Refugee Health Program Guidelines

Effective October 2021
FFY 2021–2022

Florida HEALTH

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Refugee Health Program Contact Information

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SHAREPOINT TABLE OF CONTENTS

Link to RHP SharePoint:

floridahealth.sharepoint.com/sites/DISEASECONTROL/EPI/Pages/Refugee-Health.aspx

ACRONYMS

Acronym	What It Stands For
ACIP	**Advisory Committee on Immunization Practices**
AoS	**Adjustment of Status**
ARHC	**Association of Refugee Health Coordinators**
CDC	**Centers for Disease Control and Prevention**
CHD	**County Health Department**
COVID-19	**Coronavirus Disease 2019**
DCF	**Florida Department of Children and Families**
DGMQ	**CDC, Division of Global Migration and Quarantine**
DOH	**Florida Department of Health**
EDN	**Electronic Disease Notification System**
FGM/C	**Female Genital Mutilation and Cutting**
Florida SHOTS	**Florida State Health Online Tracking System**
HHS	**Department of Health and Human Services**
HIPAA	**Health Insurance Portability and Accountability Act**
HMS	**Health Management System**
IGRA	**Interferon-Gamma Release Assay**
INA	**Immigration and Nationality Act**
IOM	**International Organization for Migration**
LLS	**Language Line Solutions**
LPR	**Lawful Permanent Resident**
NGO	**Non-Governmental Organization**
OBRM	**Office of Budget and Revenue Management**
ORR	**Office of Refugee Resettlement**
OVME	**Overseas Visa Medical Examination**
PRM	**Bureau of Population, Refugees, and Migration**
QS	**Quarantine Station**
RHP	**Refugee Health Program**
RMA	**Refugee Medical Assistance**
R&P	**Reception and Placement**
RPC	**Refugee Processing Center**
SAMS	**Secure Access Management Services**
SDN	**Secure Data Network**
SIV	**Special Immigrant Visa**
SQ/SI	**Afghanistan Parolees**
STD	**Sexually Transmitted Disease**
TB	**Tuberculosis**
TST	**Tuberculin Skin Test**
TVPA	**Trafficking Victims Protection Act of 2000**
UNHCR	**United Nations High Commissioner for Refugees**
USCIS	**United States Citizenship & Immigration Services**
USDOS	**United States Department of State**
VOT	**Victim of Trafficking**
WHO	**World Health Organization**

ESTABLISHMENT OF THE U.S. REFUGEE RESETTLEMENT PROGRAM

The federal Refugee Resettlement Program was created by the Refugee Act of 1980 (and expanded by the Refugee Education Assistance Act of 1980) to provide for the effective resettlement of refugees and to assist them in quickly becoming economically self-sufficient after their arrival to the U.S. The Act established the Office of Refugee Resettlement (ORR), which funds and administers federal refugee resettlement programs and services.

TITLE 8--ALIENS AND NATIONALITY, CHAPTER 12--IMMIGRATION AND NATIONALITY, SUBCHAPTER IV--REFUGEE ASSISTANCE

Sec. 1521. Office of Refugee Resettlement; establishment; appointment of Director; functions

(a)There is established, within the Department of Health and Human Services, an office to be known as the Office of Refugee Resettlement (hereinafter in this subchapter referred to as the "Office''). The head of the Office shall be a Director (hereinafter in this subchapter referred to as the "Director''), to be appointed by the Secretary of Health and Human Services (hereinafter in this subchapter referred to as the "Secretary").

(b)The function of the Office and its director is to fund and administer (directly or through arrangements with other federal agencies), in consultation with the Secretary of State, programs of the Federal Government under this subchapter. [CITE: 8USC1521]

Refugee resettlement is a public/private partnership in the U.S. federal and state agencies work with non-governmental organizations (NGOs) to provide effective and coordinated resettlement and integration services to refugees. There are nine national resettlement agencies that assist with these efforts. For more information, visit unhcr.org/en-us/us-resettlement-partners.html.

Federal Agency Involvement in the Refugee Resettlement Process

Federal Agency	Role in Refugee Resettlement
U.S. Citizenship and Immigration Services (USCIS)	Determines which applicants qualify for refugee status and are eligible for admission to the U. S
U.S. Department of State (USDOS), Bureau of Population, Refugees, and Migration (PRM)	Coordinates resettlement policy Manages overseas processing, cultural orientation, transportation to the U.S., and provides funds to private, non-profit NGOs for initial reception and placement (R&P) activities for newly arrived refugees
Department of Health and Human Services (HHS), Office of Refugee Resettlement	Responsible for the domestic program of refugee resettlement services which includes cash and medical assistance Provides funding for refugee services programs through state governments and NGOs
Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ)	Provides guidelines for medical screening and treatment in the U.S. and overseas

ROLE OF THE RESETTLEMENT AGENCIES

Resettlement agencies, such as Catholic Charities and Lutheran Social Services, receive funding from USDOS and ORR to assist individuals given refugee status with resettlement and integration in the U.S. Resettlement agencies work with these individuals to obtain their refugee health services and subsequent health care visits. Most resettlement agencies only serve refugees for 30 days from their arrival date. In some cases, other populations eligible for refugee benefits, such as Afghan and Iraqi Special Immigrant Visas or asylee derivatives, may receive assistance from refugee resettlement agencies.

Although all refugees are sponsored by resettlement agencies, other arrivals eligible for refugee benefits (for example, asylees, parolees) may not be sponsored by a resettlement agency.

While many Cuban arrivals are not sponsored by a resettlement agency, many attend the Parolee Orientation Program shortly after arrival in Miami and assistance is provided with obtaining resettlement needs and benefits.

ELIGIBLE POPULATIONS FOR REFUGEE BENEFITS

The following groups are eligible for refugee programs and benefits—refugees, asylees, Cuban/Haitian asylum applicants, Cuban/Haitian entrants, Amerasians, Afghan and Iraqi Special Immigrants, and certain victims of severe forms of human trafficking.

TITLE 45—PUBLIC WELFARE, CHAPTER IV—OFFICE OF REFUGEE RESETTLEMENT, ADMINISTRATION FOR CHILDREN AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 400—REFUGEE RESETTLEMENT PROGRAM—Table of Contents, Subpart D—Immigration Status and Identification of Refugees

Sec. 400.43 Requirements for documentation of refugee status.

An applicant for assistance under Title IV of the Immigration and Nationality Act (INA) must provide proof, in the form of documentation issued by United States Citizenship and Immigration Services (USCIS), of one of the following statuses under the INA as a condition of eligibility:

- Paroled as a refugee or asylee under section 212(d)(5) of the INA
- Admitted as a refugee under section 207 of the INA
- Granted asylum under section 208 of the INA
- Cuban and Haitian entrants, in accordance with requirements in 45 CFR part 401
- Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts, 1989 [Public Law 100-461 as amended])

[CITE: 51 FR 3915, Jan. 30, 1986, as amended at 65 FR 15443, Mar. 22, 2000]

Additional Immigration Statuses Eligible for Refugee Benefits

- Afghan and Iraqi Special Immigrants under section 101(a)(27) of the INA

- Afghan Individuals Due to Urgent Evacuation and Resettlement

- Certain victims of severe forms of human trafficking under the Trafficking Victims Protection Act of 2000 (TVPA)

NOTE: The term "refugee" is used in this document, unless otherwise noted, to encompass all categories of individuals who are eligible to participate in the refugee program.

Refugees

Thousands of refugees have made Florida their home after fleeing persecution, threats, or repression in their homelands. The resettlement process is often a long and arduous one. Extensive efforts are made to help a refugee return to his or her country of origin or to settle permanently in the country of asylum, but sometimes resettlement in a third country is necessary. The U.S. is 1 of 81 countries having organized refugee resettlement programs. The other countries are Australia, Canada, Denmark, Finland, Japan, the Netherlands, New Zealand, Norway, Sweden, and Switzerland.[1]

> Definition of a refugee: someone who has fled his/her country of origin due to a well-founded fear of persecution for reasons of race, religion, nationality, social group, or political opinion.

The U.S. refugee resettlement program prioritizes refugee applications using a three-tiered process to establish case priority.[2] Priority One cases are those referred by the United Nations High Commissioner for Refugees (UNHCR) or U.S. Embassies. Priority Two is used for USDOS-identified groups of concern. Priority Three is reserved for close family members (spouses, unmarried children, and parents) of persons who have become permanent U.S. residents.

A USCIS officer will interview priority case applicants and approve or deny the refugee resettlement application. Upon approval, the refugee is matched with an American resettlement agency by the Refugee Processing Center (RPC) in Arlington, Virginia. The refugee must go through medical clearance, security clearance, and cultural orientation prior to entering the U.S. The resettlement agencies must also provide an assurance letter to the USDOS "assuring" it is prepared to receive the refugee. This entire pre-travel process may take up to two years to complete.

The International Organization for Migration (IOM) usually arranges air travel to the U.S. for refugees, in coordination with the USDOS. Prior to leaving the country of asylum, the refugee signs a promissory note agreeing to repay the travel costs incurred by the U.S. government. The IOM sends a detailed itinerary to the resettlement agency. The resettlement agency will make arrangements to assist the refugee upon arrival at the airport and to help them adjust to their

new life in the U.S.[3] Refugees must apply for lawful permanent resident (LPR) status after one year in the U.S.[4]

Asylees

Asylum status is very similar to refugee status, except the person applies for resettlement from within the U.S. or at one of the ports of entry (U.S. border, airport, or seaport). Asylees must meet the legal definition of a refugee. USCIS asylum officers either grant asylum based on the initial interview with the asylum seeker or refer the applicants whose cases are not granted to immigration judges who adjudicate their claims.[5]

Derivative asylees are individuals who come to the U.S. to join a family member who has previously received asylum and enter the U.S. under section 208C of the INA. All asylees are eligible for the same benefits as refugees.

[1] Source: U.S. Committee for Refugees and Immigrants website, http://refugees.org/explore-the-issues/our- work-with-refugees/refugeeresettlementprocess/, last accessed 9/13/2016.
[2] Source: Refugee Council USA website, www.rcusa.org/eligibility/, last accessed 9/13/2016.
[3] Source: U.S. Committee for Refugees and Immigrants website, www.rcusa.org/resettlement-process-eligibility/, last accessed 9/13/2016.
[4] Source: U.S. Department of Homeland Security, U.S. Citizenship and Immigration Services website, www.uscis.gov/green-card/green-card-through-refugee-or-asylee-status/green-card-refugee, last accessed 9/13/2016.
[5] Source: U.S. Citizenship and Immigration Services website, www.uscis.gov/humanitarian/refugees-asylum/asylum/obtaining-asylum-united-states, last accessed 9/13/2016.

Cuban/Haitian Entrants

ORR-funded refugee assistance was extended to Cuban and Haitian nationals who do not qualify as refugees or asylees under Title 45 of the Code of Federal Regulations. Eligible individuals, as defined by the Refugee Education Assistance Act of 1980, include parolees[6], asylum applicants, and others who have not yet received a final non-appealable and legally enforceable order of deportation or removal.

> **TITLE 45—PUBLIC WELFARE CHAPTER IV—OFFICE OF REFUGEE RESETTLEMENT, ADMINISTRATION FOR CHILDREN AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES**
>
> PART 401—CUBAN/HAITIAN ENTRANT PROGRAM—Table of Contents
>
> Sec. 401.12 Cuban and Haitian entrant cash and medical assistance
>
> Except as may be otherwise provided in this section, cash and medical assistance shall be provided to Cuban and Haitian entrants by the same agencies, under the same conditions, and to the same extent as such assistance is provided to refugees under Part 400 of this title.

[CITE: 45CFR401.12]

Any individual granted parole status as a Cuban/Haitian Entrant (status pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are being provided, are eligible for services.

U.S.-Cuba Compromise: Migration Accord of 1994

In 1994, the U.S. and Cuba entered into a migration agreement in which 20,000 Cubans are admitted to the U.S. each year. Under the Accord, Cuba agreed to try to prevent its citizens from leaving by boat or raft and formally agreed not to punish Cubans who are interdicted by the US Coast Guard. Migration Accord entrants come to the U.S. through the refugee admissions program, with immigrant visas, as parolees, or through a special lottery. The special lottery system provides a mechanism by which persons who do not qualify as refugees or immigrants may seek to enter the U.S.[7] Due to the number of applicants remaining in the 1998 lottery queue, the U.S. Interests Section in Havana is not currently accepting entries to the Cuban lottery.

Amerasians

Certain Amerasians from Vietnam who are admitted to the U.S. as immigrants are also eligible to receive ORR assistance and services.[8] An Amerasian is a child born in Vietnam between January 1, 1962, and before January 1, 1976, who was fathered by an American citizen. A spouse, child, parent, or guardian accompanying or following an Amerasian may be eligible under this program.

[6] Certain individuals are granted "parole" under section 212(d) (5) of the INA, as amended. Parolees are granted temporary entry into the U.S. "on a case-by-case basis for urgent humanitarian reasons or significant public benefit." (INS, *Report to Congress: Use of the Attorney General's Parole Authority Under the Immigration and Nationality Act Fiscal Years 1997—1998)*.

[7] This special lottery system is unique to Cuba and separate from the worldwide diversity visa lottery for which Cubans are also eligible. (http://havana.usembassy.gov/diversity_program.html), last accessed 9/13/2016.

[8] Pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988.

Afghan and Iraqi Special Immigrant Visas (SIV)

Special immigrant status is available under section 1059 of the National Defense Authorization Act for FY 2006 to Afghan and Iraqi nationals who worked directly for the United States Armed Forces, or under the authority of the Chief of Mission, as a translator or interpreter, and to their spouses and children. Once admitted to the U.S. as permanent residents, these individuals and their families may eventually acquire U.S. citizenship.

Afghan Individuals Due to Urgent Evacuation and Resettlement:

Effective September 30, 2021, the Afghanistan Supplemental Appropriations Act, 2022, authorized citizens or nationals of Afghanistan paroled into the U.S. between July 31, 2021 and September 30, 2022. Additionally, a spouse or child of any Afghan humanitarian parolee described above who is paroled into the U.S. after September 30, 2022. Refer to ORR-PL-22-02, released on 10/14/2021, for additional information.

- Afghan individuals who receive Special Immigrant (SI/SQ) Parole
- Afghan individuals who receive SI Conditional Permanent Residence
- Afghan humanitarian parolees who are admitted to the U.S. due to urgent humanitarian reasons or significant public benefit

Victims of Trafficking (VOT)

The Trafficking Victims Protection Act of 2000 is a federal law that makes adult VOT, who have been certified by HHS, eligible for benefits and services to the same extent as refugees. VOTs who are under 18 years of age are also eligible for benefits to the same extent as refugees but do not need to receive certification from HHS. VOT eligibility for refugee services begins on the date of the certification or eligibility from ORR.

Severe forms of trafficking in persons means:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such an act has not attained 18 years of age.
- 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.

See the Human Trafficking Section on page 64 for additional information and resources.

ELIGIBILITY DETERMINATION ASSISTANCE

The Refugee Health Program (RHP) follows the eligibility guidelines set forth by Department of Children and Families (DCF) Refugee Services in the *Refugee Program Eligibility Guide for Service Providers*. The manual should be used when attempting to determine eligibility for services and for eligibility inquiries.

The manual is available online at
myflfamilies.com/service-programs/refugee-services/webguides/masterguide.pdf

ELIGIBILITY DETERMINATION DOCUMENTATION

Documentation proving eligibility for refugee health services must be maintained in the client record. These documents must include the alien number, immigration status and arrival date of the client. A picture ID should also be retained in the file.

ORR Statuses and Documentation Requirements:

ORR's policy guidance and documentation requirements for eligibility for refugees should be reviewed by all RHP clinical staff.

acf.hhs.gov/orr/policy-guidance/status-and-documentation-requirements-orr-refugee-resettlement-program

Executive Office for Immigration Review (EOIR):

EOIR provides an automated electronic case portal and an information portal to check on the status of cases with the United States Immigration Court.

portal.eoir.justice.gov/InfoSystem/Form?Language=EN

EOIR also provides an automated toll-free case information telephone hotline at
800-898-7180.

REFUGEE HEALTH ELIGIBILITY TRAINING

This presentation provides information on different immigration documents and how to use them to determine client eligibility.

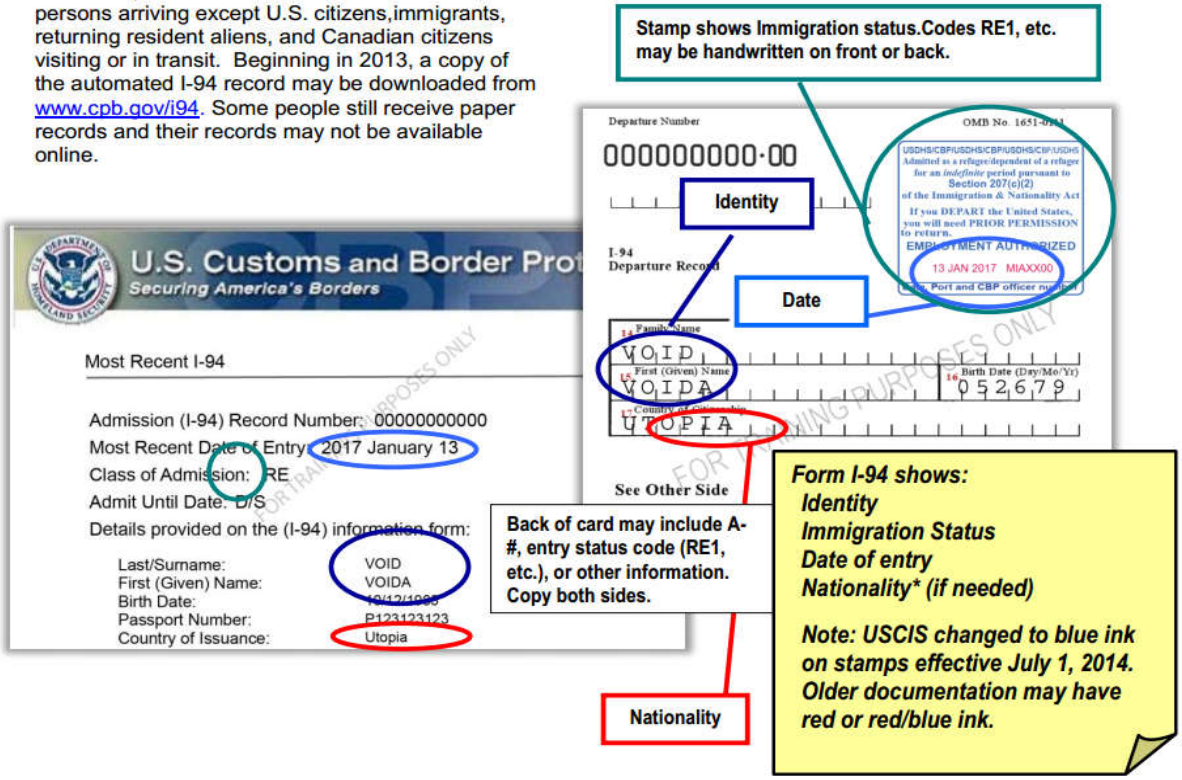
register.gotowebinar.com/recording/3904167179204900355

CHDs are encouraged to review the DCF presentation posted on SharePoint. There are two versions—one with the presentation and the second with the presentation and speaker notes.

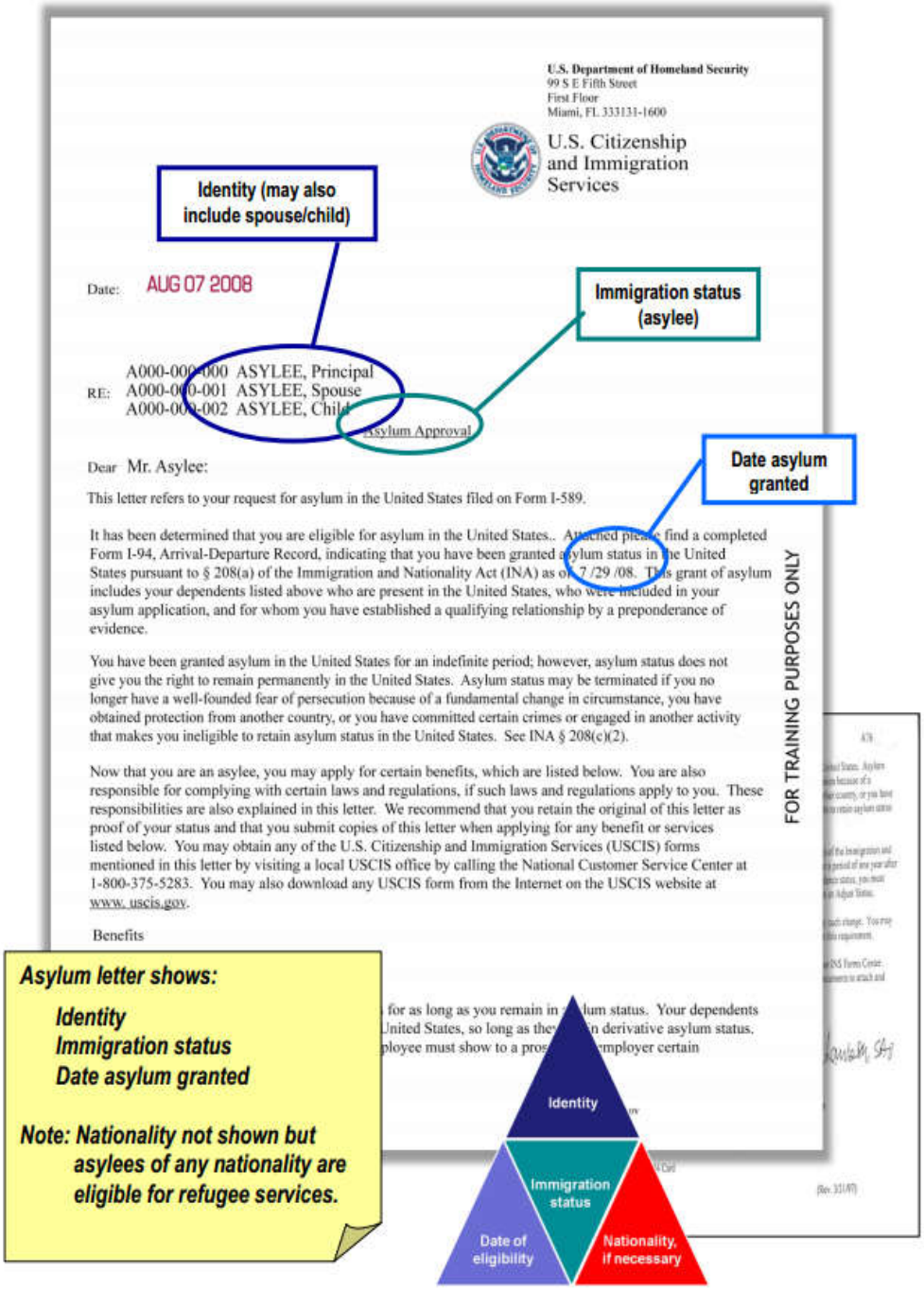
ACCEPTABLE FORMS OF ELIGIBILITY BY I-94 STATUS

Refugee Eligibility Documentation

An immigration inspector at a Port of Entry issues **Form I-94, ARRIVAL/DEPARTURERECORD**, to all persons arriving except U.S. citizens,immigrants, returning resident aliens, and Canadian citizens visiting or in transit. Beginning in 2013, a copy of the automated I-94 record may be downloaded from www.cpb.gov/i94. Some people still receive paper records and their records may not be available online.

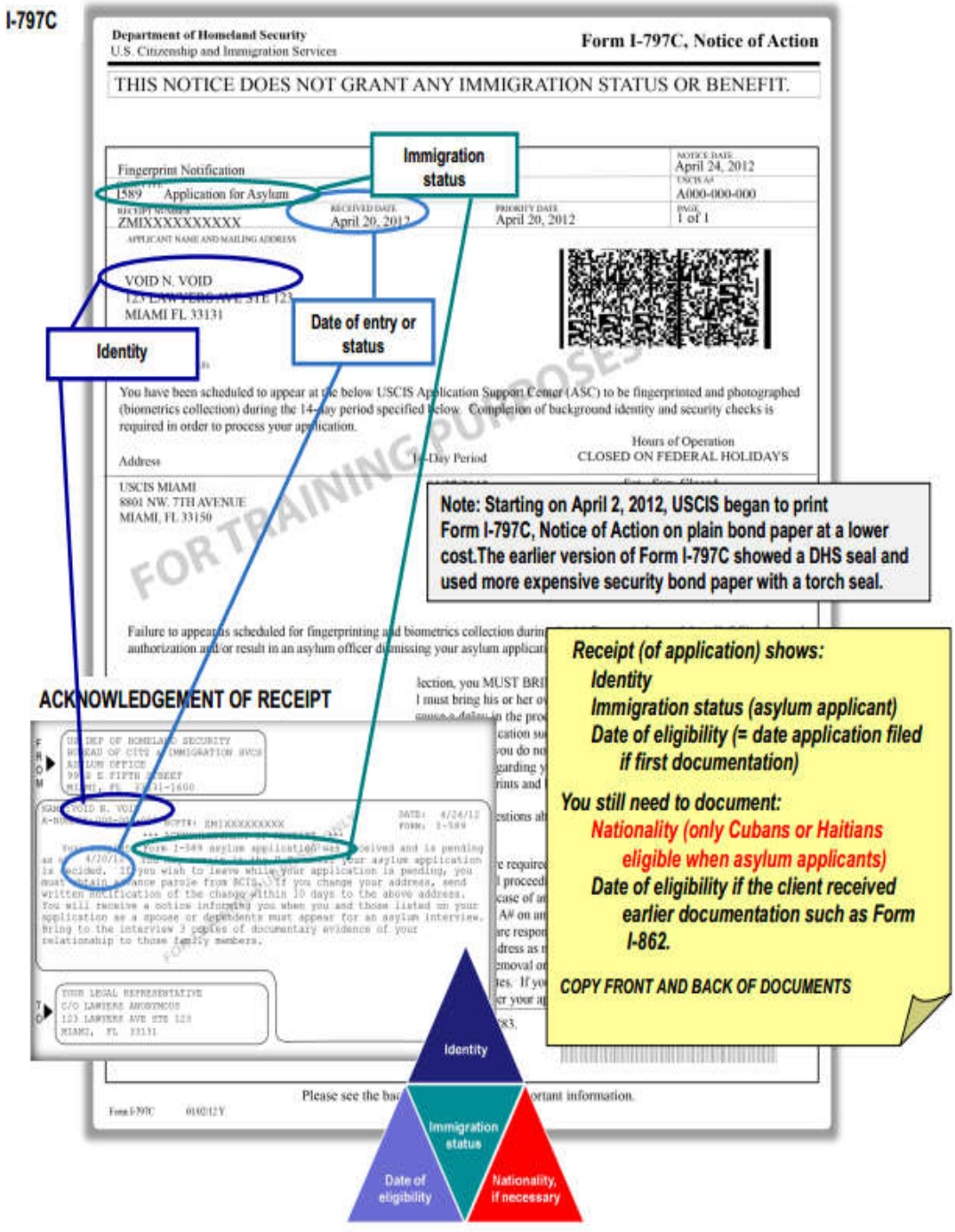


Asylee Eligibility Documentation



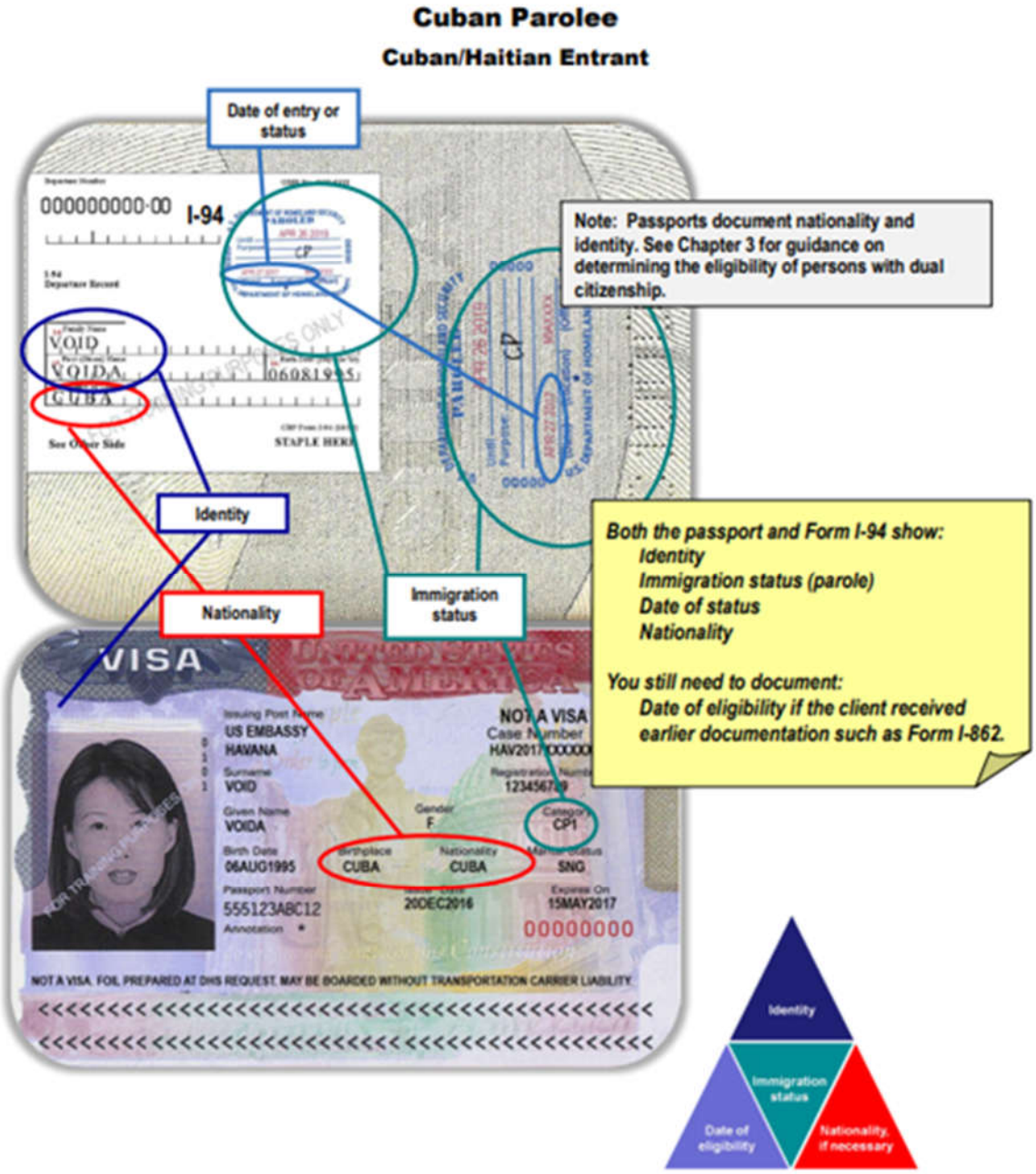
The date in which asylum was granted should be replaced in HMS by removing the old arrival date and replacing with the new date (Asylum Granted Date).

Asylee Eligibility Documentation



This document shows that a client has applied for asylum and is awaiting approval.

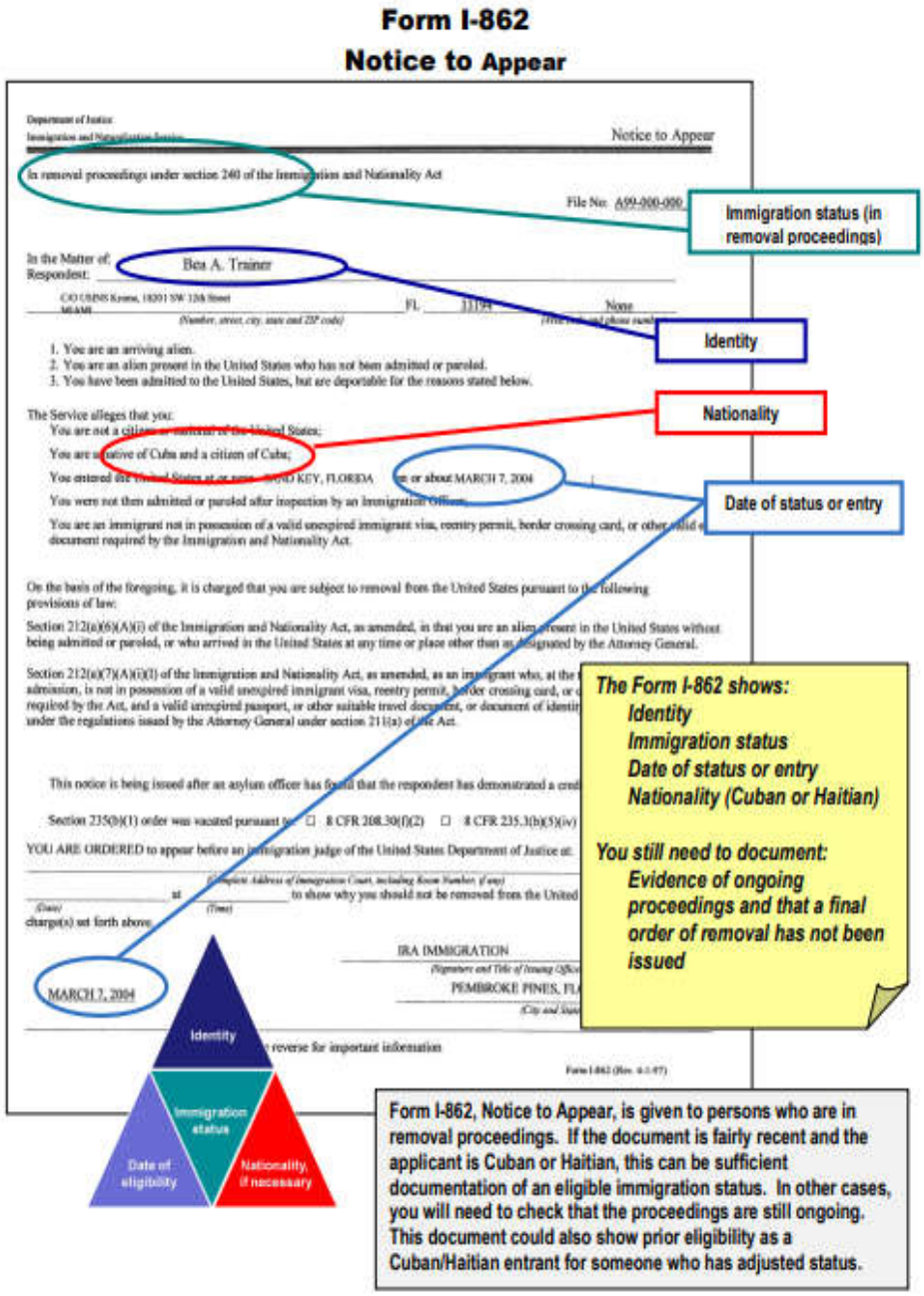
Parolee Eligibility Documentation



This documentation shows proof of the client's identity, immigration status, date of entry and nationality.

You may frequently see this document for clients who walk into the county health department.

Parolee Eligibility Documentation (Notice to Appear)—Cuban/Haitian Clients Only



Parolee Eligibility Documentation (Notice to Appear)—Cuban/Haitian Clients Only

U.S. Department of Homeland Security
Immigration and Customs Enforcement — New Court Location

Date: June 21, 2019

To: [redacted] File No: [redacted]

From: Immigration and Customs Enforcement
Enforcement and Removal Operations
126 Northpoint Drive
Houston, TX 77060

This notice is to advise you that the Notice to Appear, I-862, issued to you on April 23, 2019 at Livingston, TX has been filed with the Office of the Immigration Judge at Houston, TX. The mailing address for the Office of the Immigration Judge is:

1801 Smith Street, Suite 900
Houston, TX 77002

You should direct all correspondence concerning your case to this address. You are reminded that you are required to provide written notice within five (5) days of any changes in address or telephone number to the Office of the Immigration Judge listed in this notice.

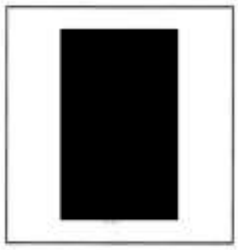
[redacted]

[redacted]

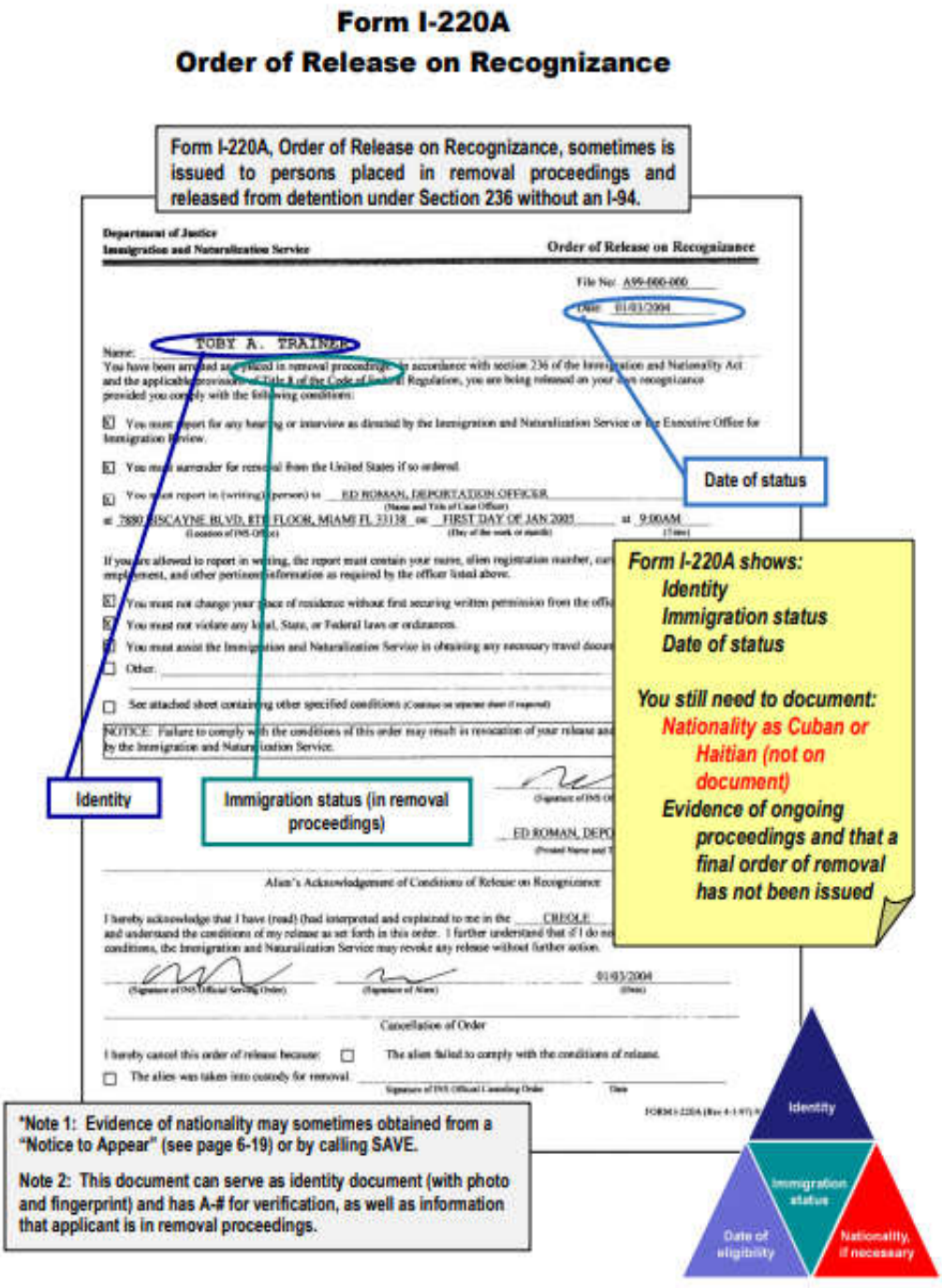
X
Respondent's Signature

Deportation Officer
Title

Respondent's Right Index Fingerprint

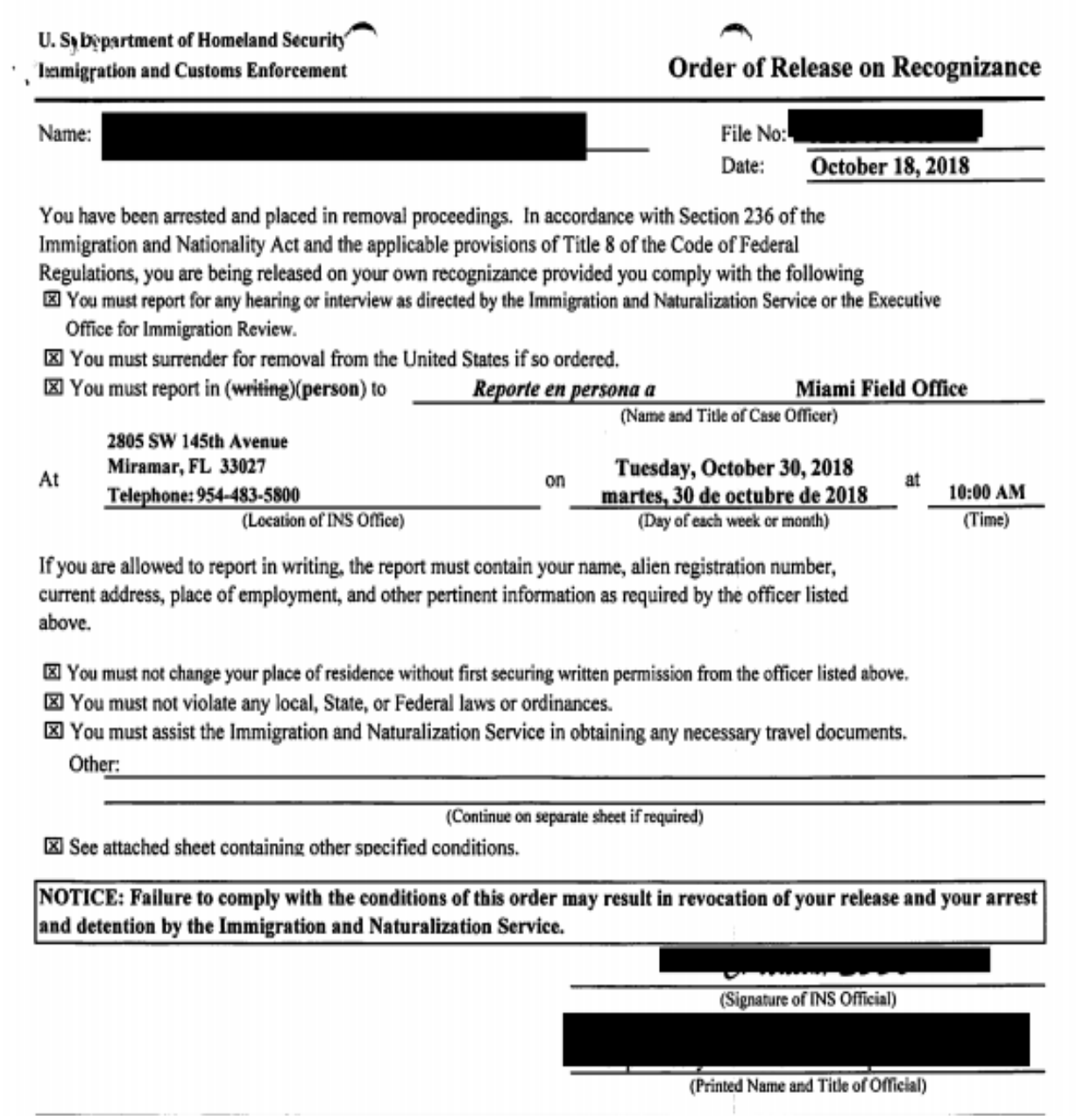


Parolee Eligibility Documentation (Order of Release)—Cuban/Haitian Clients Only



Form I-220A, Order of Release on Recognizance, sometimes is issued to persons placed in removal proceedings and released from detention under Section 236 without an I-94.

Parolee Eligibility Documentation (Order of Release)—Cuban/Haitian Clients Only



U. S. Department of Homeland Security
Immigration and Customs Enforcement

Order of Release on Recognizance

Name: [redacted]

File No: [redacted]

Date: **October 18, 2018**

You have been arrested and placed in removal proceedings. In accordance with Section 236 of the Immigration and Nationality Act and the applicable provisions of Title 8 of the Code of Federal Regulations, you are being released on your own recognizance provided you comply with the following

☒ You must report for any hearing or interview as directed by the Immigration and Naturalization Service or the Executive Office for Immigration Review.

☒ You must surrender for removal from the United States if so ordered.

☒ You must report in (~~writing~~)(**person**) to ***Reporte en persona a*** **Miami Field Office**
(Name and Title of Case Officer)

At **2805 SW 145th Avenue, Miramar, FL 33027, Telephone: 954-483-5800** (Location of INS Office) on **Tuesday, October 30, 2018 martes, 30 de octubre de 2018** (Day of each week or month) at **10:00 AM** (Time)

If you are allowed to report in writing, the report must contain your name, alien registration number, current address, place of employment, and other pertinent information as required by the officer listed above.

☒ You must not change your place of residence without first securing written permission from the officer listed above.

☒ You must not violate any local, State, or Federal laws or ordinances.

☒ You must assist the Immigration and Naturalization Service in obtaining any necessary travel documents.

Other:

(Continue on separate sheet if required)

☒ See attached sheet containing other specified conditions.

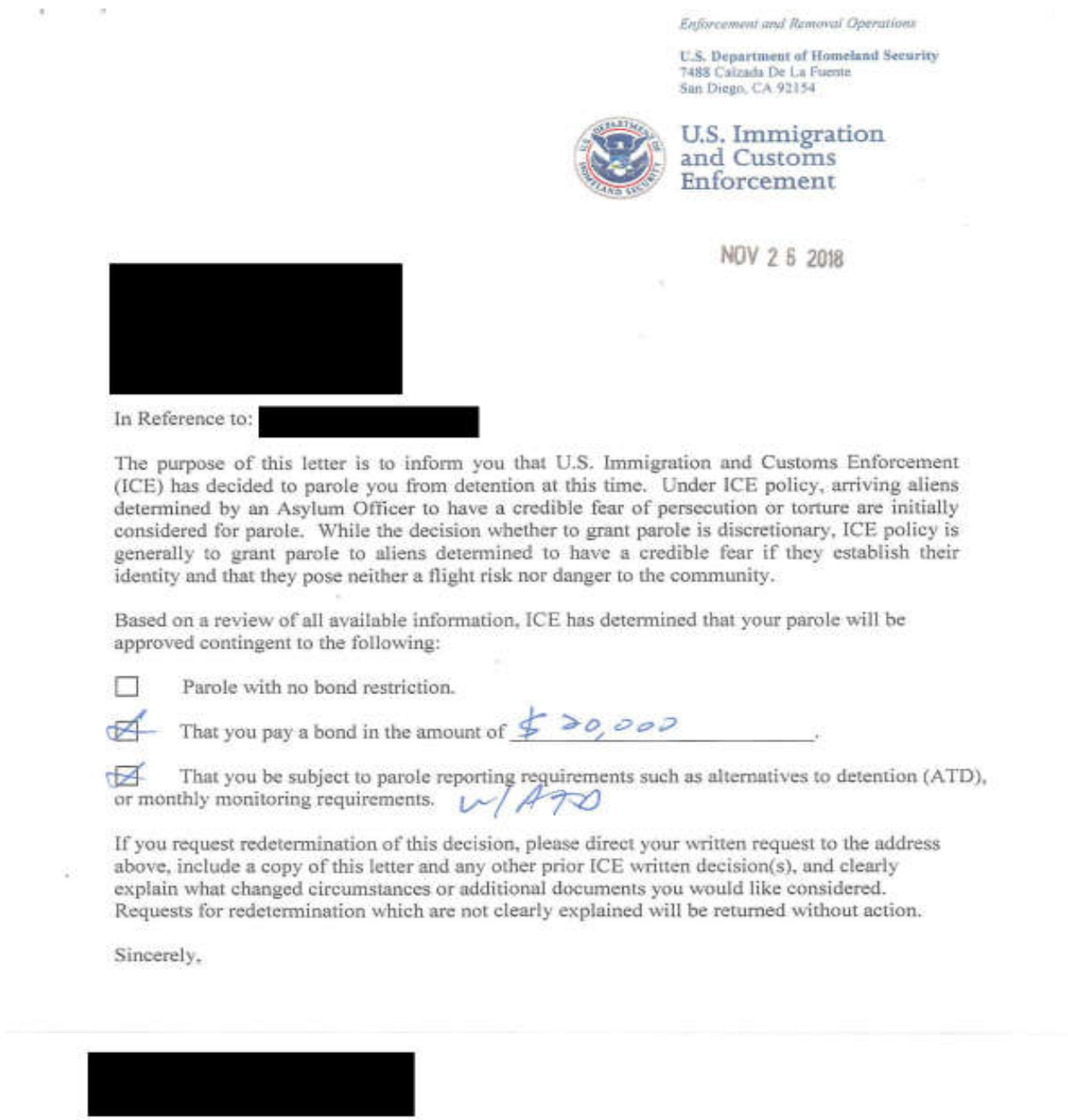
NOTICE: Failure to comply with the conditions of this order may result in revocation of your release and your arrest and detention by the Immigration and Naturalization Service.

[redacted]
(Signature of INS Official)

[redacted]
(Printed Name and Title of Official)

Form I-220A, Order of Release on Recognizance, sometimes is issued to persons placed in removal proceedings and released from detention under Section 236 without an I-94.

Parolee Eligibility Documentation (Order of Release)—Cuban/Haitian Clients Only



Enforcement and Removal Operations

U.S. Department of Homeland Security
7488 Calzada De La Fuente
San Diego, CA 92154

U.S. Immigration and Customs Enforcement

NOV 2 6 2018

[redacted]

In Reference to: [redacted]

The purpose of this letter is to inform you that U.S. Immigration and Customs Enforcement (ICE) has decided to parole you from detention at this time. Under ICE policy, arriving aliens determined by an Asylum Officer to have a credible fear of persecution or torture are initially considered for parole. While the decision whether to grant parole is discretionary, ICE policy is generally to grant parole to aliens determined to have a credible fear if they establish their identity and that they pose neither a flight risk nor danger to the community.

Based on a review of all available information, ICE has determined that your parole will be approved contingent to the following:

☐ Parole with no bond restriction.

☒ That you pay a bond in the amount of $ 20,000.

☒ That you be subject to parole reporting requirements such as alternatives to detention (ATD), or monthly monitoring requirements. w/ATD

If you request redetermination of this decision, please direct your written request to the address above, include a copy of this letter and any other prior ICE written decision(s), and clearly explain what changed circumstances or additional documents you would like considered. Requests for redetermination which are not clearly explained will be returned without action.

Sincerely,

[redacted]

Form I-220A, Order of Release on Recognizance, sometimes is issued to persons placed in removal proceedings and released from detention under Section 236 without an I-94.

Parolee Eligibility Documentation (Order of Release)—Cuban/Haitian Clients Only

IMMIGRATION BOND OMB No. 1653-0022; Expires 08/31/2017

Power of Attorney Number
(Bonded Alien) File No. [redacted]
Bond Receipt No.

A.
Name of Obligor: [redacted]
Street Address of Obligor: [redacted]
City, State and Zip Code: [redacted]
Telephone: [redacted] Name of Agent/Co-Obligor (if any-Surety Bonds only):
Address (if different from that of Obligor):
Telephone: Address to use for notice purposes: ☒ Obligor ☐ Agent ☐ Both
If this is executed by a surety company the rate of premium is: ____% and the amount of premium is:
The name and address of the person who executed a written instrument with the surety company requesting it to post bond is:

B. Information about alien for whom bond is furnished:
Name: [redacted]
Current Location (i.e., where detained): [redacted]
Date and country of birth: [redacted] / CUBA Nationality: CUBA
Date, port and means of arrival in the United States: 05/03/2019 / PASO DEL NORTE, TX, BRIDGE
Alien to reside at: [redacted]
Telephone number at alien's residence: [redacted]

C. In consideration of the facts recited in paragraph or paragraphs herein numbered [redacted] and captioned [redacted] BOND CONDITIONED UPON THE DELIVERY OF AN ALIEN. (and in any rider or riders lettered and captioned , the above named obligor and the agent acting on its behalf (if any), by subscribing hereto, hereby declare that they are firmly bound unto the United States in the sum of Two Thousand Five Hundred dollars ($ 2500.00) unless the guarantee of the bond is that the alien shall not become a public charge, the obligor, and the agent acting on its behalf (if any), declare themselves bound in such amount or successive amounts as are prescribed in paragraph (G-2) herein as liquidated damages and not as penalty, which sum is to be paid to the United States immediately upon failure to comply with the terms set forth in any such paragraph or rider. The obligor and agent further agree that any notice to him/her in connection with this bond may be accomplished by mail, directed to him/her at the above address. The obligor acknowledges receipt of a copy of the executed bond and any attached rider or riders specified above.

Form I-220A, Order of Release on Recognizance, sometimes is issued to persons placed in removal proceedings and released from detention under Section 236 without an I-94.

Victims of Trafficking

The US Health and Human Services (HHS), Office of Trafficking in Persons has upgraded their notification system that issues HHS Certification, Eligibility, and Interim Assistance Letters to all Refugee Health Programs in the nation.

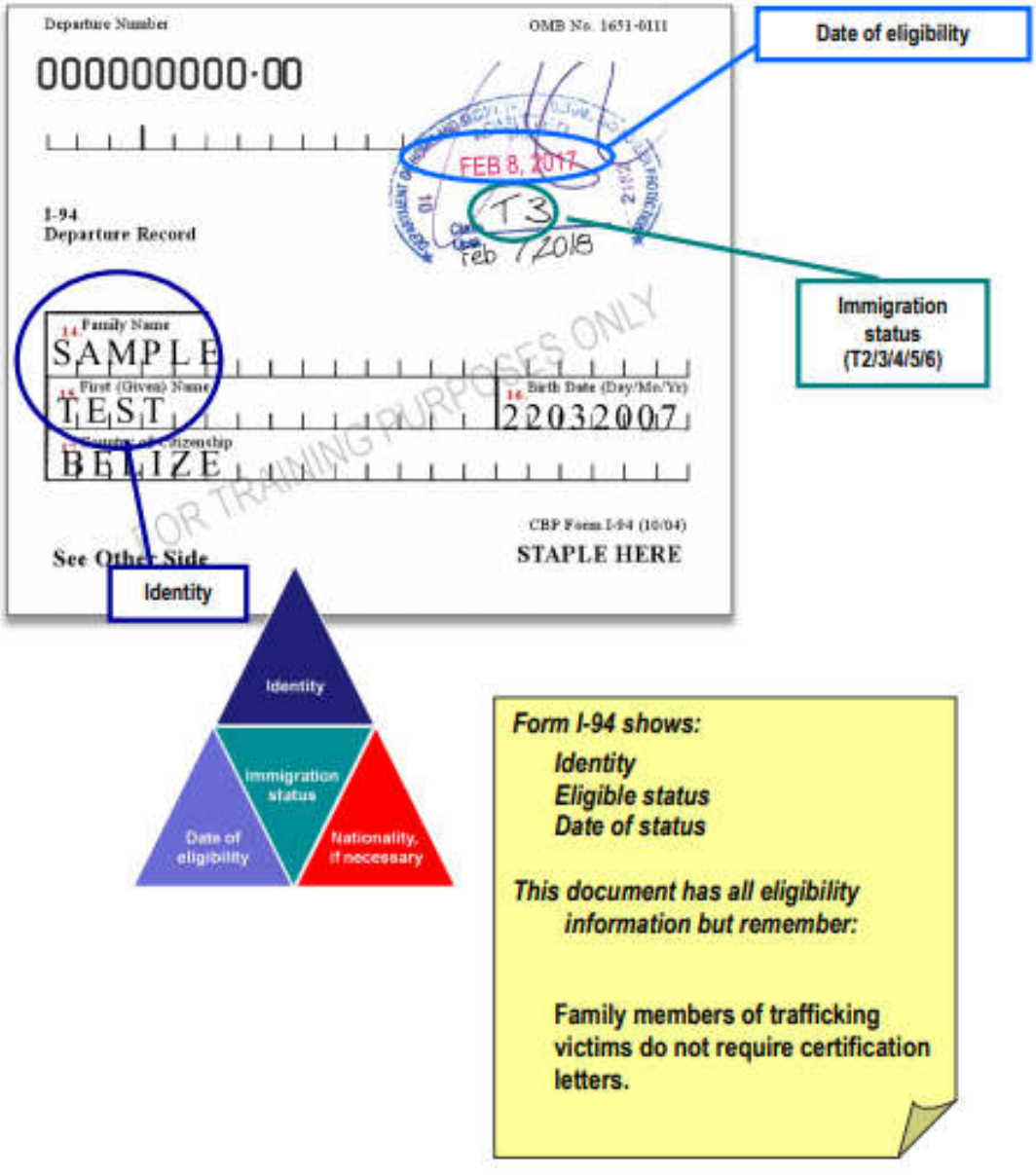
The State Health Office (SHO) receives notifications for all eligible clients via email, in the beginning of each month. The Office of Trafficking in Persons is no longer providing eligibility or certification letters for the clients, just client specific information in a secured list. The Nurse Consultant will notify the appropriate CHD, via email, of the client settling in the county. This email, with the spreadsheet listing the VOTs, will serve as the eligibility verification tool. The CHD will be responsible for contacting the point of contact to inquire if the client is interested in receiving the health services. CHD staff are required to notify the Nurse Consultant, via email, as to whether the client received services or not to ensure the SHO database is up to date for reporting purposes.

Children of VOTs are not required to have eligibility documentation.

Victims of Trafficking

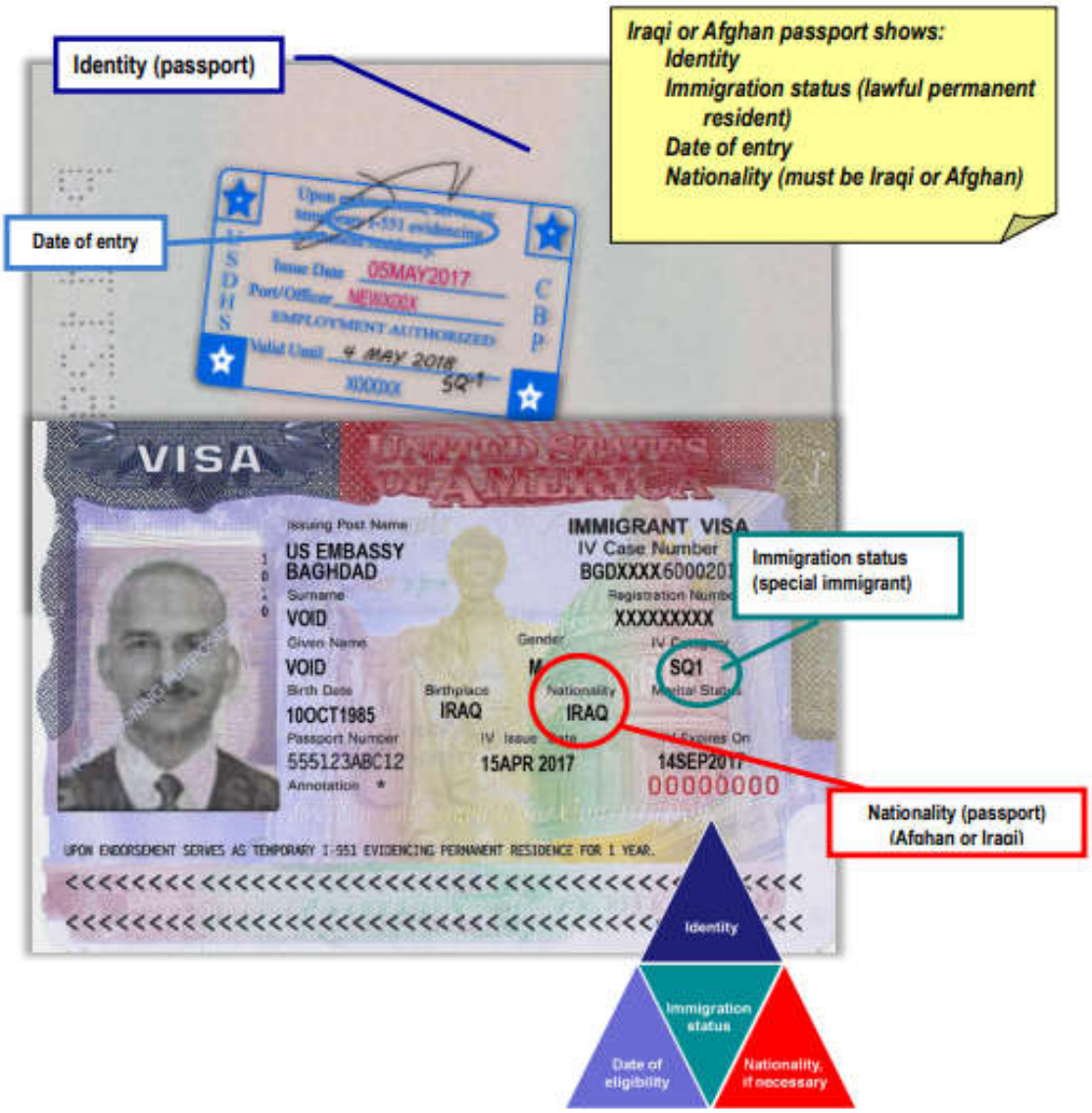
Family Member Eligibility --Trafficking Victim

"T" visa holders already in the United States at the time of the approval of their status may present Form I-797A, Notice of Action, rather than this I-94. See page 6-22 for an example of this Form I-797A. The Notice Date is the date of eligibility.



Children of VOTs are not required to have eligibility documentation.

Special Immigrant Visa



Iraqi or Afghan passport shows Identity Immigration status (lawful permanent resident), Date of entry, and Nationality (must be Iraqi or Afghan).

Self-Declaration of Eligible Immigration Status

Self-Declaration of Eligible Immigration Status: If you are unable to verify the client's nationality in cases where the client has the I-220A, Release on Recognizance, and no other documentation, have the client sign the Self-Declaration of Eligible Immigration Status form to not delay the service. The form should be scanned into the client's record in HMS.

Exhibit 5-1

Self-Declaration of Eligible Immigration Status

Declaration

I, _____, declare, under penalty of perjury, that I am in an immigration status that makes me eligible for Refugee Resettlement Program assistance and services. The following statuses are eligible for Refugee Resettlement Program benefits:

(1) Individuals paroled as refugees or asylees under §212(d)(5) of the Immigration and Nationality Act (INA)
(2) **Refugees** admitted under §207 of the INA
(3) **Asylees** whose status was granted under §208 of the INA
(4) **Cuban and Haitian entrants,** in accordance with the requirements in 45 CFR §401.2
(5) Any individual granted parole status as a Cuban/Haitian Entrant (Status Pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided
(6) A national of Cuba or Haiti who was paroled into the United States and has not acquired any other status under the INA and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered
(7) A national of Cuba or Haiti who is the subject of removal, deportation or exclusion proceedings under the INA and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered
(8) A national of Cuba or Haiti who has an application for asyhum pending with the INS and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered
(9) Certain **Amerasians** from Vietnam who are admitted to the U.S. as immigrants pursuant to §584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988.
(10) **Victim of a Severe Form of Human Trafficking** under P.L. 106-386, Victims of Trafficking and Violence Protection Act of 2000, enacted October 28, 2000.
(11) **Iraqi and Afghan Special Immigrants** under Section 1059 of the National Defense Authorization Act for Fiscal Year 2006, P.L. 109-163 & Section 1244 of the National Defense Authorization Act for Fiscal Year 2008, P.L. 110-181, effective January 28, 2008.
(12) **Lawful permanent residents**, provided the individuals previously held one of the statuses identified above

_____ _____
Signature **Date**

Florida Refugee Health Program

Each state has a designated agency to administer and monitor refugee program activities within its jurisdiction. In Florida, DCF has this responsibility, but has designated the responsibility of administering refugee health services to the Department of Health (DOH) RHP through a signed Memorandum of Agreement. Refugee Medical Assistance (RMA) funds are received from DCF, DOH RHP provides fiscal oversight, and the county health departments (CHDs) are reimbursed after services have been performed. In FFY 2020–2021, Florida received over 5,000 eligible arrivals. There are currently 32 CHDs that provide health assessment and immunization services to newly arrived refugees.

Florida Refugee Health Program Background

Florida has been the destination for thousands of refugees since the inception of the refugee resettlement program in 1980. Many of the new arrivals come from areas of the world where preventive health care is lacking or non-existent. Most reach our state with a variety of health conditions that can be treated quickly and in a cost-effective manner through early diagnosis and treatment. It is imperative that communicable diseases such as tuberculosis (TB) and sexually transmitted diseases (STDs) are diagnosed and treated promptly to protect the health of all Floridians.

The vision of the Florida RHP is to be a leader in providing culturally sensitive health services to persons who have fled their home country due to persecution (political, religious, or economic) in search of a better life and self-sufficiency in the U.S. Within this vision is the goal of the protection of public health from communicable disease through the review of overseas visa medical examination (OVME) records and the provision of health assessments and immunizations. This is accomplished through the administration and oversight of a health assessment program, and collaboration between DOH personnel, DCF, federal agencies, resettlement agencies, and the national Association for Refugee Health Coordinators (ARHC).

FLORIDA REFUGEE HEALTH PROGRAM SERVICES OVERVIEW

The RHP, in cooperation with the CHDs, offers voluntary post-arrival health assessment and immunization services to eligible new refugee arrivals. A high priority is placed on communicable disease screening, although chronic disease screening and health education services are also offered.

The refugee health assessment is to be initiated and completed within 240 days of a refugee's arrival date. For specific information pertaining to who is authorized to perform a health assessment, see Clinical Guidance for Refugee Health Assessments. Immunizations must be initiated within one year of the date of arrival and after the health assessment has been initiated. Vaccinations may not be provided after 12 months from the date of arrival, regardless if the series has been completed.

Refugee health services are provided at no charge to the clients, including the immunizations which are required for a refugee's adjustment of immigration status to Lawful Permanent Resident, provided they initiate and complete the health assessment within 240 days of the date of arrival and immunizations are administered within one year of arrival. These services are authorized by section 400.107 of the Code of Federal Regulations, Title 45.

Qualified interpretation services should be used as necessary and are required by law (see the Interpretation Services Section, page 46).

Role of the Refugee Health Program Office

The RHP will support the efforts of the CHDs by furnishing:

- Technical assistance to enhance the effectiveness of the program. The technical assistance shall include, but is not limited to, the following areas:
    - Regular summaries of arrival and health assessment information on refugees resettling in Florida.
    - Development of policies, procedures, and protocols regarding the health assessment, referral processes, and follow-up services.
    - The provision of bilingual and bicultural educational materials for specific refugee groups to CHDs, state agencies, and other organizations.
    - Provide on-going communication using a statewide distribution list, conference calls, and webinars.

- Reimbursement for services rendered to eligible refugee clients.

- Quality improvement monitoring of select CHD RHPs.

Quality Improvement Monitoring

The top 12 counties that receive the largest number of arrivals per federal fiscal year are subject to biannual quality improvement reviews. Counties may be subject to more frequent quality improvement reviews as needed. This process involves random medical chart auditing to ensure that standards of care are followed.

- The CHDs that meet this criterion are subject to biannual quality improvement desk reviews. This process involves random medical chart auditing to ensure that standards of care are followed.

- Any CHD not meeting expectations for clinical standards of care will be subject to a Corrective Action Plan.

CHD RHP Changes in Staffing

All CHDs should provide written notification to the State Health Office via email, within two weeks, for any CHD RHP personnel changes serving as key leads to the program. Up-to-date information is imperative for the State Health Office to maintain accurate information on SharePoint and the statewide distribution list, and for the program's knowledge in providing on-going technical assistance.

COVID-19 PANDEMIC

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a virus that causes a respiratory disease, COVID-19. It is assumed there is no pre-existing human immunity to the pathogen.

As a result of the global pandemic, many aspects of United States Refugee Admissions Program (USRAP) processing ground to a halt or were severely impacted in FFY 2020–2021, which dramatically slowed the rate of refugee resettlement. Although the situation has improved in most locations, progress is uneven and not linear. USRAP travel was suspended from March through July 2020, and as a result only 493 refugees traveled on emergency cases from March 19 until July 29 of that year.

The CDC established specific behavioral measures to reduce the spread of COVID-19 in worksite settings; CDC created Information for Healthcare Professionals about Coronavirus (COVID-19) (cdc.gov/coronavirus/2019-ncov/hcp/index.html). To ensure the health and safety of staff and clients, as well as reduce exposure to the virus, Florida's CHDs may modify clinical practices addressing scheduling appointments, service delivery and staffing coverage. In addition, certain counties may adhere to additional ordinances their respective counties enacted. These efforts may impact when a refugee receives services.

The CDC has developed COVID-19 guidance for newly resettled refugees. Several COVID-19 resources are available in 18 languages including the Welcome Book for Refugees at: cdc.gov/coronavirus/2019-ncov/need-extra-precautions/refugee-populations.html .

Due to the continued spread of COVID-19, ORR issued Policy Letter (PL) 21-08 to the states. The letter states that pursuant to 45 C.F.R. § 400.300, states may provide a waiver to extend the time frame in providing health services. The policy was enacted October 1, 2021 and will remain in effect through September 30, 2022 unless otherwise specified.

ARRIVAL NOTIFICATION PROCESS

RHP headquarters and CHDs receive notification of new refugee arrivals to Florida from the CDC Miami-Dade Quarantine Station via the Electronic Disease Notification (EDN) system. The arrival notification form varies depending on the CDC quarantine station that processes the arrival. Occasionally, a CHD may not receive prior notification of a refugee who has not been processed through EDN (for example, if a client has resettled from another state, the client has recently been granted asylum, or the client is an irregular maritime or land arrival). CHD clinic staff is expected to check EDN daily to monitor new arrivals in their jurisdiction.

Refugee Arrivals

Refugees, who must apply to enter the U.S. at refugee processing posts outside of the U.S., receive assistance from a resettlement agency. The national resettlement agency prepares a form on each refugee containing demographic information and medical information obtained from the OVME, including any Class A or Class B or any other significant medical health condition the refugee may have.

Derivative Asylee Arrivals

Derivative asylees have a family member who has been granted asylum in the U.S. The primary asylee can apply for immediate family members to come to the U.S. and becomes the derivative asylee's sponsor. In most cases, there is no support from a resettlement agency. Derivative asylees receive an OVME before leaving their home country, and upon their arrival in the U.S. are processed at a quarantine station.

Afghan and Iraqi Special Immigrant Visa (SIV) Arrivals

SIVs can choose to enter the U.S. at their own expense or they can enter through the USDOS Reception and Placement Program, as refugees do. If they enter at their own expense, they can arrive at any U.S. airport. SIVs entering through the Reception and Placement Program receive assistance from resettlement agencies and usually enter through a quarantine station.

Afghan Individuals Due to Urgent Evacuation and Resettlement:

Afghan evacuees are located at eight U.S. military bases and at overseas locations. After the initial 21-day quarantine and vaccination period, Afghan evacuees are resettling to locations that have been offered by the resettlement agencies and other organizations in the U.S. and Florida.

Arrival Notifications for Refugees, Derivative Asylees, and SIVs

Although most of Florida's arrivals enter the U.S. through Miami, several arrivals enter through

other quarantine stations, located at designated major airports in the U.S. The notifications for these arrivals are sent to the CDC in Atlanta, Georgia, for data entry into the EDN. Upon entry into the EDN, arrival notifications are electronically available to the state and jurisdiction where the refugee is scheduled to resettle.

Arrivals entering the U.S. through the Miami International Airport are processed by the CDC Miami Quarantine Station, in collaboration with staff from the Miami-Dade RHP. Staff at the quarantine station forward the notifications to the CDC in Atlanta for data entry into the EDN. CHDs can access the arrival notifications in the EDN if they have received a digital certificate from the Secure Data Network (SDN). (See the EDN Section, page 88, for more information about this process.)

Cuban Parolees

Cubans, who do not meet the legal definition of a refugee, can apply for entrance to the U.S. by applying at the U.S. Interest Section housed in the Swiss Embassy in Havana, Cuba. The documentation from the Interest Section is comprised of a letter from the Officer in Charge of Immigration entitled Authorization for Parole of an Alien in the United States, indicating the person entering the country has been paroled under the 1994 U.S.- Cuba Migration Accord, demographic information on the parolee, and a copy of the OVME.

Arrival Notifications for Cuban Parolees

Arrival notifications for Cuban parolees are processed in Miami. The arrival notifications are forwarded via traceable mail to the CDC EDN for entry into the EDN. Each day, the headquarters RHP staff then upload this information by notification date into the Health Management System (HMS).

Notification of VOT

The RHP Central Office receives notifications from ORR for adults who have been certified, or children who have been designated, as a VOT. The certification or eligibility letter contains the VOT's name and their sponsor's or case manager's contact information. Central Office will contact the CHD if a certification/eligibility letter identifies a VOT in that county. The CHD is responsible for making contact and offering RHP services. If you find that the VOT resides in another county when attempting to schedule a health assessment for the VOT, please inform Central Office. If a CHD receives a VOT referral from anyone outside of RHP Central Office, please forward the information to Central Office to confirm eligibility.

Other Arrivals

There are several groups arriving or already in Florida who are eligible for refugee services but may not have an arrival notification (for example, irregular maritime arrivals, border crossers, and primary asylees). Irregular maritime arrivals and border crosser populations refer to Cuban/Haitian entrants who may have arrived via water or land (U.S./Mexico or U.S./Canada border) and have received an immigration status that deems them eligible for refugee benefits, such as public interest parole.

APPOINTMENT SCHEDULING FOR REFUGEE HEALTH SERVICES

Upon receipt of the refugee's arrival notification from the EDN or the sponsoring resettlement agency, the CHD RHP should attempt to contact the refugee or refugee's sponsor to schedule a health assessment. The health assessment must be initiated and completed within eight months from their date of arrival to comply with federal timeframes. However, every attempt should be made to provide services within 30 days from their date of arrival to ensure the refugee receives services before employment and school schedules interfere with scheduling. If health assessment services have not been initiated and completed within eight months, the CHD will not be reimbursed for services via the RHP.

Appointments for Refugees Sponsored by a Resettlement Agency

Resettlement agencies that assist **refugees** with resettlement and integration also assist refugees with scheduling and attending their health assessment; however, resettlement agency services are typically only available for 30 days from their date of arrival. RHPs should make every effort to provide services within 30 days so the resettlement agencies may assist the refugee with transportation and interpretation needs, etc.

When the resettlement agency contacts the CHD RHP to schedule an appointment, scheduling staff should make every effort to provide an appointment date and time while the staff are on the phone. The CHD RHP should request the following information from the resettlement agency prior to the refugee's appointment:

- Copy of the OVME, if not available in EDN
- Copy of the American Council of Voluntary Agencies arrival notification form, if not available in EDN
- Copy of the I-94 card or other eligibility documentation. Please see Attachment H-Department of State's Refugee I-94 Automation letter.
- Picture ID

Note: The absence of these forms and documents at the time of scheduling should not prevent the RHP from providing an appointment date and time to the resettlement agency staff. At the time of the appointment, a copy of the refugee's picture ID and I-94 card or other documentation of immigration status and arrival date must be copied and retained in the refugee's file in HMS.

Appointments for Arrivals Not Sponsored by a Resettlement Agency

The CHD RHP should contact refugees via phone or certified letter, using the information provided on the arrival notification form received via EDN. Letters sent to refugees should be in the appropriate language based on the refugee's country of origin. Bilingual staff or telephonic interpretation services should be used when contacting a refugee by phone. A minimum of three attempts to contact the client must be documented in HMS. The next available appointment should be given to the refugee to ensure compliance and minimize the chances of interference with employment or school.

The CHD RHP should request that the refugee bring the following information to the appointment:

- Their I-94 card or other eligibility documentation with arrival/asylum/certification date
- Picture ID
- Copy of their OVME, if available
- Insurance coverage (for example, Medicaid card), if applicable
- Current medications
- Any medical records the refugee may have

Note: At the time of the appointment, a copy of the refugee's picture ID and I-94 card or other documentation of immigration status and arrival date must be copied and retained in the refugee's file in HMS.

Walk-Ins

Accepting walk-in appointments may be done at the discretion of the local CHD RHP. The CHD RHP does not receive arrival notifications for primary asylees, irregular maritime arrivals, border crossers, and other arrivals that may be eligible for refugee benefits. These arrivals may hear about refugee health services by word of mouth or through a local social service agency. As such, CHDs may have walk-ins or phone calls requesting appointments from clients with no corresponding arrival notification. RHP staff should inquire about the client's immigration status and date of asylum grant or date of arrival in the U.S. to gauge eligibility for refugee benefits. If you are unsure of their eligibility, ask the walk-in/caller to bring their immigration documents to the appointment or prior to the appointment. If, after reviewing their documents, you are still unsure of their eligibility, contact the RHP Central Office for assistance. When scheduling the appointment, ask them to bring any of the remaining items listed in the previous section. If an unsponsored client is outside of their 90-day eligibility window and does not have Medicaid, services may be provided on a case-by-case basis.

Contact the RHP Central Office for guidance and approval.

General Scheduling Information

- CHDs need to prioritize patient scheduling based on medical or psychological conditions assessed during the initial contact (phone, fax, face-to-face). Medical conditions may include but are not limited to Class A/B status, lack of medication, or any other significant medical or psychological conditions identified.

- All refugees should be given the first available appointment. Scheduling should be made as flexible as possible to accommodate the refugee's schedule.

- Refugees who arrive at their appointment without an I-94 card or photo ID should not be denied services; however, these services cannot be coded to program component 18 and will not be reimbursed by RHP. Eligibility can be determined through EDN, HMS, or RHP State Health Office staff.

- Refugees who arrive at their appointment without a photo ID should have a photo taken and scanned into HMS. Once the refugee has obtained a photo ID, it should be scanned into HMS.

- Missed appointments (health assessments and immunizations) should be rescheduled in a timely manner.

- Reminder notices should be sent to refugees for follow-up immunizations, in their language to the extent available.

- Interpreters should be used for scheduling, as necessary.

Relocation Information—Jurisdictional

Refugee do not always resettle in Florida. If you discover that they are residing in another state, please update the information in EDN.

Instructions to Access EDN to Change Address

Step 1: Click the link to access EDN:
https://auth.cdc.gov/

Step 2: Enter your username and password

Step 3: Click "Alien Search" on left side

Step 4: Enter the file or alien number (use dashes and capitals if applicable)

Step 5: Click on any of the associated family members when list populates

Step 6: Click view/update address

Step 7: Enter new address on address line 1

Step 8: Select all names in the batch transfer to simultaneously update address for all family members listed

Step 9: Click “Save”

Step 10: Click “Change Address”

Relocation Information—Within Florida

Refugees do not always resettle in the county designated to receive them. If you discover that the refugee is residing in another county, contact RHP Central Office staff to perform the jurisdictional change in EDN.

If a refugee has begun services in one county and has presented in another county for the remaining services, the staff should contact the initiating CHD to transmit a Continuity Care Document (see Health Management System section.)

If the refugee does not receive health services at the CHD, CHD staff should code in HMS according to the appropriate code:

Codes for Unscreened Clients

Service	Description	Code
Attempt to Contact	This code can be used by refugee health clinical or clerical staff to document an attempt to contact a refugee client for services.	3103
Decline Services	This code can be used by refugee health clinical or clerical staff to document when a refugee client verbally declined or refused services.	3110
Unable to Locate	This code can be used by refugee health clinical or clerical staff to document the inability to reach a refugee client for service after three attempts by letter or phone have been completed.	3114
No Show	This code can be used by refugee health clinical or clerical staff to document a refugee client **not** attending a confirmed refugee health assessment appointment.	3116*****
Insufficient Address	This code can be used by refugee health clinical or clerical staff to document return to sender letters that have be sent to refugee clients to initiate services.	3117*****
Moved	This code can be used by refugee health clinical or clerical staff to document the confirmation that a refugee client has moved outside the CHD catchment area for services.	3118*****

Codes for Screened Clients

REFUGEE HEALTH ASSESSMENT - PC 18 ***INITIATED*** **CPT CODES 99381, 99382, 99383, 99384, 99385, 99386, 99387**	**5550**

Use this code to document the **start** of the refugee health assessment. The physical examination components of the assessment must be completed by a clinician level of registered nurse or higher. All other components of the assessment can be coded by other Refugee Health clinical staff. Please refer to the Refugee Health Program Guidelines, Protocol: Core Services (Attachment B) for detailed information about the required assessment components.

REFUGEE HEALTH ASSESSMENT – PC 18 ***IN PROGRESS*** **CPT CODES 99391, 99392, 99393, 99394, 99395, 99396, 99397**	**5551**

Use this code to document the **continuation** of the refugee health assessment when it was already initiated at your CHD, however the health assessment is not completed in this visit. The physical examination components of the assessment must be completed by a clinician level of registered nurse or higher. All other components of the assessment can be coded by other Refugee Health clinical staff. Please refer to the Refugee Health Program Guidelines, Protocol: Core Services (Attachment B) for detailed information about the required assessment components.

REFUGEE HEALTH ASSESSMENT – PC 18 ***COMPLETED*** **CPT CODES 99391, 99392, 99393, 99394, 99395, 99396, 99397**	**5552**

Use this code to document the **completion** of the refugee health assessment. The physical examination components of the assessment must be completed by a clinician level of registered nurse or higher. All other components of the assessment can be coded by other

Refugee Health clinical staff. Please refer to the Refugee Health Program Guidelines, Protocol: Core Services (Attachment B) for detailed information about the required assessment components. **Note:** the health assessment can be completed in one visit. However, program guidelines allow for up to three visits to complete. Please use the ***Initiated or In Progress*** code if you are unable to complete all the required components as outlined in the Refugee Health Program Guidelines during a visit.

REFUGEE HEALTH ASSESSMENT- PC18 **5553**
TRANSFER

CPT CODES 99391, 99392, 99393, 99394, 99395, 99396, 99397

CSR	EA	Tim	#	Ag	Se	Rac	FTI	Re	Ou	Di	Su

Use this code to document the continuation of refugee health assessment services when the health assessment was already initiated at another CHD or outside provider, however the health assessment is not completed in this visit. **Note:** The first visit for a client who has transferred is 5553 and the second visit, of which the assessment is completed, is 5552.

Special Coding Note: This code should not be used for clients who completed the refugee heath assessment at another CHD of outside provider and now only need immunization services. See HMC Immunization-only visit description.

REFUGEE HEALTH ASSESSMENT – PC 18 **5554**
MINIMAL VISIT

CPT CODE 99211

CSR	EA	Tim	#	Ag	Se	Rac	FTI	Re	Ou	Di	Su

Provision of extended services, referrals, or other interventions to eligible refugees, following RHP guidelines and DOH policies.

Registered nurses under protocol, mid-level practitioners, or physicians employed by county health departments review an established refugee client's overseas and domestic medical records including, but not limited to, medical history, current health status, age, allergies, physical exam documentation, and laboratory results to address abnormal findings from the domestic refugee health assessment, following RHP guidelines and DOH policies. This in- person,

minimal office visit is appropriate if the refugee health assessment has already been coded as completed (5552) for the client; however, extended services, referrals, or other interventions are required to ensure continuity of care. Health care practitioners act according to their legal scope of practice and routinely provide counseling relevant to the findings and needs for the client.

Note: This code should be used when applicable, according to RHP guidelines and DOH policies.

REFUGEE HEALTH ASSESSMENT – PC 18	**5555**
IMMUNIZATION-ONLY VISIT	
CPT CODES *IMMUNIZATION PRODUCT CODE/S ONLY*	

CSR	EA	Tim	#	Ag	Se	Rac	FTT	Re	Ou	Di	Su

Assessment and counseling for the administration of immunizations to eligible refugee clients, following the Advisory Committee on Immunization Practices (ACIP) guidelines.

Registered nurses under protocol, mid-level practitioners, or physicians employed by county health departments assess the client's eligibility for the Refugee Health Program, and review immunization and medical history, current health status, age, and allergies to determine the medical appropriateness of immunizations according to ACIP guidelines. The visit includes a thorough immunization assessment and, if applicable, immunization administration with appropriate documentation in Florida SHOTS and the Health Management System (HMS). Counseling relevant to the findings and needs and providing information regarding immunizations to be administered and possible side effects are routinely performed. Clients are informed of the timeframe of when to return for the next immunization appointment for completion of the immunization series, if applicable.

Use this code to document assessment, counseling, and administration of immunizations to eligible refugee clients once the refugee health assessment has been completed. **Note:** This code is to designate an immunization-only visit and should be coded with appropriate immunization product-specific CPT codes, following ACIP guidelines.

Special Coding Note: This code is appropriate for eligible clients who are receiving a vaccine dose within 12 months of arrival. In addition, HMS should reflect appropriate documentation for a refugee health assessment which was completed within 240 days from the date of arrival. Immunizations administered to refugees after 12 months of arrival are not eligible for reimbursement through PC18.

INTERPRETATION SERVICES

Interpretation may be needed when scheduling appointments or during the refugee health assessment. Whenever interpretation is used, the method should be documented in HMS. For many of the clients served by the RHP, English is an unfamiliar language. This causes a significant barrier when attempting to cover family medical history and during the provision of medical care services. Due to the linguistic and cultural barriers experienced by the clients, interpretation services are an integral part of the services provided in the RHP. Providers should make every effort to ensure that clients are aware of the interpretation services available to them. Providers should also display posters in the office that allow the clients to identify the language they speak. These materials are available from the RHP State Health Office.

Using trained bilingual/bicultural interpreters is always recommended. Bilingual CHD staff trained in medical interpretation should be used, if available. Using family members, especially the children of clients, is strongly discouraged as most clients are not comfortable discussing health matters in front of their family. Asking a child to interpret medical conditions may traumatize a child and, in many cultures, using a child for interpretation upsets the family's social order.

The program covers the cost of telephonic interpretation services used in conjunction with the health assessment and immunizations. The use of a qualified medical interpreter in the health assessment is crucial. It is important that the medical interpreter understand the refugee health assessment before they begin to interpret.

As a medical professional, learning some basic words and phrases in the languages most spoken by your clients will be beneficial. Knowing how to greet a client and ask simple questions in their native language is advantageous. It is unrealistic to expect someone to speak all languages, but a sufficient amount that will enable a client to feel comfortable until an interpreter arrives will benefit everyone.

On-Site Interpretation

Upon entering the examination room, the provider should introduce him/herself directly to the client and then allow the interpreter to complete the introduction. It is important to relay the role of the interpreter, the purpose of the medical office visit, and the commitment by all parties to maintain medical information confidentiality to the client. Interpreters are required to keep information confidential and are not allowed to express their own thoughts, beliefs, advice, or answers about health issues to a client. Providing the client with this information at the beginning of the appointment helps set the tone for the visit and establishes the medical professional as the lead during the medical visit.

When a health care provider uses an on-site interpreter, the provider should:

- Face and speak directly to the client.
- Arrange seating to facilitate communication between the provider and the client. The interpreter should be seated next to, but slightly behind the client.
- Watch the client, not the interpreter during the office visit and observe the client's body language and other behavioral cues. If a problem is suspected, the interpreter can help explain any nonverbal messages from the client.
- Speak in first person.
- Speak in a normal voice, clearly, and not too quickly.
- Speak in short sentences, no more than two or three sentences at a time. Expecting an interpreter to remember long explanations may lead to omissions and errors. Do not stop in the middle of a sentence and ask the interpreter to interpret because the entire sentence is needed before interpreting can be properly completed.
- Ask one question at a time and use simple, straight-forward sentences. Avoid metaphors, slang, or jargon. Explain all medical terms in simple language. Allow extra time as the amount of time needed to interpret may take longer than it takes to be spoken in English. Explanations will take longer, especially if the client is not familiar with western medicine.
- Allow time for clients to ask questions and seek clarification.
- Refrain from engaging in long discussions with the interpreter. Excluding a client from the conversation is never recommended. In turn, an interpreter should never engage in a lengthy discussion with the client without informing the health care provider about the content of the discussion.
- The interpreter may have interpreted for the client on prior occasions and may be familiar with the health history, but it is always important to obtain an accurate, current health history.

If necessary, an interpreter may ask that you speak slower, to repeat something he/she didn't quite understand, or to add an explanation for something the client may not be able to understand without some background information. Health care providers should be aware that some English words may not have a correlate in other languages.

It is important to remember that refugees may know some English and may understand comments or gestures made to other providers or to the interpreter. Be conscious of discussions or comments in the presence of your clients. Reinforce verbal interaction with materials written in the client's language and with visual aids. Document, in the progress notes, the name of the interpreter who interpreted for the client.

Telephonic Interpretation

Utilizing telephonic interpretation is another method of communication for CHD staff. Telephonic interpretation should be used when a qualified, bilingual staff member is unavailable. Telephonic interpretation can be used through a conference or three-way calling system.

The DOH contracts with Language Line Solutions (LLS) to provide telephonic interpretation services. Telephonic interpretation services that are used in conjunction with health assessments or immunizations are available at no cost to the CHD RHP. When using LLS, the RHP staff member must provide the LLS operator with the master account number for RHPs, the client's alien number, and the numerical county code for the CHD. This information is required for verification of charges for services provided by the RHPs statewide. Document in HMS that LLS was used and the interpreter's ID number. To obtain the master account number for RHPs or to verify the CHD county code, contact the Refugee Health Program Administrator at 850-901-6903.

Phone Calls

When you receive a call, tell the limited-English caller that you are placing the call on hold and say, "One moment please." Dial the LLS toll-free number (1-866-874-3972) and provide the RHP account number, alien number, and the numerical CHD county code to the operator. If you know the client's language, request the language for the caller. If you do not have the alien number for the client yet, obtain the alien number after you initiate the call with the interpreter and the client.

If you do not know the client's language, the LLS operator can assist you in determining the language needed. Brief the interpreter about the call, explaining who you are and why you are calling and conference in your limited-English speaking caller. At the end of the call, say, "End of call" to the interpreter.

When placing a call to a limited-English speaker, dial the Language Line Services toll-free number, using the instructions above. Request the language for the caller. Brief the interpreter about the call, explaining who you are and why you are calling and conference in your limited-English speaking person. At the end of the call, say "End of call" to the interpreter.

If you need assistance placing a call to a limited-English speaker, please inform the interpreter at the beginning of the call.

ON-SITE

Funding for on-site interpreters that are not employees of the CHD is unavailable from the RHP. When a limited-English speaking client is present in the office and you are unable to use a bilingual CHD, staff trained in medical interpretation, dial LLS at 1-866-874-3972. Provide the operator with the RHP master account number, the client's alien number, and the CHD's numerical county code. Request the language for the speaker. When connected with an interpreter, brief them about the nature of the visit or appointment. At this point, you can use the speakerphone feature of the phone for the duration of the call.

PURPOSE OF THE REFUGEE HEALTH ASSESSMENT

Many of the refugees who arrive in Florida come from areas of the world where preventive health care is not a priority and, as such, may reach the state with a variety of health conditions that can be promptly addressed with early diagnosis and treatment. Some may have a communicable disease or condition, such as TB, which could represent a threat to public health. Information on the status of Class A/B and significant health conditions should be recorded in HMS, in the Clinician Portal, under the Refugee Health tab. If the refugee has not already been entered into HMS, the OVME information is available in EDN. Refugees with Class A/B or significant health conditions should be prioritized and scheduled first.

Most refugees will have received an OVME prior to departure for the U.S. The OVME and the health assessment differ in both scope and purpose. These differences are detailed in the table below.

Comparison of the Overseas Visa Medical Exam and the Refugee Health Assessment

Overseas Visa Medical Exam	Refugee Health Assessment
Purpose: To identify refugees with medical conditions that, by law, would exclude them from entering the U.S.	Purpose: To eliminate health-related barriers to successful resettlement and to protect public health in the U.S.
Scope: • Communicable diseases of public health significance • Current or past physical or mental disorders that are or have been associated with harmful behavior • Drug abuse or addiction	Scope (Refugee Act, §412(b)(5)): • Follow-up (evaluation, treatment, and/or referral) of Class A and B conditions identified during the OVME • Identify persons with communicable diseases of potential public health importance that were not identified during or developed after the OVME • Introduce incoming refugees to the U.S. health care systems • Identify conditions that could impact

Overseas Visa Medical Examination (OVME) (CDC Form DS-2053 and DS-2054)

The OVME serves as an exclusion process to identify those with physical or mental disorders that might prove harmful to the general U.S. population (Class A conditions). Testing is provided for TB, syphilis and other STDs, Hansen's disease (leprosy), and other physical and mental disorders.

Federal regulations require the same OVME for most refugees worldwide. The exam is limited in that it provides only minimal baseline medical information on new arrivals. Supplemental

testing for refugees arriving from areas of the world where certain diseases may be endemic are not always included in the OVME. Another limitation in the overseas examination is that the exam may have been completed up to a year before the refugee's departure to the U.S.; therefore, the possibility exists that a refugee may develop active TB or another communicable disease after the OVME but before departure to the U.S.

Refugee Health Assessment

(See the Clinical Guidance section for detailed information on the refugee health assessment.)

The health assessment is often a new arrival's first encounter with the U.S. health care system. RHP staff plays an important role in establishing the new arrival's confidence in the health care system and their likelihood to seek care in the future. Patient materials on health education, information about local community health resources, and advice on accessing the health care system should be an integral part of the health assessment process and should be made available in the appropriate languages for RHP clients. (See Attachment J for additional information on cultural competency.)

Health assessment programs should be coordinated with services provided by resettlement agencies to ensure effective resettlement of new arrivals and the prompt identification and treatment of medical problems. Refugee clients should be routinely referred to primary care providers during the initial appointment to provide continuity of care for any conditions identified during the health assessment. Referral for Class A, B1, and B2 TB conditions should be made to the TB clinics within the CHDs.

Providers involved in the provision of health assessments to new arrivals should have an understanding of, and be sensitive to, the psychological trauma some individuals may have experienced in the migration process. The health assessment process can serve as an opportunity for providers to discuss with RHP clients the potential psychosocial difficulties they may experience during resettlement and refer them for counseling, if necessary. Health care providers should assess for key indicators of trafficking and domestic violence.

Table 1: Required Timeframes* for Completing a Health Assessment by Immigration Status

Immigration Status	Timefr
Refugee	8 months from date of initial arrival in U.S.
Asylee	8 months from date asylum status was granted
Derivative Asylee	8 months from date of initial arrival in U.S.
Cuban/Haitian Asylum Applicant	8 months from date asylum application was filed with USCIS
Cuban/Haitian Entrant/Parolee	8 months from date of initial arrival in U.S.
Amerasian	8 months from date of initial arrival in U.S.
Afghan & Iraqi Special Immigrant	8 months from date of initial arrival in U.S.
Afghan Evacuees	8 months from date of initial arrival in U.S.
Victim of Trafficking	Adults—8 months from certification date Children—8 months from eligibility date

Requirements for Designated Medical Providers in Florida

Providers must:

- Be a Florida CHD.
- Demonstrate clinical capacity and cultural competence in providing refugee health services to all eligible refugees.
- When possible, employ bilingual, bicultural health aides recruited from the predominant refugee ethnic groups in Florida; bilingual staff are encouraged to complete department- approved interpreter training when available.
- Provide interpreter services for limited English proficient clients to overcome bilingual or bicultural barriers to care.
- Make appointments, when necessary, and have a protocol to follow up with refugees who do not keep their appointments and enter the appropriate Health Management Component (HMC) code in HMS.
- Demonstrate linkages to appropriate primary care or specialty care providers for referrals and follow-up services and enter the appropriate HMC code in HMS.
- Assure that referrals for general and specialty follow-up care are appropriate and timely and, when possible, in proximity to the client's home.
- Maintain patient records in accordance with the rules and regulations that govern recordkeeping in CHDs.
- Comply with OMB Circular A87 (2 CFR 225) which requires employees who are paid and working on a federal grant (activity) to maintain accurate timekeeping records. Timekeeping must be maintained in the DOH Employee Activity Record System (EARS) under Refugee Health Program Component 18.
- Provide education and information to orient refugees to the U.S. health care system.
- Have access to encrypted email for receipt of confidential information sent electronically.

CLINICAL GUIDANCE FOR REFUGEE HEALTH ASSESSMENTS

A licensed health care provider such as a physician, nurse practitioner, or credentialed registered nurse in a CHD setting must perform the refugee health assessment. See Attachment K (DOHP 425-3-18) for guidelines specific to the credentialing process for registered nurses. Licensed practical nurses cannot perform health assessments; however, they can assist with vitals; medical history intakes; mental health, vision, and hearing screenings; immunization administration; referral assistance; and other duties assigned to support staff. Newly hired RNs or RNs who are not currently providing the health assessment, but want to be able to do so, will need to complete credentialing before functioning in this capacity. CHDs shall create their own written protocol which provides for supervision of the RN by a licensed physician for the procedures by which patients may be assessed, pursuant to section 154.04, Florida Statutes. CHDs that bill to Medicaid when clients initiate the health assessment are required to have a Refugee Health Assessment Standard of Care (SOC). A sample SOC is available on SharePoint.

All clients should be routinely instructed to establish with a primary care provider. Only a licensed medical doctor or licensed advanced practice registered nurse (APRN) can prescribe medications following DOH and CHD policies. Refugees with abnormal physical assessment results should be referred to a primary or specialty care providers with appropriate documentation and follow-up in HMS. Clinical judgement should be used when referring patients to the emergency room if objective or subjective findings reveal an urgent concern that extends past the function or capacity of the CHD and for which waiting for an appointment with a specialist or primary care physician would possibly harm the patient or the public.

In accordance with ORR State Letter #12-09, core services represent a minimum standard of care for refugees who meet the screening criteria. Extended screening services are available and should be used based on a refugee's risk factors or clinical indicators. The screening criteria for core and extended services are defined below.

Please document in HMS if an interpreter is used in the provision of services, the refugee's language, the mode of interpretation, and, if face-to-face, who provided the interpretation.

Ensure that services and employees time are coded to PC18 in the DOH's HMS.

Core Services

Review of the Overseas Visa Medical Exam

Refugees resettling in the U.S. receive an overseas visa medical examination (OVME) prior to departure for the U.S. The OVME is the same for most refugees worldwide and the components of the exam are specified by federal regulations set by the CDC. This mandatory examination is designed to exclude individuals who have communicable diseases of public health significance, physical or mental disorders that involve harmful behaviors, or problems with drug abuse or addiction. Conditions identified during the overseas exam that require follow up in the U.S. are designated as Class A or Class B. The OVME is done by a physician working under contract with the IOM or by a local panel physician, using locally available facilities (that is laboratory, X-rays). The CDC DGMQ is responsible for oversight of all overseas examinations. The OVME and associated records in EDN should always be reviewed by a clinician and uploaded into HMS.

Note on asylees: While most asylees have not received an OVME, many have received a medical or psychological evaluation in support of their application for asylum. The CHD should ask the asylee to bring this documentation with him/her to the assessment.

Cultural factors may limit an uninhibited exchange of health history. A complete review of the following documents, if available, is important to augment the health history of the refugee:

- OVME recorded on the DS 2053
- Chest X-ray report
- Immunization record, if available all immunizations received prior to arrival into the U.S. should be entered into Florida SHOTS and the client's health records
- List of current medications
- Medical history and other medical records as available

Class A or B Condition: The CDC notifies the CHD refugee health contact if Class A/B conditions are identified during a refugee's OVME via EDN. For Class A or B TB conditions, the area TB manager also receives the notification via EDN.

Class A: An alien with an excludable condition may apply for a waiver to enter the U.S. The waiver process generally includes assurance from a private medical provider or an appropriate public health agency in the U.S. that necessary medical or psychological follow-up services will be provided upon arrival. Class A conditions include:

- Chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, syphilis
- Tuberculosis (active, infectious)
- Drug addiction
- Hansen's disease/leprosy (infectious)
- Mental illness with violent behavior

Class B: Class B conditions do not require a waiver, but the refugee will require follow-up medical care upon arrival in the U.S. Significant health problems noted as Class B conditions include physical or mental abnormalities, diseases, or disabilities, serious in degree or permanent in nature, amounting to a substantial departure from normal well- being. Class B conditions requiring follow up soon after arrival in the U.S. include:

- Tuberculosis, active, not infectious; extrapulmonary; old or healed TB; contact to an infectious case-patient; positive Tuberculin Skin Test (TST)
- Hansen's disease, not infectious
- Other significant physical disease, defect, or disability

Immunization Report: The State Health Office will send an Immunization Report to the CHDs via email monthly to ensure compliance with documenting vaccines in Florida SHOTS. The report identifies refugees who do not have their arrival date entered in Florida SHOTS or have received a vaccine beyond 365 days from their date of arrival.

Unscreened Report: The State Health Office will send an Unscreened Report via email monthly which identifies refugees who have not yet initiated the health assessment, including those with an A/B status. CHDs are responsible for attempting to schedule refugees, entering appropriate HMC codes for attempts to contact, merging duplicate records in HMS, and updating addresses in EDN if a refugee has relocated.

Each CHD should regularly monitor Class A/B arrivals and schedule refugees with an A/B status in a prompt manner. To pull an A/B report from EDN:

1. Log in to EDN
2. Navigate to the report tab
3. Select Alien Line List Report
4. Select an arrival date range
5. Choose "any" for TB Class
6. Select your county as the jurisdiction
7. Run report

Medical History: Obtaining a medical history during the domestic refugee health assessment is required for all refugees. The purpose of taking the medical history is to record any significant past or current medical condition or disability, preventive care (for example, immunizations and dental work), and any relevant family or social history. During this medical history process, it may be possible to detect an obvious speech or hearing problem and to assess the patient's mental status. Clinicians should try to be concise about the sequence of historical events as they may provide clues to the refugee's risk for certain medical conditions, particularly infectious disease, psychological problems, and growth/nutritional abnormalities.

A complete medical history should include:

- Biographical data, for example, migration history

- Present health status/Review of Systems
  - General (ex. recent fever, night sweats, weight loss)
  - Skin
  - Eyes
  - Ears
  - Nose
  - Mouth
  - Throat
  - Neck
  - Breast
  - Respiratory (ex. cough, hemoptysis)
  - Cardiovascular
  - Gastrointestinal (ex. diarrhea)
  - Urinary
  - Gynecological (ex. abnormal discharge)
  - Musculoskeletal
  - Neurologic
  - Psychiatric
  - Endocrine
  - Allergies
  - Other recent illness in self or family

- Current health information:
  - Current medications
  - Immunization status
  - Risk factors for sexually transmitted infections, if applicable

- Past health status: summarize and record chronological data as completely as possible:
  - Childhood illnesses
  - Serious or chronic illness
  - Serious physical trauma
  - Hospitalizations
  - Surgery
  - Dental care
  - Emotional stress/mental illness
  - Social history (ex. history of drug use, including alcohol and tobacco)
  - Obstetrical history
  - Family history

Allergies: List all reported allergies. If the refugee denies allergies, document no known allergies (NKA).

Current Medications: List all current medications, including non-prescription (over-the-counter) medications, traditional and/or herbal remedies, and therapies. The use of traditional and herbal therapies is common and can have significant health consequences due to drug-to-

drug interactions, teratogenicity, and contaminations with toxins. Determine if the refugee has adequate medications on hand.

Medical Problems: Record any conditions the refugee has had in the past or present. This information should include:

- Recent fever
- Diarrhea
- Cough
- Weight loss
- Night sweats
- Hemoptysis
- Known medical problems

Injuries/Accidents: List all past or present injuries/accidents.

Surgery: List all past or present surgical procedures.

Recent Family Illness: Record any conditions that indicate a communicable health condition or condition that will affect the family's integration.

Physical Assessment (Refer to Attachment A and B)

Head Circumference: Document the head circumference in centimeters for children up to and including 24 months of age.

Height: Document the height in inches

Weight: Document the weight in pounds

Body Mass Index (BMI): Document calculation for refugees ≥2 years old

Blood Pressure: Required for all refugees 3 years and older

Nutritional Status: Record the refugee's type of diet and history of weight gain or loss in the nutrition assessment in HMS.

Oral Health Screening: Perform an oral health screening on all refugees age 2 years and older. Document the appearance of gums, tooth loss, caries, and any present signs of inflammation.

Visual Acuity: Document results of eye exam using the Snellen eye chart or equivalent for children. For preverbal children**,** have the child follow a toy object or finger up, down, and to each side.

Hearing (Whisper Test): The clinician should stand an arm's length behind the refugee, so they cannot read the examiner's lips. The refugee is instructed to cover the tragus of the ear not being tested with one finger to obscure sound. The examiner whispers a distinct two-syllable word and then asks the patient to repeat the word. The test is then repeated for the other ear. For preverbal children, stand behind the child and whisper their name or snap fingers on one side and note if their head turns towards the sound. The test is then repeated for the other ear.

Audiometry Testing: Provide testing based on results of Whisper Test, as available.

Hearing Milestones	
0–3 months	Turns to you when you speak; is soothed by your voice when crying
4–6 months	Notices toys with sounds; responds to "no" and changes in your tone of voice
7 months–1 yr.	Responds to simple requests; turns or looks up when their name is called; recognizes words for common items
1–2 yrs.	Follows simple commands; points to simple pictures in books when they are named
2–3 yrs.	Understands difference in meaning (stop/go, up/down); can follow two requests ("pick up book and set on table")
3–4 yrs.	Responds to their name when called from another room; responds to simple who, what, when, and where questions
4–5 yrs.	Pays attention to simple stories and can answer questions about it

Eyes/Ears/Nose/Throat: Document any abnormalities.

Eyes: Using penlight, inspect size, shape, and symmetry of pupils. Ask patient to follow penlight up, down, and to each side. Assess alignment for inward or outward deviation.

Ears: Using an otoscope, first check for any foreign body. Then assess for any edema, lesions, discharge, or inflammation.

Nose: Tilt patient's head back, using penlight, or for convenience, use same speculum as used for ears, check for septum deviation or perforation. Examine each nostril for redness, swelling, or drainage. Mucosa should be pink. Ask if stuffy or allergies.

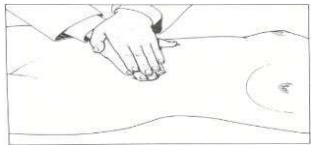
Throat: Inspect lips, gums, tongue, and the pharynx. Inspect lips for color and moisture. Inspect gums for ulceration, swelling, and color. Using a light and tongue blade, inspect tongue for redness, ulcers, white patches, nodules or lesions. Check tonsils for masses, lesions, nodules, drainage, or redness by asking the patient to open their mouth and say "ahh" while simultaneously pressing down on middle of tongue with tongue blade.

Chest/Lungs/Heart: Document any abnormalities.
Chest: Assess shape and symmetry of chest and position of ribs. With a stethoscope, listen to the rate, rhythm, and depth of breathing.

Lungs: Assess for quality and location of breath sounds, chest expansion as they inhale, and respiratory rate. Assess color of nail beds. Document the presence of a chronic cough (note whether the cough is productive or non-productive and character of secretions), wheezes, and hemoptysis.

Heart: Assess the heart rate, rhythm, and sounds by listening to the five sites (aortic, pulmonary, erb's point, tricuspid, and mitral). Document complaints or report of chest pain, palpitations, shortness of breath on exertion (for example, climbing stairs), dizziness/light-headed, edema to extremities, and abnormal heart rate.

Abdomen Palpation: Place the patient in a supine position. Ask patients with abdominal pain to point to the area of greatest pain. Deep palpation of the abdomen is performed by placing the flat of the hand on the abdominal wall and applying firm, steady pressure. It may be helpful to use two-handed palpation (see figure below), particularly in evaluating a mass. Here the upper hand is used to exert pressure, while the lower hand is used to feel. One should start deep palpation in the quadrant directly opposite any area of pain and carefully examine each quadrant. At each costal margin, it is helpful to have the patient inspire deeply to aid in palpation of the liver, gallbladder, and spleen. Document masses or pain.



Postural Assessment: Refer to Attachment E. A visual scan will detect significant asymmetries in posture – presence of head tilt, unlevel shoulders, abnormal gait, pelvis or scoliosis (back view); forward head carriage where ear lobes are anterior to shoulders, exaggeration of spinal curves (side view). Document CPT Code 97750 in Services in HMS.

Pap Smear: Recommended (not required) for sexually active women and all women >21 years of age every three years to identify changes in the cells of the cervix that show cervical cancer or conditions that may develop into cancer. Please note: Although the Pap smear is an important part of the physical assessment, the initial visit may not be an appropriate time or setting to perform a Pap smear, particularly if there is concern for past sexual abuse or if it would be particularly against a cultural norm. If not performed at the initial screening, assist the refugee with an appropriate referral. Only an MD or trained APRN can perform a Pap Smear.
For information about female genital mutilation and cutting, please see Attachment I.

General Education/Counseling: Provide introductory information about key health-related topics relevant to newly arriving refugees. Health education content must be documented in the patient record. Educational content of the health assessment should be delivered using

cultural competence (Refer to Attachment J) including, but not limited to:

- *Introduction to the U.S. health care system* — Refugees should be informed of their responsibilities regarding their own health status and use of health care, including primary care, emergency services, and dental care.
- *Introduction of the concept of primary care and preventive care* — Refugees should be knowledgeable about the importance of immunizations, early and periodic screening for children, and regular checkups for adults.
- *Access to health services* — Orient refugees to the logistics of office-based health care services, which may include the use of phone systems, scheduling appointments, after- hours coverage, missed appointments, and urgent care.
- *Insurance* — Brief introduction to the role of insurance in paying for health services and pharmaceuticals, including the role of Medicare, Medicaid, and private health insurance.
- *Immunizations* – Inform refugees about vaccine requirements for school attendance and adjustment of immigration status.
- *Emergency services and 911* — Provide information regarding the appropriate use of these services.
- *Disaster Preparation* — Provide information regarding creating a plan for disasters and local resources.
- *Oral health/dental care* — Education should emphasize personal hygiene, prevention of early childhood caries (use of dental sealants), use of fluoridated water and toothpaste, and regular dental care.
- *Medications* — Explain over-the-counter medications vs. doctor-prescribed medications; following directions as prescribed; and not to share prescription medication.
- *Healthy lifestyle* — Discuss nutrition, diet, exercise, tobacco cessation, safe sex, injury prevention and safety promotion.

For access to culturally relevant educational resources in multiple languages:

National Institute of Health: healthreach.nlm.nih.gov/

Referrals: Counseling and coordination of care with other providers or agencies should be provided and consistent with the nature of the problem(s) and the refugee's and/or family's needs. Document all applicable referrals in the HMS medical record, if indicated: TB, Vision, Mental Health, Hearing, OB/GYN, Dental, Communicable Diseases, Family Planning, Primary Care Provider (PCP), Disability Services, Pediatrics, Other (specify) (for example, high cholesterol, high blood sugar, or high blood pressure). For a sample referral form see Attachment N. If a referral form is given to a client, a copy should be uploaded into HMS. Be sure to instruct the client if a referral appointment has been made for them or if they are to schedule their own referral appointment.

- The CHD should demonstrate linkage to appropriate primary care or specialty care providers for follow-up services. Clients with an abnormal health condition that

requires ongoing care and treatment should have documentation of a referral to a primary care or appropriate specialty care provider. The CHD should ensure that referrals for general and specialty follow-up are appropriate and timely and, when possible, in proximity to the client's home. All refugees should be routinely referred to a primary care provider as a measure of continuity of care. The primary care referral code, R041, and any specialty referral codes should be documented in Services in HMS. When making referrals, provide refugees with provider names, phone numbers, and directions. Always document the referral information in the HMS medical record.

- The RHP has case managers in Duval, Hillsborough, and Orange counties to assist with referrals that should be used for refugees with ongoing medical care needs.

Mental Health: Required for refugees ≥14 years of age. Programs should make every effort to use the Refugee Health Screener-15 (RHS-15; Refer to Attachment F). Scan the completed RHS-15 into the client's record in HMS. If you are unable to complete the RHS-15 in its entirety, use the questions below in order to assess if a referral is needed. Document the questions and the client's responses in HMS. Document the mental health screening code, 97126, in Services in HMS. CHD staff should always review the OVME for any documented mental health history Class A or Class B distinctions during the initial refugee health visit. Prompt and appropriate referrals should be used as needed.

Questions to ask:

- How are you coping with the changes since arriving in the U.S.?
- Are you being helped by a sponsor, family member(s), or friends?
- Is there anything that is causing stress or worry for you or your family?
- Are you having any difficulties sleeping?
- Are you having difficulties with memory/concentration?
- Do you have any past mental health problems and/or treatment?
- How would you say you are feeling today?

Refer clients to a licensed clinician for a mental health assessment as appropriate based on responses and document referral. Do not ask leading questions and be sure to ask questions individually.

Human Trafficking

CHDs should post information on human trafficking in appropriate multiple languages wherever the public sees public health messages in CHD facilities. CHD staff are responsible for completing the TRAIN module on Human Trafficking, Blue Campaign (Course ID 1062487), as well as the TRAIN modules, SOAR Online. The State Health Office receives electronic notifications from the Department of Health and Human Services Office on Trafficking Persons regarding all certified Victims of Trafficking (VOT) who are resettling in Florida and are eligible to receive refugee health services and other public health benefits (acf.hhs.gov/otip/victim-assistance/services-available-to-victims-of-trafficking). The State Health Office will email the CHD clinical contact at the county where the VOT is resettling and provide an email containing a VOT spreadsheet. When a CHD receives a VOT notification, the CHD is responsible for contacting the representative of the individual (such as a case manager) to offer RHP services. If a CHD receives a referral or for a VOT from a local organization, the CHD should contact the State Health Office to confirm eligibility. Notify the State Health Office when the client accepts RHP services and an appointment is scheduled.

CHD staff in a variety of clinics may see VOT before they have been rescued from their trafficker(s). A VOT may look like many of the people you help every day. When providing one-on-one consultation, you can help trafficking victims get the assistance they need by looking beneath the surface for key indicators.

Key Indicators of Human Trafficking:

- Evidence of being controlled
- Evidence of an inability to move or leave job
- Bruises or other signs of battering
- Fear or depression
- Lack of passport, immigration, or identification documentation

Screening Questions to Assess Whether a Person is a VOT:

- Can you leave your job or situation if you want?
- Can you come and go as you please?
- Have you been threatened if you try to leave?
- Have you been physically harmed in any way?
- What is your working or living conditions like?
- Where do you sleep and eat?
- Do you sleep in a bed, on a cot, or on the floor?
- Have you ever been deprived of food, water, sleep, or medical care?
- Do you have to ask permission to eat, sleep, or go to the bathroom?
- Are there locks on your doors and windows so you cannot get out?
- Has anyone threatened your family?
- Has your identification or documentation been taken from you?
- Is anyone forcing you to do anything that you do not want to do?

Communicating With Known or Possible Victims

Health care providers should use therapeutic communication when interacting with known or possible victims. A trauma-informed approach can be used which applies basic knowledge of trauma and acknowledges the impact it has on a person's life. Communication is prefaced with a supportive intent and is strategic to avoid re-traumatization. When performing a health assessment on a trauma victim, empower them by offering choices when applicable. For example, a provider could ask, "Would you like to keep your shirt on during the exam or use a gown?" It is also important to explain each step of the assessment and what you are doing as you progress. In all communication, a health care provider should be sure to be consistent, supportive, and non-judgmental.

The Department of Health's Approach

Florida takes a public health approach to combatting human trafficking. Given the diverse populations the DOH serves, there is great potential for victims of human trafficking to encounter the DOH. DOH is committed to moving from awareness to action in its efforts to eradicate human trafficking in Florida.

Reporting a Victim of Trafficking

- If a health care provider at a CHD identifies a VOT who is a minor, the child welfare laws apply, mandating reporting regardless of whether the victim wants you to report it or not. This is applicable for both labor and sex trafficking. See section 39.201, Florida Statutes.

- If a health care provider at a CHD identifies a VOT who is an adult (18 or older), they can only report it with the consent of the victim. To ensure permission is given, the provider should call the Human Trafficking Hotline (**1-888-373-7888)** in the presence of the victim.

- If human trafficking is suspected, the clinician should:
    - Discuss the suspicion with the clinician 's supervisor.
    - Call the **Human Trafficking Hotline at 1-888-373-7888** (TTD/TTY).
    - Follow existing mandatory reporting protocols for victims of child abuse.
    - Follow existing protocols for victims of domestic violence.
    - Provide information. Certified trafficking victims may be eligible for public benefits and services to the same extent as refugees.

The HHS Rescue and Restore website is a great resource for information and materials, including toolkits for health care providers, posters, and fact sheets. Other information, training, and resources are listed below.

Information/Resources	Links
ORR Anti-Trafficking in Persons	acf.hhs.gov/otip
National Human Trafficking Resource Center	polarisproject.org/
Human Trafficking: *The Role of the Health Care Provider*	ncbi.nlm.nih.gov/pmc/articles/PMC3125713/
Sexual Exploitation of Children	centerforchildwelfare.fmhi.usf.edu/SexualExploitation.shtml
Human Trafficking and Health Care	polarisproject.org/human-trafficking-and-the-health-care-industry/
Florida Statewide Council on Human Trafficking	myfloridalegal.com/pages.nsf/Main/8AEA5858B1253D0D85257D34005AFA72
Human Trafficking Nursing Toolkit	acf.hhs.gov/otip/training-technical-assistance/resource/nhhtacadultscreening
Trauma-Informed Human Trafficking Screenings	humantraffickinghotline.org/resources/trauma-informed-human-trafficking-screenings
HHS Rescue and Restore	acf.hhs.gov/archive/otip/outreach-material/rescue-restore-campaign-tool-kits

Domestic Abuse and Sexual Violence: It is highly recommended for all clients to be assessed for domestic and sexual violence. The client must be alone, or if a child is present, the child must not be of verbal age. Once total privacy has been established, ask questions as stated in HMS and provide the appropriate referral. If abuse has been identified or suspected, follow section 39.201, Florida Statutes.

If you need help, advocates at the National Domestic Violence Hotline understand immigration issues and can talk with you about your situation. The hotline has Spanish speakers available, as well as translators for more than 170 languages, 24 hours a day. For help, call 1-800-799-SAFE (7233) or TTY 1-800-787-3224. Additional information can be found at thehotline.org.

Core Lab Services (Refer to Attachment B)

Urinalysis (U/A): Required for all refugees old enough to provide a clean-catch urine specimen.

Pregnancy Testing: Urine pregnancy test should be performed for all women of childbearing age and pubescent adolescent girls. Repeat pregnancy test if date of last unprotected sex is within 14 days and first test was negative (if menses is not reported since last unprotected sex) using an opt-out approach.

- This does not apply to women who have had tubal ligation or a hysterectomy or are no longer ovulating.
- Indicate if currently pregnant or breast feeding, and document last Pap smear (PAP) and menstrual period (LMP).
- It is necessary to obtain a pregnancy test before providing live vaccines.
- Consider testing any refugee (including children) who has a history of sexual assault (including incest or underage marriage).

CBC With Differential: Required for all refugees. A complete blood count can provide information for many conditions, including indication of parasitic infections with elevated eosinophils (>400 cells/µL).

Comprehensive Metabolic Panel: Required for all refugees to evaluate organ function and check for conditions such as diabetes, liver, and kidney disease.

Lead Testing: The CDC recommends that refugee health screening clinics perform an initial blood lead test for all infants and children ≤ 16 years of age. Older adolescents (> 16 years) should also be tested if there is a high index of suspicion (siblings with elevated blood lead level (EBLL), suspected environmental exposures, etc.). All pregnant or breast-feeding women and adolescent girls should be tested. Testing must be completed within 90 days of arrival into the United States.

A repeat blood lead test should be performed 3 to 6 months after refugee children ≤ 6 years are placed in their permanent residence. The repeat blood lead test should be considered a medical necessity regardless of the initial test's result. Children and adolescents, 7-16 years, should be retested in 3 to 6 months with EBLL at initial screening. For adolescents > 16 years of age, consider performing a repeat blood lead test in 3 to 6 months. For pregnant and breast-feeding women and adolescent girls, a repeat blood test is recommended with EBLL at initial screening.

Refer to the Lead Screening Quick Guide (Attachment Q) for additional information.

In accordance with the most recent CDC guidelines, a lead poisoning case and EBLL is defined as a blood lead level ≥5 µg/dL. All capillary blood lead levels ≥5 µg/dL should be confirmed with a venous test. Children with blood lead levels ≥5 µg/dL must be reported to LPPP for case management and follow-up activities that may include investigation of the child's home and other environments for lead hazards, as well as testing of all family members. Lead poisoning is a reportable disease in Florida and all blood lead test results are required to be reported to the Lead Poisoning Prevention Program (LPPP) with

electronic reporting being the preferred method. If the county health department contracts lead testing to a commercial lab (ex: Quest or LabCorp), the commercial lab will report the test result to LPPP. If the test is performed at the county health department, the county health department must report the results to Ms. Sudha Rajagopalan, LPPP Coordinator, at Sudha.Rajagopalan2@flhealth.gov.

Assay of Iron: Required for refugee children age 6 months to 6 years old to screen for iron deficiency or iron overload.

Newborn Screening: Recommended within the first year of life. Refer to the Florida Newborn Screening Program or a primary care provider for the provision of newborn screening services.

Measles (Rubeola), Mumps, Rubella (MMR) Antibody: Recommended for all adult refugees born 1957 or later who lack immunization verification. Children 18 years and younger do not need an MMR antibody test prior to immunization.

Varicella Zoster Antibody: Recommended for all adult refugees who lack immunization verification.

Internal Parasites: Required for all refugees based on their point of departure and pre-departure presumptive therapy in accordance with CDC guidelines. In cases when documentation is not available, it is reasonable to assume presumptive treatment has been received by the refugee if the refugee is from a population where the pre-departure presumptive treatment program is currently implemented and as long as they had no contraindications at the time of departure. Refer to Attachment P.

- If a refugee is from Africa, Asia, the Middle East, Latin America, or the Caribbean (which includes Cuba and Haiti), and did not receive pre-departure presumptive parasite treatment, perform two O&P tests on separate morning stools at least 48 hours apart, a CBC with differential for eosinophil count, and a *Strongyloides* serologic test. See Superbill for CPT codes. If a refugee is from Eastern Europe and did not receive presumptive pre-departure parasite treatment, perform two O&P tests on separate morning stools at least 48 hours apart and a CBC with differential for eosinophil count only, as *Strongyloides* serologic testing is not required for refugees from Eastern Europe.

- If a refugee is from sub-Saharan Africa and did not receive pre-departure presumptive parasite treatment, the refugee should additionally be tested for Schistosomiasis. Refer to Superbill, Attachment L, for CPT code.

- If a refugee did receive pre-departure presumptive treatment, perform a CBC with differential only.

- Pre-departure presumptive parasite treatment should be documented on the

overseas records; however, it is recognized that it may not be consistently documented. If a refugee was processed in a country that has a presumptive parasite treatment program in place, it is reasonable to assume that the refugee received pre-departure presumptive parasite treatment as long as the refugee had no contraindications at the time of departure. To determine in what country a refugee was processed, refer to the Overseas Processing Entity (OPE) that is listed on the refugee's overseas records.

- If a refugee did receive pre-departure presumptive treatment, but the refugee has gastrointestinal symptoms and/or diarrhea, anemia, or weighs less than fifth percentile, collect two O+P tests and a *Strongyloides* test.

Tuberculosis: All refugees 6 months of age or older must be screened for tuberculosis, regardless of Bacillus Calmette-Guérin history, unless medically contraindicated.

In 2020, the Tuberculosis (TB) Program implemented new TB templates and TB Risk Screening processes in HMS. The implementation of the templates and other navigational enhancements may require modifications to current RHP processes in which daily visits with patients are charted. The TB processes require the creation of a clinical visit and the completion of a TB Risk Screening, a new feature in the medical history.

The TB templates contain specific sets of questions, result views, and educational guidance for a specialized set of processes to reduce the work associated with data collection. The risk screening process identifies all RHP clients as at risk for TB because they are foreign born from a high incidence country. If you have questions about TB Screening or the new TB Templates, you can contact the State Health Office RHP or the TB Program regional nurses at DLTBNursingConsultants@flhealth.gov.

TB tests include:

- Tuberculin Skin Test (TST): Appropriate for infants up to two years of age. Perform and record the date the TST is placed, the date read, and diameter of induration in millimeters. The skin test should be read by qualified personnel between 48–72 hours.

- Due to the current national shortage of purified protein derivative products, in general, IGRA testing is preferred to TST for children two years and older.

- Until the shortage is resolved, limited supplies of purified protein derivative should be prioritized to test persons under two years of age.

- Interferon-Gamma Release Assay (IGRA): Appropriate for refugees ≥ two years of age. Record date of IGRA and result. Refer all positive test results to the CHD TB clinic.

- TST and IGRA should not be administered for at least 28 days after receiving a varicella, smallpox, or any live-virus vaccine.

- A repeat IGRA or a TST can be performed when the initial IGRA result is indeterminate, borderline, or invalid.

If a client reports that they are relocating before follow-up interventions have been initiated or completed or if a client needs continuity of care regarding known or suspect TB disease or LTBI, an interjurisdictional form (IJN) should be sent to the appropriate public health contact for both in-state or out-of-state relocation (refer to Attachment O). Review the Extended Services section for information specific to chest X-ray guidelines.

For more information regarding TB testing, refer to CDC guidelines.

cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html

Chlamydia/Gonorrhea (CT/GC) Amplified Urine Test: Required for female refugees <25 years old who are sexually active or female refugees ≥25 years old who have risk factors (refer to Risk Factor Checklist, Attachment C) who do not have documented pre-departure testing. Risk factors must be documented for those screened outside of the recommended age range. Testing can also be performed for anyone with symptoms.

Symptoms for females:

- Unusual vaginal discharge
- Intermenstrual vaginal bleeding
- Lower abdominal or pelvic pain
- Burning on urination
- Pain, bleeding, or discharge from the rectum

For males, only test if they have symptoms (urethral discharge, dysuria, or rectal pain or discharge) or if they have been sexually assaulted.

Syphilis RPR (screening): Required for all refugees ≥15 years of age if no overseas results are available and for children <15 with risk factors (refer to Risk Factor Checklist, Attachment C, Risk factors must be documented for those screened outside of the recommended age range.

Symptoms:

- Firm, round, small, and painless sore (chancre), on the genitals, anus, or mouth
- Rash on the body, especially on the palms of the hands or the soles of the feet
- Swelling or enlargement of the lymph nodes

HIV Testing and Counseling: Required for all refugees 13–64 years of age, using an opt-out approach. Screening all refugees, including those ≤12 years and ≥64 years of age, is also encouraged and is reimbursable. If a refugee has a documented history of HIV on the OVME,

testing should still be offered using an opt-out approach; however, it is important to refer the client to the HIV program on the first encounter for proper linkage to care. Referrals should be documented in HMS. If a refugee opts out, document that in HMS.

Risk factors for HIV include:

- Injected drugs or steroids, during which equipment (such as needles, syringes, cotton, water) and blood were shared with others
- Unprotected vaginal, anal, or oral sex (that is, sex without using condoms)
- Exchanged sex for drugs or money
- Received a blood transfusion or clotting factor during 1978–1985
- A diagnosis of, or treatment for, hepatitis, TB, or STD such as syphilis

For more information regarding HIV testing, refer to CDC guidelines:

Screening for HIV Infection During the Refugee Domestic Medical Examination. Centers for Disease Control and Prevention. (2012). Retrieved from cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html

Hepatitis Screening and Immunization: Hepatitis B panels should be performed when a refugee is from a country with intermediate (≥2%–7%) or high (≥8%) prevalence of chronic HBV infection and did not receive testing for HBsAg overseas.

Hepatitis A or B vaccinations are only reimbursable by the RHP if an adult refugee is not immune, does not have an active/chronic infection, and has a risk factor for hepatitis A or B. Risk factors should be documented in the electronic medical record. If a risk factor is present, the applicable hepatitis screening test can be ordered to ensure that the client does not have an active/chronic infection nor previous immunity prior to vaccination. Refer to Attachment D.

Hepatitis C screening should be performed at least once in a lifetime for all adults aged ≥18 years and for all pregnant women during each pregnancy. Children born to mothers with hepatitis C virus infection should have one-time hepatitis C testing regardless of age. Regardless of age or setting prevalence, all persons with risk factors should be tested for hepatitis C, with periodic testing while risk factors persist. Any person who requests hepatitis C testing should receive it.

For more information regarding hepatitis testing, refer to CDC guidelines:

Hepatitis Screening Guidelines (2019). Centers for Disease Control and Prevention. Retrieved from cdc.gov/immigrantrefugeehealth/guidelines/domestic/hepatitis-screening-guidelines.html.

Malaria Testing: Due to the complexity of malaria testing, it is not feasible to perform in a refugee clinic setting. Refugees from sub-Saharan Africa who did not have contraindications should be assumed to have received pre-departure presumptive antimalarial therapy. If a refugee from sub-Saharan Africa did not receive pre-departure presumptive antimalarial therapy, presumptive antimalarial treatment can be considered domestically, if there are no

current contraindications, in accordance with CDC post-arrival presumptive malaria treatment guidelines. Refugees should be assessed for signs and symptoms of malaria and referred to an emergency room if signs or symptoms are present. Symptoms include fever and flu-like illness, including shaking chills, headache, muscle aches, and tiredness. Nausea, vomiting, and diarrhea may also occur. Malaria may cause anemia and jaundice.

For more information regarding malaria, refer to CDC guidelines:

Malaria: Domestic Guidelines (2019). Centers for Disease Control and Prevention. Retrieved from cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html#table2.

Other mosquito-borne disease
Many mosquito-borne diseases that are not found in the U.S. can potentially be introduced to Florida via infected travelers including immigrating refugees. Malaria, dengue, Zika, chikungunya, and yellow fever are examples of diseases that infected travelers could introduce to Florida mosquitoes and cause disease outbreaks. For this reason, when suspected cases of these diseases are identified, the county epidemiology staff immediately notify local mosquito control to help prevent local introductions. To ensure rapid mosquito control response, please promptly notify your epidemiology program if a client is suspected or know to have any reportable condition including mosquito-borne diseases.

- County epidemiology contact information can be found at FloridaHealth.gov/CHDEpiContact
- The current list of reportable conditions in Florida is available at FloridaHealth.gov/diseases-and-conditions/disease-reporting-and-management/_documents/reportable-diseases/_documents/reportable-diseases-list-practitioners.pdf

Laboratory Results Responsibilities: Each CHD should have a process for electronically reviewing lab results in HMS and informing clients of abnormal results in a prompt manner. Review of lab results and follow-up if needed should be documented in HMS.

All practitioners, hospitals and laboratories in Florida are required to notify DOH of diseases or conditions of public health significance under section 381.0031, Florida Statutes, and Chapter 64D-3, Florida Administrative Code. Practitioners, hospitals, medical facilities, laboratories, schools, nursing homes, state institutions or other locations providing health services are required to notify DOH of diseases or conditions and the associated laboratory test results listed in the *Table of Reportable Diseases or Conditions to Be Reported*, Rule 64D-3.029, Florida Administrative Code.

For information regarding diseases and conditions that are reportable by law, refer to floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/index.html

Extended Lab Services

Chest X-ray (PA & Lateral): Required for all individuals with a positive TB skin test or IGRA. A chest X-ray should also be performed for those individuals classified as TB Class A or TB Class B during the overseas medical exam and for those who have symptoms compatible with TB disease, regardless of TB test results. Each CHD should designate a staff member to monitor clients' compliance when chest X-rays are ordered and ensure that chest X-ray reports are uploaded in HMS, reviewed by a clinician, and result in a TB program referral as needed.

Syphilis Enzyme Immunoassay (EIA): Recommended for all refugees with a positive syphilis RPR screening. Refugees with positive confirmatory results should be referred to the STD clinic in the CHD.

Continuity of Care

CHDs should routinely ask clients if they initiated the refugee health assessment at another CHD or outside provider. Anytime a client reports that they have had services elsewhere, records should be obtained to determine what services were already provided. If a client-initiated services at another CHD, a clinical summary known as a Continuity of Care Document (CCD) can be generated through HMS and sent to the medical records point of contact. It is very important for CHDs to review medical records for clients who have transferred (initiated at one CHD or outside provider and continue services at a different CHD) to ensure that appropriate referrals are made in the new county if needed. When requesting or sending a CCD from one CHD to another CHD, Direct Messaging can be used within the HMS. If a client requests to have access to their medical record, HealthVault can be used. HealthVault provides patients the ability to view online, download, and transmit their health information. Patients must sign the HealthVault consent form and provide an email address.

To view a pre-recorded webinar for using both Direct Messaging and HealthVault see the link below:

floridahealth.sharepoint.com/sites/INFORMATIONTECHNOLOGY/CLINIC/ClinicInformatics/meaningfuluse/SitePages/Home.aspx

*For more information on how to create a CCD in HMS, see page 94.

Refugee Health Assessment References:

CDC, *Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees*, www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html Accessed on September 23, 2021.

CDC, *Domestic Intestinal Parasite Guidelines*, www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html. Accessed on September 23, 2021.

CDC, *General Refugee Health Guidelines*, www.cdc.gov/immigrantrefugeehealth/pdf/general.pdf. Accessed on September 23, 2021.

CDC, *Guidelines for Screening for Tuberculosis Infection and Disease During the Domestic Medical Examination for Newly Arrived Refugees*, www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html. Accessed on September 23, 2021.

CDC, *Childhood Lead Poisoning Prevention*, www.cdc.gov/nceh/lead/. Accessed on September 23, 2021.

CDC, *Screening for Viral Hepatitis During the Domestic Medical Examination of Newly Arrived Refugees* https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/hepatitis-screening-guidelines.html. Accessed on September 23, 2021.

CDC, *Recommendations for Hepatitis C Screening Among Adults — United States, 2020*, www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm . Accessed on September 23, 2021.

CDC, *Screening for HIV Infection During the Refugee Domestic Medical Examination*, www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html. Accessed on September 23, 2021.

CDC, *Advisory Committee for Immunization Practices (ACIP): ACIP Vaccine Recommendations*, www.cdc.gov/vaccines/hcp/acip-recs/index.html. Accessed on September 23, 2021.

DOH, *Practitioner Lead Reporting Requirements*, FloridaHealth.gov/environmental-health/lead-poisoning/practioner-reporting-lead.html. Accessed on September 23, 2021.

CDC, *Immigrant and Refugee Health, Global Migration and Quarantine, Centers for Disease Control and Prevention, United States Department of Health and Human Services*, www.cdc.gov/ncezid/dgmq/index.html. Accessed on September 23, 2021.

Massachusetts Department of Public Health, *Postural Screening Assessment*, https://www.mass.gov/doc/postural-screening/download. Accessed on September 23, 2021.

Negash, Eskinder. *Revised Medical Screening Guidelines for Newly Arriving Refugees*, ORR State Letter #12-09, 07/29/13. Office of Refugee Resettlement, Administration for Children and Families, United States Department of Health and Human Services, www.acf.hhs.gov/orr/resource/state-letter-12-09. Accessed on September 23, 2021.

IMMUNIZATION GUIDELINES

Review Immunization Certification/Documents

To protect U.S. public health, the ORR encourages all refugees to be vaccinated as soon as possible after entry into the U.S. Review the refugee's Immunization Certification/documents to ensure that every refugee is appropriately immunized against vaccine-preventable diseases according to the vaccine schedules of the CDC's Advisory Committee on Immunization Practices (ACIP). It is also necessary to review vaccination history in order to prevent redundant vaccine administration. Vaccination criteria are based on age appropriateness, to protect against disease that can cause an outbreak, and protect against disease that has or is in the process of being eliminated in the U.S. Checking for laboratory evidence of immunity (i.e., antibody levels) is an acceptable alternative to vaccination when previous vaccinations or disease exposure are likely. However, the clinician should be familiar with the efficacy and interpretation of available serologic tests when relying on testing as proof of immunity.

Vaccinations through the RHP will assist refugees when they apply for adjustment of status to lawful permanent resident. All immunizations received prior to arrival into the U.S. should be entered into Florida SHOTS and documented in the client's health records. CHDs should now be entering the adult vaccine inventory into Florida SHOTS under Program Component 18 and no longer enter under Program Component 05 (Refer to page 46). All Florida SHOTS should be imported into HMS or entered manually.

Notice from the Department of Health and Human Services:

Although U.S.-bound refugees are not required to be vaccinated prior to arrival in the U.S., vaccination during the overseas medical examination is recommended for their health. While the goal is to provide at least two doses of each vaccine, the vaccines administered depend on availability and logistics at each site as well as the refugee's date of arrival. First vaccine doses are given at the overseas medical screening examination (approximately three to six months prior to departure), and second doses are typically given one to two months after the initial dose. Refugees who undergo multiple medical examinations overseas may receive additional vaccine doses. Live-virus vaccines will not routinely be administered less than four weeks before departure, except in certain outbreak settings.

Immunizations in a CHD Setting:

- Immunizations are still an eligible benefit even if a refugee has received a health assessment somewhere else in the U.S. However, immunizations need to be completed within one year of arrival and a refugee must have completed the health assessment within eight months from the arrival date. If the refugee had the health assessment with an outside provider, they must show documentation that should then be uploaded into the clinician portal under the clinician reports tab in HMS.

- If an eligible refugee had their immunizations initiated within one year of their date of arrival and the health assessment was completed within eight months of their date of arrival (regardless of where the health assessment was provided), **a CHD may provide immunizations to a refugee for up to one year from the date of the refugee's arrival.**

- The RHP can only reimburse ORR-approved vaccines for eligible adult refugees within the first year from their date of arrival and in accordance with age-appropriate guidelines set by ACIP. (See the immunization electronic resources for a direct link to the latest immunization schedule.)

- Providers should refer to the DS-3025 (Vaccination Worksheet) form to determine which vaccinations were received overseas.

The Hepatitis B Vaccine: *Memo*

Per the Department of Health and Human Services, refugees are offered pre-vaccination testing for hepatitis B virus infection. Refugees are tested for hepatitis B surface antigen (HBsAg) and receive hepatitis B vaccine only if HBsAg negative. Typically, HBsAg-negative persons receive up to two hepatitis B vaccine doses, if due. However, negative household contacts of hepatitis B-positive persons may be given an additional (third) dose of hepatitis B vaccine. Because the third dose may be given close to the time of departure, states should be aware that if such persons are re-tested less than one month after vaccination, their hepatitis B surface antigen may be falsely positive.

The Varicella Vaccine: *Memo*

Per the Department of Health and Human Services, there has been an outbreak of varicella (chickenpox) among refugees from various countries. Although the varicella vaccine is not required for refugees before departure to the United States, it is possible that a varicella vaccine was administered 14 days prior to departure for the United States to decrease the risk of varicella. Always assess the overseas medical record to determine if a first dose of the varicella vaccine was already administered. The second varicella vaccine dose should be given at least four weeks after dose 1 for people aged 13 years or older or at least three months after dose 1 for children younger than 13.

The Influenza Vaccine: The Influenza vaccine is reimbursable by PC18 and can be administered once per client within the first year of arrival for adjustment of status. The Centers for Disease Control and Prevention has developed four seasonal flu documents in 11 different languages to improve knowledge of seasonal flu in refugee populations. The documents are: Flu and You, Cleaning to Prevent Flu, Talking to Children About Flu, If Your Child Gets Sick with Flu. To view or download these documents visit https://www.cdc.gov/immigrantrefugeehealth/resources/index.html. Accessed September 23, 2021.

Human Papillomavirus (HPV) and Zoster Vaccines: These are no longer required for adjustment of status but are still reimbursable by the RHP if applicable per the ACIP schedule.

Immunization Electronic Resources: Review the following sources for more information on the updated CDC immunization schedule guidelines.

Vaccination Program for U.S.-Bound Refugees (2021). Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas-guidelines.html#vaccination-program. Accessed September 23, 2021.

Evaluating and Updating Immunizations During the Domestic Medical Examination for Newly Arrived Refugees (2021). Centers for Disease Control and Prevention.
Retrieved from www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/immunizations-guidelines.html . Accessed September 23, 2021.

Recommended Immunization Schedule for Adults (2021). Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/vaccines/schedules/hcp/adult.html.
Accessed September 23, 2021.

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger (2021). Centers for Disease Control and Prevention.
Retrieved from www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html.
Accessed September 23, 2021.

FLORIDA SHOTS – REFUGEE HEALTH SERVICE

Manually Receiving Inventory

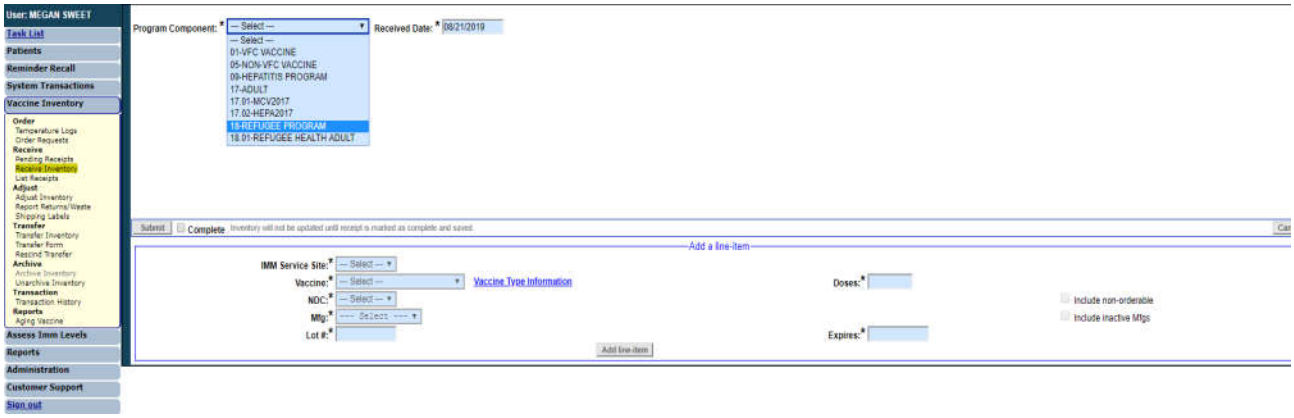
Users should manually receive vaccine into their CHD's Florida SHOTS account when receiving a vaccine which was purchased with CHD funds directly from the Florida Alternative Contract Source (ACS) such as Cardinal. This vaccine should then be charged to Florida SHOTS when administered. This type of vaccine is considered "Program 18" in Florida SHOTS.

To manually receive inventory, follow these steps:

1. Log into Florida SHOTS.
2. Select **Vaccine Inventory.**
3. Select **Receive Inventory.**
4. Select **Program Component 18.**
5. Complete the vaccine information at the bottom of the page and select **Add line-item**. If you have more than one vaccine to add, you should continue adding line items. Then, upon completion, check **Complete** and then click **Submit.**

These vaccines are now listed in your CHD's inventory and are available for administrations recorded within Florida SHOTS.

Figure 1



Accepting Pending Receipts

- Vaccines ordered from the CDC contract through Florida SHOTS is identified as Program Component 18.01 in Florida SHOTS. You will receive an auto-generated pending receipt in Florida SHOTS for this vaccine.
- Pending receipts in Florida SHOTS notifies your office that the vaccine has been shipped as well as any vaccine transfers from another provider. By accepting a pending receipt, you confirm having received the vaccine and that the vaccine will be added to your inventory.

- If there are unapplied pending receipts for your site(s), those with inventory rights will be notified when logging into Florida SHOTS to "Apply Pending Receipts/Transfers." There is also an option on the toolbar to view pending receipts.

Select on **Line Items** to apply this receipt to your inventory balance.

Figure 2

Adding a Vaccination Record

When entering refugee client data into Florida SHOTS, CHDs are **REQUIRED** to select **Refugee Health Services** and then code the vaccine to PC01 for Vaccine for Children (VFC) *only if the patient is under 19 years of age.*

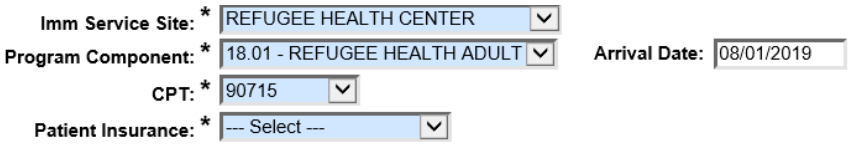
Figure 3

For patients 19 years of age and older, if you are using a vaccine that has been received into inventory as PC18, you will select **18-Refugee Program** for the Program Component. If you are using vaccine that has been received into inventory as PC18.01 you will select **18.01 – Refugee Health Adult** for the Program Component. As this serves the same function as the **Refugee Health Services** checkbox, that checkbox will no longer be shown.

Figure 4

After you have selected one of the two Program Components, you will need to enter the **Arrival Date.** Please be sure to check the refugee's paperwork to ensure the correct date is entered here.

Figure 5



For the **Arrival Date** to be accepted, it:

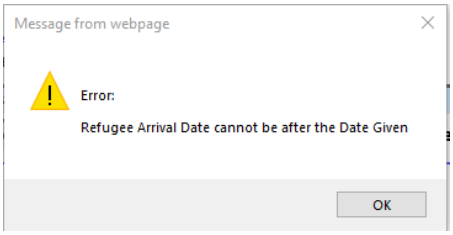
- Must be less than 365 days prior to the date of administration.
- Cannot be prior to the patient's DOB.
- Must not be after the date of administration.

If the **Arrival Date** is greater than 365 days, you will receive a warning message.

Figure 6

If you attempt to add a vaccination that was administered before the **Arrival Date** you will receive an error message. Once OK is selected, enter the correct date of administration or **Arrival Date** before proceeding with adding the shot.

Figure 7



Manually Receiving Inventory

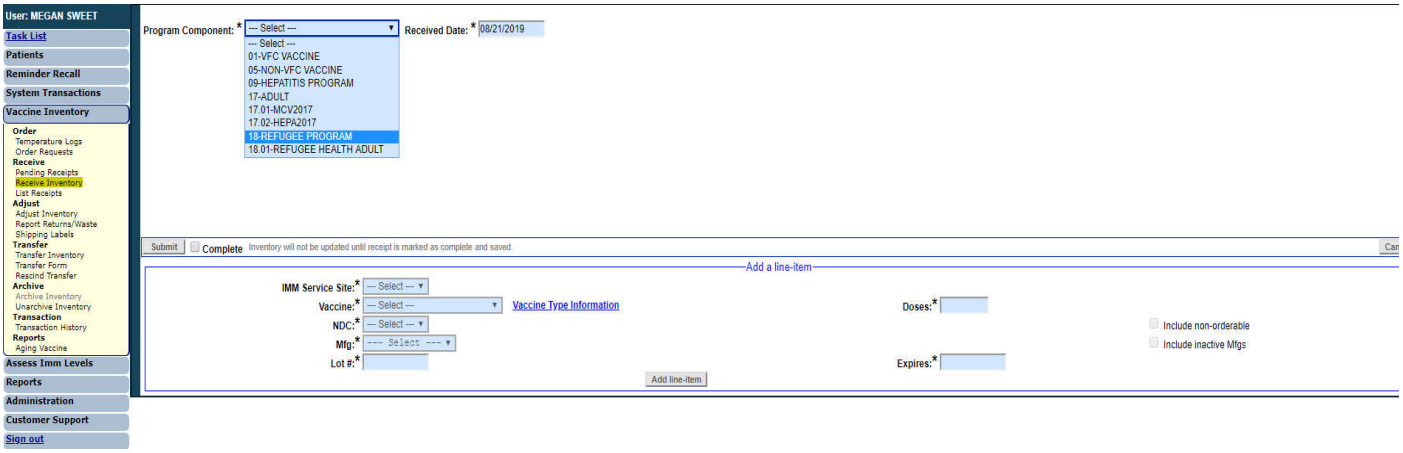
Users should manually receive vaccine into their CHD's Florida SHOTS account when receiving a vaccine which was purchased with CHD funds directly from the Florida Alternative Contract Source (ACS) such as Cardinal. This vaccine should then be charged to Florida SHOTS when administered. This type of vaccine is considered "Program 18" in Florida SHOTS.

To manually receive inventory, follow these steps:

6. Log into Florida SHOTS.
7. Select **Vaccine Inventory.**
8. Select **Receive Inventory.**
9. Select **Program Component 18.**
10. Complete the vaccine information at the bottom of the page and select **Add line-item**. If you have more than one vaccine to add, you should continue adding line items. Then, upon completion, check **Complete** and then click **Submit.**

These vaccines are now listed in your CHD's inventory and are available for administrations recorded within Florida SHOTS.

Figure 1



Accepting Pending Receipts

- Vaccines ordered from the CDC contract through Florida SHOTS is identified as Program Component 18.01 in Florida SHOTS. You will receive an auto-generated pending receipt in Florida SHOTS for this vaccine.
- Pending receipts in Florida SHOTS notifies your office that the vaccine has been shipped — as well as any vaccine transfers from another provider. By accepting a pending receipt, you confirm having received the vaccine and that the vaccine will be added to your inventory.
- If there are unapplied pending receipts for your site(s), those with inventory rights will be notified when logging into Florida SHOTS to "Apply Pending Receipts/Transfers." There is also an option on the toolbar to view pending receipts.

Select on **Line Items** to apply this receipt to your inventory balance.

Figure 2

Adding a Vaccination Record

When entering refugee client data into Florida SHOTS, CHDs are **REQUIRED** to select **Refugee Health Services** and then code the vaccine to PC01 for Vaccine for Children (VFC) - *only if the patient is under 19 years of age.*

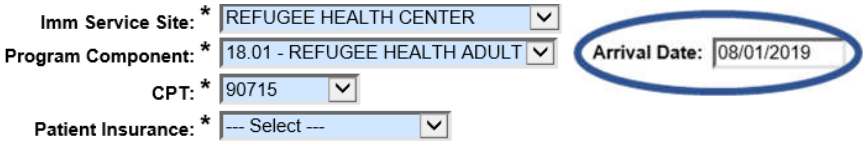
Figure 3

For patients 19 years of age and older, if you are using a vaccine that has been received into inventory as PC18, you will select **18-Refugee Program** for the Program Component. If you are using vaccine that has been received into inventory as PC18.01 you will select **18.01 – Refugee Health Adult** for the Program Component. As this serves the same function as the **Refugee Health Services** checkbox, that checkbox will no longer be shown.

Figure 4

After you have selected one of the two Program Components, you will need to enter the **Arrival Date.** Please be sure to check the refugee's paperwork to ensure the correct date is entered here.

Figure 5



For the **Arrival Date** to be accepted, it:

- Must be less than 365 days prior to the date of administration.
- Cannot be prior to the patient's DOB.
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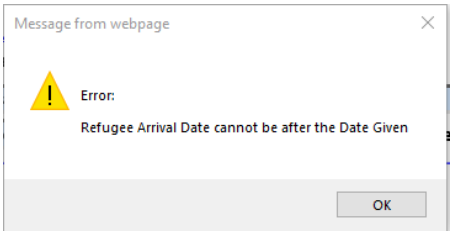
If you attempt to add a vaccination that was administered before the **Arrival Date** you will receive an error message. Once OK is selected, enter the correct date of administration or **Arrival Date** before proceeding with adding the shot.

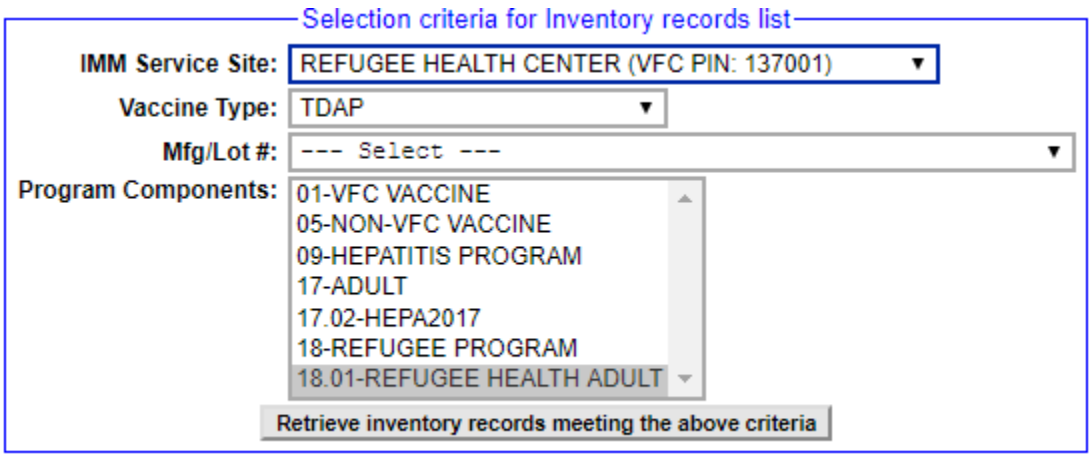
Figure 7



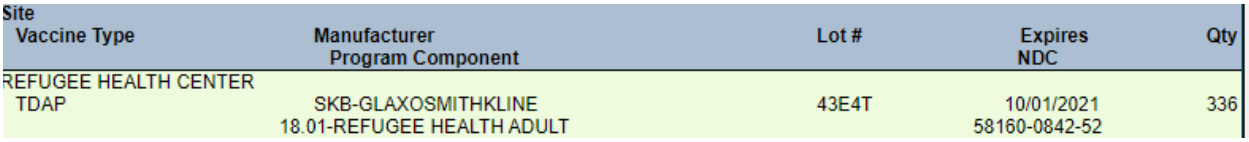
Transferring Inventory

There may be times when you need to transfer RHP vaccines from your PC 05 inventory to PC 18.01. To do so, follow these steps:

1. Select **Vaccine Inventory**
2. Select **Transfer Inventory**
3. Select your **IMM Service Site**, the **Vaccine Type** you are transferring, the **Mfg/lot #** (you may want to leave this option blank), and the **Program Component**
4. Select **Retrieve inventory records meeting this above criteria**



The results that meet the criteria you selected will be displayed.



Site Vaccine Type	Manufacturer Program Component	Lot #	Expires NDC	Qty
REFUGEE HEALTH CENTER TDAP	SKB-GLAXOSMITHKLINE 18.01-REFUGEE HEALTH ADULT	43E4T	10/01/2021 58160-0842-52	336

5. Select the lot that you are transferring

This will bring you to the **Transfer Inventory** page.

6. Enter the **Effective Date**
7. Leave **Receiver PIN** blank
8. **Providing Organization** is already populated with your organization
9. **Site** select your site from the drop-down menu
10. Enter the **Transfer Quantity**
11. Select the transfer **Reason.** The only reason listed will be **Pay Back Inventory**. It is okay to use this reason.
12. Enter a **Comment** detailing the reason for the transfer

13. Click **Submit**

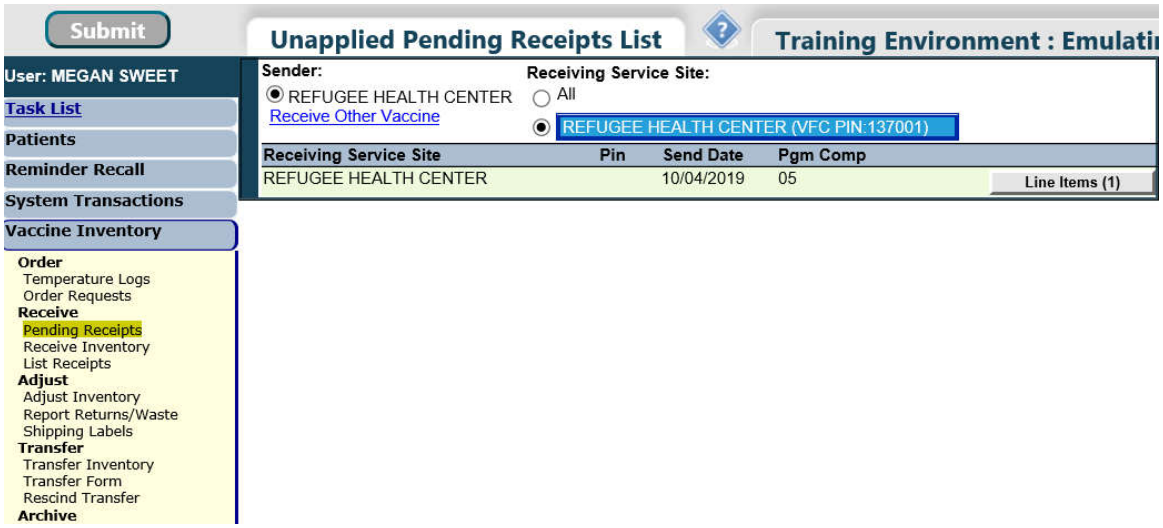
You will get a pop-up letting you know that your transfer out was successful.

Accepting Transfers to Change Program Components

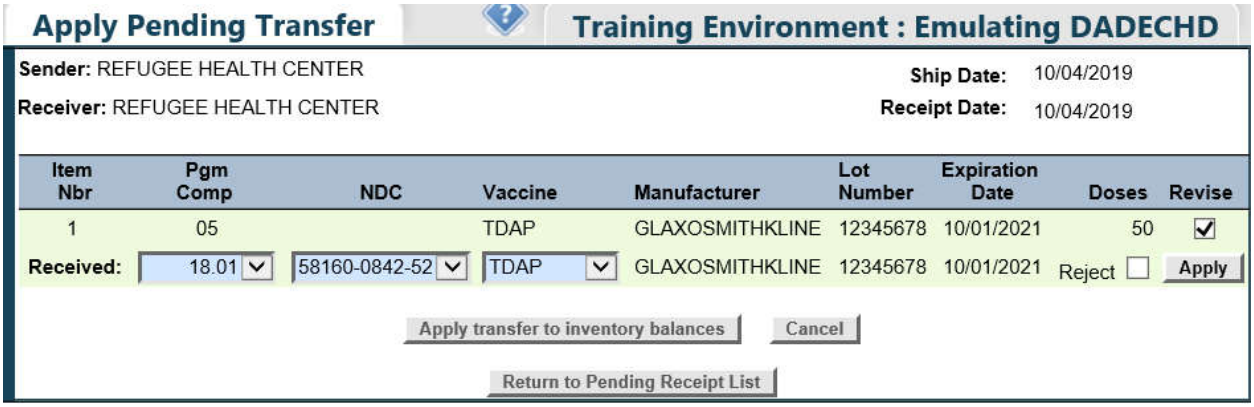
To successfully complete the transfer of the inventory into PC18.01 (Refugee Health Adult), you must accept the pending transfer receipt that was created in the previous step.

1. Select **Pending Receipts** from the Florida SHOTS menu

This page will display any pending receipts for your organization. Be sure you only select the ones for your PIN.



2. Click on ***Line Items*** to go to the **Apply Pending Transfer Page**. The information for the inventory you transferred will be displayed here. Check the information to make sure the *lot*, *type*, and *expiration date* of the vaccine are correct. Now *check* the box on the right-hand side that says ***Revise;*** checking this box will give you the option to change your program component from **05 to 18.01.**



Now you have successfully added your current Refugee Inventory into your new Refugee 18.01 component.

ELECTRONIC DISEASE NOTIFICATION SYSTEM

The Electronic Disease Notification (EDN) system is a secure online database that provides electronic notification to state and CHDs of refugees, derivative asylees, Cuban and Haitian parolees, and SIVs arriving in the U.S., and immigrants with a Class A/B TB condition. EDN contains results of arriving refugees' OVMEs and immunization records and is housed within the Secure Access Management Services (SAMS), an umbrella system maintained by CDC. Effective January 1, 2011, EDN is the only method of receiving notification of the arrival of refugees, derivative asylees, and SIVs for counties that routinely receive refugees; therefore, CHD RHPs must obtain access to EDN. If you already have access based on your affiliation with DOH programs, please ensure your access is expanded to include refugee arrival notifications.

EDN managers at the CDC will assign an access level to each user, which will determine the data that can be viewed. Users will only have access to the demographic information and medical records for arrivals within their jurisdiction. RHP users can only view refugee arrivals; TB program users can only view Class A/B refugee and immigrant arrivals. Users who work in the Refugee Health and TB programs can view all arrivals in their jurisdiction.

Obtaining Access to the EDN

A user (RHP staff) must obtain access to the EDN via SAMS.

SAMS is the replacement e-authentication system that does not use digital certificates.

To register with the SAMS Partner Portal, please click the following link or cut and paste it into your browser:

https://im.cdc.gov/iam/im/SAMS3/ui/index.jsp?task.tag=SAMSRegistration

SAMS Partner Portal Registration

Registration consists of the following steps:

1. Online Registration
2. Identity Verification (if required for your application)
3. Access Approval

Online registration with the SAMS portal takes about five minutes. Please have the following available before you begin:

- Your home address — This must match the documentation you intend to use for proofing if applicable.
- Your organization or employer and their address

- Your telephone number

Should you have questions about the SAMS Partner Portal or the registration process, please contact our Help Desk for assistance or refer to the SAMS User FAQ at https://auth.cdc.gov/sams/samsfaq.html.

Once the identity verification has been completed, an email will be sent with the following information:

Thank you for registering with CDC's SAMS Partner Portal. Your registration information has been received and is currently pending approval.

To provide individuals with access to non-public information, U.S. law ***requires*** the identity of potential users be verified. This step is critical in helping to protect people's private data and in helping to prevent information misuse. Please be assured that CDC and its programs have made every effort to keep this necessary process as simple and non-intrusive as possible. Also, be assured that your identity information will only be used to help determine your suitability for access and that these data will not be shared outside of CDC programs.

To complete identity verification, please print the form included in this email message and follow the instructions provided below. The required steps are as follows:

1. Complete the Applicant Section in the included form—part of the information has been pre- filled for you based on the information you supplied during registration.

2. Take the printed form, along with appropriate photo identity documentation to a Proofing Agent (a Notary Public or person specifically designated by CDC to conduct identity verification). Have them verify your identity and complete the Notary Proofing Agent Section. Acceptable forms of photo ID are:

    - Driver's license or ID card issued by a state or outlying possession of the U.S.
    - U.S. passport or passport card
    - U.S. military ID card

3. Confirm the photo ID being submitted contains your home address information. If the photo ID being used does ***not*** include your home address, for example, if a U.S. passport is used, please submit a photocopy of a utility bill, pay stub, voter registration card, or other document which displays your current home address and can be used for validation. Confirm the home address information on your photo ID, or other supplemental documentation, matches the home address you provided when you registered with SAMS. If the address does ***not*** match, for example, because you recently moved, please submit a photocopy of a utility bill, pay stub,

voter registration card, or other document which displays your current home address that can be used for validation.

Please note: Your home address in SAMS must be valid as you will receive physical mail at this address as part of the SAMS ID proofing process. *If the home address used for registration is incorrect, please contact the SAMS Help Desk for further assistance.*

4. Upload, fax, or mail the completed form, ***along with photocopies of your identity documentation***, to the website, fax number or address supplied below. ***Scanned copies of documentation cannot be received via email.***

5. To upload a scanned PDF:
You may upload a ***single*** PDF that includes all of your proofing documentation (form, scan(s) of identification, notary stamp, supplemental documentation, etc.) by logging into SAMS using your SAMS username and recently established password. To upload a document, visit the following link:

https://transfer1.cdc.gov/w/NdDtY2NOaj6CVDyu

For step-by-step instructions on how to upload a document, please reference the guide.

You will receive an email notification when your documentation has been successfully delivered to the CDC Proofing Authority.

To Fax:

Toll Free: 877-681-2899

To Mail:

Centers for Disease Control and Prevention Attn: Proofing Authority
1600 Clifton Road MS K-94
Atlanta, GA 30329

Once the completed form has been processed, you will receive a confirmation letter and further information regarding your access to CDC applications, "**Using the EDN."**

On the home page, click on EDN. There are several basic functions available that are commonly used. These functions are listed on the toolbar on the left side of the webpage and include alien list, alien search, batch print, and reports. These functions are described in detail below.

Alien List allows the user to**:**

- View a list of the refugees (and/or Class A/B TB immigrants) who have arrived in

their jurisdiction within the last year.

- View the electronic and scanned health and demographic information in an alien's EDN forms.

- Update the address of an alien who has moved within or outside the user's jurisdiction.

Alien Search allows the user to**:**

- Search for an alien in any jurisdiction (if the alien arrived in the U.S. more than one year ago, you must specify an arrival date range to search for records).

- Obtain the contact information for the health department in the jurisdiction where an alien resides (once the search has been completed, click on the plus [+] sign located next to the alien number).

Batch Print allows the user to**:**

Print a group or "batch" of alien records by selecting one of the following categories: notification date/range, arrival date/range, file number (for a family of refugees), and alien number.

Report(s) allow the user to**:**

Define a list of aliens by choosing one or more of these fields: Notification Date, Arrival Date, TB Classification, Alien Type (for example, refugee, asylee, etc.), and Jurisdiction.

Technical Assistance

A "Quick Help Overview" for EDN is available under the Help tab on the login page. The EDN Quick Help Document will assist you with navigating the EDN system. The document explains all functions of the system in full detail. To access the overview, click on Help, then under Help Links, click on EDN Quick Help Document.

If you need additional assistance with the functions of the system or are experiencing technical difficulties, you can reach the CDC EDN Help Desk by calling 1-866-226-1617.

For more information or assistance, contact the SAMS Help Desk between the hours of 8:00 a.m. and 6:00 p.m. EST, Monday through Friday (excluding U.S. federal holidays), by calling 1-877-681-2901 or by email at: samshelp@cdc.gov.

HEALTH MANAGEMENT SYSTEM

HMS is a statewide, distributed computerized system used by CHDs in daily business and clinical operations.

The HMC of HMS is used to collect public health service and time data at the program component level for reporting to the HMC Reporting System. At the state level, data from all the CHDs is collected and analyzed to support departmental planning, budgeting, management, and administration, as well as reporting to the governor and state legislature.

IMPORTANT: CHDs may only code ORR-approved CPT codes for the CHD to be reimbursed by RHP State Health Office. Local system administrators are responsible for allowing CHDs access to the ORR-approved codes. Approved CPT codes can be found in the Superbill (Attachment L) and the Refugee Health Quick Guide (Attachment M).

Accessing HMS

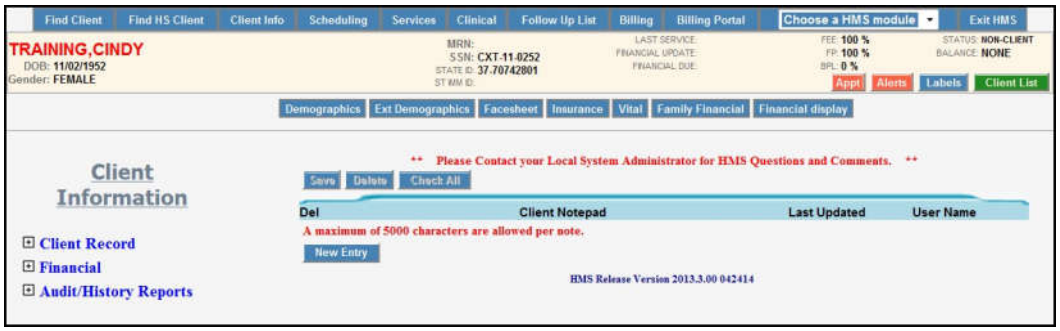
The Client Information page is used to capture specific client data in the HMS. This section addresses how to access and explore the Client Information page.

Steps to Access the Client Information Page

1. Log in HMS
2. Click ***Find Client***
3. Type Search criteria in the corresponding fields
4. Click ***Search HMS***
5. Select Client from the Search Results list

At a minimum, enter the client's last name, first name, and date of birth to access client information.

All possible client matches for the criteria entered are displayed in the **Search Results** list. Click on the client's name to select them. The Client Information page displays after selecting a client.



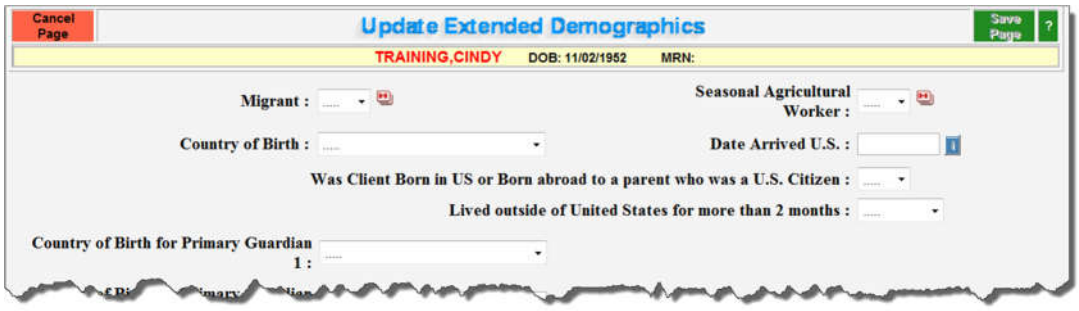
Accessing the Client Demographics Page

The client registration process consists of collecting and capturing client data in the HMS and importing client data from the Florida State Health Online Tracking System (Florida SHOTS). This section addresses how to access the Client Demographics page and how to search for a client in HMS and Florida SHOTS. It also addresses how to import data from Florida SHOTS to HMS and how to process the Financial Update Alert message.

Viewing Extended Demographics

To view or update the client's extended demographics, select **Extended Demographics** under Client Record from the Client Information menu. The Update Extended Demographics page displays. **IMPORTANT**: The required fields listed below must be completed to receive reimbursement from the RHP.

- Last Name
- First Name
- Jurisdiction (Initial County of Resettlement)
- Date of Birth
- Gender
- Country of Birth
- I-94 Status
- Sponsor
- Arrival Date
- Port of Entry
- Address
- City
- State
- ZIP

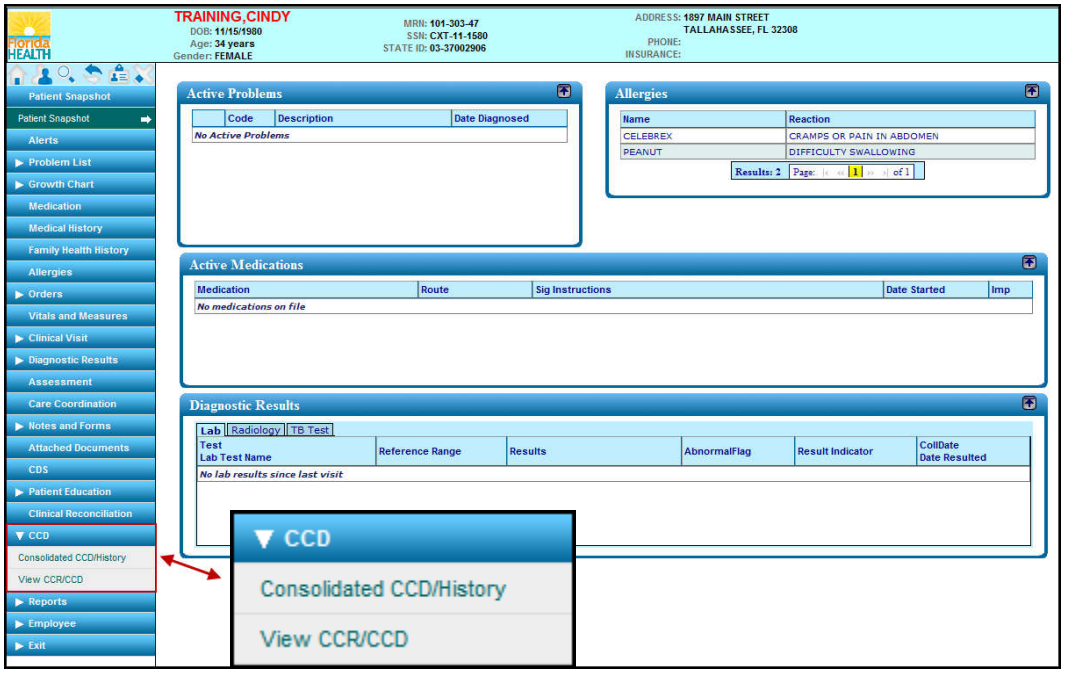


Accessing the Continuity of Care Document Via the Clinician Portal

The Continuity of Care Document Record (CCD) (CCR) provides a means for one health care practitioner to aggregate all pertinent patient data. In turn, the aggregated data can be forwarded to another CHD in support of the patient's continuity of care. **Important:** This resource should be used when a refugee has received services in another county. This information can then be shared with a county by using the HealthVault.

After selecting a client, the Clinician Portal displays. The CCD is accessible from the left side navigation. Click **CCD** to expand the CCD menu options.

Select **Consolidated CCD/History** to view the client's consolidated CCD or **View CCR/CCD** to view the client's CCD.



Clinician Portal — CCD Menu

Steps to Access the CCD Via the Clinician PortaL

1. Select Client in HMS
2. Click ***CCD***. The CCD menu expands.
3. Click One of the following:
   a. ***Consolidated CCD/History*** to view the client's consolidated CCD
   b. ***View CCR/CCD*** to view the client's CCD

Steps to Transmit the CCD to a Provider (CHD)

1. Access The ***CCD*** page.
2. Click ***Transmit to Provider***.
3. Verify Email address in the ***From*** field and select an email address if needed.
4. Do one of the following:
   a. Type Provider email address in the ***To*** text box
   b. Select ***Search*** button to search the Healthcare Provider Directory
5. Type Subject in the ***Subject*** text box
6. Verify Clinical Summary is attached
7. Type A message to the provider in the ***Message*** text box.
8. Click ***Send*** button.

To report HMS issues, please follow the procedures below.

1. If you have a local process in place, follow that procedure first.
2. Submit a Help Desk Ticket (CSC Ticket) stating your issue. Include as much detail as possible to minimize the chance of misrouting the ticket.
3. If you do not have access to this application, please send an email to DL HMS Support. A ticket will be created and routed accordingly. Please remember to encrypt all emails containing client information.

For security reasons, ensure your local HMS System Administrator has been notified of the issue prior to submitting your support request. You can do this by having the HMS System Administrator submit the ticket or including the HMS System Administrator on your email request. While this is our recommended process, you should always follow your local support process providing it satisfies the above requirements.

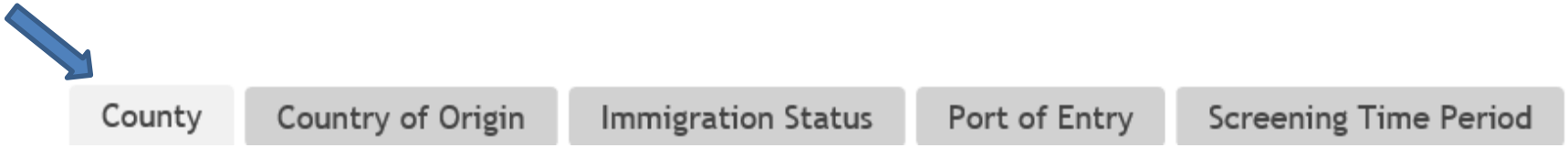
Refugee Health CHD Reports

Refugee Health CHD staff have the ability to use five reports located in HMS's Report Portal that may be beneficial to the program. The RHP reports are located on page 4. The reports can be exported as an Excel or PDF document. The reports can be accessed here:

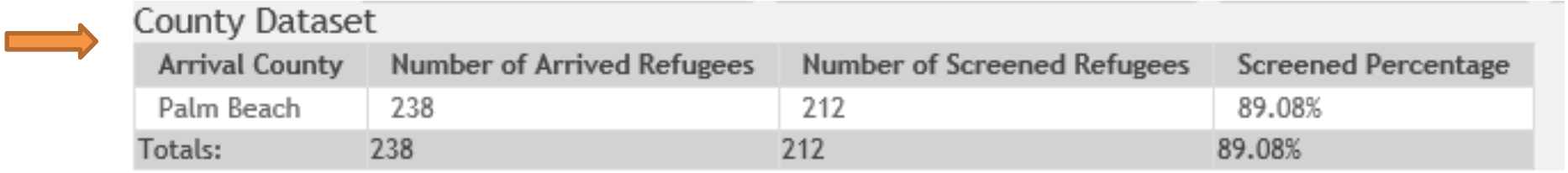
http://dcs-doh-ws10/ReportPortal/rdPage.aspx?rdReport=RefugeeHealth.RefugeeScreeningReport

Step 1: Select the county in which you are trying to pull data for, along with the specific timeframes, and click submit.

Step 2: Once the data are returned, you should have five tabs which will indicate the type of reports that are available. Each tab below will show different results based on the tab selected.



County Tab: Shows the number of arrivals by county (demographic county).



County Dataset

Arrival County	Number of Arrived Refugees	Number of Screened Refugees	Screened Percentage
Palm Beach	238	212	89.08%
Totals:	238	212	89.08%

Country of Origin Tab: Shows the number of arrivals, by specific county, by the country of birth.

Country of Origin Dataset

Country of Birth	Number of Arrived Refugees	Number of Screened Refugees	Screened Percentage
	0	0	0.00%
CUBA	168	149	88.69%
CYPRUS	1	0	0.00%
EGYPT	1	1	100.00%
EL SALVADOR	2	2	100.00%
HAITI	43	41	95.35%
IRAQ	5	5	100.00%
JORDAN	2	2	100.00%
MYANMAR	1	1	100.00%
SYRIA	15	11	73.33%
Totals:	238	212	89.08%

Immigration Status Dataset

Refugee I-94 Status	Number of Arrived Refugees	Number of Screened Refugees	Screened Percentage
	0	0	0.00%
PAROLEE 212 D 5	189	169	89.42%
REFUGEE 207	49	43	87.76%
Totals:	238	212	89.08%

Port of Entry Tab: Shows the number of arrivals, by the port of entry into the U.S.

Port of Entry Dataset

Refugee Arrival Port	Number of Arrived Refugees	Number of Screened Refugees	Screened Percentage
	4	4	100.00%
Ambrose	1	1	100.00%
Atlanta Int'l Airport	1	1	100.00%
Brownsville Airport	10	10	100.00%
Calexico	1	1	100.00%
Charleston Int'l Airport	2	2	100.00%
El Paso Int'l airport	2	2	100.00%
Ft. Lauderdale Int'l airport	1	1	100.00%
JFK AIRPORT (NEW YORK CIT	2	2	100.00%
JFK Airport (New York City)	1	1	100.00%
Laredo-Convent Bridge	3	1	33.33%
Laredo-Juarez Lincoln Bridge	4	4	100.00%
Laredo Int'l Airport	29	26	89.66%
Miami Int'l Airport	56	54	96.43%
MIAMI INT'L AIRPORT	19	9	47.37%
Newark Int'l Airport	1	1	100.00%
NEWARK INT'L AIRPORT	8	4	50.00%
Not Specified	1	1	100.00%
Palm Beach Int'l Airport	5	5	100.00%
Pharr	2	2	100.00%
Port Everglades (Ft. Lauderdale)	11	11	100.00%
Progresso	36	34	94.44%
Roma	6	6	100.00%
San Luis	1	1	100.00%
San Ysidro	30	28	93.33%
Tampa Int'l airport	1	0	0.00%
Totals:	238	212	89.08%

Screening Time Period: Shows the number of days taken to initiate a health assessment at the CHD. NOTE: This is for all visits, not just initial.

Screening Days Dataset

Screening County	Screened Within 0 to 30 Days	Screened Within 31 to 60 Days	Screened Within 61 to 90 Days	Screened Within 91 to 239 Days	Screened After 240 Days
Palm Beach	13	90	145	34	2
Totals:	13	90	145	34	2

Reimbursement Process for Refugee Health Services

Each state has a designated agency to administer and monitor refugee program activities within its jurisdiction. In Florida, the DCF has this responsibility but has designated the responsibility of administering refugee health services to the Department of Health (DOH) Refugee Health Program (RHP) through a signed Memorandum of Agreement. Refugee Medical Assistance (RMA) funds are received from the DCF, DOH RHP provides fiscal oversight, and the county health departments (CHDs) are reimbursed after services have been performed. There are currently 32 CHDs that provide health assessment and immunization services to newly arrived refugees.

DOH administers the Refugee Health Program in accordance with guidelines established in 45 CFR 400, and refugee health protocols developed by the ORR. According to federal policies, organizations that provide refugee health services are eligible to receive RMA reimbursement for costs incurred if refugee health services are initiated within the program timeframes.

To receive reimbursement, the provider or CHD must:

- Verify that the person is eligible for refugee services (through EDN, HMS, or contacting the RHP State Health Office).
- Conduct the health assessment and document findings in the HMS and coded to PC18.
- Administer immunizations and document the immunization type, dose, and date administered in Florida SHOTS and HMS and coded to PC18.

Note: All client services must be documented in HMS. Staff time must be coded to PC18 in HMS and "set" records should be created in the Financial and Information Reporting System to establish payroll re-allocations to charge OCA SRSXX. Refer to Attachment L, RHP Superbill, which describes laboratory services and immunizations that are eligible for reimbursement and CPT codes that are to be entered in HMS.

Payment Process:

- Since October 1, 2015, CHDs have been reimbursed based on cost-reimbursement. The RHP State Health Office will run a FLAIR expenditure report monthly and submit it to the DOH Office of Budget and Revenue Management (OBRM).
- The OBRM prepares an invoice and submits it to the DCF Refugee Services for CHD RHP services.

- The DCF journal transfers reimbursement funds to the OBRM.
- The OBRM transfers payment via Transaction 30 to CHDs for RHP services.
- Reimbursement of expenditures may take up to 60 days.

Allowable Use of Funds

CHDs must use the reimbursement funds to cover expenses associated with the provision of refugee health services. Allowable expenditures are divided between direct service and administrative costs. Administrative expenditures may not exceed 18 percent of a county's total reimbursement during the state fiscal year. Excess funds, or administrative expenses that exceed 18 percent of total reimbursement, may be recouped by the RHP Central Office through reductions in future reimbursement payments. The following describes allowable direct services and administrative expenditures.

Allowable Direct Service Expenses

- Direct service staff salary and fringe including:
    - Physicians
    - Nurses
    - Eligibility, registration, and scheduling
    - Phlebotomists
    - Referral specialists
    - Medical records

- Clinical expenses that support the functioning of the program:
    - Laboratory services
    - Vaccines
    - Medical supplies
    - Equipment and equipment rental or maintenance associated with direct service functions of the RHP clinic operations
    - Biomedical hazardous waste
    - Health education materials
    - Clinical training or staff development

Allowable Administrative Expenses

- Staff salary and fringe including:
    - Management, not involved in daily RHP clinic operations
    - Fiscal or billing
    - Janitorial
    - Security services

- Administrative expenses that support the functioning of the program:
    - Rent associated with administrative functions of the RHP clinic operations
    - Utilities
    - Risk management
    - Communications (phone and Internet) associated with administrative functions of the RHP clinic operations
    - Office supplies associated with administrative functions of the RHP clinic operations
    - Furniture associated with administrative functions of the RHP clinic operations
    - Equipment and equipment rental or maintenance associated with administrative functions of the RHP clinic operations
    - Printing associated with administrative functions of the RHP clinic operations
    - Postage associated with administrative functions of the RHP clinic operations
    - Staff travel associated with administrative functions of the RHP clinic operations

There is also a list of federally categorized "not allowable charges." For example, bank fees cannot be charged to the program. In addition, CHDs should ensure billable staff hours due to the COVID-19 pandemic are not charged to the program. These "not allowable charges" will be separated out from the monthly invoice and corrected and allocated to another source.

If a refugee is referred for follow-up care within the CHD, the refugee becomes a client of the program where they are accessing services (for example, TB, STD, Family Planning, etc.) These programs and clinics may bill Medicaid or another third-party payor directly if the refugee has current coverage. The RHP cannot be billed for services provided outside of the scope of the health assessment and immunizations. Refer to Superbill, Attachment L.

RMA funds must only be used to support refugee health services. **All expenditures using reimbursed RMA funds must be coded to OCA SRSXX or SRAXX, where XX = Federal Fiscal Year End.**

CHDs are required to reconcile the expenditures associated with each OCA (SRS and SRA) to verify that the CHD is reimbursed for valid expenditures. Any expenditures moved after the monthly invoice has been generated and sent to DCF for reimbursement must be communicated to the RHP State Health Office budget analyst or the CHD's total annual expenditures will not be accurate.

In cases of invoice issues, the RHP State Health Office has implemented an audit procedure. The CHD Invoice Inquiry (Attachment R) will be sent to the corresponding CHD and will need to be

filled out and returned to the budget analyst by the next business day. If a response from the budget analyst is needed, it will be sent to the CHD within two business days.

REFUGEE HEALTH ASSESSMENT

MEDICAL HISTORY & OVERSEAS MEDICAL RECORD INFORMATION

Review of Overseas Medical Records: ☐ Yes ☐ No ☐ N/A (no records available)
Class A or B Condition reported on overseas medical exam: ☐ Yes ☐ No ☐ N/A
If yes, please list and evaluate: _____
_____

Review Immunization Certification/Documents: ☐ Yes ☐ No ☐ N/A (no records available)

Allergies: _____ **Current Medications**: _____

Medical Problems: _____

Injuries/Accidents: _____ **Surgery:** _____

Recent Family Illness: _____

PHYSICAL ASSESSMENT

Height: _____ **Weight**: _____ **BMI**: _____ (if ≥ 2 yrs.) **Head Circumference** (if ≤ 2 yrs. (in.): _____

Blood Pressure (if ≥ 3 yrs): ☐ L ☐ N ☐ H_____ **Nutritional Status**: ☐ Abnormal ☐ Normal

Oral Health Screening: ☐ Abnormal ☐ Normal ☐ Caries ☐ Tooth Loss ☐Signs of Inflammation

Visual Acuity (Snellen Chart or equivalent): ☐ Abnormal ☐ Normal Right Eye: _____ Left Eye: _____

Hearing (Whisper test or snap test): ☐ Abnormal ☐ Normal

Audiometry Testing: ☐ Abnormal ☐ Normal ☐ N/A

Eyes/Ears/Nose/Throat: ☐ Abnormal ☐ Normal – Findings: _____

Chest/Lungs/Heart: ☐ Abnormal ☐ Normal – Findings: _____

Abdomen Palpation: ☐ Abnormal ☐ Normal – Findings: _____

Postural Assessment: ☐ Abnormal ☐ Normal – Findings: _____

Pap Smear: ☐ Abnormal ☐ Normal ☐ N/A – Findings: _____

General Education/Counseling: ☐ Healthy Lifestyle ☐ Emergency Services ☐ Immunizations
☐ Safe Sex ☐ Tobacco Cessation ☐ Other: _____

Domestic & Sexual Violence/Human Trafficking: ☐ Referral necessary ☐ No referral necessary

Adults: Establish total privacy; client must be alone, or if a child is present, the child must not be of verbal age. Ask three questions:

- Have you been physically hurt (hit, pushed, shoved, burned, slapped, and/or bitten), insulted, or threatened (to take away income, children, and/or pets) by your loved one, partner or significant other?
- Have you ever been touched sexually against your will or without your consent?
- Is anyone forcing you to do work that you do not want to do (i.e. have you been threatened and/or can you come and go as you please)?

Children: Establish total privacy. Do not ask the questions below if unable to.

- Do you feel safe in your home and at school?
- Has anyone in your family or a school ever hit, kicked, punched, slapped, shoved or bit you?
- Have you ever been touched sexually against your will or without your consent?

Client Name	**ID#**	**Date**

Mental Health (≥ 14 years old): ☐ Referral necessary ☐ No referral necessary

Use RHS-15 Screener (preferred) or abbreviated assessment below:

- How are you coping with the changes since arriving in the U.S.?
- Are you being helped by a sponsor, family member(s), or friends?
- Is there anything that is causing stress or worry for you or your family?
- Are you having any difficulties sleeping?
- Are you having difficulties with memory/concentration?
- Do you have any past mental health problems and/or treatment?
- How would you say you are feeling today?

LAB SERVICES

Urinalysis: ☐ Abnormal ☐ Normal – Findings: _____

Pregnancy Test: ☐ Positive ☐ Negative ☐ LMP _____
Currently Pregnant? ☐ Yes ☐ No
Currently Breast Feeding? ☐ Yes ☐ No

CBC w/differential: ☐ Abnormal ☐ Normal – Findings: _____

CMP: ☐ Abnormal ☐ Normal – Findings: _____

Lead Testing (Birth – 16 yrs, adolescents ≤ 16, pregnant/lactating women and girls): ☐ Abnormal ☐ Normal

Assay of Iron (6 mos – 6 yrs): ☐ Abnormal ☐ Normal

Tuberculin Skin Test (TST) (Birth up to 2 years):
Placed: _____ Read: _____ Results: _____ ☐ Abnormal ☐ Normal

IGRA – QFT TB Gold Test or T-Spot (≥ 2 years old): ☐ Abnormal ☐ Indeterminate ☐ Normal

Chlamydia/Gonorrhea (Females ≤ 25 yrs who are sexually active and who do not have documented pre-departure testing, or anyone (regardless of age or gender) with risk factors or symptoms.
☐ Positive ☐ Negative – Findings: _____

HIV Counseling and Testing: ☐ Positive ☐ Indeterminate ☐ Negative

Syphilis RPR Screening (≥15 required if no overseas results or <15 yrs if sexually active, sexually assaulted, or w/ risk factors)
☐ Abnormal ☐ Normal

Ova & Parasites x2 (if client did not receive pre-departure presumptive parasite treatment or if symptoms are present)

☐ Abnormal (specify _____) ☐ Normal

Strongyloides Antibody (if coming from an area of prevalence and did not receive pre-departure presumptive parasite treatment or if symptoms are present)

Schistosomiasis Antibody (if coming from sub-Saharan Africa and did not receive pre-departure presumptive parasite treatment)

Hepatitis B core antibody (HBcAb) (If coming from a country of intermediate to high prevalence or if a risk factor is present and did not receive testing overseas) ☐ Positive ☐ Negative

Hepatitis B surface antibody (HBsAb) (If coming from a country of intermediate to high prevalence or if risk factor is present and did not receive testing overseas): ☐ Positive ☐ Negative

Hepatitis B surface antigen (HBsAg): (If coming from a country of intermediate to high prevalence or if a risk factor is present and did not receive testing overseas): ☐ Positive ☐ Negative

Hepatitis C antibody (Anti-HCV): (Adults aged ≥18 years & all pregnant women during each pregnancy) ☐ Positive ☐ Negative

Client Name	**ID#**	**Date**

Rubella Antibody (Adults who were born 1957 or later and lack immunization records): ☐ Positive ☐ Negative

Rubeola Antibody (Adults who were born 1957 or later and lack immunization records): ☐ Positive ☐ Negative

Mumps Antibody (Adults who were born 1957 or later and lack immunization records): ☐ Positive ☐ Negative

Varicella Antibody (Adults who lack immunization records): ☐ Positive ☐ Negative

EXTENDED SERVICES
(IF CLINICALLY INDICATED)

Chest X-Ray (PA & Lateral) ☐ Abnormal ☐ Normal

Syphilis (confirmatory): ☐ Positive ☐ Indeterminate ☐ Negative

REFERRALS

☐ TB ☐ Vision ☐ Mental Health ☐ Hearing ☐ OB/GYN ☐ Dental ☐ Communicable Diseases

☐ Family Planning ☐ Primary Care ☐ Disability Services ☐ Pediatrics ☐ Other (specify)_____

INTERPRETATION

Was an interpreter used in the provision of services? ☐ Yes ☐ No

If yes, what language? (specify) _____

What mode of interpretation? ☐ Face-to-face _____ ☐ Telephonic

If face-to-face interpretation, who provided the service?
- ☐ CHD bilingual employee
- ☐ Contracted interpreter
- ☐ Resettlement agency representative
- ☐ Other (specify) _____

PROGRESS NOTE

_____

_____

_____

_____

_____

_____

_____ _____

Assessment completed by: (Name and Title) **Date**

_____ _____ _____

Client Name **ID#** **Date**

Attachment B

REFUGEE HEALTH ASSESSMENT PROTOCOL: CORE SERVICES

Physical Assessment: *Core Elements*	**Children**	**Adults**
Document review of overseas records	✓	✓
Obtain a medical and social history	✓	✓
Height, Weight, BMI *(BMI * ≥ 2 yrs)*	✓	✓
Head Circumference	✓ ** ≤ 2 yrs*	
Blood Pressure	✓ ** ≥ 3 yrs*	✓
Nutritional Status	✓	✓
Oral Health Screening	✓ ** ≥ 2 yrs*	✓
Visual Acuity	✓	✓
Hearing (Whisper Test)	✓	✓
Audiometry Testing	Based on results of Whisper Test, or in lieu of the Whisper Test	Based on results of Whisper Test, or in lieu of the Whisper Test
Eyes/Ears/Nose/Throat	✓	✓
Chest/Lungs/Heart	✓	✓
Abdomen Palpation	✓	✓
Postural Assessment	✓	✓
Pap Smear (Document referral for PCP if not available)		✓ **If sexually active or ≥ 21 yrs, if available.*
General Health Education	✓	✓
Domestic & Sexual Violence/ Human Trafficking Assessment	Strongly recommended	Strongly recommended
Mental Health Assessment (RHS-15 or abbreviated version)	✓ ** ≥ 14 yrs*	✓
Malaria Assessment	✓ **Routinely assess for signs and symptoms if from sub-Saharan Africa and refer to ER if symptoms are present.*	✓ **Routinely assess symptoms if from sub-Saharan Africa and refer to ER if symptoms are present.*

Attachment B

REFUGEE HEALTH ASSESSMENT PROTOCOL: CORE SERVICES

Laboratory Tests: *Core Elements*	**Children**	**Adults**
Urinalysis	✓ **If old enough for clean catch.*	✓
Pregnancy Test	✓ **Childbearing age or sexually active.*	✓
CBC with Differential	✓	✓
Comprehensive Metabolic Panel (CMP)	✓	✓
Lead Testing	✓ **6 months – 16 yrs, adolescents >16, pregnant and lactating girls*	✓ **pregnant and lactating women*
Assay of Iron	✓ **6 months – 6 yrs*	
Stool O&P (x2)	✓ **If client did <u>not</u> receive pre-departure presumptive parasite treatment (Albendazole), if symptomatic, or if client weighs less than fifth percentile.*	✓ **If client did <u>not</u> receive pre-departure presumptive parasite treatment (Albendazole), if symptomatic, or if client weighs less than fifth percentile.*
Strongyloides Antibody IGG	✓ **If from Africa, Asia, Middle East, Latin America, or Caribbean and did <u>not</u> receive pre-departure presumptive parasite treatment (Ivermectin or high-dose Albendazole).*	✓ **If from Africa, Asia, Middle East, Latin America, or Caribbean and did <u>not</u> receive pre-departure presumptive parasite treatment (Ivermectin <u>or</u> high-dose Albendazole).*
Schistosomiasis IGG	✓ **If from <u>sub-Saharan</u> Africa and did <u>not</u> receive pre-departure presumptive parasite treatment (Praziquantel).*	✓ **If from <u>sub-Saharan</u> Africa and did <u>not</u> receive pre-departure presumptive parasite treatment (Praziquantel).*
TST	✓ ** Birth up to 2 years*	
IGRA-QFT TB Gold or T-Spot	✓ ** ≥ 2 yrs*	✓
Gonorrhea/Chlamydia	✓ **<u>Females</u> who are sexually active <u>or</u> males or females with risk factors, symptoms, or history of sexual assault.*	✓ **<u>Females</u> ≤ 25 yrs who are sexually active and who do not have documented pre-departure testing <u>or</u> adults with risk factors, symptoms, or history of sexual assault.*
Syphilis RPR (screening)	✓ ** ≥15 required if no overseas results are available or <15 yrs if sexually active, have been sexually assaulted, or have risk factors for congenital syphilis.*	✓ **All adults if no overseas results are available.*

Attachment B

REFUGEE HEALTH ASSESSMENT PROTOCOL: CORE SERVICES

HIV Counseling & Testing (opt-out method)	✓ ** ≥ 13 yrs* (encouraged for everyone)	✓ ** ≤ 64 yrs* (encouraged for everyone)
Hepatitis B Panel (HBcAb, HBsAb, HBsAg)	✓ **If coming from a country of intermediate to high prevalence of Hepatitis B or if risk factors apply. Do not repeat domestically if client was tested for HBsAg overseas.*	✓ **If coming from a country of intermediate to high prevalence of Hepatitis B or if risk factors apply. Do not repeat domestically if client was tested for HBsAg overseas.*
Hepatitis C Antibody (Anti-HCV)	✓ ***If child has an HCV-positive mother or if risk factors apply.**	✓ **At least once in a lifetime for all adults aged ≥18 years, all pregnant women during each pregnancy, and if risk factors apply.*
Measles, Mumps, Rubella (MMR) Antibody		✓ **If immunization history is unavailable. Unnecessary if born before 1957.*
Varicella Zoster (VZ) Antibody		✓ **If immunization history is unavailable.*
Preventive Interventions: *Core Elements*	**Children**	**Adults**
Review of immunization history and administration of immunizations, following Advisory Committee on Immunization Practices (ACIP)	✓ (Bill to Vaccines for Children Program ≤18 yrs)	✓
Routine Referrals: *Core Elements*	**Children**	**Adults**
Primary Care Referral	✓	✓
Newborn Screening Program	✓ **Refer to Florida Newborn Screening Program for infants birth-1 yr*	

Key:

✓	Applicable
*	Specifications apply

Attachment C

Refugee Health Risk Factor Checklist

Instructions: Indicate reported risk factors by checking the box next to each risk factor. Provide screening for each of the following conditions, if one or more risk factor is identified. Retain this checklist in the patient's medical record for documentation of required screening.

	Chlamydia
	Sexually active female, under 25 years of age
	Female - multiple sex partners within the last year
	Female - unprotected sex (anal, oral, or vaginal)
	Female - history of prior STD
	Men who have been sexually assaulted
	Men with symptoms (urethral discharge, dysuria, or rectal pain or discharge)
	Infants born to infected mothers
	Consider for children who have a history of sexual assault. However, management and evaluation of such individuals require consultation with an expert.
	Persons who have symptoms or leukoesterase (LE) detected in urine sample

	Gonorrhea
	Sexually active female, under 25 years of age
	Female - multiple sex partners
	Female - previous gonorrhea diagnosis
	Female- unprotected sex (anal, oral, or vaginal)
	Infants born to infected mothers
	Men with symptoms (urethral discharge, dysuria, or rectal pain or discharge)
	Men who have been sexually assaulted
	Persons who have symptoms or leukoesterase (LE) detected in urine sample
	Consider for children who have a history of sexual assault. However, management and evaluation of such individuals require consultation with an expert.

	Syphilis
	For syphilis, refugees 15 years and older should routinely be tested if no overseas results are available (syphilis screening is required as part of the overseas exam). For refugees <15 years, only test if there is a risk of congenita syphilis (mother who tests positive for syphilis), those who are/have been sexually active/assaulted.
	Unprotected sex (anal, oral, or vaginal)
	Mulitple sex partners
	Men who have sex with men
	Have HIV and engage in any of the above activities
	All refugees from countries that are endemic for treponemal subspecies (e.g., yaws, bejel, pinta).

UPDATED April 19, 2018, per ORR

Hepatitis B Panel Testing Per Country Prevalence

Continent	Country	Test for Hepatitis B Routinely (as prevalence is high)	Don't Test for Hepatitis B Routinely (as prevalence is low)
Central America	All but Panama		X
	Panama	X	
South America	Colombia		X
	Venezuela		X
	Brazil		X
	French Guiana		X
	Paraguay		X
	Guyana	X	
	Suriname	X	
	Ecuador	X	
	Peru	X	
	Bolivia	X	
	Chile	X	
	Argentina	X	
	Uruguay	X	
North America-Caribbean	Cuba		X
	Dominican Republic	X	
	Haiti	X	
Africa	All	X	
Asia	All-including:	X	
	Afghanistan	X	
	Iraq	X	
	Iran	X	
	Syria	X	
	China	X	
	Myanmar (Burma)	X	
	Thailand	X	
	Malaysia	X	

The ABCs of Hepatitis – for Health Professionals

	HEPATITIS A is caused by the hepatitis A virus (HAV)	**HEPATITIS B** is caused by the hepatitis B virus (HBV)	**HEPATITIS C** is caused by the hepatitis C virus (HCV)
U.S. Statistics	• Estimated 24,900 new infections in 2018	• Estimated 21,600 new infections in 2018 • Estimated 862,000 people living with chronic HBV infection in 2016	• Estimated 50,300 new infections in 2018 • Estimated 2.4 million people living with HCV infection in 2016
Routes of Transmission	Fecal-oral route. HAV is transmitted through: • Close person-to-person contact with an infected person • Sexual contact with an infected person • Ingestion of contaminated food or water Although viremia occurs early in infection, bloodborne transmission of HAV is uncommon.	Percutaneous, mucosal, or nonintact skin exposure to infectious blood, semen, and other body fluids. HBV is concentrated most highly in blood, and percutaneous exposure is an efficient mode of transmission. HBV is transmitted primarily through: • Birth to an infected mother • Sexual contact with an infected person • Sharing contaminated needles, syringes, or other injection-drug equipment Less commonly through: • Needle-sticks or other sharp instrument injuries • Organ transplantation and dialysis • Interpersonal contact through sharing items such as razors or toothbrushes or contact with open sores of an infected person	Direct percutaneous exposure to infectious blood. Mucous membrane exposures to blood can also result in transmission, although this route is less efficient. HCV is transmitted primarily through: • Sharing contaminated needles, syringes, or other equipment to inject drugs Less commonly through: • Birth to an infected mother • Sexual contact with an infected person • Unregulated tattooing • Needle-sticks or other sharp instrument injuries
Incubation Period	15–50 days (average: 28 days)	60–150 days (average: 90 days)	14–182 days (average range: 14–84 days)
Symptoms of Acute Infection	**Symptoms of all types of viral hepatitis are similar and can include one or more of the following:** • Jaundice • Fever • Fatigue • Loss of appetite • Nausea • Vomiting • Abdominal pain • Joint pain • Dark Urine • Clay-colored stool • Diarrhea (HAV only)		
Likelihood of Symptomatic Acute Infection	• <30% of children <6 years of age have symptoms (which typically do not include jaundice) • >70% of older children and adults have jaundice	• Most children <5 years of age do not have symptoms • 30%–50% of people ≥5 years of age develop symptoms • Newly infected immunosuppressed adults generally do not have symptoms	• Jaundice might occur in 20%–30% of people • Nonspecific symptoms (e.g., anorexia, malaise, or abdominal pain) might be present in 10%–20% of people
Potential for Chronic Infection after Acute Infection	None	Chronic infection develops in: • 90% of infants after acute infection at birth • 25%–50% of children newly infected at ages 1–5 years • 5% of people newly infected as adults	Chronic infection develops in over 50% of newly infected people

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Continued on next page

	HEPATITIS A	HEPATITIS B	HEPATITIS C
Severity	• Most people with acute disease recover with no lasting liver damage; death is uncommon but occurs more often among older people and/or those with underlying liver disease	• Most people with acute disease recover with no lasting liver damage; acute illness is rarely fatal • 15%–25% of people with chronic infection develop chronic liver disease, including cirrhosis, liver failure, or liver cancer	• Approximately 5%–25% of persons with chronic hepatitis C will develop cirrhosis over 10–20 years • People with hepatitis C and cirrhosis have a 1%–4% annual risk for hepatocellular carcinoma
Serologic Tests for Acute Infection	• IgM anti-HAV	• HBsAg, plus • IgM anti-HBc	• No serologic marker for acute infection
Serologic Tests for Chronic Infection	• Not applicable—no chronic infection	Tests for chronic infection should include three HBV seromarkers: • HBsAg • anti-HBs • Total anti-HBc	• Assay for anti-HCV • Qualitative and quantitative nucleic acid tests (NAT) to detect and quantify presence of virus (HCV RNA)
Testing Recommendations for Chronic Infection	• Not applicable—no chronic infection Note: testing for past acute infection is generally not recommended	• All pregnant women should be tested for HBsAg during an early prenatal visit in each pregnancy • Infants born to HBsAg-positive mothers (HBsAg and anti-HBs are only recommended) • People born in regions with intermediate and high HBV endemicity (HBsAg prevalence ≥2%) • People born in U.S. not vaccinated as infants whose parents were born in regions with high HBV endemicity (≥8%) • Household or sexual contacts of people who are HBsAg-positive • Men who have sex with men • People who inject, or have injected, drugs • Patients with alanine aminotransferase levels (≥19 IU/L for women and ≥30 IU/L for men) of unknown etiology • People with end-stage renal disease including hemodialysis patients • People receiving immunosuppressive therapy • People with HIV • Donors of blood, plasma, organs, tissues, or semen	• All adults aged 18 years and older, at least once • All pregnant women during each pregnancy • People who currently inject drugs and share needles, syringes, or other drug preparation equipment (routine periodic testing) • People who ever injected drugs • People with HIV • People who receive maintenance hemodialysis (routine periodic testing) • People who ever received maintenance hemodialysis • People with persistently abnormal ALT levels • Prior recipients of transfusions or organ transplants, including: - people who received clotting factor concentrates produced before 1987 - people who received a transfusion of blood or blood components before July 1992 - people who received an organ transplant before July 1992 - people who were notified that they received blood from a donor who later tested positive for HCV infection • Healthcare, emergency medical, and public safety personnel after needle sticks, sharps, or mucosal exposures to HCV positive blood • Children born to mothers with HCV infection • Any person who requests hepatitis C testing should receive it

Continued on next page

	HEPATITIS A	HEPATITIS B	HEPATITIS C
Treatment	• No medication available • Best addressed through supportive treatment	• Acute: no medication available; best addressed through supportive treatment • Chronic: regular monitoring for signs of liver disease progression; antiviral drugs are available	• Acute: AASLD/IDSA recommend treatment of acute HCV without a waiting period • Chronic: over 90% of people with hepatitis C can be cured regardless of HCV genotype with 8–12 weeks of oral therapy
Vaccination Recommendations	**Children** • All children aged 12–23 months • Unvaccinated children and adolescents aged 2–18 years **People at increased risk for HAV infection** • International travelers • Men who have sex with men • People who use injection or noninjection drugs • People with occupational risk for exposure • People who anticipate close personal contact with an international adoptee • People experiencing homelessness **People at increased risk for severe disease from HAV infection** • People with chronic liver disease • People with HIV infection **Other people recommended for vaccination** • Pregnant women at risk for HAV infection or severe outcome from HAV infection • Any person who requests vaccination **Vaccination during outbreaks** • Unvaccinated people in outbreak settings who are at risk for HAV infection or at risk for severe disease from HAV **Implementation strategies for settings providing services to adults** • People in settings that provide services to adults in which a high proportion of those people have risk factors for HAV infection	• All infants • All unvaccinated children and adolescents aged <19 years • Sex partners of HBsAg-positive people • Sexually active people who are not in a mutually monogamous relationship • Anyone seeking evaluation or treatment for a sexually transmitted infection • Men who have sex with men • Anyone with a history of current or recent injection-drug use • Household contacts of people who are HBsAg-positive • Residents and staff of facilities for developmentally disabled people • Health care and public-safety personnel with reasonably-anticipated risk for exposure to blood or blood-contaminated body fluids, • Hemodialysis, predialysis peritoneal dialysis, and home dialysis patients • People with diabetes mellitus aged <60 years and people with diabetes mellitus aged ≥60 years at the discretion of the treating clinician • International travelers to countries with high or intermediate levels of endemic HBV infection (HBsAg prevalence of ≥2%) • People living with hepatitis C • People with chronic liver disease (including cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, and an ALT or AST level greater than twice the upper limit of normal) • People living with HIV infection • People who are incarcerated • Pregnant women who are identified as being at risk for HBV infection during pregnancy • Anyone else seeking long-term protection	• There is no hepatitis C vaccine
Vaccination Schedule	• Single-antigen hepatitis A vaccine: 2 doses given 6–18 months apart depending on manufacturer • Combination HepA-HepB vaccine: typically 3 doses given over a 6-month period	• Infants and children: 3–4 doses given over a 6- to 18-month period depending on vaccine type and schedule • Adults: 2 doses, 1 month apart or 3 doses over a 6-month period (depending on manufacturer)	• No vaccine available

Hepatitis Guidelines

Event	Action	Billing and Coding
Subjective Findings: (*Client reports symptoms fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, gray-colored bowel movement, joint pain, jaundice)*	1. Order Hepatitis Panel 2. Refer to PCP	1. CPT Codes: 86704, 86706, 86708, 86803, 87340 2. R041
Objective Findings: (*Elevated liver enzymes, ALT/AST, of unknown etiology*)	1. Order Hepatitis Panel 2. Refer to PCP	1. CPT Codes: 86704, 86706, 86708, 86803, 87340 2. R041
A client is from a country of intermediate to high prevalence of Hepatitis B and was not tested for Hepatitis B overseas (HBsAg) (Refer to *Hepatitis B Panel Testing Per Country Prevalence in Attachment D*)	Order Hepatitis B Panel	CPT Codes: 86704, 86706, 87340
A client has one or more risk factors for Hepatitis A (*Refer to ABCs of Hepatitis in Attachment D*)	1. Order total HAV antibody 2. If the client is not already immune and does not have an active or chronic infection proceed with Hepatitis A and/or B vaccination 3. In HMS, document specific risk factor/s that applied and if the vaccine was given.	1. Total HAV CPT: 86708 2. Hepatitis A Vaccine CPT: 90632
A client has one or more risk factors for Hepatitis B (*Refer to ABCs of Hepatitis in Attachment D*)	1. Order Hepatitis B panel 2. Upon results, if the client is not already immune and does not have an active or chronic infection proceed with Hepatitis B vaccination. 3. In HMS, document specific risk factor/s that applied and if the vaccine was given.	1. CPT Codes for Hepatitis B Panel: 86704, 86706, 87340 2. CPT Codes for Hepatitis B Vaccine: 90746
A client was born between 1945-1965 or has one or more risk factors for Hepatitis C (Refer to ABCs of Hepatitis in Attachment D)	1. Order Hepatitis C Antibody (Anti-HCV) 2. If ordered due to a risk factor, document risk factor in HMS.	Anti-HCV CPT: 86803
A client who was tested for some type of Hepatitis per guidelines above is noted to have an active or chronic infection upon reviewing lab results	1. Refer to CHD Hepatitis Program 2. Refer to Primary Care	1. R044 2. R041
A child needs to be vaccinated for Hepatitis per CDC Guidelines and does not have an immunization record	No titer testing is necessary. Proceed with vaccination per CDC guidelines.	Bill to Vaccines for Children (VFC) Program

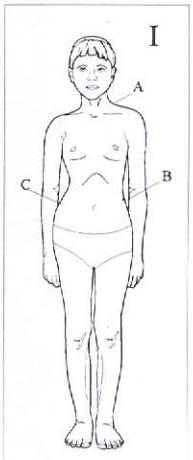
POSTURAL ASSESSMENT
(Massachusetts Department of Public Health postural screening manual)

Why do the screening?

Nine out of ten young people have completely normal spines. In most others, a curve in the spine is usually mild and does not get worse. Those curves that do get worse may result in medical problems, pain, and obvious physical deformity if not treated. The best prevention for this condition is a postural screening once a year between the ages of 10-14 (period of rapid growth).

Table D-1: Frequently Asked Questions About Postural Screening	
"Curvature-of-the-Spine"	KYPHOSIS or ROUNDBACK: a curve in the spine from front to back.
	SCOLIOSIS: a side-to-side curve; most often needs treatment
What causes it?	The cause is unknown, but it is not contagious. It is not preventable and sometimes runs in families. Girls need treatment more often than boys.
Can you feel it?	It can be difficult to see and feel it during the early stages.
How is it treated?	Most people with a mild curve will only need medical observation.
	If the curve grows worse, a back brace is worn until bone growth stops. This does not limit most activities.
	Special exercise may also be included.
	In extreme cases, spinal surgery is performed.
What if it is not treated?	It is possible that medical problems will occur later in life including obvious physical deformity, pain and arthritic symptoms, and/or heart and lung disorders.
How is the screening done?	A postural screening is a simple 30 second observation of the back: first standing, then bending forward. Screeners look for any unevenness of shoulders, hips, or one side of the back. Shirts are removed for better viewing.

REFER IF ANY 2 OUT OF 3 PRESENT



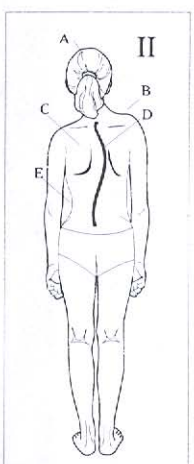
A- Shoulder
B- Waist
C- Hip

A. Shoulder
Is one shoulder higher than the other?

B. Waist
Is the waistline the same on both sides or is there a larger space between the arm and flank on one side?

C. Hip
Are the hips level and symmetrical or is one side higher and more prominent?

REFER IF ANY 3 OUT OF 5 PRESENT



A- Head
B- Shoulder
C- Scapula
D- Spine
E- Waist

A. Head
Does the head line up over the crease in the buttocks or does it lean to one side?

B. Shoulder
Is one shoulder higher than the other?

C. Scapula
Is the wing on one shoulder blade higher or more prominent than the other?

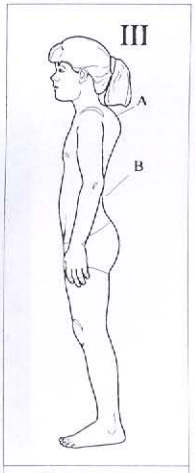
D. Spine
Does there appear to be a curve when you observe the spine?

E. Waist
Is the waistline the same on both sides or is there a larger space between the arm and flank on one side?

REFER IF EITHER PRESENT

A. Roundback
Is there an exaggerated roundness in the upper back?

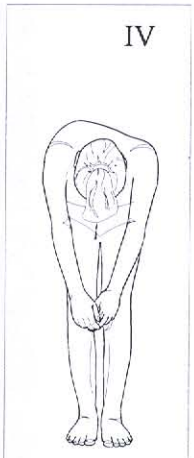
B. Sway Back
Is there an exaggerated arch in the low er back?



A- Roundback
B- Swayback

REFER IF PRESENT

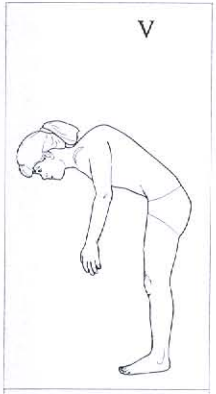
Chest Cage Hump
Are both sides of the back symmetrical or is the chest cage prominent or bulging on one side?



Chest Cage Hump

REFER IF PRESENT

Spine Hump
Is there an accentuated midline hump?



Spine Hump

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

Refugee Health Screener-15 (RHS-15)

English Version

Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.

DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

ID#

DATE

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	*NOT AT ALL*	*A LITTLE BIT*	*MODERATELY*	*QUITE A BIT*	*EXTREMELY*
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

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REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS	*NOT AT ALL*	*A LITTLE BIT*	*MODERATELY*	*QUITE A BIT*	*EXTREMELY*
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	**0**	**1**	**2**	**3**	**4**
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	**0**	**1**	**2**	**3**	**4**
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	**0**	**1**	**2**	**3**	**4**
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	**0**	**1**	**2**	**3**	**4**

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ID#

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REFUGEE HEALTH SCREENER-15 (RHS-15)

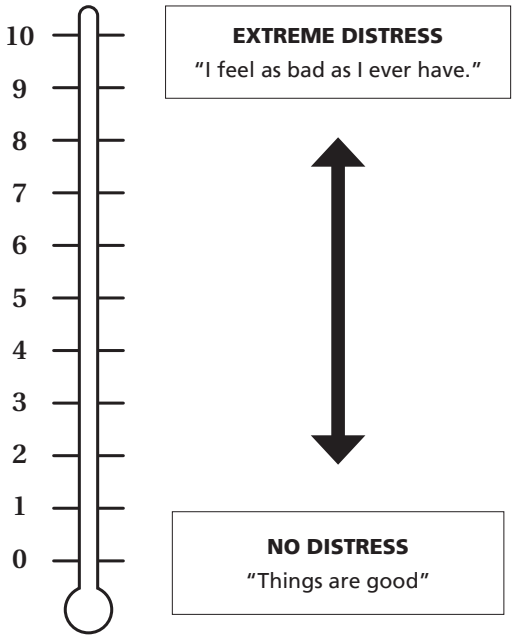
PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

14. Circle the one best response below. Do you feel that you are:

Able to handle (cope with) anything	**0**
Able to handle (cope with) most things	**1**
Able to handle (cope with) some things, but not able to cope with other things	**2**
Unable to cope with most things	**3**
Unable to cope with anything	**4**

Add Total Score of items 1–14 ☐

15. Distress Thermometer



Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

SCORING SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

CHECK ONE: ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

Adjustment of Status and Civil Surgeons

Adjustment of status (AoS) refers to the process by which certain aliens are allowed to apply for lawful permanent resident (LPR) status while they are in the U.S. and is a separate process from the RHA. AoS applications are made to USCIS and most applicants are required to have a medical examination. The medical examination must be conducted by a physician who has been designated as a civil surgeon by USCIS, and the results of the exam must be submitted to USCIS on the Form I-693, Report of Medical Examination and Vaccination Record.

Note: Persons admitted to the U.S. with **refugee or asylee dependent** status and applying for AoS do not need the full medical examination, **if there were no medical grounds of inadmissibility (Class A conditions) identified during their OVME**. **Refugees and asylee dependents** do, however, need to comply with the vaccination requirements. LHD physicians providing only the vaccination sign off for **refugees** do not need to apply to USCIS for civil surgeon status (See Attachment I regarding the designation of LHD physicians as civil surgeons for the purpose of providing the "vaccination sign off" for **refugees**).

AoS and I-693 Requirements by Immigration Status

Status	Timing	I-693 Requirements
Refugee, except Class A	Required after 1 year in U.S.	Page 1 Page 5 Vaccination Form Designated civil surgeon or LHD Physician may sign form
Refugee-Class A	Required after 1 year in U.S.	Pages 1-5 New waiver application required
Asylee (Dependent)	Optional after 1 year in U.S.	Page 1 Page 5 Vaccination Form Designated civil surgeon must sign form
Asylee (U.S. grant)	Optional after 1 year in U.S.	Pages 1-5
Cuban Entrant/Parolee	Optional after 1 year in U.S.	Pages 1-5
Afghan & Iraqi Special Immigrant	None-enter U.S. as LPR	NA
Amerasian	None-enter U.S. as LPR	NA
Victim of Trafficking	Optional after physically present in the U.S. for a continuous period of at least three years in T-nonimmigrant status, or a continuous period during the investigation or prosecution of the acts of trafficking, provided that the Attorney General has certified that the investigation or prosecution is complete, whichever time is less.	Pages 1-5

Selected Adjustment of Status and Civil Surgeon Resources

Information/Resources	Link
Form I-693: Report of Medical Examination and Vaccination Record	https://www.uscis.gov/sites/default/files/document/forms/i-693.pdf https://www.uscis.gov/sites/default/files/document/forms/i-693instr.pdf
Technical Instructions for Civil Surgeons	https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/medical-history-and-physical-exam.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fimmigrantrefugeehealth%2Fexams%2Fti%2Fcivil%2Ftechnical-instructions%2Fcivil-surgeons%2Fmedical-history-physical-examination.html
General Information on Medical Examinations	https://www.cdc.gov/immigrantrefugeehealth/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fimmigrantrefugeehealth%2Fexams%2Fmedical-examination.html
Medical Examination: Frequently Asked Questions	https://www.cdc.gov/immigrantrefugeehealth/about/medical-exam-FAQs.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fimmigrantrefugeehealth%2Fexams%2Fmedical-examination-faqs.html
Civil Surgeon Locator	https://my.uscis.gov/findadoctor
Designation of Health Departments as Civil Surgeons for Refugees Adjusting Status	https://www.uscis.gov/policy-manual/volume-8-part-c-chapter-3
Information on Civil Surgeons	https://www.uscis.gov/i-910
Law Concerning Refugee and Asylee AoS and Medical Examination Requirement *Cite: 8CFR Part 209 Section 209.1* *8CFR Part 209 Section 209.2*	https://www.govinfo.gov/app/details/CFR-2012-title8-vol1/CFR-2012-title8-vol1-sec209-1
Health-Related Waivers	https://www.uscis.gov/policy-manual/volume-9

Designation as a civil surgeon allows physicians to perform the medical exam required of some applicants for AoS. Physicians interested in being registered as a designated civil surgeon must submit the following information and documentation to their local USCIS office:

- A letter to the USCIS District Director requesting consideration
- A copy of your current medical license

- A current resume that shows four years of professional experience, not including a residency program
- Proof of U.S. citizenship or lawful status in the U.S.
- Two signature cards showing name typed and signature below

Local USCIS offices can be found at: https://egov.uscis.gov/office-locator/#/

United States Department of State

Washington, D.C. 20520

September 4, 2015

PROGRAM ANNOUNCEMENT 2015-20

From: **Lawrence Bartlett, Director, Office of Admissions**
Bureau of Population, Refugees, and Migration

To: **Reception and Placement Agencies**

Beginning September 7, 2015, U.S. Customs and Border Protection (CBP) will automate the issuance of I-94 records for refugees at Ports of Entry (POEs). This will streamline the inspection process for refugees at the POEs and bring the I-94 process for refugees in line with that of nearly all other travelers entering the U.S.

With this change, refugees will no longer receive the paper I-94 card at the POE and will need to obtain their I-94 record online. When a refugee is admitted, CBP will create an electronic admission record for each individual. CBP hosts an I-94 website, wherein a refugee can obtain a printed document containing his or her I-94 information. This electronic version of form I-94 will be available at **www.cbp.gov/I94** and can be obtained after a refugee enters his or her name, date of birth, and alien number into the proper fields. The electronic record will be available within hours of the refugee's arrival at the POE. Note: The refugee's alien number must be entered into the passport number field regardless of whether the refugee has a passport number. The alien number should be entered as numbers only without the preceding "A".

CBP will stamp the transportation boarding letter upon admission to the U.S. This letter is provided to the Principal Applicant (PA) of each refugee case by the Resettlement Support Center (RSC) overseas. The boarding letter introduces all the members of the refugee case to the airlines and U.S. security agencies by providing identifying information, including photos, and affirms that they have been approved for refugee status, may travel aboard an airline to and within the U.S. to their resettlement destination, and apply for admission to the U.S. The PA of the refugee case presents this letter to CBP upon arrival at the POE. Beginning September 1, 2015, the transportation boarding letter will be the only document provided to the

refugee with an official CBP refugee stamp. The refugee must retain this transportation boarding letter and a copy of the document must be placed in the refugee case file.

Although this change is scheduled to take place on September 1, affiliates should expect to see some refugees arrive with paper I-94 cards throughout September as the change is implemented. If a refugee receives a stamped I-94 record at the POE, there is no need to also obtain the electronic I-94 record.

This change will affect how refugees obtain Social Security Cards. Beginning September 7, 2015, the Social Security Administration (SSA) will require two documents from newly-arrived refugees in order to issue a social security card: 1) an original transportation boarding letter stamped by CBP with a refugee stamp and 2) a printout of the I-94 obtained online. Affiliate staff will need to ensure that online I-94 copies are printed for each individual and copies are placed in case files. Refugees must present an I-94 printout for each member of their case as well as the original stamped copy of the transportation boarding letter to SSA. SSA will also continue to accept the I-765 Card (Employment Authorization Document, EAD) with the category code "A3" which the refugee receives after entering the U.S. If an EAD is presented, there is no need to present the boarding transportation letter and the I-94 printout.

If a refugee has not received the I-765 (EAD) Card and loses the stamped transportation boarding letter, the affiliate should notify their headquarters agency. The headquarters agency will notify their PRM Program Officer and request that a replacement copy of the transportation boarding letter be generated. PRM will then send a copy (via pdf) of the letter to SSA headquarters along with contact information for the refugee(s) (i.e., residence address, phone number, and SSA office address the refugee plans to visit) who will then work with the relevant SSA regional/field office to have the affected refugees appear at the local office. The refugee(s) should not approach the local SSA office until contacted by the SSA office employee. Each member of the refugee case will have to have a printout of the I-94 obtained online to present to SSA as well as their replacement DOS transportation boarding letter. This process - when transportation letters are lost - is time consuming; therefore, it is important that the transportation boarding letters be kept in a secure location to prevent any delays with obtaining a Social Security card.

If you have questions regarding this announcement please contact Irving Jones at 202-453-9248.

Female Genital Cutting (FGM/C)

Female genital mutilation and cutting (also known as female circumcision, female genital mutilation, and female genital excision) refers to all procedures involving partial or total removal of female genitalia or other injury to female genital organs for any cultural, religious, or otherwise non-therapeutic reasons. This practice, although pervasive throughout the world, is common in many refugee populations, particularly those from East Africa (for example, Somalia, Ethiopia, and Sudan). This controversial practice is considered a human rights violation by many and is illegal in the U.S. for females under 18 years of age. The World Health Organization (WHO) has condemned the practice and is making efforts to end it. The practice poses adverse medical consequences, including direct complications from the procedure (anesthesia or sedation complications, bleeding, acute infection), increased risk of death for both mother and infant in subsequent pregnancies, post-traumatic stress disorder, and urinary tract infections, among others. In addition, there may be adverse consequences for the woman's sexual well-being.

An external genital examination will reveal whether a girl or woman has undergone this procedure. Although this examination is required on the OVME, it may not have been performed. As such, the RHA presents an opportunity to identify women who have had the procedure. The exam may also provide opportunities to interrupt the practice in future generations of the family and/or population. When the practice is identified, the health care provider should record what type of procedure was performed (see table below). Culturally sensitive counseling and educational materials should be offered and, when necessary, referrals provided (for example, for complications or post-traumatic stress disorder). The refugee should be informed that the procedure is illegal in the U.S.

World Health Organization Categorization of Female Genital Cutting	
Type I	Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision)
Type III	Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)
Type IV	All other harmful procedures to the female genitalia for nonmedical purposes (e.g., piercing, incising, pricking, scraping, and cauterization)

In providing care for clients affected by FGC, health care professionals should start by examining their own personal attitudes towards the practice. For example, they may regard FGC as oppression of women, but this view is not shared by all circumcised women who see FGC as part of their "honor" and self-identity. Also, health care professionals need to be aware that in many cultures:

- FGC is carried out with the best interest of young girls at heart, however harmful it may seem from a Western viewpoint.
- It is sanctioned by the community and endorsed by loving parents in the belief that it will ensure their daughter's health, chastity, hygiene, fertility, honor, and eligibility for marriage.

- It is seen as “normal” to the women who are affected by it.

An appropriate approach to FGC should include:

- Using appropriate, non-judgmental terminology when referring to FGC (consider refraining from using the Western term “female genital mutilation,” ask for the client’s own terminology for FGC or use such words as ‘cutting,’ or ‘female circumcision’).
- Being sensitive to the possibility that the woman may wish to discuss issues associated with FGC; however, avoid raising the subject when there is no apparent reason to do so.
- Consider a referral to a female doctor.
- Reassure women that any questions relating to FGC are to do with health care, not the U.S. laws.
- Avoid discussing FGC in a family consultation; it is not customary to discuss the topic around family members.
- Be aware that the client may never have had a gynecological examination.
- Be aware that pelvic examination may be difficult, painful, or impossible and should not be continued if it is unduly uncomfortable for the client.
- Document findings in detail to minimize the need for repeat examinations and so that future needs can be anticipated and arranged.
- Recognize that a woman may regard her genitalia as normal; she may be unaware that she has undergone FGC or may even deny that this is the case.
- Recognize that women may be unaware that there are medical complications associated with FGC.

Information/Resource	Link
CDC-FGM/C Screening Guidance	https://www.cdc.gov/reproductivehealth/womensrh/female-genital-mutilation.html
BRYCS-Female Genital Cutting	https://brycs.org/blog/female-genital-cutting-fgc/
World Health Organization-Female Genital Mutilation	https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
World Health Organization-Care of Girls	https://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/

and Women Living with FGM	
Ethnomed-Dysuria, Symptoms in Somali Girls and Women	https://ethnomed.org/resource/dysuria-symptoms-in-somali-girls-and-women/
Office on Women's Health-Female Genital Cutting	https://www.womenshealth.gov/a-z-topics/female-genital-cutting

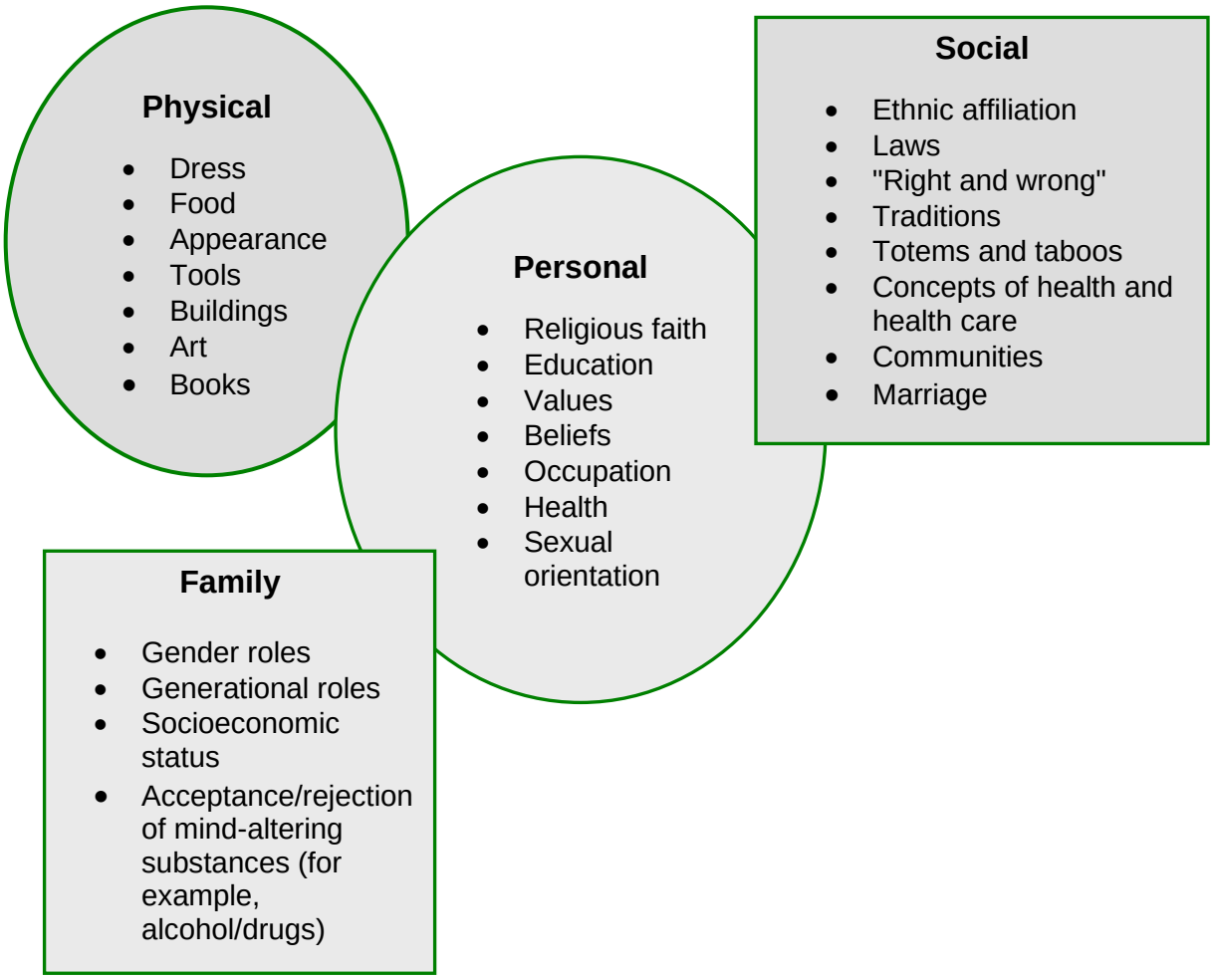
Attachment J

Cultural Competency

Effective communication is essential to providing quality health care, as language and cultural barriers can lead to serious complications and adverse outcomes. In addition to the effect the inability to communicate can have on client outcomes, cultural and linguistic barriers can also have an effect on costs by increasing inefficiencies and unnecessary testing.

Cultural competence goes beyond cultural awareness or cultural sensitivity. The U.S. Office of Minority Health defines cultural competence as “the ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter.”

There are many factors that influence our feelings about various cultures:



Culture, Belief, and Health-Related Needs

There are no magic recipes for approaching patients from another culture. Each patient is unique. Each culture is a filter, not a lens. We all look at the world through the filter of our culture but also with our own eyes.

There are sensitive issues that all health care providers and volunteers who work with people from other cultures should know:

- Patient autonomy and decision making are perceived as misguided concepts in some cultures. Sometimes the individual or the family makes the decisions; at other times, they want the doctor to decide.

- The funnel for medical information is not always the patient, but in many cases a designated family member, which can be confusing for health care workers and volunteers and interfere with health-related laws, such as the Health Insurance Portability and Accountability Act (HIPAA).

- Refugees often arrive from war-torn countries. A startling percentage of refugee women were raped abroad. Most suffer some degree of trauma and many have no experience with medical exams.

- Refugees are in particular need of sensitive services from interpreters. A high percentage of them suffer from post-traumatic stress disorder, depression, substance abuse, and histories of sexual assault, starvation, deprivation, and/or ill health in refugee camps.

Other important issues that cut across many cultures:

- A number of refugees are not literate in their own language.

- Refugees may be suspicious of the U.S. health care system. It can bewilder them.

- Folk healers are common, even among refugees who seek formal health care.

- Compliance and follow up is often poor due to language and cultural barriers.

- In many cultures, it is not considered appropriate to display emotions, while in other cultures it may be considered obligatory to show strong emotion about serious illness, even in a clinical setting where they may disturb other clients.

- Pain medication is often poorly understood.

- In some cultures, patients are expected to be stoic about pain and may not be honest when communicating about the pain they feel. They may have withdrawn or refused access to pain medication for immediate family members.

- Confidentiality is critical, yet misunderstood. For this reason, it is vital to stress to the patient and family that all health care workers and volunteers must respect confidentiality (and why).

Folk Medicine and Remedies

Some folk remedies can lead to cultural misunderstanding and possible charges of child neglect or abuse. Health care professionals need to take special care to ascertain if practices such as coining and cupping are being used before child protective services is notified. For more information on folk medicine and remedies, please see the Internet resources on the following page.

Cultural Competence: Questions for Your Program

How does your clinic appear to clients?

- What poster or sign is on your door?
- In what languages are the materials in your reception area?
- Do the images of people throughout your clinic reflect the diversity of your clients?
- Are your patient education materials simple, attractive, and multilingual?

How can you make your clinic more welcoming to clients from diverse cultures?

- Order or make a multilingual "welcome" poster.
- Post miniature flags of your clients' home countries.
- Gather international posters and wall hangings.
- Collect magazines in several languages.
- Order multilingual education materials with colorful pictures.
- Display a world map and highlight countries of origin of clients served in your clinic.

"What is your language" materials

"What is your language" materials include a list of languages in English and multiple languages with the translated statement "Point to your language" beside it. A client can point to the language poster/card/brochure to identify his or her language. Make sure the materials are easily accessible to clients.

Do you post information stating the client's right to a free interpreter?

Agencies that receive federal funding are required to post signage stating that any client with limited English proficiency has the right to an interpreter at no cost. This signage should be multilingual, reflecting the dominant languages spoken by area residents or by clients.

How do staff members greet your clients?

For a number of cultures, a business-like approach in clinical settings seems rude. Shaking hands may be unacceptable between men and women from some cultures. Some clients may avoid your

eyes to show respect for authority. For these reasons, it is important to establish a warm relationship yet remain sensitive to the cultural meaning of physical gestures and behavior.

Strategies

- Take your time! For many cultures, a first meeting in a clinical setting ideally begins with a pleasant conversation. It can include questions about neutral subjects, to put the client at ease. The goal is to establish a relationship of warmth and trust. Only then is it helpful to proceed to some of the delicate questions that surround health care.

- Ask your interpreters and bilingual staff how to greet clients. Your interpreter and bilingual staff have a wealth of cultural knowledge. You can also consult a local ethnic group or resettlement agency. Acquiring cultural information can help put your clients at ease.

- Hire bilingual multicultural staff. Hiring qualified staff from the cultures of your clients provides the greatest reassurance that your organization understands and respects the cultural issues around health care. Acquiring such staff members also promotes trust.

Cultural Competence in Health Care: Internet Resources

Cultural and ethnic health profiles are valuable tools for staff and volunteers. Most are brief (a few pages or less) and free of charge. They provide information about the culture, language, and/or important health issues that affect the population. Such documents can be used as a tool to stimulate informal discussions among staff, volunteers, and interpreters on these complex issues. Cultural profiles and other information on cultural competence and overcoming linguistic and cultural barriers can be accessed through the websites listed below.

Information/Resource	Link
Traditional Health Practices-Southeast Asian Refugees	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1003313/pdf/westjmed00093-0047.pdf
Traditional Health Practices-Somali Bantu	https://ethnomed.org/resource/somali-bantu-refugees/
Health Information Translations-Repository of Translated Materials	https://www.healthinfotranslations.org/
Cultural Competence in Health and Human Services	https://npin.cdc.gov/pages/cultural-competence
Physician's Practical Guide to Culturally Competent Care	https://cccm.thinkculturalhealth.hhs.gov/
Refugee Health Profiles	https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html
Cultural Competence in Refugee Service Settings	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7990563/pdf/heq.2020.0094.pdf

SECTION **PAGE**

I. Policy

Standardized methodology to credential registered nurses (RNs) with the county health department (CHD) system to advance their scope of practice to perform assessments for adult health screenings and child health check-up screenings.

II. Authority

Sections 154.04(c) and 464.003(20), Florida Statutes

III. Scope

Registered Professional Nurses (RN)

IV. Definitions

A. Assessment: The process by which a patient's condition is appraised or evaluated.

B. Practice of Professional Nursing: The performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical and social science.

C. Registered Nurse: Any person licensed in this state or holding an active multistate license to practice professional nursing under Chapter 464, Florida Statutes.

V. Procedures

A. Assessing Education, Training and Experience

The prior education, training, and experience of each nurse must be assessed before the nurse performs nursing health assessments on CHD clients.

B. Continuing Education

The Office of County Health Systems or the CHD that has a Florida Board of Nursing provider number may award continuing education contact hour credit.

C. Initial Certification and Credentialing

1. Complete the required college or CHD health assessment course which must include didactic and practicum training that covers all of the following areas:

    a. Health history and database

    b. Psychosocial assessment

    c. Skills of inspection, palpation, percussion, and auscultation

d. Review of body systems

e. Recognition of abnormal findings

f. Recording of findings using the problem oriented record

2. Document successful completion of the didactic training with one of the following:

   a. Official college transcripts verifying completion of a health assessment course.

   b. Continuing education course certificate verifying completion of a health assessment course.

3. Document successful completion of the practicum training:

   a. The CHD nursing director, or their designee, should arrange for supervised nursing health assessment experiences to evaluate the competency of registered nurses who have completed the required didactic course work.

   b. An advanced registered nurse practitioner (ARNP), medical doctor (MD), or doctor of osteopathy (DO) employed by the Department of Health should evaluate in writing the nurse's competency in performing the health assessment on a minimum of four adult clients and/or four pediatric clients based on the population served, utilizing a local nursing health assessment checklist and CHD protocols and procedures. If both adult and pediatric clients are served, a minimum of eight health assessments must be performed.

4. Issue a certificate that credentials the nurse to perform nursing health assessments on CHD clients following a satisfactory evaluation of the nurse's clinical competence. A sample for initial certification and credentialing is provided as Appendix A.

D. Annual Evaluation and Biennial Recertification

Once the professional registered nurse is credentialed to perform nursing health assessments, the CHD nursing director, or their designee, must provide annual performance evaluation of the nurse's competency in performing nursing health assessments.

Biennial recertification is required for documenting the registered professional nurses' ongoing role in competently performing nursing assessments.

Note: Sexually transmitted disease (STD) assessments require additional specialized training. See Internal Operating Procedure: IOP 360-22 Credentialing of a Sexually Transmitted Disease Registered Nurse Clinician.

VI. Training

Courses are available through the Florida Board of Nursing and the Nursing Reference Center.

VII. Supportive Data and References

A. County Organization and Intergovernmental Relations, Chapter 154, Florida Statutes http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0100-0199/0154/Sections/0154.04.html, accessed 3/18

B. Florida Nurse Practice Act, Chapter 464, Florida Statutes http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0464/0464ContentsIndex.html&StatuteYear=2014&Title=%2D%3E2014%2D%3EChapter%20464, accessed 3/18

C. Internal Operating Procedure: IOP 360-22 Credentialing of a Sexually Transmitted Disease Registered Nurse Clinician https://floridahealth.sharepoint.com/sites/DISEASECONTROL/Policies/IOP_360-22_STDCredentialRN.pdf accessed 3/18

D. Nursing Reference Center http://web.b.ebscohost.com/nrc/search?vid=1&sid=3af4697b-b6e5-4b57-b010-c98433c6c1be%40sessionmgr102 accessed 3/18

E. Taber's Cyclopedic Medical Dictionary, Edition 19, F.A. Davis Company, 1997.

VIII. History Notes

This policy replaces and supersedes DOHP 180-3-15, dated March 2015.

IX. Signature and Effective Date

Celeste Philip, MD, MPH
Surgeon General and Secretary

4/12/18
Date

Appendix A
Sample Certificate for Initial Credentialing

This is to certify that _____ has satisfactorily completed the didactic training in Nursing Health Assessment that includes:

- Health History and Database
- Psychosocial Assessment
- Skills of Inspection, Palpation, Percussions, and Auscultation
- Review of Body Systems
- Recognition of Abnormal Findings
- Recording of Findings

On the _____ day of _____ 20 ____

Signature: _____ Signature: _____
CHD Director/Administrator Employee

Signature: _____
Supervising Physician

This is to certify that _____ has satisfactorily completed the supervised practicum in Nursing Health Assessment.

On the _____ day of _____ 20 ____

Signature: _____ Signature: _____
CHD Director/Administrator Employee

Signature: _____
Supervising Physician

This is to certify that _____ has satisfactorily completed the requirements to be credentialed to perform Nursing Health Assessments on CHD clients. Adult and pediatric clients may be assessed and the following medications ordered and delivered:
_____.

Course Title: _____

On the _____ day of _____ 20 ____

Signature: _____ Signature: _____
CHD Director/Administrator Employee

Signature: _____
Supervising Physician

Appendix B
Example Sample Biennial Credentialing

This is to certify that _____ has satisfactorily completed the biennial requirement of four supervised Nursing Health Assessments for adult clients and four supervised nursing health assessments for pediatric clients.

The following medications may be ordered and delivered:
_____.

On the _____ day of _____ 20 ____

Signature: _____ Signature: _____
CHD Administrator/Director Employee

Signature: _____
Supervising Physician

This is to certify that _____ continues to meet the credentialing requirements to perform Nursing Health Assessments on department CHD clients.

Course Title: _____

On the _____ day of _____ 20 ____

Signature: _____ Signature: _____
CHD Administrator/Director Employee

Signature: _____
Supervising Physician

_____ County Health Department

Refugee Health Program

PC 18 Superbill

DEMOGRAPHICS - MEDICAL RECORD #

HMS LABEL

RESULTS:

N = Normal A = Abnormal I = Indeterminate L = Low

H = High Y = Yes N = No Pos = Positive Neg = Negative

1	Billing Provider	
2	Service Provider	
3	Service Provider	
4	Service Provider	
5	Service Provider	
6	Service Provider	

INITIAL	PERIODIC	SERVICE DESCRIPTION	Core Services RHAP rate
99381	99391	Physical Exam (0-1 years)	
99382	99392	Physical Exam (1-4 years)	
99383	99393	Physical Exam (5-11 years)	
99384	99394	Physical Exam (12-17 years)	
99385	99395	Physical Exam (18-39 years)	
99386	99396	Physical Exam (40-64 years)	
99387	99397	Physical Exam (65+ years)	

Physical Examination (Per Refugee Health Assessment Program Guidelines)	Results
Medical HX. & Overseas Med. Exam Review (if applicable)*	Y N
Height / Weight / BMI (CDC Guidelines) *	L N H
Blood Pressure (≥3 Years Old) *	L N H
Nutritional Status *	A N
Oral Health Screening *	A N
Visual Acuity (Snellen Chart or equivalent for children) *	A N
Hearing (Whisper Test) *	A N
Eyes / Ears / Nose / Throat *	A N
Chest / Lungs / Heart *	A N
Abdomen Palpitation (Masses and / or Pain) *	A N
General Health Education *	Y N
Domestic Violence	Y N
97750 Postural Assessment *	A N
96127 Mental Health Screening *	A N

Required for reimbursement

CPT CODE	**Extended Services** (Clinically Indicated / Based on Risk)	Results
71045	Chest X-ray Single View	A N
71046	Chest X-ray (PA & Lateral)	Pos Neg
86780	Syphilis Confirmatory	Pos Neg
86701-87535	HIV Confirmatory: Genius and NAT	Pos Neg
87086	Urine Culture	A N
99211	Minimal Nurse Visit (Must be a different date of service than P.E.)	Y N

HMC CODE	**Eligibility**	PROVIDER
9030	Eligibility Determination	
9010	Case Management	

Referrals - Partial list - most common referrals provided

PCP	R041	TB	R049	HIV	R050
STD	R015	Pediatrics	R047	Mental Health	R002
FP	R023	WIC	R007	Vision/Hearing	R045
Dental	R033	OBGYN	R046	Domestic Violence	R022

Other: (Specify) R999 ☐

Other: (Specify) R999 ☐

Other: (Specify) R999 ☐

*** Complete list of referrals is shown on the back of the Superbill - use it as needed**

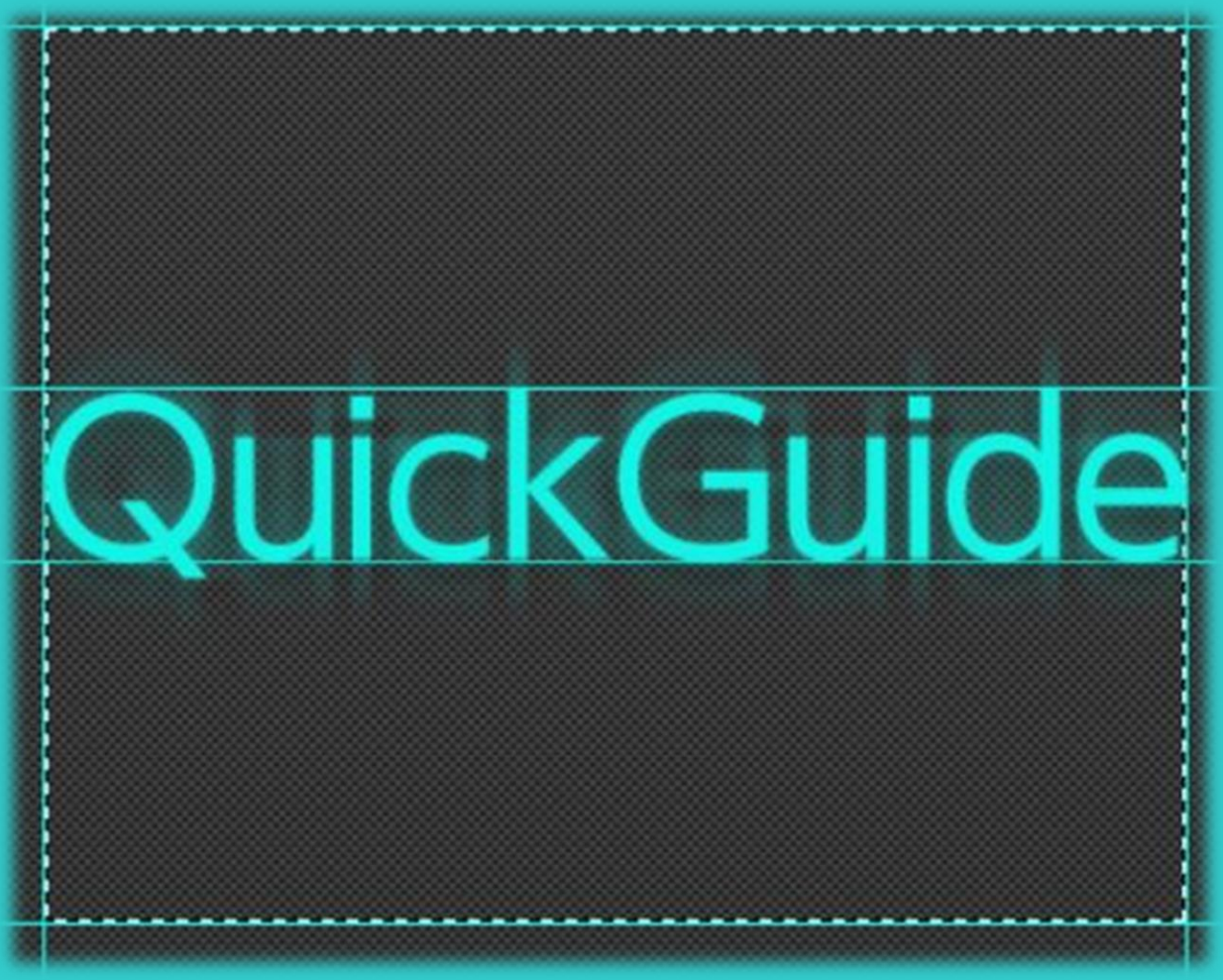
CPT CODE	**LAB SERVICES**	RESULTS	Provider
81000/81001 / 81002/81003	81005 Urinalysis	A N	
81025/84703	Pregnancy Test	Pos Neg	
	Currently Pregnant?	Y N	
	Currently Breast Feeding?	Y N	
85025	CBC with differential	A N	
80053	Comprehensive Metabolic Panel	A N	
83655	Lead Testing (6 Mths - 16 Yrs old)	A N	
83540	Assay of Iron (6 Mths - 6 Yrs old)	A N	
86580	TB Skin Test (PPD) Implant ____ Reading	A N	
86480 / 86481	IGRA-QFT TB Gold Test or Tspot TB Tst	A N	
86682*	Write lab test name on lab requisition *Strongyloides* Antibody IGG	A N	
86682*	Write lab test name on lab requisition Shistosoma Antibody IGG	A N	
87491 / 87591	Chlamydia / Gonorrhea: RNA - TMA	Pos Neg	
87389	HIV-1/HIV-2 Single Result, antibody	Pos Neg	
86592 / 86593	Syphilis RPR Monitor / Reflex Test	A N	
87209 / 87177	Stain/Smear- Ova & Parasites (X2)	A N	
86708	Hepatitis A antibody (HAV)	Pos Neg	
86704	Hepatitis B Core antibody (HBcAb)	Pos Neg	
86706	Hepatitis B Surface antibody (HBsAb)	Pos Neg	
87340	Hepatitis B Surface Antigen (HBsAg)	Pos Neg	
86803	Hepatitis C antibody (Anti-HCV)	Pos Neg	
86787	Varicella Zoster antibody	Pos Neg	
86762	Rubella Antibody	Pos Neg	
86765	Rubeola Antibody	Pos Neg	
86735	Mumps Antibody	Pos Neg	

IMMUNIZATIONS			Adult	Pedi
Tetanus, Diptheria, Pertusis (TDaP)	90715	Z23		
Tetanus, Diptheria (TD)	90714	Z23		
Measles - Mumps - Rubella (MMR)	90707	Z23		
Varicella (VZV)	90716	Z23		
Zostavax (Shingles)	90736	Z23		
Human Papilloma Virus (HPV9)	90651	Z23		
Influenza 3+	90686	Z23		
Hepatitis A	90632	Z23		
Hepatitis B	90746	Z23		
Inactivated Poliovirus (IPV)	90713	Z23		
Haemophilus Influenzae (Hib)	90645	Z23		
Diptheria, Tetanus, Pertusis (DTaP)	90700	Z23		
DTaP - Hib - IPV (Pentacel)	90698	Z23		
DTaP - Hep B - IPV (Pediarixl)	90723	Z23		
Meningococcal (Menactra)	90734	Z23		
Pneumococcal (Prevnar)	90669	Z23		
ProQuad (MMR-VZV)	90710	Z23		

Referral Code	Referral Type	Service Provider
R001	Nutrition Assessment	
R002	**Psychosocial Counseling/Mental Health**	
R003	Parenting Education & Support	
R004	Childbirth Education	
R005	Breastfeeding Education & Support	
R006	Interconceptional Counseling & Education	
R007	**Women, Infant & Children Nutritional (WIC)**	
R008	Food Resources	
R009	Housing Assistance	
R010	Child Protection System	
R011	Healthy Families Florida Department of Health	
R012	Adult Education	
R013	General Education Degree (GED)	
R014	Other Educational Resources	
R015	**Sexually Transmitted Infections (STI)**	
R016	Long-Term Mental Health Services	
R017	Economic Self Sufficiency Services	
R018	Transportation Services	
R019	Medicaid Referral	
R020	Child Support Enforcement	
R021	Daycare Resources	
R022	**Domestic Violence**	
R023	**Family Planning**	
R033	**Dental Health Clinics**	
R034	Home Visiting Program Services	
R038	Outside Interpretation Services - former Linguistic Services	
R041	**Primary Care Services**	
R045	**Vision/Hearing**	
R046	**OBGYN**	
R047	**Pediatrics**	
R048	Disability Services	
R049	**Tuberculosis (TB)**	
R050	**HIV**	
R051	Newborn Screening (infant-12 months)	
R999	Other Referrals	

Notes Section

ATTACHMENT M



Refugee Health

HMS Quick Guide for Refugee Services

Program Description and Definition

County health department staff provide health services to eligible refugees. Staff must evaluate refugees for health conditions that require follow-up care and treatment via the Refugee Health Assessment. ***Non-eligible clients should have services coded to PC 29 or PC 37 and employee time spent providing those services should be coded to these alternate program components as well.***

HMC Codes

Service	Description	Code	Notes
Refugee Health Assessment- ***Initiated***	Use this code to document the **start** of the Refugee Health Assessment	5550	***You must code to one of the following age-appropriate CPT codes :99381 – 99387**
Refugee Health Assessment- ***In Progress***	Use this code to document the **continuation** of the Refugee Health Assessment	5551	***You must code to one of the following age-appropriate CPT codes :99391 - 99397**
Refugee Health Assessment- ***Completed***	Use this code to document the **completion** of the Refugee Health Assessment	5552	***You must code to one of the following age-appropriate CPT codes: 99391 - 99397**
Refugee Health Assessment- ***Transfer*** *******formerly entitled "Follow-Up"*	Use this code to document the continuation of refugee health assessment services when the health assessment was already initiated at another CHD or outside provider; however, the health assessment is not completed in this visit.	5553	***The first visit for a client who has transferred is 5553 and the second visit, during which the assessment is completed, is 5552.** ***You must code to one of the following age appropriate CPT codes 99391-99397** *This code should not be used for clients who completed the refugee health assessment at another CHD or outside provider and only need immunization services. *See HMC immunization-only visit description*
Post Refugee Health Assessment- ***Minimal Visit***	Use this code to document a minimal office visit when the refugee health assessment has previously been coded as completed; however, extended services, referrals, or other interventions are needed for continuity of care.	5554	***This code should be used when applicable, according to RHP guidelines and DOH policies.** ***CPT code 99211 should be used in conjunction with this visit.**
Refugee Health ***Immunization-Only Visit***	Use this code to document assessment, counseling, and administration of immunizations to eligible refugee clients once the refugee health assessment has been completed.	5555	***This code is to designate an immunization-only visit and should be coded with appropriate immunization product-specific CPT codes, following ACIP guidelines.** ***This code is appropriate for eligible clients, regardless of where they completed the refugee health assessment, as long as immunizations are initiated within one year of arrival. HMS should reflect appropriate documentation for a refugee health assessment which was completed within eight months from the date of arrival.**

Codes for Unscreened Clients

Service	Description	Code
Attempt to Contact	This code can be used by refugee health clinical or clerical staff to document an attempt to contact a refugee client for services.	3103
Decline Services	This code can be used by refugee health clinical or clerical staff to document when a refugee client verbally declined or refused services.	3110
Unable to Locate	This code can be used by refugee health clinical or clerical staff to document the inability to reach a refugee client for service after three attempts by letter or phone have been completed.	3114
No Show	This code can be used by refugee health clinical or clerical staff to document a refugee client **not** attending a confirmed refugee health assessment appointment.	3116
Insufficient Address	This code can be used by refugee health clinical or clerical staff to document return- to -sender letters that have be sent to refugee clients to initiate services.	3117
Moved	This code can be used by refugee health clinical or clerical staff to document the confirmation that a refugee client has moved outside the CHD catchment area for services.	3118

Referral Codes

Service	Code
Eligibility Determination	9030
Case Management	9010
Nutrition Assessment	R001
Psychosocial Counseling/Mental Health	R002
Parenting Education & Support	R003
Childbirth Education	R004
Breastfeeding Education & Support	R005
Interconnectional Counseling & Education	R006
Women, Infant & Children Nutritional (WIC)	R007
Food Resources	R008
Housing Assistance	R009
Child Protection System	R010
Healthy Families Florida Department of Health	R011
Adult Education	R012
General Education Degree (GED)	R013
Other Educational Resources	R014
Sexually Transmitted Disease (STD)	R015
Long-Term Mental Health Services	R016
Economic Self Sufficiency Services	R017
Transportation Services	R018
Medicaid Referral	R019
Child Support Enforcement	R020
Daycare Resources	R021
Domestic Violence	R022
Family Planning	R023
Dental Health Clinics	R033
Home Visiting Program Services	R034
Linguistics Services	R038
Primary Care Services	R041
Communicable Diseases	R044*****
Vision/Hearing	R045*****
OBGYN	R046*****
Pediatrics	R047*****
Disability Services	R048*****
Other Referrals	R999

CPT Codes

History & Physical Exam	
CPT Code	**Service Description**
99381 / 99391	PHY INITIAL EVAL UNDER AGE 1 / PERIODIC PHYSICAL EXAM UNDER AGE 1
99382 / 99392	PHY INITIAL EVAL AGE 1-4 / PERIODIC PHYSICAL EXAM AGE 1-4
99383 / 99393	PHY INITIAL EVAL AGE 5-11 / PERIODIC PHYSICAL EXAM AGE 5-11
99384 / 99394	PHY INITIAL EVAL AGE 12-17 / PERIODIC PHYSICAL EXAM AGE 12-17
99385 / 99395	PHY INITIAL EVAL AGE 18-39 / PERIODIC PHYSICAL EXAM AGE 18-39
99386 / 99396	PHY INITIAL EVAL AGE 40-64 / PERIODIC PHYSICAL EXAM AGE 40-64
99387 / 99397	PHY INITIAL EVAL OVER 65 / PERIODIC PHYSICAL EXAM OVER 65
99211	Nurse Visit
99213	Office/Outpatient visit

Lab Tests/Preventive Health	
CPT Code	**Service Description**
71010	Chest x-ray, frontal
71020	Chest x-ray, PA and lateral
80047	Basic metabolic panel
80048	Basic metabolic panel
80053	Comprehensive metabolic panel
81000	Urinalysis
81001	Urinalysis
81002	Urinalysis
81003	Urinalysis
81005	Urinalysis
81025, 84703	Urine pregnancy test
82728	Assay of ferritin
83540	Assay of iron
83550	Iron total and IBC
83655	Assay of lead
84702	Chorionic gonadotropin assay, quantitative
84703	Chorionic gonadotropin assay, qualitative
85025	Complete CBC w/ WBC differential
85046	Reticulocyte/Hgb concentrate
86480	TB test cell 3mmune measure [IGRA]
86481	TB ag response t-cell susp [IGRA]
86580	TST/PPD reading
86592	Syphilis test non-treponemal [VDRL or RPR]
86593	Syphilis test non-treponemal, quantitative
86658	*Enterovirus* antibody
86682	Helminth antibody
86682	Strongyloides Angibody IGG
86682	Shistosoma Antibody IGG
87389	HIV-1/HIV-2 4th generation antibody
86701, 87535	HIV confirmatory test, antibody
86708	Hepatitis A antibody total
86704	Hepatitis B core antibody total
86706	Hepatitis B surface antibody
87340	Hepatitis B surface antigen EIA
86803	Hepatitis C antibody

87522	Hepatitis C antibody confirmatory
86735	Mumps antibody
86762	Rubella antibody
86765	Rubeola antibody
86774	Tetanus antibody
86767	Varicella-zoster antibody
86780	Syphilis confirmatory
86787	Varicella-zoster antibody
87086	Routine urine culture
87110	*Chlamydia* culture
87177	Ova and parasites smear
87207	Parasite blood smear
87209	Ova/parasites stain
87270	*Chlamydia* DFA
87320	*Chlamydia* EIA
87491	*Chlamydia* and gonorrhea DNA amplification probe
87591	Gonorrhea
87810	*Chlamydia* immunoassay

****Please choose only ***one*** CPT code****

CPT Codes (Continued)

Immunization	
CPT Code	**Service Description**
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
90632	Hepatitis A vaccine, adult dosage
90633	Hepatitis A vaccine, pediatric/adolescent
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90636	Hepatitis A and hepatitis B (HepA-HepB)
90645	*"Haemphilus influenza"* b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
90646	*"Haemphilus influenza"* b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	*"Haemphilus influenza"* b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	*"Haemophilus influenza"* b vaccine (Hib)
90649	*"Haemophilus influenza"* b vaccine (Hib)
90650	Human papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90651	HPV vaccine non valent IM
90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90680/90681	Rotavirus vaccine
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV)
90698	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Haemophilus influenza *Type B*, and poliovirus vaccine, inactivated (DTaP - Hib - IPV)
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90704	Mumps virus vaccine, live, for subcutaneous use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use

90707	Measles, mumps and rubella virus vaccine (MMR), live
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	Poliovirus vaccine, inactivated, (IPV)
90714	Tetanus and diphtheria toxoids (Td)
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap)
90716	Varicella virus vaccine, live
90718	Tetanus and diphtheria toxoids (TD) absorbed, greater than 7, IMM use
90720	Diphtheria, tetanus toxoids, and whole- cell pertussis vaccine and *Haemphilus influenza* B vaccine (DTP-Hib), for intramuscular use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and *Haemphilus influenza* B vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV)
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal, polysaccharide vaccine (any group(s)), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90736	Zoster (shingles) vaccine, live, for subcutaneous injection
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748	Hepatitis B and *Haemphilus influenza* b vaccine (HepB-Hib), for intramuscular use

Client's Label	
Parent/Guardian Name: (if applicable)	**Telephone Number:**

Referred to:

TB ☐ Dental ☐ OB/GYN ☐ PCP ☐ WIC ☐ Vision ☐ Hearing ☐ Pediatric PCP ☐

Family Planning ☐ Mental Health ☐ Communicable Diseases ☐ Other ☐ Specify: _____

Information for above program or provider was given and client informed to schedule their own appointment ☐

A referral appointment was scheduled for the client per the information below ☐

Client signed Release of Information form ☐

Program or Provider: _____ Appointment Date: _____ Appointment Time: _____

Location: _____

Detail Referral Instructions for Client:

BP _____ Weight _____ Height _____ BMI _____ LMP _____ UPT _____ Allergies _____

From: (name of person making referral)	**Title:**	**Telephone number: (of RHP clinic)**

Address: (of RHP clinic)

Reason for Referral/Notes to Referral Agency:

Interjurisdictional TB Notification (IJN) Form

Type of Referral:
- ☐ **Active/Suspect TB** - See Section 1
- ☐ **TB Contact** - See Section 2
- ☐ **Class A/B** - See Section 3
- ☐ **TB Infection** - See Section 4

Date of Expected Arrival ☐

Online directory of state and big city TB programs:
www.tbcontrollers.org/community/statecityterritory/

Referring Jurisdiction Information:

City | County | State

Person Completing Form | Email

Phone | Fax

Form Sent to:

Date IJN Form Sent

Name | Phone | Fax | Location

Name | Phone | Fax | Location

Return Follow-Up Form To:

Follow Up Requested

Name | Jurisdiction | Location

Phone | Fax

Referred Person's Information:

Last Name | First Name | Middle Initial | AKA

DOB | Sex | Hispanic | Race/Ethnicity

Country of Birth | Primary Language | Interpreter Needed?

New Address:

#/St/Apt | City | State | Zip

Phone 1 | Type | Phone 2 | Type

Alternate Contact Name | Phone | Email

Referred Person's Name | DOB

SECTION 1: Active/Suspect TB Disease

RVCT Number

Site of Disease | Most Recent Respiratory Smear

Treatment Status | Most Recent Respiratory Culture

Results Attached: Please attach all applicable results

RVCT | TST/IGRA | Radiology | Smear(s) | NAAT | Culture(s)/Pathology

DST/Mutation Analysis | Submitted for Genotyping | Gentype

SECTION 2: TB Contact Investigation

Date of Last Exposure | Contact Priority

Initial TB test | Date | Results: attach results | TST mm

8-12 week post exposure | Date | Results: attach results | TST mm

Radiology | Treatment Status

SECTION 3: Immigrants & Refugees - Class A/B

Classification | Alien # | EDN Transfer Complete

TST/IGRA | US Radiology | Sputa

Treatment Status

SECTION 4: TB Infection - Non-Contact or Class A/B

Results Attached: TST/IGRA | Radiology | Sputa | Treatment Status

Referred Person's Name | DOB

SECTION 5: TB Treatment Summary

Current Treatment Summary for:

Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	

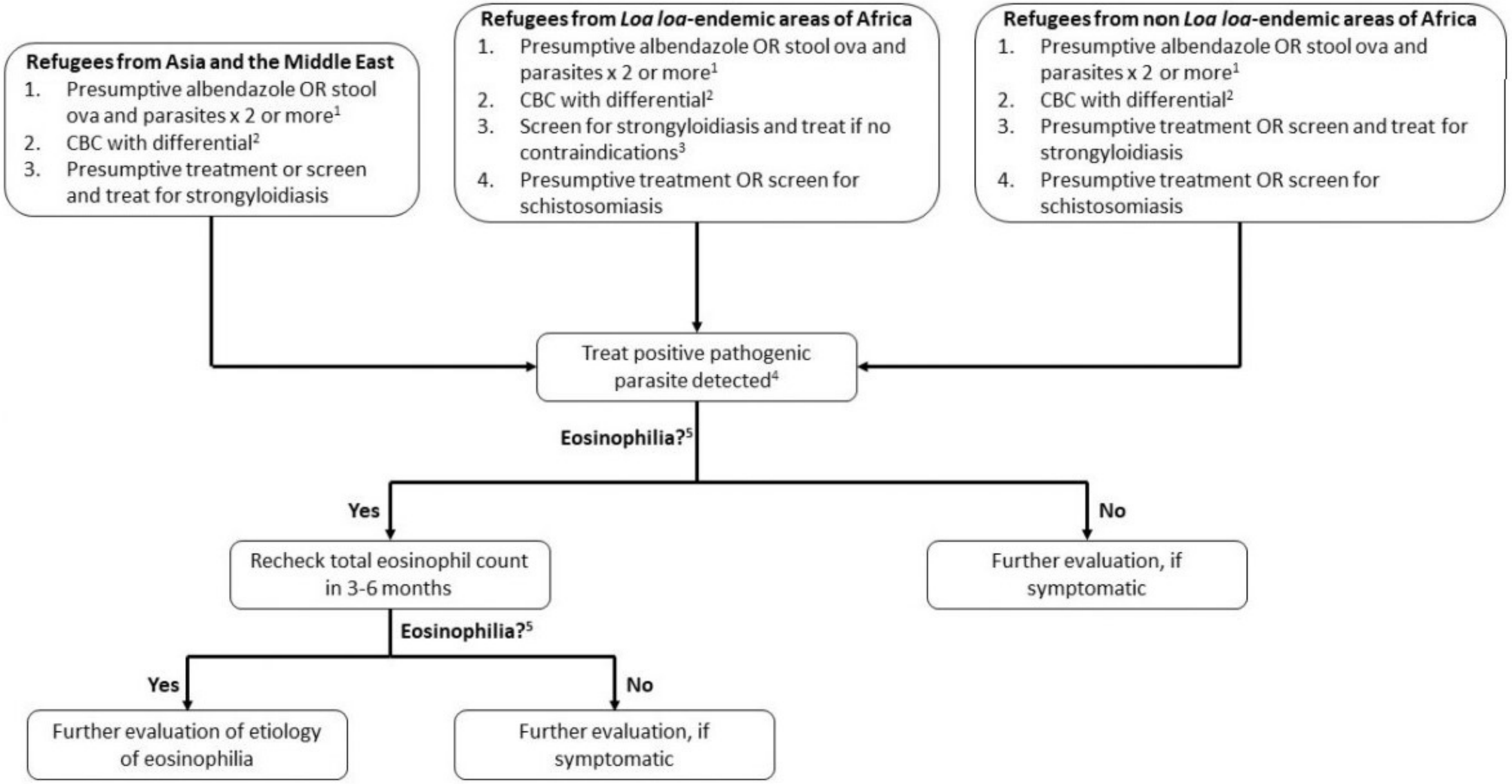
Estimated Date of Completion | Last DOT dose administered on: | # of doses given for travel

Prescription Given | Side Effects or Adherence Problems | MAR/DOT Log Attached

Comments:

Note: This form contains confidential patient information. Please comply with HIPAA regulations when sending this form.

Attachment P



Refugee Health Program Lead Screening Quick Guide

Lead screening recommendations for all newly arrived refugee infants, children, adolescents, and pregnant and lactating women and girls.

Population:	Initial Lead Screening Test:	Follow-up testing with blood test:	Actions:
All refugee infants and children ≤ 16 years of age.	✓	• Within 3 to 6 months for all refugee infants and children ≤ 6 years, regardless of initial screening result. • Within 3 to 6 months for children and adolescents 7-16 years with elevated blood lead level (EBLL) with a result of ≥ 5 µg/dL at initial screening.	• Refer to Primary Care Physician (PCP) or Pediatrician with notification of the elevated initial lead level since the RHP clients will be past the 90-day eligibility for RHP. • For RHP clients already established with a PCP or Pediatrician, the physician should be notified of the elevated lead level. • Document the referral and notification in Health Management System (HMS.)
Refugee adolescents > 16 years of age if there is a high index of suspicion, risk factors or clinical signs/symptoms of lead exposure.	✓	• Consider repeat testing within 3 to 6 months for adolescents >16 years of age with risk factors (e.g., sibling with EBLL, environmental risk factors.)	• Refer to PCP or Pediatrician with notification of the elevated initial lead level since the RHP clients will be past the 90-day eligibility for RHP. • For RHP clients already established with a PCP or Pediatrician, the physician should be notified of the elevated lead level. • Document the referral and notification in HMS.
All pregnant and lactating women and girls.	✓	• Follow-up blood lead testing is recommended within 1 month for those with EBLL of 5 to 44 µg/dL upon initial screening. • Follow-up blood lead testing is recommended within 24 hours for those with EBLL of ≥ 45µg/dL upon initial screening.	• For RHP clients with EBLL of 5 to 44 µg/dL upon initial screening: Refer to PCP as soon as possible for risk assessment of lead exposure. • For RHP clients already established with a PCP, the physician should be notified of the elevated lead level. • For RHP clients with EBLL of ≥ 45 µg/dL upon initial screening: Refer to Emergency Room. • Document the referral and notification in HMS.

Attachment R

Refugee Health Program

County Health Department Invoice Inquiry

The purpose of this invoice inquiry is to monitor County Health Department spending and identify any problem areas or necessary adjustments. Please answer below with accurate and up to date information for your county. Return the completed document no later than the following business day.

CHD Invoice Issue (*Do Not Edit*):

CHD Response (provide a brief justification or plans to resolve the issue):

CHD Staff Contact Information:

Please include contact information for budget staff responsible for providing the information above.

Central Office Notes (*Do Not Edit*):

Once the inquiry has been received by the Budget Analyst, it will be returned with notes from Central Office.