Virginia Newcomer Health Program Manual

Recommendations for Initial Refugee Medical Screenings

VDH VIRGINIA DEPARTMENT OF HEALTH

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CONTENTS

Introduction 3
Eligible Populations 5
The Overseas Medical Examination 7
Electronic Disease Notification System (EDN) 8
Refugee Resettlement Agencies 9
Refugee Health Education and Outreach (RHEO) Program 11
Refugee Benefits 12
Timeframes 13
Documentation 14
Billing and Reimbursement 15
Preparing for the First Visit 18
History and Physical 19
Labwork 20
  Laboratory Testing for ALL Clients 20
  Laboratory Testing for Certain Clients 22
Tuberculosis (TB) Screening 25
Immunizations 26
Vaccine Requirements 27
Ova and Parasite 28
Malaria 29
Interpretation and Translation 30
Mental Health Screening 31
Referrals 32
Form I-693 33
Education 37
When to Contact Newcomer Health 38
Appendix A 39
Appendix B 40
Appendix C 41
Appendix D 43
Appendix E 44
Appendix F 45
Appendix G 46

Paperwork flow of Overseas Medical Exams.....47
Paperwork and appointment referral flow.....48
Resources.....49
Forms.....50
References.....51

INTRODUCTION

The United States has a long history of welcoming immigrants and refugees. The Refugee Act of 1980 created a uniform system of services for refugees resettling in the United States. Its purpose was to provide for the effective resettlement of refugees in the U.S. and assist new arrivals with achieving economic self-sufficiency as quickly as possible.

Refugees receive a medical examination overseas prior to arrival in the U.S. and a comprehensive domestic Refugee Medical Screening as soon as possible after arrival. The purpose of the domestic medical screening is to identify and eliminate health-related barriers to successful resettlement and protect the health of the U.S. population. In states that resettle refugees, public health departments or other medical providers conduct domestic medical screenings following protocols and guidance issued by the federal Department of Health and Human Services, Office of Refugee Resettlement (ORR) in coordination with the Centers for Disease Control and Prevention.[1] The Immigration and Nationality Act, as amended, authorizes ORR to fund state costs of Refugee Medical Screenings. Federal regulations authorize states to provide medical screenings in accordance with ORR requirements. ORR reimburses states for the costs of domestic refugee medical screenings through the Cash and Medical Assistance (CMA) Grant.

In Virginia, local health departments (LHDs) in a refugee's city or county of residence perform the screenings with oversight and guidance from the Newcomer Health Program (NHP). The NHP resides within the Virginia Department of Health (VDH), Office of Epidemiology (OEPI), Division of Clinical Epidemiology (DCE). The Virginia Newcomer Health Program's mission is to provide initial refugee medical screenings to newly arrived refugees and other qualified individuals, to address health issues that may affect successful resettlement, and to identify and intervene on diseases and conditions related to public health. The NHP coordinates and facilitates the provision of initial refugee medical screenings for newly arrived refugees and other qualified entrants, including asylees, Afghan and Iraqi Special Immigrant Visa (SIV) holders, Cuban and Haitian entrants, certified victims of trafficking, Amerasians, Afghan Humanitarian Parolees, Unaccompanied Afghan Minors, and Ukrainian Humanitarian Parolees.

The Virginia Department of Social Services (DSS), Office of New Americans (ONA) administers the ORR federal grant that funds Refugee Medical Screenings. Through a memorandum of

[1] The Immigration and Nationality Act, as amended, authorizes ORR to fund state costs of refugee medical screenings. Federal regulations authorize states to provide medical screenings in accordance with the requirements prescribed by ORR.

agreement, DSS reimburses VDH for the administrative and direct costs of conducting these screenings.

Virginia's current refugee medical screening protocols became effective February 1, 2013[2], in response to new federal guidelines that created a nationwide minimum standard for conducting medical screenings and reimbursement for those costs. The new guidelines were the first major change in the domestic refugee medical screenings service provision since 1995. Previously, service provision varied from state to state, and within Virginia services varied by health district. This Newcomer Health Program Manual describes the required refugee medical screening protocols, forms, data submittal, and reimbursement processes.

[2] Prior 2/1/2013, refugee medical screenings consisted of two different levels of health assessments, each having a separate flat fee reimbursement rate.

ELIGIBLE POPULATIONS

Throughout this document, the term "refugee" refers to the following eligible groups:

- **Refugee:** Any person who is outside his or her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a social group. Eligible participants hold the legal immigration status of a refugee, which is granted prior to their arrival in the U.S.

- **Asylee**: Any person who, after arrival in the U.S., applies for asylum and demonstrates that he or she qualifies under the U. S. refugee definition. Once granted asylum an asylee is eligible for all services and support available to refugees, including refugee medical screenings. Asylees may petition for immediate family members (spouse or unmarried child and under 21 years) who are outside of the U.S. to join them in the U.S. Approved family members are granted derivative asylee status (also known as "Follow to Join") and are eligible for refugee services upon arrival in the U.S.

- **Special Immigrant Visa Holders (SIVs) from Iraq and Afghanistan**: Any individual granted SIV status under Section 8120 of Public Law No. 111-118 of the Department of Defense Appropriations Act of 2010.

- **Cuban/Haitian Entrant:** Any individual from Cuba or Haiti who has been admitted or paroled into the U.S. under P.L 96-422 or obtains that immigration status after arrival.

- **Amerasians:** Individuals of Asian and American descent, primarily children fathered by American service members and born between 1/1/1962 and 1/1/1976.

- **Trafficking Victim (Victim of Severe Form of Trafficking in persons)**: An individual who is subjected to (1) Sex Trafficking, which is recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act [any sex act, on account of which anything of value is given to or received by a person], in which a commercial sex act is induced by force, fraud, or coercion, or in which the person forced to perform such an act is under the age of 18 years; or (2) Labor Trafficking, which is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery. Victims of trafficking are

eligible for ORR benefits and services and other federal benefits, provided they have been certified as a victim of trafficking by ORR.

- **Afghan Humanitarian Parolees and Unaccompanied Afghan Minors:** effective September 30, 2021, citizens or nationals of Afghanistan paroled into the United States between July 31, 2021 and September 30, 2022, are eligible for refugee benefits. Additionally, a spouse or child of any Afghan humanitarian parolee described above, who is paroled into the United States after September 30, 2022, is entitled to the same benefits and assistance. The benefits and assistance will be available until March 31, 2023, or the end of an individual's parole term, whichever is later.

- **Ukrainian Humanitarian Parolees**: effective May 21, 2022, citizens or nationals of Ukraine paroled in the United States between February 24, 2022 and September 30, 2023 are eligible for refugee benefits. This benefit extends to individuals who last habitually resided in Ukraine and were paroled between February 24, 2022 and September 30, 2023. Additionally, any spouse or child of any Ukrainian Humanitarian Parolee describe above, who is paroled in the United States after September 30, 2023, is also eligible for benefits.

Any individual with one of the above designations is eligible for a refugee medical screening and follow up immunizations. **A copy of each individual's eligibility document shall be maintained in the LHD individual client chart** (See Documentation Section).

Additional information about the different categories and the requirements for documenting immigration status is available on the ORR website[3].

[3] https://www.acf.hhs.gov/orr/policy-guidance/status-and-documentation-requirements-orr-refugee-resettlement-program

THE OVERSEAS MEDICAL EXAMINATION

Any person resettled to the U.S. with refugee status is required by law to undergo a medical examination overseas, prior to resettlement in the U.S. The medical examination is designed to identify certain medical conditions known as excludable "Class A" conditions that may deny a person entry into the U.S. Currently these excludable, Class A conditions include:

- A communicable disease of public health significance
- A physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the applicant or others
- A history of a physical or mental disorder associated with behavior which posed a threat to the property, safety, or welfare of the applicant or others and which is likely to recur or lead to other harmful behavior
- Drug abuse or addiction

The overseas medical examination also aims to identify "Class B" conditions. Class B conditions are physical or mental disorders that do not constitute specific excludable conditions but do represent a significant departure from normal health or well-being. Such conditions may interfere with an individual's ability to care for himself or herself, attend school or work and may require extensive medical treatment or institutionalization in the future.

The overseas medical documentation provides valuable background information for new arrivals. When possible, overseas medical documents should be carefully reviewed ***prior to*** the initial refugee medical screening in the U.S. **Place a copy of the overseas medical documentation in the LHD individual client chart.** [See Documentation Section.]

ELECTRONIC DISEASE NOTIFICATION SYSTEM (EDN)

The Electronic Disease Notification System (EDN) is a database developed by the Centers for Disease Control and Prevention (CDC) that houses overseas medical information for all refugees and for those immigrants with notifiable (Class A or B) conditions.

The EDN system:

- Contains U.S. Department of State (DS) form information, results of overseas medical exams and treatment, and immunization records.
- Notifies state and local health departments of refugees, newly arrived immigrants with classified medical conditions, and in some cases, asylees, and Cuban and Haitian entrants in the jurisdiction
- Provides access to DS information and scanned overseas DS forms.
- Allows you to download information about refugees and immigrants in your jurisdiction for data analysis
- Includes a TB Follow-Up Worksheet that allows users to enter domestic TB evaluation outcome information for those arrivals with reportable TB conditions

All health districts in Virginia are permitted to have access to the EDN system. Access to EDN is **required** for health districts that serve more than five refugees and/or TB Classified immigrants each year. LHD personnel with access to EDN receive an email notification when a refugee or TB Classified immigrant arrives in their jurisdiction. The email does not contain any specific information about the new arrival. Upon receiving an email, LHD personnel need to access the EDN system to generate a copy of the overseas medical examination. LHDs will also generate and complete a TB Follow-Up Worksheet for arrivals with TB classified conditions.

See Figure 1 for an Overseas Medical Exam Paperwork Flow and Figure 2 for a Review of EDN Paperwork Screening and Referral.

For additional information about obtaining access to the EDN system, please contact the Newcomer Health Program Coordinator at 804-864-7911 or Jill.Grumbine@vdh.virginia.gov.

REFUGEE RESETTLEMENT AGENCIES

Upon arrival in the United States, refugees receive assistance from refugee resettlement agencies throughout the state. The refugee resettlement agencies operating in Virginia are:

- Catholic Charities of the Diocese of Arlington, Migration and Refugee Services has offices in:
  - Arlington
  - Fredericksburg
  - Manassas
- Commonwealth Catholic Charities has offices in:
  - Newport News
  - Richmond
  - Roanoke
- Church World Services has offices in:
  - Harrisonburg
  - Winchester
- Ethiopian Community Development Council has an office in:
  - Arlington
- International Rescue Committee has offices in:
  - Charlottesville
  - Richmond
- Lutheran Social Services of the National Capitol Area has offices in:
  - Fairfax
  - Dale City

Virginia's resettlement agencies play a vital role in the lives of refugees resettling in the U.S. Prior to a refugee's arrival, agencies secure and furnish housing for the individual or family. In addition to providing housing assistance, resettlement agencies help refugees apply for social service benefits, schedule initial refugee medical screenings, register for school, assist with employment placement, and enroll in English language training. Nine resettlement sites across Virginia employ Health Liaisons who help refugees address their medical needs. Health districts are encouraged to establish good working relationships with local resettlement agencies and Health Liaisons and communicate with them on a regular basis.

Refugee dialogue groups exist in each area of the state where refugees resettle. Facilitated by local resettlement agencies, these groups are referred to as the Virginia Community Capacity Initiative (VCCI) and are designed to convene stakeholders involved in the lives of refugees.

VCCI groups include representatives from resettlement agencies, school systems, law enforcement, social services, housing managers, employers, health officials and other community agencies that interact with refugees. The idea behind the groups is to discuss what each community's capacity is to resettle refugees. Health districts are encouraged to participate in these groups. For information on how to become involved with your local group, please contact the local refugee resettlement agency in your area.

A list of local resettlement agencies and their contact information is included in Appendix A at the end of this document.

REFUGEE HEALTH EDUCATION AND OUTREACH (RHEO) PROGRAM

The Refugee Health Education and Outreach (RHEO) Program is a federally funded program administered by the Office of New Americans. The RHEO program is designed both to address the challenges refugee-eligible populations have in navigating the U.S. health care system and to increase health and mental health care providers understanding of the unique health and emotional health needs of refugee-eligible populations.

RHEO services facilitate a community-based system of care that is comprehensive, coordinated, planned, and responsive to each refugee's strengths and needs while providing the continuum of care needed for self-sufficiency and community integration. It provides a framework of service delivery that promotes and enhances:

1. Access to community health and emotional health services beyond initial medical screenings and other health services provided upon arrival;
2. Education on health resources and good health practices;
3. Health and mental health providers' understanding of the unique health and emotional needs of refugee populations in their communities; and
4. Coordination and partnerships among community service providers.

The RHEO grant partially funds the positions of staff known as Health Liaisons who are based in resettlement agencies statewide. RHEO staff provide health and mental health support and assistance beyond the initial medical screening, with the goal of eliminating health-related barriers to self-sufficiency and community integration. There are no age limits for a person to receive RHEO services. Priority is given to eligible clients who have been in the U.S. two years or less and continue to face serious challenges in accessing health and mental health services.

RHEO staff responsibilities include:

1. Facilitate the delivery of health training and educational materials for both case managers and refugee-eligible clients
2. Provide assistance to case managers on issues related to refugee medical screening, Medicaid services, and health-related barriers to receiving the health services needed for self-sufficiency and community integration.
3. Ensure that eligible clients are referred to the national Health Insurance Marketplace or community healthcare facilities offering services to the uninsured.

REFUGEE BENEFITS

The Office of Refugee Resettlement (ORR) oversees eligibility and benefits programs for those individuals who qualify for the programs it oversees. Benefits may include:

- Refugee Cash Assistance (for those not eligible for TANF or SSI)
- Medicaid or Refugee Medical Assistance (for those not eligible for Medicaid)
- Refugee Social Services
- Matching Grant

Detailed information is available on the ORR website[4].

[4] https://www.acf.hhs.gov/orr/about/what-we-do

TIMEFRAMES

Initial refugee medical screenings for refugees and other qualified individuals **should be provided within 30 days of arrival to the United States**. For refugee-eligible populations who do not enter the U.S. through a resettlement agency and approach the LHD beyond the 30 days, the screening **may be** provided within 90 days of arrival to the United States. If there are extenuating circumstances that may warrant an extension to the 90-day rule, please contact the Newcomer Health Program at 804-864-7911 or jill.grumbine@vdh.virginia.gov for guidance. Health screening services, except for immunizations, shall NOT be provided beyond eight months after entry into the United States or the date in which eligibility is determined.

Immunizations for adults, who don't qualify for Medicaid, may be provided for up to one year after the date of arrival. In the case of asylum seekers and trafficking victims, the date status was granted shall be used as the date of initial eligibility. The Newcomer Health program may provide reimbursement for vaccines provided to individuals, who don't qualify for Medicaid for up to one year after the initial date of eligibility.

DOCUMENTATION

Health departments shall maintain an individual patient chart for each person receiving an initial refugee medical screening. Specific documentation forms are available for documenting initial refugee medical screening results. Copies of these forms are available on the Newcomer Health Program website[5]. Use of these forms is encouraged and preferred. However, health departments using locally-created forms may continue to do so as long as all pertinent information is captured.

For all individuals receiving Interferon Gamma Release Assay (IGRA) testing, results shall be documented in Web Vision. Currently, the best place in Web Vision to document these results is under the immunization tab in the comments section. When documenting IGRA results, health districts shall include:

- The date the test was performed
- The type of test used (T-Spot or Quantiferon)
- The result of the test (Positive Negative, indeterminate, borderline)
    - Note if indeterminate or borderline results, follow up test results shall also be documented

When no documentation of having been vaccinated is available, VDH requires serologic testing for Varicella and Measles, Mumps, Rubella (MMR) as evidence of immunity to infection. Results of serology shall be documented under contraindications in the Immunization section of Web Vision. MMR antigens must be documented separately.

In addition to medical records, a copy of an individual's eligibility for services shall be maintained in the chart. This may include a copy of the I-94, a copy of the letter granting asylum, or any other document that identifies the individual as being eligible for services under the refugee program. A list of acceptable documentation is available on the ORR website[6].

LHDs shall follow the Library of Virginia's Records Retention Schedule when determining how long individual patient records need to be kept. Schedules are available on the Library of Virginia website[7].

[5] http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/newcomer-health-program/services-and-resources-for-health-providers/
[6] https://www.acf.hhs.gov/orr/resource/status-and-documentation-requirements-for-the-orr-refugee-resettlement-program

[7] http://www.lva.virginia.gov/agencies/records/retention.asp

BILLING AND REIMBURSEMENT

All health districts, except for Fairfax, are required to use Web Vision to bill the NHP for provided services. Health districts must use procedure codes provided by the NHP. An encounter form with required codes has been developed and is available on the Newcomer Health website[8]. Not all codes included on the form are reimbursable (in particular, vaccines for children and certain vaccines for adults). However, those codes have been included in an effort to streamline Web Vision entry.

Health districts shall choose the appropriate code when billing for History & Physical (H&P) codes. Districts should use the full fee code for MDs, the NP code for Nurse Practitioners, and the PHN code for Public Health Nurses. PHNs should thoroughly review the encounter prior to submitting it to billing staff to ensure accuracy. PHNs may wish to consider highlighting all procedures applicable to an individual client prior to the screening and then review the form after the screening is done and place a mark next to all of the procedures provided for that particular client. This can help avoid charging the NHP for services which were not actually rendered to the client.

The NHP generates bills on the first business day after the 20th of each month. Health districts must enter codes in Web Vision prior to this date, or services may be denied. Changes made to client bills after the 20th of the month will not appear until the next billing cycle and will result in delayed payment to the district.

An Initial Health Screening Report Form must be sent by fax or by encrypted email to the NHP for districts to receive reimbursement for an initial refugee medical screening. Please make sure forms are legible, accurate, and complete. Follow-up Vaccine Forms must also be submitted before reimbursement can be provided. As an additional reminder, reimbursement for vaccines is only available for one year from the date of arrival or date of eligibility determination for groups other than refugees. All forms should be sent by encrypted email to newcomerhealth@vdh.virginia.gov or faxed to 804-864-7913. The forms are available on the Newcomer Health website[9].

The NHP is unable to provide reimbursement for vaccines for children. When providing vaccines to children, health districts shall bill Medicaid.

As of July 1, 2022, the Department of Medical Assistance Services (DMAS) and its managed care organizations (MCOs) now provide coverage for evidence-based, preventive services to all full-

[8] http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/newcomer-health-program/services-and-resources-for-health-providers/

[9] http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/newcomer-health-program/services-and-resources-for-health-providers/

benefit Medicaid adult populations in accordance with Item 304.EEEE of the 2022 Virginia Appropriations Act. The covered preventive services include all ACIP recommended vaccines. Therefore, if the client has Medicaid at the time of service, LHDs shall bill all vaccines for adults to Medicaid.

If Medicaid denies vaccines for adults or if the client is not eligible for Medicaid, the Newcomer Health Program can cover the following:

- Td/Tdap
- MMR*
- Varicella*
- Flu – one dose per flu season
- Pneumococcal
- COVID-19
- Hepatitis B
- Polio

Districts MUST attempt to bill Medicaid prior to requesting reimbursement for vaccines from the Newcomer Health Program.

*In some cases, titers are recommended prior to vaccination. See Immunizations section for additional information.

The following billing practices are not allowed and will result in denied charges:

- Billing for a History and Physical and a Nurse Visit on the same day
- Inappropriate lab testing based on age
- Billing for a Hepatitis B Surface Antigen and a Hepatitis B panel on the same day (the panel includes the surface antigen test)
- Billing for a capillary blood sample and a venous blood sample on the same day

All health districts are reminded that they may use the RF exception code when billing for chest x-rays (71010, 71020).

For Northern Virginia ONLY

As a reminder, districts in Northern Virginia (Alexandria, Arlington, Fairfax, Loudoun, and Prince William) are permitted to use the higher NOVA reimbursement rates in Web Vision. This applies only to those codes with preapproved NOVA rates.

End of Year Billing

The NHP operates on the federal fiscal year (October 1-September 30). When approaching the end of the fiscal year, health districts must pay close attention to their billing practices. Any charges from September 30 or prior **MUST** be entered into Web Vision by October 20, or charges may be denied.

PREPARING FOR THE FIRST VISIT

Prior to the first visit, providers should carefully review all available records. This includes findings from the overseas medical exam, any lab or diagnostic reports provided, and all immunization records. Review of these records will assist in developing a plan of care for the patient.

Providers may also wish to use CareRef[10], an interactive tool that can be used to determine what services/tests are appropriate to provide to an individual.

[10] https://careref.web.health.state.mn.us/

HISTORY AND PHYSICAL

A thorough health history and physical examination is a required component of the initial refugee health screening. A physician, nurse practitioner, public health nurse (PHN), or any combination of these three may perform this (ex: the PHN may collect the health history and the physician or nurse practitioner may perform the physical exam). The health district's reimbursement depends upon who performs the physical. (Reimbursement is calculated as follows: MD – 100%, NP – 85%, PHN – 50% of the total cost of the H&P code.) Note, when PHNs perform a health assessment, they may not provide a medical diagnosis. Instead, PHNs may provide a nursing diagnosis and document what they observe during the assessment (i.e. breath sounds abnormal).

- History – Includes review of overseas medical records; careful questioning on symptoms such as fever, weight loss, abdominal complaints, skin issues, review of systems for symptoms and complaints, known medical conditions, etc.
- Physical – includes, at minimum, assessment of nutritional status, height, weight, head circumference for children <2 years, pulse, respiratory rate, blood pressure, hearing and vision, oral exam, skin assessment, listening to heart and lung sounds, palpation for liver and spleen enlargement (defer for assessment by PHN), full lymph node exam (PHNs may defer full lymph node exam, but should assess gross cervical and axillary abnormalities). Genital exam may be deferred.
- Developmental status should be assessed for children aged 9-30 months according to the CDC and the American Academy of Pediatrics guidelines.

Additional information is available on the CDC website[11].

[11] https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html

LABWORK

LABORATORY TESTING FOR ALL CLIENTS

The following laboratory testing should be performed for **all refugees** receiving a health screening:

- CBC

- Urinalysis – if old enough to provide a clean-catch urine specimen. For adults also receiving urine testing for Chlamydia/GC, collect the urine for this test first, and then collect the clean catch for urinalysis.
    - Health districts may choose which type of urine dip to perform based on local resources.

- HIV – for all refugees 13-64 years of age, unless they decline. If a refugee declines HIV testing, be sure to document this in the chart. HIV testing is *encouraged* for all refugees, regardless of age.
    - Children less than 13 years of age should be screened unless there is documentation that the mother is HIV negative and the child does not have any risk factors for HIV (history of blood product transfusion, early sexual activity, or history of sexual violence or abuse). In most situations, complete and accurate information regarding risk factors will not be available. Therefore, most children under 13 years will need to be tested.

- Hepatitis B
    - **Check the overseas medical records. If testing was already performed, it does not need to be repeated.**
    - **Adults**
        - If not previously tested, all adults should have the following testing performed
            - HBsAG
            - Total anti-HBc
            - Anti-HBs
        - If the HBsAG is negative and the Hepatitis B vaccine series is complete, no further testing or vaccination is needed

        - If HBsAg was negative, vaccination records indicate that the vaccination series is complete, the refugee is in a high-risk group[12], or there is a concern for high-risk exposure since the original screen, then it is reasonable to repeat testing following arrival.
        - If HBsAg was negative and no previous doses of vaccine were received, then the refugee should be tested for immunity by serology with total anti-HBc and anti-HBs. **It is reasonable to start the hepatitis B vaccine series while awaiting results.** If serologic testing returns negative, then the series should be completed. If serology for both anti-HBc and anti-HBs are positive, then no further vaccine doses are needed.
    - **Children 18 years of age and younger**
        - If not previously tested should have
            - HBsAG
            - Total anti-HBc
            - Anti-HBs
        - If HBsAG is negative and the vaccine series is incomplete, finish the series
        - If the HBsAG is negative and the vaccine series is complete, no additional testing or vaccination is necessary.
    - **Pregnant People**
        - Screen during each pregnancy (first trimester preferred), regardless of vaccination status or testing history
        - Those with a history of appropriately timed panel screening (HBsAG, total anti-HBc, anti-HBs) with no subsequent risk only need HBsAG screening.
    - Any individual who has a positive Hepatitis B Surface Antigen (HBsAg) result needs to be referred for Hepatitis D testing and for additional follow-up. Additional information is available on the CDC website[13].

- Tuberculosis – all refugees shall be screened, and if appropriate, tested for TB.

[12] Injection-drug users; Gay, bisexual, and other men who report male-to-male sexual contact; Persons needing immunosuppressive therapy, including chemotherapy, immunosuppression related to organ transplantation, and immunosuppression for rheumatologic or gastroenterologic disorders; Persons with elevated liver enzymes (alanine aminotransferase [ALT] ≥19 IU/L for women and ≥30 IU/L for men or abnormal aspartate aminotransferase [AST]) of unknown etiology; People needing Hemodialysis; Household, needle-sharing, or sex contacts of persons known to be HBsAg positive; Persons who are the source of blood or body fluids for exposure that might require postexposure prophylaxis (e.g., needlestick, sexual assault); Persons who have a history of sexual exploitation, including child marriage; Persons with HIV infection; Persons infected with hepatitis C virus; Incarcerated persons (although unlikely among newly arrived refugees); Children whose mothers haves a history of HBV infection or cleared infection

[13] https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/hepatitis-screening-guidelines.html

- Districts may choose which method of testing they will use for assessing TB infection status:
  - Interferon Gamma Release Assay (IGRA) is the preferred method of assessing for TB Infection
  - Children less than 2 years of age should have a TST since IGRA use is not approved for this age group.
- Individuals who are symptomatic should have additional appropriate testing including:
  - TST or IGRA
  - Chest x-ray
  - Sputum Collection (sputum samples for TB should be sent to the state lab: Division of Consolidated Laboratory Services)
- Individuals who have positive TSTs or IGRAs should receive appropriate follow up and treatment:
  - Chest x-ray
  - Treatment for Latent TB Infection (LTBI) as long as there is no evidence of active TB disease
- Additional information is available on the CDC website[14].

NOTE: For very young children, a venous blood sample may be deferred. In lieu of venous blood sample testing, health districts may collect a capillary blood sample and perform blood lead testing and a CBC. When doing so, districts will need to fill the microtainer to the second line in order for the lab to perform both tests. When using this option, if either parent has an abnormal lab test (i.e. HIV+, HBsAG+) children may need to have additional testing.

Additional note: When health departments have difficulty drawing blood on an individual, a referral may be made to Lab Corp for them to draw the blood. This should not be a routine practice and should be reserved for only those cases where the health department has made multiple attempts to draw blood without success.

LABORATORY TESTING FOR CERTAIN CLIENTS

Perform lab testing for individuals meeting the following specified criteria.

- Basic Metabolic Panel (include BUN and creatinine)
  - Indicated for those with signs and symptoms or comorbidities
  - Consider for those with high rates of chronic renal disease (Hmong refugees)

[14] https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html

- Cholesterol – can be done non-fasting
    - Men ≥35 years
    - Women ≥45 years
    - Men 20-35 years and women 20-45 years who are at risk for coronary artery disease (diabetics, tobacco users, hypertension, family history of cardiovascular disease before age 50 years in male relatives or age 60 years in female relatives, or a family history suggestive of familial hyperlipidemia)

- Pregnancy Testing for women of childbearing age

- Hepatitis C Screening
    - All new adult arrivals ≥18 years of age
    - All pregnant women during each pregnancy

- Syphilis Screening
    - Everyone ≥15 years if no overseas result available
    - Children <15 years if any of the following apply:
        - Sexually active or history of sexual assault
        - All at risk children (mother tests positive)
        - **Adult** refugees from countries* that have endemic rates of other Treponemal subspecies (yaws, bejel, pinta)
            - *see Appendix B for the List of Countries with Endemic Rates of Other Treponemal subspecies

- Chlamydia and Gonorrhea Urine Testing
    - Women ≤25 years who are sexually active or have risk factors[15], if there is no overseas documentation
    - Women ≥25 years with risk factors[15]
    - All symptomatic refugees or those with leukoesterase detected in a urine sample
    - Consider testing refugees who have a history of sexual assault

- Serology for Vaccine Preventable Diseases
    - Varicella
        - All refugees aged 19 and older

[15] new sexual partner or multiple sexual partners, sex partner with concurrent partners, sex partner who has a sexually transmitted infection

        - Do not test if the individual has already received 1 or 2 doses of varicella vaccine. Provide additional dose of vaccine, as needed.
    - MMR
        - All refugees aged 19 and older
            - Do not test if the individual has already received 1 or 2 doses of MMR vaccine. Provide additional dose of vaccine, as needed.

- Blood Lead Level
    - All refugee children ≤16 years of age
    - Refugee adolescents >16 years of age with a high index of suspicion or clinical signs/symptoms of lead exposure
    - All pregnant and lactating women and girls
        - Pregnant or breastfeeding women should be prescribed a prenatal vitamin
    - Follow up testing 3-6 months after arrival for:
        - Refugee children ≤6 years of age regardless of initial result
        - Anyone with an elevated BLL at initial screening should have a follow-up test 3-6 months after the initial test

- Newborn Screening
    - All refugee children ≤6 months of age (should be sent to DCLS)

**Testing for STIs in asymptomatic clients is covered by current protocols; patients with symptoms must be referred to a clinician. Other lab testing should be included in local health department standing order protocols.

All lab testing should be sent to Lab Corp except for T-Spots, which are sent to Oxford, and Newborn Screening Tests and Sputum Samples, which are sent to DCLS.

TUBERCULOSIS (TB) SCREENING

A thorough TB screening shall be a part of every initial refugee health screening. Health districts are strongly encouraged to use the TB512, TB Risk Assessment, developed by the VDH TB Program. The TB512 is available on the VDH TB Program website[16] along with instructions for using the form[17].

Individuals from High TB Burden Countries should be screened and tested appropriately. The High TB Burden Country list is posted on the VDH TB Program website[18].

Health districts choosing not to use the TB -512 will need to document each individual's risk for acquiring TB infection and progressing to TB disease. This shall at minimum include:

- Screening for TB symptoms
- Screening for TB Infection Risk
- Screening for developing TB Disease if infected
- Findings of the screening (previous treatment for LTBI and/or TB disease, no risk factors for TB infection, risks for infection and/or progression to disease, possible TB suspect, previous positive TB test without prior treatment)
- Actions taken (issuance of a screening letter, referral for CXR, referral for medical evaluation, administering a TST or IGRA, issuance of sputum containers, etc.)

Review overseas medical information carefully. Testing for individual clients may vary depending on results from overseas. For those individuals who have documentation of a positive IGRA result, testing does not need to be repeated. For individuals >2 years of age who had a TST overseas, perform IGRA testing. For individuals <2 years who received a TST overseas, repeat the TST. Individuals previously treated for active TB disease do not need a repeat test (TST or IGRA).

Health districts are strongly encouraged to offer treatment to those diagnosed with LTBI. Whenever possible, health districts that provide treatment for LTBI are encouraged to treat using a short course treatment regimen.

Refugees identified overseas with a TB classification will need a TB follow up worksheet completed in the EDN system.

[16] https://www.vdh.virginia.gov/content/uploads/sites/4/2016/01/TBRisk.pdf

[17] http://www.vdh.virginia.gov/content/uploads/sites/112/2016/10/512-Instructions_Dec-2016.pdf

[18] https://www.vdh.virginia.gov/content/uploads/sites/175/2022/02/High-Burden-TB-Countries-2022.pdf

IMMUNIZATIONS

Immunizations are an essential component of the health screening. Health departments shall assess the need for vaccines on an individual basis. For refugees who arrive with written documentation of vaccines, health departments may use such documents when assessing the need for immunizations. Any documentation that can be considered a valid dose of a particular vaccine shall be entered into Web Vision.

Health departments are reminded that adults 19 years of age and older, in most cases, should have blood drawn for MMR and Varicella serology. For adults who have already received one or more doses of MMR or Varicella vaccine, there is no need to draw serology; individuals with documentation of an incomplete series should complete the vaccine series appropriately. In addition, adults born prior to 1957 are considered immune, and do not need MMR serology or vaccine.

There are certain vaccines, which are required when refugees apply for adjustment of status to legal permanent residence (Green Card). Vaccine requirements differ depending on the age of the individual. A table outlining age and vaccine requirements for adjustment of status purposes is on the following page. Regardless of status adjustment requirements, adults and children should be vaccinated according to Advisory Committee and Immunization Practices (ACIP) standards. As of July 2022, DMAS and its MCOs now cover ACIP recommended vaccines. Health districts shall bill Medicaid for adult and pediatric vaccines.

Health departments shall provide a copy of the immunization record to each client.

VACCINE REQUIREMENTS

VACCINE	AGE						
	BIRTH – 1 MONTH	**2-11 MONTHS**	**12 MONTHS-6 YEARS**	**7-10 YEARS**	**11-17 YEARS**	**18-64 YEARS**	**≥65 YEARS**
DTP/DTaP/DT	NO	YES		NO			
Td/Tdap	NO			YES, use Tdap as one dose of the 3-dose series			
IPV	NO	YES				NO	
MMR	NO		YES, if born in 1957 and later				NO, if born before 1957
Rotavirus	NO	YES, 6 weeks to 8 months old	NO				
Hib	NO	YES, 2 through 59 months	NO				
Hepatitis A	NO		YES, 12 months through 18 years	NO			
Hepatitis B	YES, birth through 59 years						NO
Meningococcal (MenACWY)	NO				YES, 11 through 18 years		NO
Varicella	NO		YES				
Pneumococcal	NO	YES, 2 through 59 months (PCV)		NO			One dose PCV15 followed by PPSV23 or one dose PCV20
Influenza	NO	YES, 6 ≥ months (annually when flu vaccine is available in country of exam)					
COVID-19	NO, if <6 months	YES, ≥6 months See COVID-19 site[19] for additional information					

Table 1 Above requirements are as of 5/16/2023

[19] https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/vaccinations.html#covid-19-vaccination

OVA AND PARASITE

Because of the increased incidence of parasitic infections in refugees, many groups are receiving presumptive treatment prior to departing overseas Refugee Processing Centers. Documentation of any treatment provided overseas will be included in the overseas medical information packet available in EDN. Specific information about recommended overseas treatment is available on the CDC website[20].

For refugees who did not receive pre-departure treatment, VDH recommends that they receive presumptive treatment, unless there is a contraindication. These clients should be provided with prescriptions to have filled at a local pharmacy. Clinicians are encouraged include a diagnosis code on the prescription ***(B78 – Strongyloidiasis, B89 – unspecified intestinal parasite, B73 Onchocerciasis).*** **This will help avoid a denial by Medicaid.** See appendices C and D for dosing recommendations.

For refugees who are unable to receive presumptive treatment, testing for O&P is an option and is available through LabCorp. The LabCorp test kits contain two containers, one with formalin and one with PVA. **Both containers must be filled for proper testing.** Three specimens should be collected to maximize the sensitivity of the test. Health district staff should use their judgement and evaluate each situation independently to determine whether or not collecting three specimens is possible. Travel history should also be listed in the test requisition form.

The complete *Domestic Intestinal Parasite Guidelines* are available on the CDC website[21].

[20] https://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas-guidelines.html

[21] https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html

MALARIA

The CDC recommends the following for treating malaria in refugees from sub-Saharan Africa:

Recommendations for Post-arrival Presumptive and Directed Treatment for Malaria for Refugees from Sub-Saharan Africa (See Appendix E for a list of these countries)

Refugees who have received recommended pre-departure presumptive or directed therapy:

Refugees who have received pre-departure treatment with a recommended antimalarial drug or drug combination do not need further evaluation or treatment for malaria unless they have clinical symptoms.

Refugees who have not received the recommended presumptive or directed pre-departure treatment:

It is recommended that refugees originating in sub-Saharan Africa, who have not received pre-departure therapy with a recommended regimen, receive presumptive treatment within three months of arrival, unless there is a contraindication (women in the first trimester of pregnancy, infants weighing less than 5 kilograms, known allergies to medication type).

Testing is recommended for patients who are symptomatic.

Post-arrival presumptive anti-malarial treatment Atovaquone-proguanil (trade name Malarone) or artemether-lumefantrine (trade names Coartem, Riamet) are the medications of choice for presumptive treatment for malaria. Atovaquone-proguanil and artemether-lumefantrine are effective treatment for *P. Falciparum* malaria (as well as *P. Malariae* and the blood stages of *P. Vivax* and *P. Ovale*). In addition, there is little parasitic resistance to these medications, the treatment regimens are short, and they are generally well tolerated with few adverse effects. All other available medications have higher rates of adverse effects (e.g., mefloquine) or more complex dosing regimens of combination medications (e.g., quinine/quinidine plus a second agent) and are of limited use for presumptive treatment. Therefore, newly arriving sub-Saharan refugees should receive presumptive therapy with atovaquone-proguanil or artemether-lumefantrine (Table 2) on arrival or during their new arrival refugee medical visit. (See Appendix F)

The complete CDC *Malaria: Domestic Guidelines* are available on the CDC website[22].

[22] https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html

INTERPRETATION AND TRANSLATION

Health districts are required to use trained, qualified interpreters when providing services to refugees. VDH currently has contracts with three companies for this purpose. The VDH approved interpreter companies are: Lionbridge Technologies, Propio LS LLC, and Voiance Language Services. LHDs should decide which company best suits their needs. A one-time reimbursement fee is available to districts to cover the cost of interpretation.

Whenever possible, health districts shall provide Vaccine Information Statement (VIS) forms in the native language of the person receiving vaccines. VIS forms[23] are currently available in many languages other than English.

[23] http://www.immunize.org/vis/

MENTAL HEALTH SCREENING

Mental health is an important part of overall health and should be addressed during the initial refugee health screening. Virginia has adopted the Refugee Health Screener 15 (RHS-15), which is a self-administered tool approved for individuals aged 14 years and older. As of the date of publication of this manual, the RHS-15 is available in Arabic (Iraqi), Burmese, Karen, Nepali, Somali, Farsi, Russian, French, Amharic, Tigrinya, Spanish (Cuban) and Swahili, Dari, Pashto, and Ukrainian. The RHS-15 may be administered using the English version and a telephonic interpreter if needed.

Exceptions to the mental health screening must be approved by the State Refugee Health Coordinator.

Health districts administering the mental health screening tool should ensure that referral processes are established prior to implementing a mental health screening program. A referral to an appropriate mental health provider shall be made when any client screens positive on the RHS-15. A screening is considered positive if the overall score is greater than or equal to 12, or if the distress thermometer is greater than or equal to five (5).

The referral process varies among health districts. In areas where the Community Services Board (CSB) provides the needed service, health districts are encouraged to coordinate follow-up mental health services with the CSB. In health districts where the CSB does not provide the required service, health districts should identify private providers who accept Medicaid and provide interpretation services.

Health districts in need of a copy of the RHS-15 may contact the Newcomer Health Coordinator at Jill.grumbine@vdh.virginia.gov.

REFERRALS

Public Health Nurses shall make appropriate referrals to healthcare providers for any conditions identified during the initial refugee medical screening. In addition, clients who were identified with any medical conditions during the overseas medical exam that require additional attention must be referred for follow up. Results of the initial refugee medical screening, including lab results, shall be made available to the primary care physician providing follow up to the client.

Health districts are encouraged to provide a formal, written referral for any issues that require follow-up. Health districts shall document any referrals in the patient chart. An example of a written referral is provided in Appendix G.

A copy of the referral should be provided to the client and to the resettlement agency caseworker as soon as possible.

FORM I-693

Health departments are permitted to act as Designated Civil Surgeons for the purposes of completing Form I-693, which is the medical form needed to apply for adjustment of status to legal permanent residence. This permission applies to those with refugee status only, and only for the purposes of completing in vaccine portion of form I-693. The following information regarding Blanket Civil Surgeon Authority is from the United States Customs and Immigration Services (USCIS) website[24].

(Note, to access the hyperlinks in the information below, please go to the USCIS website).

Blanket Designation of State and Local Health Departments [1] See INA 209.

1. **Overview**
    a. USCIS has the authority to designate either individual physicians or members of a specified class of physicians as civil surgeons, provided they meet the legal requirements. [2] As specified under INA 232(b), 8 CFR 232.2(b), and 42 CFR 34.2(b). Through policy and in agreement with the Centers for Disease Control and Prevention (CDC), USCIS designated all state and local health departments as civil surgeons. Health departments may only use this blanket civil surgeon designation to complete the vaccination assessments for refugees seeking adjustment of status. [3] See INA 209.
    b. This blanket designation eases the difficulties encountered by refugee adjustment applicants in complying with the vaccination requirement. It also relieves USCIS of the need to maintain lists of health departments and the names of individual physicians at these health departments.
2. **Eligible Physicians**
    a. Participation in this blanket civil surgeon designation is entirely voluntary and at the discretion of each health department. Health departments may only participate under this blanket designation if they have physicians authorized to provide medical services who meet the professional qualifications of a civil surgeon [4] As described in Chapter 1, Purpose and Background, Section C, Professional Qualifications [8 USCIS-PM C.1(C)]. since only these qualifying physicians may certify the vaccination assessment for refugees seeking adjustment of status. This includes volunteer physicians at state and local health departments.

[24] https://www.uscis.gov/policymanual/HTML/PolicyManual-Volume8-PartC-Chapter3.html

b. Eligible physicians at health departments may, but are not required to, personally perform the vaccination assessment. Nurses or other medical professionals may perform the vaccination assessment and complete the vaccination record in the Report of Medical Examination and Vaccination Record (Form I-693), as long as the health department physician reviews and certifies the Form I-693.
c. Neither health departments nor eligible physicians at health departments need to obtain approval from USCIS prior to performing the vaccination component of immigration medical examinations as specified in the next section. Blanket designated civil surgeons are exempt from both application and fee requirements for civil surgeon designation.
d. However, health departments and eligible physicians must review and be familiar with the Technical Instructions for the vaccination requirements before they can begin performing vaccination assessments. [5] The Technical Instructions are available online25.

3. Scope

a. Pursuant to the understanding reached between USCIS and CDC, health departments may only use this blanket civil surgeon designation to complete the vaccination assessments for refugees seeking adjustment of status. [6] See INA 209. Therefore, health departments operating under this blanket designation should examine government-issued documents presented by the applicant to verify that he or she is a refugee. [7] Refugees may present their Arrival-Departure Record (Form I-94), Refugee Travel Document (Form I-571), or Employment Authorization Document (Form I-766) as evidence of refugee status. However, health departments completing the vaccination assessment will not know whether a refugee seeks adjustment under INA 209 or under another provision. Therefore, when reviewing a vaccination assessment completed by a blanket designated civil surgeon for a refugee seeking adjustment, the officer should confirm that the refugee is adjusting under INA 209 before accepting the vaccination assessment performed by a blanket designated health department. This blanket designation does not cover asylees seeking adjustment of status. [8] See INA 209.
b. Accordingly, health departments operating under this blanket designation are authorized only to perform the vaccination component of the immigration medical examination for refugees seeking adjustment of status. If a health department physician would like to perform parts of the immigration medical

[25] http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html

examination other than the vaccination assessment, the physician must obtain designation as a civil surgeon through the standard application process. [9] As outlined in Chapter 2, Application for Civil Surgeon Designation [8 USCIS-PM C.2].

c. Refugees who require the entire medical exam, [10] See 8 CFR 209.1(b). will likewise need to visit a physician designated as a civil surgeon through the standard application process. [11] However, blanket-designated health departments may still perform the vaccination component of the medical exam for refugees who require the entire medical exam.

4. **Recording and Certification Requirements** – Health departments operating under the blanket civil surgeon designation must record the vaccination assessment on the Report of Medical Examination and Vaccination Record (Form I-693) as follows:
    a. Ensure the applicant's information and certification are completed
    b. Complete the vaccination record
    c. Complete the civil surgeon's information and certification
5. **Signature and Stamp Requirements** – In accordance with the agreements reached with CDC, health departments operating under the blanket civil surgeon designation are required to certify Form I-693 by providing the attending physician's signature and seal or stamp of the health department
    a. Physician Signature
        i. The attending physician must sign Form I-693. A signature stamp may be used. Health department nurses or other health care professionals may, but are not required to, co-sign the form. However, a form that has been signed only by a registered nurse, physician's assistant, or other medical professional who is not a licensed physician is not sufficient.
        ii. If a form for a refugee adjusting status has been signed only by a medical professional employed by the health department (without an accompanying signature by a medical doctor), a Request for Evidence (RFE) should be sent to the applicant for corrective action.
    b. Health Department Stamp or Seal
        i. The health department is also required to affix either the official stamp or raised seal (whichever is customarily used) of that health department on the space designated on the form.
6. **Final Processing**
    a. It is permissible for blanket-designated civil surgeons to annotate "The examination was limited in scope to only that needed in order to complete the applicant's vaccination assessment." For those choosing to include this statement, it should be written in either:

   i. the box where they place the official health department stamp or seal at the end of Part 4 or
   ii. the "Remarks" box at the end of Part 7 Vaccination Record
b. As with all immigration required medical examinations, the signed Form I-693 must be placed in a sealed envelope, according to the form's instructions[26].
c. Provide a copy of the original document to the client and retain a copy for the chart.

Per email communication with USCIS, blanket civil surgeon authority extends to V-93 (derivative refugee status) applicants. (USCIS, 2019).

[26] www.uscis.gov/sites/default/files/document/forms/i-693instr.pdf

EDUCATION

Health departments shall provide client-specific health related information as needed. This can include information on individually identified diseases or conditions, good health practices, chronic disease prevention, treatment for Latent TB Infections, etc.

The following websites offer information in a variety of languages:

HealthReach[27]: Offers health information specifically geared toward refugees

MedlinePlus[28]: Offers general health information

Ethnomed[29]: Offers general health information

Health districts are encouraged to use any other appropriate health related educational materials available.

Health districts may wish to consider developing resource lists specific to the local community. This may include information on local free clinics, providers who accept Medicaid, etc.

[27] https://healthreach.nlm.nih.gov/searchresults?keywords=Refugee&country=&population=&language=&format=&records=30

[28] https://medlineplus.gov/languages/all_healthtopics.html

[29] http://ethnomed.org/patient-education

WHEN TO CONTACT NEWCOMER HEALTH

Health departments should contact the NHP whenever questions arise about eligibility for reimbursement, billing questions, etc. In addition, health departments should notify the NHP for unusual situations occur. These situations may include but are not limited to:

- Increase in incidence of elevated blood lead levels in children
- Diagnosis of malaria
- Diagnosis of TB
- Other unusual conditions/diagnoses (Ebola, Hansen's Disease, etc.)

APPENDIX A

VIRGINIA RESETTLEMENT AGENCIES

Catholic Charities of the Diocese of Arlington
Migration and Refugee Services
Director: **Belayneh Loppisso**
http://www.ccda.net

Arlington Office
80 North Glebe Road
Arlington, VA 22203
Contact: Laurel Collins
Phone: (571) 364-8007

Manassas Office
8247 Shoppers Square
Manassas, VA 20111
Contact: Zamir Azam
Phone (571) 364-8008

Fredericksburg Office
100 Riverside Parkway
Suite 135
Fredericksburg, VA 22406
Contact: Kat Renfroe
Phone: (540) 899-6510

Woodbridge Office
13000 Harbor Center Dr
Suite 100
Woodbridge, VA 22192
Contact: Elias Jovani Boroni
Phone (571) 292-2259

Commonwealth Catholic Charities
Refugee Resettlement Program
Director: **Vacant**
http://cccofva.org/

Richmond Office
1601 Rolling Hills Drive
Richmond, VA 23229
Contact: Abubakar Abdelrahman
Phone: 804-545-6283
URM Contact: Jennifer Ward
804-545-5937

Roanoke Office
2131 Valley View Blvd NW
Roanoke, VA 24012
Contact: Ashley Proffitt
Phone: (540) 342-0411

Hampton Office
740 Thimble Shoals Blvd – Suite F
Newport News, VA 23606
Contact: Kristen Larcher
Phone: (757)337-6953

Church World Service
Director: **Susannah Lepley**
http://www.cwsglobal.org

Harrisonburg Office
250 East Elizabeth Street, Suite 215
Harrisonburg, VA 22802
Contact: Sarah Alice Coleman
Phone: (540) 433-7942

Winchester Office
2273 Valley Avenue
Winchester, VA 22601
Contact: Hamidullah Amiry
Phone: (540) 762-4414

Ethiopian Community Development Council
Director: **Sarah Zullo**
http://ecdcus.org

Arlington Office
901 South Highland Street
Arlington, VA 22204
Contact: Sarah Zullo
Phone: (703) 685-0510

International Rescue Committee
Director: **Harriet Kuhr**
www.rescue.org/charlottesville

Charlottesville Office
375 Greenbriar Dr.
Suite 200
Charlottesville, VA 22901
Contact: Kendall Repass
Phone: (434) 979-7772 x 105

Richmond Office
2004 Bremo Rd
Suite 200
Richmond, VA 23226
Contact: Justin Gandy
Phone: (804) 308-9144

Lutheran Social Services
Director: **Hameed Girowal**
http://www.lssnca.org/lss/wwd_refugee

Fairfax Office
3975 Fair Ridge Drive
Suite 100 North
Fairfax, VA 22033
Contact: Kimberly LeBlanc
Phone: (202)723-3000 ext 133

Woodbridge Office
3320 Noble Pond Way
Suite 202
Woodbridge, VA 22193
Contact: Salimah Shamsuddin
Phone: (571)233-1651

APPENDIX B

*LIST OF COUNTRIES WITH ENDEMIC RATES OF OTHER TREPONEMAL SUB-SPECIES

(SEE SYPHILIS SCREENING INSTRUCTIONS)

REGION	COUNTRY	
Africa	Angola Benin Burkina Faso Cameroon Central African Republic Chad Cote d'Ivoire Democratic Republic of the Congo Ethiopia Gabon Ghana	Liberia Mali Mauritania Niger Republic of the Congo Rwanda Senegal Somalia South Africa Sudan Togo
Americas	Colombia Ecuador Haiti Guyana Martinique Mexico Surinam Venezuela	
Asia	Cambodia India Indonesia Pakistan Sri Lanka	
Middle East	Saudi Arabia	
Western Pacific	Papua New Guinea Solomon Islands Vanuatu	

APPENDIX C

RECOMMENDED MEDICATION REGIMEN AND STANDARD DOSING FOR PRESUMPTIVE TREATMENT OF PARASITIC INFECTIONS[30]

Refugee Population	**Regimens by Pathogen**		
	Soil-transmitted helminths: **Albendazole[31]**	**Strongyloidiasis:** **Ivermectin[31]**	**Schistosomiasis[32]:** **Praziquantel[33]**
Adults			
Asia, Middle East, North Africa, Latin America, & Caribbean	400 mg orally for 1 day	Ivermectin, 200 mcg/kg/day orally once a day for 2 days	Not recommended
Sub-Saharan Africa, non *Loa loa*-endemic areas	400 mg orally for 1 day	Ivermectin, 200 mcg/kg/day once a day for 2 days	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance).
Sub-Saharan Africa, Loa loa endemic area	400 mg orally for 1 day	If Loa loa cannot be excluded, treatment may be deferred until after arrival in the United States -OR Albendazole 400 mg twice a day for 7 days	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance).
Pregnant Women			
Asia, Middle East, North Africa, Latin America, & Caribbean	Not recommended	Not recommended	Not applicable
Sub-Saharan Africa	Not recommended	Not recommended	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance).

[30] https://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf

[31] Although WHO states ivermectin and albendazole may be given concurrently, it is recommended that ivermectin be taken on an empty stomach and albendazole with fatty foods.

[32] All sub-Saharan African countries except Lesotho are considered endemic for schistosomiasis.

[33] Praziquantel, if not co-administered, should be administered at least one day prior to either ivermectin or albendazole. Praziquantel should be taken with liquids during a meal.

Refugee Population	Regimens by Pathogen		
	Soil-transmitted helminths: **Albendazole**[34]	**Strongyloidiasis:** **Ivermectin**[31]	**Schistosomiasis**[35]**:** **Praziquantel**[36]
Children			
Asia, Middle East, North Africa, Latin America, & Caribbean	12-23 months of age: 200 mg orally for 1 day. Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200 mcg/kg/day orally once a day for 2 days Should not be used presumptively if	Not applicable
Sub-Saharan Africa	12-23 months of age: 200 mg orally for 1 day. Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200 mcg/kg/day orally once a day for 2 days. Should not be used presumptively if	Children under < 4 years of age should not receive presumptive treatment with praziquantel. Only for children from sub-Saharan Africa

[34] Although WHO states ivermectin and albendazole may be given concurrently, it is recommended that ivermectin be taken on an empty stomach and albendazole with fatty foods.

[35] All sub-Saharan African countries except Lesotho are considered endemic for schistosomiasis.

[36] Praziquantel, if not co-administered, should be administered at least one day prior to either ivermectin or albendazole. Praziquantel should be taken with liquids during a meal.

APPENDIX D

PRAZIQUANTEL AND IVERMECTIN DOSING BASED ON WEIGHT AND TABLET SIZE FOR PREDEPARTURE PRESUMPTIVE TREATMENT OF US-BOUND REFUGEES[40]

Drug and Dosing	Weight (kg)
Praziquantel[37,38]	
Not recommended	Not recommended <15
1 tablet (600 mg)	15-18
1 ½ tablets (900 mg)	19-25
2 tablets (1200 mg)	26-30
2 ½ tablets (1500 mg)	31-40
3 tablets (1800mg)	41-50
Ivermectin[39]	
Not recommended	<15
1 tablet (3 mg)	15-24
2 tablets (6 mg)	25-35
3 tablets (9 mg)	36-50
4 tablets (12 mg)	51-65
5 tablets (15 mg)	66-79
200 mcg/kg	≥80

[37] Better tolerated if divided into two doses

[38] Using 600-mg praziquantel tablets

[39] Using 3-mg ivermectin tablets

[40] https://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf

APPENDIX E

LIST OF SUB-SAHARAN AFRICAN COUNTRIES

Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Comoros
Congo (Brazzaville)
Congo (Democratic Republic)
Côte d'Ivoire
Djibouti
Equatorial Guinea
Eritrea
Ethiopia
Gabon
The Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Réunion
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Somalia
South Africa
Sudan
Swaziland (Eswatini)
Tanzania
Togo
Uganda
Western Sahara
Zambia
Zimbabwe

APPENDIX F

DOSING OF ANTIMALARIALS FOR PRESUMPTIVE OR DIRECTED TREATMENT OF *P. FALCIPARUM* MALARIA IN SUB-SAHARAN AFRICAN REFUGEES AFTER ARRIVAL TO THE UNITED STATES.

Presumptive Therapies		
Medication	**Child Dosing** ***Children weighing 5 kg to ≤ 35kg***	**Adult Dosing** ***Persons weighing > 35kg***
Atovaquone-proguanil (Malarone™) (adult tablet = 250 mg atovaquone/100 mg proguanil) (pediatric tablet = 62.5 mg atovaquone/25 mg proguanil)	**5-8 kg:** Two pediatric tablets once a day for 3 days **9-10 kg:** Three pediatric tablets once a day for 3 days **11-20 kg:** One adult tablet once a day for 3 days **21-30 kg:** Two adult tablets once a day for 3 days **31-35 kg:** Three adult tablets once a day for 3 days	Four adult tablets once a day for 3 days
Artemether-lumefantrine (Coartem™) (20 mg artemether and 120 mg lumefantrine)	A six-dose regimen (given at 0, 8, 24, 36, 48, and 60 hours) is recommended with 1 to 3 tablets per dose, depending on body weight: **5 to < 15 kg:** One tablet, then one tablet after 8 hours, then one tablet twice daily (morning and evening) on each of the following 2 days (total course: 6 tablets) **15 to < 25 kg:** Two tablets as a single dose, then two tablets after 8 hours, then two tablets twice daily (morning and evening) on each of the following 2 days (total course: 12 tablets) **25 to < 35 kg:** Three tablets as a single dose, then three tablets after 8 hours, then three tablets twice daily (morning and evening) on each of the following 2 days (total course: 18 tablets)*	A standard 3-day treatment schedule with a total of 6 doses (total course: 24 tablets). Initial dose consists of four tablets, after 8 hours four more tablets (dose 2). Then four tablets twice daily (morning and evening) for the following 2 days.*

*Should be taken with foods rich in fat, such as milk. If vomiting occurs within 1 hour after taking the medicine, another dose should be taken.

NOTE: More speciic guidance, including information on directed therapy alternatives and how to access CDC's Malaria Hotline for clinical consultation, can be found at the CDC Malaria website[41].

[41] https://www.cdc.gov/malaria/diagnosis_treatment/index.html

APPENDIX G

WRITTEN REFERRAL TEMPLATE

Insert Letterhead

Date_____

To: Refugee Caseworker

Re:

Place Patient Label here

Your client, named above, is in need of medical follow up for the following condition(s).

- □ Hypertension
- □ Eye Exam
- □ Dental Evaluation
- □ Chest X-ray □ Voucher Given
- □ Other Medical Condition _____

_____

_____

Patient's next immunizations due on or after: _____

- □ Appointment Made Appointment Date and Time:_____
- □ Call for appointment (Number to call)

Please let me know if you have questions, or if I can be of further assistance. I can be reached Monday through Friday from XX a.m. until XX p.m. at (xxx) xxx-xxxx.

Sincerely,

Name

Refugee Health Program Coordinator

PAPERWORK FLOW OF OVERSEAS MEDICAL EXAMS

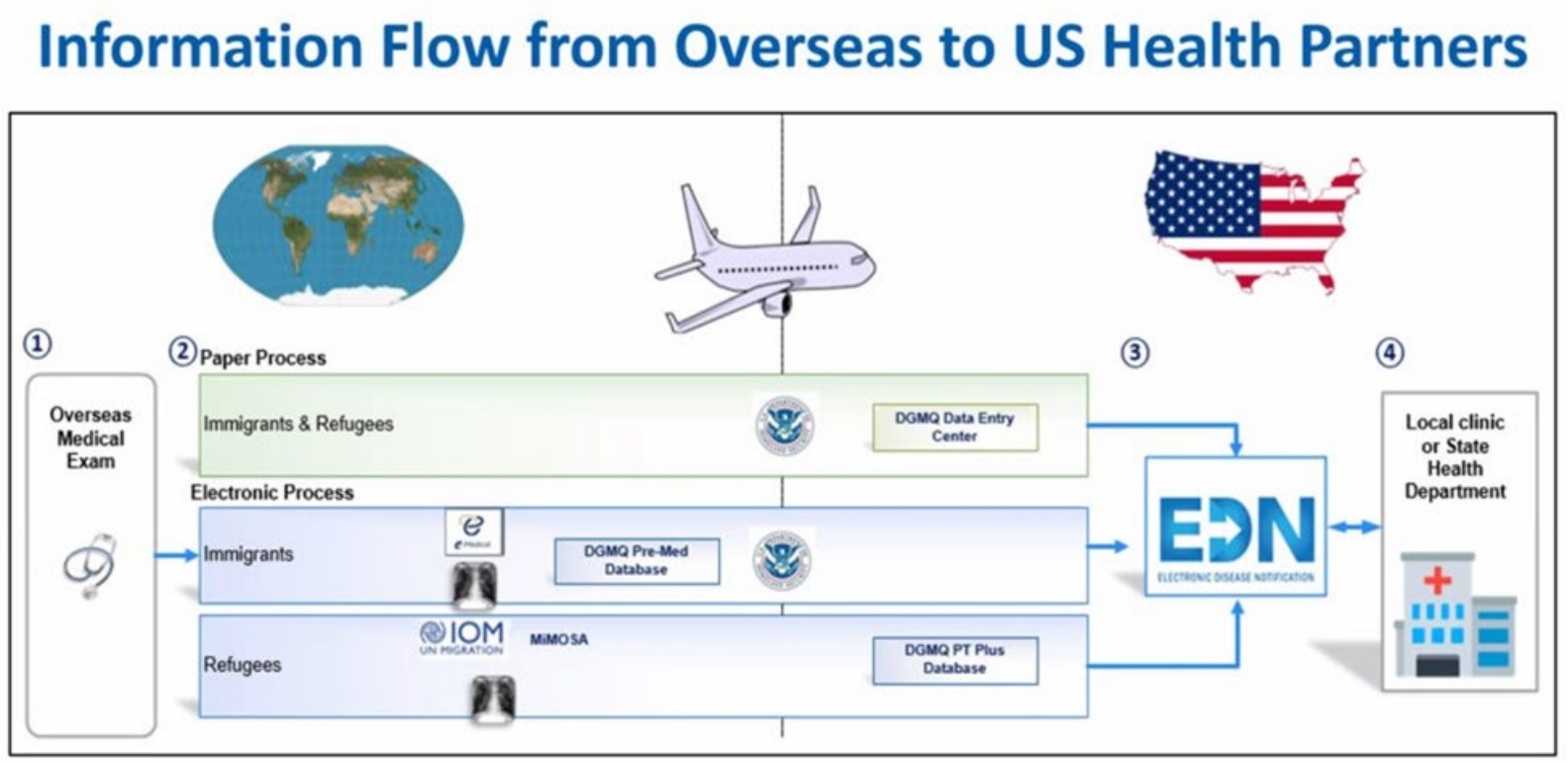

Figure 1

PAPERWORK AND APPOINTMENT REFERRAL FLOW

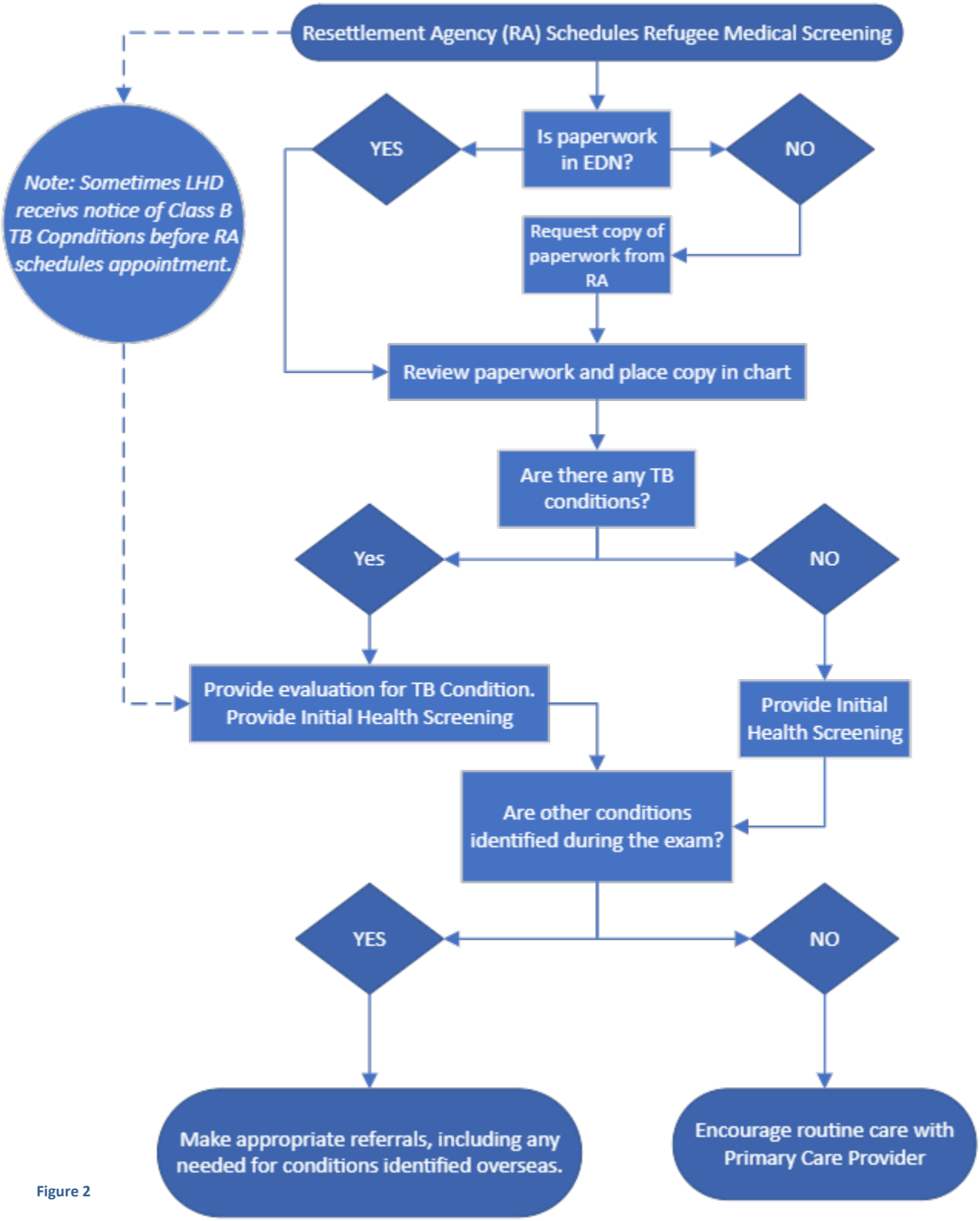

Figure 2

RESOURCES

Centers for Disease Control and Prevention Immigrant and Refugee Health
https://www.cdc.gov/immigrantrefugeehealth/index.html

Refugee Health Profiles https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html

VDH Newcomer Health Program - http://www.vdh.virginia.gov/tuberculosis-and-newcomer-health/newcomer-health-program/

DSS Office of New Americans - http://www.dss.virginia.gov/family/ons/index.cgi

Office of Refugee Resettlement - https://www.acf.hhs.gov/orr

Switchboard www.SwitchboardTA.org

CORE https://coresourceexchange.org/

FORMS

Please go to the Newcomer Health Website[42] to print the most up to date forms.

[42] https://www.vdh.virginia.gov/newcomer-health/services-and-resources-for-health-providers/

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