2025 Refugee Needs Assessment



Understanding Capacity and Gaps in the Michigan Home Visiting System

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Acknowledgements

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EXECUTIVE SUMMARY

Purpose & Objectives

The Refugee Systems of Care project conducted a comprehensive needs assessment to evaluate the capacity and gaps within Michigan's home visiting system for refugee and newcomer families. The primary objectives were to: (1) Assess the experience of professionals and refugee families in the home visiting system, (2) Identify support gaps, challenges, and barriers, and (3) Make recommendations to increase access and improve quality of services for refugee families in the home visiting system.

Key Findings

- **Language & Communication:** Language barriers are a critical challenge. There is a shortage of translated materials in common refugee languages (e.g., Kinyarwanda, Dari, Kiswahili). Over-the-phone interpretation is commonly used but service providers view consistent, in-person interpretation and bilingual staff as more effective strategies to build trusting relationships with families.
- **Navigating Systems & Resources:** Refugee families face difficulties accessing public benefits, healthcare, and other community resources. Home visitors play a vital role in helping families navigate these systems, but staffing shortages, limited time for case management, and high turnover disrupt service continuity in the home visiting system.
- **Community Partnerships:** Effective collaboration with refugee-serving agencies enhances support but is hampered by staff turnover and unclear roles. Partnership between home visiting programs and refugee support systems is essential to wholistically support families' adjustment to a new community.
- **Staffing & Sustainability:** There is a shortage of bilingual and bicultural staff, including home visitors and community health workers. Costs of language services and limited wraparound services for refugee families are threats to sustainability for home visiting programs.

Recommendations

Home visiting professionals would benefit from refugee resource guides, translated and culturally adapted materials, trauma-informed training, and peer-to-peer learning communities. Home visiting programs should strengthen partnerships with refugee-serving organizations and recruit bilingual and bicultural workers. System leaders should make investments in increased case management support, sustainable funding for culturally responsive services, and enhanced data collection to improve the reach and effectiveness of home visiting services for refugee families.

Impact

Implementing these recommendations will ensure families receive high-quality, culturally sensitive home visiting services. Home visiting will benefit from a more adaptable and sustainable system that fosters stronger community partnerships, cross-sector collaboration, and system-wide data collection practices to evaluate the reach and effectiveness of home visiting services for refugee families.

INTRODUCTION

Home visiting is a free and voluntary service for parents during pregnancy and early childhood to ensure families are supported to create a safe and nurturing environment for their children. In Michigan, the home visiting system implements evidence-based models with proven outcomes in the areas of maternal and child health, child development and school readiness, and reduction in child maltreatment. Home visiting is positioned to provide direct support to families, as well as connect them with a range of community services available in the areas where refugee families are settled. Additionally, many home visiting programs are designed to provide trauma-informed care. However, the experiences of refugee families often differ from those typically addressed in these programs because their needs are unique and often unfamiliar to home visiting providers.

The Center for Quality Family Support (CQFS) provides training, technical assistance, and implementation support for maternal, infant & early childhood home visiting programs. The Center's mission is to deliver empowering & compassionate support to evidence-based home visiting providers resulting in high-quality family support services. The Center's goals are to:

- Develop and inform the home visiting workforce
- Strengthen home visiting programs to achieve high-quality implementation and improve outcomes for families
- Provide access to personalized, relationship-based program support
- Serve as the Michigan Central Administration for Healthy Families America programs
- Serve as the Michigan State Office for Parents as Teachers programs
- Develop a system of support in Michigan for home visiting programs serving refugee families

The Refugee Systems of Care (RSoC) project was created to develop a system of support for evidence-based home visiting programs in Michigan that serve pregnant and parenting refugee families. The project objectives are:

- Increase refugee families' participation in home visiting
- Support home visiting programs in service delivery
- Strengthen connections between home visiting programs and refugee services at the state and local level

To identify strategies that strengthen home visiting services for refugee families, the project completed a literature review and an environmental scan.

- The Literature Review Serving Refugee Families Through Home Visiting analyzed scholarly research on refugee and immigrant families with young children, including their strengths, challenges, and promising home visiting practices that are culturally and linguistically responsive.
- The Environmental Scan of Refugee-Responsive Home Visiting gathered insights from websites, interviews, surveys, and a site visit to understand how home visiting programs are currently engaging refugee families and identify successful strategies for serving refugee families through home visiting.

The 6 refugee-responsive home visiting practices outlined below are are intended to strengthen home visiting services by making them more responsive, accessible, and effective in meeting the needs of refugee families.

1. Welcome Refugee Families

- *Welcome refugee families in home visiting programs by acknowledging their unique circumstances, fostering cultural sensitivity, and promoting their successful adjustment to new communities.*

2. Incorporate Feedback from Refugee Families

- *Both home visiting programs and refugee families benefit when families are involved in the development, implementation, and evaluation of programs. Successful programs leverage feedback from the refugee community to deepen relationships, adapt services, and respond to families' needs.*

3. Leverage Community Partnerships

- *Partnering with refugee support organizations, such as refugee service providers, faith-based organizations, and community-based organizations, allow home visiting programs to identify community support systems, language service providers, cultural experts, and immigration legal aid to deepen community ties.*

4. Increase Linguistic and Cultural Responsiveness

- *Successful programs hire staff that showcase the cultural and linguistic backgrounds of their community, utilize interpreters and translation services to bridge language gaps, and adapt service delivery to meet the unique needs that every family has.*

5. Provide Training and Support to Home Visitors

- *Home visitors play a critical role in supporting refugee families. Successful programs provide home visitors with targeted training, reflective supervision, and ongoing professional development to prioritize their wellbeing and sustain the quality of care they provide to refugee families.*

6. Collect Data on Participation and Impact

- *The fair distribution of funding and the effectiveness of home visiting relies on the accurate representation of refugee families in home visiting data. Successful programs utilize data on refugee family demographics, strengths, and needs to support funding applications and identify areas for program improvement.*



Building on these foundational activities, the project conducted a needs assessment to further explore capacity and gaps in order to inform recommendations for improving support to refugee families through home visiting.
In this report, the following key terms and acronyms will be used:

KEY TERM	DEFINITION
Community Health Worker (CHW)	A Community Health Worker or CHW is a frontline public health worker who shares the language, culture, and lived experience of the community they serve, acting as a trusted liaison between families and health or social services to improve access, cultural responsiveness, and self-sufficiency through outreach, education, advocacy, and support.
Early Head Start - Home Based (EHS)	Early Head Start-Home Based or EHS is a home visiting model that offers comprehensive child development and family support services for low-income families during pregnancy and with children 0-3.
Healthy Families America (HFA)	Healthy Families America or HFA is a home visiting model that provides family-centered support for expectant and new parents from pregnancy through age 5, helping them bond with their child and connect to health and community resources.
Home Visiting Programs (HVPs)	Home visiting programs or HVPs refers to home visiting programs that use an evidence-based model to provide home-based services to families during pregnancy and with children aged 0-5.
Infant Mental Health (IMH)	Infant Mental Health or IMH is a home visiting model that supports families with children from prenatal to age 3 who may be struggling to bond, by helping build strong parent-child relationships through mental health professionals.
Maternal Infant Health Program (MIHP)	Maternal Infant Health Program or MIHP is a home visiting model that helps Medicaid-eligible pregnant women and families with infants (prenatal to 12 months) learn health and parenting skills through support from a nurse and social worker.
Michigan Home Visiting Initiative (MHVI)	The Michigan Home Visiting Initiative or MHVI is a statewide system of evidence-based programs that support pregnant individuals and families with young children by providing in-home services focused on parenting, child development, health, and family well-being.
Nurse-Family Partnership (NFP)	Nurse-Family Partnership or NFP pairs young, first-time pregnant moms with a nurse for individualized support throughout pregnancy and until their child turns 2 years old.
Parents as Teachers (PAT)	Parents as Teachers or PAT is a home visiting model that helps parents and caregivers from pregnancy through entry into kindergarten build parenting confidence and support their child's development and learning.
Play and Learning Strategies (PALS)	Play and Learning Strategies or PALS is a home visiting model that teaches parents how to strengthen bonding and support their baby's development through play, serving families with infants from 15 months old through age 5.

Purpose

A needs assessment is a comprehensive, participatory process of collecting data to identify needs and develop recommendations. The RSoC project conducted a needs assessment to evaluate the current capacity of evidence-based home visiting programs (HVPs) to serve refugee families and identify needs and gaps at all levels of the home visiting system. The objectives of the needs assessment were to:

- Assess the experiences, challenges, and needs of HVPs serving refugee families
- Assess the experiences, challenges, and needs of pregnant and parenting refugee families enrolled in home visiting services
- Identify the gaps in support and needs of home visiting professionals to effectively serve refugee families
- Make recommendations to support HVPs and the home visiting system

During the needs assessment process, home visiting supervisors, home visitors, and refugee families enrolled in HVPs shared their perspectives and experiences to create a shared understanding of the needs and gaps in the home visiting system. Furthermore, the process highlighted the successes and strengths HVPs use in their work with refugee families. The experiences of professionals and refugee families were evaluated based on refugee-responsive home visiting practices to identify gaps in capacity and/or reach. The assessment incorporated supplementary data to identify key demographics among refugee communities in Michigan, evaluated service recipient demographics in Michigan's most prevalent home visiting model, and deepened understanding of training and support needs among home visiting professionals related to serving refugee families.

METHODOLOGY

The needs assessment combined data collection and supplementary data sources to assess the needs of home visiting professionals and refugee families enrolled in evidence-based home visiting programs in the focus area. The goal of the needs assessment was to identify gaps in reach and capacity within the Michigan home visiting system. Data collection methods included surveys, focus groups, and interviews that collected information directly from key stakeholders in the home visiting field, including program leaders, direct service providers, and refugee families.

The activities of the needs assessment are limited to a 7-county focus area in Michigan, namely Ingham, Kalamazoo, Kent, Macomb, Oakland, Washtenaw, and Wayne counties. According to the Office of Global Michigan, these counties comprise 83% of all refugee children aged 0-5 in Michigan who received public benefits from the State of Michigan or were served by refugee service providers funded by the Office of Global Michigan.[1] For this reason, the RSoC team engaged home visiting programs in this focus area.

[1] Data includes arrivals from 01/01/2015 - 06/13/2024. This percentage is based on a summary of refugee children aged 0-5 from the Data Management System (DMS), which includes individuals who are served by contracted providers of the Office of Global Michigan and/or have a public benefits case indicating an immigration status eligible for benefits and services of the federal Office of Refugee Resettlement (ORR). For more information on ORR benefits and services, visit https://acf.gov/orr/programs/refugees.

The RSoC team distributed a survey to all 85 HVPs in the 7-county focus area to identify programs that are most likely to be serving refugee families. Forty-five (45) of the 85 HVPs in the focus area (53%) responded to the survey. Among the 45 survey respondents, 24 program leaders indicated that their programs are currently serving refugee families and 11 program leaders responded that they are unsure if their programs are serving refugee families. These 35 programs represent 41% of all HVPs in the focus area and are the HVPs in Michigan that are most likely to be aware of the successes, challenges, and gaps in serving refugee families within the Michigan home visiting system.

The RSoC team engaged these 35 HVPs during the needs assessment process to evaluate the reach and capacity of the home visiting system to serve refugee communities in Michigan. More details about the home visiting programs engaged in the needs assessment process can be found in Appendix A.

Additionally, the needs assessment analyzes and synthesizes supplementary data sources to contextualize and deepen the findings. The RSoC team incorporated data from the Office of Global Michigan (OGM), professional development evaluation results, and Maternal Infant Health Program (MIHP). These sources provide important context on the demographics of eligible refugee families, demographics of families enrolled in MIHP, and training and support needs of home visiting professionals. By employing a mixed-method approach, the assessment offers a more comprehensive understanding of the capacity and reach of the home visiting system to support refugee communities in Michigan.



Data Collection

The RSoC team employed a mixed-methods approach to understand the experiences of both home visiting professionals serving refugee families and refugee families enrolled in home visiting services. This approach combined qualitative and quantitative data collection through surveys, focus groups, and interviews.

The RSoC team developed protocols for surveys and focus groups targeting home visiting professionals, including direct service providers and those in supervisor or program manager roles. The team developed a separate protocol for interviews with refugee families to capture their experiences in home visiting.

The recruitment process took place in 3 stages. The bullet points below outline how the RSoC team engaged home visiting professionals and enrolled families to gather service-level insights.

- **Supervisors and Program Managers:** The team first engaged supervisors and program managers in home visiting programs that were likely serving refugee families. Surveys and focus groups were used to glean information from them.
- **Direct Service Professionals:** Supervisors and program managers identified direct service professionals in their programs with experience serving refugee families to participate in surveys and focus groups.
- **Refugee Families:** Direct service professionals identified refugee families on their caseload to participate in interviews.

The data collection methods used were:

- **Surveys:** The team implemented 2 surveys that targeted home visiting professionals: one protocol was developed for home visiting leaders and one protocol was developed for direct service professionals. These surveys invited home visiting professionals to share more information about their program, their service population, and their capacity to provide refugee-responsive services to families.
- **Focus Groups:** The team conducted 2 sets of focus groups: the first protocol was developed for home visiting leaders and the second protocol was developed for direct service professionals. These focus groups provided a forum for in-depth discussions, enabling participants to share detailed feedback on their capacity to provide refugee-responsive services and identify opportunities for growth.
- **Interviews:** The team partnered with direct service professionals to identify and engage families with lived experience as a refugee who had been enrolled in an HVP for at least 6 months. Interviews were designed to gather direct feedback on refugee families' experiences, needs, and concerns related to home visiting services.



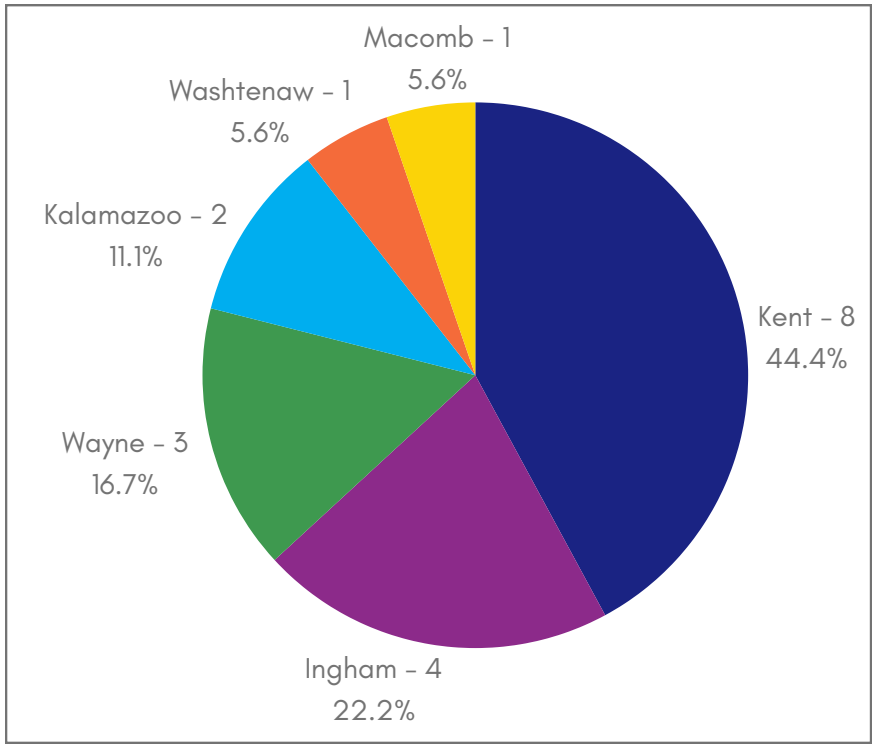
Supervisor Survey

The RSoC team developed a survey to identify the challenges, barriers, and resources that home visiting supervisors and program managers encounter when serving refugee families. The team distributed the survey to supervisors and program managers at the 35 HVPs most likely to serve refugee families in the focus area. Participation was voluntary and un-incentivized. The team distributed the survey in July 2024 using REDCap, a secure online data collection platform. Of the 35 supervisors and program managers who received the survey, 18 (51%) completed the survey. The following breaks down these 18 survey responses by county and model of program leaders.

Kent County had the highest response rate, with 8 of 18 program leaders (44.4%) completing the survey, followed by Ingham County with 4 of 18 (22.2%). Figure 1 below shows the response rate by county. Six (6) out of 18 program leaders (33.3%) used the Maternal Infant Health Program (MIHP) model, making it the most frequently used model among respondents. Figure 2 shows the breakdown response rates by model, which include Nurse Family Partnership (NFP), Play and Learning Strategies (PALS), Parents as Teachers (PAT), Healthy Families America (HFA), Early Head Start - Home-Based (EHS), and Infant Mental Health (IMH).

Figure 1

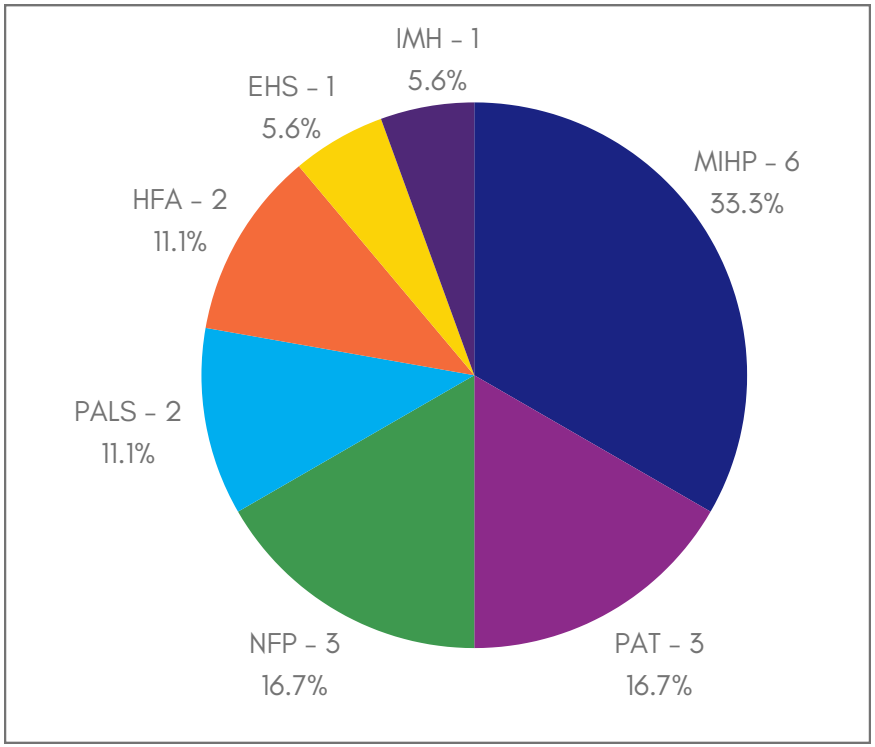
Supervisor Survey Participation by County



Note. n = 18, percentages do not add to 100%, one supervisor provided services in both Washtenaw and Wayne counties.

Figure 2

Supervisor Survey Participation by Model



Note. n = 18

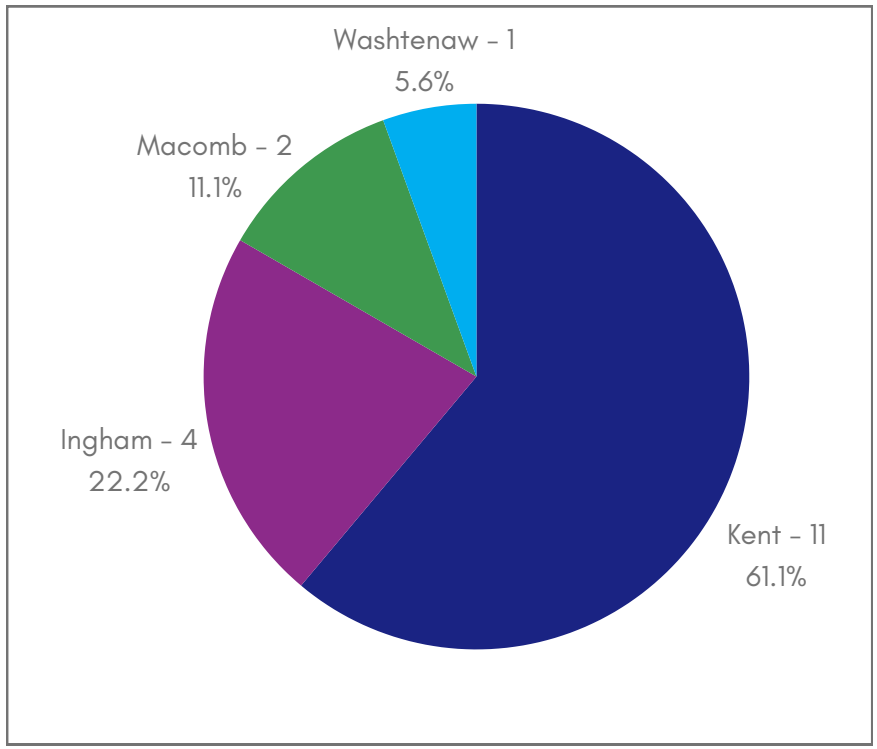
Home Visitor Survey

The RSoC team developed a survey to understand the experiences and needs of home visitors serving refugee families. Staff sent the survey to 35 program supervisors and asked them to forward it to home visitors with relevant experience serving refugees. Supervisors identified those home visitors and shared the survey link. Participation was voluntary and un-incentivized. The team distributed the Home Visitor Survey in August 2024 using REDCap, a secure online data collection platform. Of the home visitors who were identified by program supervisors, 18 home visitors responded to the survey.

The highest number of responses came from Kent County, with 11 out of 18 home visitors (61.1%) completing the survey. Figure 3 shows the breakdown of response rates by county. Half of the home visitors (9 out of 18 respondents) implemented the MIHP model. Figure 4 below shows the breakdown of response rates by home visiting model.

Figure 3

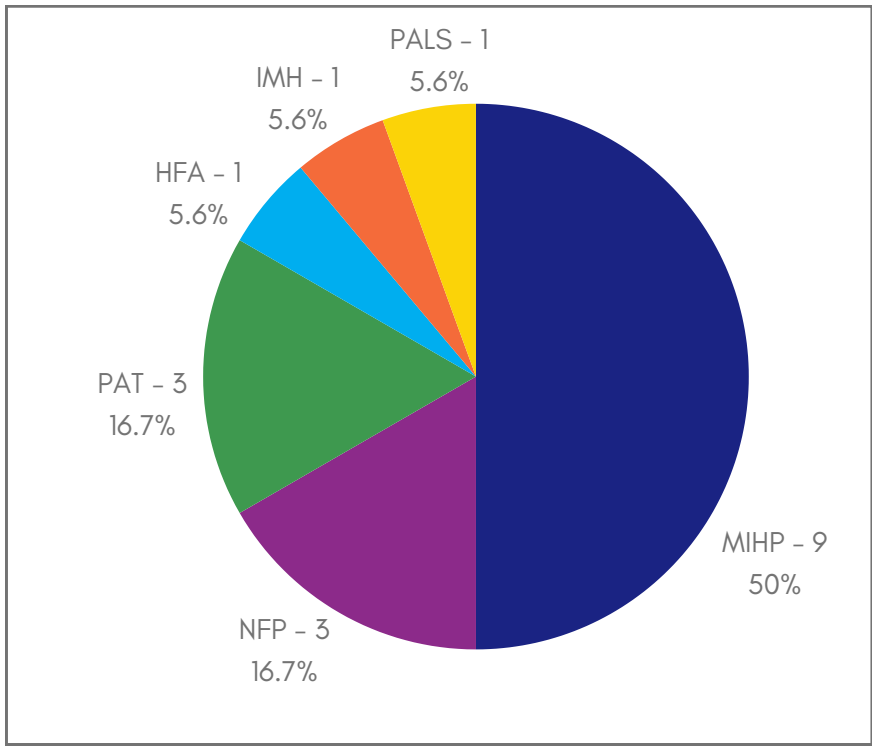
Home Visitor Survey Participation by County



Note. n = 18

Figure 4

Home Visitor Survey Participation by Model



Note. n = 18

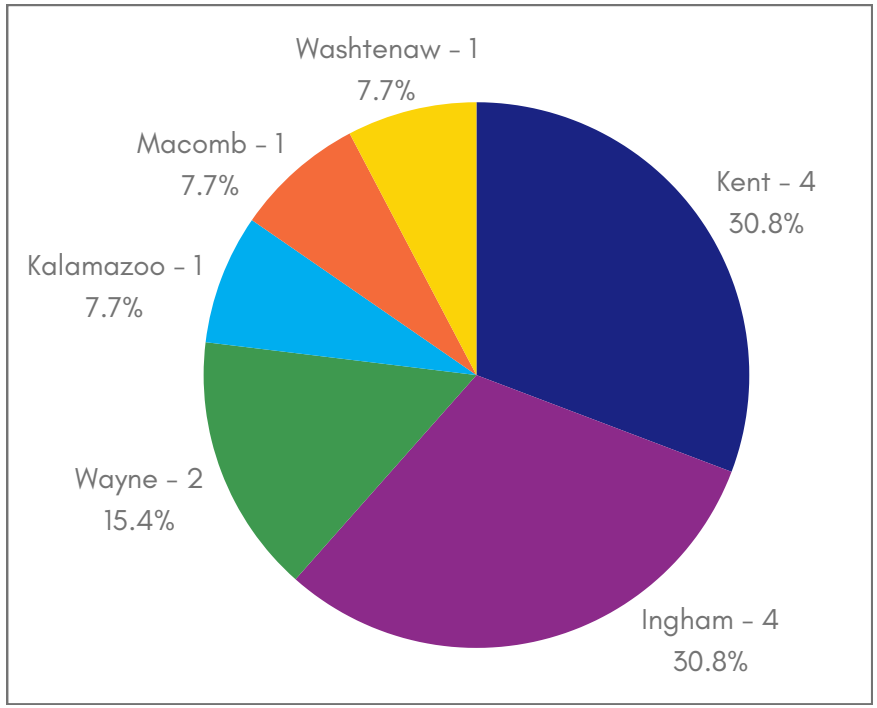
Supervisor Focus Groups

To gain deeper insight into the experiences of home visiting providers, the RSoC team conducted focus groups with supervisors in the focus area. Respondents to the Supervisor Survey were invited to provide an e-mail address and opt-in to participate in a focus group. Those who opted in were contacted via e-mail to schedule focus groups. Participation was voluntary and un-incentivized. The focus groups took place virtually via Microsoft Teams in September 2024. Three (3) focus groups were conducted with 13 of the 18 survey respondents, resulting in a 72% participation rate among home visiting supervisors.

The highest focus group participation was among supervisors in Kent (30.8%) and Ingham (30.8%) counties, where 4 supervisors from each county attended a focus group out of 13 total focus group participants. Figure 5 below shows the participation by county. The MIHP model was the most widely implemented among respondents, with 7 out of 12 (53.8%) supervisors reporting its use. Figure 6 shows the breakdown of model response rates, which includes NFP, EHS, HFA, PALS, and PAT. For more information on Supervisor Focus Group topics, see Appendix B.

Figure 5

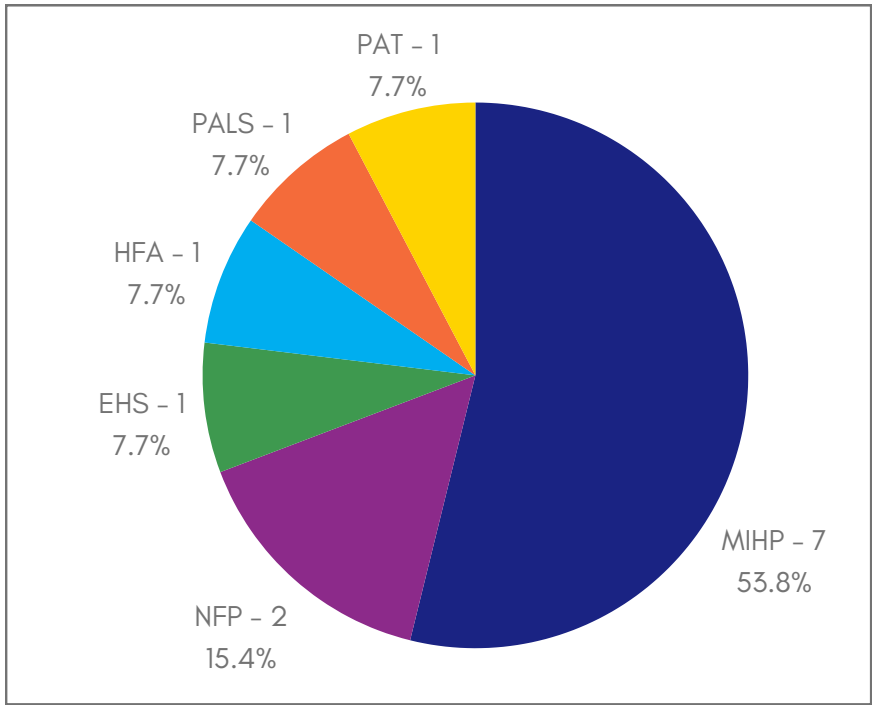
Supervisor Focus Group Participation by County



Note. $n = 13$

Figure 6

Supervisor Focus Group Participation by Model



Note. $n = 13$

Home Visitor Focus Groups

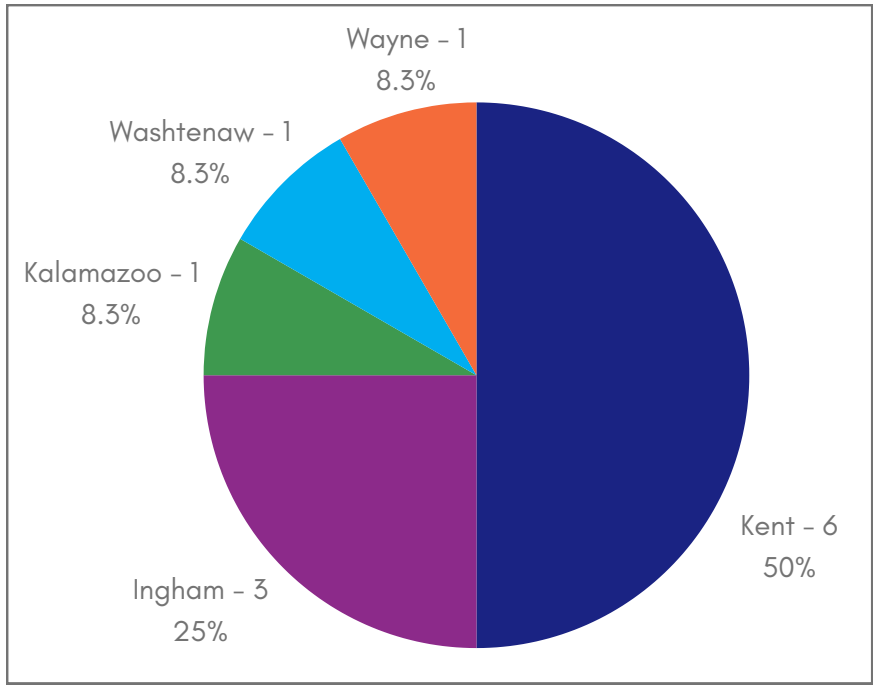
To gain deeper insight into the experiences of home visitors, the RSoC team conducted focus groups with home visitors in the focus area. Home visitors who responded to the Home Visitor Survey had the opportunity to opt-in to participate in a focus group. The RSoC team contacted those who opted in via email to schedule the focus groups. Participation was voluntary and un-incentivized. The focus groups took place virtually via Microsoft Teams in October 2024. Three (3) focus groups were conducted with 12 of the 18 home visitor survey respondents, resulting in a 67% focus group participation rate among home visitors.

The highest response rate was among direct service workers from Kent County, where 6 out of 12 home visitors (50%) participated in the focus groups. Figure 7 below shows the response rate by county. The MIHP model was the most widely implemented among respondents, with 6 out of 12 (50%) home visitors reporting its use. Figure 8 shows the breakdown of model response rates, which also included NFP, EHS, HFA, PALS, and PAT.

For more information on Home Visitor Focus Group topics, see Appendix C.

Figure 7

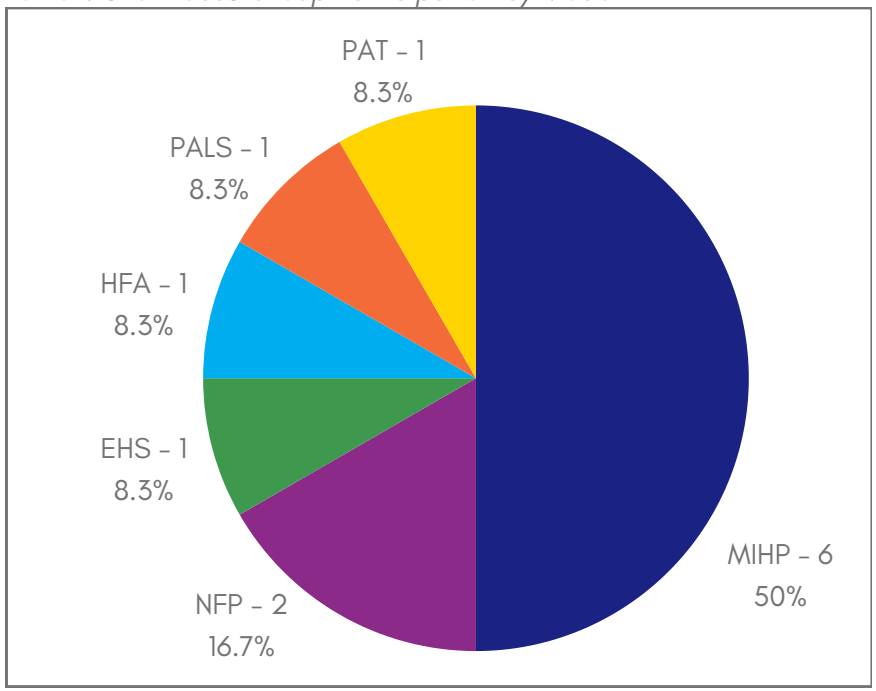
Home Visitor Focus Group Participation by County



Note. $n = 12$

Figure 8

Home Visitor Focus Group Participation by Model



Note. $n = 12$

Family Interviews

To gain deeper insight into the experiences of refugee families enrolled in home visiting services, the RSoC team developed an interview protocol. Home visitors who responded to the Home Visitor Survey were given the opportunity to opt-in to identify and recruit eligible families on their caseload to participate in interviews. Of the 18 home visitors who completed the survey, 11 (61%) opted in to recruit refugee families for interviews. The RSoC team provided home visitors with recruitment materials, including a flyer and a recruitment message. The recruitment message explained the eligibility criteria, provided details about the interview process, and details about the $50 Visa gift card incentive for families who participated.

The RSoC team informed home visitors of the eligibility criteria for families to participate in interviews:

- At least one family member self-identified as a refugee or was identified by the home visitor as someone who was forced to flee their country of origin.
- The family had been enrolled in home visiting services for at least six months.

The RSoC team instructed home visitors to review privacy, confidentiality, and support families in completing a release of information form for each family. After families complete the release of information, the RSoC team scheduled a screening call with them to discuss the interview process and decide the time and location for interviews to take place. Of the 11 home visitors who initiated the interview recruitment process, 1 home visitor (9%) successfully recruited 3 refugee families to participate in interviews.

The RSoC team conducted interviews in-person at locations chosen by the caregivers. Home visitors provided information about the caregivers' preferred language and the RSoC team contracted interpretation services to conduct interviews in the families' preferred language. All 3 caregivers chose Spanish as their preferred language. The RSoC team facilitated an in-person interview with each of the 3 families in January 2025. The team audio recorded and transcribed all interviews with consent from caregivers. All 3 caregivers received services in Kent County and were enrolled in the same home visiting program. For more information on family interview questions, see Appendix D.

Limitations

The surveys, focus groups, and interviews were limited by several factors. Firstly, all the data collection methods relied on self-report data therefore selective reporting may limit the accuracy of findings. Secondly, no representatives from Oakland county participated in the activities, limiting the geographic scope of activities. Finally, recruitment challenges for the focus groups and interviews limited the comprehensiveness of findings. The voluntary and unincentivized nature of the data collection methods likely contributed to a smaller sample size. All families who participated in interviews were Spanish-speaking and were recruited by the same home visitor in Kent County, which narrowed the variety of perspectives captured. Home visitors cited high workloads as a barrier to supporting family recruitment and some expressed concern about the lack of compensation for supporting recruitment efforts. These factors likely contributed to the limited sample size among family participants.

Supplementary Data

In addition to primary data collected through surveys, focus groups, and interviews, the RSoC team analyzed supplementary data sources to provide broader context for understanding the reach and capacity of home visiting services for refugee families. These supplementary data sources offered key insights into the arrival trends of refugee families eligible for home visiting services, the demographics of refugee families and MIHP-enrolled mothers in the focus area, and the professional development needs of home visitors working with this population. By incorporating these data sources, the assessment presented a more comprehensive picture of both the demographics of refugee families and the needs of home visiting professionals.

Refugee Arrivals & Demographics, FY20-FY24

The Office of Global Michigan (OGM) shared data with the RSoC team to clarify the areas where home visiting services are most needed among pregnant and parenting refugee families. This data provides insight into the cultural and linguistic adaptations needed for the home visiting system to improve the reach and capacity of home visiting services for refugee families.

OGM shared data on the number of refugee children ages 0-4 who were resettled in Michigan between fiscal years 2020-2024. OGM received this data from the Bureau of Population, Refugees, and Migration's Refugee Processing Center.[2] This data provides arrival trends over the last 5 years of the refugee children eligible for home visiting service.

Additionally, OGM shared data on the number of refugee children aged 0-5 who received public benefits through the State of Michigan or received services from OGM-contracted providers.[3] This data is reported by State of Michigan employees and by OGM's contracted refugee service providers. This data provides information on the county of enrollment, country of origin, and the number of refugee children who are eligible for home visiting services.

Lastly, OGM shared data on the demographics of refugee arrivals of all ages in the focus area. This data clarifies the linguistic background of refugees in the focus area and provides insight into the most common spoken languages of recent refugee arrivals to Michigan.



[2] Post-Arrival Demographic reports are publicly available. https://www.wrapsnet.org/admissions-and-arrivals/
[3] The Office of Global Michigan provides funding to at least 53 agencies in Michigan that provide services to refugees. These partners provide a range of services to support the successful resettlement and integration of refugee communities in Michigan, including social services, employment services, legal services, and health services, among others.

Maternal Demographics, MIHP Enrolled Clients, FY24

The Maternal Infant Health Unit, which oversees MIHP, provided the RSoC team with data on maternal demographics in the focus area. The RSoC team analyzed the primary language and English language proficiency of MIHP-enrolled caregivers. This data provided information on the language access needs and linguistic background of MIHP-enrolled caregivers.

Professional Development Evaluations, FY24

The Michigan Home Visiting Initiative (MHVI) collected evaluation data on the training offered to home visiting professionals, including data gathered from attendees of the MHVI Conference. This data provided insights into the type and topic of training requests made by home visiting professionals. For more information on the MHVI or MHVI evaluations, see Appendix E.

MHVI provided five training sessions for home visiting professionals, including a seven-part series on Deepening Reflective Practice in Home Visiting, Caregiver Mental Health training, Home Visitor Safety training, Mandated Reporter training, and Substance Use training. During FY24, 952 home visiting professionals participated in at least one training or conference session.

Evaluation data is collected following each training session to gather participants' recommendations for future training topics. MHVI received and categorized the participants' training recommendations into the Core Knowledge Framework areas (see Appendix E). The areas that were most requested include Professional Practice (90), Parent Health and Nutrition (87), and Cultural and Linguistic Responsiveness (48). The RSoC team received evaluation data from the MHVI team and analyzed the feedback of home visiting professionals to identify opportunities to support their training needs.

At the 2024 MHVI Conference, the RSoC team facilitated a session titled "Serving Families who are Refugees through Home Visiting." The RSoC team shared findings from the literature review they conducted "Serving Refugee Families Through Home Visiting" of refugee-responsive home visiting practices and lessons learned. During the session, the team distributed a survey to attendees to gather feedback on the types of support most helpful in their work with refugee families. Sixty-five (65) session attendees completed a brief survey to identify the resources they found most valuable in their roles.

FINDINGS

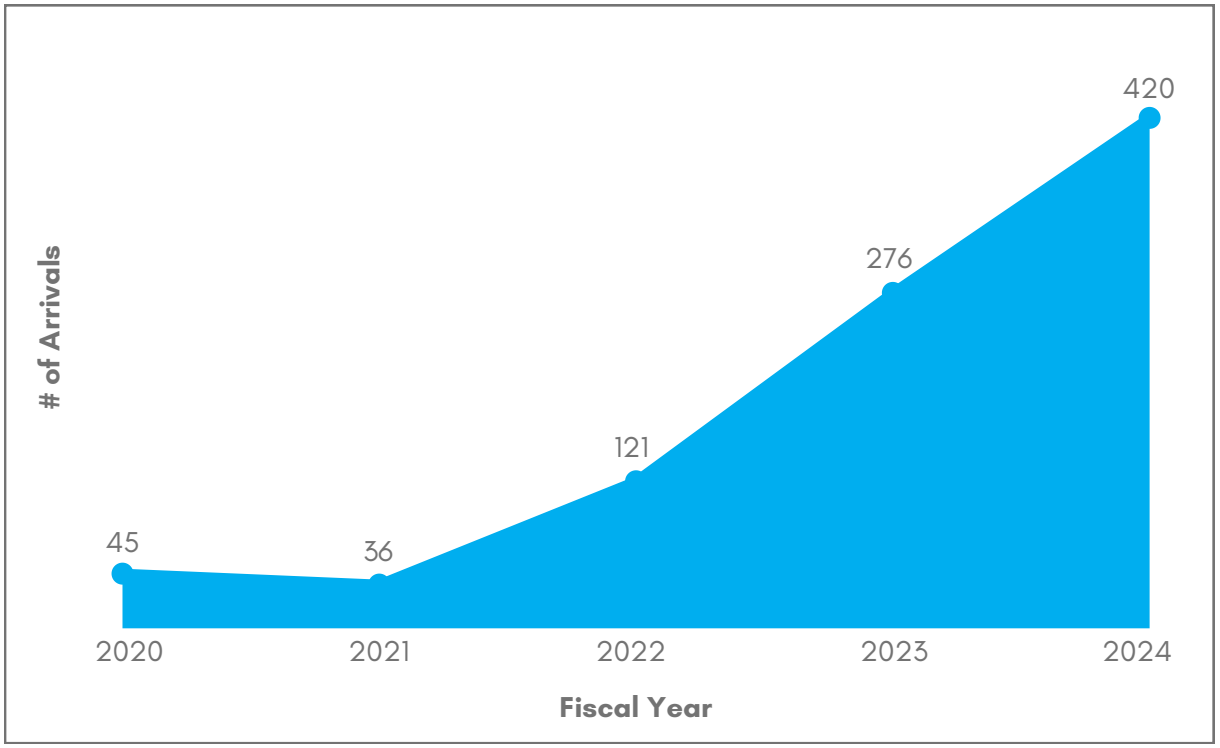
System Insights

The RSoC team analyzed data from OGM and the Supervisor Survey to better understand the number of eligible refugee children, the demographics of eligible refugee children, and the capacity of home visiting programs in the focus area to provide refugee-responsive services.

The arrival of refugee children aged 0-4 has increased significantly over the last 5 years. Figure 9 illustrates this trend. The number of arrivals of refugee children aged 0-4 increased by 833% over a 5-year period.

Figure 9

Number of Arrivals of Refugee Children Ages 0 - 4, FY20-FY24

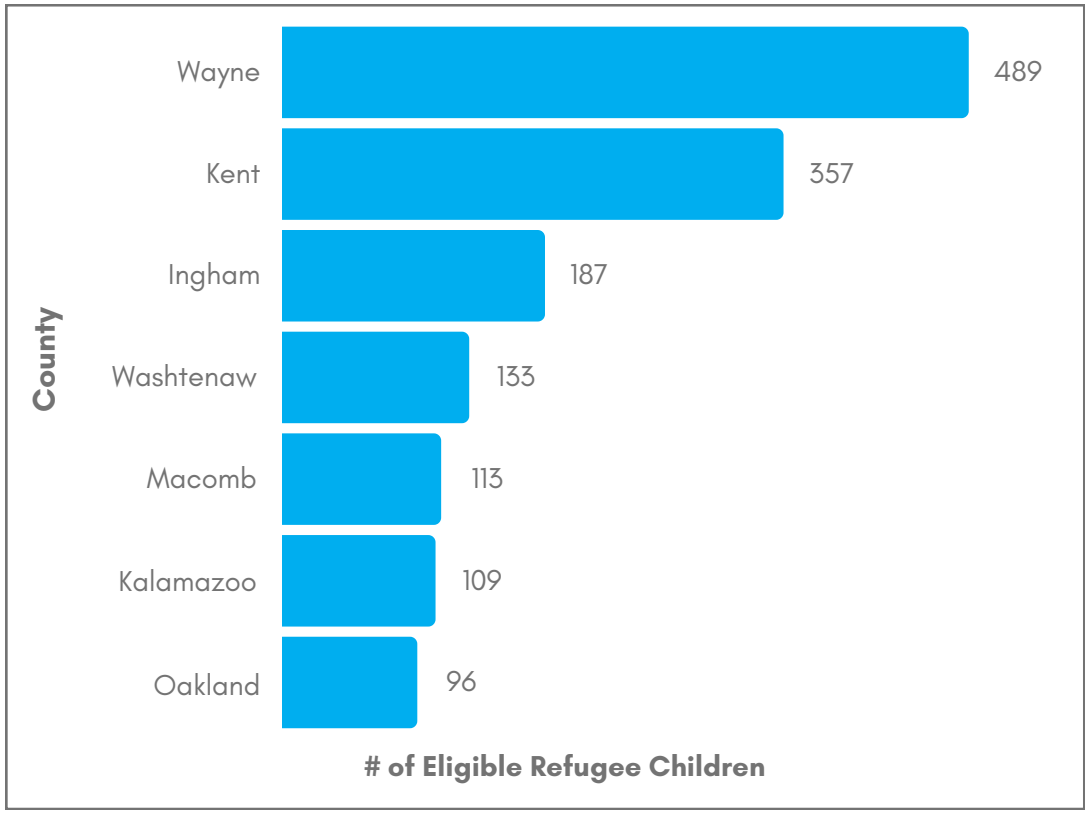


Data source: Worldwide Refugee Admissions Processing System (WRAPS), Refugee Processing Center

The number of arrivals provided information about general trends. In order to understand the distribution of home-visiting eligible children across the focus area, the RSoC team reviewed data from the OGM Data Management System. The State of Michigan and contracted providers of OGM use the Data Management System to track services provided to refugees in Michigan. This database provided the best available count of refugee children eligible for home visiting services in the focus area. Based on data from the Data Management System, there were 1,484 refugee children eligible for home visiting services in the focus area. In figure 10, the breakdown by county demonstrates the areas of highest need for refugee-responsive home visiting services in each of the focus counties. Wayne was the county with the largest number of eligible refugee children with 489, followed by Kent (357), Ingham (187), Washtenaw (133), Macomb (113), Kalamazoo (109), and Oakland (96).

Figure 10

Number of Eligible Refugee Children, FY 20-24 Total by County



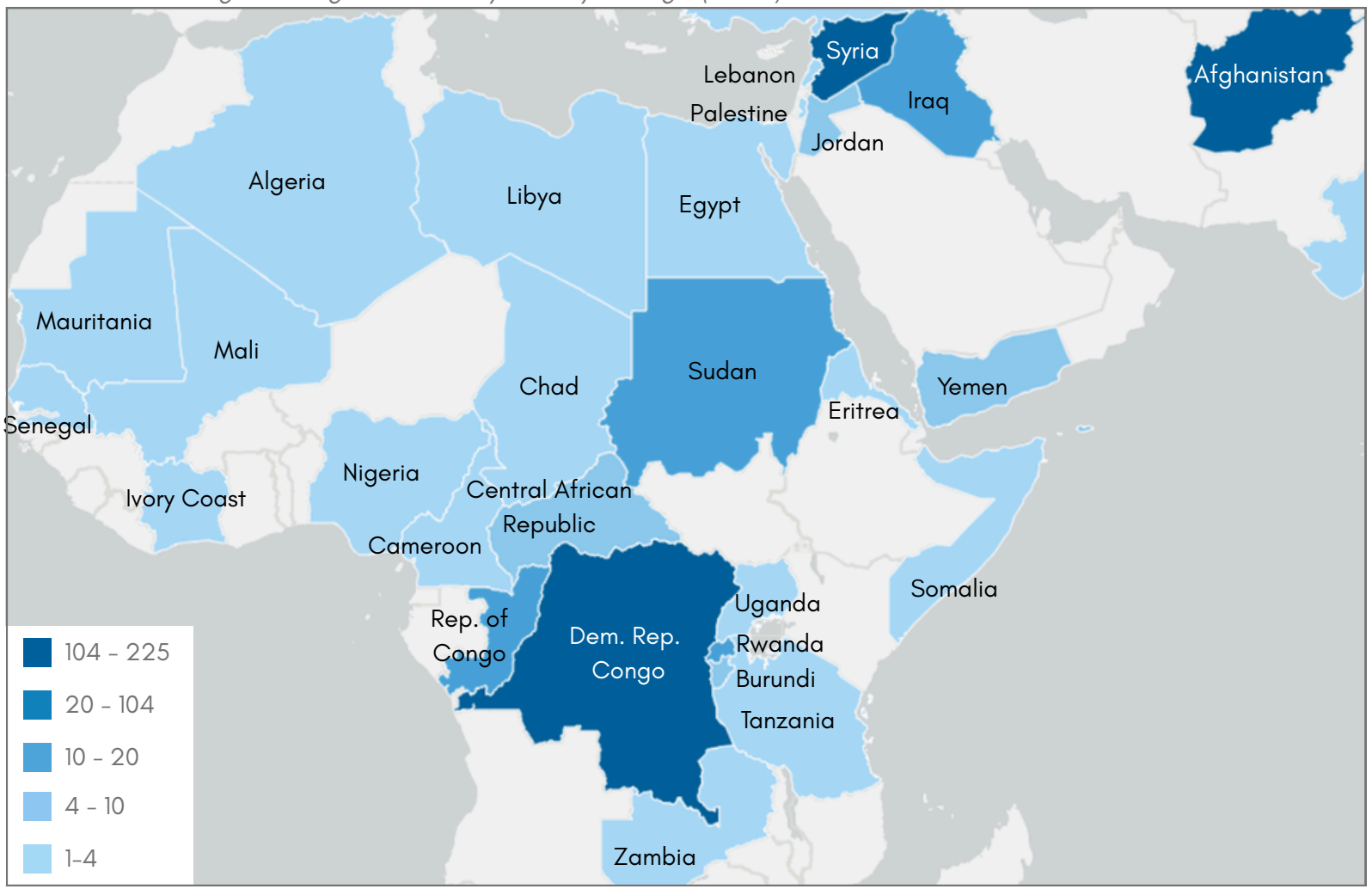
Note. n = 1,484. *Data source:* Office of Global Michigan Data Management System (DMS)

Additionally, the Data Management System provides important information about the demographics of refugee children in the focus area. One way to understand their cultural backgrounds is by examining the countries of origin of refugee children who received services from OGM contracted providers and the State of Michigan.

In Figures 11 through 14, the heat maps show the prominence of different countries of origin among home visiting-eligible refugee children. The countries shaded in dark blue are the areas of the highest need for cultural responsiveness. Lighter shades of blue indicate lower numbers of children served from a given country.

Figure 11

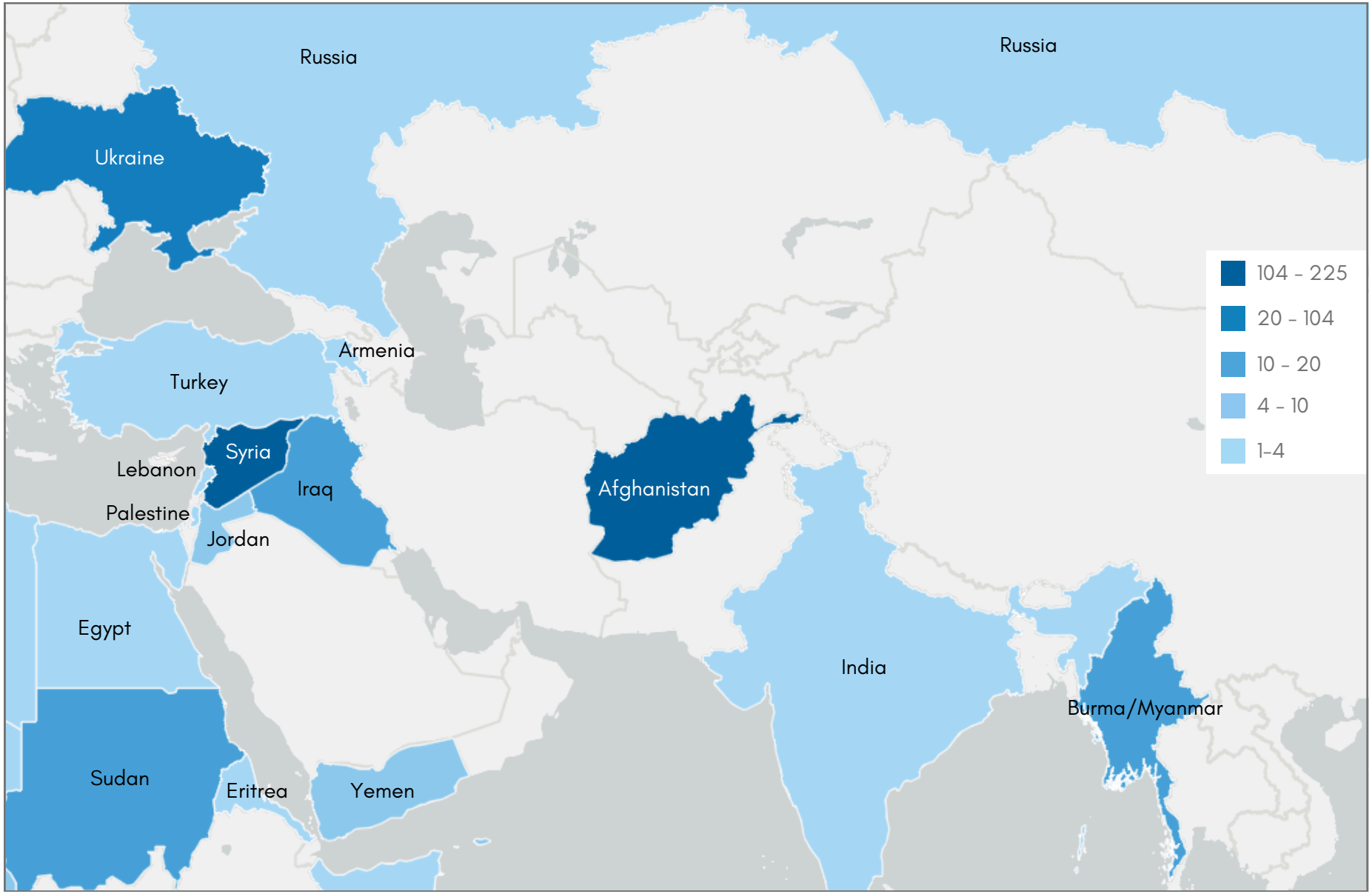
FY20-FY24 Total Eligible Refugee Children by Country of Origin (Africa)



Data source: Office of Global Michigan Data Management System (DMS)

Figure 12

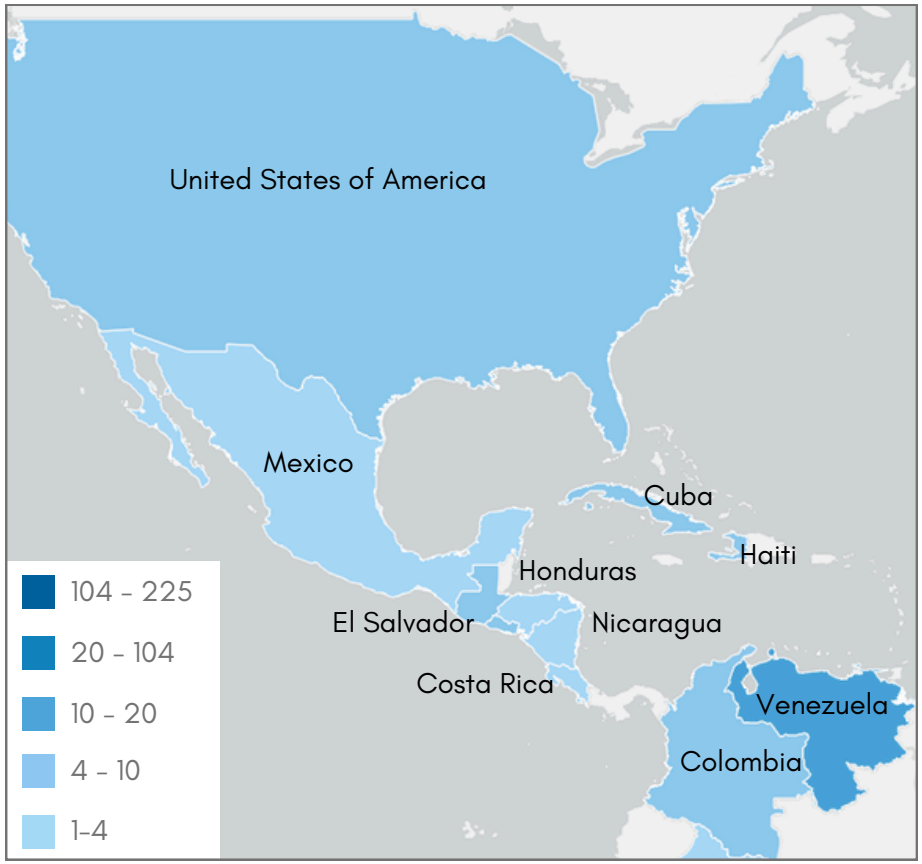
FY20-FY24 Total Eligible Refugee Children by Country of Origin (Asia & Middle East)



Data source: Office of Global Michigan Data Management System (DMS)

Figure 13

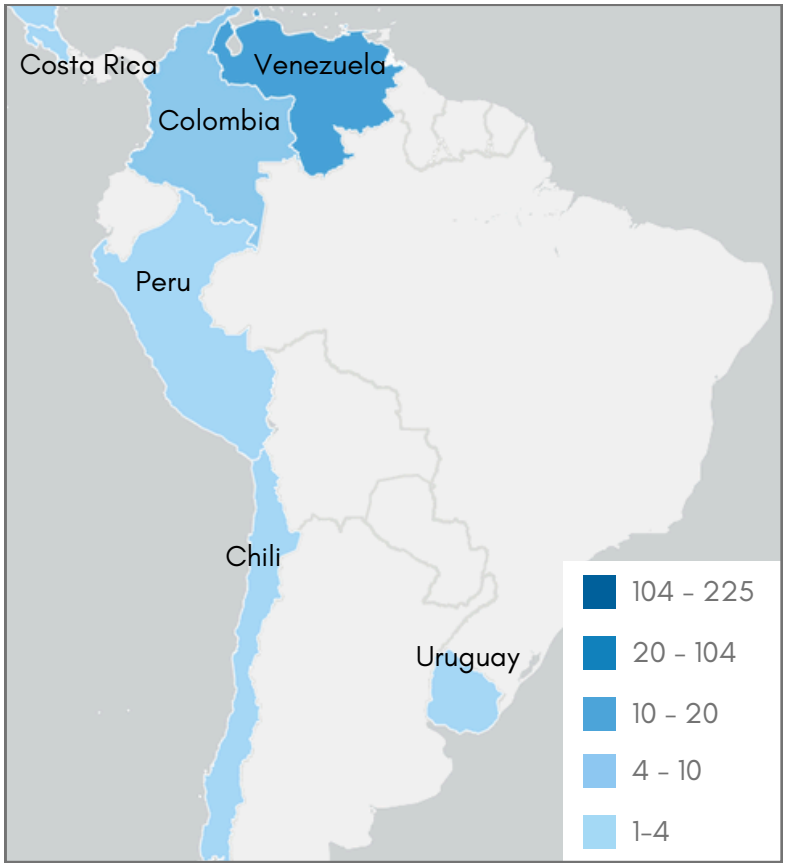
FY20-FY24 Total Eligible Refugee Children by Country of Origin (North & Central America)



Data source: Office of Global Michigan Data Management System (DMS)

Figure 14

FY20-FY24 Total Eligible Refugee Children by Country of Origin (South America)



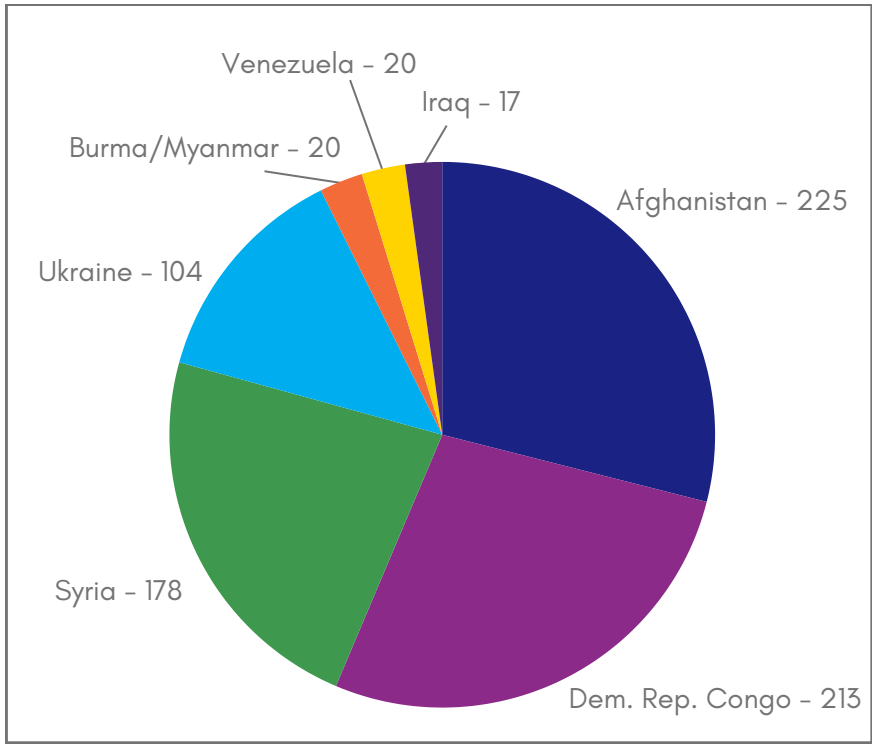
Data source: Office of Global Michigan Data Management System (DMS)

Figure 15 illustrates the distribution of countries of origin with the highest numbers of refugee children, including Afghanistan, Democratic Republic of the Congo, Syria, Ukraine, Burma/Myanmar, Venezuela, and Iraq.

To understand the linguistic background of refugee communities in Michigan, the RSoC team analyzed the arrival demographics for refugee households during the same time period. In Figure 16, the top spoken languages among refugee households in the focus area are shown, with Arabic (999 households), Kinyarwanda (438), Dari (247), Spanish (231), and Kiswahili (190) being the top 5 languages spoken.

Figure 15

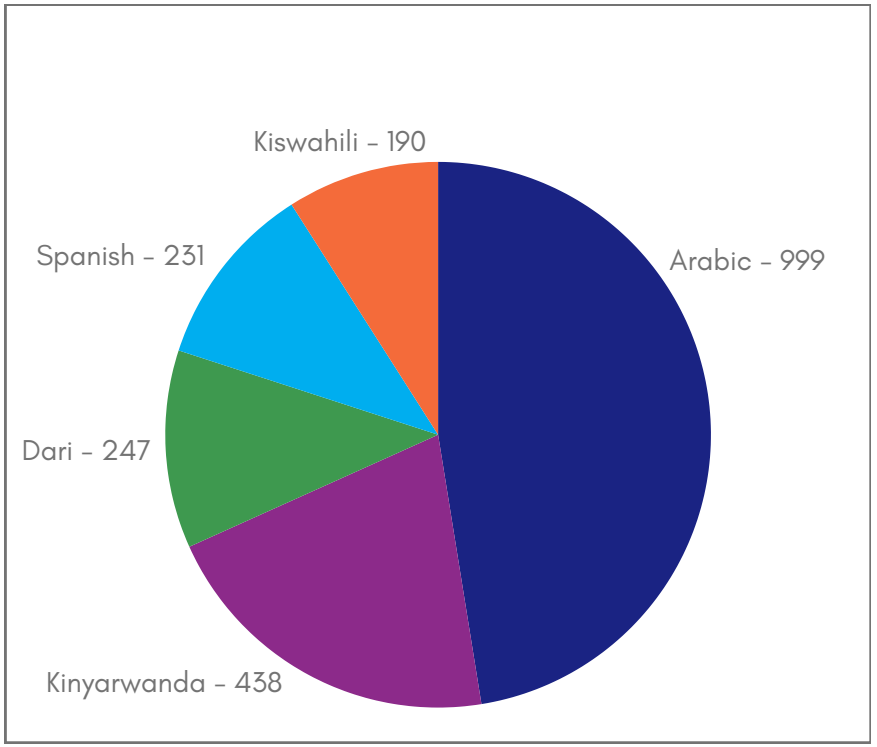
Top Countries of Origin, FY20-FY24 Total Eligible Refugee Children



Note. n = 1,484, top 7 countries of origin represent 52% total eligible children. Data source: Office of Global Michigan Data Management System (DMS)

Figure 16

Top Spoken Languages, All Refugee Households

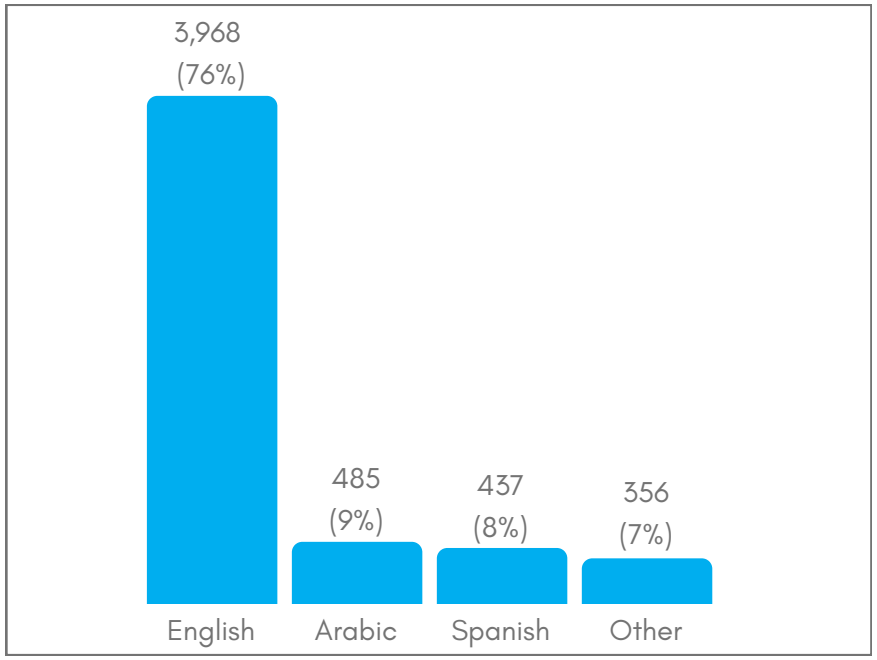


Note. n = 2,984, top 5 spoken languages represent 71% of languages spoken by all refugee households. Data source: Office of Global Michigan Data Management System (DMS)

While demographic information is limited across the broader home visiting system, the Maternal Infant Health Unit provided the RSoC team with aggregate demographic data on MIHP-enrolled mothers, including information on the language spoken and English proficiency. In FY24, MIHP served 5,246 maternal caregivers in the focus area. In this group, 3,968 (76%) spoke English as a primary language, followed by 485 for Arabic (9%), 437 for Spanish (8%), and 356 (7%) for speakers of other languages. Combined, 1,278 (24%) caregivers enrolled in MIHP in FY24 spoke a language other than English as a primary language. In Figure 17, the relative prominence of primary language of MIHP-enrolled caregivers is shown.

Figure 17

Primary Spoken Language of MIHP Clients in FY24

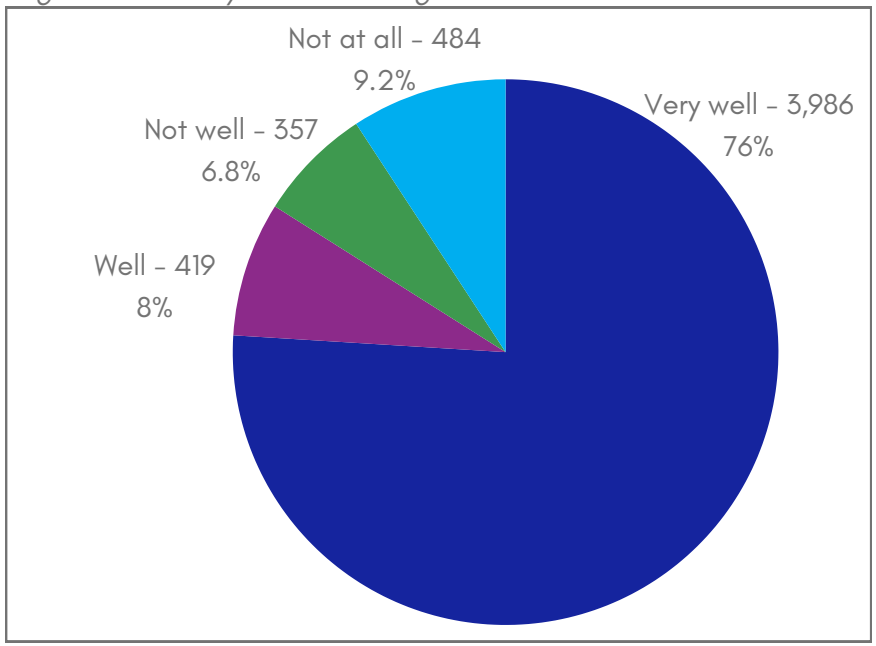


Note. n = 5,246

In addition, the Maternal Infant Health Unit provided information about the English fluency of MIHP-enrolled caregivers. The level of English proficiency is an important indicator to assess needs related to language access for enrolled clients. Language support is needed for caregivers who report speaking English 'not well' or 'not at all'. Among the 5,246 caregivers served in FY24, 3,986 caregivers (76%) reported speaking English 'very well', 419 caregivers (8%) reported speaking English 'well', 357 (7%) reported speaking English 'not well', and 484 (9%) reported speaking English 'not at all'. Figure 18 illustrates the breakdown of English proficiency for MIHP-enrolled caregivers. Based on FY24 data for MIHP-enrolled caregivers in the focus area, approximately 841 (16%) of enrolled clients required language assistance to effectively communicate with home visiting providers.

Figure 18

English Proficiency of MIHP Caregivers in FY24



Note. n = 5,246

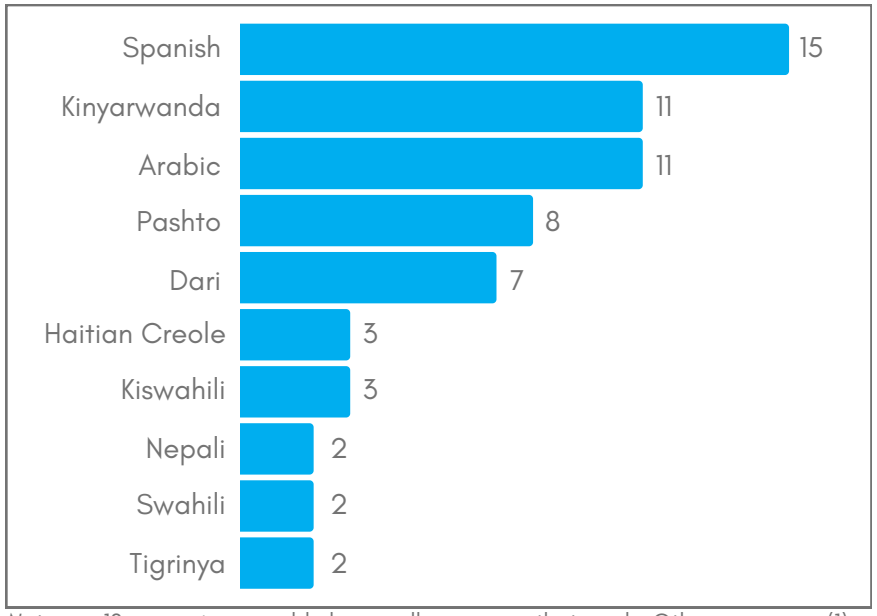
Program Insights

In the Supervisor Survey, 12 home visiting supervisors reported the number of refugee families their programs served in the past year. Responses ranged from 0 to 400 with a total of 697 refugee families reported to have been served in the last program year.

Eighteen (18) home visiting program leaders reported whether their program collects data on the spoken language and/or country of origin of families enrolled in their program. The most common response was that their program collects data on 'language spoken only' (11 or 61%), followed by 'both language spoken and country of origin' (5 or 27%), and finally 'neither' (2 or 11%).

Figure 19

Family Language Spoken, Home Visiting System



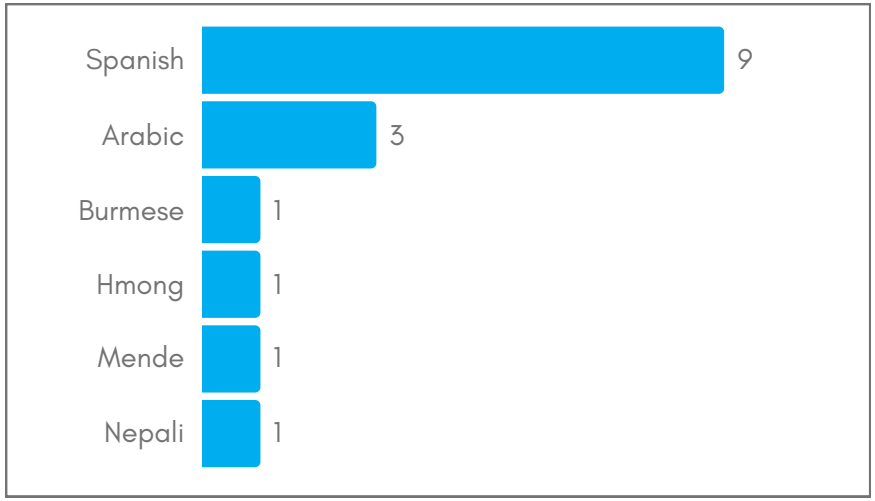
Note. n = 18, supervisors could choose all responses that apply, Other responses (1): Amharic, Bengali, Burmese, French, Karen, Kibembe, Kinyabwisha, Kinyamulenge, Portuguese, Sango, Urdu

These data suggest that there were a variety of data collection practices among home visiting programs. Many programs operated within models that did not require the collection of data on language spoken or country of origin, and in some cases, their data systems may not include fields for this information.

Home visiting programs leaders were asked about the languages spoken and countries of origin of their home visiting staff and families they serve. Figure 19 illustrates the most commonly spoken language among families served with 15 programs who serve Spanish-speaking families, followed by Kinyarwanda (11), and Arabic (11). Figure 20 shows the number of programs with staff who speak a given language, with Spanish (9) and Arabic (3) being the only languages with more than one program reporting staff members who speak those languages.

Figure 20

Staff Languages Spoken, Home Visiting System

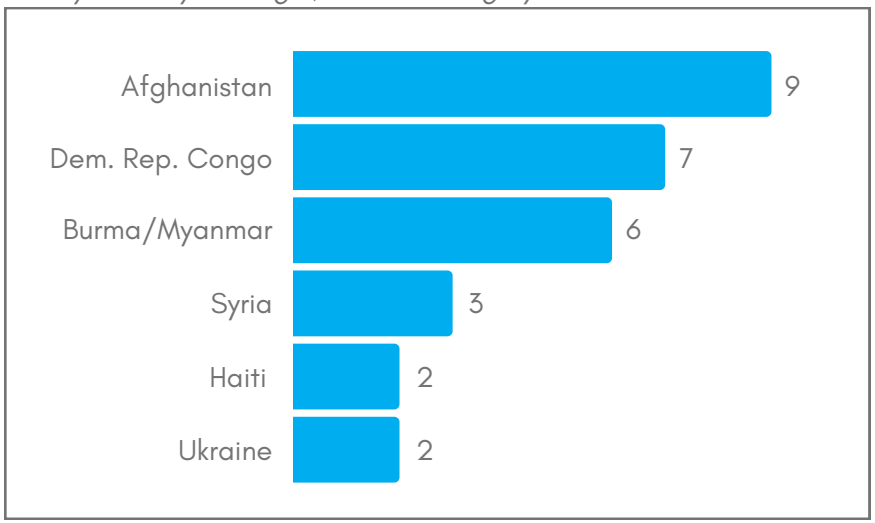


Note. n = 18, supervisors could choose all responses that apply.

Figures 21 and Figure 22 illustrate the countries of origin for both families served and home visiting staff. This data illustrates the number of programs who have at least one family or at least one staff member from a given country of origin.

Figure 21

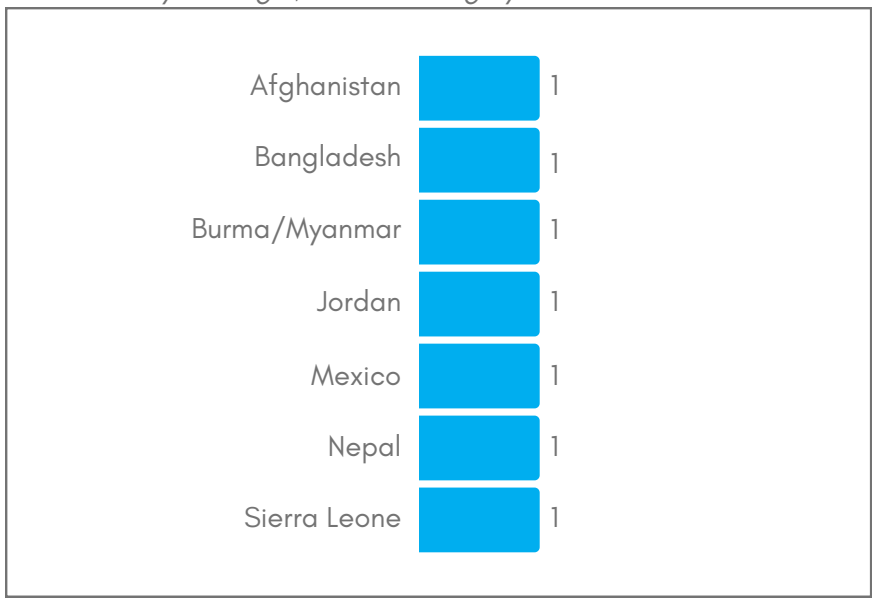
Family Country of Origin, Home Visiting System



Note. n = 18, supervisors could choose all responses that apply or none, other responses (1): Colombia, Cuba, Eritrea, Ethiopia, Guatemala, Honduras, Iraq, Jordan, Mexico, Nepal, Pakistan, Palestine, Rwanda, Sudan, Uganda, Yemen

Figure 22

Staff Country of Origin, Home Visiting System



Note. n = 18, supervisors could choose any responses that apply or none.



Home Visitor Insights

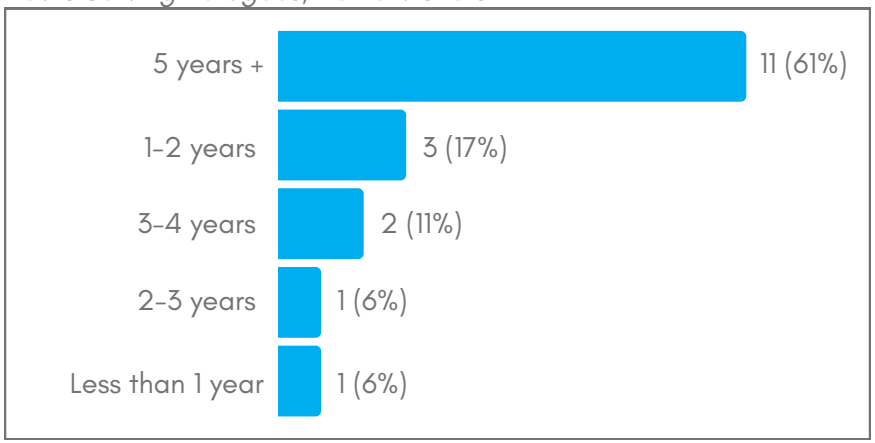
The home visitor survey and MHVI training evaluations provided important insights into the experiences and needs of home visiting professionals who provide direct services to families.

Home Visitor Survey

In the Home Visitor Survey, home visitors were asked how long they have been serving refugee families. Among the 18 survey respondents, 11 (61%) reported working with refugee families for more than 5 years. Figure 23 illustrates the years of experience among direct service workers.

Figure 23

Years Serving Refugees, Home Visitors



Note. n = 18

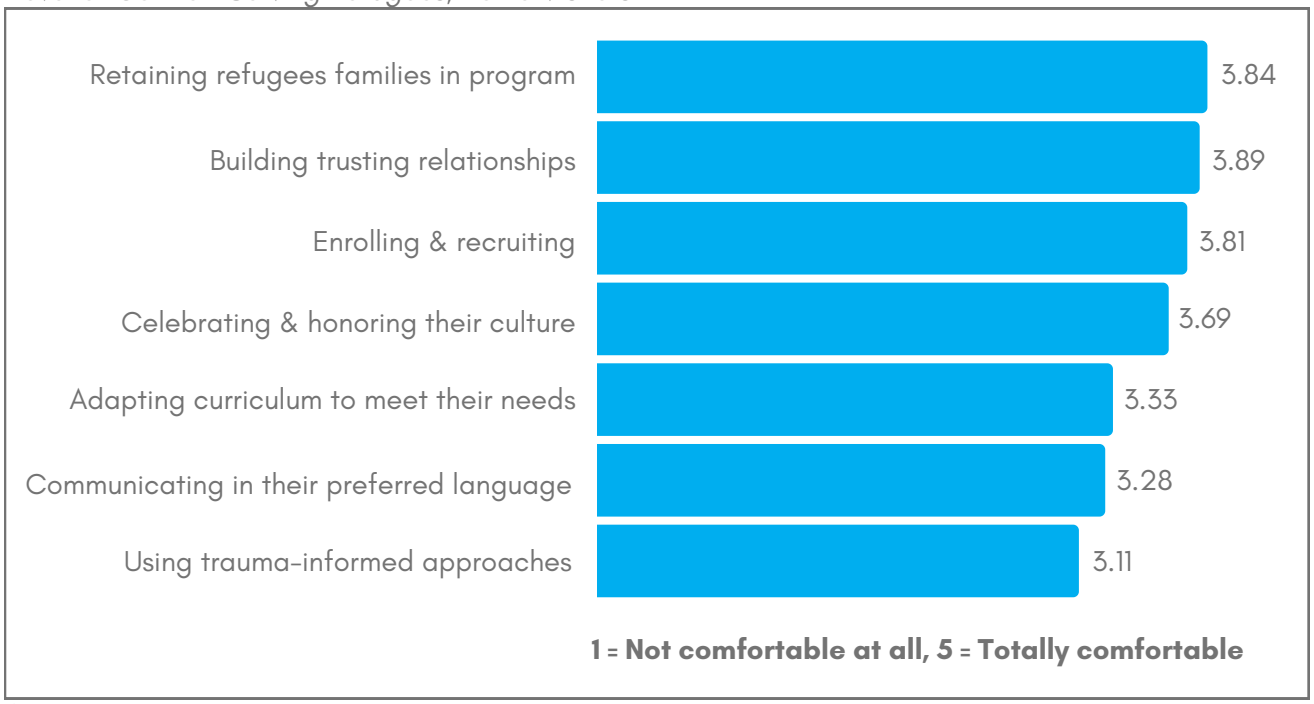


Most of the home visitors who responded to the survey had extensive experience serving refugee families, with 11 (61%) reporting 5 years or more. Only 1 home visitor (6%) reported less than 1 year of experience serving refugee families.

Home visitors were asked to rate their level of comfort, using a 5-point Likert scale with 5 being 'totally comfortable' and 1 being 'not comfortable at all', achieving goals with refugee families. Home visitors reported the highest level of comfort in their ability to retain refugee families in the program (3.94 out of 5), building trusting relationships (3.89 out of 5), and enrolling and recruiting refugee families (3.69 out of 5). The areas where home visitors reported the lowest level of comfort were using trauma-informed approaches (3.11 out of 5), communicating in their families' preferred languages (3.28 out of 5), and adapting curriculum to meet the needs of families (3.33 out of 5). Figure 24 illustrates the mean comfort level of direct service worker respondents in each of the categories.

Figure 24

Level of Comfort Serving Refugees, Home Visitors



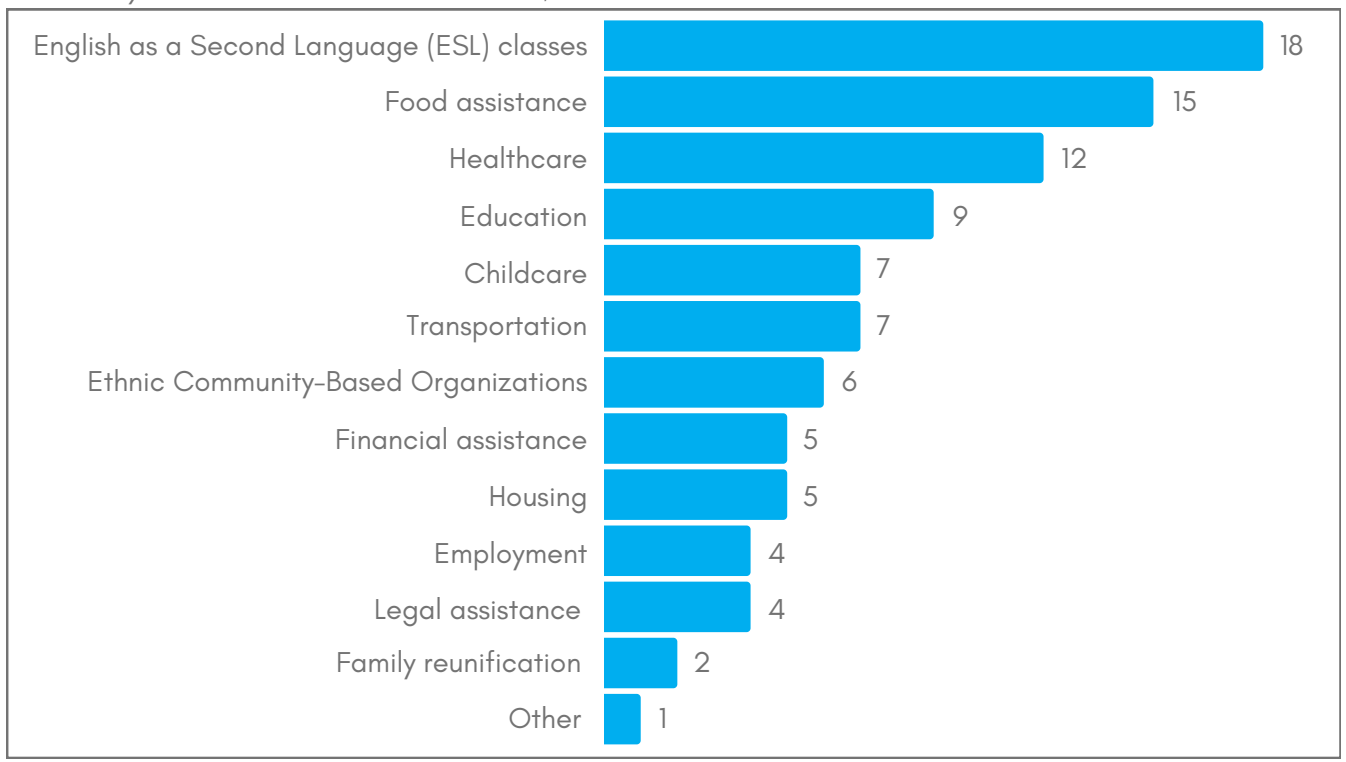
Note. n = 18

On average, home visitors reported moderate levels of comfort across all categories when working with refugee families, with every item averaging between 3.1 and 3.9 on a 5-point Likert scale. While they felt relatively more confident in areas like building trusting relationships, enrolling families, and supporting retention, these are still mid-range scores—indicating average rather than high levels of comfort. Lower ratings in areas such as trauma-informed approaches, communication in families' preferred languages, and curriculum adaptation suggested areas where home visitors may feel less prepared. It's important to note that these scores reflected perceived comfort rather than demonstrated effectiveness.

The survey asked home visitors to identify community resources in their area that have the capacity and skills to support refugee families across various referral needs. Participants could select all applicable resources, with a maximum of 18 responses per category (reflecting the 18 total survey participants). The most commonly available resources reported were English as a Second Language (ESL) classes, food assistance, and healthcare. In contrast, family reunification services, legal assistance, and employment support were reported as least available. Figure 25 includes a full breakdown of each resource and the number of respondents who identified them as available in their communities.

Figure 25

Community Resources Available to Families, Home Visitors



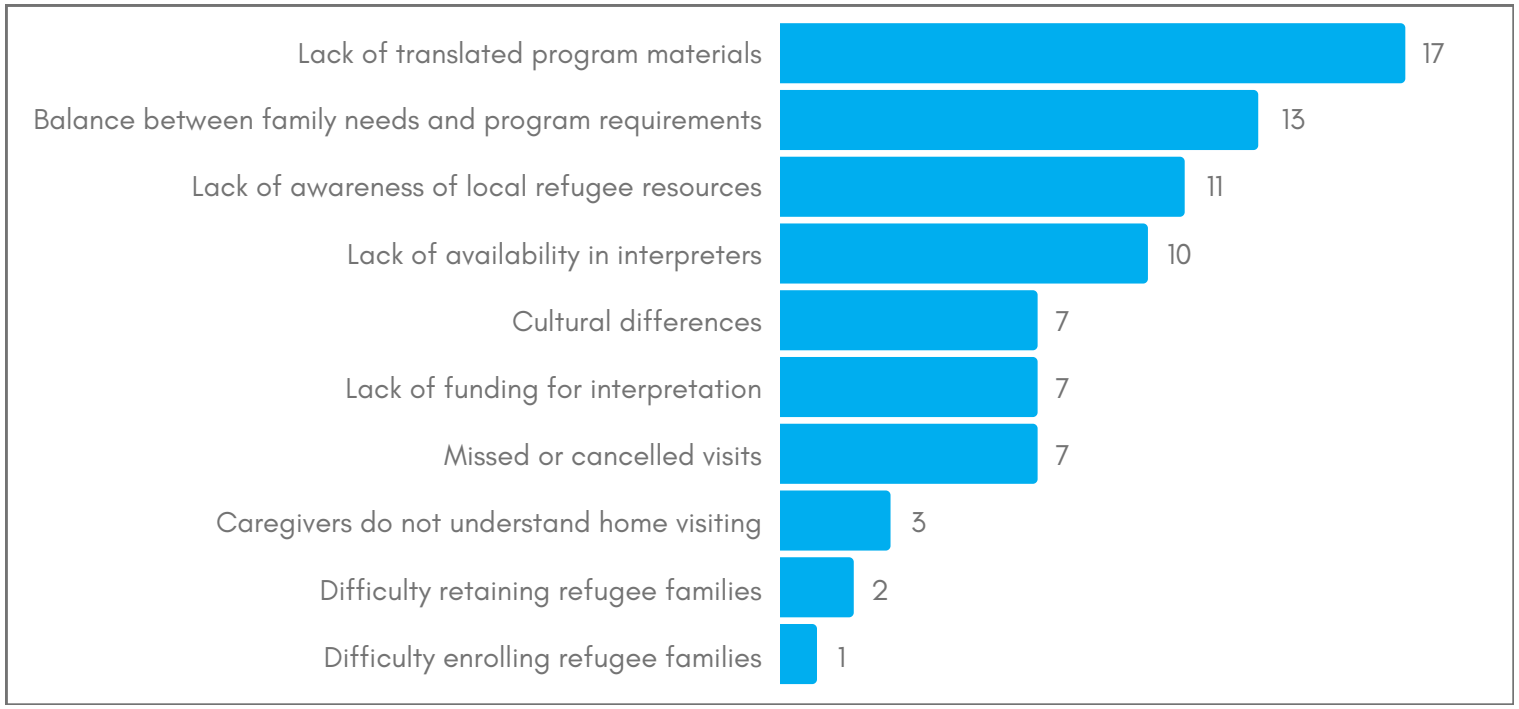
Note. n = 18, home visitors could choose all that apply or none. "Other" included employment, education, and legal assistance if parents had some English or interpreter support.

The resource availability data highlighted both strengths and gaps in the community infrastructure supporting refugee families. All home visitors (18 out of 18) reported that English as a Second Language (ESL) classes are available in their communities. Food assistance and healthcare services were also frequently reported as being available. In contrast, supports such as family reunification, legal assistance, and employment services were identified less often. Other supports, such as education, childcare, and transportation, were reported with moderate frequency.

The survey asked home visitors to identify the barriers and challenges they encounter when working with refugee families. Participants could select all that apply, with a maximum of 18 responses per category. The most frequently reported barriers included lack of translated program materials, difficulty balancing family needs with program requirements, and limited awareness of local refugee-specific resources. Figure 26 below illustrates the full range of challenges identified by survey respondents.

Figure 26

Barriers & Challenges to Serving Refugees, Home Visitors



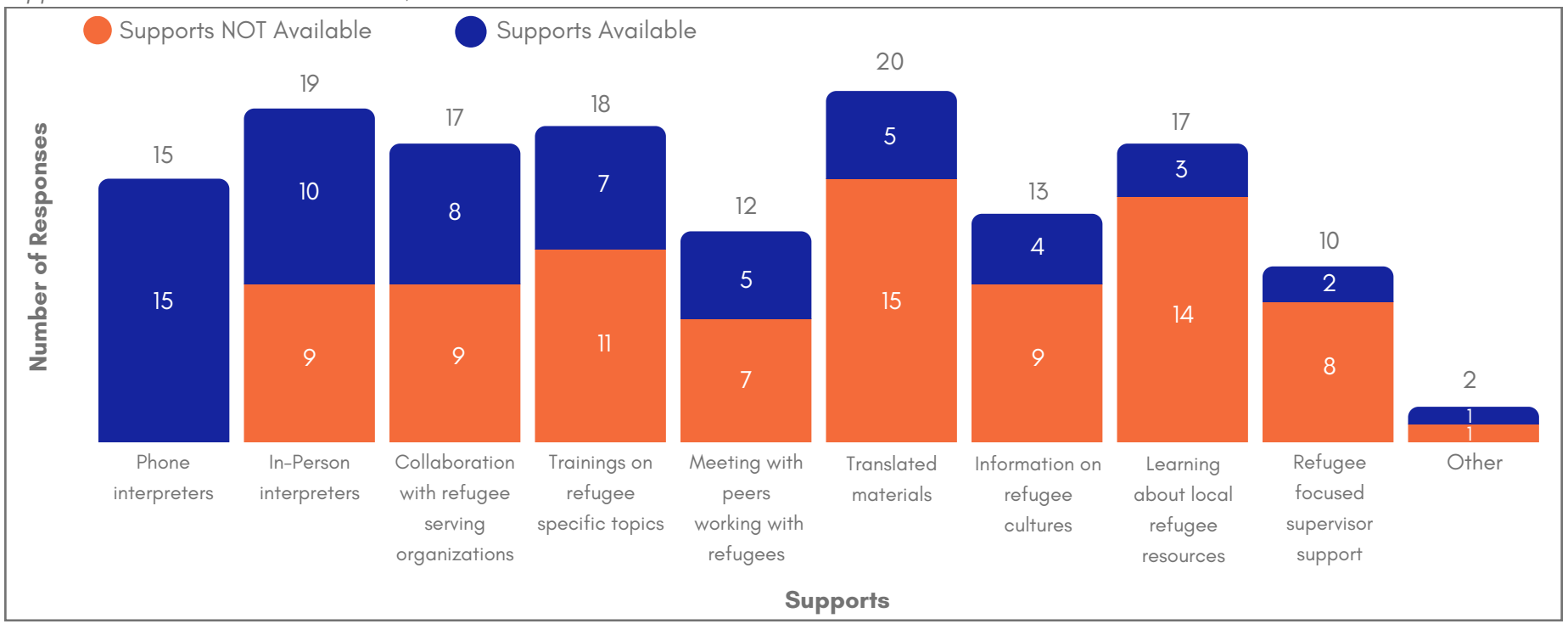
Note. n = 18, home visitors could choose all that apply or none.

Home visitors reported relatively few challenges with enrolling and retaining refugee families. However, several challenges impact the delivery of services. The most frequently reported challenge was the lack of translated program materials. Similarly, the availability of interpreters and funding for interpretation were also identified as challenges. Home visitors also noted difficulty balancing family needs with program requirements.

The survey asked home visitors to identify which supports their programs currently provide to assist in serving refugee families, as well as which supports are NOT currently available. Each of the 18 participants could respond to both questions. In some cases, respondents reported that a support was both available and NOT available. In Figure 27, the most prominent support available to home visitors was phone interpretation, with 15 out of 18 (83%) respondents reporting it was available and no respondents reporting that is was NOT available. In-person interpretation is available to 10 out of 18 (56%) respondents and NOT available to 9 out of 18 (50%). The most frequently reported support gaps include access to translated materials (83% NOT available), opportunities to learn about local refugee resources (78% NOT available), and training on refugee-specific topics (61% NOT available).

Figure 27

Supports Available and NOT Available, Home Visitors



Note. n = 18, home visitors could choose all that apply or none, in some cases home visitors selected both available and NOT available for the same support

Overall, these findings highlighted clear opportunities to strengthen the infrastructure of refugee-responsive home visiting. Interpretation and emerging training efforts are strengths to build upon. Additionally, focus should be given to addressing key gaps in translated materials, cultural knowledge, and supervisory support to ensure that home visitors are equipped to serve refugee families with confidence and consistency.



MHVI Training Evaluation Data

Survey data from the 2024 Michigan Home Visiting Initiative (MHVI) conference and FY24 training opportunities offered valuable insight into the professional development needs of home visiting professionals serving refugee families.

MHVI provided statewide professional development opportunities for home visiting professionals coordinated by CQFS during FY24, including 6 training offerings and the MHVI Conference. These events were attended by 952 unique participants from 250 organizations across Michigan. Post-training evaluations asked participants to suggest future training topics. The RSoC team found that 32 of the 48 requests (67%) for training related to Cultural and Linguistic Responsiveness were specific to serving immigrant and refugee families, including topics such as:

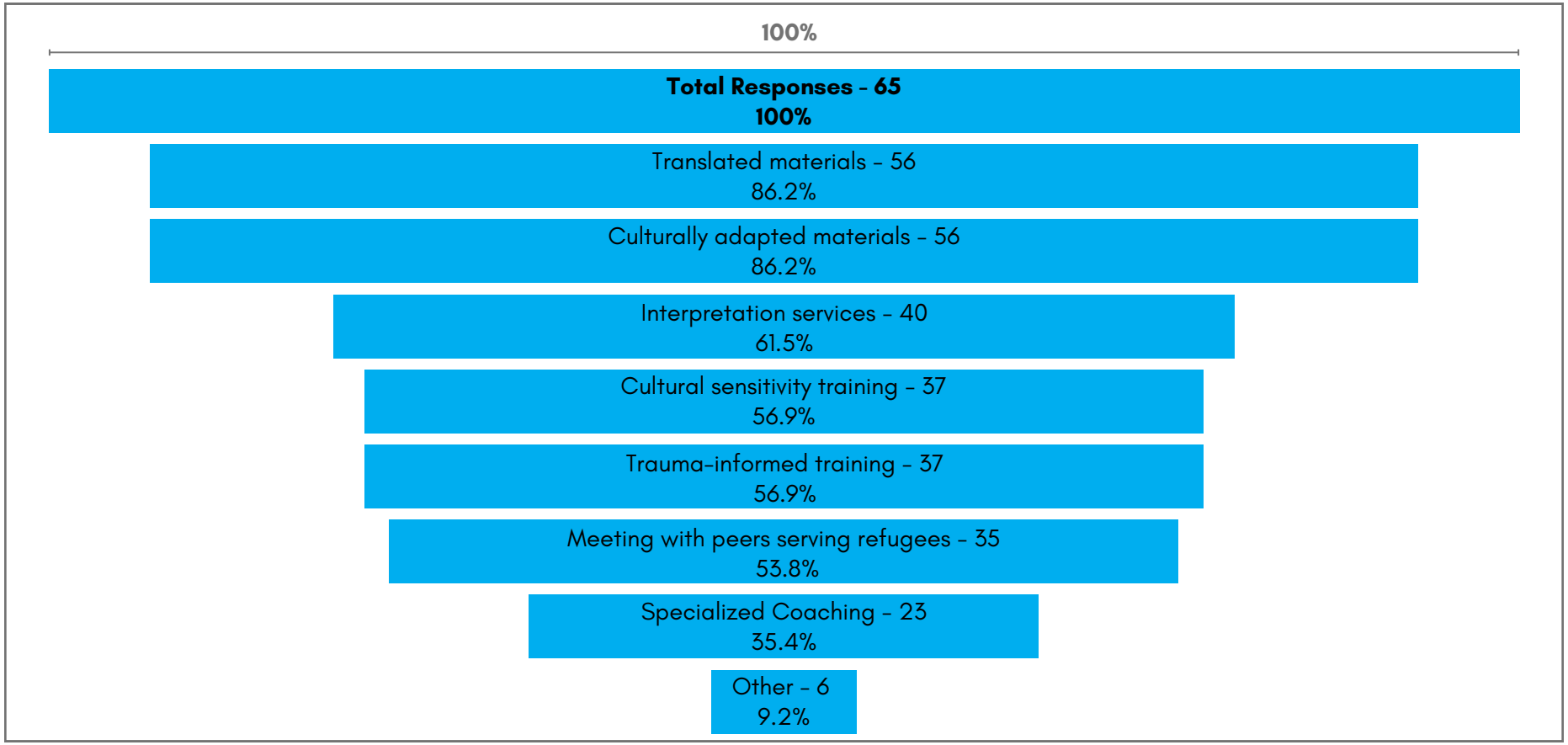
- Supporting immigrant/refugee families through home visiting
- Bridging language gaps when you don't have an on-site interpreter
- Hear from a panel of refugees who received home visiting and what was helpful and not helpful to them in the process
- How to assist families in completing applications for a green card
- How to assist families with immigration services
- Working with undocumented families
- Refugee mental health & substance use (how to bring it up, how to assist them to learn about it, how to help them recognize signs/symptoms)
- Supporting refugee families with safety (safe sleep, gun safety, mental and physical safety, etc.)
- Cultural consciousness

These requests signaled a strong need for more training and support the home visiting field in developing knowledge and skills related cultural sensitivity, language access, mental health, and immigration services. The fact that these themes emerged organically across statewide professional development opportunities reinforces the findings in the focus area and underscore the broader need for training across the home visiting system.

During the 2024 MHVI conference, the RSoC team surveyed attendees at the Serving Refugee Families Through Home Visiting session. The survey asked attendees to identify supports that would be most helpful in their work with refugee families. Respondents could select multiple options, with the most commonly identified needs shown in Figure 28.

Figure 28

Most Helpful Home Visiting Supports for Serving Refugee Families



Note. n = 65

The open-ended responses in the "Other" category further reinforced the need for culturally responsive services and systemic support. These included:

- "Improving services and coordination with resettlement agencies"
- "Access to mental health services and culturally specific support groups, especially for women"
- "Hiring staff with lived refugee experience to increase representation"
- "Ensuring consistent interpretation services, including languages such as Haitian Creole"
- "Building stronger connections with community-based organizations that specialize in working with refugee populations"

These responses highlighted that in addition to practical tools like translated materials and interpretation, home visiting professionals need cross-sector collaboration and cultural responsiveness to respond to the needs of refugee families. Together, these insights provided valuable direction for training, capacity development, and cross-sector partnerships within the Michigan home visiting system.

Key Themes from Interviews and Focus Groups

Several key themes emerged in the qualitative analysis of the focus groups with home visiting professionals and interviews with refugee families. This section describes the successes, challenges, and barriers described by home visiting professionals and refugee families enrolled in home visiting services in 6 important categories.

Language & Communication

Successes

Many home visiting staff highlighted effective strategies and helpful resources that support their work with refugee families. Only a few focus group participants shared that their program has access to in-person interpretation services during home visits. These participants shared how beneficial it is compared to using over-the-phone interpreters. One participant shared:

> *"We're able to take real [in-person] interpreters with us when we go, and I feel like that's super valuable. And I have used a phone interpreter, they just miss so much of the context of being in the home visit or you know, a nonverbal cue, things like that. So being able to have a real interpreter, especially because many of the medical practices now don't have that option, it's a really, really nice thing that we're able to offer our clients."*

When in-person interpreters are not available, home visiting staff shared strategies that help when using over-the-phone interpretation, such as working with the same interpreter when possible. A few staff also shared that having staff that speak the same language as their families is even better for both the home visiting program and ability to serve these families:

> *"I think the greatest strength that we found this year is having a nurse that looks like and speaks the same language as the families. We've had Spanish speaking nurses for a long time, but this year we have an Arabic speaking nurse and she's also Muslim and she, you know, wears a hijab and all of that. And we've had a huge influx in being able to service the Muslim Arabic speaking population because they trust her..."*

Additionally, home visiting staff highlighted successful strategies when it comes to translating materials for their families. Several participants emphasized how creating materials with more visuals can help share information with their non-English speaking families and helps to counteract literacy challenges. Home visiting staff also provided ways they have been able to locate translated materials through their local health department, as well as identifying translated resources on their own that they can share with families:

> *"Our health department has a lot of educational materials in different languages. And that's been helpful when explaining things like hypertension or preeclampsia and pregnancy and things like that. And then if something's not available in their language, I just try to find something that is. For instance, like lead testing. That's always kind of confusing to explain in plain language, so I have found like a resource that I just use when they don't know what it is and just use that as a handout to try to explain it."*

During interviews, refugee families provided insights into the availability of translated materials, the importance of interpretation services, and how these language services impacted their experiences in home visiting. All three families who participated in interviews spoke Spanish, received services from a Spanish-speaking home visitor, and received additional home visiting services from a home visitor with the assistance of an in-person interpreter. They noted that not having to rely on interpretation services made the process easier and helped build trust with their Spanish-speaking home visitor. One family shared:

> *"There is a certain closeness to a person that speaks Spanish and explains something in my own language and I can understand. I feel closer to the person."*

The other two families shared that when in-person interpreters are used during visits, having the same person every time helps them to build trust:

> *"I feel it's better to bring the same interpreter every time because we can establish a relationship and I can trust the interpreter too."*

One parent also shared about how a consistent, trusting relationship with the home visitor is more important to them than the interpretation service itself:

> *"It's not about the interpreter that I don't feel fully connected to [the English-speaking nurse home visitor], it's not always the same person. I have two nurses that rotate. Sometimes it's more about the relationship with the person."*

Regarding access to translated materials, families shared that their home visitor brings them materials in Spanish, in addition to connecting them with community resources that are available in Spanish.

Challenges

The most common challenge shared among focus group participants was related to the limitations of over-the-phone interpretation services that are often the only option for home visitors to use during visits with refugee families. Some of the challenges with over-the-phone interpretation services include long waiting times to get connected with a translator, lack of availability of interpreters in some languages, and the hinderance it causes to home visit activities. Focus group participants described how communicating with their families during visits using a third-party who is on the phone can get in the way of developing a strong relationship with their families and increases the time it takes to have conversations

and accomplish tasks. One focus group participant shared,

> *"There's a long wait time, and that's kind of cutting into your time at the visit. Plus, just technical difficulties like getting disconnected and things like that, not hearing them and just some things getting lost in translation a little bit with the language barrier. That can be difficult."*

Beyond logistics, some home visitors expressed concern when the interpreter wasn't a good fit for the family. This was especially a challenge in cases where the interpreter knew the family personally, creating a conflict of interest. Others noted that families appeared to "connect more with the interpreter" than the home visitor, which could impact relationship building. Additionally, participants shared concerns about how some information discussed during home visits is specialized or complicated (e.g., medical or health-related information). These participants shared how they have encountered scenarios where the interpreter was unable to translate certain information accurately, further supporting the argument for high quality interpreters.

Another barrier home visiting programs reported is the cost of interpretation. Focus group participants shared how there is a lack of funding available for their program to pay for high quality interpretation services for their visits and translation of materials and resources for their non-English speaking families. Several focus group participants noted the expense of reimbursing for interpretation services:

> *"It is really expensive and kind of clunky. It is hard to use and get reimbursed for, it probably takes 75% of a home visitor's reimbursement to go to an interpreter."*

Finally, participants reported a persistent lack of translated materials in languages beyond English and Spanish. Even when materials were available, several home visitors pointed out that some families may not be literate in their primary language, further complicating communication and understanding during visits.

Building Trusting Relationships & Partnerships

Successes

Focus group participants shared several key successes in their work with refugee families. Many home visitors noted that refugee families are highly engaged in services and rarely missed scheduled visits. In addition to this engagement, home visitors expressed how refugee families consistently demonstrate warmth and hospitality. One home visitor shared:

> *"I feel like our engagement with our refugee families is probably better than any other population that we work with because the things that we do are really helpful to them."*

Home visitors reflected on the cultural significance of food, explaining that in many refugee communities, sharing meals with guests is a way to build comfort and trust. This practice often became a natural and appreciated part of home visits.

A common theme was the reciprocal learning that occurred between home visitors and families. Home visitors described how meaningful it was to learn about their families' cultures and perspectives:

"One thing that I love about working with refugee families is just learning about their culture. And you know differences and how they're acclimating to American culture, what they think is weird. And just yeah, just it's a, it's a great learning experience. You know, I come with something to share, but I also take more with me that I find to be very rich from the time that I'm able to spend with the family."

Interview data from refugee families echoed these successes, emphasizing the value of a supportive and empathetic relationship with their home visitor. All three families interviewed described feeling comfortable discussing personal matters with their home visitor, which helped build strong bonds of trust. When home visitors listened with empathy and without judgment—and followed up with consistent support and helpful resources—families reported feeling deeply connected and supported. Here is how families described their relationship with their home visitor:

"I've been so open with her, we talk about absolutely everything, we've covered every topic."

"I don't talk about my problems with my family, but I feel comfortable talking to [my home visitor] about it."

"I feel I could trust her from the beginning, she is a very good listener and she is important to me...Sometimes it feels like I've known her forever."

Challenges

While strong relationships are key to successful home visiting, building those connections with refugee families may come with unique challenges. Home visitors reported that refugee families often face more immediate and complex basic needs, such as housing, employment, or healthcare access, compared to non-refugee families. These pressing concerns can take precedence over home visiting activities and make consistent engagement more difficult to sustain. Additionally, participants share cultural differences also present challenges, particularly when the content of home visiting activities does not align with the traditions or expectations of some refugee families. Topics such as safe sleep, discipline, or even the concept of play may be entirely new or culturally unfamiliar, requiring home visitors to thoughtfully navigate these differences to maintain trust and relevance. Home visitors described their approaches to addressing cultural differences with sensitivity and respect. Rather than immediately presenting educational materials, many home visitors begin by asking open-ended questions to learn more about their families' beliefs and practices. One home visitor explained:

"If I was going to talk to a family about safe sleep, you don't go in and just start talking about this is what safe sleep is like, you just kind of ask the family because there's a lot of cultural considerations for that. So, you know, we just ask more open-ended questions like, what is sleep like for your child?"

Other focus group participants echoed this approach, emphasizing how open-ended questions serve not only to gather information but also to foster trust.

Cultural Adaptation & Sensitivity

Successes

A recurring theme in the focus group discussions centered around the importance of learning about each family's background and culture. Participants described how understanding the country and culture from which a family comes not only improves communication but also helps home visitors better connect with the families they serve. One participant emphasized the value of meeting families where they are, taking the time to understand their experiences before jumping in with their own information or assumptions:

> *"Walking into their home for the first time and finding out a little bit about their background, their story. Before I just jump in with my information and assumptions about what they need. Yeah, I think that is probably the biggest thing, it's finding out what they already know and then I can help them take that next step, I guess."*

A common theme in focus group conversations was about navigating situations where cultural differences make certain topics or activities more difficult. Home visiting staff and supervisors shared examples of how they have served families that approach topics such as parenting, medical care, reproductive health, mental health, and child development differently from cultural norms in the United States. These cultural differences can create misalignments between the services provided and the family's practices. Focus group participants shared how they have adjusted to these differences by asking questions to learn about their families' preferences and perspectives, taking time to ensure safety and confidentiality to build trust, and providing tailored information and recommendations to best meet the needs of their families while still providing high quality services and recommendations.

Interviews with families further highlighted the positive outcomes of these culturally sensitive practices. Families expressed appreciation for their home visitors' efforts to educate them on local norms while still respecting and honoring their own cultural practices. Families shared the following when asked about how their home visitor honors their cultural practices:

> *"I've had a good experience. And if I'm not comfortable, we just talk about it and the discomfort goes away. They're so professional."*

> *"Coming from my culture, we have things that are part of our identity that are maybe not best to continue here and they've helped me with that."*

> *"They give me the option of doing something different if I want to, or keep [my traditions] the same."*

Challenges

While some home visitors already take it upon themselves to learn about the cultures of the families they serve, participants shared a strong desire for more training on cultural dimensions of care. Focus group participants expressed interest in gaining a deeper understanding of the cultural backgrounds of refugee families. Many participants expressed that structured, group training opportunities would enhance their ability to connect and serve effectively. Similarly, there was a call for more training on trauma-informed care. Home visitors shared their need for additional tools and strategies to address these complex needs and provide more compassionate, informed support to refugee families.

When asking home visitors about adjustments they made in their collaboration with refugee families, one of the final aspects shared during focus groups was the amount of flexibility needed in approaching sensitive topics with families. Cultural differences often play a significant role in shaping how these topics are received, and home visitors must be patient and understanding when navigating these conversations. Subjects such as mental health, reproductive health, and intimate partner violence require culturally sensitive approaches. As a result, home visitors often wait until a trusting relationship has been established before broaching these subjects. They also emphasize providing educational information in a non-judgmental manner and asking questions to better understand the family's perspective. One focus group participant shared,

> *"Maybe I need to take a step back and think if it's not part of their culture, to get down on the floor and play with their child; It's not that they don't care, it's that they don't know."*

In addition to navigating sensitive topics, another common challenge noted by focus group participants was the gap in culturally relevant materials. Many of the activities, topics, and assessments used by home visitors are not tailored to the unique needs of refugee families. This included safety-related topics such as safe sleep practices, which may vary across cultures and require thoughtful, respectful discussion. One home visitor focus group participant pointed out how these cultural differences can lead to discrepancies or inaccuracies in data and assessments:

> *"It's like lot of ASQ like assessments or any safe sleep. You know, it's really not necessarily culturally compatible and that's really frustrating to me…Yes, we might not do all these activities with our children because we don't have that or culturally we do something different, that doesn't mean we are not engaged. So, that can be challenging. Whether you're taking the test for yourself or whether you're interpreting because I am directly asking the question as it states, but I know even though their answer is going to be no, that doesn't mean they're not involved."*

Navigating Systems & Resources

Successes

During focus groups, home visiting staff shared how they support refugee families in navigating complex systems and connecting with community resources. Focus group conversations emphasized that while refugee families often prefer to receive visits in their homes, helping them connect with broader community networks—such as refugee service agencies, libraries, parks, and playgroups—can improve their wellbeing and sense of belonging. Home visitors described these connections as critical steppingstones in building trust and encouraging community engagement.

During interviews, families shared many supports and systems that their home visitors helped them to navigate and access including Medicaid, WIC, food stamps, career fairs, Early On, and basic needs support, such as clothing, diapers, and car seats. One family shared:

> *"I tell her I have a need, and she will look for something in the community to help with the problem. She will call and set up an appointment."*

Furthermore, families shared how important it was for them to have their home visitor there to help with scheduling appointments and educating them about how various systems work, including accessing health care:

> *"She helped with everything, understanding the system, referrals, and orientation during pregnancy and after."*

> *"It was wonderful to have an organization help [us who are] new in the area going through pregnancy and not understanding the systems, I thought that was wonderful."*

Challenges

Despite the many successes in supporting refugee families, focus group participants highlighted ongoing challenges in meeting the complex and varied needs of these families. Participants reported that refugee families face significant challenges accessing healthcare, transportation, and housing. Home visitors noted that although they make referrals and assist families in navigating these systems, they often encounter gaps in services that leave families' needs unmet. Focus group participants noted that many gaps remain in community services and supports for refugee families. One focus group participant described the secondhand stress that home visitors experience when they are unable to support their families' needs:

> *"With me as a nurse trying to focus on health related things, [health topics] are not always like the forefront in their mind. They're more focused on getting established in this country and really in need of things that are beyond my own wheelhouse. So sometimes it feels a little helpless for me as a nurse, just not able to answer all those questions as far as like citizenship and things like that. So, I try my best to connect them to other resources, but that's definitely something that comes up a lot."*

Participants identified the lack of language-accessible community resources and services as a significant challenge. They noted that even when services are available, language barriers often make them inaccessible to refugee families. Home visitors reported that their programs are frequently required to bridge this gap, which extends beyond their typical role. Several participants also noted the need for additional funding to address these gaps and provide necessary supports.

Collaboration & Community Partnerships

Successes

The most common supportive factor discussed in focus groups regarding their work with refugee families was the connections with refugee support service agencies. Staff shared about the services the refugee support agencies provide to families including connections to community resources, helping with connecting children to schools and medical care, and even providing classes for adults. Some home visiting staff shared how they have partnerships with refugee service providers and receive referrals from them:

"We've had [a local agency] connect us with refugee families interested in child care work, and they provide interpretation during our trainings. Through our home visiting program, [the agency] also sends us referrals. Since the families already trust them, it makes for a really smooth transition. We're very fortunate."

When asked about partnerships they have leveraged in their work with refugee families, focus group participants shared about local organizations in their communities such as free clinics, job and education training centers, churches and religious organizations, health departments, local support groups, and intermediate school districts (ISDs). These supports were discussed in terms of where home visitors have referred their refugee families as well as how they have collaborated with these different groups to provide resources to their refugee families.

Challenges

Despite many positive partnerships, home visitors and supervisors identified several key challenges in working with referral partners and organizations serving refugee families. A major barrier was staff turnover within refugee agencies, which disrupted established relationships and made it difficult to maintain consistent collaboration. As one participant shared,

"Turnover on the part of the [refugee resettlement] agencies makes it hard to have connections that are still there when you need them."

Additionally, role confusion and communication gaps between organizations often led to duplicated efforts or missed responsibilities. These breakdowns in coordination resulted in families falling through the cracks. There were also misaligned expectations between referring agencies and home visiting programs. This was particularly challenging when partners assumed home visitors would take on case management or interpretation responsibilities beyond the scope of their role. As one participant explained,

"The referral partner feels they need us to come in and do like the case management piece, right? Like the Medicaid management, the resource management and that is OK to an extent, but that's not the focus of what we do."

Participants also described how challenges arise when families are referred to external resources but cannot meaningfully access them due to language, eligibility, or cultural barriers. When those referrals fall short, the burden often shifts back to home visiting programs to fill the gap. As one participant noted:

"It is costing my agency more dollars to be able to give those things out because they can't utilize the community resources we refer them to."

Programmatic Factors

Focus group participants described several program-level factors that affect their work with refugee families. These included staffing gaps, funding limitations, the need for additional refugee case management support, and challenges with data collection. Participants also noted that the increasing demand for services and the growing refugee population have made it more difficult to meet all families' needs.

Staffing

Focus group participants emphasized the importance of having bilingual staff as one of the most effective ways to bridge communication gaps between home visitors and refugee families. Participants reported that when home visitors speak the same language as the families they serve, communication is clear and relationships are easier to build. Several programs also described ongoing efforts to recruit staff who better reflect the populations they serve.

Additionally, some participants highlighted the importance of having bilingual community health workers (CHWs) as part of the team. CHWs are trusted members of the community who help families navigate healthcare systems, provide culturally relevant support, and assist with case management tasks. Focus group participants reported that when CHWs and home visitors work together, families benefit from more coordinated support, particularly in addressing language barriers and accessing services. One participant shared:

> *"So it's super helpful [for nurses] and social workers when they have that community health worker partnering with them in the homes."*

Despite these strengths, staffing gaps remain a challenge in recruiting and retaining bilingual staff and staff who share the cultural background of the families served. As one supervisor shared:

> *"We have missed the mark on being able to hire someone of the population to fill that role."*

These shortages hinder effective communication and the ability to fully address the unique needs of refugee families. Additionally, the availability of CHWs, who play a vital role in supporting families, is often limited by funding and recruitment challenges.

Additional Refugee Case Management Support

Focus group participants emphasized how home visitors frequently go above and beyond typical case management tasks to meet the needs of refugee families. Home visitors expressed deep engagement with families, frequently assisting them with daily tasks such as reading mail, scheduling appointments, and helping navigate complex systems. One home visitor shared:

> *"They're very thankful for any help that I can provide, which feels very little sometimes for their needs, but I just try my best."*

Home visitors reported that refugee families often expressed warmth and gratitude during visits. Participants noted that these interactions contributed to building trust and rapport.However, many home visitors observed that formal support for refugee families often declines after the initial resettlement period. Home visitors reported that they often provide informal support in these areas. One home visitor explained:

> *"I know that families have government support, and I believe it's for the first six months, and so after that time sometimes there can be some difficulty with connection to services and things like that."*

In addition, home visitors reported they often must balance families' immediate needs with the activities outlined in the program's model curriculum. Many basic needs—such as sorting through mail, scheduling appointments, and assisting with system navigation—take priority, leaving limited time for program activities. One home visitor shared:

> *"I feel like with refugees we spend a lot of time doing things that are not necessarily program requirements because they're important for the families that we visit. You know, sometimes I think that my ability to speak English is more valuable during the visit than the fact that I'm a nurse, especially for newer families. They just, you know, they greet you with a stack of mail or a list of phone calls, they need appointments scheduled."*

Participants explained that visits often took longer than planned, with time spent on basic tasks leaving less time for planned activities or topics. They also noted that the need for interpretation services further extends visit length, particularly when virtual interpretation services are used. One participant shared:

> *"The time commitment of interpreting everything, just our visits and just the scheduling a visit, contacting the family, going out to do a visit. It just takes almost twice as long as an English-speaking client."*

Moreover, home visitors expressed concern over how the amount they can bill is not reflective of the additional time spent with families. As one home visitor shared:

> *"I wish I could seek more reimbursement for the longer [time] I'm in those homes. Because I'm getting paid the same for a 30-minute visit as a 2-hour visit, and most of our visits are around 90 minutes."*

Data Collection

Most supervisors reported tracking the primary language spoken by families enrolled in programs. Some supervisors also shared general awareness of clients' country of origin, though this was not formally collected. Some programs also track the use of interpreters internally for operational purposes to help meet client needs. A few supervisors mentioned noting referral sources from community partners, though this is used only for connecting families to services rather than as part of official recordkeeping. One supervisor shared,

> *"We have some internal data, like number of languages spoken, but we don't have anything that tells us specifically who is a refugee."*

Despite these strengths, supervisors across all focus groups consistently shared that refugee-specific data is not systematically collected within their programs. Participants stated that they do not directly ask about or document refugee status, citing concerns about intrusiveness and the potential to undermine the trust and rapport necessary for effective service delivery. They emphasized that refugee status is not a required data element in reporting systems and that staff often rely on knowledge from families or referral agencies to understand a family's background. As one supervisor summarized,

> *"Refugee status is not something that's asked on enrollment forms or tracked anywhere. It's just something we know from working with the families."*

Participants described the lack of formal requirements or standardized fields for refugee identification across reporting systems as a key barrier to consistent data tracking.

Summary of Findings

Language & Communication

Bilingual staff, in-person interpretation, and translated materials are vital to effective service delivery for refugee families. Families benefit most when paired with bilingual home visitors or consistent professional interpreters, and they feel a stronger connection when home visitors share both language and cultural backgrounds. Home visitors have developed strategies to bridge language gaps, including assigning the same interpreter across visits, using visual materials to overcome literacy challenges, and locating translated resources through community partners. Despite these efforts, significant barriers remain. Programs face limited availability of in-person interpreters for key refugee languages, a shortage of translated resources, and funding constraints that restrict consistent access to high quality language services. Kinyarwanda, Dari, and Kiswahili were identified as particularly underrepresented among staff and program materials, underscoring the need for targeted investment.

Building Trusting Relationships & Partnerships

Trust and consistency are central to successful engagement with refugee families. Both home visitors and families emphasized that empathy, cultural respect, and emotional support are key to building these bonds. When trust is established, families feel safer, more supported, and more willing to engage fully in home visiting services. Strong relationships are a cornerstone of effectiveness in home visiting, contributing to family wellbeing and sustained participation in programs. Needs assessment data suggest that home visitors who take time to listen, honor families' traditions, and provide reassurance foster deeper connections and higher levels of engagement. At the same time, cultural differences, competing needs, and past experiences of trauma can make relationship-building more complex. Developing trust often requires time, patience, and flexibility, with home visitors balancing the demands of program delivery while creating space for families to feel understood and respected. Despite these challenges, home visitors remain committed to partnering with families in ways that value their culture and lived experiences.

Cultural Adaptation & Sensitivity

Home visitors actively adapt their approaches to align with families' cultural practices, often using open-ended conversations, transparent communication, and culturally sensitive strategies. Families reported that these practices help them feel respected, supported, and able to balance their family values with adapting to new norms. Flexibility, patience, and communication emerged as key ingredients for navigating cultural differences. When home visitors take time to understand families' backgrounds and traditions, they are better able to provide tailored support while maintaining program fidelity. Despite these strengths, systemic barriers remain. Many curricula do not fully account for minority cultural traditions, creating tension between program requirements and families' practices. Home visitors also identified gaps in culturally relevant materials and called for more structured training on cultural dimensions of care and trauma-informed practice. Expanding multilingual hiring, investing in interpretation and translation resources, and developing culturally competent materials are critical steps to enhance services for refugee families.

Navigating Systems & Resources

Home visitors play a critical role in helping refugee families access essential services such as healthcare, education, employment, and public benefits. Families benefit when home visitors provide guidance to navigate unfamiliar systems, make referrals, and offer culturally responsive support that helps them build stability in new communities. Despite these strengths, families continue to face major barriers. Participants identified healthcare, transportation, and housing as some of the most difficult areas to access. Even when services are available, language barriers and a lack of refugee-specific resources often make them inaccessible. As a result, home visitors are frequently required to step in, extending beyond their intended scope to fill gaps in community infrastructure. The persistence of these barriers highlights both the critical bridging role home visitors play and the limits of what programs can do alone. Without stronger community infrastructure, expanded language-accessible resources, and coordinated funding, refugee families will continue to have unmet needs that undermine their stability and wellbeing.

Collaboration & Community Partnerships

Collaboration between home visiting programs and community organizations is a powerful asset in supporting refugee families. Strong partnerships with refugee-serving organizations facilitate access to medical care, education, job training, and other basic needs, creating smoother referral pathways and more holistic support. Families benefit when these partnerships build trust and leverage community resources that are responsive to their needs. However, sustaining these partnerships is challenging. Participants identified barriers such as high staff turnover, limited capacity, unclear role expectations, and inconsistent coordination between organizations. These gaps can make referrals less effective and reduce families' ability to meaningfully access services. Overall, partnerships are essential but depend on continuity, clarity, and communication to succeed. Strengthening these foundational elements along with investing in community capacity will be critical to ensuring refugee families receive consistent, coordinated, and culturally responsive support.

Programmatic Factors

Most home visitors in the assessment had extensive experience serving refugee families. Still, staffing shortages, especially among bilingual and bicultural professionals, limit the ability of programs to consistently meet families' needs. CHWs and bilingual professionals are critical to enhance language access and help families navigate health and social services. Workforce development investments are also needed. Professional development in cultural responsiveness, working with interpreters, and trauma-informed practice would strengthen staff capacity. Peer learning opportunities are important tools to share effective practices, mentor newer staff, and support staff retention. Finally, the lack of comprehensive case management beyond the resettlement period is a significant challenge for home visitors. When formal supports end, home visitors are often left to bridge gaps in healthcare, education, housing, and employment systems. More sustained, coordinated services are needed so families are not left to navigate these systems on their own.

Data Collection

Most programs do not formally track refugee status, which limits the ability to measure service reach and tailor supports across the system. While home visitors are often familiar with a family's background, a lack of standardized data collection systems prevents accurate tracking of refugee participation across the home visiting system. Programs serving refugee populations may lack the tools needed to collect and use this information effectively. There is a need for greater alignment between program models, data systems, and the realities of serving refugee families. Building awareness of the value of this data and advocating for more representative data collection practices can enhance the home visiting systems' ability to provide supports that are responsive to the needs of all families.

RECOMMENDATIONS

The findings from this needs assessment highlight key opportunities for home visiting providers and the home visiting system to strengthen their responsiveness to refugee families. Many programs in the focus area are already engaging in successful strategies to support refugee families and have identified areas of highest need to improve their capacity to serve refugee families. Furthermore, there are important opportunities for the home visiting system to sustainably support the needs of programs and refugee families. The recommendations outlined in this assessment reflect a clear path forward for strengthening home visiting services for refugee families at both the program and system levels. Grounded in the 6 refugee-responsive home visiting practices, these recommendations are intended to guide actionable improvements that build on the strengths already present in many programs across Michigan. Moreover, there are critical system changes needed to ensure that refugee families have consistent access to high-quality, culturally responsive care. Implementing these recommendations will require sustained collaboration, intentional investment, and a shared commitment to welcoming refugee families as valued members of our communities.

Program Recommendations

The following recommendations are informed by the 6 refugee-responsive home visiting practices, as well as key findings from the environmental scan and needs assessment and are intended to guide programmatic efforts to strengthen services for refugee families.

1. Welcome Refugee Families

- **Recruit and Retain Families:** Intentional outreach, high-quality language services, and culturally responsive service delivery are strategies to effectively reach and support refugee families in home visiting.
- **Expand Case Management Supports:** Explore flexible approaches to integrating case management within or alongside home visiting services to provide continued support for refugee families beyond their initial resettlement period.

2. Incorporate Feedback from Refugee Families

- **Strengthen Feedback Loops:** Embed meaningful, ongoing feedback mechanisms that elevate refugee family voices in shaping services. Use both qualitative and quantitative feedback to inform program design, enhance cultural relevance, and build trust.

3. Leverage Community Partnerships

- **Facilitate Partnerships and Bridge-Building:** Strengthen relationships with refugee-serving agencies to improve referral pathways, enhance communication, and identify opportunities for collaborative initiatives or shared staffing models.

4. Increase Linguistic and Cultural Responsiveness

- **Adapt Materials & Approach:** Ensure that home visiting materials are culturally relevant and linguistically appropriate by sourcing or adapting resources that reflect families' lived experiences. When culturally relevant materials are unavailable, use cultural curiosity and open-ended questions to ground home visiting activities in families' own traditions, values, and beliefs.
- **Provide Resources for Home Visitors:** Ensure home visitors have access to relevant tools—such as quick-reference guides, toolkits, or other resources—to support language access, service navigation, and understanding of refugee resettlement.
- **Recruit and Support a Multicultural Workforce:** Strengthen efforts to recruit, hire, and retain bilingual and bicultural staff, including CHWs, by addressing barriers and improving outreach to qualified candidates who reflect the communities served.

5. Provide Training and Support to Home Visitors

- **Encourage Participation in Training Opportunities:** Support home visitors and supervisors in accessing continued training on trauma-informed care focused on forced migration, cultural sensitivity, working with interpreters, and language access best practices to build confidence and capacity in serving families from different cultural backgrounds.
- **Promote Peer-to-Peer Learning and Communities of Practice:** Encourage staff participation in refugee-specific learning communities where home visitors and supervisors can engage in ongoing discussion, share strategies, and collaboratively resolve challenges related to serving refugee families.

6. Collect Data on Participation and Impact

- **Enhance Data Collection Practices:** Ensure consistent tracking of refugee-specific demographics, participation rates, and program outcomes. Use these data to inform program improvements and address gaps.



System Recommendations

In addition to strengthening program practices, this assessment identified several structural and systemic challenges that require action at the system level from funders, model developers, and policy leaders. Addressing these broader barriers will be critical to ensure access to home visiting services for refugee families and consistent, high-quality support for refugee families.

1. Adapt Model Requirements

Collaborate with home visiting model developers and funders to revisit qualification requirements for home visitors and adapt curriculum content to better reflect the needs of refugee families. Many home visiting models have requirements that may unintentionally limit programs' ability to recruit and retain staff that are representative of communities served and weaken programs' ability to address the needs of refugee families. Curricula often include topics such as safe sleep, breastfeeding, and nutrition, which require adaptation to be respectful of the cultural backgrounds of refugee families. Making these adaptations can be facilitated by adequate staffing, training, and adapted materials. In addition, many models were not designed considering the challenges refugee families face, including language barriers, cultural differences, and the impacts of trauma and forced migration. Greater flexibility in both staff qualification pathways and curriculum content is needed to ensure models are equipped to offer high-quality services to refugee families.

2. Provide Funding for Responsive Care

Prioritize funding across the home visiting system to support workforce development and linguistic and cultural responsiveness. This assessment identified Kinyarwanda, Dari, and Kiswahili as essential language gaps to improve home visiting responsiveness for refugee families. Home visitors must be equipped with the resources, training, and compensation necessary to provide high-quality, culturally responsive care. Many programs lack adequate funding for essential services, such as in-person, professional interpretation. Interpretation is critical for consistent and effective service delivery and should be universally funded to ensure meaningful communication and engagement with refugee families in the home visiting system. Creating flexible and robust funding structures for language services throughout the home visiting system will help ensure that both home visiting staff and refugee families have what they need to build trusting relationships and provide a nurturing home environment for refugee children to thrive.

3. Invest in Post-Resettlement Support

Encourage investment in post-resettlement services that extend beyond the initial months following a refugee family's arrival to Michigan. Currently, many refugee families do not have their basic needs met, leaving home visitors to invest significant time and energy in case management activities. This not only increases home visitors' workloads but also limits the time they can spend on core curriculum activities and relationship development. Expanding post-resettlement support services, such as employment services, medical

coordination, financial literacy, and housing support, will help alleviate these pressures on home visitors and provide refugees with the foundation they need to thrive in their new communities. State leaders should consider funding dedicated support roles, such as bilingual CHWs, who can bridge the gap between home visiting services and refugee post-resettlement support programs. CHWs would be well-positioned to provide culturally responsive care, build trust within refugee communities, and offer basic needs support to families.

4. Expand Workforce Pathways

Bilingual and bicultural home visitors bring invaluable experience that allow for better communication, rapport-building, and trust. Home visiting model developers, funders, and policymakers should assess the qualification standards that may unintentionally exclude capable bilingual and bicultural staff. Investing in workforce development initiatives that support bilingual and bicultural staff is critical for meeting the unique needs of refugee families. By including language and cultural knowledge as key skills for home visitors, programs will be better equipped to deliver culturally responsive services and bridge the gap between refugee families and the broader support systems available to them. This could involve considering alternative qualifications based on lived experience, which can be just as valuable as formal education.

5. Support Cross-Sector Collaboration

Convene partners across systems that link home visiting programs with refugee-serving organizations. These partnerships could include organizations that provide legal assistance, housing support, mental health services, employment resources, among others. Coordination of care across service systems can improve holistic support for refugee families that addresses their unique needs. Strengthening these partnerships at both the state and local levels will help create a more cohesive and responsive system of care for refugees. By working across sectors, home visiting programs and refugee services can improve coordination and the overall effectiveness of services for refugee families.

6. Strengthen System-wide Data Systems

Promote the development of unified, refugee-specific data collection standards across home visiting models. Data collection varies significantly between programs, making it difficult to track participation rates, measure outcomes, or understand the specific needs of refugee families. System-wide standards for collecting demographic data would provide more consistent, reliable insights that can inform policy, funding decisions, and program planning. Data on preferred language, spoken language, written language, and country of origin are important to develop system-wide strategies to support the cultural and linguistic responsiveness of the home visiting system. By ensuring that data collection accurately represents important demographics of all families, policymakers and home visiting administrators can design more targeted, effective interventions to ensure consistent, high-quality services for all families in Michigan.

The recommendations provided in this report are a roadmap for both immediate action and long-term systemic change. By developing practical resources, facilitating training, and strengthening community partnerships, the Refugee Systems of Care team can support the home visiting system in deepening its implementation of refugee-responsive home visiting practice. Furthermore, advocacy for sustainable funding and enhanced data collection will ensure that these services will continue to evolve to meet the unique needs of refugee populations in Michigan.

Ultimately, the success of the RSoC project will depend on collaboration at every level – from home visiting providers to community organizations and funders. Through sustained effort and a shared commitment to responsive care, we can build a system of care that supports refugee families throughout their journey and creates a safe and nurturing environment for children of all backgrounds to thrive. By embracing cultural responsiveness, fostering community partnerships, and providing training and support to the home visiting field, the RSoC project can support the development of a more welcoming home visiting system for refugee families.



APPENDIX A

The following home visiting programs were engaged by the RSoC team in the needs assessment process. These 35 programs indicated in a survey that their programs currently serve or are unsure if they serve refugee families within the 7-county focus area.

Among home visiting models engaged in the needs assessment, MIHP accounted for the largest share of this group with 13 programs. The breakdown of the remaining model groups is: 6 IMH programs, 5 EHS programs, 4 PAT programs, 3 NFP programs, 2 HFA programs, and 2 PALS programs. Furthermore, survey responses provide insight into where home visiting services are most likely being provided to refugee families. Kent County accounted for the largest share with 12 programs. The breakdown of the remaining counties is: 7 programs in Macomb County, 7 programs in Wayne County, 5 programs in Washtenaw County, 4 programs in Oakland County, 3 programs in Ingham County, and 3 programs in Kalamazoo County.

Program Name	Home Visiting Model	County Served
ACCESS Community Health and Research Center	Parents as Teachers (PAT)	Wayne
Arbor Circle - Healthy Families America	Healthy Families America (HFA)	Kent
Arbor Circle - Infant Mental Health	Infant Mental Health (IMH)	Kent; Other
Babies R Precious, LLC	Maternal Infant Health Program (MIHP)	Macomb; Oakland; Wayne
Bright Beginnings - Kent ISD	Parents as Teachers (PAT)	Kent
Capital Area Community Services	Early Head Start (EHS)	Ingham
Cherry Health	Maternal Infant Health Program (MIHP)	Kent
Community First Health Centers	Maternal Infant Health Program (MIHP)	Macomb; Other
Corewell Health - Baby Scholars	Play and Learning Strategies (PALS)	Kent
Corewell Health - Maternal Infant Health Program	Maternal Infant Health Program (MIHP)	Kent
D.A. Blodgett St. John's - Early Childhood Attachment	Infant Mental Health (IMH)	Kent
Easterseals MORC	Infant Mental Health (IMH)	Oakland; Macomb
Ingham County Health Department - MIHP	Maternal Infant Health Program (MIHP)	Ingham
Ingham County Health Department - NFP	Nurse-Family Partnership (NFP)	Ingham
Kalamazoo County Health and Community Services - HFA	Healthy Families America (HFA)	Kalamazoo
Kalamazoo County Health and Community Services - NFP	Nurse-Family Partnership (NFP)	Kalamazoo
Kent County Health Department - MIHP	Maternal Infant Health Program (MIHP)	Kent

Program Name	Home Visiting Model	County Served
Leaps and Bounds Family Services	Parents as Teachers (PAT)	Macomb; Wayne
Macomb County Health Department - MIHP	Maternal Infant Health Program (MIHP)	Macomb
Macomb County Health Department - NFP	Nurse-Family Partnership (NFP)	Macomb
Mama and Me Maternal Infant Health Program	Maternal Infant Health Program (MIHP)	Washtenaw; Wayne; Other
Michigan Medicine	Maternal Infant Health Program (MIHP)	Washtenaw
My Pregnancy Coach	Maternal Infant Health Program (MIHP)	Macomb; Wayne; Other
Network180	Infant Mental Health (IMH)	Kent
Oakland Community Health Network	Infant Mental Health (IMH)	Oakland
Oakland Livingston Human Service Agency (OLHSA)	Early Head Start (EHS)	Oakland
Seeds for Success - KRESA	Parents as Teachers (PAT)	Kalamazoo
Starfish Family Services - EHS	Early Head Start (EHS)	Wayne
Trinity Health	Maternal Infant Health Program (MIHP)	Kent; Other
University of Michigan Health West Community Health Center	Maternal Infant Health Program (MIHP)	Kent
Vibrant Futures	Play and Learning Strategies (PALS)	Kent
Washtenaw County Community Mental Health	Infant Mental Health (IMH)	Washtenaw
Washtenaw County Health Department - MIHP	Maternal Infant Health Program (MIHP)	Washtenaw
Washtenaw Intermediate School District	Early Head Start (EHS)	Washtenaw
Wayne Metropolitan Community Action Agency	Early Head Start (EHS)	Wayne

APPENDIX B

The following outlines the core question areas that guided focus group discussions with home visiting supervisors. Facilitators explored key topics related to serving refugee families, including program successes and challenges, language access, service barriers, available supports and resources, partnerships with community organizations, referral and data tracking practices, and opportunities for additional support. These domains were designed to gather insight into program-level experiences and inform strategies for strengthening refugee-responsive home visiting services.

- **Successes and Challenges:** The focus group facilitator asked about the duration of the programs' service to refugee families and the number of families served annually and probed for insights into the strengths of refugee families and the successful strategies supervisors implemented. The facilitator also asked about challenges, including ineffective strategies and adjustments made in response.
- **Language Access and Communication:** The facilitator asked how programs provide language access for refugee families, including the availability of essential documents, translation and interpretation services, and communication strategies for families with limited English proficiency. The facilitator also probed for barriers such as funding constraints, staffing limitations, and gaps in interpreter availability.
- **Barriers and Solutions:** The facilitator asked about challenges supervisors face, including resource limitations, cultural considerations, and service accessibility. The facilitator also asked about programmatic barriers like funding for interpretation, staff capacity, and lack of referrals, and probed for strategies developed to address these issues.
- **Supports and Resources:** The facilitator asked about the supports most helpful for supervisors, such as training, coaching, peer collaboration, and materials tailored to refugee families. The facilitator also asked about resource gaps and asked what additional supports would improve service delivery.
- **Partnerships and Community Collaboration:** The facilitator asked about supervisors' relationships with community agencies that support refugee families, such as resettlement agencies and ethnic-based organizations. The facilitator also asked how these partnerships developed, the frequency of communication, and how they strengthened service delivery.
- **Referral and Data Tracking:** The facilitator asked how programs manage referrals for refugee families and track demographic data, such as language spoken and country of origin. The facilitator probed for challenges in collecting and using this data and how it helps demonstrate need, program impact, and service gaps.
- **Additional Supports and Opportunities:** The facilitator asked about supervisors' interest in peer learning and collaboration opportunities, including meetings to review policies, practices, and strategies for improving services to refugee families. The facilitator also asked about areas where on-site support could enhance programs.

APPENDIX C

The following outlines the core question areas that guided focus group discussions with home visitors. Facilitators explored topics related to the delivery of home visiting services for refugee families, including family strengths, engagement strategies, language access, service barriers, and collaboration with community partners. Discussions also focused on the supports home visitors currently receive, the challenges they face, and the additional resources or learning opportunities that could strengthen refugee-responsive service delivery.

- **Successes and Challenges:** The facilitator asked about home visitors' experiences working with refugee families, including the strengths of these families and the effective strategies for engaging them. The facilitator inquired about how home visitors adapt their approaches to meet the cultural, linguistic, and trauma-informed needs of refugee families. The facilitator also asked about challenges faced and how home visitors navigate these challenges.
- **Language Access and Communication:** The facilitator asked how home visitors communicate with families who do not speak English, exploring verbal and written communication methods. The facilitator probed about the effectiveness of interpretation services, bilingual staff, translated materials, and other methods used to ensure meaningful language access for refugee families.
- **Barriers and Solutions:** The facilitator asked about the obstacles home visitors face in adapting services for refugee families, such as cultural differences, lack of resources, and family hesitancy to engage. The facilitator inquired about the solutions home visitors' programs have implemented to address these challenges and discussed strategies to increase participation and build trust with refugee families.
- **Supports and Resources:** The facilitator asked about the supports home visitors currently receive, such as access to interpreters, training on refugee-specific topics, and collaboration with community organizations. The facilitator also probed for additional resources that could enhance home visitors' ability to serve refugee families more effectively.
- **Partnerships and Community Collaboration:** The facilitator inquired about existing partnerships with refugee-serving organizations and other community resources supporting families with housing, healthcare, employment, and other essential services. The facilitator asked about the barriers to establishing new partnerships and explored ways to strengthen current collaborations.
- **Additional Supports and Opportunities:** The facilitator asked home visitors about their interest in peer learning opportunities, including shared learning, best practices, and training focused on working with refugee families. The facilitator also inquired about additional guidance needed to navigate available resources and improve service delivery.

APPENDIX D

The following outlines the core question areas used during semi-structured interviews with refugee families enrolled in home visiting services. The interviews included open-ended questions designed to maintain consistency across conversations while allowing flexibility in responses. Topics explored included families' overall experiences with home visiting, cultural and linguistic considerations, challenges and successes, referrals to community resources, and recommendations for improvement. These domains were developed to better understand the perspectives of refugee families and to identify opportunities to improve the responsiveness and impact of home visiting programs.

- **Overall Experience with Home Visiting:** The RSoC team asked families to describe their experiences with the home visiting program, including how the visits were structured, what aspects of the visits they enjoyed, and how the services benefited them, particularly regarding child development and family support.
- **Recruitment and Enrollment:** The RSoC team inquired about how families first learned about the program, their motivations for enrolling, and any concerns or uncertainties they had at the start. The RSoC team also asked about initial interactions with the program and what factors helped families feel welcomed.
- **Cultural and Linguistic Considerations:** The RSoC team probed how the presence of a home visitor who speaks their preferred language impacted the families, and how culturally relevant materials and practices were incorporated. The RSoC team also asked how the home visitor could better understand and incorporate the families' cultural background into visit activities.
- **Barriers and Challenges:** The RSoC team asked families to reflect on any challenges they faced in participating in the program, including logistical barriers, communication issues, or difficulties accessing resources. The RSoC team inquired about suggestions families had for overcoming these challenges.
- **Successes and Impact:** The RSoC team asked families to describe the positive aspects of the program, including instances when the home visitor went above and beyond. The RSoC team also inquired about how home visiting services benefited the families, such as improving access to resources, promoting child development, and enhancing stress management techniques.
- **Community Resources and Referrals:** The RSoC team asked how their home visitor connected them with community resources, including healthcare, housing, food, or legal support. The RSoC team probed about the appropriateness of these referrals and whether language assistance was provided.
- **Recommendations for Improvement:** The RSoC team asked families to provide feedback on how the program could be improved. The RSoC team inquired about strategies that could make families feel more welcomed, improve communication, or enhance service delivery.

APPENDIX E

The visual below illustrates the Michigan Home Visiting Core Knowledge Framework, which outlines the foundational areas of knowledge essential for all home visitors across models. This framework serves as the basis for statewide professional development standards and reflects shared priorities across Michigan's home visiting system.



The Michigan Home Visiting Initiative aims to improve consistency in home visiting throughout the state and ensure that home visitors have the tools that they need to support families. This is accomplished by setting system-wide standards, using data to drive decision making, and collaborating with partners and representatives at all levels of the state system. One of the system-wide standards that was developed and published by Michigan's Home Visiting Leadership is the Michigan Home Visiting Core Knowledge Framework. This framework is used across home visiting models to set a standard of knowledge for all home visitors.

Each of these core knowledge areas includes sub-topics that are common to home visiting regardless of which model is used. This framework is updated regularly to include new research and be responsive to evolving family needs. The Michigan Home Visiting Core Knowledge Framework guides all professional development efforts in the home visiting system to ensure that activities reflect the evolution of research and promising practices.