in their ability to carry out many different activities during home visits and address a wide range of topics with families. They felt especially confident in building and maintaining trusting relationships with caregivers based on mutual care and respect; tailoring visits while still delivering curricula as intended; collecting data; and addressing topics like child health and development, maternal health, and overall family well-being.

- Home visitors reported the lowest levels of confidence working with fathers, uninterested or fussy children, and caregivers who seemed uninterested or distracted. They also felt less confident addressing topics such as co-parenting, past trauma, and the legal system and services, although still more than half reported confidence in these areas.

- Home visitors reported high job satisfaction and low frustration overall, even though they were not satisfied with their pay and opportunities for promotion. Most said they were very likely to remain in their jobs for the next 6 months. They also reported high levels of compassion satisfaction and low levels of burnout and secondary trauma. Overall, home visitors remained committed to working with families and making a positive difference in their communities.

Implications for Tribal MIECHV Implementation

The findings presented above span the breadth of MUSE study domains. In each section below we highlight a key theme that emerged from findings, often synthesized across chapters, and suggest an implication for Tribal MIECHV program implementation. Just as key findings represent high level summaries that apply to a varying degree to different programs, the implications will be more relevant to some community and program contexts than others. Also, some may remain relevant to the post-COVID environment while others less so. Decisions on actionable implications will need to be informed by careful consideration of local program context.

Engaging Fathers and Other Household Members in Home Visits

Theme: Most caregivers participating in Tribal MIECHV programs lived with partners or other family members, yet other household members rarely participated in home visits. The lack of participation by other household members in home visits may be due to several factors including home visiting models' focus on the primary caregiver (Sandstrom et al., 2015), visit scheduling and availability of other household members (especially fathers or partners) (Sandstrom and Lauderback, 2019), and, as MUSE findings demonstrate, challenges engaging other family members in virtual visits during COVID-19 (Salvador et al., 2025). MUSE findings suggest that a lack of training and professional development for home visitors on engaging other household members may also contribute. Only 6 percent of trainings provided to Tribal MIECHV home visitors addressed serving multi-generational households and non-traditional caregivers, and only around a third of home visitors reported high levels of confidence working with multi-generational families. Similarly, only two percent of trainings addressed engaging fathers in home visiting, and fewer than one-fifth of home visitors reported high levels of confidence doing so.

Implication: Exploring opportunities to strategically engage additional household or family members in home visits could potentially extend and amplify the benefits of home visiting beyond the caregiver and child. The strong support networks and collective parenting practices of Native communities could present an opportunity to extend home visiting's benefits to other family members. While other studies have identified a range of strategies for increasing father engagement (Kleinman et al., 2023; Sandstrom et al., 2015; Stolz & LaGraff, 2025), less is known about ways of engaging extended family or other household members. Learning from related research and exploring the views of home visiting staff, caregivers, and models on the benefits, challenges, and constraints related to engaging

additional family and household members in Tribal MIECHV home visits could be an important next step. Such work could consider and expand existing findings on father engagement by exploring, first, how barriers and facilitators to engaging fathers may differ in the Tribal MIECHV context, and, second, how they may be relevant to engaging extended family caregivers in the multigenerational households common in Native communities.

Tailoring Tribal MIECHV Home Visits

Theme: Responsive tailoring of home visit content is likely central to successful caregiver engagement, satisfaction, and retention. Because home visiting programs serve families with varied experiences, resources, and needs, home visitors must be able to tailor their visits to the unique circumstances of the families they serve. Home visitors described tailoring as continually considering caregivers' goals, needs, and interests when developing home visit plans and then listening to and observing caregiver cues to respond in the moment with appropriate adjustments to their plans. They drew on their in-depth understanding of wide-ranging home visiting topics and deep connections with caregivers to effectively tailor home visits, often incorporating cultural knowledge and practice. Home visitors made home visits work for families by making in-visit adjustments in response to time constraints, caregiver needs, emerging crises, or various challenges experienced during visits. Caregivers that participated in MUSE agreed that their home visitors planned and adjusted visits according to their needs and preferences.

Implication: Ensuring adequate support for home visitors to tailor home visit content is critical. While we couldn't determine the impacts of tailoring on various aspects of implementation, MUSE findings suggest that proactive and responsive tailoring of home visit content may be central to successfully engaging caregivers (chapters 3 and 6), an overwhelmingly positive caregiver experience (chapter 5), and high caregiver retention (chapter 4). While MUSE findings demonstrate that tailoring is a strength of Tribal MIECHV home visitors, the importance of tailoring suggests that training and supervision to support home visitors to customize and adapt visits, while also attending to model requirements, is fundamental. Identifying the critical components of tailoring and amplifying these could support programs and new home visitors in this important practice.

Contributing to Community

Theme: Home visitors viewed their work within the community as valuable and meaningful, and this commitment to serving one's community can help to guard against burnout. When asked about their contribution to their community, home visitors reported that their work (1) was contributing to a brighter future for the local community, (2) made a positive difference in the local community, (3) was meaningful to the local community, and (4) made them feel more connected to the community. In addition, when asked how satisfied they were with various aspects of their job, nearly all home visitors reported that they were satisfied with their ability to contribute to others in a meaningful way. In interviews, they reflected on the reciprocal nature of providing services to members of one's own Native community and highlighted the nuanced ways they relate to their work, their programs, and to the families they serve. For some, a deeply relational approach to home visiting and commitment to serving one's community may be protective factors against some common issues that impact home visitor retention, including burnout.

Implication: Staff recruitment strategies that emphasize serving one's community may help attract and retain home visitors. Staff recruitment strategies emphasizing cultural relevance, relational skills, and commitment to serving one's community may help attract and retain staff who are both well-qualified and deeply invested in serving their community. Hiring qualified home visitors remains a challenge, particularly when seeking individuals with strong interpersonal skills, experience working with children and families, and similar cultural backgrounds as the communities served. Beyond implications for home visitor recruitment and retention, investing in local workforce development and hiring staff who share community ties with the families they serve (including former program participants) can support positive relationship building and foster collaborative home visiting environments.

Aligning and Streamlining Tribal MIECHV Workforce Supports

Theme: Tribal MIECHV programs provided a robust system of workforce supports to ensure that home visitors were equipped to carry out the many activities required of them. On average, home visitors who participated in MUSE spent 3–4 hours in training each month, received around 2 one-on-one supervision sessions and 1–2 group supervision sessions each month, and benefited from ongoing peer support. While staff generally regarded training as helpful, engaging, and related to their day-to-day work, data show that there are opportunities to make training more relevant. Only about half of home visitors reported that training was individualized to meet their needs, and one third said that training did not offer

techniques or materials that were relevant for the families and communities they serve. While training was provided on a very wide variety of topics, data collection and entry was the most frequent training topic. Data collection was also regularly discussed in both one-on-one and group supervision. While the frequency of topics covered varied by type of supervision (e.g., individualized versus group), supervision generally focused on supporting home visitors' emotional well-being, working with individual families, and case management, in addition to data collection. Nearly half of all supervision sessions integrated reflective practice, which program managers were more likely to view as important compared to home visitors. Home visitors were generally satisfied with the amount of support they received. They found training, supervision, and peer support to be helpful across a broad range of topics, but the sources of support seen as most helpful varied somewhat by topic.

Implication: Workforce supports can be optimized by strategically leveraging the relative strengths of supervision, training, and peer support while also exploring ways to streamline training for data collection and enhance reflective supervision. A multi-pronged approach, drawing on the distinct strengths of supervision, training, and peer collaboration, appears to be effective. Home visitors felt that supervision was most helpful when focused on supporting individual families, caseload management, policies and procedures, and tracking family progress. Peer support seems to be most relevant for team collaboration and facilitating problem-solving for families in complex situations. Understanding these strengths can help programs tailor the delivery of supports and prioritize the efficient and effective use of resources. In addition, future efforts could focus on finding ways to both streamline data demands and create more efficient approaches to equipping home visitors with the necessary skills to collect vital data. Finally, better understanding how reflective supervision is implemented in Tribal MIECHV contexts will be important to ensuring this practice benefits home visitors more fully.

Seeking Professional Development and Opportunities for Advancement

Theme: Home visitors participating in MUSE consistently valued professional development opportunities and wanted more pathways to advancement. When asked to rate the importance of various home visitor support strategies, home visitors rated both continuing education opportunities and coursework in early childhood development as very important, whereas program managers felt these two strategies were less important. Across supervision topics, home visitors were least satisfied with the frequency and helpfulness of discussions on professional development. Relatedly, when asked how satisfied they were with

different aspects of their jobs, home visitors were least satisfied with their chances for promotion.

Implication: Professional development opportunities and career pathways can strengthen the Tribal MIECHV workforce and may improve home visitor job satisfaction and retention. In response to home visitor concerns, programs might consider adopting a more structured approach to professional development with dedicated time and resources allocated to assessment of skills, developing professional growth plans, and supervisory discussions on the topic. Opportunities could include employer-sponsored continuing education, support for obtaining early childhood credentials, technical assistance focused on skill building for home visitors, and model training beyond required courses. Investing in these strategies may help prepare individuals who share cultural backgrounds with home visiting families (including former home visiting participants) and thus strengthen the home visiting workforce for Native community contexts. Similarly, support for Tribal MIECHV programs to define professional growth pathways, provide leadership training, and develop competency frameworks could result in more opportunities for advancement (Sparr et al., 2022).

Addressing compensation including benefits and other incentives

Theme: Low wages are a concern among staff and likely a barrier to retention. Consistent with what has been reported by studies of other home visiting contexts (Sandstrom et al., 2020), when asked about their pay, 36 percent of home visitors said their pay was less than they deserved for the work they did and only 18 percent reported that it was enough for them to live comfortably. Sixty-nine percent, however, reported that their compensation was fair for their qualifications. When asked how satisfied they were with various aspects of their jobs, pay ranked next to last, just behind their chances for promotion. Among home visitors who reported being less committed to remaining in their position, 50 percent reported salary as a factor, indicating compensation's direct impact on retention.

Implication: Investing in better pay, benefits, and other incentives can help retain experienced staff who are deeply committed to serving their communities. While funding constraints can make increasing pay difficult, addressing compensation remains a high priority. Compensation assessments examining pay and benefits by role, exploring fairness in pay and promotion practices, and benchmarking compensation to industry standards could be useful for Tribal MIECHV programs. Beyond pay, other incentives could include longevity pay, enhanced health and retirement benefits, paid parental leave, and increased vacation accrual.

Implications for Future Research

As an implementation study, MUSE described how Tribal MIECHV programs implemented multiple home visiting models across a wide range of Native communities. Below we reflect on the implications of MUSE findings for future studies, including suggested goals of future research, methodological considerations for researchers, and topics that are ripe for further exploration.

Considerations for Future Research Goals and Approaches

More research is needed on Tribal MIECHV programs in post COVID-19 contexts. While some MUSE data were collected before COVID-19, most data were collected between July 2020 and December 2021 and were thus deeply influenced by the impact of COVID-19 on caregivers and staff and the shift to virtual home visiting. Therefore, most of the findings in this report–except where we note COVID differences—have to be interpreted in light of COVID-19, which limits their generalizability. For more information on how Tribal MIECHV programs were impacted by COVID-19 see *Continuing Home Visiting Services During COVID-19: A Brief From the Multi-Site Implementation Evaluation of Tribal Home Visiting* (Salvador et al., 2025). We learned a lot about how home visiting is implemented by Tribal MIECHV programs, but additional research is needed to better understand the extent to which implementation practices observed during the study period have been sustained or changed post-COVID. This includes how home visiting practice has changed to include hybrid in-person and virtual service delivery.

The MUSE community engaged approach is an important foundation to expand upon in future studies of home visiting in Native communities. The MUSE study invested time and resources in a deeply community-engaged approach, beginning with the design of the study and continuing through the dissemination phase (Salvador et al., 2024a). The engagement made the study rigorous and relevant because community partner input resulted in adaptations of standard measures and the development of new ones to produce more reliable and valid information about home visiting in Native communities. Community engagement has contributed to sustainable research partnerships; several partners from the MUSE study have signed on to the CIRCLE-HV multi-site study, demonstrating the value of investing in relationships that lay the foundation for further collaborative learning. Thus, it is important for future research to include deep conversations about focus, feasibility, and scope with community partners as studies are conceptualized and launched. Future viable and rigorous research with Native communities depends on similar community engagement.

Further exploring the values that lead Native communities to engage in home visiting and the priority outcomes they hope to achieve is an important precursor to examining the effectiveness of these programs. Most home visiting studies focus on outcomes that derive from research and practice in non-Native contexts. Assumptions that these same outcomes are the most salient for Native communities may be misguided; MUSE partners expressed the importance of defining successful and effective home visiting services within the context of Native worldviews and local values and priorities for children and families. Additional research could build on MUSE's effort to describe how Native community values informed program planning within *Understanding Planning Tribal Home Visiting Implementation* (Salvador et al., 2024b). Efforts like *CIRCLE-HV* and future studies can help to articulate key intended outcomes across home visiting programs in Native communities and explore options for studying those outcomes in ways that are both rigorous and relevant.

Studies that examine the impact of Tribal MIECHV programs on outcomes important to Native communities can fill critical gaps in the knowledge base and inform Native communities' decision-making and planning processes. After meaningful attempts to identify key, relevant outcomes with and for Native communities and develop measures to accurately assess those outcomes, effectiveness research that integrates Western and Native research paradigms is an important next step. Native paradigms emphasize the value of engaging communities in the research that is anchored in relationality, respect, reciprocity, relational accountability, and place (Moyer et al., 2024). Applying these principles can ensure the optimal utilization of Western scientific methods within Native community contexts. Engaging in relationships with communities to identify appropriate research methods ensures the most rigorous science. These methods support the identification of priority questions and salient outcomes, the use of feasible and effective methods, the collection of reliable and valid data, and the accurate and meaningful interpretation of findings. Community engagement can ensure that rigorous yet feasible and acceptable designs, measures, and methods are employed in future impact studies. Results of such studies can increase our understanding of how well home visiting achieves outcomes of importance to Native communities and can ultimately support informed community decision-making about model selection and implementation.

Incremental research that answers discrete questions, such as those that use rapid-cycle methods, can provide timely, useful information and reduce burden. MUSE was an ambitious study at the outset and expanded to address key questions raised by community partners. We sought to answer a wide range of questions about varying aspects of

implementation. This resulted in a complex data collection protocol with multiple data sources and instruments that left some participating sites feeling overwhelmed. The variety of data collected also contributed to lengthy analysis and report writing timelines. Future studies examining more focused and specific questions could produce actionable findings more quickly.

Topics for Future Research

Better understanding the facilitators and barriers to caregiver recruitment and retention could extend Tribal MIECHV's reach to even more families. While MUSE did not examine caregiver recruitment specifically, staff described both successes and challenges with recruiting and enrolling families. Tribal MIECHV programs' overall success in retaining families suggests that programs are employing effective and potentially unique family engagement strategies. Future studies could explore how elements of community context (e.g., existence of/collaboration with other home visiting and early childhood programs in the service area) and the service and policy environment (e.g., supportiveness of Tribal/organizational leadership) influence recruitment efforts. Findings could inform efforts to reach families served by Tribal MIECHV programs, including different types of caregivers and communities that could benefit from participating.

Assessing the effects of economic strain on caregiver participation and outcomes can help programs tailor services to meet the needs of families within the economic contexts of their communities. MUSE showed that most families enrolled in Tribal MIECHV programs experienced some degree of economic strain, but we were unable to delve deeply into the relationships between family economic well-being and home visiting services or outcomes. Other research on family economic well-being in Native communities suggests that unique factors—including subsistence living, cultural capital, and collective responsibility—impact experiences of economic strain in Native community contexts (Raj et al., 2023). A better understanding of how to measure family economic well-being and its relationship to family stress could help programs tailor home visiting services to better support families.

Examining practices that facilitate relationship-building in Tribal MIECHV could inform training, supervision, and peer support strategies that enhance these practices. MUSE established that Tribal MIECHV home visitors are successfully building relationships with caregivers, which provides multiple benefits. An in-depth study of how relationships are formed and sustained could support new Tribal MIECHV grant recipients as they build their programs and enhance efforts of existing programs. Formative research designed to develop a conceptual model of relationship building and identify core skills, model

components, and institutional practices could inform both implementation and evaluation efforts.

Understanding how home visitors tailor their visits to families, and the impact of that tailoring, is essential for ensuring that adequate time, resources, and organizational supports are in place for this critical work. Home visitors draw on detailed knowledge of family needs, preferences, and circumstances, as well as curriculum requirements and broader home visiting practices, to tailor visits effectively. This is a task that is both time-intensive and skill-based. Descriptive studies examining the information considered while tailoring, the kinds of adjustments made during visits, the amount of time spent adjusting plans and activities, and how staff are empowered and supported in tailoring can clarify the effort and burden involved. Examining how successful tailoring contributes to family engagement and outcomes can help clarify the mechanisms through which home visiting benefits families. Gaining an understanding of what successful tailoring looks like and what best facilitates the process can help programs better plan implementation; establish realistic caseload expectations; and encourage and gain sufficient ongoing resources, training and support from programs, models, and funders.

Exploring how integrating cultural practices into home visiting affects caregiver engagement and satisfaction can shed light on a critical element of Tribal MIECHV programs. MUSE findings reinforced what Tribal MIECHV programs already understand—incorporating cultural practices into home visiting services enhances service delivery in important ways (Hiratsuka et al., 2018). As noted in chapters 1 and 2 where we described the shifts in the focus of the study during the planning phases of the MUSE study, partners were clear that studying the specifics of how cultural practices work should not be a focus of MUSE due to concerns around protecting cultural information. Thus, they were not examined here. However, better understanding of the benefits of integrating cultural practice and the impacts of culturally enhanced services on caregiver engagement, satisfaction, and outcomes, as well as practices supporting this integration could lead to additional resources and support. Robust community-engaged approaches will be especially critical for pursuing these questions, given the importance of honoring and respecting cultural protocols and protected cultural information while at the same time understanding the impact of culture in effective home visiting practices.

Identifying primary influences of home visitor recruitment and retention can inform efforts to retain the Tribal MIECHV workforce and support consistent implementation. MUSE demonstrated that commitment to serving one's community was a

major factor in why home visitors continue in their jobs. Given the challenges to recruiting qualified candidates and the large investment in model training, a better understanding of how to retain home visitors, especially those from the community served, could be beneficial.

Conclusion

The MUSE study was the first multi-site study to engage Tribal MIECHV programs serving AIAN communities around the country to systematically document how home visiting services are being implemented across varied settings. It expanded previous research conducted by individual Tribal MIECHV programs in two critical ways.

First, it expanded what we know about home visiting practice in Native communities by leveraging data across programs to describe a range of approaches to home visiting services and implementation being employed to meet the needs of AIAN families. While data collection disruptions related to the COVID-19 pandemic limited the ability to identify associations among variables and across time, descriptive findings summarizing experiences across 17 AIAN communities nonetheless provide an important overview of approaches and practices that may be useful for other AIAN communities developing, enhancing, or sustaining home visiting services. They highlight that Tribal MIECHV programs are effectively recruiting, training, and supporting staff, building strong relationships with caregivers, and delivering culturally relevant and tailored home visiting services. They elevate shared learning across contexts by illuminating what communities have put into place as they built home visiting programs and the lessons they have learned in the process. It is important to understand, however, that by highlighting general trends across programs, findings from this multi-site study omit unique experiences of individual programs, and the extent to which particular findings reflect the experiences of individual programs varies. General patterns should thus not be taken as a prescription for best practices across all AIAN home visiting contexts; rather, they should be considered as an array of practices that may be used in an informed way—considering local community, context, home visiting model, etc.—to support delivery of services to families. Sharing this report first with participating grant recipients will enable Tribal MIECHV programs to identify the findings most relevant to their programs and determine how best to support their families and communities. Sharing it then broadly across the home visiting field will ensure it reaches other home visiting programs, researchers, and policy makers for a wider impact.

In addition to expanding descriptions of home visiting practice in AIAN communities, MUSE expanded methodological approaches to research with these communities. By engaging 17

partner sites to guide the identification of research questions relevant to home visiting staff and families, help tailor data collection tools and processes to align with local community protocols and needs, and contribute to the interpretation of findings, this study employed innovative strategies for engagement and for collaborative study design and interpretation (Salvador et al., 2024a). Many of these strategies worked well while others were less effective and point to directions for different approaches. MUSE provides important lessons for future efforts to gather data in collaboration with home visiting programs.[33]

[33]Lessons learned from the MUSE community engaged process are described in a forthcoming article authored by staff members and local evaluators from MUSE partnering sites.

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Appendix A: Description of Measures

Screening to Understand Needs of AIAN Families Served by Tribal MIECHV Programs: The Family Resources Check In

The Family Resources Check In (FRC) screener was created to adequately capture the needs of families in AIAN communities in ways that consider how social, cultural, and geographic settings shape family economic circumstances. The FRC was codeveloped by the MUSE study team and the Technical Working Group (TWG) specifically for the study to use with AIAN families served by Tribal MIECHV programs. See chapter 1 for details about the membership, roles, and responsibilities of the TWG. The domains and items on the FRC were drawn from existing screeners and previous research with AIAN populations. Adaptations were made based on guidance from the TWG and from grant recipients participating in MUSE who provided feedback on early versions. The FRC was developed to screen for economic strain in the domains of food security, housing, transportation, healthcare, employment, child-related expenses, and phone and internet access.

Exhibit A.1. Family Resources Check-In Screener

Family Resources Check-In Item	Never	Only 1 or 2 months	Some months but not every month	Almost every month
Food				
1. In the past year, we worried whether our food would run out before we got money to buy more				
2. In the past year, the food we bought just didn't last and we didn't have money to get more				
3. In the past year, we couldn't afford to buy nutritious food for our family				
Transportation				
4. In the past year my family had trouble getting where we needed to go because we didn't have access to a reliable vehicle				
5. In the past year my family had trouble getting where we needed to go because we couldn't afford gas				

Family Resources Check-In Item	Never	Only 1 or 2 months	Some months but not every month	Almost every month
6. In the past year my family had trouble getting where we needed to go because we couldn't afford to take the bus or other public transportation *[Additional check box here if "Public transportation is not available where I live."*				
Child-related				
7. In the past year, my family didn't have enough money to buy the basic things my child or children need (clothing, shoes, diapers, etc.)				
8. In the past year, I had to miss work, school or important appointments because I didn't have childcare				
Healthcare				
9. In the past year, I or someone else in my family couldn't afford to go to the doctor, dentist or other healthcare provider when we needed to				
10. In the past year, my family couldn't afford to pay for medications, glasses or other medical supplies that we needed				
Phone and internet				
11. In the past year, my family did not have phone service because we couldn't afford to pay for it				
12. In the past year, my family could not afford to pay for internet access *[Additional check box here if "Internet is not available where we live."*				
Employment				
13. In the past year, I or someone in my household looked for a job but could not find one				
14. In the past year, I or someone in my household had a job but it didn't pay enough to cover our family's expenses				
Housing				
15. In the past year, my family has had a safe place to live				
16. In the past year, my family has had electricity or other utilities shut off because we couldn't afford to pay the bill				

Family Resources Check-In Item	Never	Only 1 or 2 months	Some months but not every month	Almost every month
17. In the past year, my family has had a place to live that had enough space for everyone in the family				
	No	**Yes, once**	**Yes, twice**	**Yes, more than twice**
18. In the past year, my family has had to move because we couldn't afford where we were living				
	No	**< 1 week**	**Most of the month**	**All month**
19. In the past month, I have had a place to live…				

An analysis of the FRC internal consistency showed good to excellent reliability for the domains of food (alpha = .93), transportation (alpha = .88), healthcare (alpha = .86), and phone/internet access (alpha = .82). Reliability coefficients were in the moderate range for child-related expenses (alpha = .68) and employment (alpha = .67). Internal consistency was poor for the housing domain (alpha = .59); data for that domain are therefore not provided in this report. Work is ongoing to further investigate the psychometric properties of the FRC, with particular attention to the housing items, and refine the measure as a brief screener of economic strain among Native families.

Social Support

The Social Support scale included a total of seven dimensions assessed from caregiver responses to 14 items. Twelve items were selected from the Social Provisions Scale (SPS; Cutrona & Russell, 1987). Based on analyses validating a brief version of the SPS using only positively worded items (Caron, 2013), we retained two items for each of the six SPS subscales.[34] These are listed below.

1. Attachment
   a. I have close relationships that make me feel good.
   b. I feel a strong emotional tie with at least one other person.

[34] Caron (2013) excluded the *Opportunity for Nurturance* subscale in their analyses, but we retained it here because we felt it was important to the context of home visiting.

2. Guidance
    a. I have someone to talk to about decisions in my life.
    b. I have a trustworthy person to turn to if I have problems.
3. Opportunity for Nurturance
    a. There are people who call on me to help them.
    b. I feel responsible for taking care of someone else.
4. Reassurance of Worth
    a. There are people who value my skills and abilities.
    b. There are people who admire my talents and abilities
5. Reliable Alliance
    a. There are people I know will help me if I really need it.
    b. There are people I can count on in an emergency.
6. Social Integration
    a. There are people who like the same social activities I do.
    b. I am with a group of people who think the same way I do about things.

In addition, we created an additional two-item subscale specific to the context of parenting for MUSE. These are listed below.

7. Support for Parenting
    a. There are people I can count on when I need help as a parent.
    b. I have someone I can go to with questions about parenting.

Items on five of the seven subscales of the Social Provisions Scale showed high levels of internal consistency reliability (alphas ranged from 0.78 to 0.89), providing preliminary evidence that this measure works well in a population of caregivers enrolled in THV. The *Opportunity for Nurturance* (alpha = .59) and *Social Integration* (alpha = .67) subscales, however, showed relatively low levels of internal consistency reliability and should be interpreted with some caution.

Parenting Self-Efficacy

The adapted Efficacy subscale of the Parenting Sense of Competence Scale (K. O'Neill, personal communication, July 24, 2017; Gilmore & Cuskelly, 2024) included the following seven items:

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, like I do.

2. I would make a good model for a new parent to follow.
3. Being a parent is manageable, and any problems are easily solved.
4. I am an expert in caring for my child.
5. If anyone can find the answer to what is troubling my child, I am the one.
6. I am comfortable in my role as a parent.
7. I have all the skills necessary to be a good parent to my child.

Possible response options included strongly disagree, disagree, agree, and strongly agree. The internal consistency reliability was high (alpha = .83), providing preliminary evidence that this measure works well in the population of caregivers enrolled in Tribal MIECHV.

Parenting Collective-Efficacy

To develop the measure of *Parenting Collective-Efficacy*, we drew inspiration from the *Multicultural Mastery Scale for Youth* (MMSY) developed with Alaska Native communities (Fok et al., 2012). That measure expanded assessment of adolescent coping skills beyond personal agency to include communal agency "through an interwoven social network." We applied the same approach to expand individual parenting self-efficacy to include communal connections. Items were created by taking elements of the MMSY and adapting them or the parenting context. Some items were adapted fairly directly from the MMSY; for example, the item "Working together with family I can solve many of my problems" became "Working together with my family and friends, I can solve many of the problems of caring for my child."[35] Other items were modified more extensively but drew on the ideas of communal efficacy in the MMSY.

The final measure of *Parenting Collective-Efficacy* was made up of the following four items:

1. I am comfortable being a parent because my family and community are there to help me.
2. Working together with family and friends, I can solve many of the problems of caring for my child.
3. Being a parent is manageable with the support of my family and friends.
4. I am good at caring for my child because of what I have learned from my family and community about parenting.

Possible response options included strongly disagree, disagree, agree, and strongly agree.

[35] The MMSY included separate subscales for Friends and Family, which was important for understanding their adolescent populations; for the purposes of the MUSE study, this was less critical, thus we combined friends, family and community to reduce the number of items and thus, participant burden.

The internal consistency reliability of this measure was high (alpha = .92), providing preliminary evidence that it worked well in the population of caregivers enrolled in Tribal MIECHV.

Mindful Parenting

The MUSE study team developed a measure of Mindful Parenting specifically for use with the parents and caregivers of young children. This measure drew most heavily on the Mindfulness in Teaching Scale (MTS; Frank et al., 2016), which itself drew heavily from the Mindful Attention and Awareness Scale (Brown & Ryan, 2003), and the Interpersonal Mindfulness in Parenting Scale (IMP; Duncan et al., 2009). The MUSE Mindful Parenting Measure included two subscales: *Attention Regulation* and *Emotion Regulation*:

Three adapted items from the MTS measured *Attention Regulation* are listed below.

1. When I am with my child, I have difficulty staying focused on what is happening in the present.
2. I rush through activities with my child without being really attentive to him or her.
3. I am often so busy thinking about other things that I am not really listening to my child.

Possible response options for the subscale included never true, rarely true, sometimes true, often true, and always true. Since these items were negatively worded, we reverse coded the scores such that a higher score reflects greater attention regulation. The internal consistency reliability of the Attention Regulation scale was excellent (Cronbach's alpha = .88).

Items that measured *Emotion Regulation* included the following three items adapted from the MTS, two taken from the IMP, and two new items:

1. I am aware of how my moods affect the way I treat my child. (MTS)
2. When I'm upset with my child I notice how I am feeling before I take action. (MTS)
3. When I am upset with my child, I calmly tell him or her how I am feeling. (MTS)
4. I notice how changes in my child's mood affect my mood. (IMP)
5. I often react too quickly to what my child says or does. (IMP)
6. When I am feeling stressed, it is hard to pay enough attention to my child. (new)
7. I can usually manage stressful things that happen and still take care of my child. (new)

Possible response options for the subscale included never true, rarely true, sometimes true, often true, and always true.

The internal consistency of the Emotion Regulation dimension was too low to be considered reliable (Cronbach's alpha = .60). Inspection of item intercorrelations suggested that negatively phrased items contributed to the lack of reliability. Further examination of the psychometric properties and refinement of this measure will be necessary before it can provide useful information about caregivers in this population.

Reflective Supervision Rating Scale

Home visitors completed the Reflective Supervision Rating Scale (Gallen et al., 2016), which assesses domains of reflective processes and skills, mentoring, supervision structure, and mentalization. The items for each of these domains are included below. Response options were 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always. Items with an asterisk are repeated on more than one subscale.

8. Reflective Processes and Skills My reflective supervisor(s) shows me how to integrate emotion and reason into case analyses.
9. My reflective supervisor(s) guidance improves my ability to be reflective.
10. My reflective supervisor(s) explores my thoughts and feelings about the supervisory process itself.
11. My reflective supervisor(s) and I together set the agenda for supervision.
12. My reflective supervisor(s) thinks with me about how to improve my observation and listening skills.
13. My reflective supervisor(s) encourages me to talk about emotions I have felt while consulting and working with families.*

Mentoring

1. My reflective supervisor(s) and I have a trusting relationship.
2. My reflective supervisor(s) is engaged throughout the entire session.*
3. My reflective supervisor(s) is both a teacher and a guide.
4. My reflective supervisor(s) makes me feel nurtured, safe, and supported during supervision.
5. My reflective supervisor(s) allows me time to come to my own solutions during supervision.
6. My reflective supervisor(s) listens carefully for the emotional experiences that I am expressing.

Supervision Structure

1. My reflective supervisor(s) and I have a regular supervision schedule.
2. My reflective supervisor(s) questions encourage details about my practice to be shared and explored within the supervision session.
3. My reflective supervisor(s) is engaged throughout the entire session.*

Mentalization

1. My reflective supervisor(s) listens carefully for the emotional experiences that I am expressing.
2. My reflective supervisor(s) encourages me to talk about emotions I have felt while consulting and working with families.*
3. My reflective supervisor(s) keeps families' and children's unique experiences in mind during supervision.
4. My reflective supervisor(s) wants to know how I feel about my consultation or practice experiences.
5. My reflective supervisor(s) helps me explore cultural considerations in my work.

Organizational Culture and Climate

To assess organizational culture and climate, the MUSE study team adapted the *Psychological Safety and Learning Behavior in Work Teams* measure (Edmondson, 1999). The final revised organizational culture and climate measure was included on the Home Visitor and Program Manager Surveys. The items are listed in the table below; each was rated on a 4-point scale from strongly agree, agree, disagree, and strongly disagree. A total of 43 items were included in the MUSE study. All items were scored so that higher values reflected a more positive climate (items that were reverse scored are noted with an asterisk).

The following modifications to the original items were made in collaboration with MUSE program partners:

- For all items, references to "this team" were changed to "our team."
- Ten items were REVISED slightly to clarify language for the home visiting program context. These items are indicated in italics, and the original item text is included below each.
- 12 NEW items were developed with study partners and added to this measure. These items are indicated in **bold** font.
    - Five items were added to the Team Learning Behavior scale.
    - Seven items were added to the Team Leader Coaching scale.

	Items used to assess organizational culture and climate
Supportiveness of Organization Context	
1	Our team gets all the information it needs to do our work and plan our schedules.
2	It is easy for our team to obtain expert assistance when something comes up that we don't know how to handle.
3	*Revised: Our team is kept in the dark about decisions that impact day-to-day work and what may happen with the program and its staff in the future.**
	Original: This team is kept in the dark about current developments and future plans that may affect its work.
4	Our team lacks access to useful training on the job.*
5	*Revised: Excellent work pays off in this organization.*
	Original: Excellent work pays off in this company.
Clear Direction	
6	It is clear what our team is supposed to accomplish.
7	*Revised: Our team spends time making sure every team member understands their role and responsibilities.*
	Original: This team spent time making sure every team member understands the team objectives.
8	Our team has invested plenty of time to clarify our goals.

Team Psychological Safety	
9	If you make a mistake on our team, it is often held against you.
10	Members of our team are able to bring up problems and tough issues.
11	*Revised: People on our team are expected to conform to the group.* Original: People on this team sometimes reject others for being different.
12	*Revised: It is safe to try something new on our team.* Original: It is safe to take a risk on this team.
13	It is difficult to ask other members of our team for help.*
14	No one on our team would deliberately act in a way that undermines my efforts.
15	Working with members of our team, my unique skills and talents are valued and utilized.
Team Efficacy	
16	Achieving our team's goals is well within our reach.
17	*Revised: Our team can complete work as assigned without being required to put in unreasonable time or effort.* Original: This team can achieve its task without requiring us to put in unreasonable time or effort.
18	With focus and effort, our team can do anything we set out to accomplish.
Team Composition	
19	Most people in our team have the ability to solve the problems that come up in our work.
20	All members of our team have more than enough training and experience for the kind of work they have to do.
21	Certain individuals in our team lack the special skills needed for good team work.*
Team Learning Behavior	
22	We regularly take time to figure out ways to improve our team's work processes.
23	*Revised: Our team tends to handle differences of opinion privately, rather than addressing them directly as a group.** Original: This team tends to handle differences of opinion privately or off-line, rather than addressing them directly as a group.
24	*Revised: Team members go out and get all the information they possibly can from others, such as families, community members, and other program partners.* Original: Team members go out and get all the information they possibly can from others, such as customers, or other parts of the organization.
25	Our team frequently uses information and data that leads us to make important changes.
26	In our team, someone always makes sure that we stop to reflect on our team's work process.
27	*Revised: People on our team often speak up to test assumptions we might have.* Original: People in this team often speak up to test assumptions about issues under discussion.
29	We invite people from outside our team to present information or have discussions with us.
28	**NEW: People on our team are encouraged to think outside the box.**

30	**NEW: Our team uses data to see if our processes are leading to the results we want.**
31	**NEW: Members of our team are encouraged to try new strategies to see if they will work.**
32	**NEW: Members of our team support each other as we work to master new skills.**
33	**NEW: The quality of work provided by our team is improving over time.**
Team Leader Coaching	
34	Our team leader initiates meetings to discuss our team's progress.
35	Our team leader is available for consultation on problems.
36	*Revised: Our team leader is engaged in our team's day-to-day work.* Original: The team leader is an ongoing "presence" in this team-someone who is readily available.
37	**NEW: Our team leader manages crises in a calm and dependable way.**
38	**NEW: Our team leader helps us get through challenges we face in our work.**
39	**NEW: Our team leader handles personnel issues thoughtfully.**
40	**NEW: Our team leader would go to bat for us.**
41	**NEW: Our team leader has enough training and experience to be an effective leader.**
42	**NEW: Our team leader treats all team members fairly.**
43	**NEW: Our team leader doesn't really understand what our team needs to do its job well.***
* Items were reverse scored so that higher scores reflected a more positive climate.	

Appendix B: Supplemental Tables

Table 4.2. Caregiver Reasons for Enrollment

Reason	Not important	Somewhat important	Important	Very Important
Coping with past abuse/trauma	34%	13%	19%	35%
Quitting smoking	45%	5%	15%	36%
Dealing with partner or family violence	42%	8%	14%	36%
Connecting with others to talk	2%	15%	46%	38%
Quitting alcohol or drugs	54%	2%	6%	39%
Connecting to community and culture	2%	14%	45%	39%
Getting a job/better job	24%	12%	24%	40%
Legal system and services	30%	13%	17%	40%
Dealing with sadness	22%	13%	24%	41%
Getting more education/job training	21%	8%	29%	42%
Using family planning	12%	8%	32%	49%
Budgeting/making ends meet	12%	16%	23%	50%
Breastfeeding	20%	11%	17%	52%
Dealing with stress	10%	14%	24%	52%
Meeting basic needs	12%	14%	21%	54%
Making child care arrangements	6%	14%	26%	55%
Having healthy adult relationships	5%	6%	30%	59%
Co-parenting	8%	8%	23%	61%
Eating more nutritious meals and exercising	2%	6%	28%	64%
Feeding my child	6%	5%	23%	67%
Improving my overall health	2%	5%	23%	70%
Managing my child's behavior	0%	5%	18%	77%
Taking care of my baby or child	5%	4%	14%	78%
Keeping my child and home safe	2%	3%	11%	85%
My child's development	0%	1%	13%	86%
Having my child be healthy	0%	0%	14%	87%
Interacting with my child in a positive way	0%	1%	12%	88%
Having a healthy pregnancy*	0%	0%	12%	88%
Staying healthy after I have my baby*	0%	0%	10%	91%

Table 4.6 Caregiver Experience with Home Visiting Programs

Statement	Strongly disagree	Disagree	Agree	Strongly agree
I would recommend the home visiting program to my family and friends	4%	0%	22%	75%
What I get out of the home visiting program is worth the time it takes to participate	4%	0%	31%	65%
There are some things I do differently now because of my experience in the home visiting program	4%	4%	41%	51%
Will help my child reach his or her full potential	6%	2%	43%	50%
Is an excellent use of my time	7%	4%	41%	48%
Helps me get the things I need for my family	8%	0%	45%	47%
Helps me feel good about myself and my job as a parent	7%	0%	48%	44%
Will help me reach my personal goals	6%	4%	46%	44%

Table 7.3. Education Attainment by Staff Role

Educational Attainment	Home Visitors *n*	Home Visitors %	Program Managers *n*	Program Managers %
High school/GED	1	2%	0	0%
Some college/no degree	7	13%	0	0%
Technical training or certification	4	7%	0	0%
Associate degree	13	24%	3	19%
Bachelor's degree	28	51%	8	50%
Master's degree or higher	2	4%	5	31%

Table 9.3. Home Visitors That Reported Confidence in Carrying Out Home Visit Activities

Activity	Not very confident	Somewhat confident	Mostly confident	Completely confident
Communicate warmth, respect, and appreciation	0%	0%	28%	72%
Identify and communicate strengths to caregivers	2%	4%	32%	62%
Build relationships and trust	0%	4%	34%	62%

Activity	Not very confident	Somewhat confident	Mostly confident	Completely confident
Plan home visits	0%	4%	38%	58%
Conduct screenings	0%	4%	44%	52%
Tailor activities for each family	0%	2%	50%	48%
Help families access needed services	0%	16%	36%	48%
Collect data and information from caregivers	0%	4%	50%	46%
Deliver curriculum the way my program and model intends	0%	16%	38%	46%
Enter data and document what happens during home visits	0%	14%	42%	44%
Ensure my safety	0%	10%	50%	40%
Develop and use family goal plans	2%	14%	44%	40%
Work with multi-generational families and nontraditional caregivers	0%	12%	53%	35%
Manage my time	4%	20%	46%	30%
Model and coach parenting skills	2%	14%	56%	28%
Support families in managing crises	2%	20%	50%	28%
Retain families and keep my caseload slots filled	2%	20%	54%	24%
Balance family preferences with program priorities	0%	6%	72%	22%
Engage fathers in home visits	0%	29%	53%	18%
Deliver the expected number of home visits	0%	22%	62%	16%
Engage an uninterested or fussy child	2%	27%	55%	16%
Engage an uninterested or distracted caregiver	0%	33%	53%	14%

Table 9.4. Home Visitors That Reported Confidence in Addressing Topics

Topic	Not very confident	Somewhat confident	Mostly confident	Completely confident
Child development	0%	2%	35%	63%
Parent-child interaction	0%	2%	35%	63%
Breastfeeding	10%	4%	27%	58%
Child and home safety	0%	6%	35%	58%

Topic	Not very confident	Somewhat confident	Mostly confident	Completely confident
Postpartum health/postpartum care	4%	4%	35%	57%
Developmentally appropriate routines	0%	4%	38%	57%
Prenatal health/prenatal care	2%	8%	36%	54%
Feeding children (e.g., formula, solids)	0%	8%	38%	54%
Child health	0%	0%	48%	52%
Caregiver nutrition and physical activity	0%	11%	40%	49%
Caregiver physical health	2%	2%	48%	48%
Family planning	0%	4%	50%	46%
Discipline or behavior management	2%	15%	38%	45%
Caregiver emotional well-being	0%	4%	52%	44%
Basic needs (e.g., food, housing)	0%	8%	48%	44%
Connecting to community and culture	4%	21%	35%	40%
Social support	0%	8%	54%	38%
Employment	0%	19%	44%	38%
Caregiver education and job training	0%	15%	50%	35%
Making child care arrangements	0%	17%	50%	33%
Domestic violence	2%	21%	46%	31%
Alcohol, tobacco, and other drug use	0%	23%	47%	30%
Healthy adult relationships	0%	10%	60%	29%
Coparenting	0%	31%	40%	29%
Budgeting or making ends meet	4%	19%	52%	25%
Past trauma	6%	28%	43%	23%
Legal system and services	10%	35%	42%	13%

Table 9.6. Home Visitor Job Satisfaction With Specific Aspects of Their Jobs

Aspect of job	Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
My relationship with my immediate supervisor	6%	4%	40%	50%
How interesting the work is	0%	2%	49%	49%
My ability to contribute to others in a meaningful way	0%	2%	51%	47%

Aspect of job	Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
The control I have over my daily work schedule	2%	6%	45%	47%
My relationships with my coworkers	2%	6%	47%	45%
My job overall	0%	4%	55%	41%
The flexibility of my schedule	4%	4%	52%	40%
The training and professional development	2%	4%	55%	39%
The amount of vacation time I receive	2%	13%	50%	35%
Ability to meet obligations outside of work	4%	6%	56%	33%
My job security	2%	8%	61%	29%
The mentoring and support I receive	6%	10%	55%	29%
The health insurance benefits my employer offers	4%	11%	57%	28%
My physical safety while doing my job	2%	8%	63%	27%
My work-life balance	0%	6%	69%	25%
The retirement plan my employer offers	8%	2%	67%	23%
The recognition I receive	4%	14%	59%	22%
The physical workspace	4%	15%	60%	21%
The time it takes to get the job done	2%	8%	73%	17%
Balancing the different tasks that are required of me	2%	15%	67%	17%
Getting the work done given interruptions	2%	17%	65%	17%
The size of my caseload	2%	15%	70%	13%
The amount time I spend traveling to home visits	0%	9%	81%	11%
The amount of money I earn	8%	21%	63%	8%
The amount of on-the-job stress	2%	27%	67%	4%
My chances for promotion	10%	25%	60%	4%