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Refugee Health Status and Healthcare Utilization Report

Prepared for the Bureau of TB and Refugee Health,
Florida Department of Health - October 2009

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This project is funded by the Florida Department of Health, Refugee Health Program, with grants from the U.S. Department of Health and Human Services, Office of Refugee Resettlement.

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Introduction

According to the data collected and analyzed for this report, over 128,000 arrivals (individuals from other countries with an immigration status eligible for refugee benefits) entered Florida between January 1, 2003, and December 31, 2006. The majority of these individuals (over 100,000, or 78%) were from Cuba. The Florida arrivals during this time period serve as the cohort for this report.

The purpose of this study is to analyze refugee health status and health care seeking behavior to make recommendations for improving the health-related system for arrivals so that refugee health status can be improved.

People who seek asylum are not a homogeneous population. Coming from different countries and cultures, they have had, in their own and other countries, a wide range of experiences that may affect their health and nutritional state. Many of these people have been exposed to communicable diseases that have been eradicated in the United States (U.S.) or others that can pose a threat to U.S. citizens. Once in the U.S., they generally face the effects of poverty, dependence, and lack of cohesive social support. All of these factors undermine both physical and mental health. Additionally, racial discrimination can result in inequalities in health and have an impact on opportunities in and quality of life. It is important for state and local policy makers to understand the historical context as well as the barriers so that appropriate actions are taken to ensure arrivals seek out and receive the health care they need.

Arrivals' experiences shape their acceptance and expectations of health care in the U.S. Therefore, education about the American healthcare system and assistance with applying for Medicaid to cover health care costs is critical to obtaining insurance coverage and health care.

In Florida, arriving refugees and asylees receive a domestic health screening to diagnose any communicable diseases or other chronic health conditions. It is important to know how many arrivals and which arrival sub-populations then follow up with treatment for the diagnosed conditions or diseases. There are many challenges that affect arrivals' ability to attain optimum health. These new arrivals, for various reasons, may not:

- obtain domestic health screenings
- seek treatment for identified conditions
- apply for Medicaid
- be enrolled in Medicaid
- seek preventive healthcare services

Therefore, this evaluation explores which sub-populations of arrivals and regions of the state are experiencing one or more of these obstacles to good health so that efforts can be made to eliminate these obstacles in different regions of Florida or for specific identified sub-populations.

Definitions and Caveats

Definitions

Refugee - Someone who has fled his or her country because of a well-founded fear of persecution based on their race, religion, nationality, social group, or political opinion, and has been granted refugee status in a country of asylum.

Asylees - Individuals who leave their home country for reasons similar to those of refugees, but travel to the U.S. on their own and, once here, apply for asylum protection.

Parolee - Individuals may be granted parole for humanitarian reasons or for emergent or compelling reasons of "significant public benefit." In some cases, parole is authorized prior to the individual's arrival in the U.S.; parole may also be granted at the port of entry, after arrival.

Cuban or Haitian Entrant - These are individuals from either Cuba or Haiti whose immigration status is either a parolee, asylum applicant, or an individual in removal proceedings. Most Cuban entrants (71%) are parolees (almost 72,000 of the cohort for this study); while most Haitian entrants are asylum applicants (72%, just over 8,000 of the cohort for this study).

In this report, the term arrival will be used generically to refer to refugees, asylees, entrants, and parolees. On some graphs, the data will be separated based on immigration status, but, for most the term arrival is used to substitute for individuals with any of the above immigration statuses.

Voluntary Agency (VOLAG) - Non-governmental voluntary agencies that are under contract with the Department of State to provide resettlement services for arrivals.

When a graph refers to the date of arrival, it means date of arrival for refugees, entrants, and parolees but refers to the date asylum was granted for asylees.

Except where otherwise specified, enrollment in Medicaid means enrolled in Medicaid or Refugee Medical Assistance. Arrivals apply for Medicaid. If they meet the categorical and financial criteria to receive Medicaid, they are enrolled in Medicaid. If they meet the financial but not categorical criteria for Medicaid, they receive medical benefits through Refugee Medical Assistance.

Codes defining preventive care are listed in Appendix A.

Codes for treatment of different conditions are listed in Appendix A.

When the country of origin is Burma, the group includes arrivals from Myanmar (Burma), Malaysia, and Thailand.

Caveats

For all graphs depicting specific types of medical care, only arrivals who received all medical care through a Medicaid fee-for-service arrangement are included. Many arrivals in the cohort modified the type of coverage they had one or more times, sometimes receiving care through a Health Maintenance Organization (HMO) and sometimes receiving it through a fee-for-service arrangement. During the time frame of the current study, HMOs were not required to report encounter-level data to the Agency for Health Care Administration to receive reimbursements. Therefore, treatment level data are not available for time periods during which an individual was enrolled in an HMO. Therefore, graphs depicting medical treatment sought by arrivals only include data from about 39% of the arrivals in the cohort: arrivals enrolled in fee-for-service Medicaid from the time of enrollment through December 31, 2008.

On graphs that break down data by voluntary agency (VOLAG) providing resettlement services, VOLAGs represented on the graphs served at least 10 arrivals during the timeframe of the study. Data from other VOLAGS are combined in the "other" category. It should be noted that, generally, Cubans and Haitians do not have VOLAGs to help them with resettlement. Therefore, VOLAG data just apply to arrivals from other countries (about 22% of all Florida arrivals).

Any graph depicting a time lag between date of arrival and another event uses the date of arrival for entrants, refugees, and parolees and the date asylum was granted for asylees. Personal communications with data owners indicate that, although the data field is called date of arrival in source data, for asylees, the date really records date asylum was granted, because, on that date, the asylee becomes eligible to receive services available to refugees. However, Cuban (2,464 individuals) and Haitian (8,176 individuals) asylum applicants qualify for refugee services as soon as they apply for asylum. In fact, Cubans and Haitians make up 48% of asylum applicants in the cohort.

Since the results below depict asylees as a sub-population that does not take full advantage of available health services, it is important to understand how their entrance to the U.S. differs from other arrivals. As stated above, except for Haitian and Cuban asylum applicants, asylum applicants are not entitled to resettlement services until asylum is granted. It would be beneficial to understand what percent of applicants are ultimately granted asylum and the timeframe between application and asylum being granted.

The Immigration and Nationality Act states in Section 208(d)(5) that the initial interview for asylum applications filed on or after April 1, 1997 should take place within 45 days after the date the application has been filed, and a decision should be made on the asylum application within 180 days after the date the application is filed, unless there are exceptional circumstances (USCIS Immigration and Nationality Act). This 6 month processing time is said to include both the administrative asylum decision reached by a U.S. Citizenship and Immigration Services (USCIS) Asylum Officer, as well as, the defensive asylum decision reached by an Executive Office for Immigration Review (EOIR) Immigration Judge.

This 6 month period has long been the targeted processing time goal. The goal, however, has historically not been achieved. In October 2003, the average cycle time for an asylum application was 34.6 months[1]. This long cycle time was particularly due to the number of backlog cases. Backlog cases, for numerous reasons (unexpected number of applications, not enough staff, wait for background check, etc.), take longer than 6 months to be completed. By the end of 2003, there were approximately 217,800 backlog asylum applications[2]. In 2004, to alleviate the problem, the USCIS introduced the Backlog Elimination Plan to rid itself of the backlog and achieve a 6 month cycle time by the end of fiscal year 2006[3] . By August 2004, the average cycle time was reduced to 23 months[4]. In July 2005, the average cycle time was 11.47 months, and by June 2006, the average cycle time had been reduced to 8.07 months[5]. As of February 2009, the national average cycle time is 6 months for asylum applications and there is no current backlog[6].

So, the asylum recipients in our cohort generally experienced an average of between 8 and 35 months between application for asylum and awarding of asylum. However, presumably, asylum applicants from 2009 forward will be granted asylum within an average of the six month time frame.

[1] USCIS Backlog Elimination Plan Fiscal Year 2004 Third Quarter Update, 2004
[2] USCIS Backlog Elimination Plan, 2004
[3] Ibid.
[4] USCIS Backlog Elimination Plan Fiscal Year 2004 Third Quarter Update, 2004
[5] USCIS Backlog Elimination Plan, 2006
[6] USCIS Processing Time Goals, 2009

The available data regarding the percentage of asylum applicants granted asylum are incomplete. Summary tables can be found in Appendix B. The percent of adjudicated affirmative asylum cases granted asylum was 34% and 41% for federal fiscal years 2003 and 2004 respectively; more recent data are apparently unavailable in the public domain. Defensive asylum grant rates ranged from 37% in FFY 2003 to 46% in FFY 2007. Rates between federal fiscal years 2006 and 2008 have remained between 45% and 46%.

Since parolees and entrants from countries other than Cuba and Haiti are not entitled to resettlement or medical benefits, these arrivals were eliminated from the cohort before data were analyzed.

In this report, we generally use the median instead of the average. If there are extreme cases, they can pull the average towards the extreme. Under such circumstance the median (the middle entity in the group) give a more realistic picture of the "average".

The reader may notice that the total number of arrivals on any one graph may vary from other graphs. These differences are a result of missing data for the characteristics being depicted.

Method

Overview

The refugee health care study utilized seven data sources from five administrative agencies to identify the population of refugees, asylees, parolees, and Cuban/Haitian entrants entering Florida between January 1, 2003, and December 31, 2006, and to ascertain the basic demographic characteristics, health conditions, and medical services of this population.[*] The data sources represent administrative databases maintained by the Centers for Disease Control and Prevention, the Florida Department of Health, the Florida Department of Children and Families, and Florida's Agency for Health Care Administration. As a group, these databases had not previously been merged to provide a comprehensive resource for investigating arrivals' health care. Because of their dissimilarities in structure and content, as well as the amount of random error they contain, merging the sources posed a number of technical challenges.

The solution to these challenges entails two components: creating a quasi-relational database to both unite the different sources while simultaneously retaining their separation, and employing a probabilistic matching methodology to circumvent random data error. A quasi-relational database can be defined as a database containing multiple tables (i.e., component files) with internal database keys used to join the tables. In contrast to a relational database, the component data have not been subjected to the technical process of normalization. Rather, the table design essentially follows that of the original data sources, i.e., each of the seven sources becomes a separate table. Where the source data do not fit a "flat" file structure, multiple tables are used from a single source. Creation of primary and foreign keys to join the tables completes the database.

The second aspect of the technical solution—a probabilistic matching methodology—involves use of multiple sets of criteria for identifying records as belonging to the same refugee. After review of random error patterns in the data sources, nine sets of criteria were established.

1. Alien number, date of birth
2. Alien number, year of birth, first name

[*] For simplification, the entire population will be referred to as "arrivals" despite the different immigration statuses it comprises.

3. Alien number, year of birth, arrival date, gender
4. Alien number, month of birth, day of birth, arrival date, gender
5. Alien number, month of birth, day of birth, first name
6. Alien number, first name, arrival date
7. First name, date of birth, arrival date
8. Last name, first name, date of birth
9. Last name, first name, month of birth, day of birth, arrival date (excluding January 1 as a month/day of birth)

When two or more records matched on any one of the nine conditions, they were regarded as belonging to the same person. Both direct and indirect matches were generated: If records A and B matched on criteria 1, and records B and C matched on criteria 2, records A and C were regarded as matching. The use of multiple criteria prevents random data error, e.g., clerical mistakes in recording an alien number, from occluding likely matches. On the other hand, probabilistic matching also introduces the possibility of mistakenly matching records that belong to different persons. No set of matching criteria can fully resolve the considerable amount of random error present in the source data.

Identification of the Refugee Cohort

Unique arrivals entering Florida between January 1, 2003, and December 31, 2006, were identified using seven data sources from five administrative agencies:

- The Electronic Disease Notification System (EDN) and Information on Migrant Populations (IMP), based on the refugee's overseas medical screening, from the Centers for Disease Control and Prevention
- Refugee Domestic Health Assessment System (RDHAS), from the Florida Department of Health
- The Health Maintenance System (HMS), based on treatment provided by county health departments, from the Florida Department of Health
- Refugee Services Data (RSD), based on individuals receiving services sponsored by the Bureau of Refugee Services at the Florida Department of Children and Families
- The FLORIDA System, based on arrivals who apply for Medicaid, also housed in the Florida Department of Children and Families. The Medicaid ID number assigned by the FLORIDA system is then used to obtain medical encounter data from the Agency for Health Care Administration

Any person verified as an arrival in any one of these data sources became a member of the cohort for analysis using the method described below.

Implementation of the Technical Solution

In implementation, the two components of the technical solution are interactive to produce the final match of data sources. The following steps describe the process.

1. Import all source data files into separate SAS files.
2. Standardize the format of all variables designated for use in matching (alien number, last name, first name, date of birth, gender, arrival date).
3. Eliminate duplicate records.
4. From each source file, extract a file containing only alien number, last name, first name, date of birth, gender, and arrival date.

5. Append all records from the files generated in step 4 into a single file.
6. Unduplicate the file generated in step 5 to retain one record for each unique combination of alien number, last name, first name, date of birth, gender, and arrival date.
7. Assign each record in the file generated in step 6 a unique identification number.
8. Employ the nine matching criteria in a "vertical" matching of records in the file produced in step 7. Matched records are reassigned the lowest identification number among the matching records. This identification number becomes the refugee ID number, an internal database key for joining the tables.
9. Using the file produced in step 8, the refugee ID is distributed back to each source file by matching on alien number, last name, first name, date of birth, gender, and arrival date.
10. A new file is generated from the file in step 8 containing only the unduplicated refugee ID.
11. Data elements required for the analysis that allow summarization in a single value (date of birth, gender, country of origin, etc.) are added to the file generated in step 10 by matching that file to the individual source files on refugee ID. Discrepancies between files are resolved by a "majority vote" among the sources.
12. Calculated fields needed for the analyses (age at arrival, months between arrival and Medicaid enrollment, etc.) are generated for the file in step 11.

More generally, completion of these steps results in the following: All of the original source files (Medicaid excluded) have a generated record key (refugee ID) for use in matching with any of the other source files. Two new tables have been created: a refugee "alias" table (step 8 above) and a refugee table (step 12). The refugee table contains one row per refugee, with most of the "fixed" information needed for the analysis included. The refugee alias table contains multiple records per refugee based on variations in the matching criteria (i.e., alien number, last name, first name, date of birth, gender, and arrival date). The refugee alias table serves only to link the refugee table with the tables representing the original source files.

The last step involves incorporating the Medicaid data into the database. Because the Medicaid data were obtained based on the Medicaid ID number in the FLORIDA system, the refugee ID from that source is distributed to the Medicaid data by matching on the Medicaid ID. Once this is done, all of the original source files are integrated into the database by internal database keys, and the technical solution to matching the data sources is complete. Subsequent queries using table keys and standard SQL programming techniques have easy access to information from any of the seven sources or combination of those sources required to address substantive issues.

Data Clean-up

Although the probabilistic matching methodology circumvents a certain amount of random data error, the accuracy of the matching is ultimately commensurate with the accuracy of the data. Short of external research involving individual case review, data clean-up can only seek to identify and resolve *inconsistencies* in the source data. Because this entails a considerable amount of manual scrutiny, it is labor intensive, and practical constraints of project deadlines and budget limit its scope. To establish priorities, records with only one data source (i.e., those not matching to another source) in the IMP, EDN, and HMS files were targeted for review. These were cross-matched to the refugee alias table described above on selected data elements and/or partial data elements, such as date of birth or a majority of digits in an alien number. The resulting matches were manually scrutinized to identify obvious clerical errors in a data element, such as an addition of a digit or reversal of digits in an alien number. Errors so identified were manually corrected in the source data files. In all, corrected records

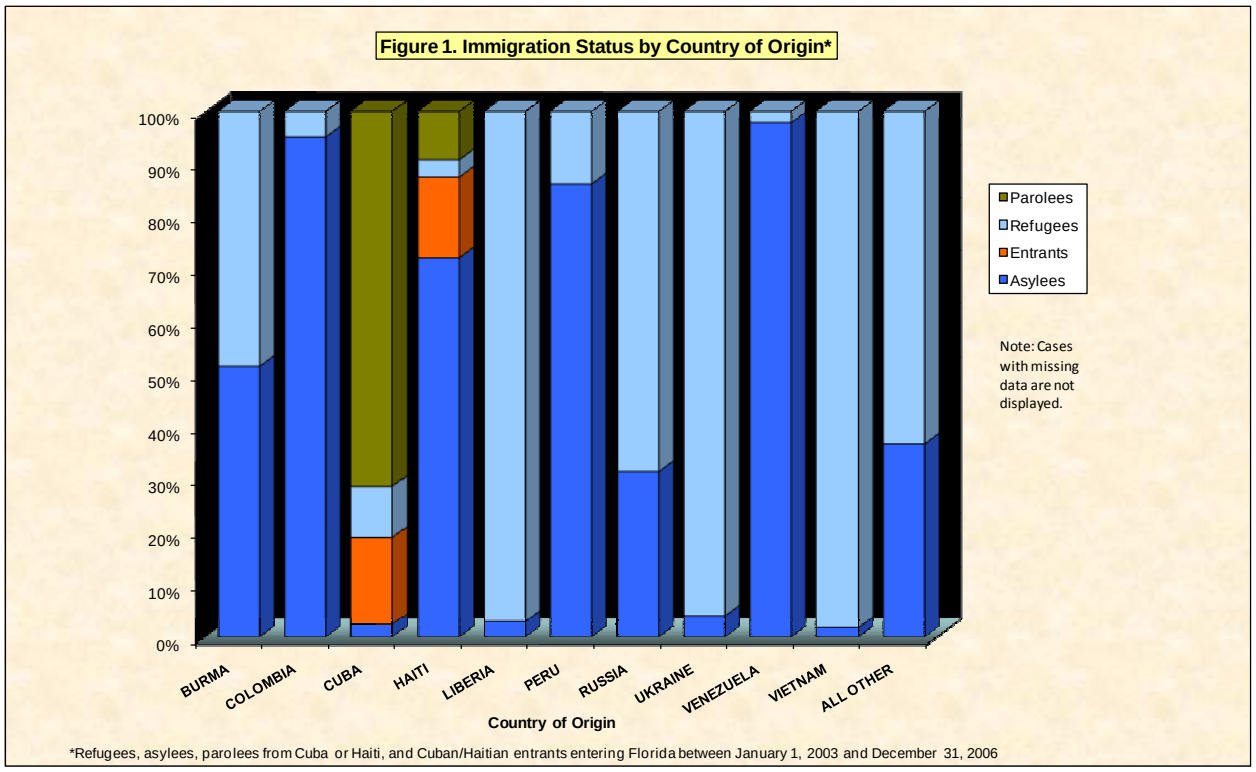
totaled 254 in the IMP file, 69 in the EDN file, and 49 in the HMS file. Following the manual correction of these records, the matching process described above was repeated to produce the final database.

Results and Analysis

Florida's Arrivals

Figures 1 through 4 were developed to gain some insight into the demographics, immigration status, age distribution, and region of resettlement, of the arrival cohort included in this evaluation.

Figure 1:



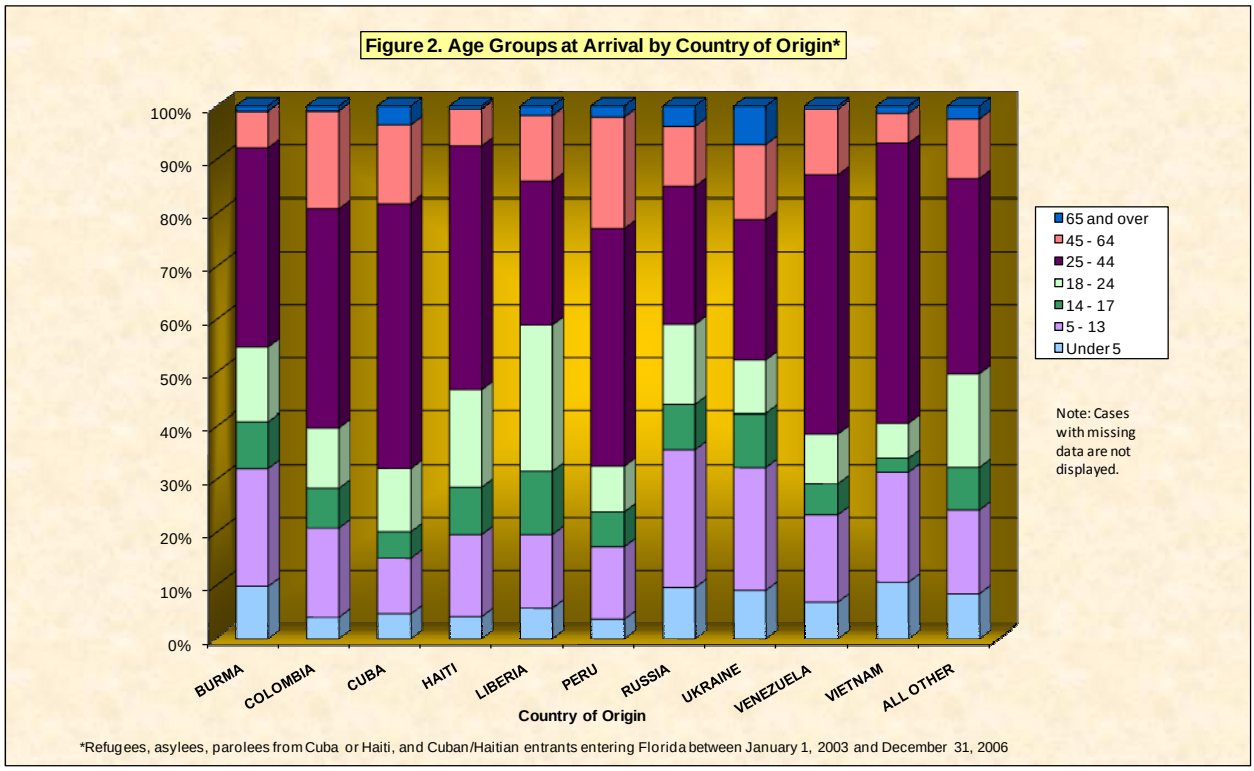
Analysis

Fifty-seven percent (57%) of Florida's (approximately) 128,000 arrivals are parolees. This is because the great majority (78%) of Florida's arrivals originate from Cuba, and 71% of Cuban arrivals are actually parolees, who enter Florida without having previously applied for refugee status. Asylees make up more than half the arrivals from Burma[7] (52%), Colombia (95%), Haiti (72%), and Venezuela (98%). Generally, arrivals from other countries are predominantly refugees, having gone through normal channels to enter the country: Liberia (97%), Russia (68%), Ukraine (98%), and Vietnam (98%).

Since such a large percentage of Florida's arrivals come from Cuba, trends for Cubans often overwhelm the results when data are analyzed for the full cohort of arrivals.

[7] When the country of origin is Burma, the group included arrivals from, Myanmar (Burma), Malaysia, and Thailand.

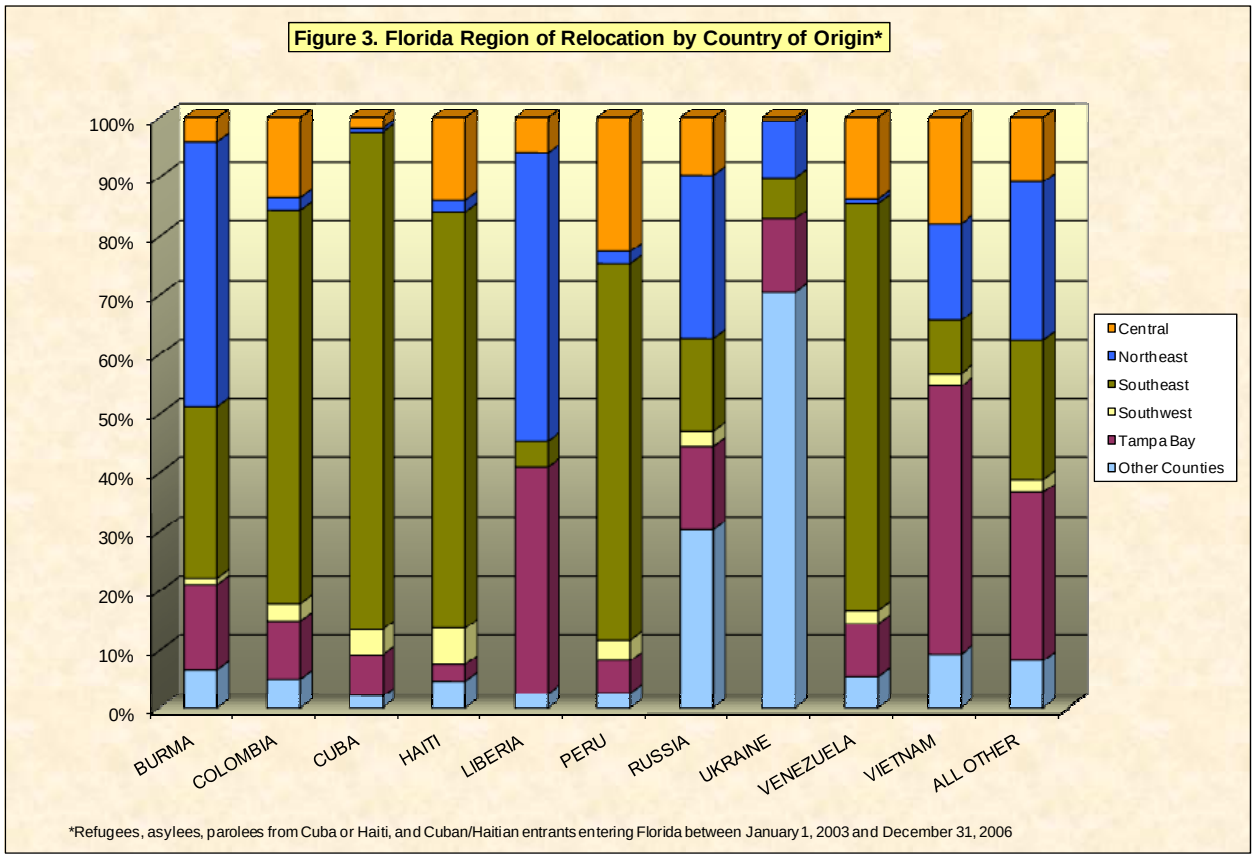
Figure 2:



Analysis

The largest group of arrivals (48%) overall are between 25 and 44 years of age. The percentage ranges from 26- 27%, for Liberians, Russians, and Ukrainians to 50% for Cubans. Although only 22% of arrivals overall are children under 18, percentages vary from 20% for Cubans to 41, 42, and 44% respectively for Burmese, Ukrainians, and Russians. So, relative proportions of age groups vary depending upon the country of origin.

Figure 3:



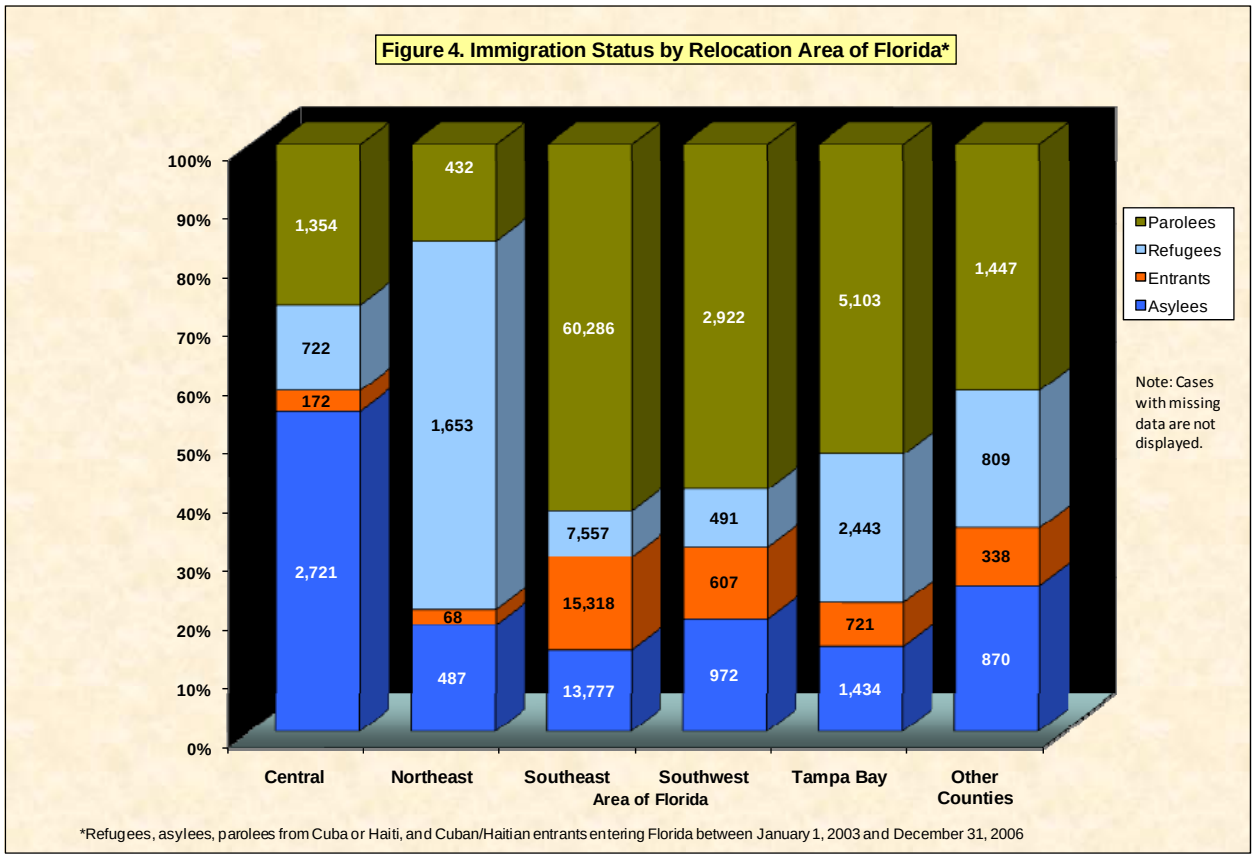
Analysis

For this graph and all other graphs depicting regions of Florida, the following definitions apply:

Southeast Region: Broward, Palm Beach, and Miami-Dade Counties
Tampa Bay Area: Hillsborough, Pasco, and Pinellas Counties
Southwest Region: Collier and Lee Counties
Central Region: Orange and Seminole Counties
Northeast Region: Duval County
Other Counties: The 47 other Florida counties in which arrivals settled

Partially because 78% of Florida's arrivals are from Cuba, and most Cubans enter Florida in the Southeast Region, 79% (approximately 102,000) of Florida's arrivals enter in this region. In fact, 84% of Cuban arrivals, 67% of Colombian arrivals, 70% of Haitian arrivals, 64% of Peruvian arrivals, and 69% of Venezuelan arrivals settle in this region. Thirty percent (30%) of Russian arrivals and 70% of Ukrainian arrivals enter Florida in other regions of the state (other counties not represented among the major regions for entry). Forty-five percent (45%) of Vietnamese arrivals enter Florida in the Tampa Bay Region. Forty-five percent (45%) of Burmese and 49% of Liberians enter Florida in the Northeast Region.

Figure 4:



Analysis

The major regions of the state differ with respect to the immigration status of their arrivals. Overall, parolees are the dominant group of arrivals by immigrations status, making up 58% of all arrivals[8]; this is not surprising because our dominant group of arrivals, Cubans, are 71% parolees. Yet the percentage of arrivals who are parolees varies considerably around the state: 27% in the Central Region; 16% in the Northeast Region; 62% in the Southeast Region; 58% in the Southwest Region; 53% in the Tampa Bay Region; and 42% in other counties.

The proportion of asylees, unique among arrivals in that many do not qualify for refugee services until they are granted asylum, also differs from one region of the state to another. While 18% of all arrivals are asylees, the percent by region varies between 14% and 19% in the Northeast, Southeast, Southwest, and Tampa Bay Regions. The one exception is the Central Florida Region where 55% of all arrivals are asylees.

For the cohort of arrivals granted asylum between January 1, 2003, and December 31, 2006, the time between application for asylum and granting of asylum varied between 8 and 35 months on average.

[8] Note: This differs slightly from the percentage in Figure 1 due to slight differences in data availability in certain data fields; fewer arrivals have accurate data about both immigration status and region of entry [Figure 4] than arrivals having accurate data regarding both immigration status and country of origin [Figure 1].

The data contained in the Refugee Domestic Health Assessment System do not include all the arrivals in the cohort. It is instructive to compare the number of arrivals in each immigration category between the two datasets.

Immigration Status by Region

Region	Chiles Center Data				RDHAS Data			
	Parolee	Refugee	Entrant	Asylee	Parolee	Refugee	Entrant	Asylee
Southeast	60,286	7,557	15,318	13,777	61,969	7,208	208	5,690
Tampa Bay	5,103	2,443	721	1,434	3434	2,118	1	592
Southwest	2,922	491	607	972	1,931	306	19	292
Central	1,354	722	172	2,721	905	677	1	1,082
Northeast	432	1,653	68	487	303	1,433	9	188
Other	1,447	809	338	870	875	569	0	301
Total	**71,544**	**13,675**	**17,224**	**20,261**	**69,417**	**12,311**	**238**	**8,145**

As would be expected, for most immigration categories, the number of arrivals is greater in the Chiles Center dataset than in the RDHAS. The difference for entrants and asylees, however, is dramatic. There are apparently 72 times as many entrants as are recorded in the RDHAS system and two and a half times as many asylees.

Opportunity for Intervention

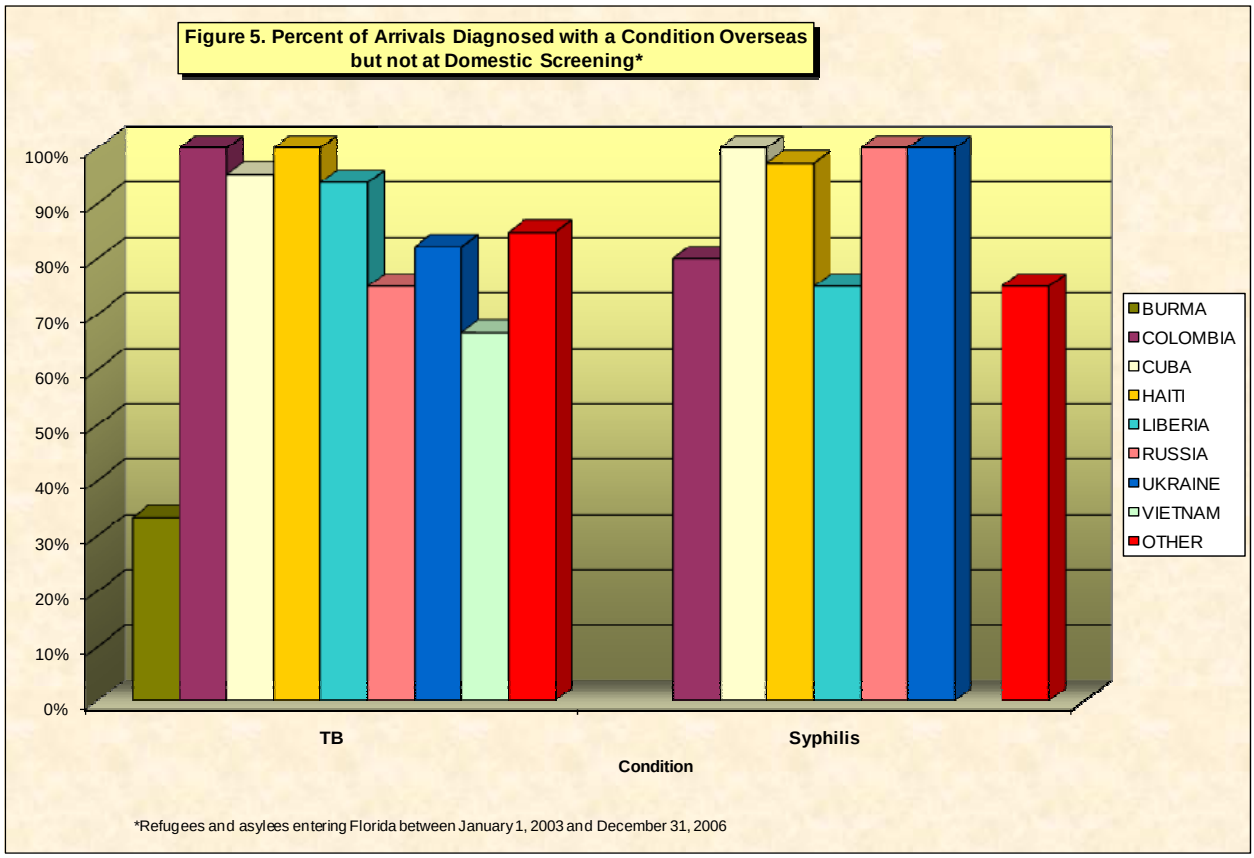
To ensure collection of data for all arrivals, the Office of Refugee Health (the Office) should explore methods to be informed of the arrival of Cuban and Haitian entrants and asylees at the time asylum is granted. Receiving such notification would allow the office to initiate efforts to contact these entrants so they may be notified of their rights to receive health care.

Comparison of Overseas Medical Screenings with Domestic Health Screenings

Persons who enter the U.S. under normal conditions for refugees (11% of Florida's arrivals) ordinarily are granted refugee status before entering the U.S. Generally, each of these refugees has had an overseas medical screening, within 12 months of embarkation and has received treatment for any communicable condition identified during the screening. These arrivals are usually assigned to a voluntary agency (VOLAG) in the county where they will be resettled. By agreement with the Department of State, the VOLAG is responsible for ensuring that arrivals under its care receive a domestic health screening within 30 to 60 days after the date of entry. Asylees should receive a domestic health screening within 30 to 60 days of being granted asylum.

The analysis below, because of data limitations, only compares the results of the two health screenings (overseas and domestic) for arrivals with records of an overseas medical screening in IMP or EDN and a domestic health screening. There are a limited number of conditions that are identified in overseas medical screenings and also reported in RDHAS: tuberculosis (TB) and syphilis. So the evaluation of agreement between the two health screenings will be limited to those two conditions. Positive results for TB were compared for x-ray results only. These results are not a certain indication of the presence of TB, but serve as an indication for further evaluation.

Figure 5:



Analysis

For some countries of origin, over 90% of the abnormal TB X-rays or syphilis diagnosed overseas were not corroborated in the domestic health screening. For TB this is true for Colombians (100%), Cubans (95%), Haitians (100%), and Liberians (94%); for syphilis this is true for Cubans (100%), Haitians (97%), Russians (100%), and Ukrainians (100%). First, it should be noted that, in most cases, these percentages represent very small absolute numbers; for instance, the 100% for Colombia represents all of two overseas diagnoses. So, perhaps these data are better left un-interpreted. If one were inclined to interpret them, they could be interpreted in two ways:

- Since the agreement is low between the two diagnoses, the quality of diagnosis is poor either in the country of origin or in the U.S. or
- Since both these conditions are treatable, countries having a low percentage of agreement (high percentage of disagreement) may be doing a good job treating the condition overseas before the refugee leaves for the U.S.

For a country like Burma (Myanmar, Malaysia, and Thailand), for which there was little disagreement between the two screenings (33% for TB), one might conclude that when a treatable condition is detected overseas, it does not seem to receive proper treatment. Here again the numbers are small, three individuals. Any interpretation of these results should be made with caution as the percentages are based on small numbers.

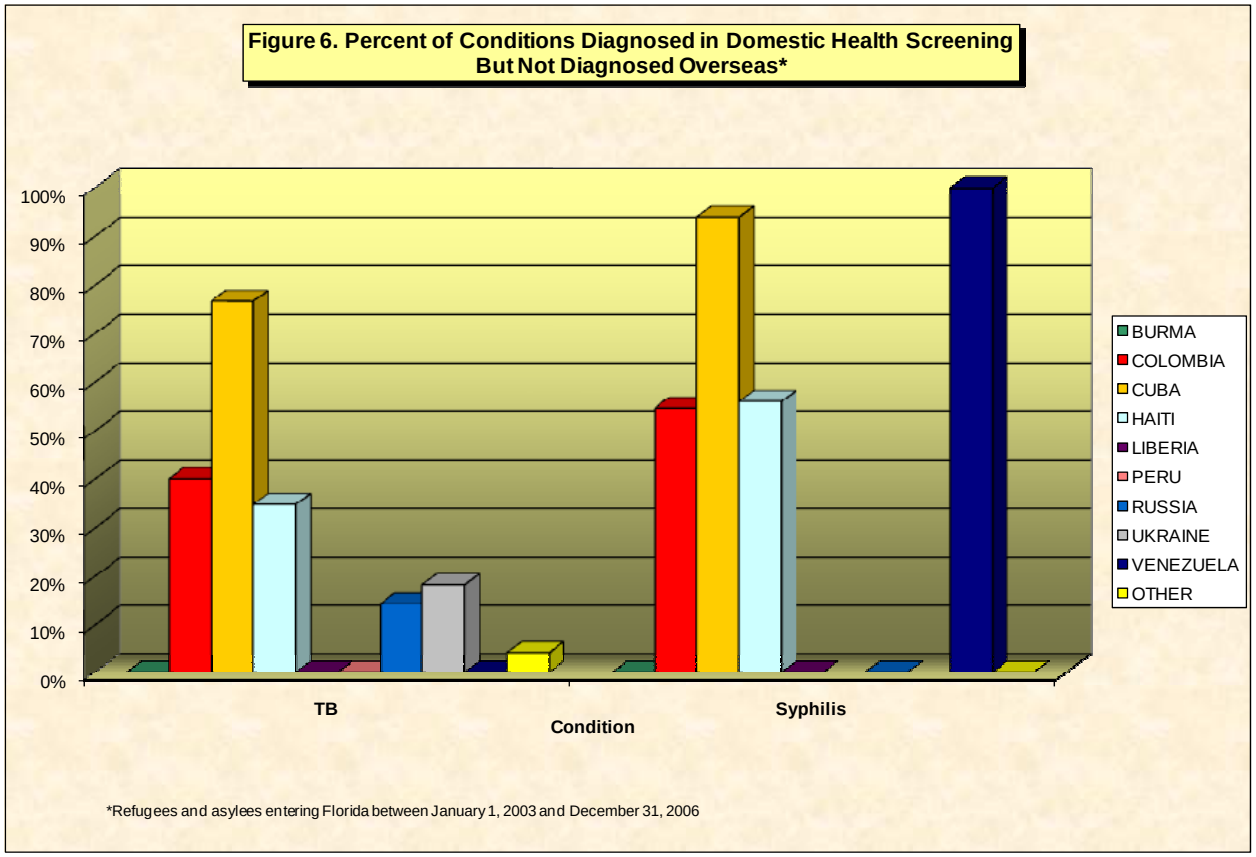
Overall, of the 171 abnormal TB X-rays overseas, 84% no longer had an abnormal TB X-ray in their domestic health screening; of the 78 cases of syphilis diagnosed overseas, 92% did not test positive in

Florida. These results combined with the higher agreement rates in Figure 6 would indicate that when these two conditions are identified overseas, they are treated before the refugee arrives in the U.S.

Opportunities for Intervention

None recommended.

Figure 6:



Analysis

Figure 6 depicts the percent for whom an abnormal TB X-ray or syphilis diagnosis was found in the domestic health screening but not reported in the overseas medical screening. For the entire group of arrivals with both screenings, only 319 abnormal TB X-rays were identified, 47% not previously diagnosed overseas; 465 cases of syphilis were identified, 86% not previously diagnosed overseas. Again, with some exceptions, the number of cases for individual countries of origin tends to be small.

Interpretation of the meaning of poor agreement between the two screenings again is unclear. If there is a high likelihood that a condition found in the U.S. was not found during the overseas medical screening, it could be interpreted to mean:

- That the overseas doctors are not doing a good job detecting illness or
- That the overseas screening took place sometime before immigration and the individuals contracted the disease after they had their screening.

For countries where there is good agreement, that is the condition was identified both in the U.S. and overseas, the results, at least for these two treatable conditions, are easier to interpret: these countries are probably not providing treatment for conditions identified overseas.

Country	% of domestic conditions not identified overseas		Number of U.S. Diagnoses	
	TB	Syphilis	TB	Syphilis
Burma	0%	0%	20	2
Colombia	40%	54%	9	5
Cuba	77%	94%	40	24
Haiti	35%	56%	15	11
Liberia	0%	0%	14	8
Peru	0%	0%	0	0
Russia	14%	0%	6	0
Ukraine	18%	0%	9	0
Venezuela	0%	100%	2	0
Vietnam	0%	0%	8	0
Other	4%	0%	46	17

Cuba has the highest level of disagreement and enough identified conditions to support interpretation. It looks as if either Cuban doctors are doing a poor job detecting TB and syphilis or there is a long delay between the overseas screening and immigration, allowing sufficient time for the refugee to contract the condition after the overseas medical screening.

Countries with low disagreement rates, meaning when a condition is identified in the U.S., it is likely to have been identified (and probably not treated) in the country of origin are: Burma, Liberia, Russia, and Ukraine.

Opportunities for Intervention

None recommended because interpretation of results is not clear cut and data from individual countries include too few individuals.

Utilization and Findings of Domestic Health Screenings

Generally, when arrivals, other than Cubans and Haitians, enter Florida, they are resettled by VOLAG staff. VOLAGs are responsible for ensuring that arrivals obtain domestic health screenings, usually from local county health departments. The U.S. State Department, which provides funding to resettlement agencies, recommends that arrivals have domestic health screenings within 30 days of entry. If the domestic health screening takes place more than 90 days after date of arrival (or date asylum is granted) Refugee Medical Assistance will reimburse for vaccinations only if there is documentation of eligibility for RMA. VOLAGs are also responsible for scheduling doctor appointments and shepherding arrivals to doctor appointments when the domestic health screening identifies a medical condition in need of treatment.

Figure 7a:

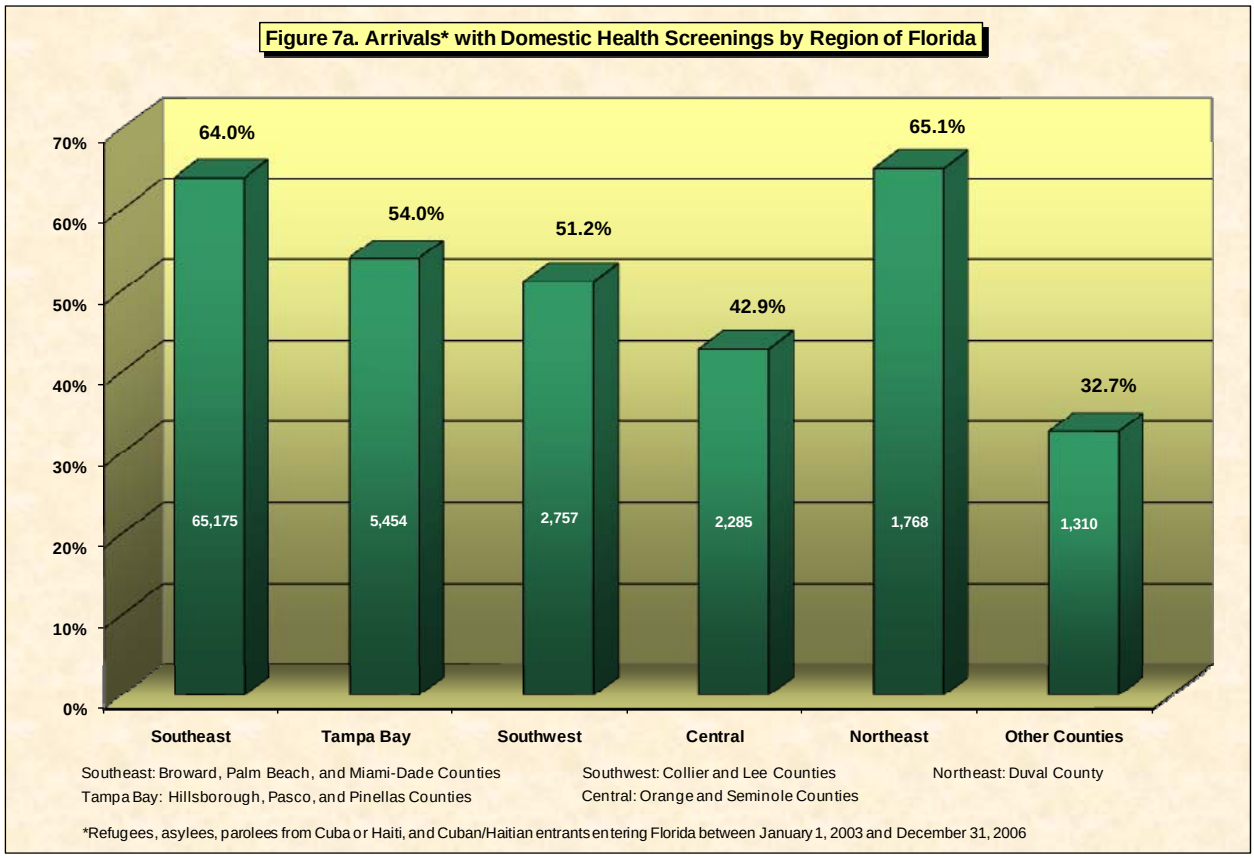
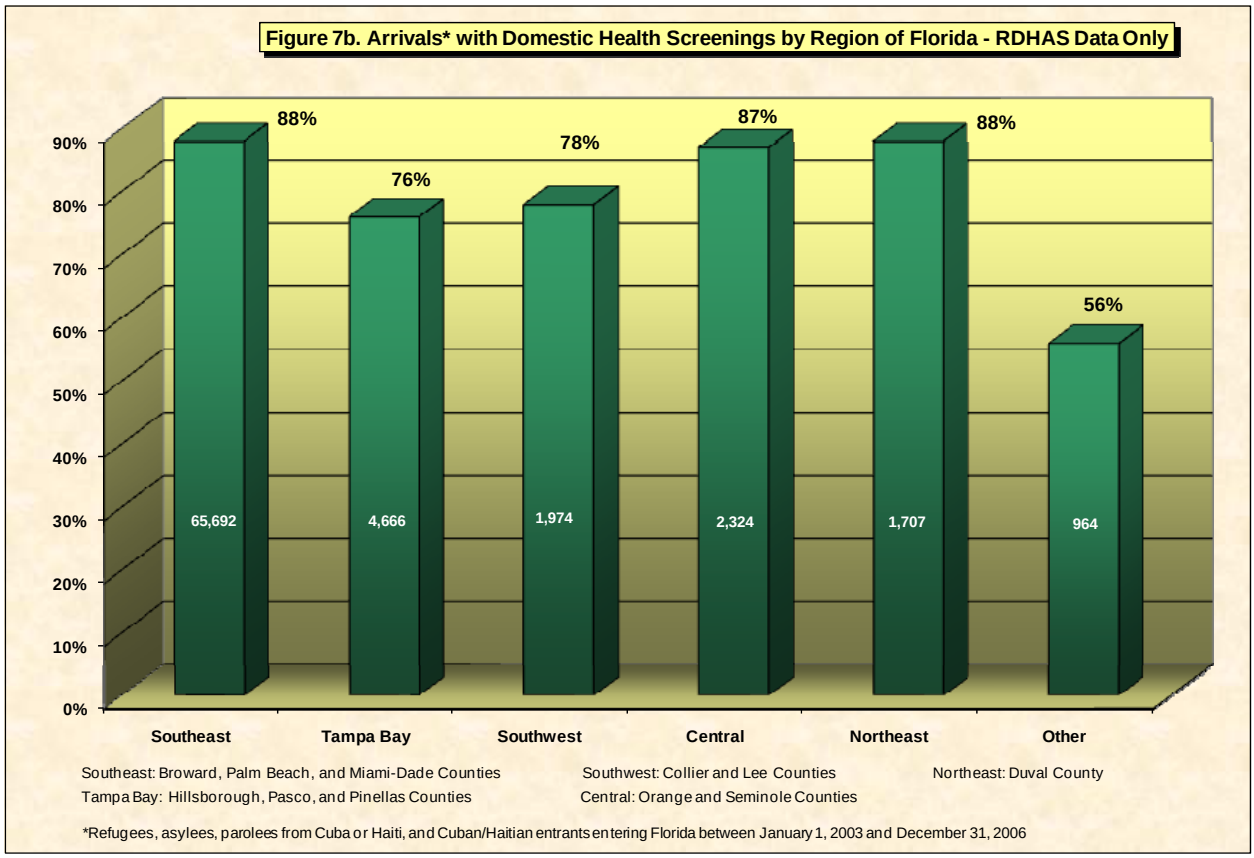


Figure 7a. Arrivals* with Domestic Health Screenings by Region of Florida
70%
60%
50%
40%
30%
20%
10%
0%
64.0%
54.0%
51.2%
42.9%
65.1%
32.7%
65,175
5,454
2,757
2,285
1,768
1,310
Southeast
Tampa Bay
Southwest
Central
Northeast
Other Counties
Southeast: Broward, Palm Beach, and Miami-Dade Counties
Tampa Bay: Hillsborough, Pasco, and Pinellas Counties
Southwest: Collier and Lee Counties
Central: Orange and Seminole Counties
Northeast: Duval County
*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 7b:



Analysis

In Northeast Florida (Duval County) and Southeast Florida (Broward, Palm Beach, and Miami-Dade Counties) over 60% of arrivals have domestic health screenings. In other areas of the state, the percentage is lower: 54% in the Tampa Bay Area (Hillsborough, Pasco, and Pinellas Counties), 51% in Southwest Florida (Collier and Lee Counties) and 43% in Central Florida (Orange and Seminole Counties). Arrivals settling in other counties are least likely to have domestic health screenings (33%). The observed differences in utilization of the domestic health screening can be interpreted in two ways:

- VOLAGs providing resettlement in the different areas of the state vary with respect to their perseverance in encouraging arrivals to have domestic health screenings or
- Figure 8 shows that immigration status is a determinant of likelihood of obtaining a domestic health screening. Asylees are least likely of all arrival groups to receive a screening followed by Cuban and Haitian entrants. Figure 4 shows that 55% of arrivals in the Central Region are asylees (compared to 18% of all arrivals). The high percentage of asylees in the Central Region could explain the low utilization of domestic health screenings in that region.

These interpretations are not mutually exclusive. There may be some truth in each of them.

Another revelation from Figures 7a and 7b is that, using this expanded cohort of arrivals (more than are contained in the RDHAS), the percent of arrivals in this cohort obtaining a domestic health screening is lower than if one only considers the individuals recorded in RDHAS. Most of the arrivals recorded in the RDHAS system have domestic health screenings. The arrivals in RDHAS consist of all arrival notifications

from the Centers for Disease Control and people who are eligible for refugee benefits presenting for refugee health services at county health departments.

Opportunities for Intervention

To improve utilization of domestic health screenings we should identify regions of the state that have the best utilization rate for asylees. If we interview VOLAGs providing resettlement services in regions getting good results to learn about outreach techniques they use, we can disseminate these techniques statewide.

There is an opportunity for more arrivals to receive domestic health screenings if the RDHAS database can include individuals identified by other sources. The Office can ask Refugee Services and the FLORIDA system to send them a monthly list of verified arrivals to identify new arrivals for inclusion. More importantly, the Office needs to devise new reporting techniques to capture Cuban and Haitian entrants and asylees at the time asylum is granted. Then, county health departments can be notified of arrivals in their region that have not yet obtained domestic health screenings. County health departments can then contact the arrivals directly or through their VOLAGs to encourage more of them to have domestic health screenings.

Figure 8a:

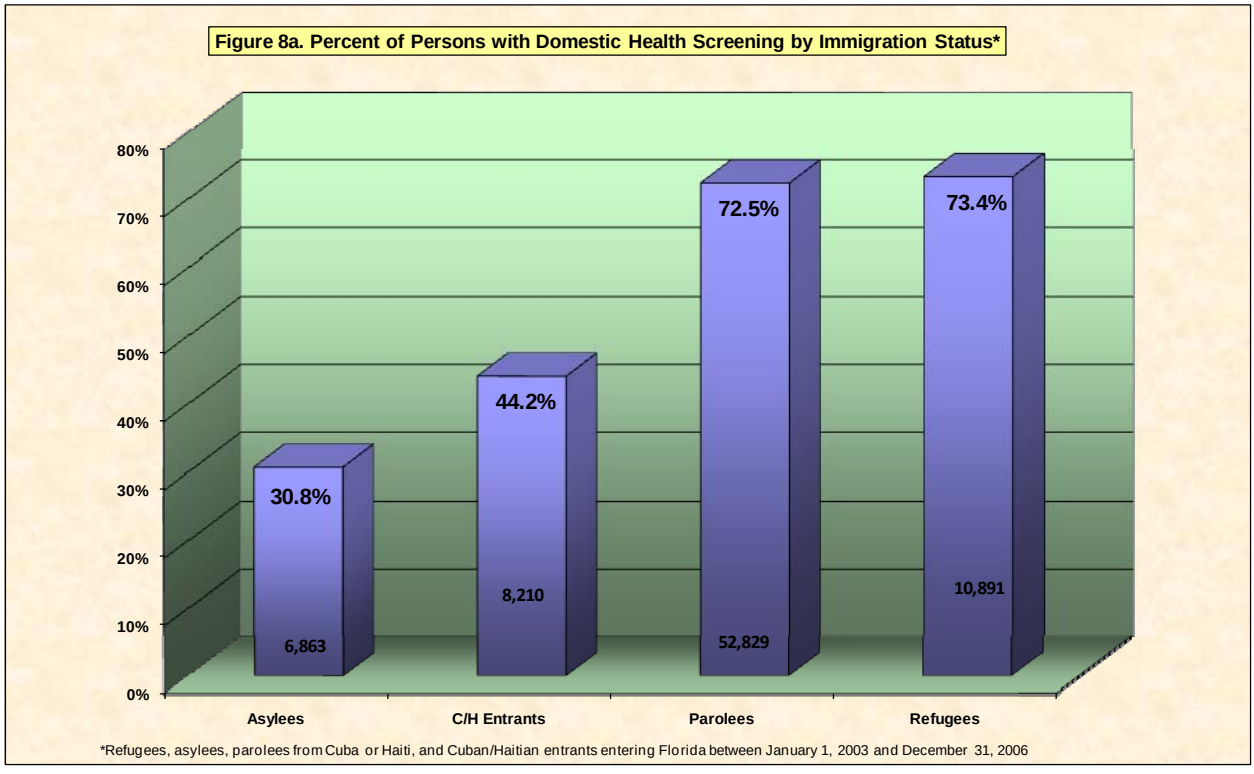
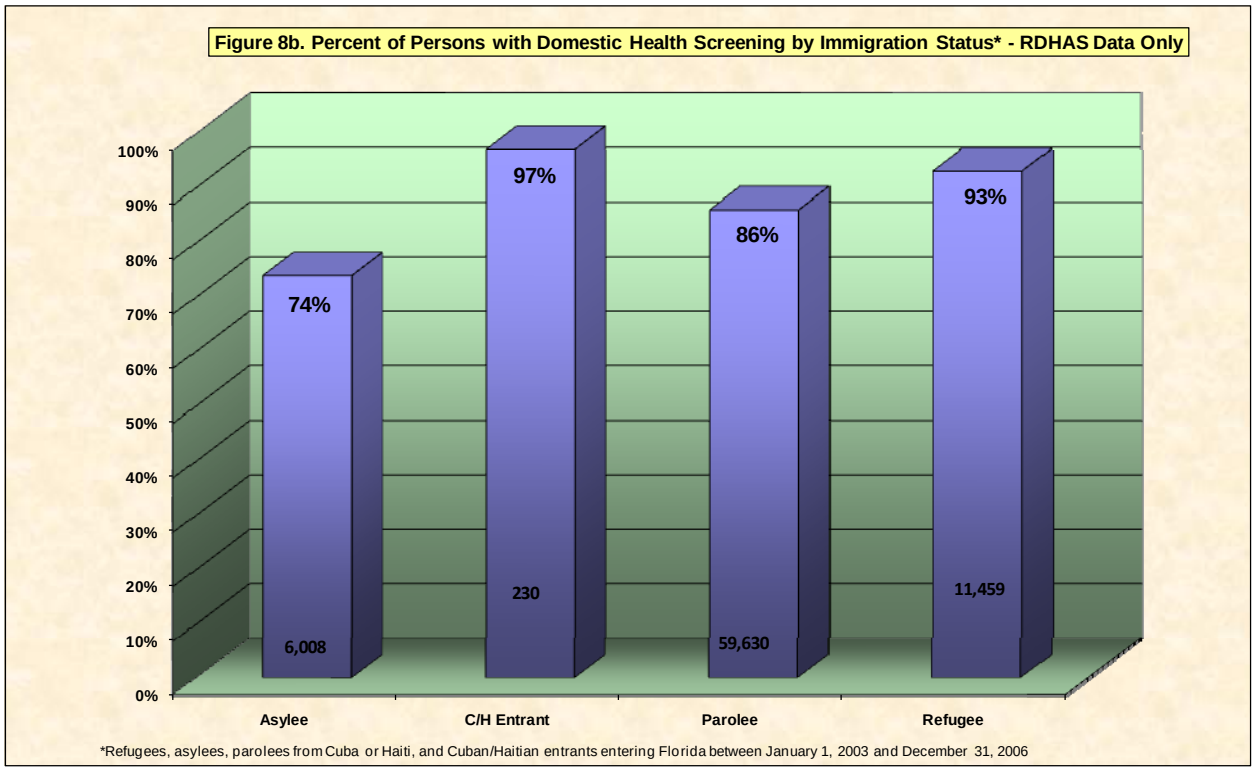


Figure 8b:



Analysis

Asylees are least likely of all arrival groups to obtain domestic health screenings (only 31% of them have such screenings). This may be due to the fact that they do not qualify for screenings until after they are granted asylum, which, for our cohort, occurred an average of between 8 and 35 months after application. By that time, the asylee could be employed full time and be well acclimated to the healthcare system. He or she may not be able to take off time for work to have a health screening, may be difficult to locate, may already have a primary care physician, and/or may not feel it is necessary to be examined by the county health department. Due to the fact that most asylees are not sponsored by a VOLAG, they may not know about the availability of health services.

Only 44% of Cuban and Haitian entrants have domestic health screenings even though this group does qualify for the screening as soon as they apply for asylum. Most of them, however, are not sponsored by VOLAGs, and, therefore, are not receiving official resettlement services. Figure 9, however, shows that Cubans on the whole are fairly successful at getting domestic health screenings (66% do), while Haitians are much less likely to do so (17% do). So, the difference cannot be explained solely in terms of the availability of resettlement services to Cubans and Haitians and may be primarily due to the low utilization rate of Haitians.

Again we see that the percent of arrivals in the RDHAS system obtaining domestic health screenings is high, indicating a benefit to the individual being reported to RDHAS.

Opportunities for Intervention

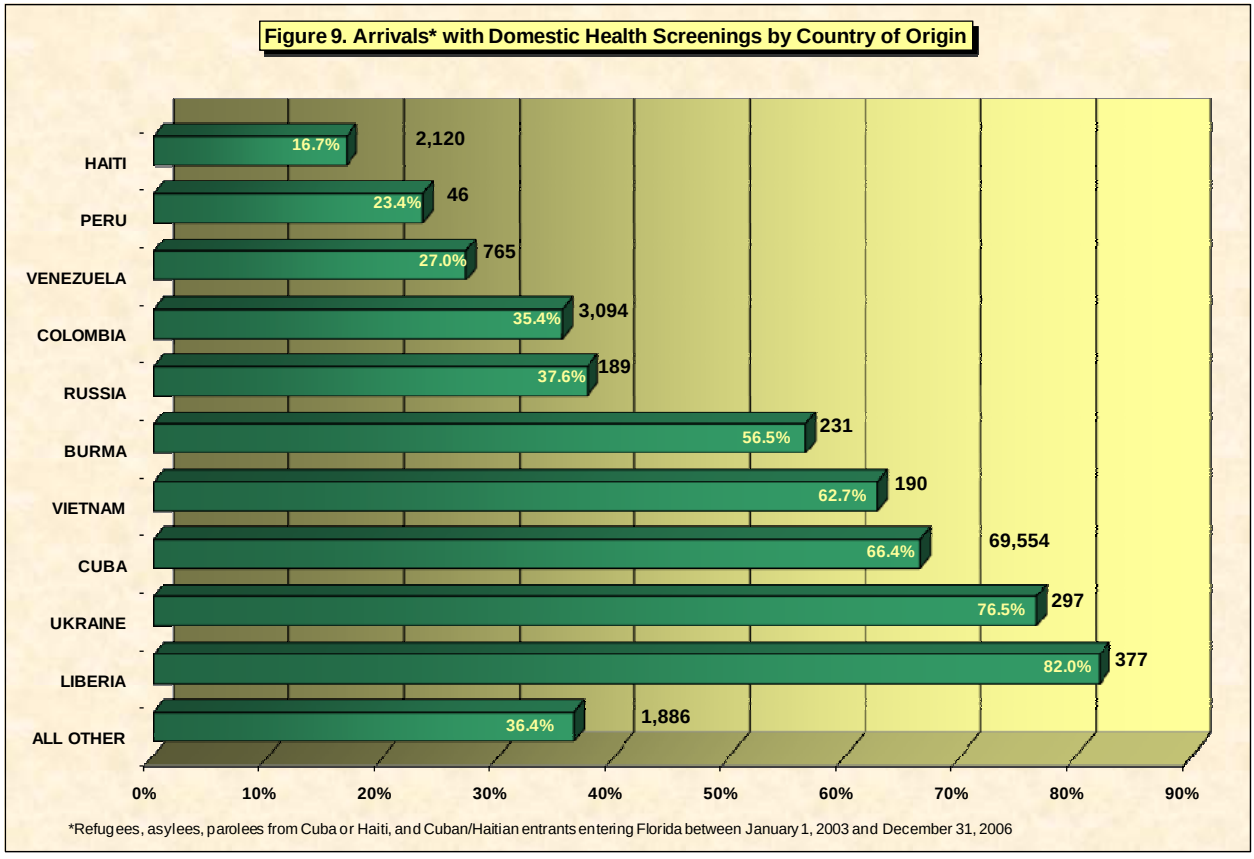
Asylum seekers can reach Florida with potentially infectious diseases. This risk is exacerbated by the fact that non-Cuban or Haitian asylum seekers can live amongst the population for a long period of time

before receiving a health screening. Health screenings can only take place after the individual has been granted asylum, thus, qualifying for certain benefits. Therefore, it is possible for individuals to share their untreated communicable diseases with the rest of the population in Florida while their asylum applications are being processed. The good news is that the time between application and asylum being granted has become shorter in recent years. Therefore, if the Office is notified when asylum is granted, it is likely that the asylee can be located and informed of his or her right to refugee health services.

The Office should decide if asylees receiving domestic health screenings after they are granted asylum is a priority. If so, areas of the state that have good asylee utilization of screenings should be identified and studied for best practices. In order to increase the number of asylee domestic health screenings, the Office may want to work at a national level to ensure that, at the time asylum is granted, the USCIS and the EOIR notifies asylees of their right to refugee health services. Parties involved in the notification process can simultaneously notify persons of their granted asylum, as well as, their right to refugee health services.

Regions of the state where asylees and Cuban and especially Haitian entrants are more likely to obtain domestic health screenings should be identified. Interviews should be conducted in these regions to uncover strategies that are successful in encouraging these two groups to obtain screenings. The same strategies can be applied in other regions of the state to increase utilization.

Figure 9:



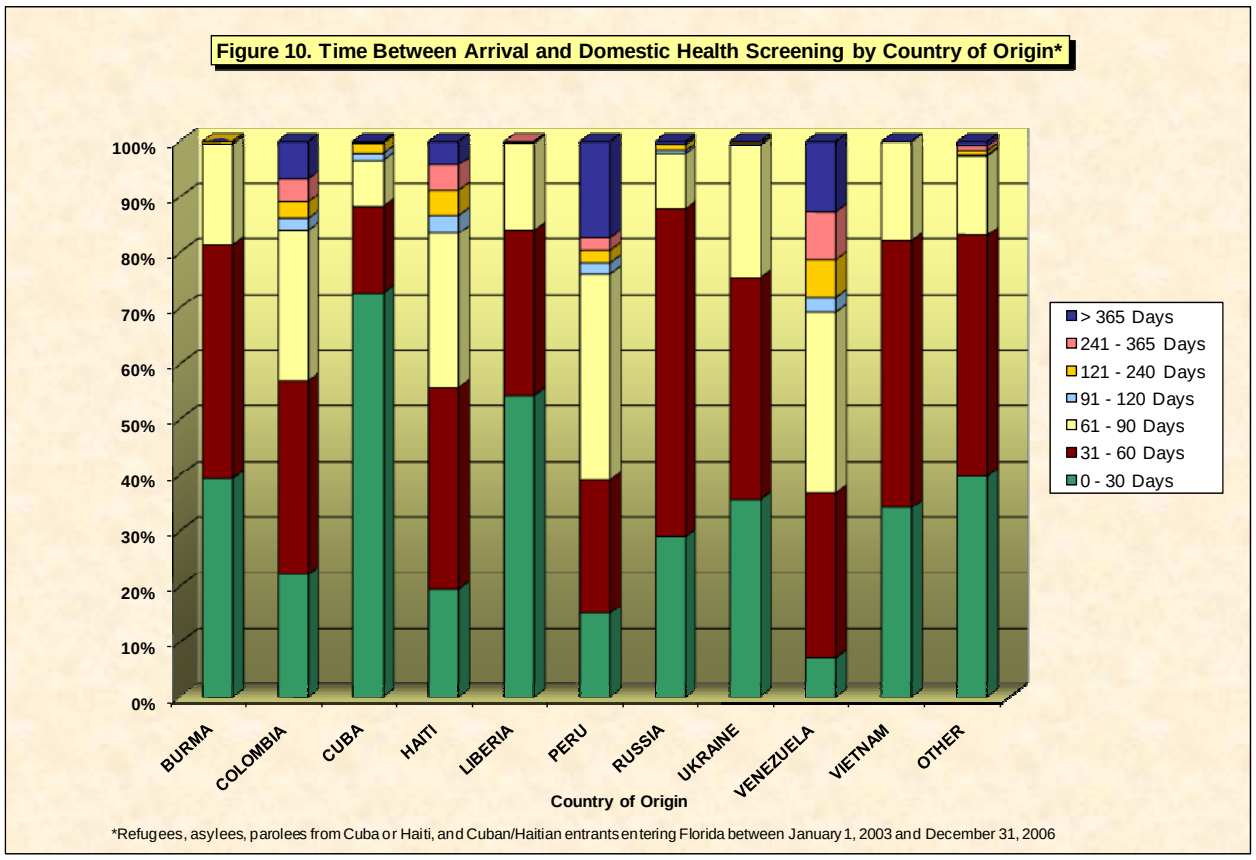
Analysis

Country of origin appears to be related to arrivals having domestic health screenings. Those most likely to have a screening are Liberians (82%), Ukrainians (76%), and Cubans (66%). Those least likely to have a screening are Peruvians (23%), Haitians (17%), and Venezuelans (27%). Arrivals from other countries of origin fall some place in between. The three countries of origin with the lowest percentage of arrivals receiving domestic health screenings also have a high proportion of asylees. That fact alone does not completely explain the result, because Colombia and Burma each have a fairly high proportion of asylees yet 35% and 56% of arrivals from these countries respectively receive screenings.

Opportunities for Intervention

Determine if there are any areas of the state that are successful in inducing Peruvians, Haitians, and Venezuelans to have domestic health screenings. Interview stakeholders to ascertain how they reach out to these populations, and document their strategies. Codify the successful strategies for application around the state to increase utilization of domestic health screenings. Having an effective strategy to reach out to asylees will go a long way in addressing this issue.

Figure 10:



Analysis

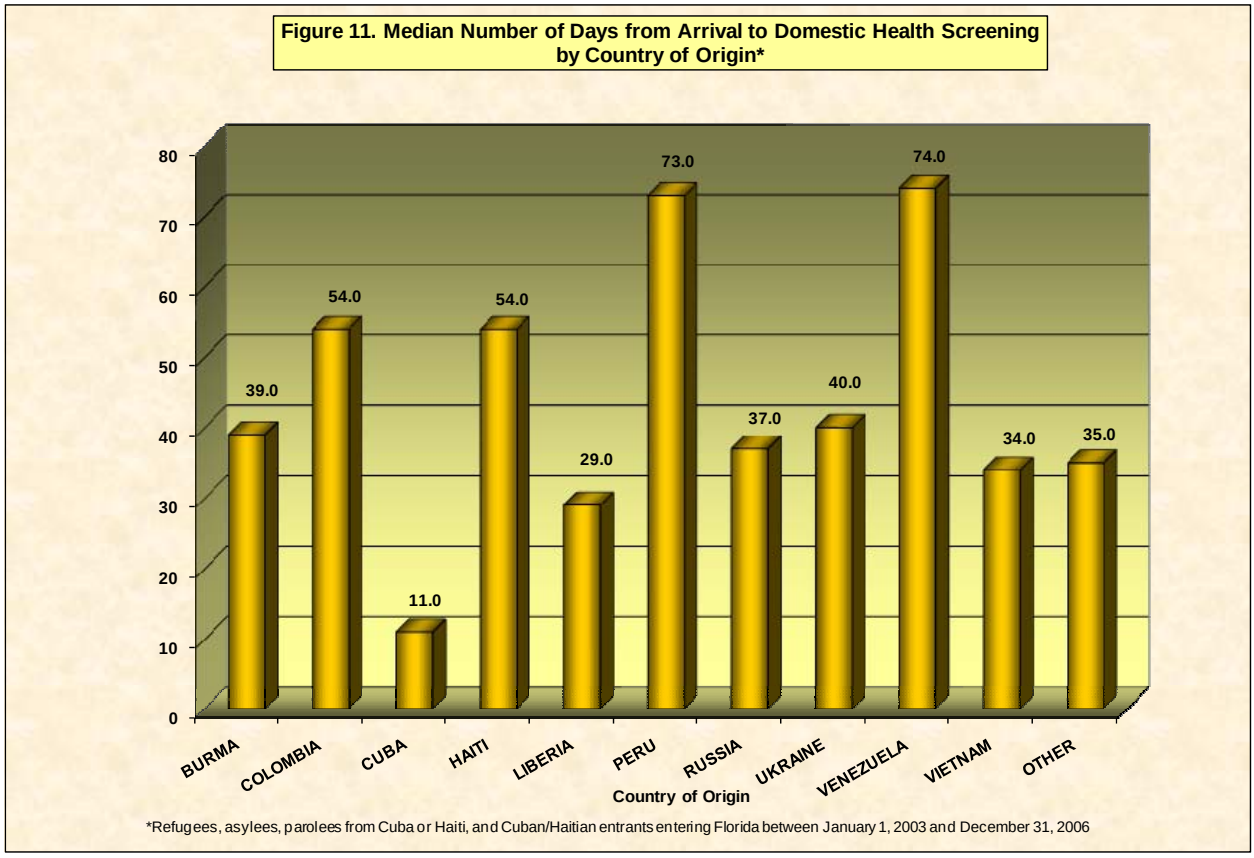
Figure 10 depicts the percent of arrivals from different countries of origin having domestic health screenings at various time intervals. Percentages are calculated based on the total number of arrivals from the country who had screenings. For simplicity, because 90 days from date of arrival (or date asylum is granted) is a meaningful interval with consequences for vaccination, we will examine the

percentage of arrivals receiving their domestic health screening within 90 days of arrival (the top of the pale yellow bar on the figure). Over 90% of Burmese, Cuban, Liberian, Russian, Ukrainians, Vietnamese, and other arrivals who have domestic health screenings have them within 90 days of arrival (or asylum); whereas, less than 80% of Peruvians and Venezuelans complete the screening within 90 days. Haitians and Colombians fall slightly above 80% but not much above. Arrivals from countries that are unlikely to obtain domestic health screenings are more likely to receive them late when they do receive them.

Opportunities for Intervention

Determine if there are any areas of the state that are successful in inducing Peruvians, Haitians, Colombians and Venezuelans to have timely domestic health screenings. Interview stakeholders to ascertain how they reach out to these populations, and document their strategies. Codify the successful strategies for application around the state to increase utilization of domestic health screenings.

Figure 11:



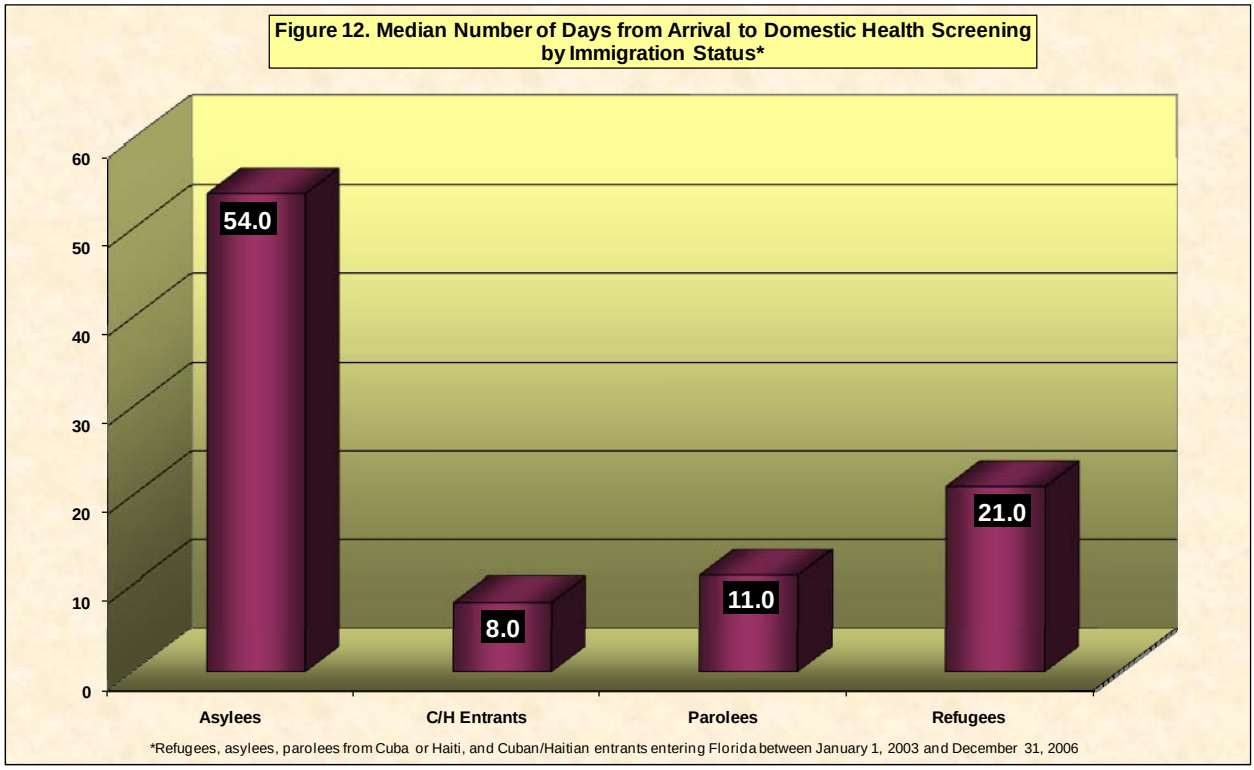
Analysis

When one examines the median days between date of arrival and the domestic health screening, a similar picture emerges: Venezuelans and Peruvians take the longest (greater than 70 days) followed by Colombians and Haitians with a median of greater than 50 days. Notably, Cubans are having their domestic health screenings within eleven days of arrival, a testament to the power of settling in an established community. The median interval for arrivals from other countries falls between twenty-nine and forty days.

Opportunities for Intervention

See Figure 10 discussion.

Figure 12:



Analysis

Immigration status is related to the median time between date of entry (or date of asylum) and date of domestic health screening. Entrants, parolees, and refugees seem to have their domestic health screenings shortly after date of entry. On the other hand, the few asylees who do have the screenings appear to delay having them.

Opportunities for Intervention

The Office needs to decide if asylees receiving domestic health screenings after they are granted asylum is a priority. If so, areas of the state that have good asylee utilization of screenings should be identified and studied for best practices. In order to increase the number of asylee domestic health screenings, the Office may want to work at a national level to ensure that, at the time asylum is granted, the USCIS and the EOIR notifies asylees of their right to refugee health services. Parties involved in the notification process can simultaneously notify persons of their granted asylum, as well as, their right to refugee health services.

Figures 13a through 13f:

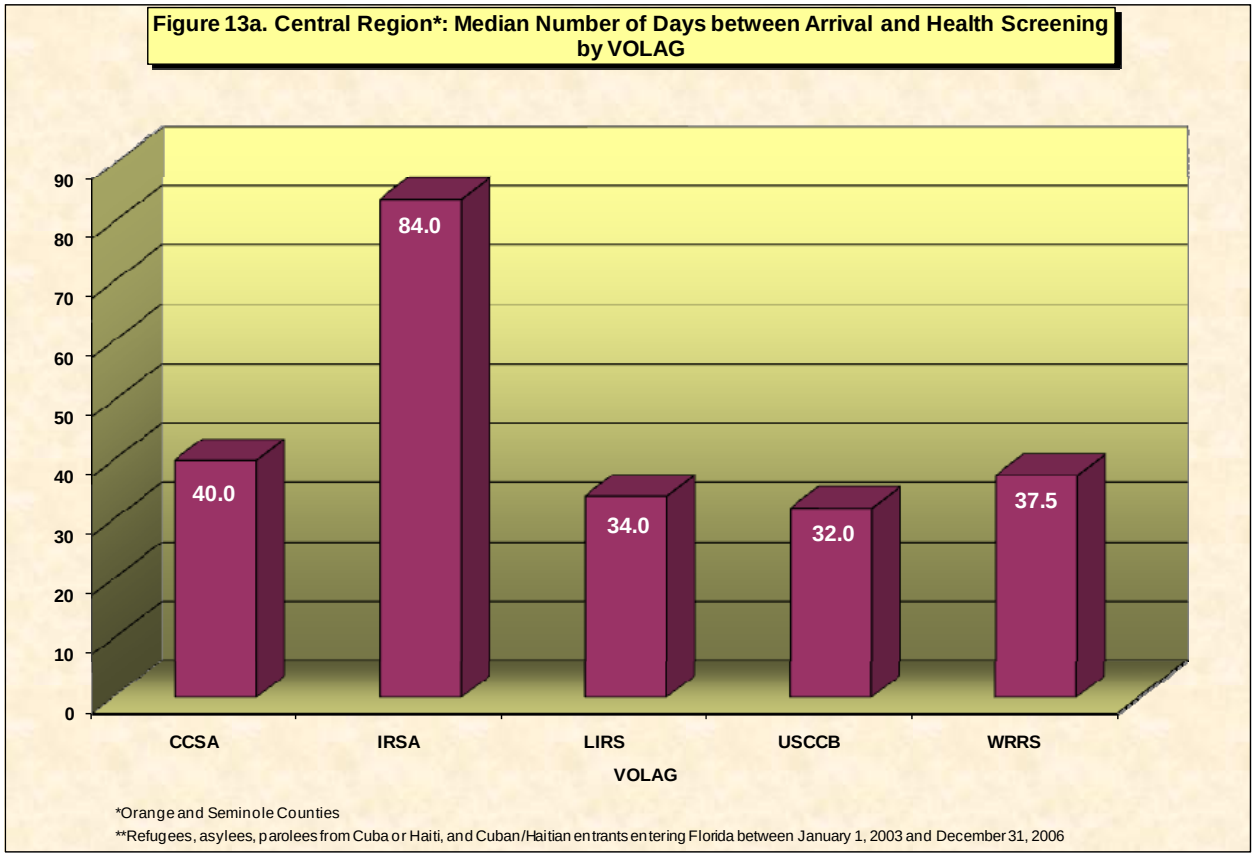
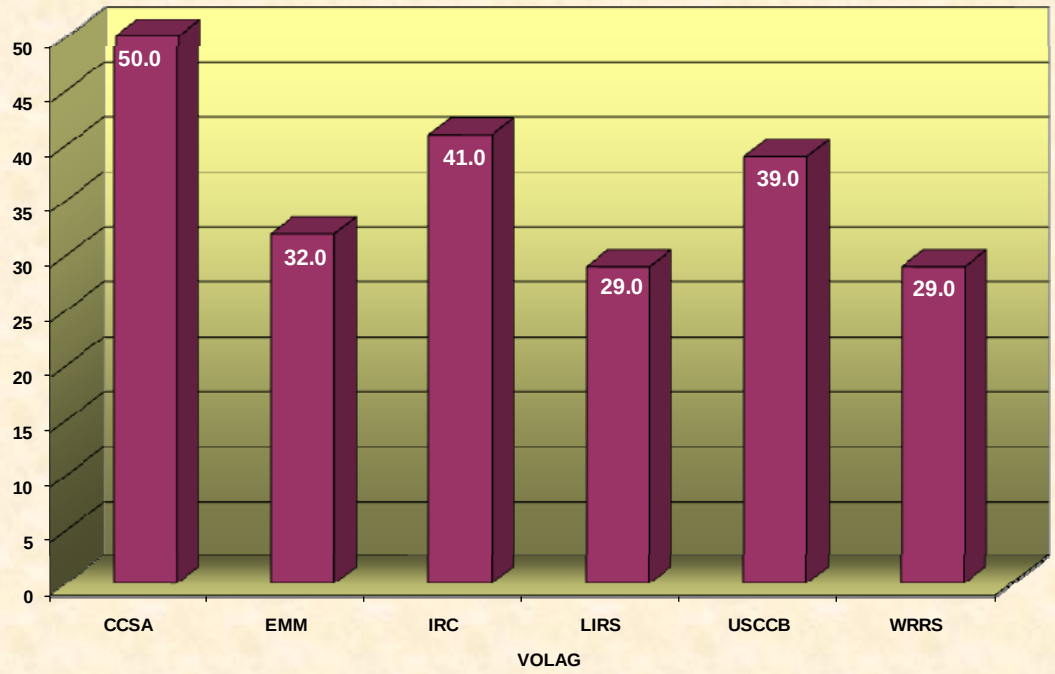


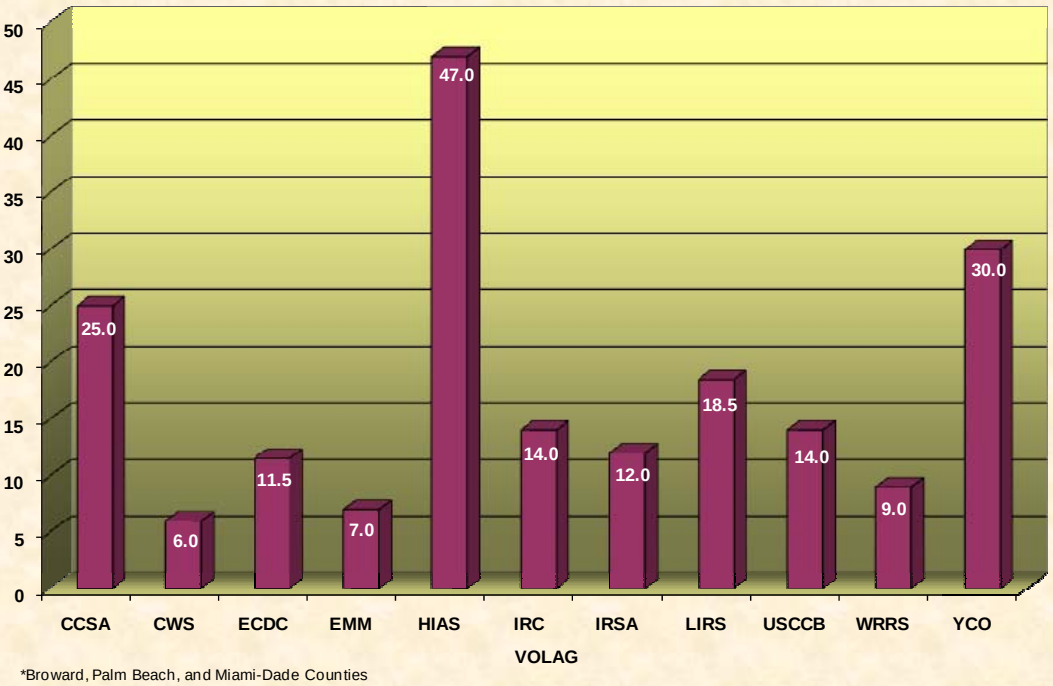
Figure 13b. Northeast Region*: Median Number of Days between Arrival and Health Screening by VOLAG**



*Duval County

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

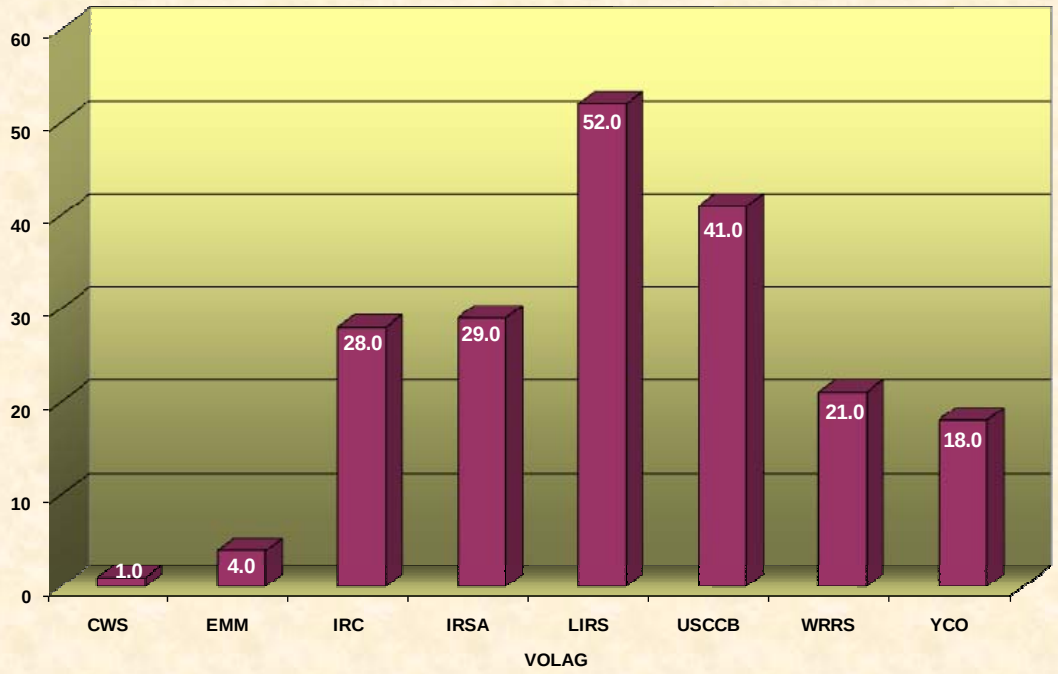
Figure 13c. Southeast Region*: Median Number of Days between Arrival and Health Screening by VOLAG



*Broward, Palm Beach, and Miami-Dade Counties

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

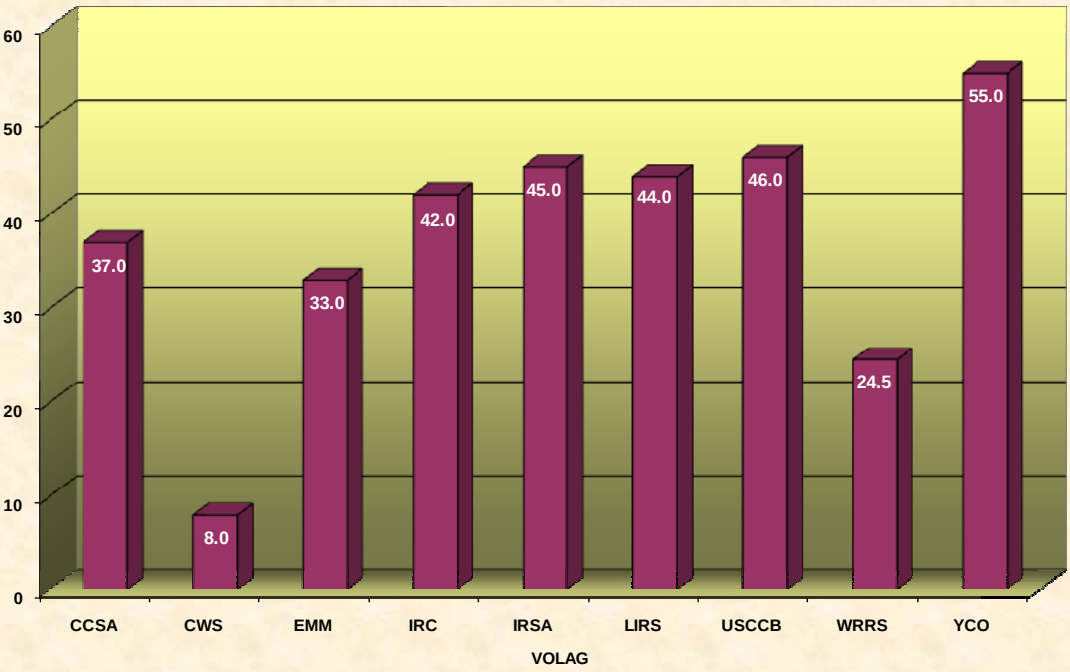
Figure 13d. Southwest Region*: Median Number of Days between Arrival and Health Screening by VOLAG



*Collier and Lee Counties

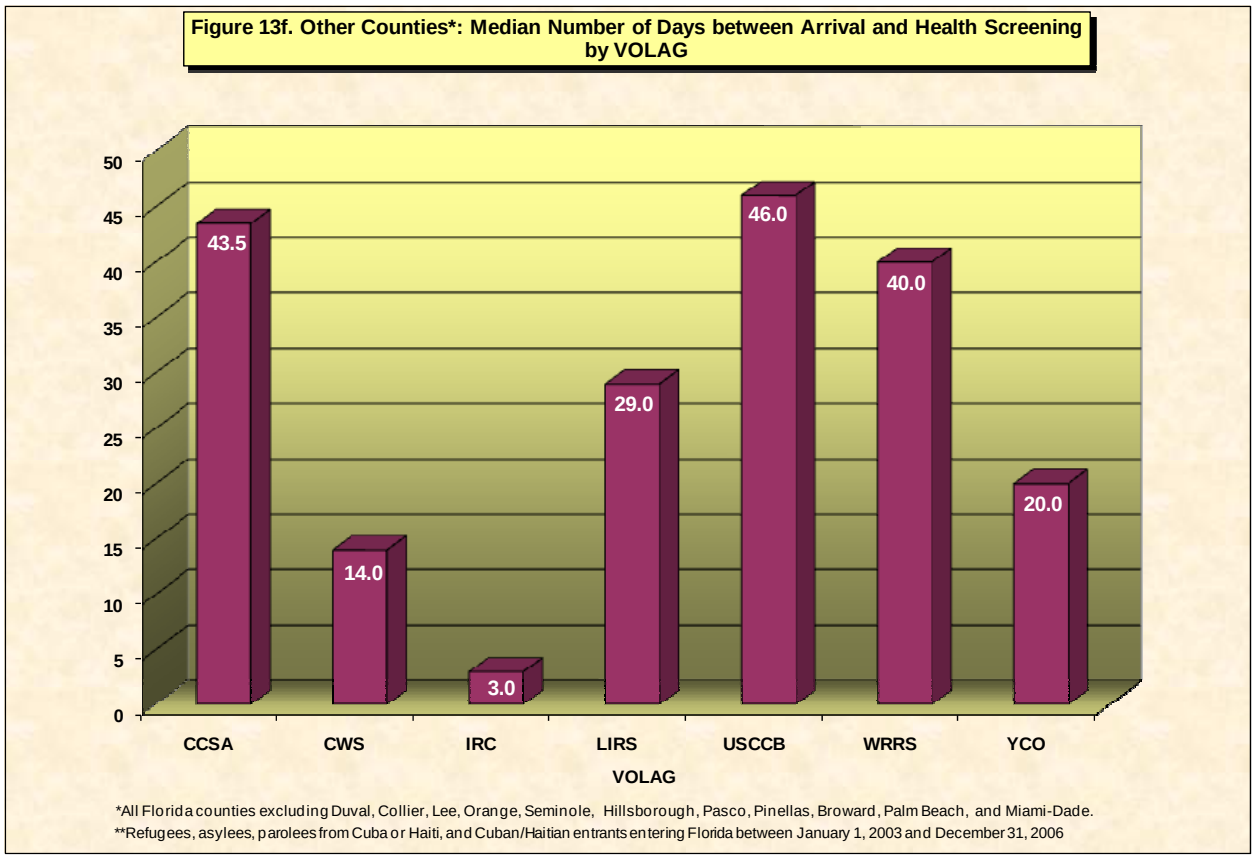
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 13e. Tampa Bay Region*: Median Number of Days between Arrival and Health Screening by VOLAG**



*Hillsborough, Pasco, and Pinellas Counties

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006



For this set of graphs and all other graphs depicting performance of individual VOLAGs, the following table serves as a guide to abbreviations:

Not every VOLAG serves arrivals in each region of the state. The graphs only include a VOLAG if it served more than ten arrivals between January 1, 2003, and December 31, 2006. In addition, there are a limited number of VOLAGs in each region that provide resettlement services. We will limit the discussion in our analysis to VOLAGs providing primary resettlement services in each region of the state.

VOLAG Abbreviations and Locations

VOLAG		Primary Provider of Resettlement Services in				
Description	Code	Central	Northeast	Southeast	Southwest	Tampa Bay
Community Christian Service Agency	CCSA					
Church World Service	CWS					
Episcopal Migration Ministries	EMM					
Hebrew Immigrant Aid Society	HIAS					
International Rescue Committee	IRC					
Immigration & Refugee Services of America	IRSA					
Lutheran Immigration & Refugee Service	LIRS					
U.S. Conference of Catholic Bishops	USSCB					
World Relief Refugee Services	WRRS					
Youth Co-Op (YCP)	YCO					
Ethiopian Community Development Council	ECDC					

Analysis

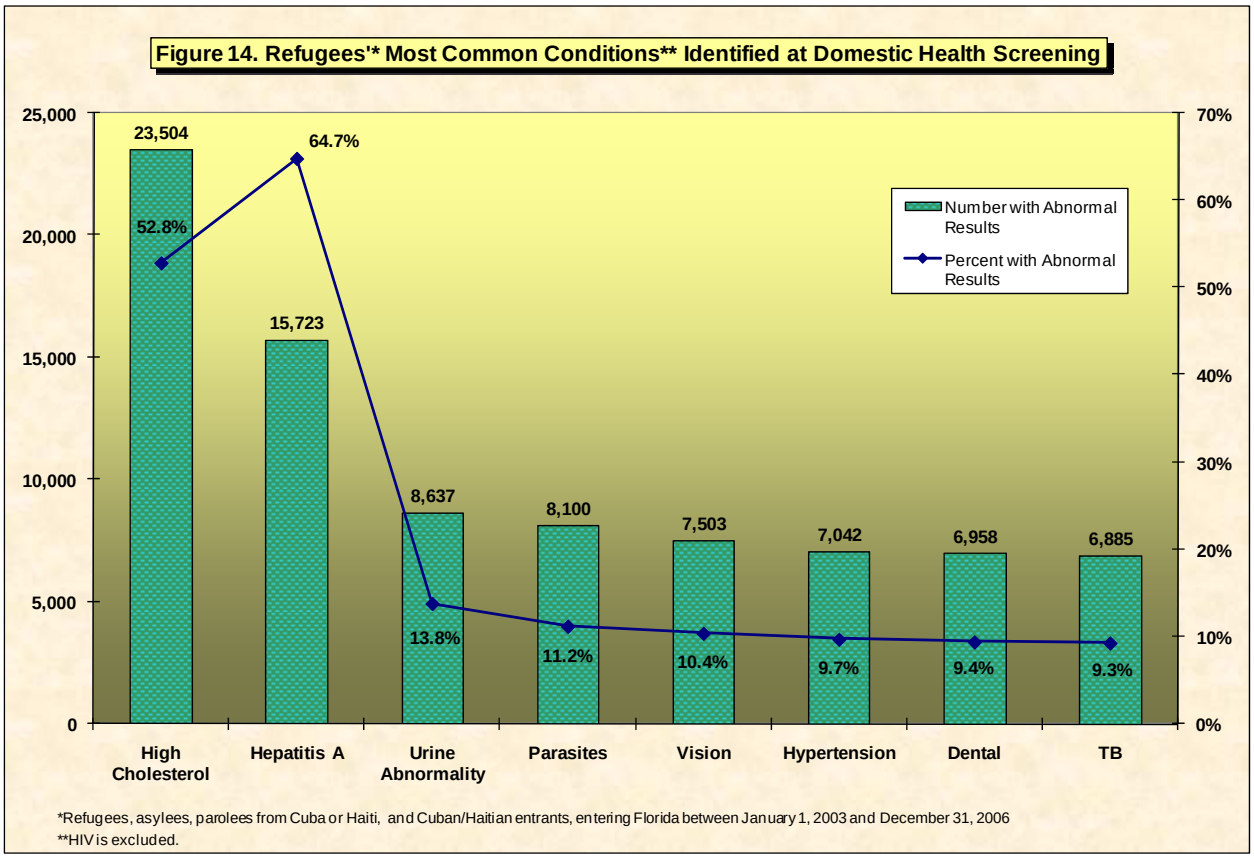
First, it should be noted that Church World Services (CWS) is getting their arrivals in early for domestic health screenings; its median number of days is never more than 14. The other resettlement agencies vary considerably from one area of the state to another.

Among the regions of the state, the Southeast seems to be most efficient, with all primary VOLAGs achieving a median of less than 20 days between entry and screening. In the Southwest, only two of the five primary VOLAGs (Lutheran Immigration and Refugee Services and U.S. Conference of Catholic Bishops) exceed a median of 30 days. VOLAGs in Tampa Bay seem to be especially slow in obtaining screenings for arrivals with over 60% of its primary VOLAGs having medians above 40 days. These regional differences could have more to do with efficiencies in practices at the county health departments rather than differences in practices among VOLAGs.

Opportunities for Intervention

System features should be studied for CWS as well as the practices and procedures of the health departments in the Southeast and the Southwest Regions to determine the most effective ways to get arrivals in for domestic health screenings as early as possible. These practices can then be incorporated into practice guidelines that can be applied statewide.

Figure 14:



Analysis

The most common condition identified during domestic health screenings is high cholesterol; over 23,000 Florida arrivals between January 1, 2003, and December 31, 2006, were diagnosed with this condition, 53% of the people who were tested. The next most common condition was hepatitis A, with almost 16,000 individuals identified (65% of individuals tested). About 10% of arrivals tested for the following conditions were diagnosed: urine abnormalities, parasites, vision problems, hypertension, dental problems, and tuberculosis (abnormal chest x-ray).

An interesting aspect of these results is the differential rate of testing. Almost all arrivals are tested for all conditions listed above except for hepatitis A, for which only about one third of arrivals are tested. The lower level of hepatitis A testing is due to the fact that such testing began in October 2005. Cholesterol testing is done for about 60% of arrivals, presumably most adults.

Opportunities for Intervention

None recommended.

Figure 15:

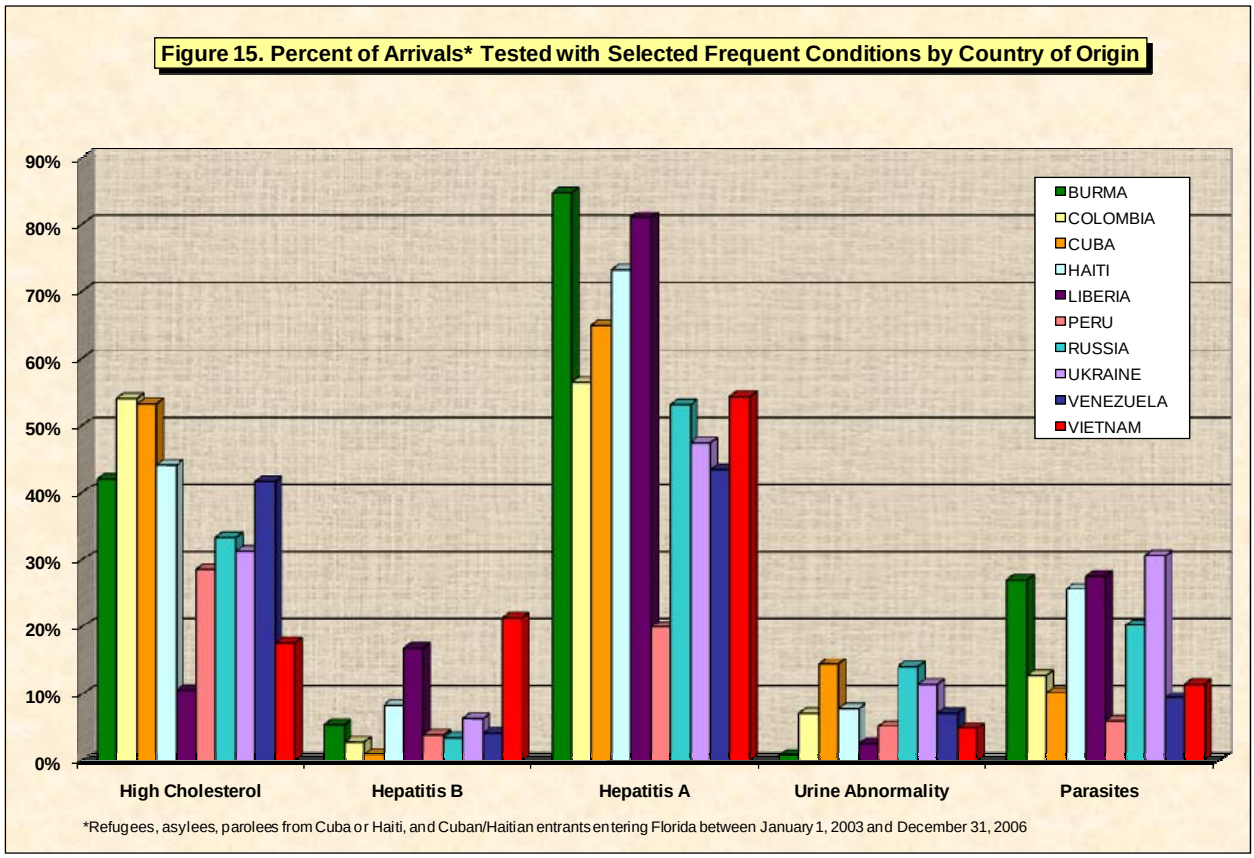


Figure 15 demonstrates the predominance of different conditions diagnosed during the domestic health screening by country of origin. All these conditions are potentially treatable. To a certain extent, their presence during a domestic health screening may reflect the quality of the health care provided in the country of origin.

Appendix B is a table that provides frequencies as well as the percentages depicted on the graph.

Analysis

Among all countries of origin, Peruvians seem the healthiest with fairly low percentages of diagnosed cases of high cholesterol, hepatitis B, hepatitis A, urine abnormalities, and parasites. This result may reflect a good healthcare system in Peru.

High cholesterol is common among most arrivals but not among Liberians and Vietnamese. Four percent (4%) or less of Colombians, Cubans, Peruvians, Venezuelans, and Russians are diagnosed with hepatitis B while 17% of Liberians and 21% Vietnamese are. Peruvians have the lowest percentage (20%) of hepatitis A, while over 80% of Burmese and Liberians who are tested are diagnosed with this condition. Less than 3% of Burmese and Liberians have abnormal urine, whereas more than 10% of Cubans, Russians, and Ukrainians do. Less than 10% of Peruvians and Venezuelans are diagnosed with parasites, while more than 25% of Burmese, Haitians, Liberians, and Ukrainians are.

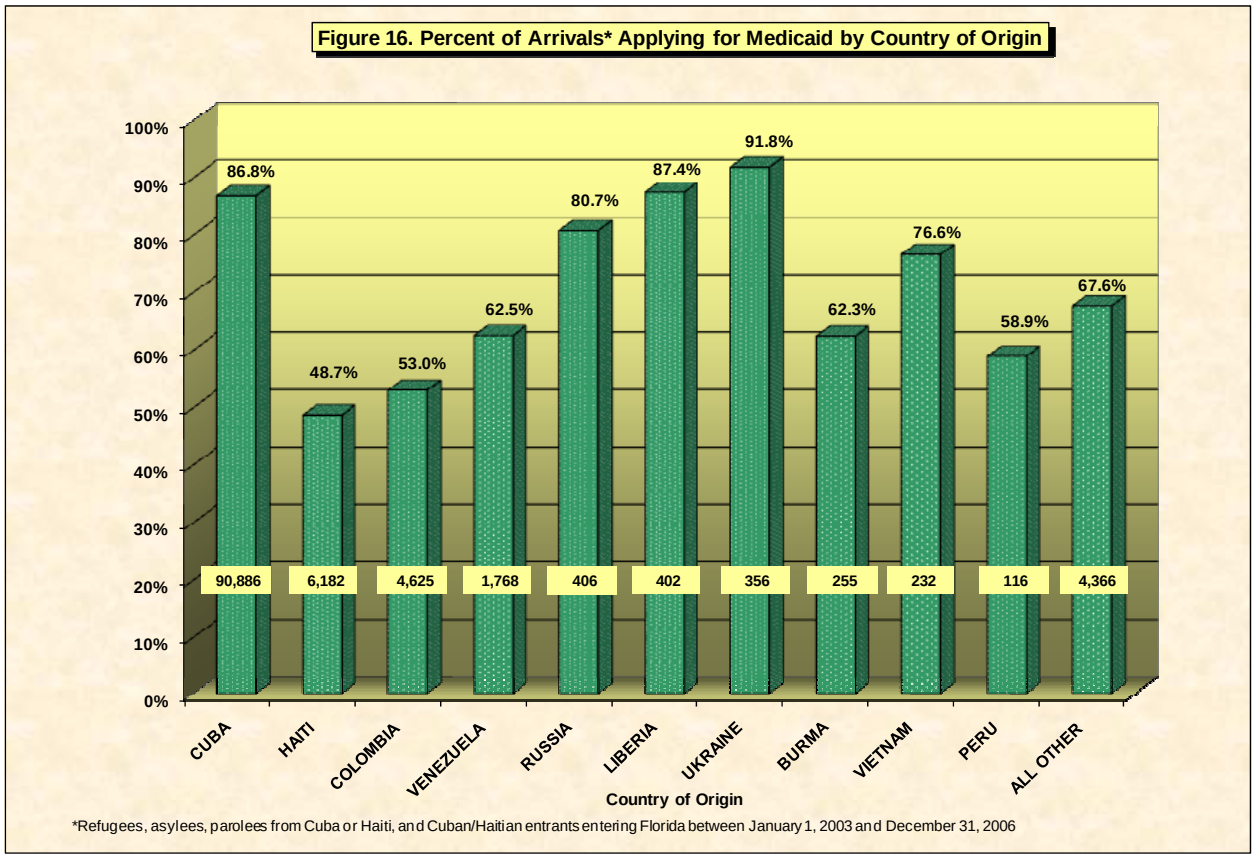
Opportunities for Intervention

None recommended.

Medicaid Application and Enrollment

For arrivals being resettled by a VOLAG, the staff assists the refugee in applying for Medicaid. As long as an individual meets the income requirements to qualify for Medicaid, they will be provided medical insurance either through Medicaid (if children or a family with children) or through Refugee Medical Assistance (if a single adult or an adult without children or a disability). Arrivals qualifying for Medicaid may remain enrolled in Medicaid for as long as they are financially eligible. Arrivals qualifying for Refugee Medical Assistance are eligible for up to eight months from date of entry if they continue to meet the criteria based on assets and income.

Figure 16:



Analysis

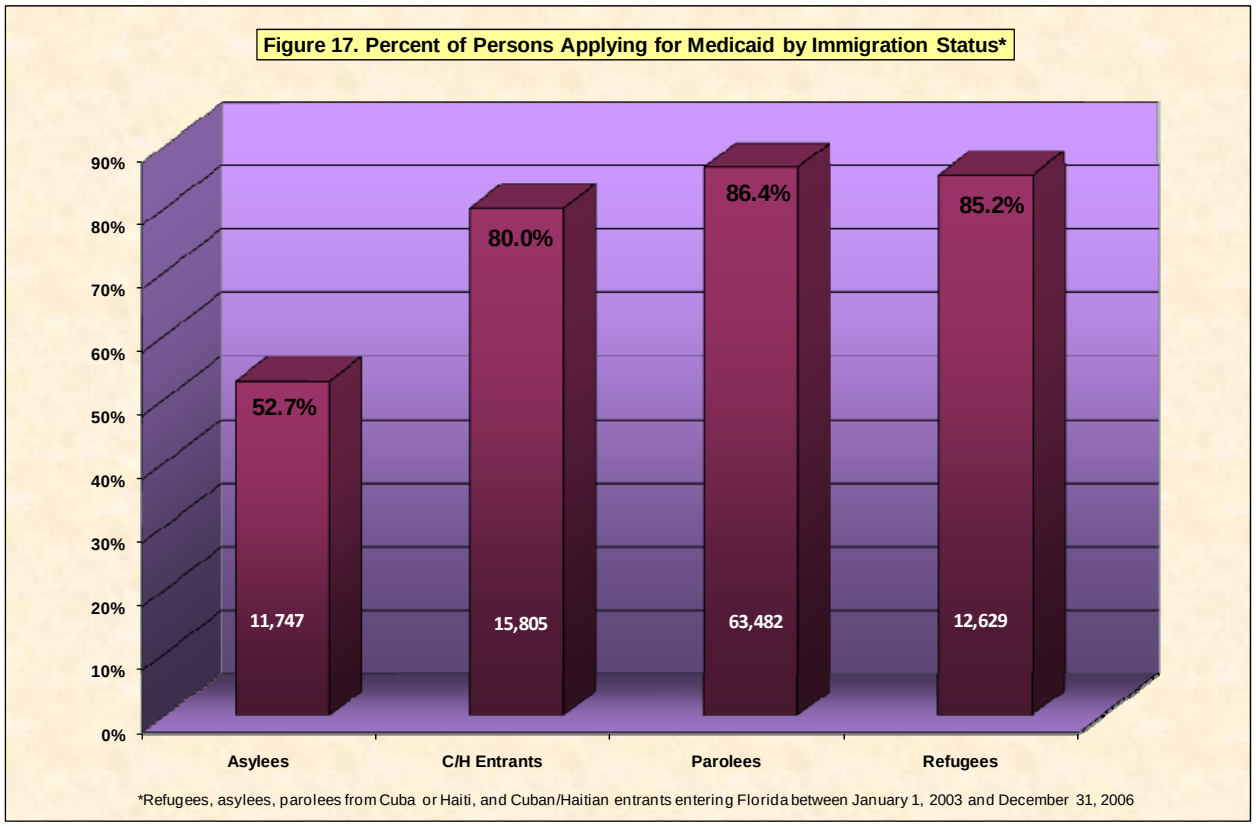
For most countries of origin, more than 50% of arrivals applied for Medicaid. Haiti is the one exception, with only 49% applying. Country of origin makes a difference in determining who applies for Medicaid. Over 80% of Cubans, Liberians, and Ukrainians applied for Medicaid. But less than 70% of Haitians, Colombians, Venezuelans, Burmese, and Peruvians did. There is no reason to believe that arrivals from the latter group of countries might be considered too wealthy to qualify for Medicaid. It is possible that asylees could be in the country long enough before asylum was granted to be earning substantial wages, or, more pessimistically, by the time asylum is granted, the asylee has lost contact with those responsible for resettlement. In fact, there is a close relationship between the nationalities of arrivals not applying for Medicaid and countries of origin with a high proportion of asylees. Overall, only 18% of

arrivals are asylees, but over 50% of arrivals from Burma (51%), Colombia (95%), Haiti (72%), Peru (92%), and Venezuela (98%) are asylees.

Opportunities for Intervention

To ensure that more arrivals have the opportunity to apply for Medicaid benefits, strategies should be implemented to follow up with asylees at the time asylum is granted. This group of arrivals needs to be guided through the application process after asylum is granted.

Figure 17:



Analysis

Figure 17 corroborates the analysis for Figure 16 in that it demonstrates that over 80% of refugees and parolees and 79% of Cuban and Haitian entrants apply for Medicaid; only 53% of asylees do.

Opportunities for Intervention

See Figure 16 recommendations.

Figures 18a through 18f:

VOLAG abbreviations and locations can be found on page 29.

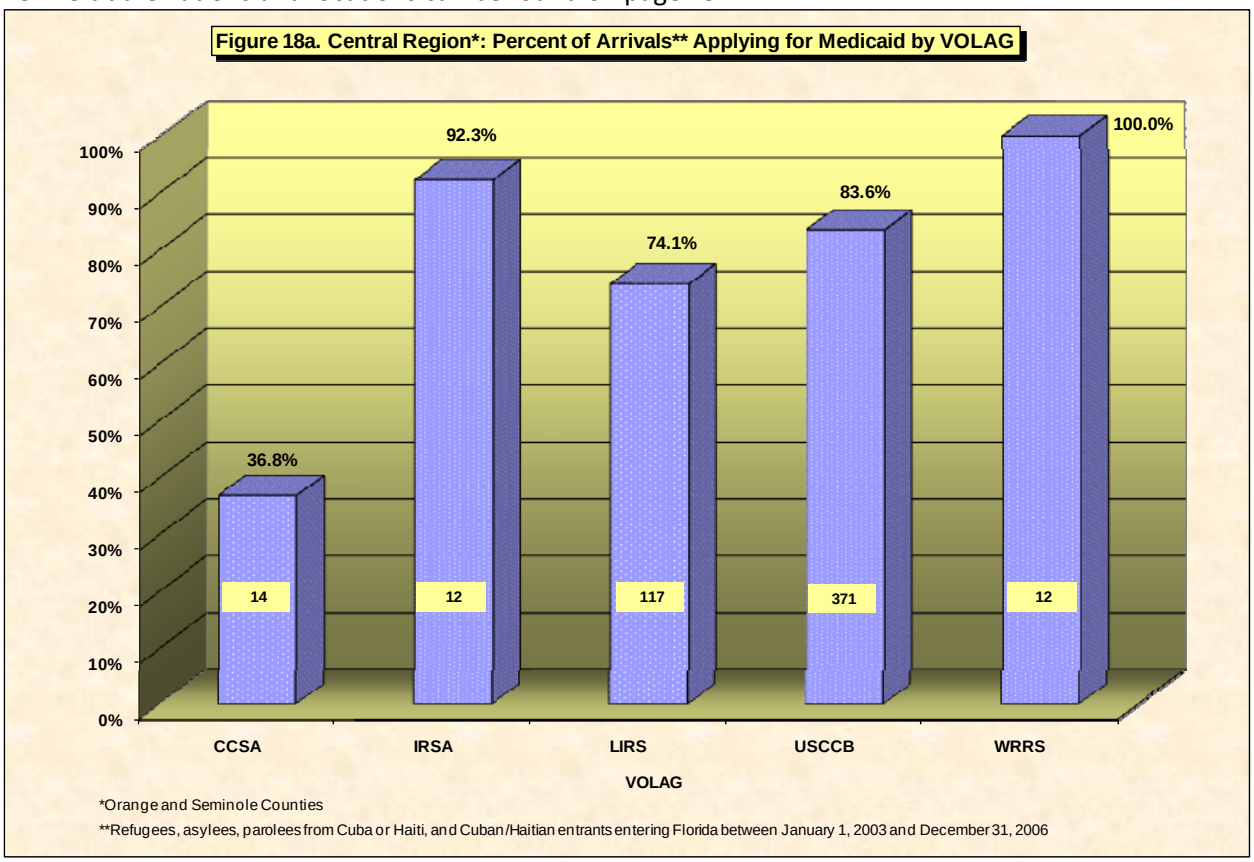
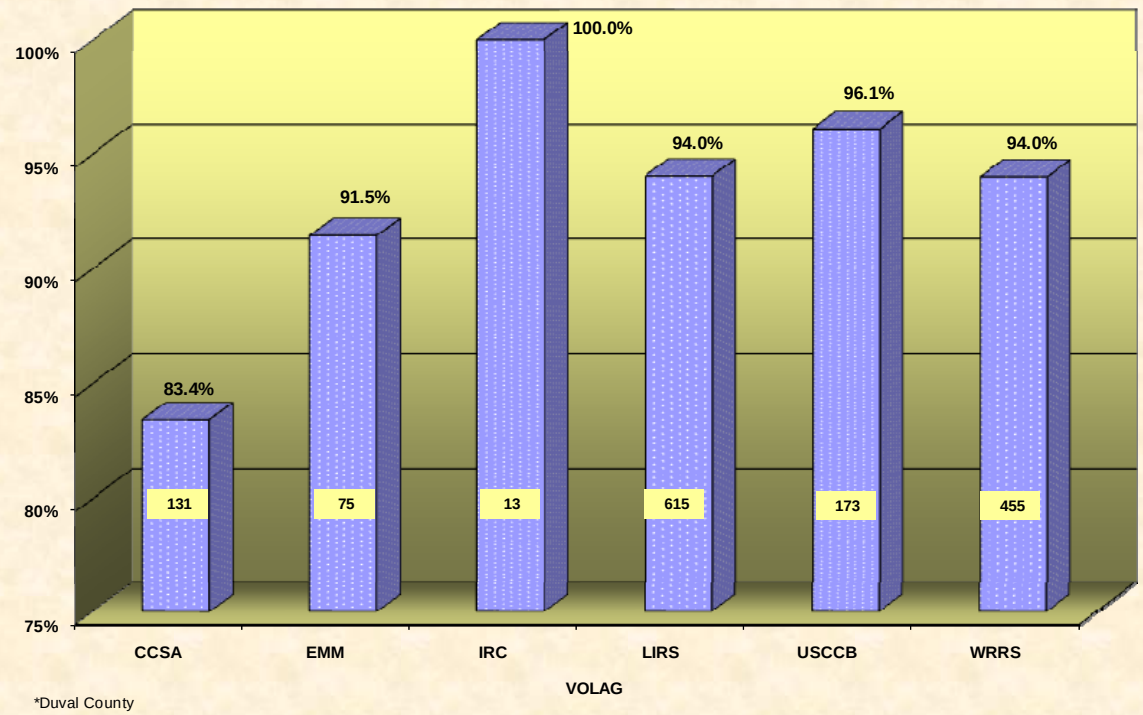


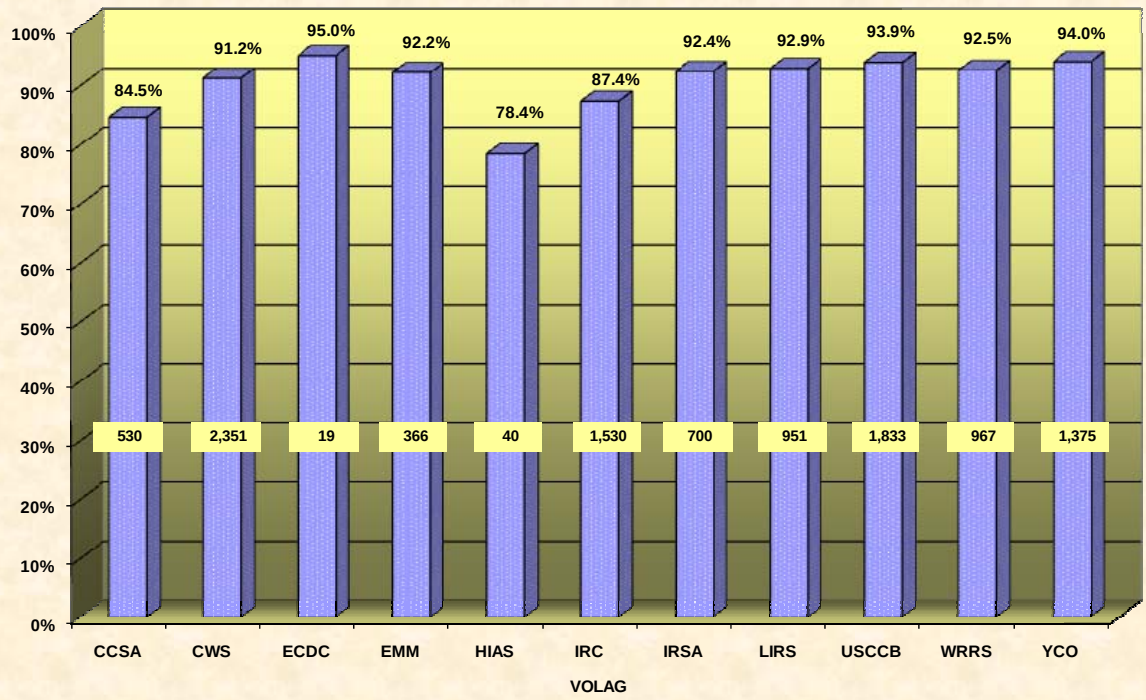
Figure 18b. Northeast Region*: Percent of Arrivals Applying for Medicaid by VOLAG**



*Duval County

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

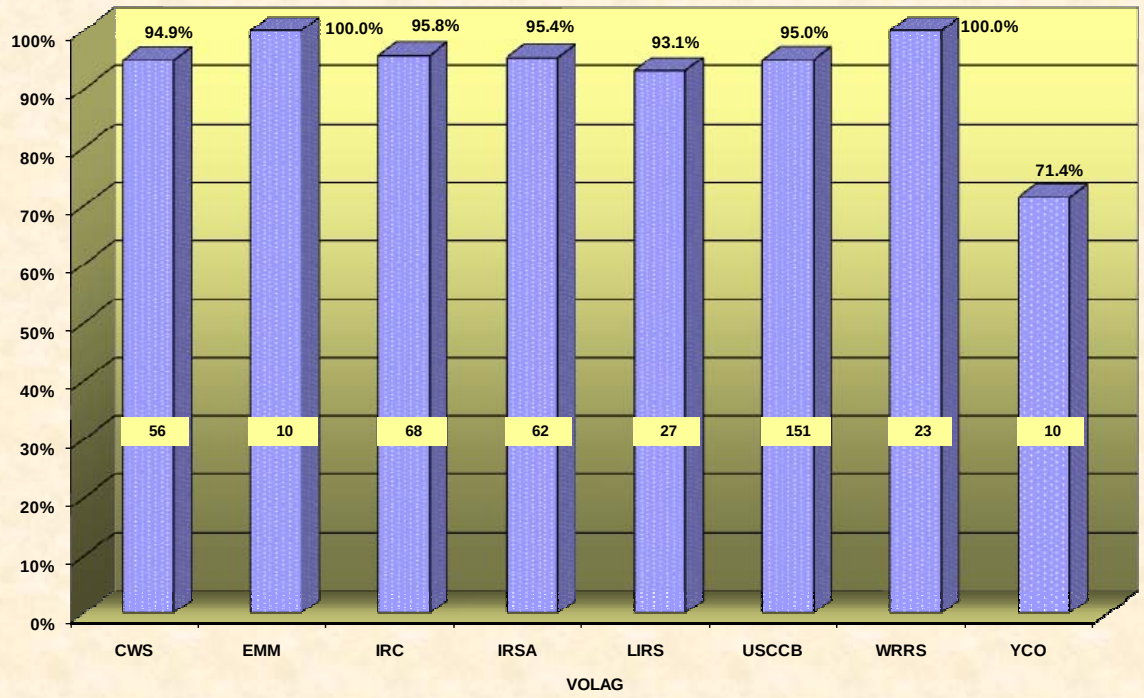
Figure 18c. Southeast Region*: Percent of Arrivals Applying for Medicaid by VOLAG**



*Broward, Palm Beach, and Miami-Dade Counties

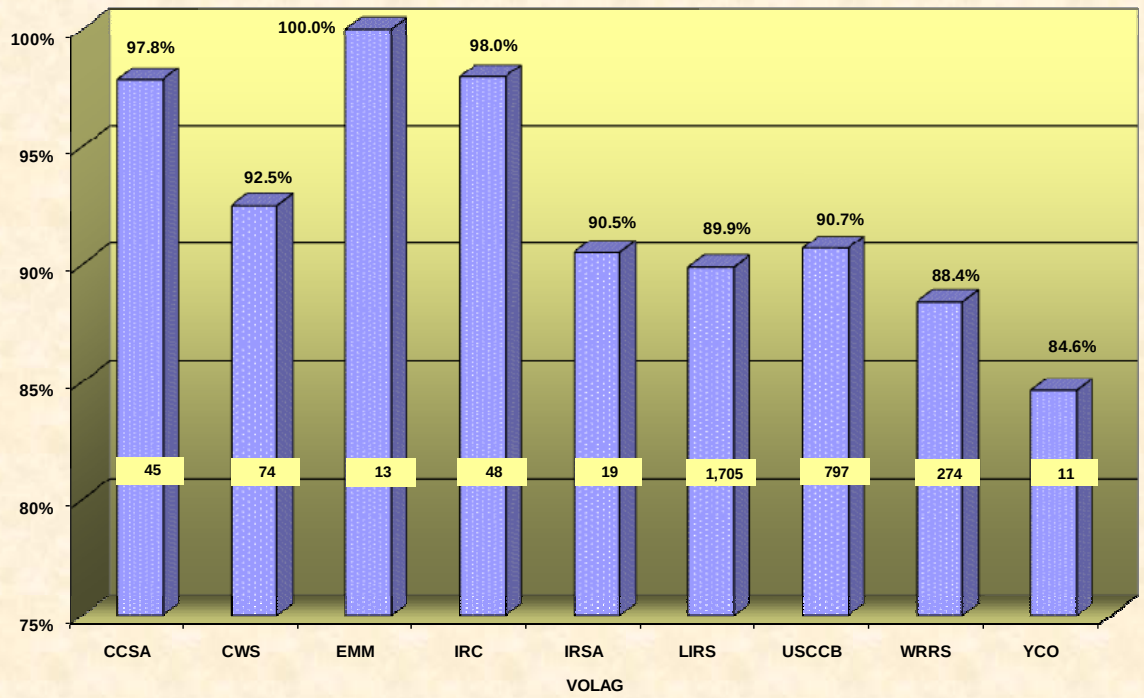
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 18d. Southwest Region*: Percent of Arrivals Applying for Medicaid by VOLAG**

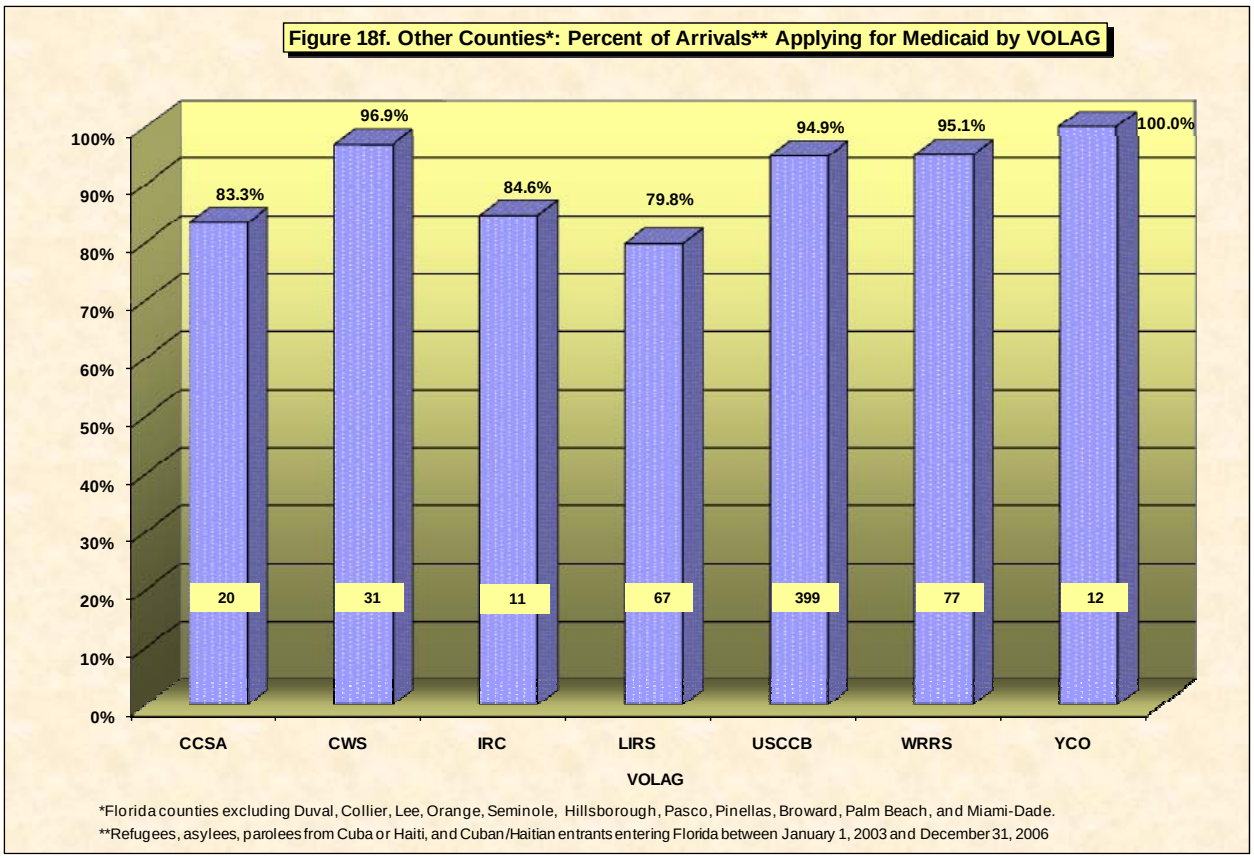


*Collier and Lee Counties
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 18e. Tampa Bay Region*: Percent of Arrivals Applying for Medicaid by VOLAG**



*Hillsborough, Pasco, and Pinellas Counties
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006



Analysis

Not all VOLAGs provide resettlement services in all areas of the state. This set of graphs emphasizes performance of VOLAGs providing services to more than ten arrivals entering Florida between January 1, 2003, and December 31, 2006, in the designated area of the state. In addition, the analysis below will be limited to the primary providers of resettlement services in each region.

Overall, most VOLAGs are doing an excellent job assisting arrivals with Medicaid applications. Some VOLAGs, specifically Church World Service (CWS) and Immigration and Refugee Services of America (IRSA) are consistently assisting over 90% of arrivals they serve in applying for Medicaid in all regions. Two VOLAGs: Lutheran Immigration and Refugee Services (LIRS) and U.S. Conference of Catholic Bishops (USCCB) only fail to achieve the 90% application rate in Central Florida (Orange and Seminole Counties), the region where the lowest proportion of arrivals apply for Medicaid and where the highest proportion of arrivals are asylees. Generally, a VOLAG's ability to provide assistance with Medicaid application differs in different areas of the state, an indication that there are probably no consistently applied, VOLAG-specific, policies and procedures throughout the state. Another possible explanation for the variability in performance could be the mix of arrivals' countries of origin served in different regions.

No VOLAG serving a large group of arrivals in the Central Region (Figure 18a) is successful in assisting over 90% of arrivals with their Medicaid application. CCSA only served 38 arrivals and WRRS served 12. The most successful VOLAG in that region is USCCB, assisting 84% of the arrivals they represent.

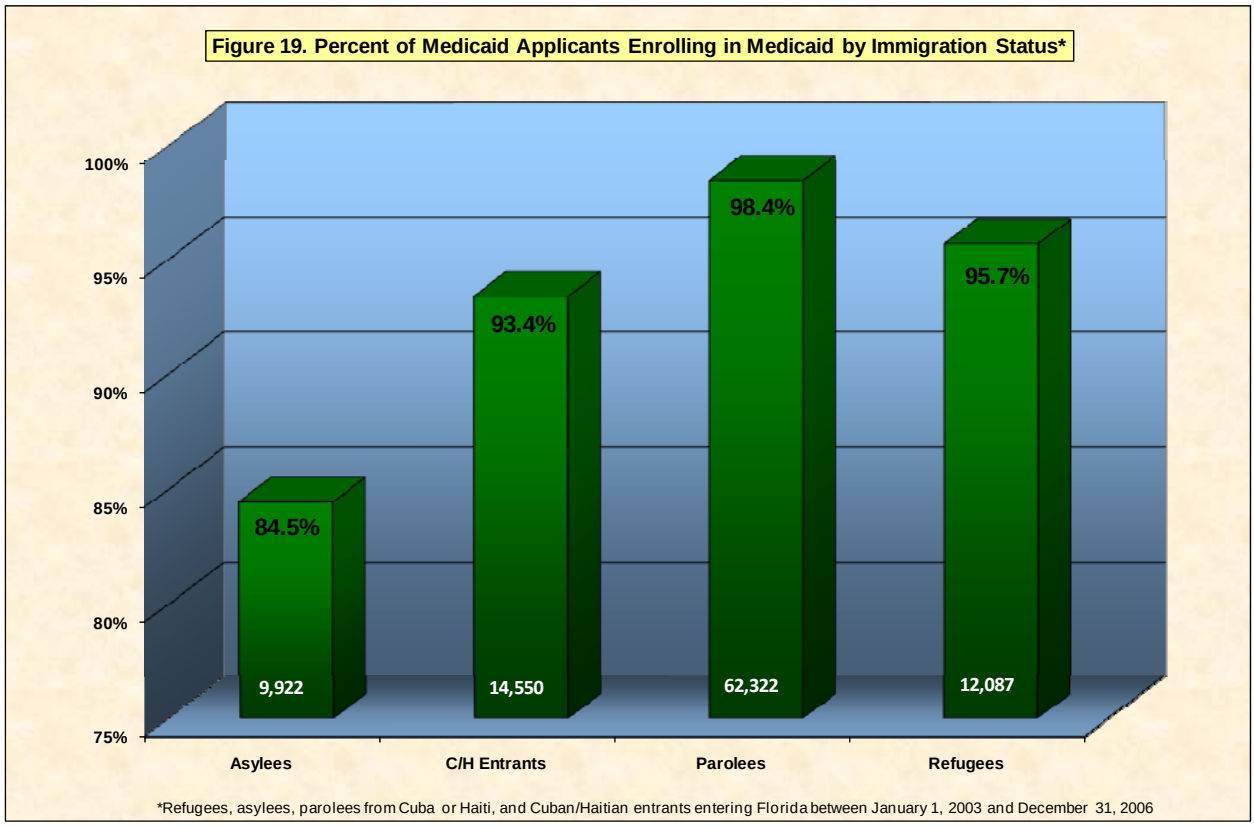
Opportunities for Intervention

Identify local VOLAGs that succeed in providing Medicaid application assistance to a high percentage of their arrivals. Through interviews, identify unique practices for these agencies, especially in reaching

out to asylees and to arrivals from countries with poor application rates. Document these practices and share them with VOLAGs around the state. It is possible that CWS and IRSA have statewide policies and procedures for enrolling arrivals in Medicaid. These procedures should be documented for application statewide.

To improve application rates in the Central Region, especially for asylees, procedures of the USCCB should be documented and recommended to other VOLAGs.

Figure 19:



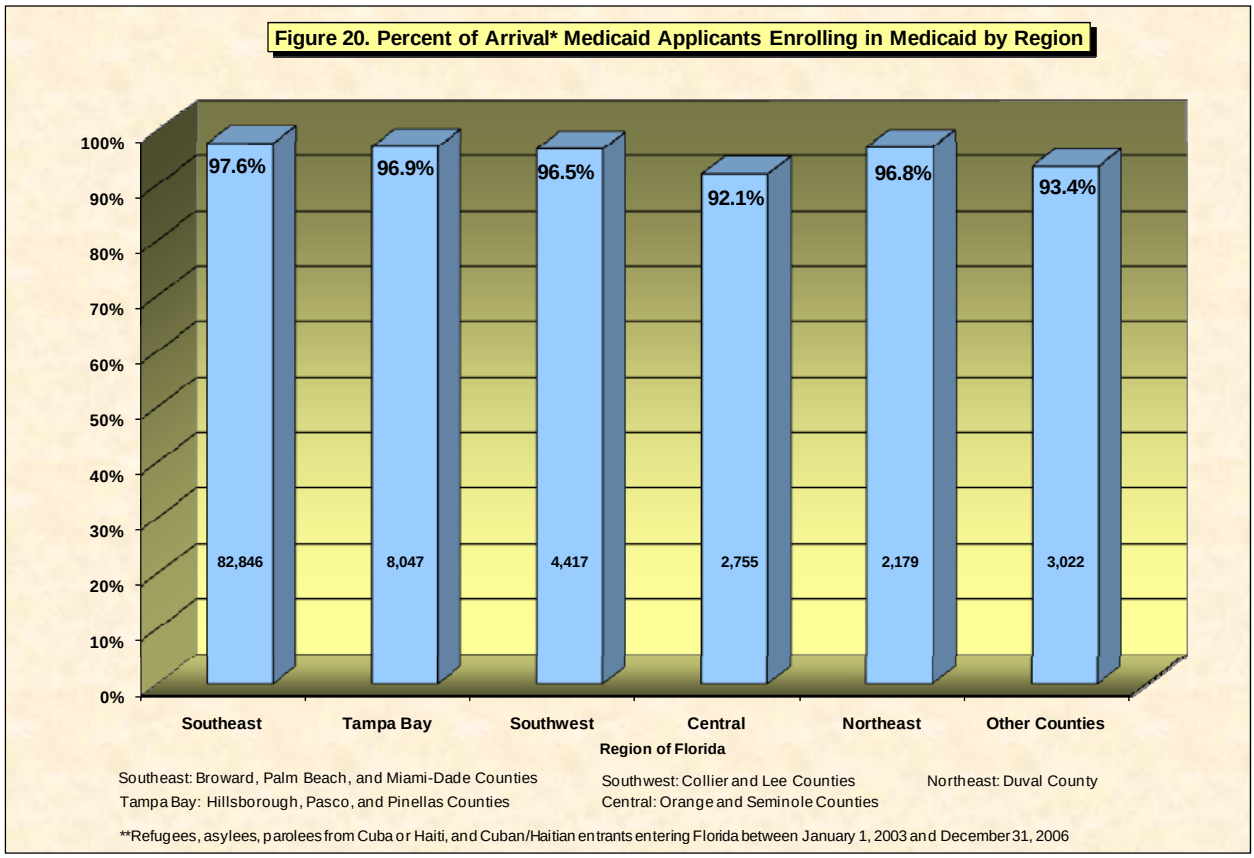
Analysis

Medicaid enrollment means enrollment in either Medicaid or Refugee Medical Assistance. Of arrivals applying for Medicaid, parolees (98%) and refugees (96%) are the most likely to be enrolled. Cuban and Haitian entrants are slightly less likely to become enrolled (93%). Asylees are the least likely to meet the eligibility criteria.

Opportunities for Intervention

None recommended.

Figure 20:



Analysis

With respect to Medicaid applicants who meet the eligibility requirements and actually do become enrolled in Medicaid, all regions of the state exceed 90%.

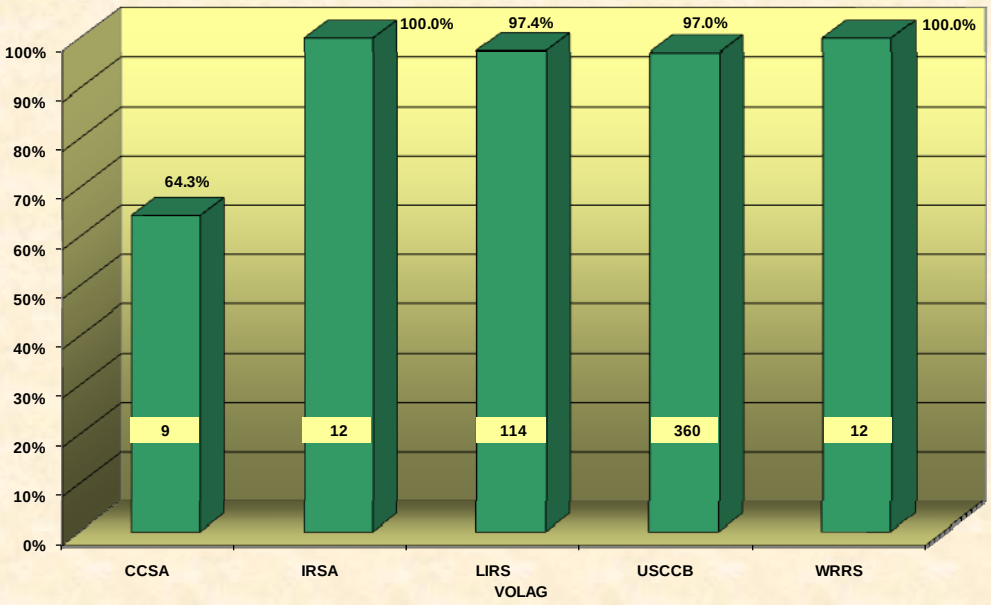
Opportunities for Intervention

None recommended.

Figures 21a through 21f:

VOLAG abbreviations and locations can be found on page 29.

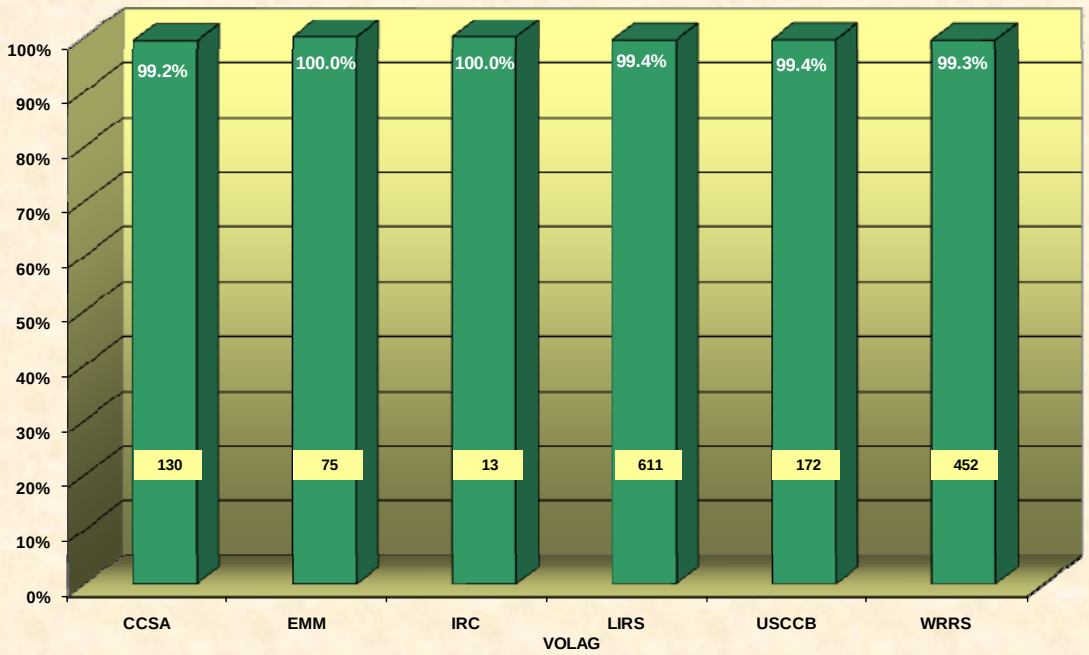
Figure 21a. Central Region*: Percent of Arrival Medicaid Applicants Enrolling in Medicaid by VOLAG**



*Orange and Seminole Counties Counties

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 21b. Northeast Region*: Percent of Arrival Medicaid Applicants Enrolling in Medicaid by VOLAG**



*Duval County

**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

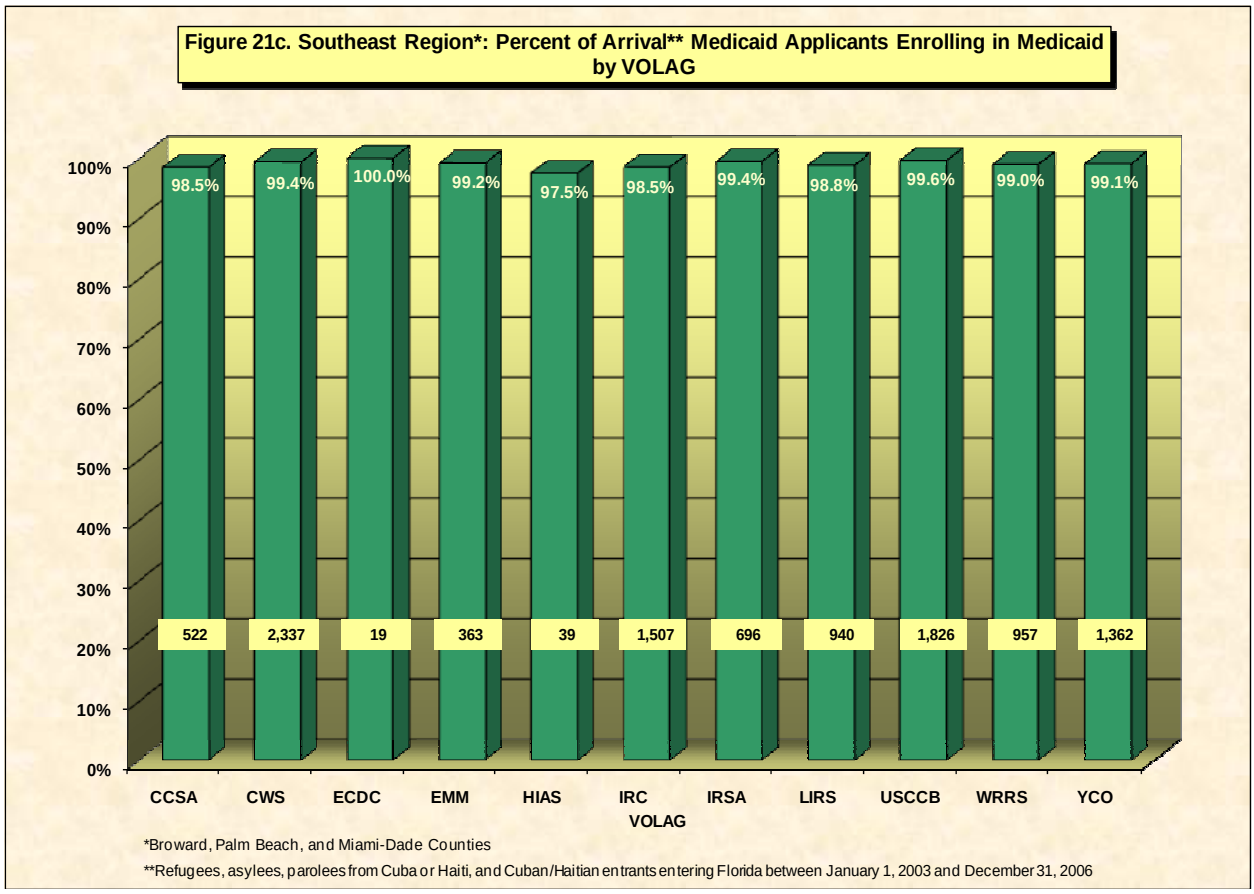
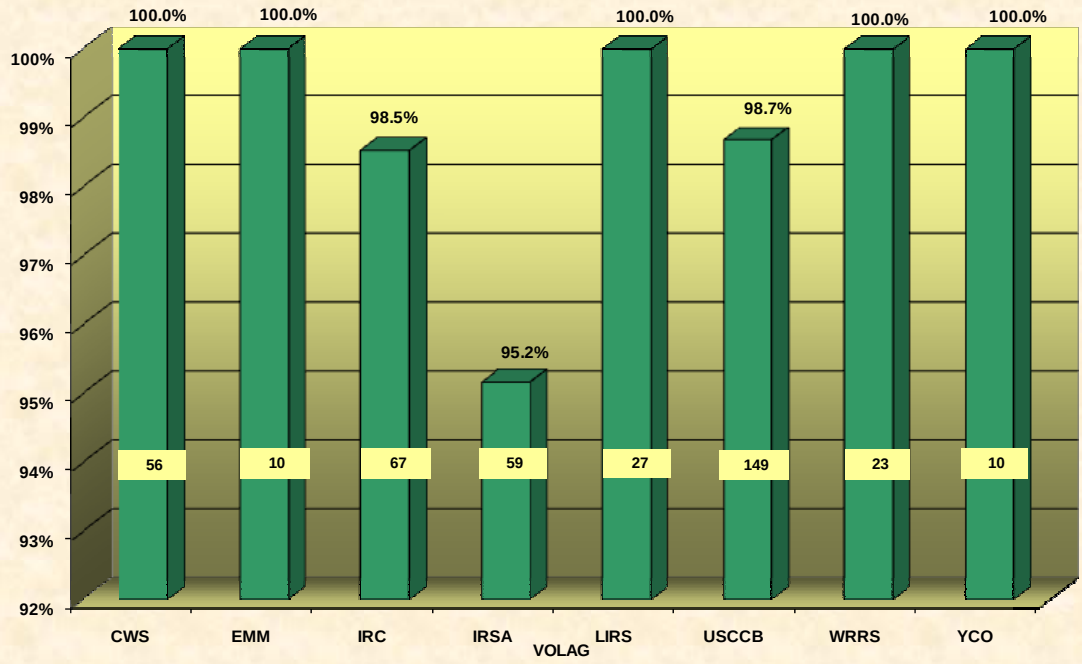


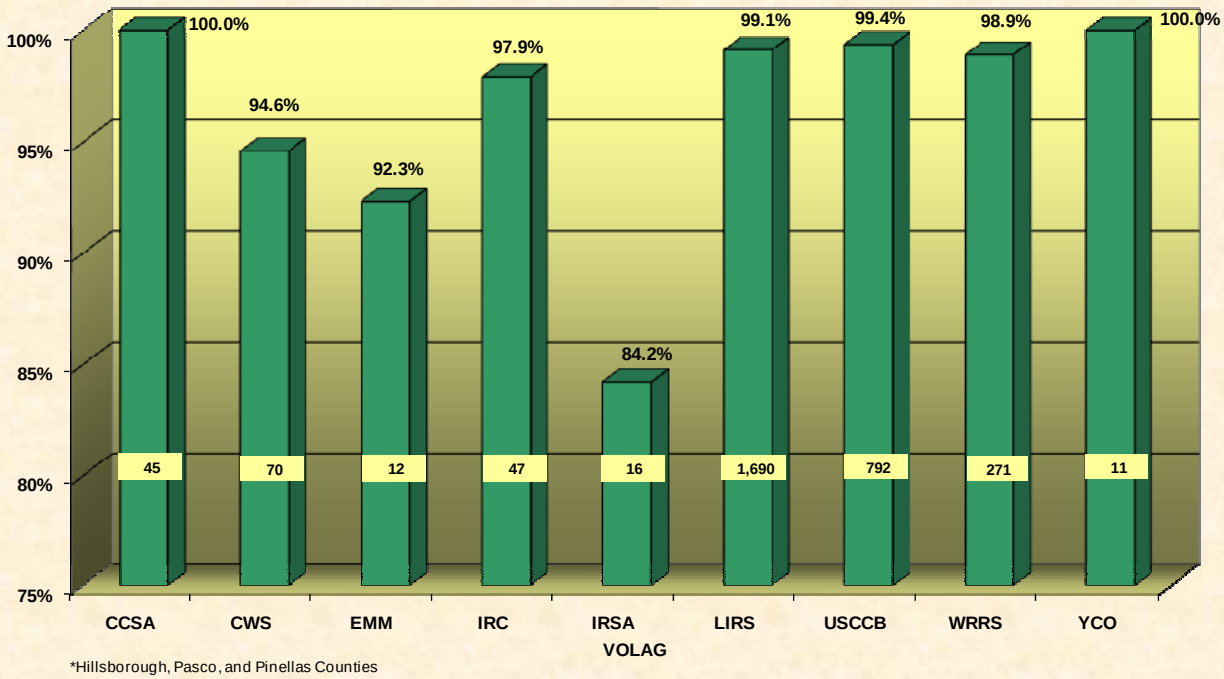
Figure 21c. Southeast Region*: Percent of Arrival** Medicaid Applicants Enrolling in Medicaid by VOLAG
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
98.5%
99.4%
100.0%
99.2%
97.5%
98.5%
99.4%
98.8%
99.6%
99.0%
99.1%
522
2,337
19
363
39
1,507
696
940
1,826
957
1,362
CCSA
CWS
ECDC
EMM
HIAS
IRC
IRSA
LIRS
USCCB
WRRS
YCO
VOLAG
*Broward, Palm Beach, and Miami-Dade Counties
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 21d. Southwest Region*: Percent of Arrival Medicaid Applicants Enrolling in Medicaid by VOLAG**

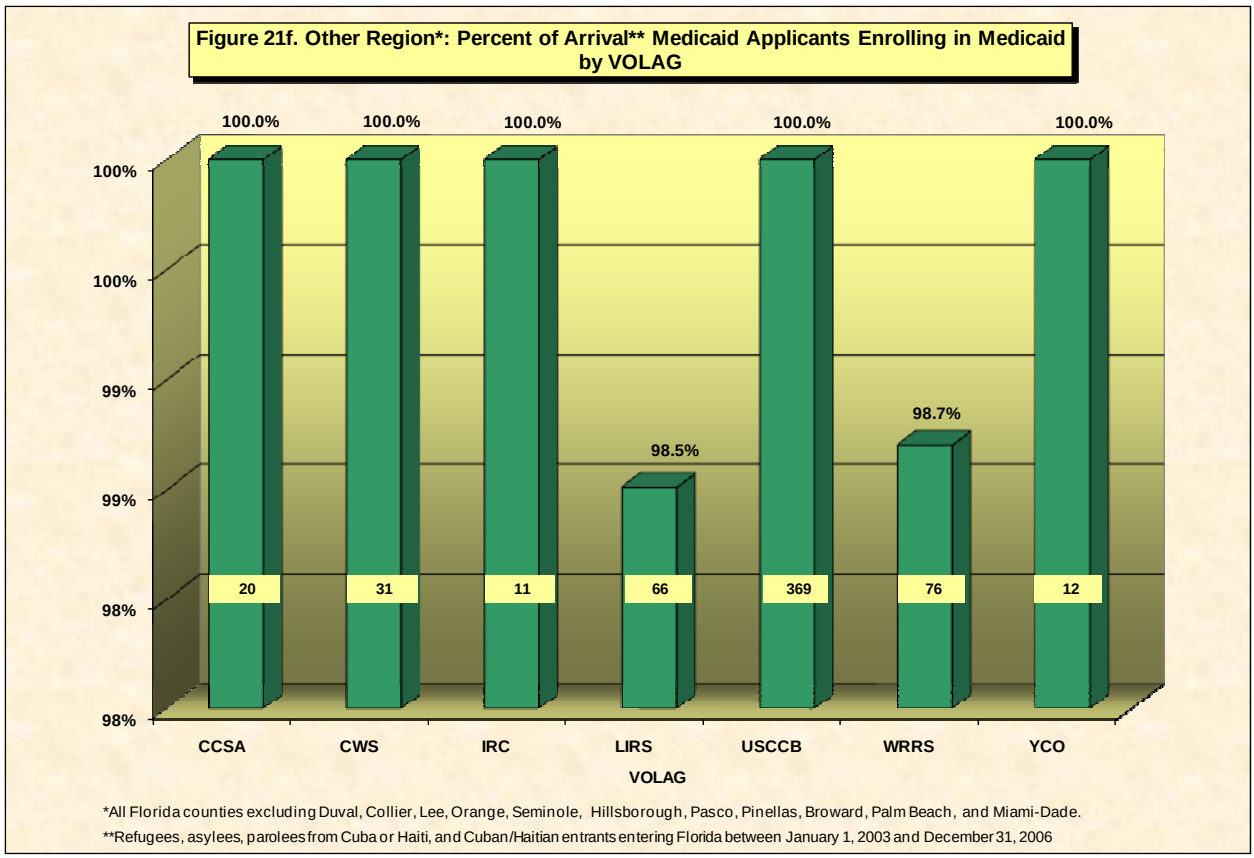


*Collier and Lee Counties
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006

Figure 21e. Tampa Bay Region*: Percent of Arrival Medicaid Applicants Enrolling in Medicaid by VOLAG**



*Hillsborough, Pasco, and Pinellas Counties
**Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006



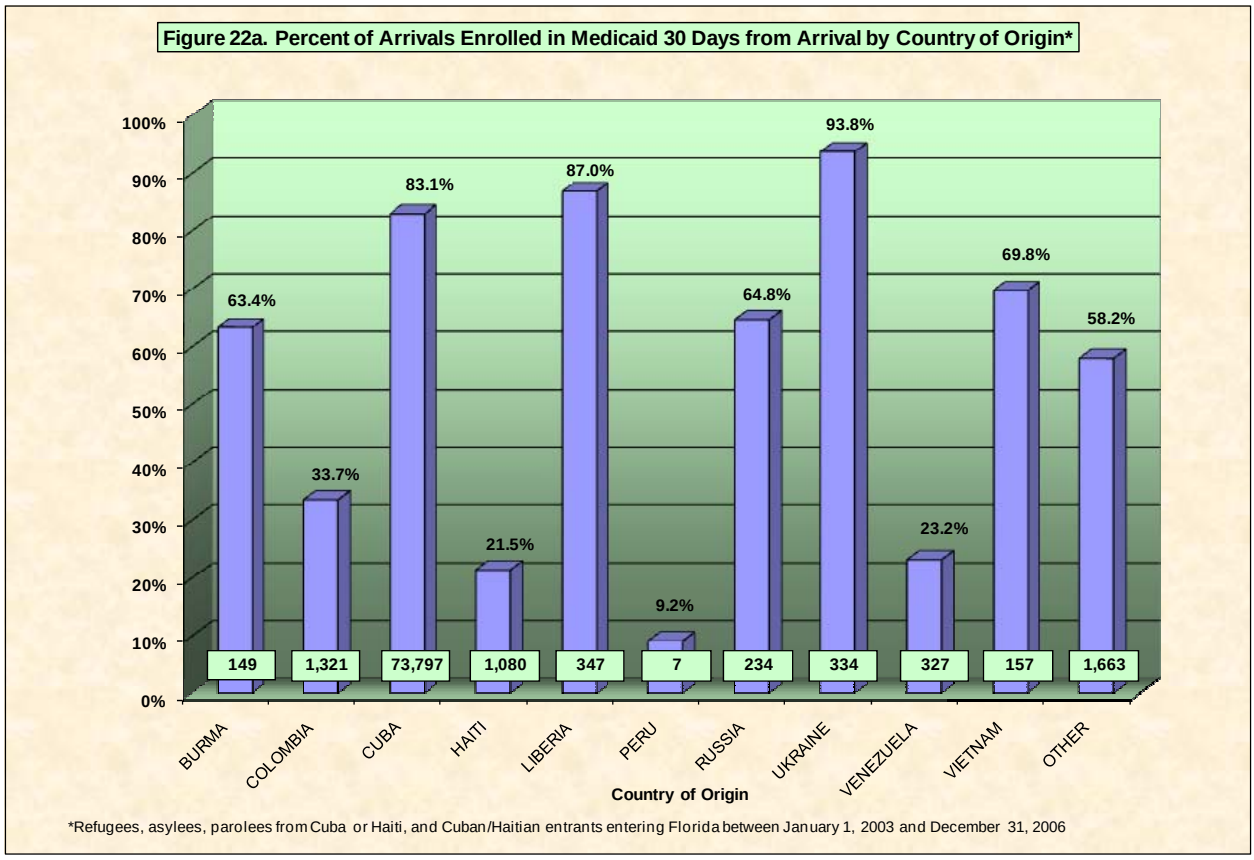
Analysis

With few exceptions, arrivals that apply for Medicaid are enrolled in Medicaid. This is an indication that VOLAG staff is knowledgeable about the Medicaid application process and follow-up as necessary when an application is denied inappropriately.

Opportunities for Intervention

None recommended.

Figure 22a:



For all parts of Figure 22, percentages are calculated based on the total number of arrivals from the country of origin that were ever enrolled in Medicaid within three years of arrival or within three years of asylum being granted as of December 31, 2008. For Florida arrivals after December 31, 2005, enrollment data for only two full years (2007 and 2008) after arrival are available.

Analysis

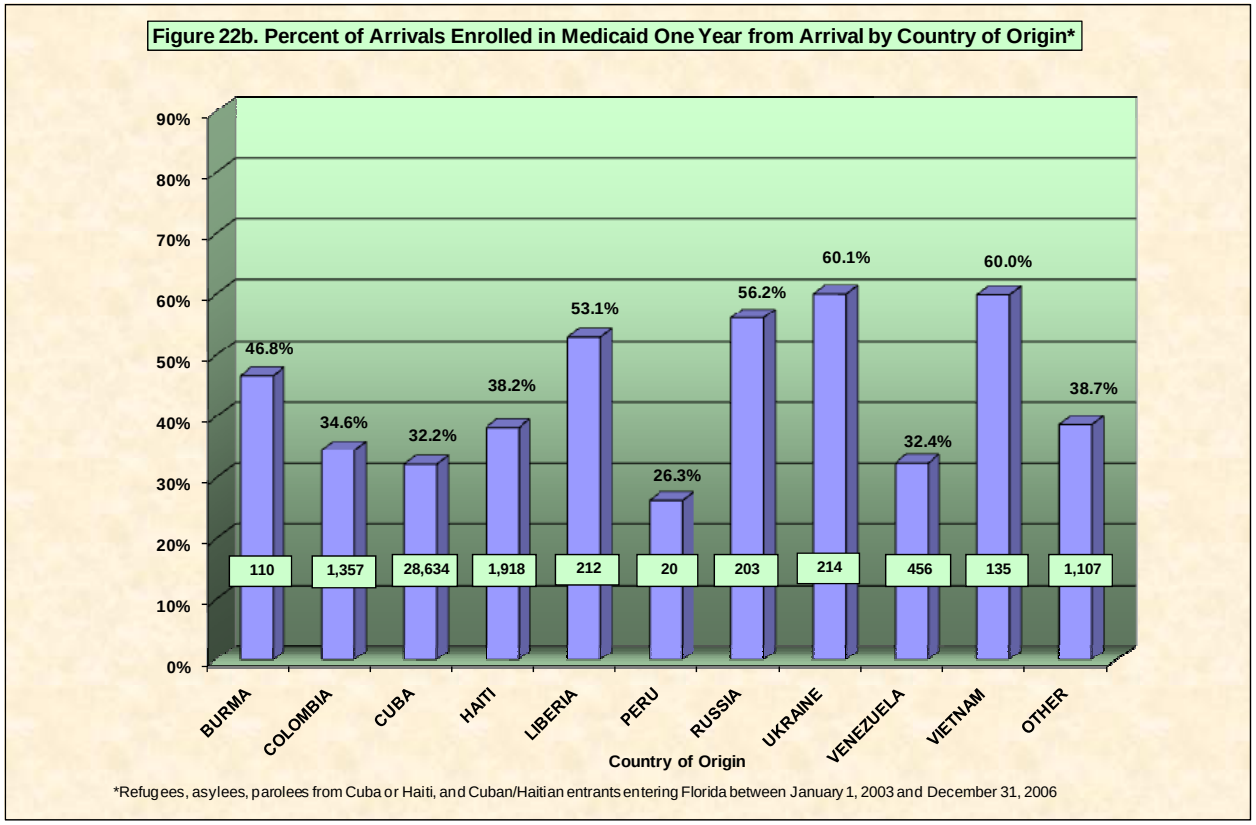
Figure 22a, depicting the percent of arrivals (who ever enrolled in Medicaid) enrolled in Medicaid within 30 days of date of arrival or date of asylum, mirrors the results in Figure 16. Arrivals from countries with a high likelihood of applying for Medicaid (over 75% applying), Ukraine, Cuba, Liberia, Russia, and Vietnam, are likely to be enrolled in Medicaid within 30 days of arrival/asylum.

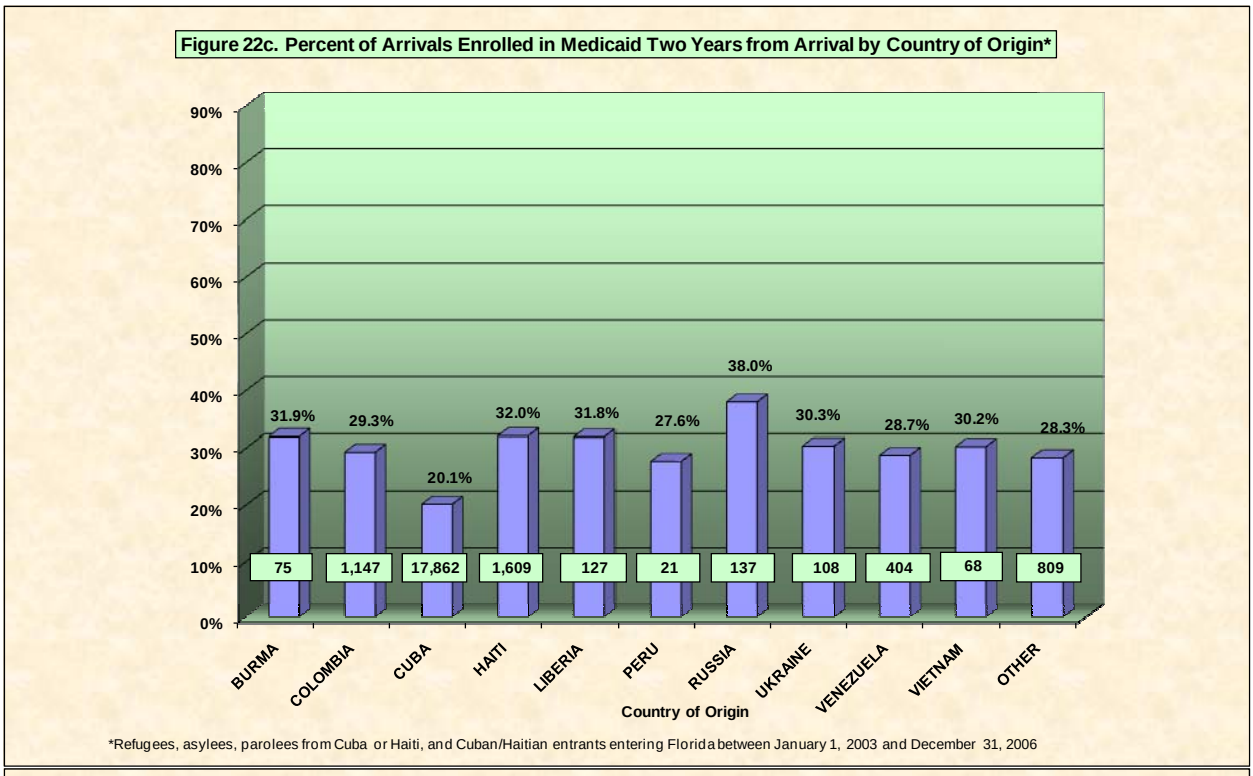
Generally, countries of origin with fewer than 65% of arrivals ever applying for Medicaid: Burma, Haiti, Colombia, Peru, and Venezuela, have low percentages enrolled in Medicaid within 30 days of arrival/asylum. The results are not proportional, however, and Burma is an exception to the rule with only 62% ever applying but 63% enrolled within 30 days of arrival. Although 63% of Peruvians eventually apply for Medicaid, only 9% are enrolled within 30 days. Only 49% of Haitians ever apply for Medicaid and 22% are enrolled within 30 days of arrival/asylum. The results are confounded by the fact that most countries with a low percent of timely enrollment in Medicaid also have a huge proportion of the arrival population as asylees (reflect back on Figure 1). The problem may be that, although asylees are entitled to health insurance benefits, by the time they are granted asylum, there are no stakeholders in the picture to help them with timely application.

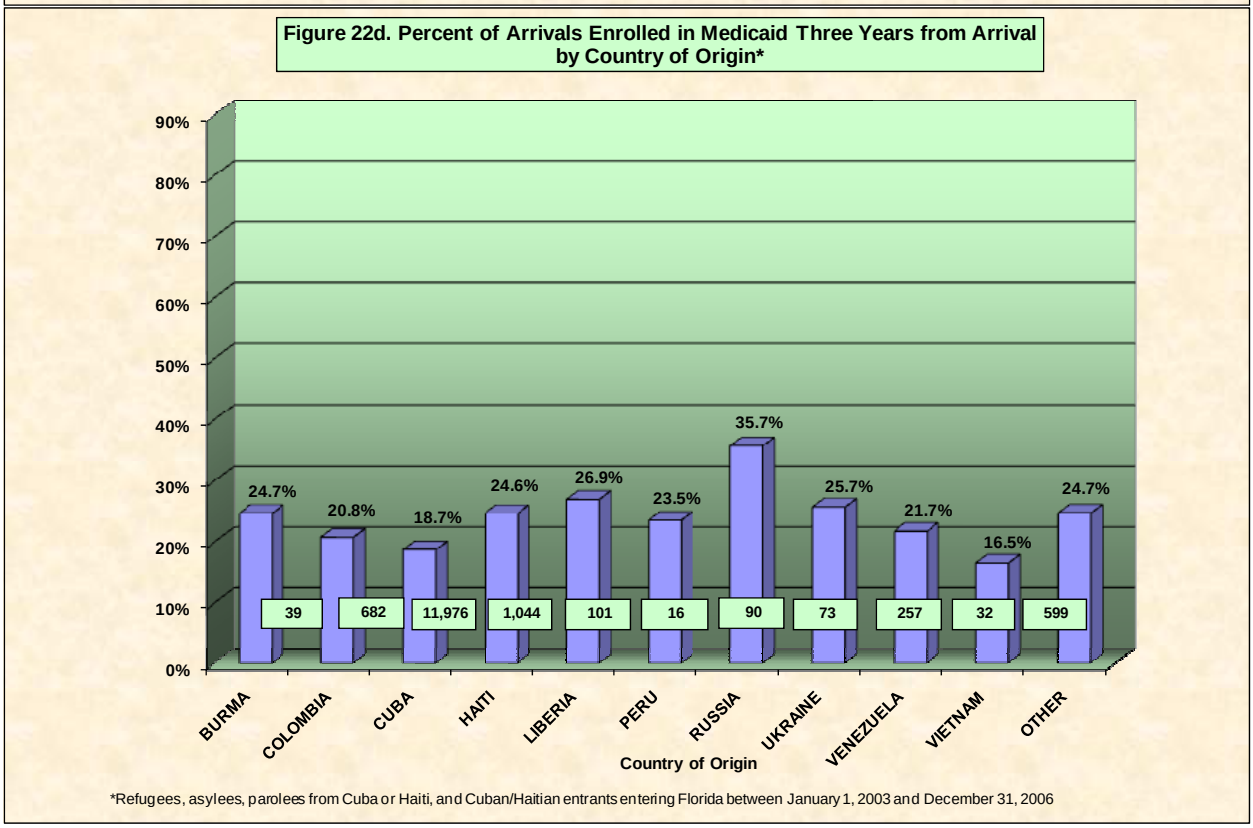
Opportunities for Intervention

An effort should be made to identify VOLAGs or areas of the state with a high success rate for timely application for Medicaid for arrivals from Haiti, Colombia, Peru, and Venezuela, and for asylees. Best practices should be identified and documented so they may be applied throughout the state.

Figures 22b through 22d:







Figures 22b through 22d examine arrival continued enrollment during the three years after date of arrival or date asylum was granted. It should be noted that, since the cohort in this evaluation entered Florida between January 1, 2003, and December 31, 2006, not all of them had been here for three years

before December 31, 2008. Data in the dataset are current through December 31, 2008. So, 2003, 2004, and 2005 arrivals do have three years' experience since eligibility date; 2006 arrivals only have two years' experience. Continued enrollment in Medicaid could indicate a continued level of poverty experienced by a refugee group and/or the fact that a higher percent of the group is children who can remain eligible even though their parents earn too much money to qualify for benefits themselves.

Since arrivals are only entitled to medical coverage through Refugee Medical Assistance for up to eight months from date of arrival, if they are still covered by Medicaid one year after date of arrival or asylum granted, they are, for the most part, covered by standard Medicaid benefits.

Analysis

At one year after date of arrival (Figure 22b), a smaller percentage of arrivals from most countries of origin are enrolled in Medicaid than had been enrolled within 30 days of arrival. A comparison of the proportion of children from a given country and the size of the drop in enrollment does not support the hypothesis that countries with a larger adult population are experiencing the largest loss in percent covered at one year (because there is a higher income threshold for continued coverage of children). Haiti, Peru, and Venezuela (all countries with a high percentage of asylees) all have a higher percent of arrivals covered by Medicaid at one year than at 30 days. Colombia, another country with many asylees, has about the same percent enrolled at one year as at 30 days. These results are consistent with late application for Medicaid for this group of arrivals.

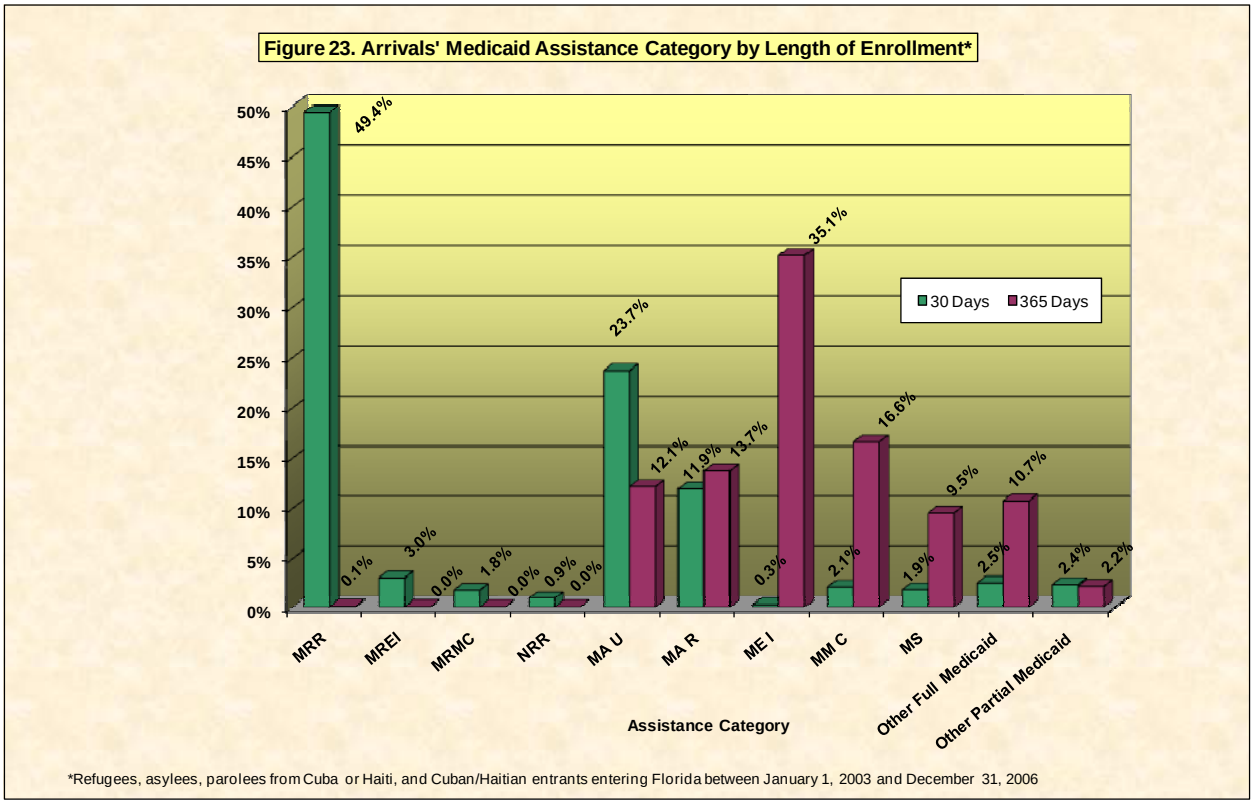
One year after arrival, more than 50% of arrivals from Liberia, Russia, Ukraine, and Vietnam who were ever covered by Medicaid, are covered. By two years after date of entry, the percentage for most countries hovers around 30%, with a low of 20%, for Cubans, and a high of 38% for Russians. By three years after arrival the percent is about 25%, with a low of 16% for Vietnamese and a high of 36% again for Russians.

Opportunities for Intervention

Optimistically, the decline in Medicaid enrollment over the years can be interpreted to mean that fewer arrivals earn low enough incomes to qualify. It can also mean that some arrivals are leaving the state of Florida and, therefore, do not show up on our Medicaid rolls.

The drop in enrollment one year after entry could indicate that arrivals are not well enough informed when their Medicaid runs out, either RMA at 8 months or straight Medicaid when renewal is required, to take the steps that are needed for continued coverage. It would be advantageous to have a person assigned to work with arrivals as their benefits end to help determine if they qualify for continued coverage.

Figure 23:



As noted above, some arrivals - children and their parents, and the disabled - can qualify for Medicaid upon entering the country. Able-bodied arrivals with no children can receive medical coverage for up to 8 months after date of entry through Refugee Medical Assistance.

Analysis

Figure 23 depicts the Medicaid Assistance categories under which arrivals in our cohort qualified for benefits thirty days and one year after coverage began. Percentages are in terms of the number of arrivals covered in the category as a percent of those covered in all categories at the interval in question. The total number covered is lower at one year than at 30 days.

Code definitions are summarized on the table below:

Medicaid Assistance Categories

Covered by Refugee Medical Assistance		Covered by Medicaid	
Code	**Definition**	**Code**	**Definition**
MRR	Direct Assistance Medical Assistance – full coverage	MAU	Medicaid for low income families (unemployed parent) – full coverage
MREI	Extended Medicaid for Earned Income – Full coverage continues for a specified time despite income increase	MAR	Medicaid for low income families (deprived child) – full coverage
MRMC	Medical coverage for children born after 9/30/83 – Full Coverage	MEI	Transitional Medicaid due to caretaker earned income – full coverage for a

Covered by Refugee Medical Assistance		Covered by Medicaid	
Code	**Definition**	**Code**	**Definition**
			limited amount of time
NRR	Direct assistance (medical non-institutional) – Limited to non-institutional care	MMC	Medicaid for children born after 9/30/83 – full coverage
		MS	SSI Medicaid for persons receiving Social Security disability benefits – full coverage

Within 30 days of obtaining Medicaid coverage, almost 85% of arrivals are classified as MRR (49%), MAU (24%), or MAR (12%). Only the 49% covered under MRR obtain medical benefits through Refugee Medical Assistance (RMA); other arrivals with classifications receiving benefits through RMA represent less than three percent of arrivals enrolled in Medicaid. Fourteen percent (14%) of covered arrivals were children covered under MAR or MMC. Only 2% of arrivals covered by Medicaid are in classifications that receive only partial benefits.

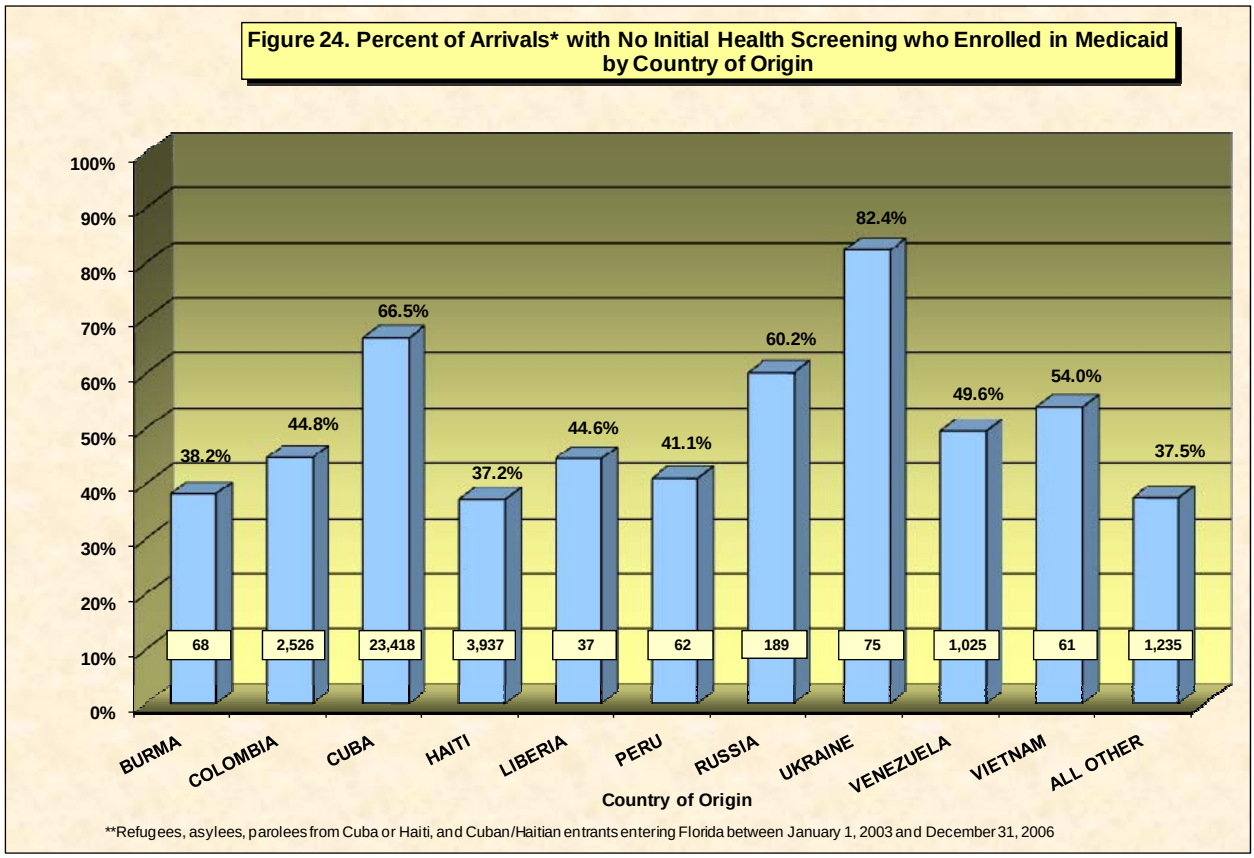
A year after initial enrollment in Medicaid, no arrivals should be classified in categories receiving benefits through RMA; and the data reflect this policy. Of arrivals enrolled in Medicaid one year after first enrollment, 98% are receiving full Medicaid benefits. Thirty-five percent (35%) have moved to MEI, transitional Medicaid, a category indicating that the enrollee exceeds the earnings criteria and is being provided coverage for a limited amount of time due to increased income; 30% are children who qualify for coverage under MAR or MMC. About 10% of arrivals are classified as MS, qualifying for Medicaid because they are receiving Social Security Disability Benefits.

The number of arrivals receiving Medicaid at one month after enrollment is 103,652 or approximately 81% of our cohort of arrivals. At one year, that number drops to 71,865 arrivals or 56% of the cohort. Approximately 30% of the adults in the cohort lose coverage over the span of the year, while only 22% of children do. What is unknown is the number of arrivals who would qualify but did not have continued coverage either because they failed to apply, were rejected in error, or had coverage dropped without proper cause.

Opportunities for Intervention

On the whole, arrivals seem to be properly classified to receive Medicaid benefits. To ensure that benefits are not terminated without proper cause, a process could be implemented so that when benefits are terminated, a health liaison at the county health department is notified at the same time as the arrival so they can investigate and offer assistance as needed for re-enrollment.

Figure 24:



Analysis

Figure 24 takes a closer look at arrivals in our cohort who did not have domestic health screenings to see how many of them were enrolled in Medicaid sometime between their date of arrival and December 31, 2008. Overall, 56% of arrivals who did not have screenings eventually find their way onto the Medicaid rolls, but there is significant variability based on country of origin. The percentage for many countries hovers around 40% (Burma, Colombia, Haiti, Liberia, and Peru), but over 80% of Ukrainians, 66% of Cubans, and 60% of Russians who did not have the screening are enrolled in Medicaid. These differences may reflect differential earning capacity of the arrival groups or it may be indicative of the level of sophistication they have about available benefits.

Opportunities for Intervention

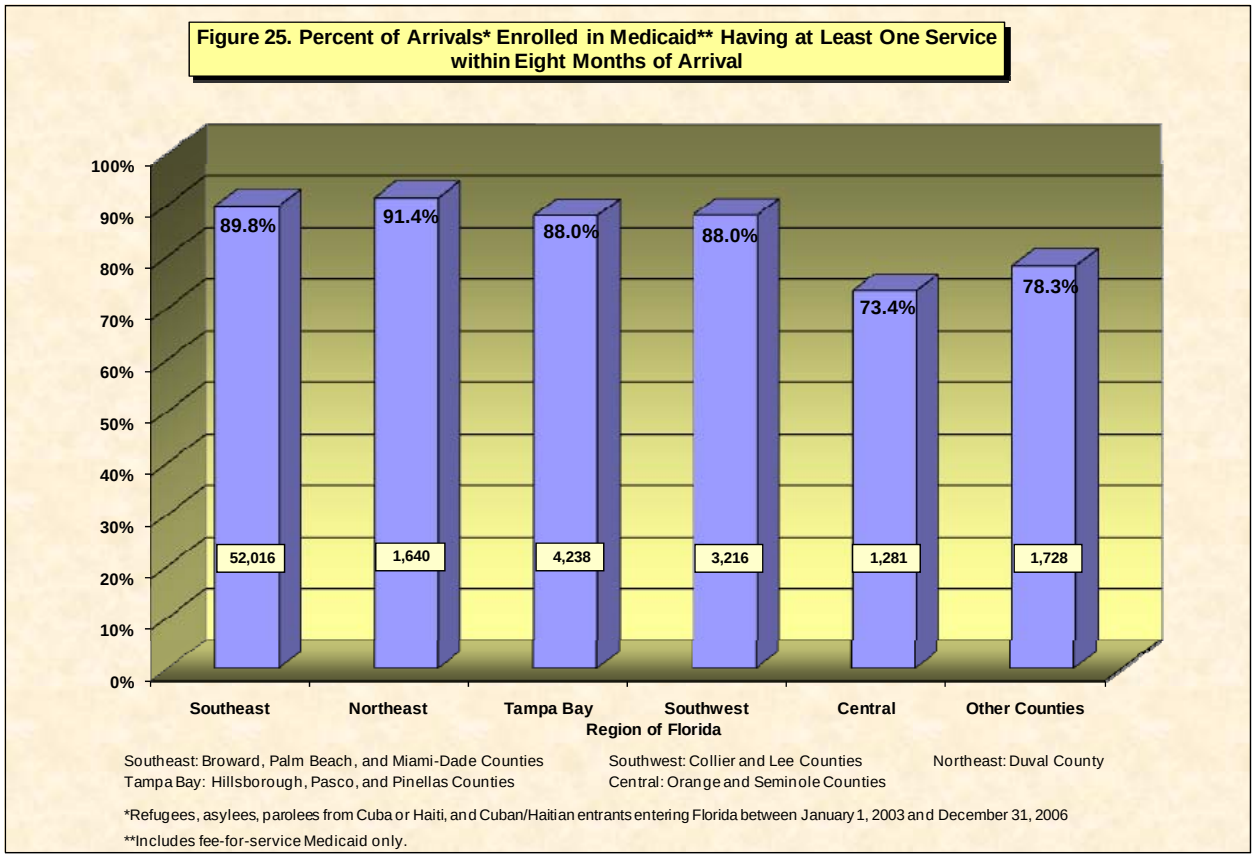
VOLAGs should be provided with tools that will help improve arrival understanding about the availability of Medicaid benefits. If the percentage of arrivals obtaining domestic health screenings can be increased through feedback to county health departments about known arrivals who have not obtained screenings, county health departments can provide education about Medicaid during the screening.

Utilization of Medical Services

Health care utilization data are derived from the approximately 39% of our cohort who were enrolled in Medicaid and received care through fee-for-service providers. We have no reason to believe that this

group of arrivals differs from the cohort as a whole in any way that would systematically affect use of healthcare services.

Figure 25:



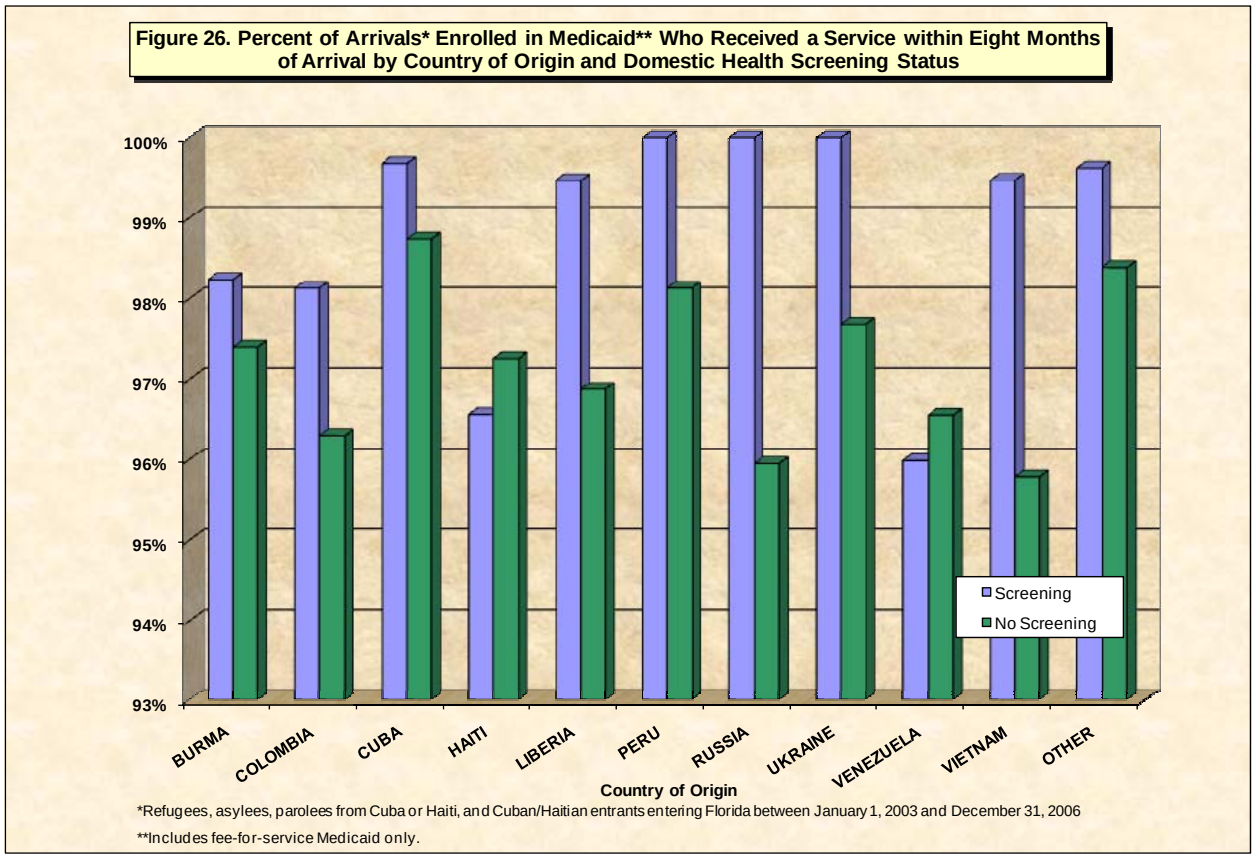
Analysis

Generally, close to 90% of arrivals enrolled in Medicaid within 8 months of entry date have at least one service within eight months of entry. In the Central Region, that figure is closer to 70%. The poorer results in this region could be a result of poorer quality education about the healthcare system or be related to the fact that this region resettles so many asylees. The asylees may be receiving advice about enrolling in Medicaid but may be unaware of the benefits it provides.

Opportunities for Intervention

It is possible that VOLAGs or anchor family members in most regions of the state are doing a fairly good job providing orientation to the healthcare system. VOLAGs in the Central Region need to be coached about providing more detailed orientation to the healthcare system, especially to asylees. Through further analysis of the data, it may be possible to identify one or more VOLAGs that are obtaining better results with respect to health care utilization, especially with asylees. Interviews with these VOLAGs may reveal some best practices, which then can be provided to VOLAGs in the Central Region.

Figure 26:



Analysis

Figure 26 compares arrivals enrolled in Medicaid within eight months of arrival who had domestic health screenings to those who did not, with respect to whether or not they received a medical service within eight months of arrival. With few exceptions, a higher percentage of most refugee groups with health screenings obtained services than arrivals from the same country who did not obtain a screening. It should be noted that this graph starts at 93%. So, most arrivals enrolled in Medicaid are receiving a service within eight months of arrival. The largest difference between arrivals receiving screenings and those who did not is for Vietnamese arrivals, a difference of just over four percentage points.

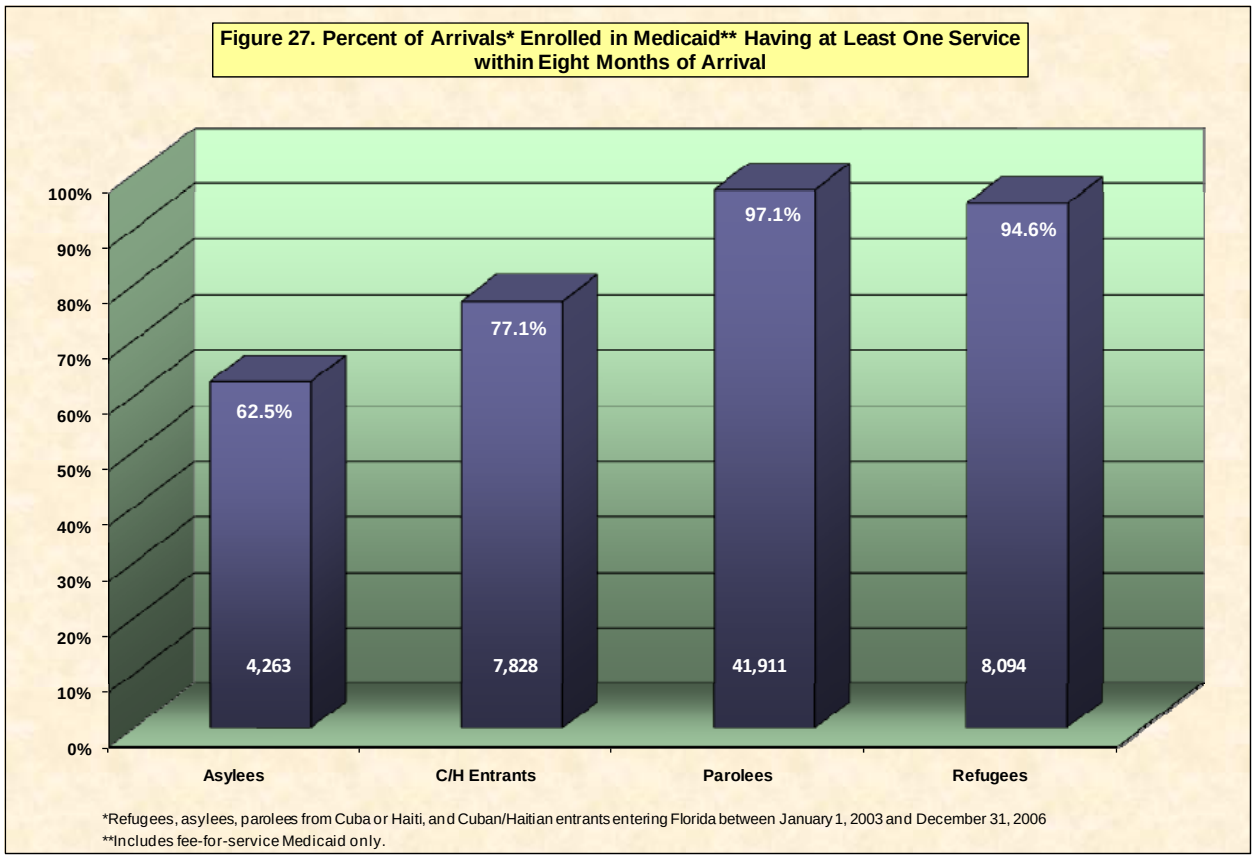
The reader might notice that the percentages on this figure are generally higher than those on Figure 25. Figure 25 displays data from the 72,500 arrivals enrolled in Medicaid within 8 months of arrival for whom data about county of resettlement are available. Figure 26 displays data for the 126,064 arrivals enrolled in Medicaid within 8 months of arrival for whom data about country of origin are available. Since a slightly different group of arrivals are included in each graph, the percentages are somewhat different. Actually, the comparison between these two graphs provides some insight into the size of data discrepancies that can be attributed to missing data.

Opportunities for Intervention

Overall, since a high percentage of arrivals are obtaining medical care, no intervention is recommended. However, if the Office can include more arrivals in the RDHAS database, and if arrivals who do not

obtain domestic health screenings can be induced to do so, the percent of arrivals getting medical care may be increased slightly.

Figure 27:



Analysis

Figure 27 shows that a high percentage (95% and above) of parolees and refugees access medical care within eight months of arrival. Only 77% of Cuban and Haitian entrants and 62% of asylees enrolled in Medicaid during that time frame do. This may be a function of the quality and timeliness of health education provided to these two groups. They seem to know enough to get enrolled in Medicaid but, once enrolled, are less likely to avail themselves of care.

Based on standard procedures, Cuban and Haitian entrants do not receive as much formal orientation to the healthcare system as do refugees and Haitian parolees.

Opportunities for Intervention

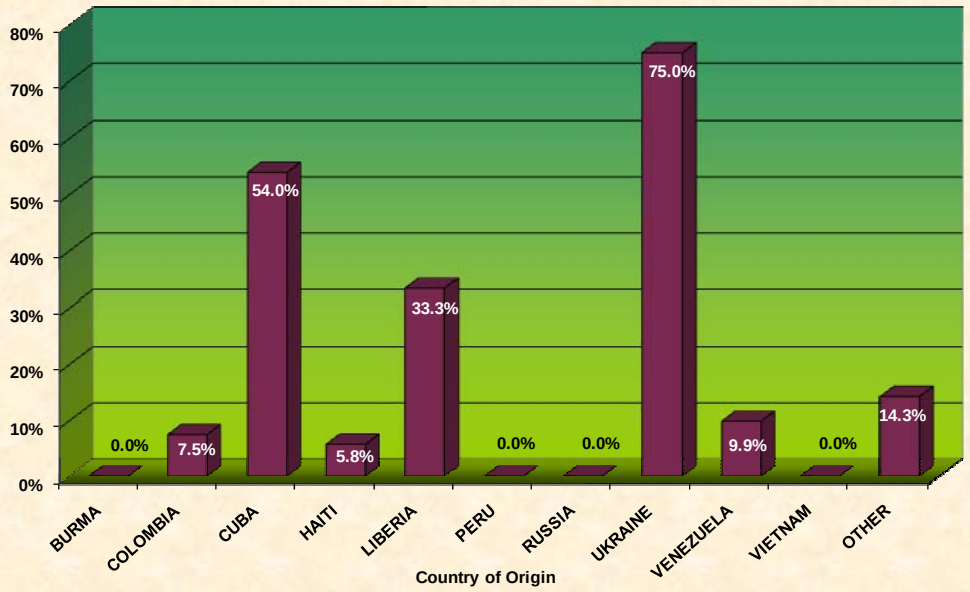
A method should be devised for local health officials to be notified when an asylee is granted asylum so they may be guided through the Medicaid application process and be provided appropriate orientation to the healthcare system.

Possibly, especially for Cuban and Haitian entrants, once an arrival becomes enrolled in Medicaid, the local health department can offer a detailed orientation to healthy choices and health care availability.

The data can be further queried to find VOLAGs whose asylees have good health care utilization results. Interviews can be conducted to identify best practices that can then be applied by other VOLAGs.

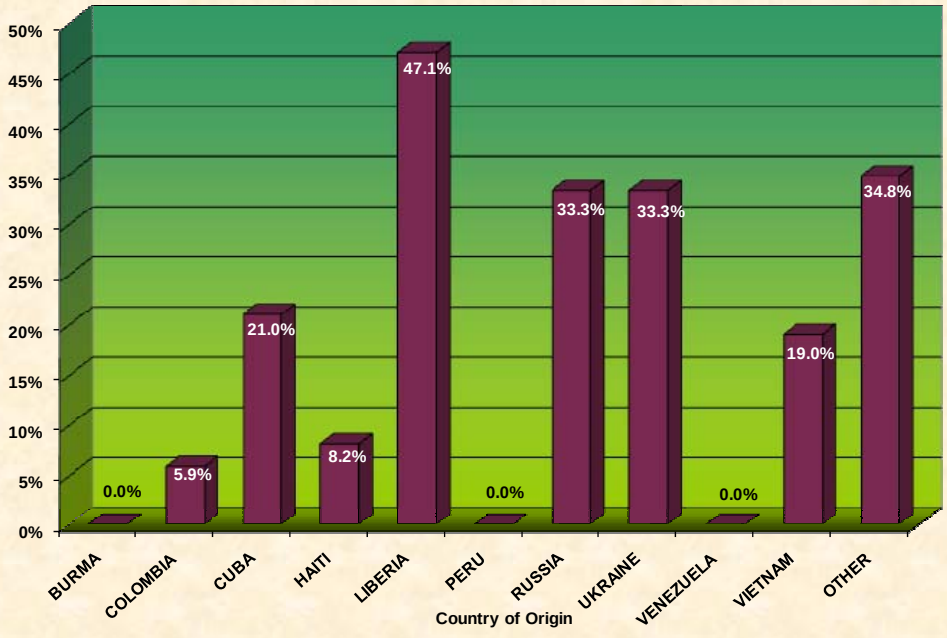
Figures 28a through 28e:

Figure 28a. Percent of Arrivals* Diagnosed with High Cholesterol Seeking Treatment by Country of Origin**



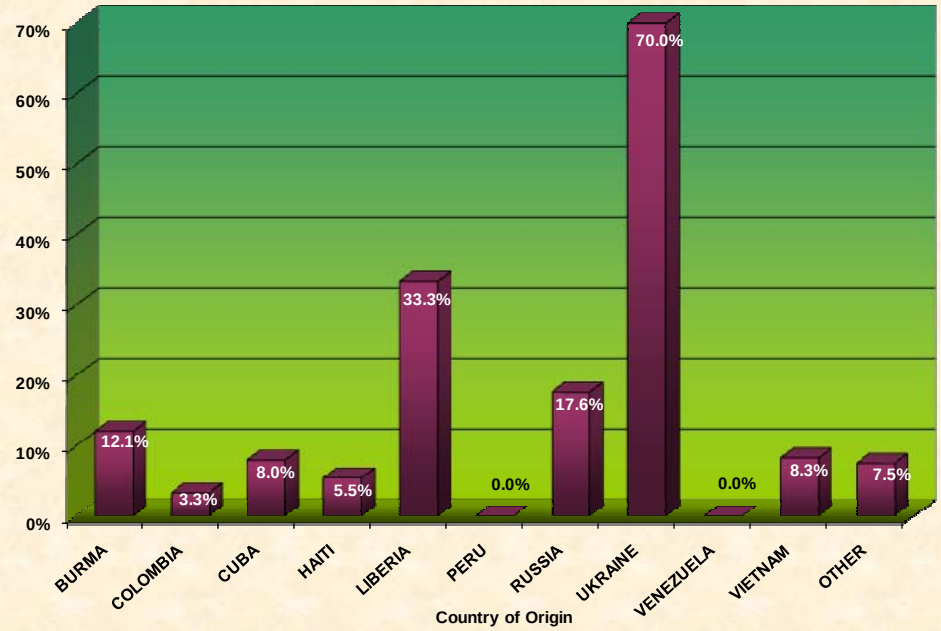
*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.

Figure 28b. Percent of Arrivals* Diagnosed with Hepatitis B Seeking Treatment by Country of Origin**



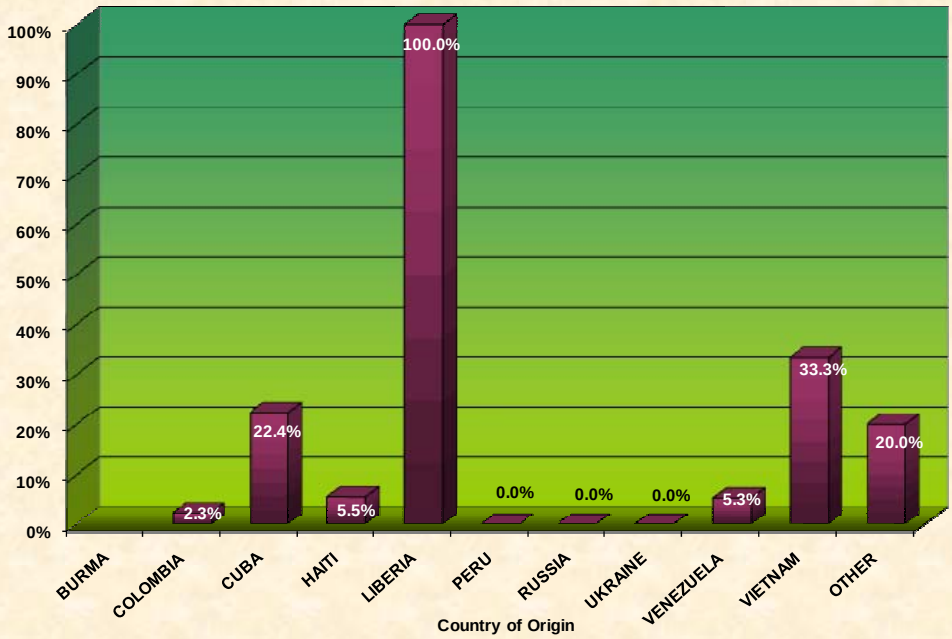
*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.

Figure 28c. Percent of Arrivals* Diagnosed with Hepatitis A Seeking Treatment by Country of Origin**

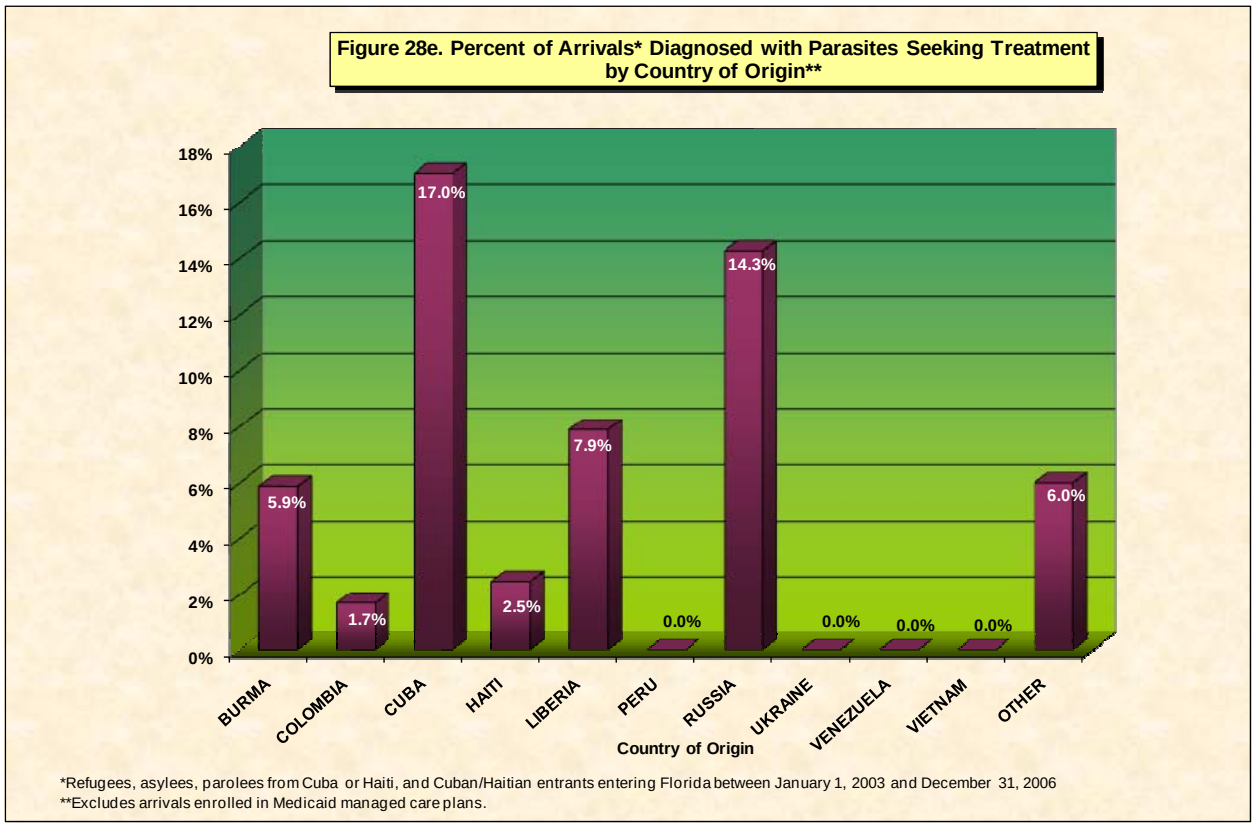


*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.

Figure 28d. Percent of Arrivals* with Urinalysis Abnormalities Seeking Treatment by Country of Origin**



*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.



Analysis

Figures 28a through 28e provide some insight about whether arrivals are seeking treatment for conditions identified during domestic health screenings (see Appendix A for a list of treatment codes). When such a condition is identified, the county health department is responsible for providing a referral for treatment to the arrival. The health departments themselves provide treatment for sexually transmitted infections and for tuberculosis. When an arrival is resettled by a VOLAG, the VOLAG is charged with ensuring that they seek treatment for identified conditions.

Before discussing the results presented in this series of figures, it is important to note that breaking down the data by arrival country of origin often results in groups of arrivals too small in number to calculate a meaningful percentage. For purposes of the discussion below, we will limit our analysis to groups of arrivals with 15 or more cases diagnosed.

In Figure 28a, meaningful percentages can be calculated for Colombians, Cubans, Haitians, and Venezuelans. Fifty-four percent (54%) of Cubans diagnosed with high cholesterol seek treatment for this condition; whereas less than 10 percent of Haitians, Colombians, and Venezuelans do. Parenthetically, a high percentage of Haitians, Colombians, and Venezuelans are asylees.

In Figure 28b, meaningful percentages can be calculated for Colombians, Cubans, Haitians, Liberians, Venezuelans and Vietnamese. For arrivals diagnosed with hepatitis B, 47% of Liberians, 21% of Cubans, and 19% of Vietnamese seek treatment. The vast majority of Colombians, Haitians, and Venezuelans go untreated.

In Figure 28c, meaningful percentages can be calculated for Burma, Colombia, Cuba, Haiti, Russia, Venezuela, and Vietnam. Overall, rates of treatment for hepatitis A are very low in arrivals from these countries. Only Burma and Russia exceed 10% but not by a lot.

In Figure 28d, meaningful percentages can be calculated for Colombia, Cuba, Haiti, and Venezuela. A low percentage of arrivals from these countries seek treatment for abnormalities in urine. Only Cuba, at 22%, exceeds 10%.

In Figure 28e, meaningful percentages can be calculated for Burma, Colombia, Cuba, Haiti, Liberia, and Venezuela. Again, only Cubans, at 17%, exceed 10% in seeking treatment for diagnosed parasites.

The first conclusion that can be made about these striking results is that, aside from diagnoses of high cholesterol, very few arrivals are seeking treatment for diagnosed conditions. Local health departments and VOLAGs (when they are providing services) are not doing their parts to ensure that individuals seek and obtain treatment. In some cases, such as for high cholesterol, parasites, and abnormal urine, lack of treatment poses a threat only to the individual's well being; in other cases, such as hepatitis A and B, lack of treatment poses a public health threat.

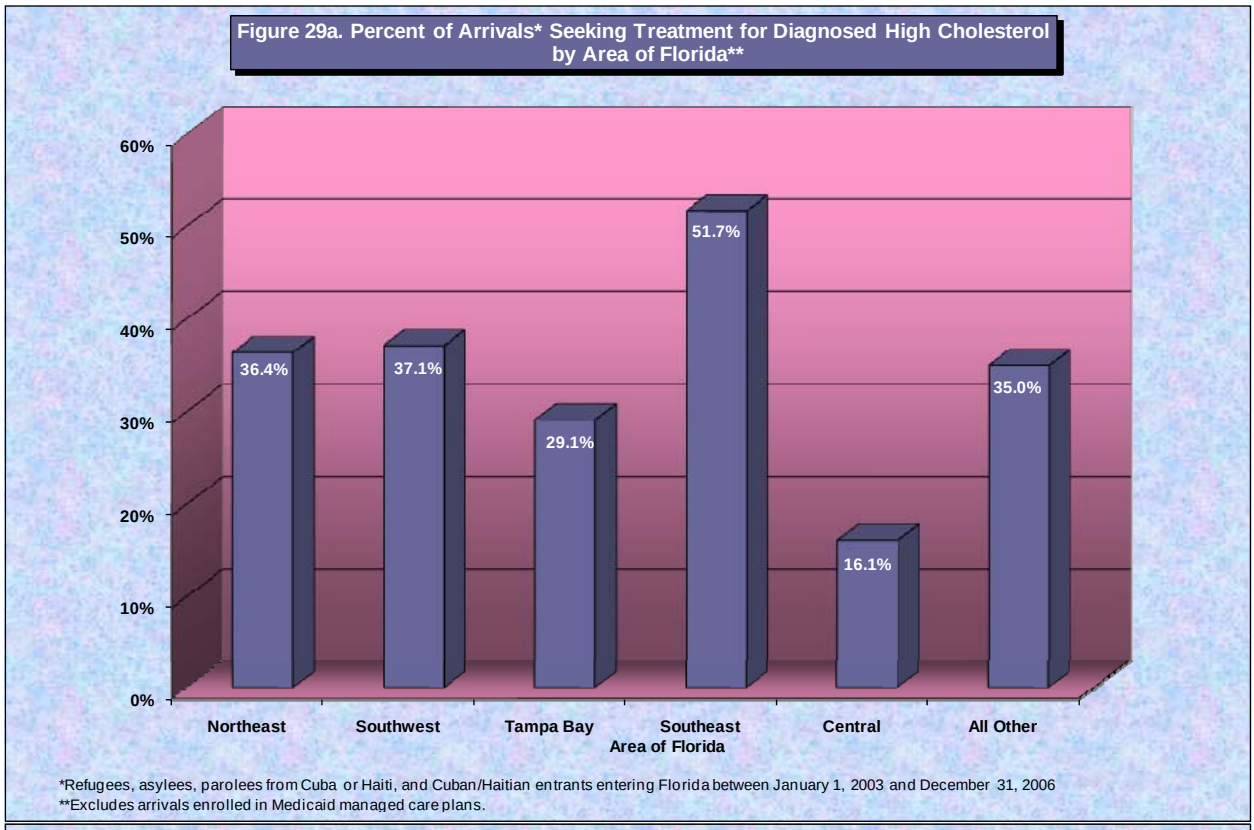
Again, it is clear that asylees are not receiving sufficient information about our healthcare system to take adequate advantage of what is available to them.

Opportunities for Intervention

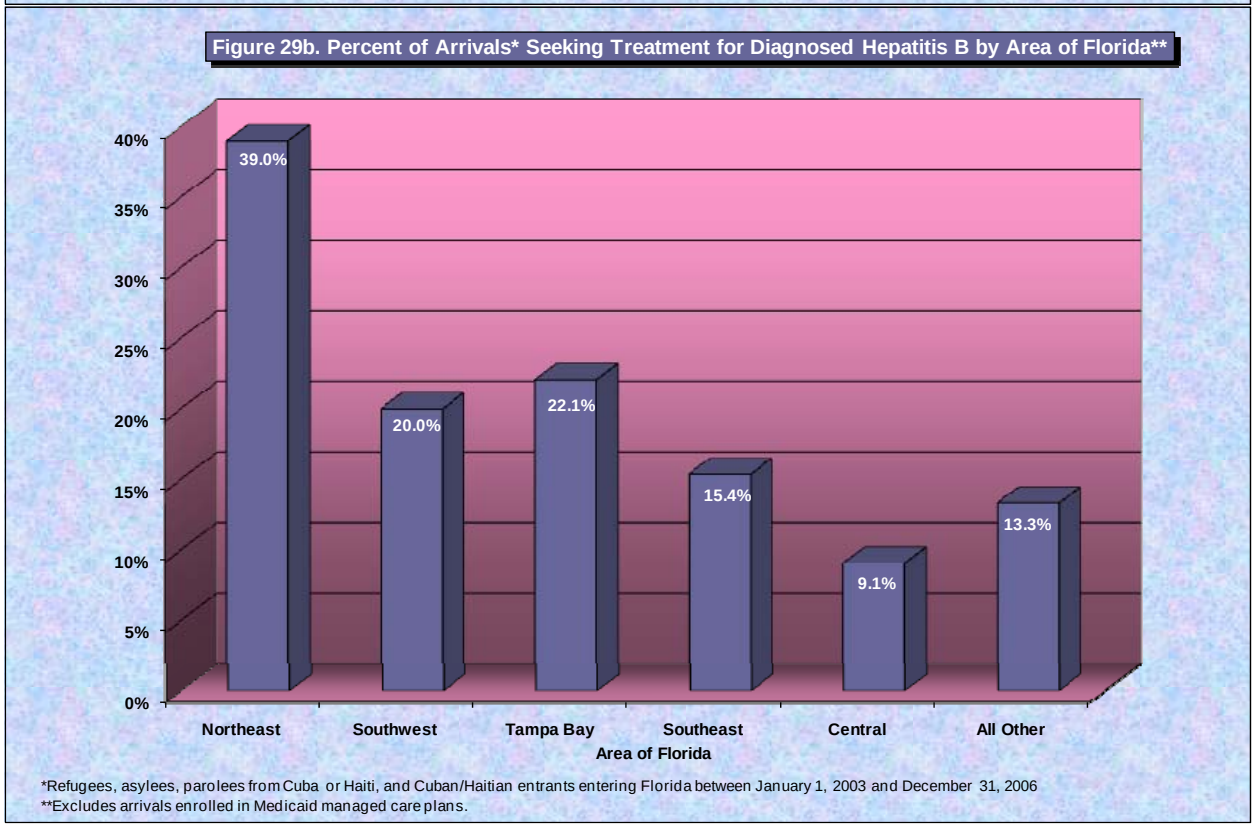
To increase the percentage of arrivals seeking treatment for diagnosed conditions, incentives need to be created to induce health departments and VOLAGs to follow up on referrals made by county health departments. This practice would improve the percentages for all arrival groups, including asylees.

Based on results reported in Figure 29 (below), it is clear that no one region of the state has a stellar record ensuring that arrivals seek treatment for diagnosed conditions. It may be possible, through further data analysis, to identify one or two health departments and/or VOLAGs with better than average records in ensuring individuals are treated for diagnosed conditions (perhaps Collier or Lee County). If best practices can be identified through interviews with health departments and VOLAGs with good results, they can be shared with other health departments. The Department of Health should develop a monitoring system through which local departments of health are required to report cases with diagnoses, referrals, and outcomes of referrals. Local health departments that do not follow through on referrals can be provided technical assistance to improve performance.

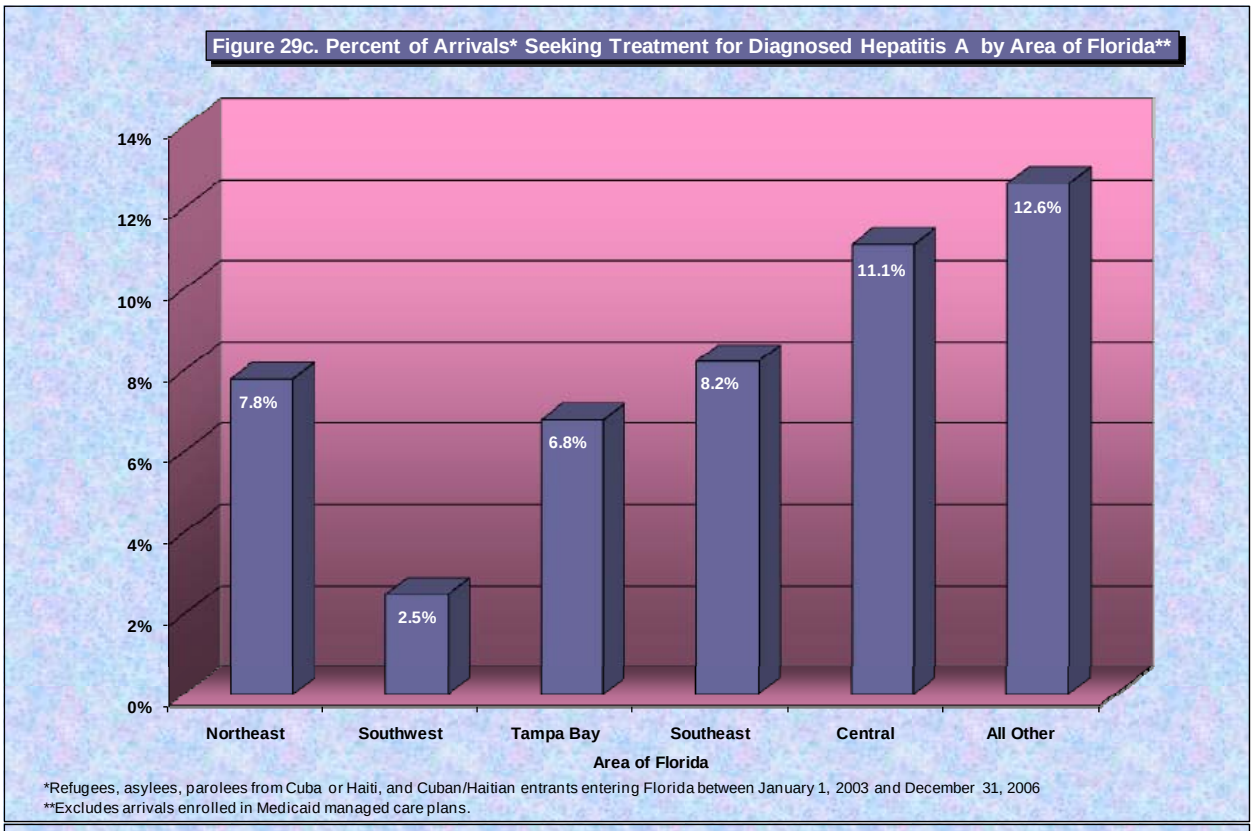
Figures 29a through 29e:



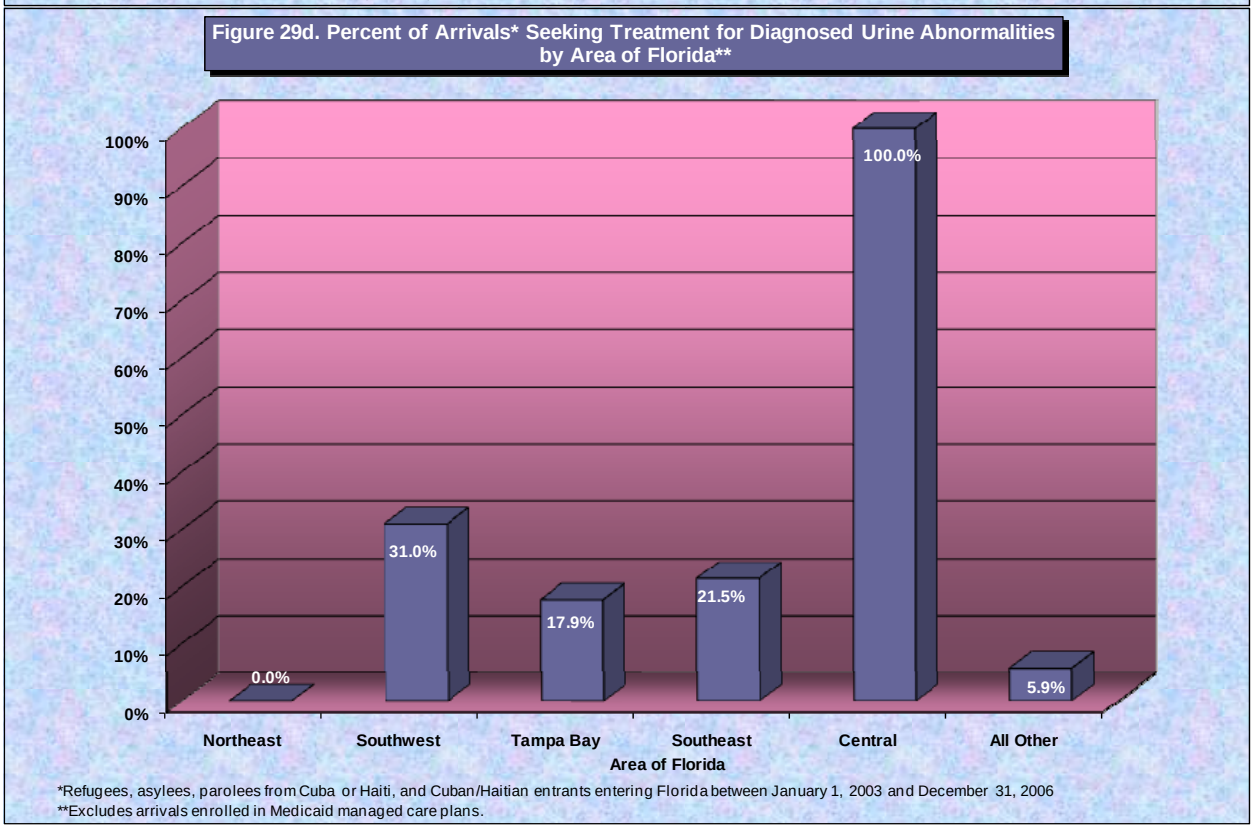
*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.



*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.



*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.



*Refugees, asylees, parolees from Cuba or Haiti, and Cuban/Haitian entrants entering Florida between January 1, 2003 and December 31, 2006
**Excludes arrivals enrolled in Medicaid managed care plans.

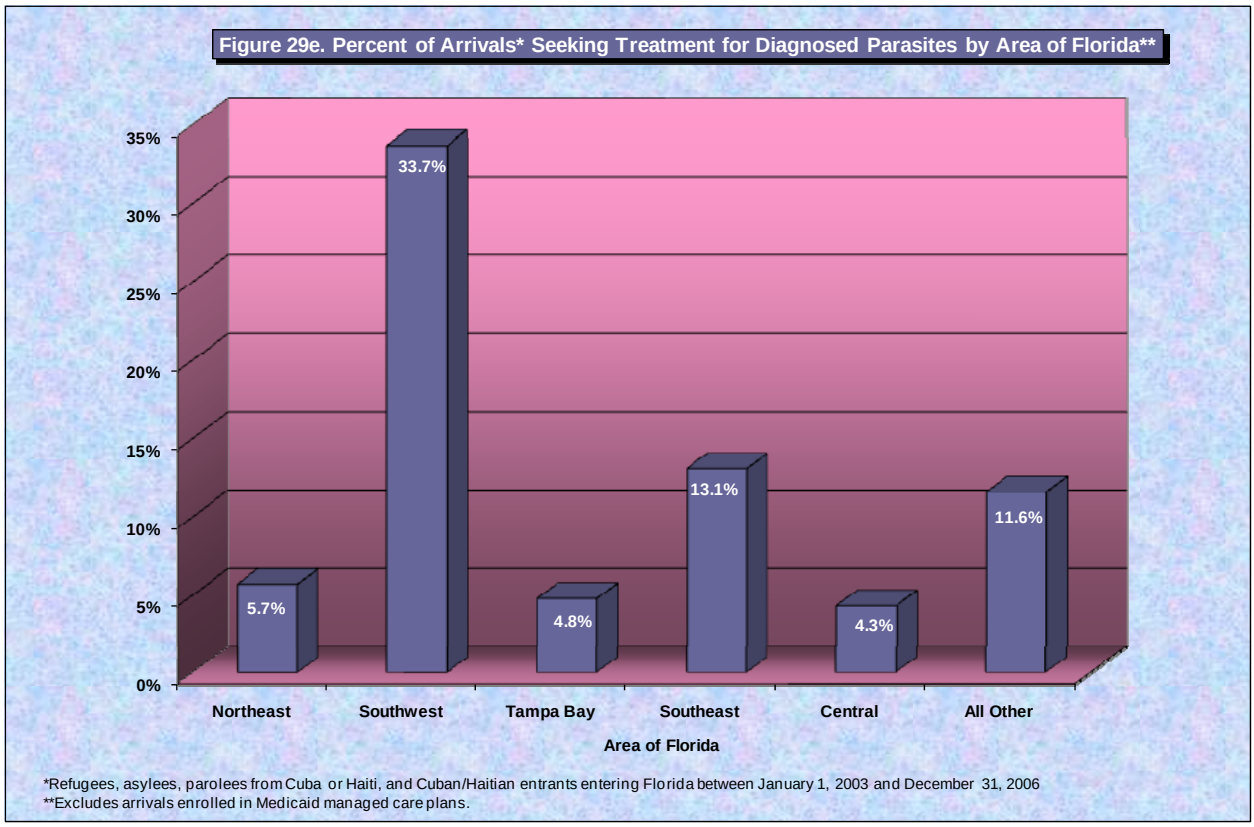


Figure 29 depicts differences in regions of the state with respect to arrivals seeking care for diagnosed conditions. Again, since often there are not many cases diagnosed for specific conditions, sometimes meaningful percentages cannot be calculated. Fifteen diagnosed cases will be used as the cut-off for analyzing percentages.

Analysis

In Figure 29a, meaningful percentages could be calculated for all regions of the state except the Northeast. The Southeast was the only region of the state where more than 50% of arrivals diagnosed with high cholesterol sought treatment for the condition.

In Figure 29b, meaningful percentages could be calculated for all regions of the state except the Central Region. Thirty-nine percent (39%) of arrivals diagnosed with hepatitis B in the Northeast sought treatment. The other regions of the state hover around 20%.

In Figure 29c, meaningful percentages could be calculated for all regions of the state. For arrivals diagnosed with hepatitis A, the Central Region, at 11%, had the highest percentage of arrivals seeking treatment.

In Figure 29d, meaningful percentages could only be calculated for the Southwest, Tampa Bay, and the Southeast Regions. Arrivals diagnosed with abnormal urine conditions are more likely to seek treatment than those diagnosed with hepatitis. The Southwest has the highest percentage (31%), followed by the Southeast (22%) and Tampa Bay (18%).

In Figure 29e, all regions had enough cases of parasites to calculate meaningful percentages. In the Southwest Region, 34% of arrivals with parasites seek treatment, almost three times greater than the Southeast at 13%. The remaining regions had treatment rates below 10%.

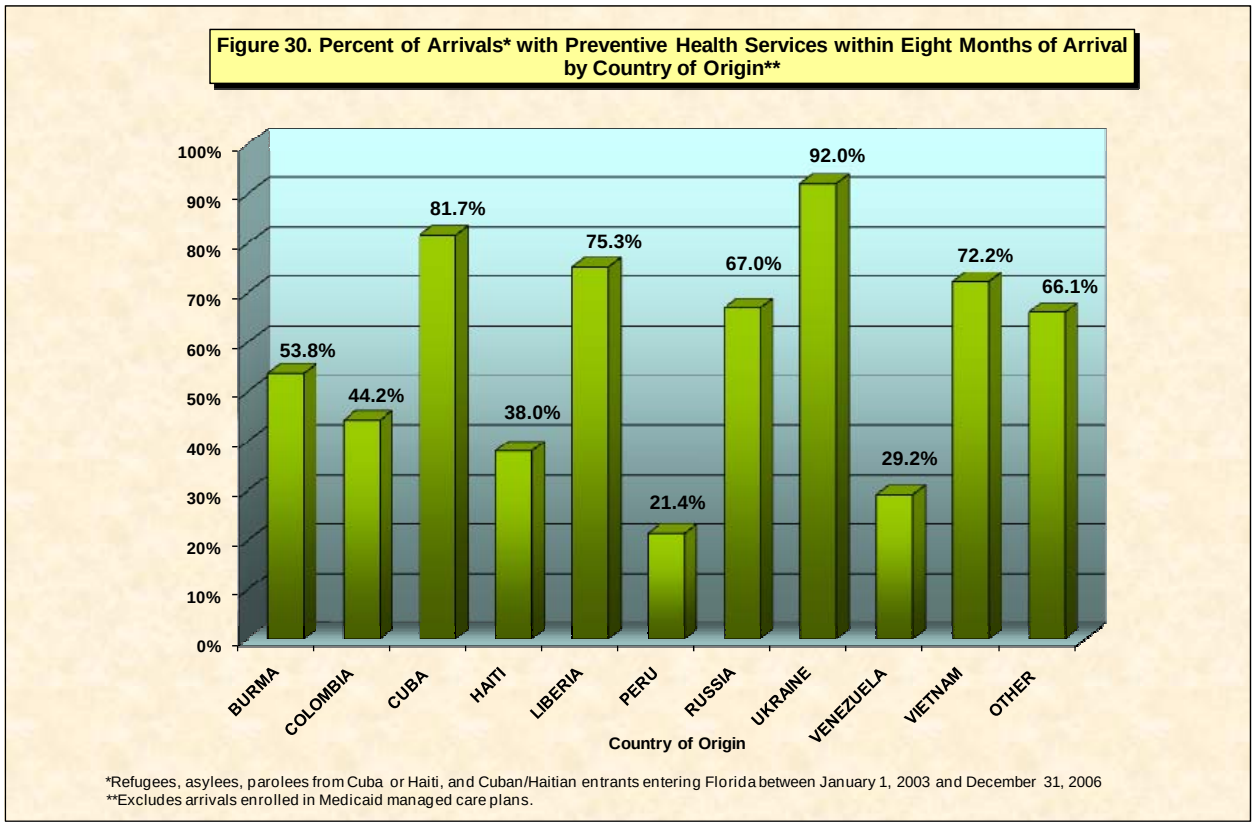
No region of the state has an outstanding record with regard to the percent of arrivals seeking treatment for identified conditions. The Southwest seems to perform a little better than the other regions; perhaps either Collier or Lee County is doing well working to ensure arrivals seek treatment.

Opportunities for Intervention

Data should be analyzed further to determine if either Collier or Lee County is doing exemplary work ensuring arrivals seek care. If so, VOLAGs and health department staff in that county should be interviewed to determine best practices that can be shared with other regions of the state.

See recommendation in Figure 28 discussion.

Figure 30:



Analysis

The utilization of preventive health care can have long term positive effects on an arrival's health status. Therefore, education about the importance of preventive health care should be a key component of arrival orientation to the healthcare system. Figure 30 displays the differences among arrival groups with respect to utilization of preventive healthcare services within eight months of date of arrival (See Appendix A for treatment codes).

More than 65% of Cuban, Liberian, Russian, Ukrainian, and Vietnamese arrivals enrolled in Medicaid receive some type of preventive healthcare service within 8 months of arrival – Ukrainians lead the

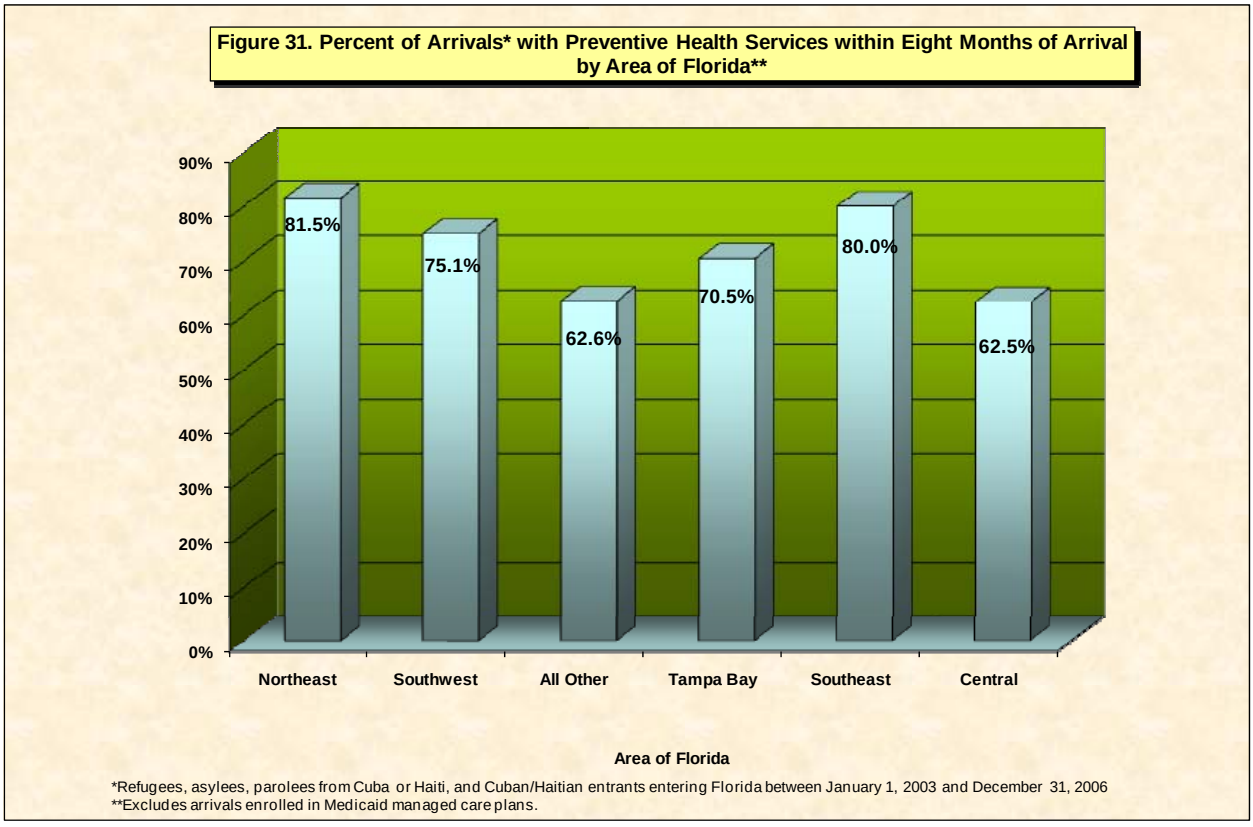
group at 92%. Arrivals from other countries are somewhat less likely to receive such services. The percentages are Burmese, 54%; Colombians, 44%; Haitians, 38%; Venezuelans, 29%, and Peruvians, 21%. Again, countries with high percentages of asylees are not making the best use of the services available to them.

Another interesting aspect of these results is the fact that, generally, a higher percentage of arrivals are seeking preventive care than are seeking treatment for diagnosed conditions.

Opportunities for Intervention

If a best practice in providing health education to asylees can be identified and implemented throughout the state, the percentages of arrivals seeking preventive health care would increase dramatically. Throughout the state, VOLAGs and county health departments can redouble their education and assistance efforts to encourage arrivals to secure a medical home and seek preventive health care.

Figure 31:



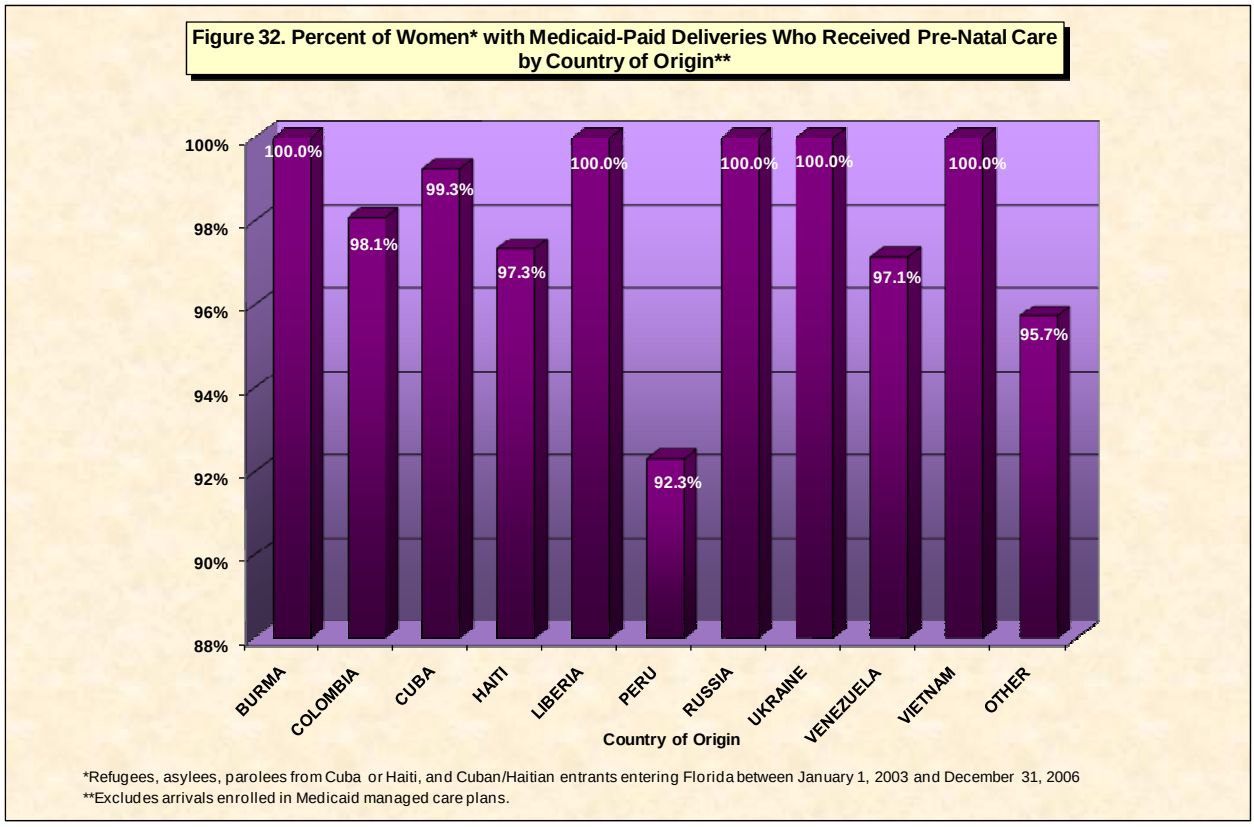
Analysis

Between 70 and 82% of arrivals enrolled in Medicaid in most regions of the state are seeking preventive health care within eight months of arrival, except in the Central Region, where the percentage is 62%. The lower figure in the Central Region could partially be due to the fact that a high percentage of arrivals in that region are asylees who are not eligible for resettlement services until they are granted asylum. Therefore, they are unlikely to receive adequate orientation to the healthcare system.

Opportunities for Intervention

See recommendations for Figure 30. Since the Southeast, where 80% of arrivals receive preventive health care, and the Northeast Region, where 82% of arrivals receive preventive health care, are getting the best results, the health education methodology in those regions should be examined to identify best practices that can be shared throughout the state.

Figure 32:



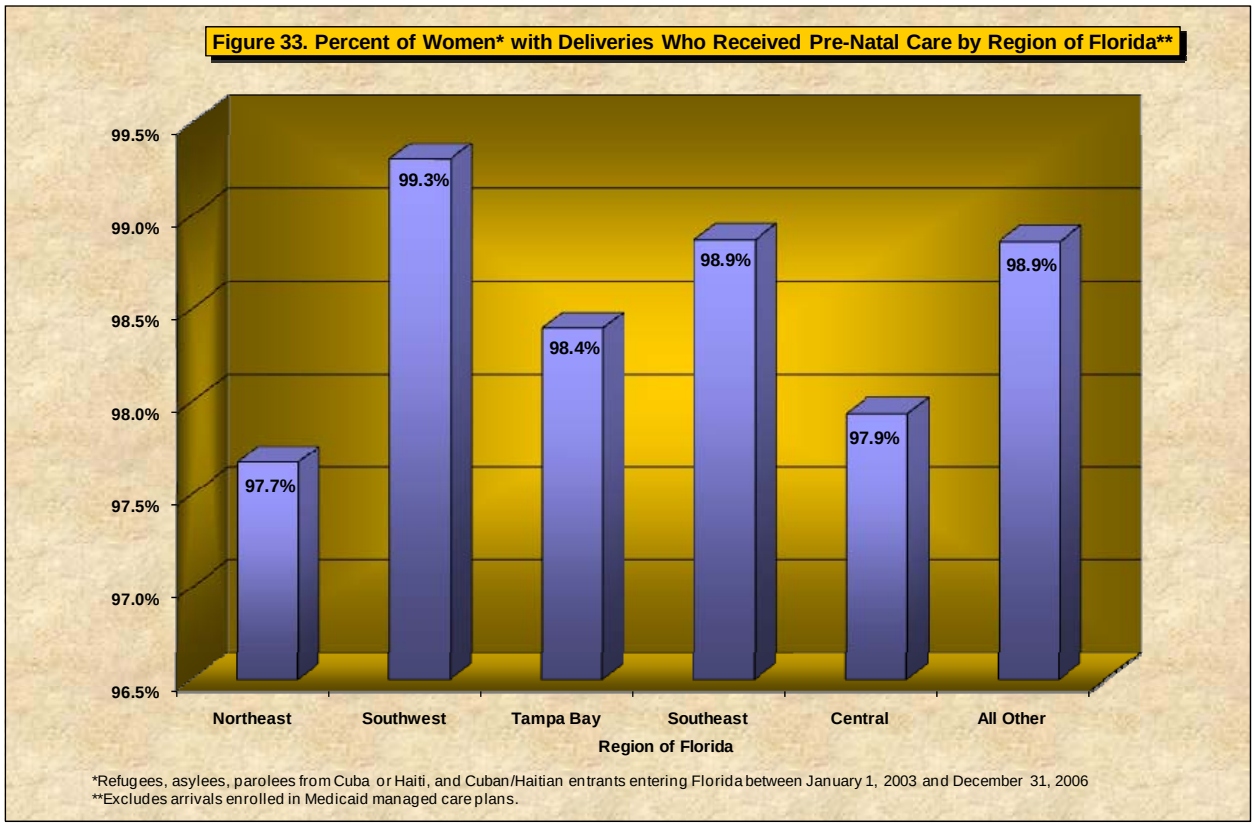
Analysis

Figure 32 shows that regardless of the country of origin, most women are receiving some prenatal care before they deliver babies. Unfortunately, we have no way of knowing when prenatal care began to determine if the prenatal care was adequate.

Opportunities for Intervention

None recommended.

Figure 33:



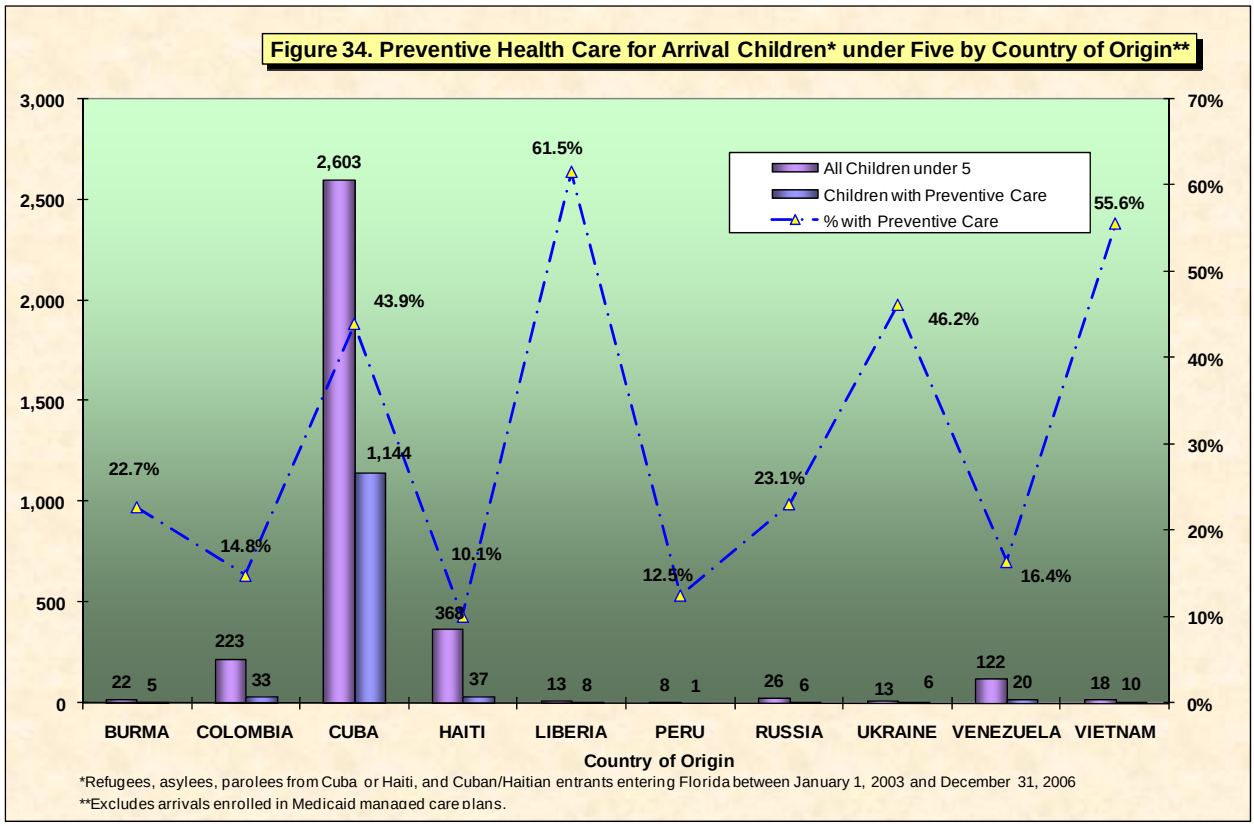
Analysis

There are no dramatic differences in the percent of women receiving some type of prenatal care by region of the state.

Opportunities for Intervention

None recommended.

Figure 34:



Analysis

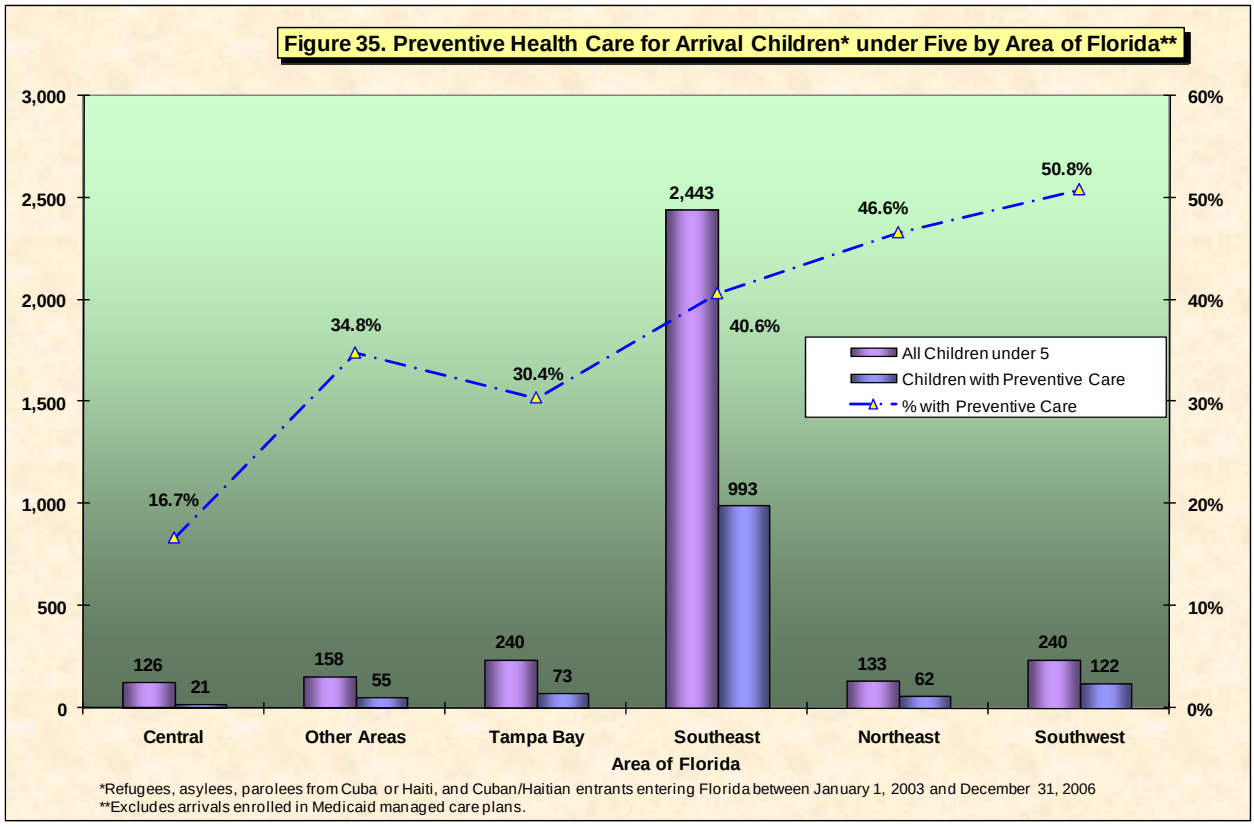
Figure 34 depicts utilization of preventive health care for children under 5 by country of origin (see Appendix A for procedure codes). Overall, approximately 35% of child arrivals in our cohort received some type of preventive care that has been reimbursed by Medicaid. As a benchmark, Perry and Kenney (2007) report that, based on the 2001, 2002, and 2003 Medical Expenditure Panel Surveys, 41% of children with continuous Medicaid or SCHIP coverage had a preventive visit in the past 12 months. The percentage of arrival children with some type of preventive health care varies considerably by country of origin. On the high end, 62% of the 13 Liberian children, 56% of the 18 Vietnamese children, 46% of the 13 Ukrainian children, and 44% of the 2,603 Cuban children received such care. On the low end, 12% of the 8 Peruvian children, 10% of the 368 Haitian children, 15% of the 223 Colombian children, 16% of the 122 Venezuelan children, 23% of the 26 Russian children, and 23% of the 22 Burmese children received preventive care.

Overall, the percentage of arrival children that receive preventive health care is much lower than the percentage of the arrival population as a whole (see Figures 30 and 31). This difference between children and the refugee population as a whole might be attributable to the specific list of treatment codes used for children and, therefore, an artifact. However, if one looks for patterns based on country of origin, similar patterns are observed for children and total populations with respect to country of origin. So, country of origin seems to be systematically related to utilization of preventive care.

Opportunities for Intervention

To optimize arrival health, the new arrivals must receive more effective education about health care available to them and the advisability of using it. Arrivals from some countries of origin may have more of a predisposition to use preventive care, but all must be encouraged to do so. Health education should probably be provided in stages after arrival to have a maximum impact.

Figure 35:



Analysis

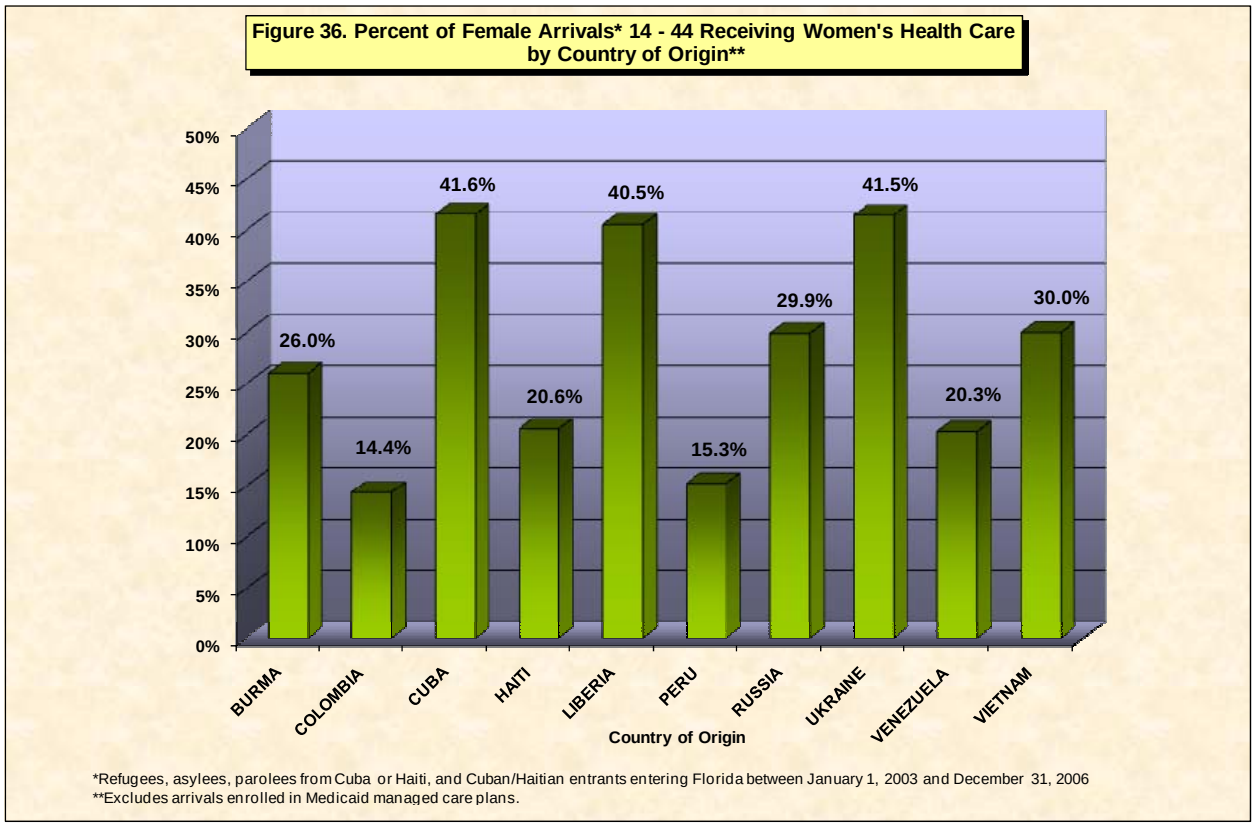
Figure 35 shows there is great variability by region of the state with respect to children receiving preventive care. The Northeast and Southwest Regions are most successful (47% and 51% respectively) in encouraging their arriving parents to seek preventive care for their children. Again, the Central Region is getting the poorest results (17%).

Opportunities for Intervention

The health education programs in the Northeast and Southwest Regions should be examined through interviews with VOLAGs and health departments, and perhaps through observation, to document best practices for dissemination to other regions of the state.

Because the Central Region obtains such poor results, which may be related to the fact that it resettles so many asylees, an additional strategy may be required to reach out to asylees at the time asylum is granted to provide individualized mentoring about the healthcare system and the benefits of utilizing it to the fullest.

Figure 36:



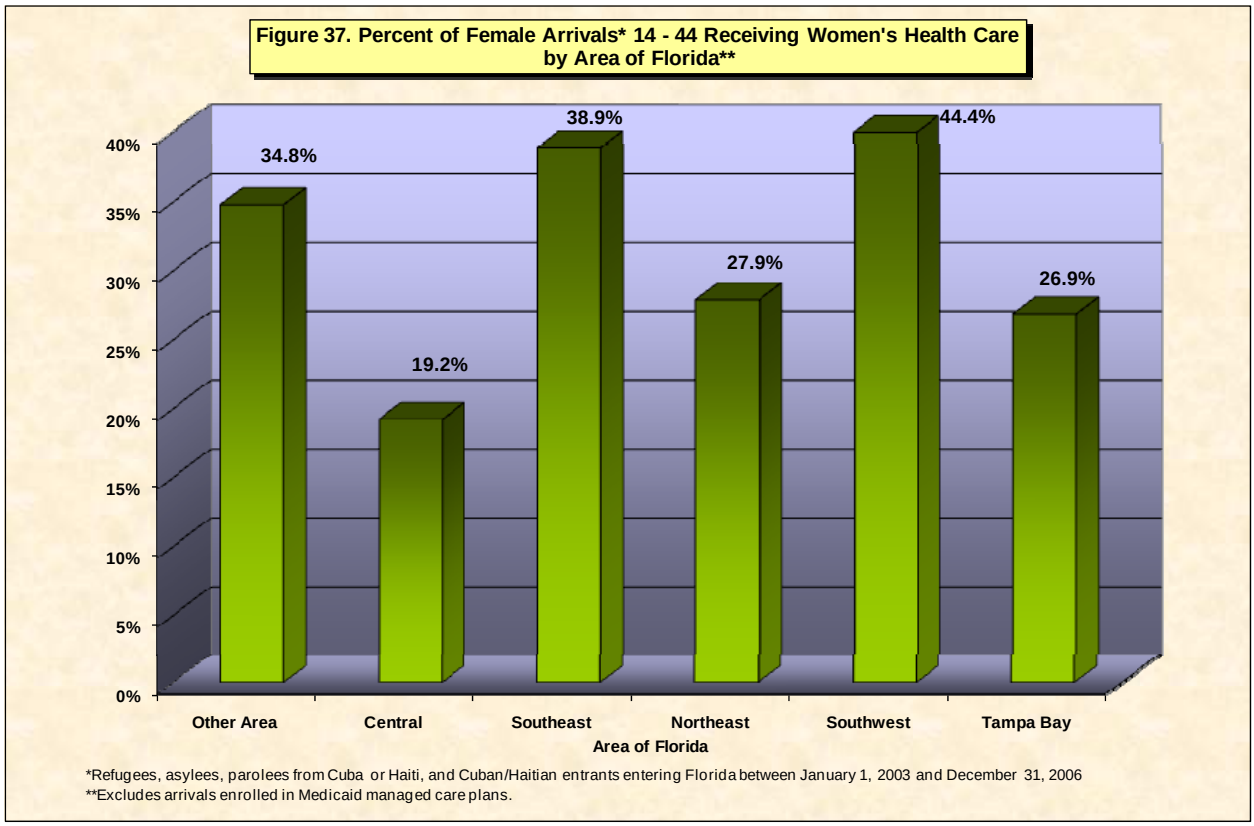
Analysis

Over 40% of Cuban, Liberian, and Ukrainian women between 14 and 44 received some type of women's health care (see Appendix A for ICD-9 and CPT codes). Percentages for women from other countries are below 30%. Haitians (21%), Colombians, (14%), Venezuelans (20%), and Peruvians (15%) are the least likely to have such care. This result again highlights possible poor health education for asylees because all of these countries (and Burma with 26% of women receiving such care) have a high proportion of asylees. In addition, women that are not utilizing health care may not have the expectation that they can and should access the available care.

Opportunities for Intervention

These results might be improved if an outreach program is developed to contact and educate asylees at the time asylum is granted. See Figure 35.

Figure 37:



Analysis

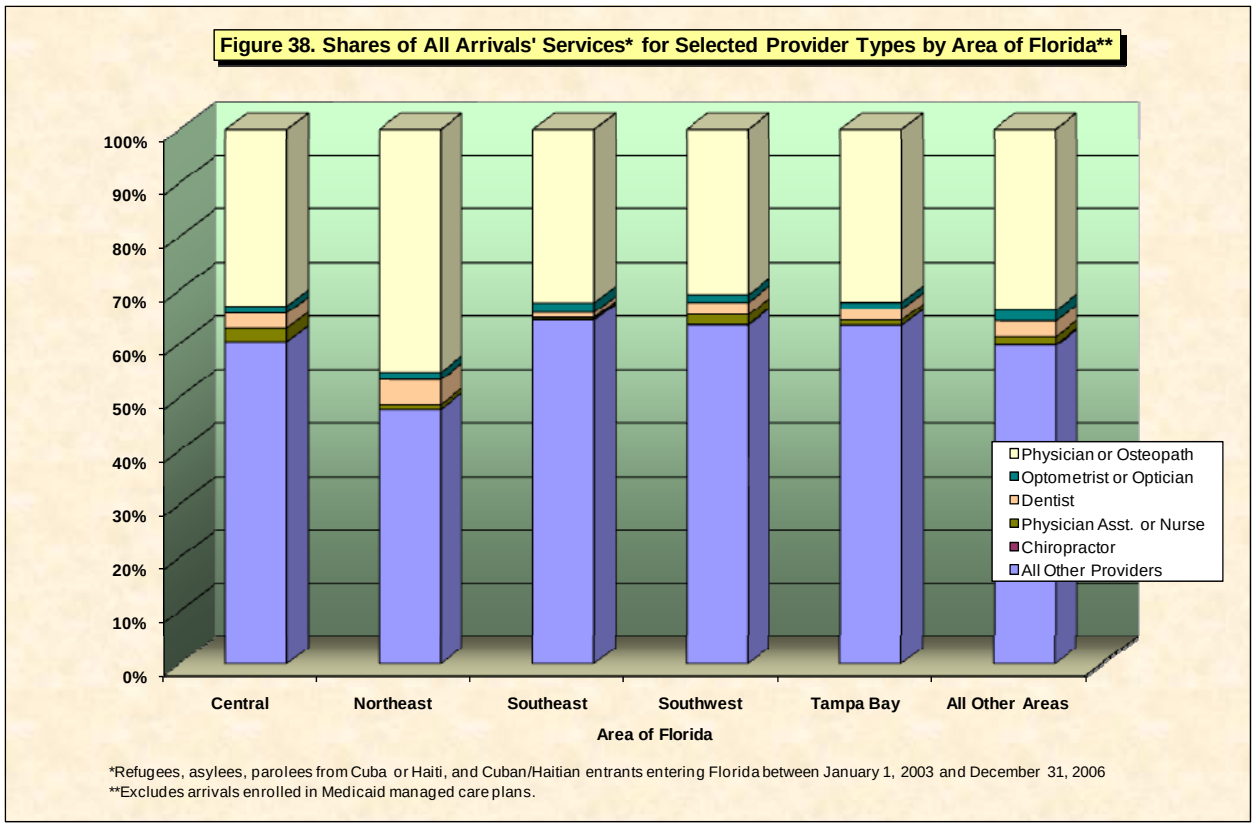
Figure 37 shows that there are considerable differences by region of the state with respect to women 14-44 receiving women's health care. This time, the Southeast and the Southwest Regions are getting the best results (39% and 44% respectively). Again, the Central Region has the worst results at 19%.

Opportunities for Intervention

In-depth interviews with VOLAGs and county health department staff in the Southeast and the Southwest Regions of the state may reveal practices that can be implemented in other regions.

Providers

Figure 38:



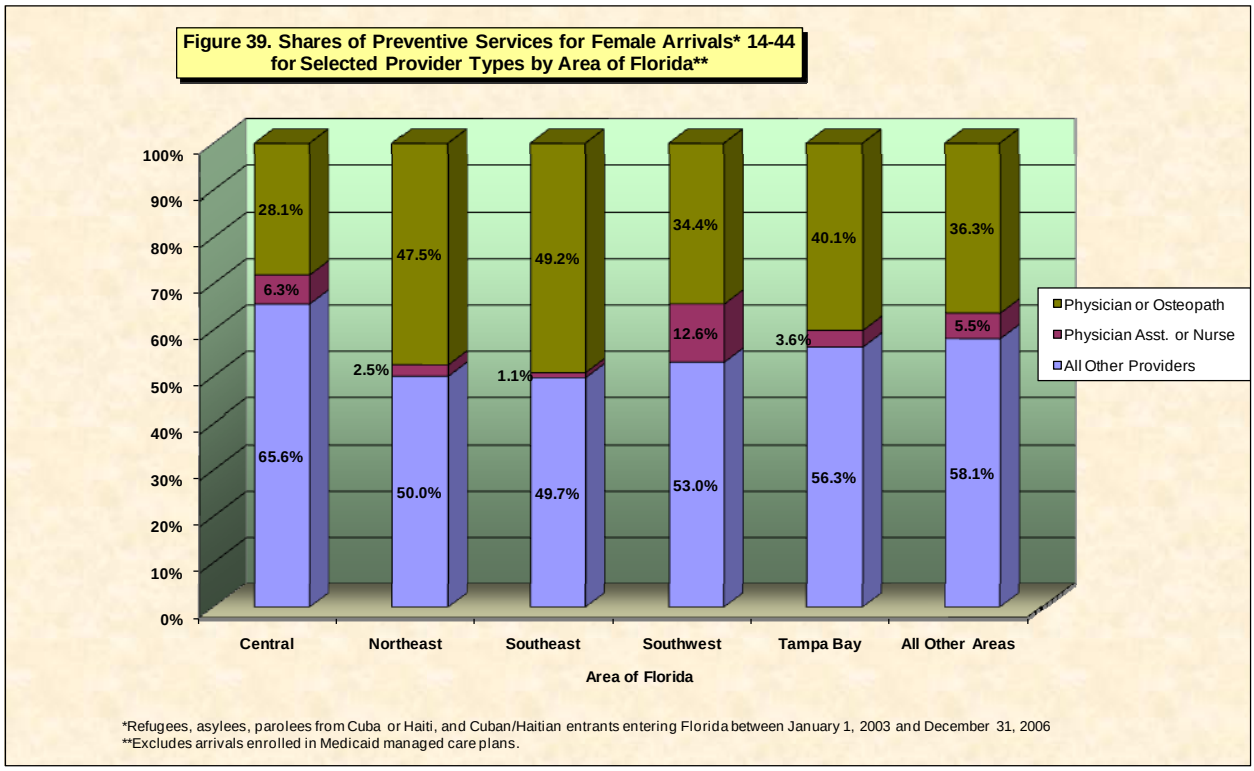
Analysis

A somewhat consistent pattern of provider types providing medical services to arrivals emerges across all regions of the state. In most regions (other than all other providers who provide 60% of services) around 30% of all services are provided by physicians and osteopaths with a many fewer services provided by dentists, physician assistants or nurses, and optometrists or opticians. In the Northeast Region, the pattern is slightly different: 48% of services are provided by all other providers while physicians and osteopaths provide 45% of the services.

Opportunities for Intervention

None recommended.

Figure 39:



Analysis

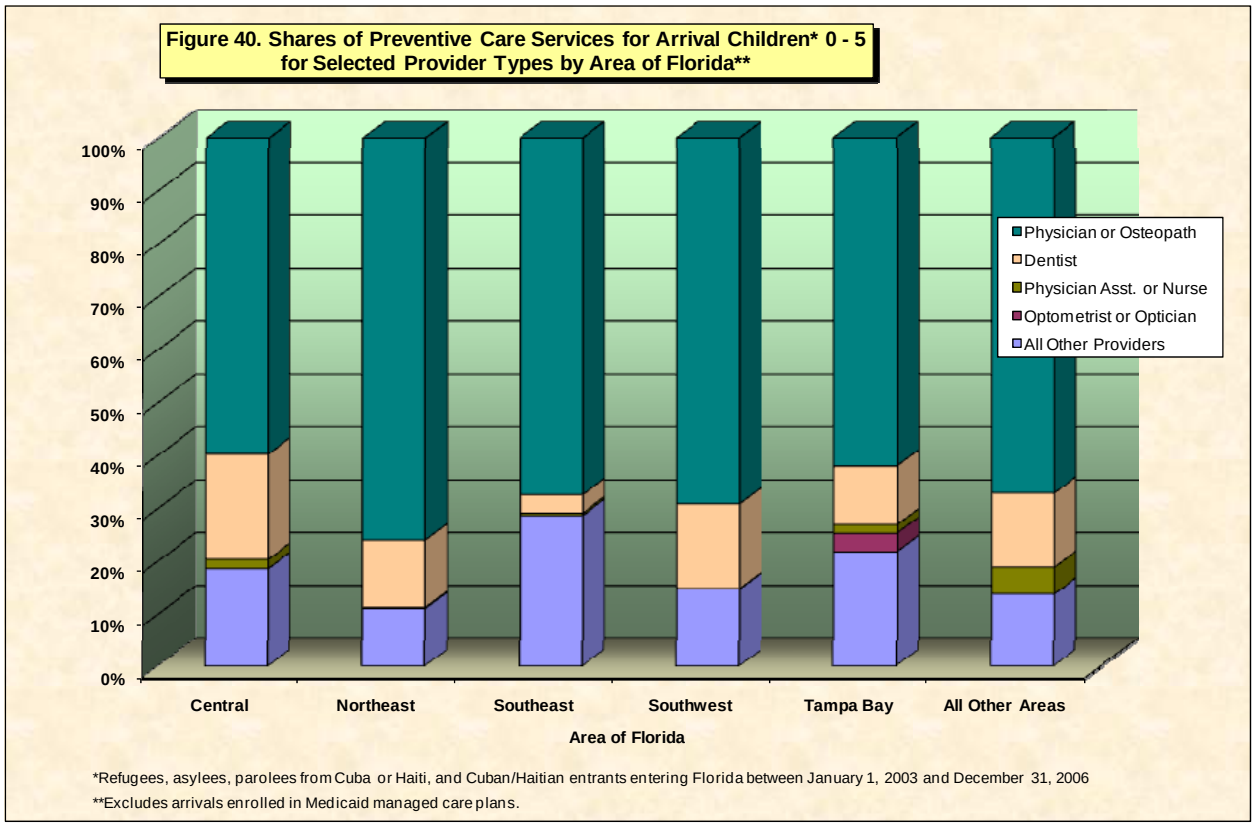
Figure 39 displays the providers of preventive services to women by region of the state. Again, the bulk of services (50% or more) are provided by all other providers. The regions differ greatly with respect to the percent of services provided by physicians or osteopaths. In the Northeast and the Southeast, 48% and 49% of services respectively are provided by physicians or osteopaths. The percentage for the Central Region is 28% and for the Southwest is 34%.

It is not clear if these regional differences are a function of billing practices, medical care specific to arrivals, or fee-for-service medical care provided to all Medicaid recipients.

Opportunities for Intervention

None recommended.

Figure 40:



Analysis

Figure 40 displays providers of preventive care for children. These services are predominantly provided by physicians and osteopaths, especially in the Northeast Region where physicians and osteopaths provide 76% of preventive care to children. At the opposite extreme, these providers are responsible for only 60% and 62% of such care in the Central and Tampa Bay Regions respectively. Another interesting finding is that, while dentists provided between 11% and 19% of preventive care for children in most regions of the state, they only provide 4% of the preventive care in the Southeast Region.

Opportunities for Intervention

The dental component of refugee health education should be examined in the Central and Southwest Regions of the state to provide best practices that can be used in the Southeast Region.

Conclusions

There are differences between countries of origin with respect to agreement between the results of overseas medical screenings and domestic health screenings. The differences are difficult to interpret because the two conditions that overlap between the two screenings are treatable. Therefore, agreement might be an indication that the condition was diagnosed overseas but not treated, rather than an indication that both screenings are effective. Also, there are very few arrivals appearing in both databases, so the numbers of cases with diagnoses are small.

A fairly high percentage of arrivals are utilizing the domestic health screening. Asylees, who are not entitled to the screening until they are granted asylum, are the exception to the rule. The most

common condition identified during the domestic health screening is high cholesterol, followed by hepatitis B, hepatitis A, urine abnormalities, and parasites.

Most arrivals are applying for Medicaid, with asylees, again, being the exception. For the most part, individuals that apply for Medicaid are being enrolled. Arrivals from countries of origin with a high percentage of asylees are enrolling in Medicaid somewhat later than other arrivals.

Overall, a low percentage of arrivals are seeking treatment for conditions identified during the domestic health screening. A higher percentage of arrivals utilize preventive health care. Preventive health care utilization varies considerably based on country of origin.

General Findings and Recommendations

Findings

General findings include:

- On almost every measure of utilization, Haitian arrivals are not taking advantage of available resources.
- Asylees are not availing themselves of available medical benefits, possibly because there are insufficient system practices to try to locate asylees after asylum is granted.
- The Central Region's poor performance on most measures may be due to the fact that many of its arrivals are asylees.
- Peruvian arrivals are the healthiest group upon arrival.
- Very few arrivals are seeking treatment for conditions diagnosed during the domestic health screening.
- Many adult but fewer child arrivals are seeking preventive care. This difference, however, may be a function of the specific treatment codes selected for analysis.
- The Southeast and Northeast Regions of Florida seem to be doing a better job of educating arrivals about seeking care for identified conditions and the importance of preventive care and possibly in providing follow-up regarding medical care.

Recommendations

Many of the recommendations in this report gravitate around the following general recommendations:

- If it is impossible to provide at least domestic health screenings and some medical education to asylees at the time they apply for asylum, there needs to be a concerted effort to locate asylees as soon as asylum is granted so they may be provided with education and guidance about medical care opportunities that are advisable and available to them.
- Haitians need to be singled out for more intense guidance about utilization of the healthcare system.
- Much can be learned by conducting interviews in the Northeast, Southwest, and Southeast Regions of the state to identify best practices in encourage utilization of health care.
- Incentives and sanctions should be implemented to encourage VOLAGs and county health departments to provide more hands-on assistance and follow up for arrivals regarding referrals for treatment.

Appendix A

Treatment codes

Prenatal care

ICD-9 Code	Code Description
V72.4	Pregnancy examination or test
V22.0 - V22.2	Supervision of normal pregnancy
V23.0 - V23.9	Supervision of high risk pregnancy
V28.0 - V28.9	Encounter for antenatal screening of mother

CPT Code	Code Description
80055	Obstetric panel
81025	Urine pregnancy test, by visual color comparison methods
59400	Routine obstetric care including antepartum
59420	Ante partum visit
59425	Antepartum care only; 4-6 visits
59426	Antepartum care only; 7 or more visits
59510	Routine obstetric care including antepartum,
59610	Routine obstetric care including antepartum
59618	Routine obstetric care including antepartum
T5906	Antepartum care; per visit
W1990	Antepartum care only
W1991	Antepartum visit plus healthy start prenatal
W1992	Antepartum visit plus healthy start prenatal
383	Antepartum hosp. , no complication
383.1	Antepartum hosp., 1 complication
383.2	Antepartum hosp., 2 complications
383A	Antepartum hosp, no complication
383B	Antepartum hosp, 1 complication
383B	Antepartum hosp, 1 complication
383C	Antepartum hosp., 2 complications
59000	Amniocentesis; diagnostic
59020	Fetal contraction stress test
59025	Fetal non-stress test
59430	Postpartum care only (separate procedure)
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation
76818	Fetal biophysical profile with non-stress
76819	Fetal biophysical profile without non-stress
76820	Fetal umbilical artery Doppler velocimetry ultrasound
76825	Echocardiography, fetal, cardiovascular
76826	Echocardiography, fetal, cardiovascular
76827	Doppler echocardiography, fetal pulsed
76828	Fetal cardiac Doppler velocimetry ultrasound
76830	Ultrasound, transvaginal
76946	Ultrasonic guidance for amniocentesis
78580	Pulmonary perfusion imaging
80048	Basic metabolic panel (calcium, total)
80051	Electrolyte panel
80053	Comprehensive metabolic panel
81000	Urinalysis, by dip stick or tablet reagent

CPT Code	Code Description
81001	Urinalysis, by dip stick or tablet reagent
81003	Urinalysis, by dip stick or tablet reagent
81005	Urinalysis; qualitative or semiquantitative
81015	Urinalysis; microscopic only
H1000	Prenatal care, at risk assessment
H1001	Prenatal care, at risk enhanced service;

Childbirth

CPT Code	Code Description
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59500	Routine Obstetric Care Including Antepartum Care, Cesarean Delivery and Postpartum Care
59501	
59514	Caesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59520	
59521	
59540	
59541	Cesarean section, extraperitoneal,
59560	Cesarean section with hysterectomy, subtotal
59561	Cesarean section with hysterectomy, subtotal
59580	Cesarean section with hysterectomy, total
59581	Cesarean section with hysterectomy, total
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
T5905	Vaginal delivery only
T5908	Vaginal delivery with circumcision
T5909	Cesarean section, low cervical
T5910	Cesarean section with circumcision
01961	Anesthesia for; vaginal delivery only
01962	Anesthesia for cesarean delivery only
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
370	C-section, no complications
370.1	C-section, 1 complication
370.2	C-section, 2 complications
370A	C-section, no complications
370B	C-section, 1 complication

CPT Code	Code Description
370C	C-section, 2 complications
372	Vaginal delivery., no complication
372.1	Vaginal delivery, 1 complication
372.2	Vaginal delivery, 2 complications
372A	Vaginal delivery, no complication
372B	Vaginal delivery, 1 complication
372C	Vaginal delivery, 2 complications
59414	Delivery of placenta (separate procedure)

General Preventive

ICD-9 Code	Code Description
V70.0 - V70.5	General medical examination
V72.0 - V72.2, V70.5 - V70.9	Special investigations and examinations
V73.0 - V73.6	Special screening examination for viral diseases
V03.0 - V03.9	Prophylactic vaccination and inoculation against bacterial diseases
V04.0 - V04.8	Prophylactic vaccination and inoculation against certain diseases
V05.0 - V05.4, V05.8, V05.9	Prophylactic vaccination and inoculation against single diseases
V06.0 - V06.6, V06.8, V06.9	Prophylactic vaccination and inoculation against combinations of diseases
V65.41	Exercise counseling
V65.42	Counseling on substance use and abuse
V65.43	Counseling on injury prevention

CPT Code	Code Description
80050	General health panel
80061	Lipid panel
99173	Screening Test of Visual Acuity, quantitative, bilateral
99383	Initial comprehensive preventive medicine
99384	New Patient, Preventive Medicine, age 12 – 17 years
99385	New Patient, Preventive Medicine, 18-39 years
99385	Initial comprehensive preventive medicine
99386	New Patient, Initial Comprehensive Preventive Medicine, 40 - 64 years
99386	Initial comprehensive preventive medicine
99387	New Patient, Initial Comprehensive Preventive Medicine, 65 years and older
99393	Periodic comprehensive preventive medicine
99394	Periodic comprehensive preventive medicine
99395	Established Patient, Prevent Medicine, 18 – 39 years
99395	Periodic comprehensive preventive medicine
99396	Established Patient, Periodic Comprehensive Preventive Medicine, 40 – 64 years
99396	Periodic comprehensive preventive medicine
99397	Established Patient, Periodic Comprehensive Preventive Medicine, 65 years and older
99401	Counseling and/or Risk Factor Reduction Intervention, Approximately 15 minutes
99402	Counseling and/or risk factor reduction
99403	Counseling and/or risk factor reduction
99403	Counseling and/or risk factor reduction
99404	Counseling and/or risk factor reduction
99406	Smoking and tobacco use cessation counseling

CPT Code	Code Description
99407	Smoking and tobacco use cessation counseling
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Established Patient, Preventative medicine counseling in a group setting (per participant) Office, other outpatient
99412	Counseling and/or risk factor reduction
99412	Physical training risk reduction
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	Inluenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use *No longer manufactured for U.S. market*
90660	Influenza virus vaccine, live, for intranasal use
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90663	Influenza virus vaccine, pandemic formula
90700	Immunization, active; diphtheria, tetanus
90701	Immunization, active; diphtheria and tetanus
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
90708	Measles and rubella virus vaccine, live, for subcutaneous use
90709	Rubella and mumps virus vaccine, live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine, live, for subcutaneous use
90711	Diphtheria, tetanus toxoids, and pertussis (DTP) and injectable poliomyelitis vaccine
90712	Poliovirus vaccine, (any type(s)) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and

CPT Code	Code Description
	Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use
90724	Influenza virus vaccine
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
90749	Unlisted vaccine/toxoid
W9843	Clinic/immunization
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
44393	Colonoscopy through stoma; with ablation
44389	Colonoscopy through stoma; with biopsy,
44391	Colonoscopy through stoma; with control
44390	Colonoscopy through stoma; with removal
44394	Colonoscopy through stoma; with removal
44392	Colonoscopy through stoma; with removal
44397	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
45392	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45391	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (EG, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45386	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyps(s), or other lesions(s) by snare technique
45381	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45379	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyps(s), or other lesions(s) by hot biopsy forceps or bipolar cautery
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema

CPT Code	Code Description
G0122	Colorectal cancer screening; barium enema
G0121	Colorectal cancer screening; colonoscopy
G0105	Colorectal cancer screening; colonoscopy
G0107	For screening Fecal Occult Blood Tests (FOBT) *Effective January 1, 2007, HCPCS code G0107 for screening Fecal Occult Blood Tests (FOBT) is being terminated and replaced by Current Procedural Terminology (CPT) code 82270*
G0104	Colorectal cancer screening; flexible sigmoidoscopy
45336	Historic code for Flexible Sigmoidoscopy
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45334	Sigmoidoscopy, flexible; with control of bleeding (EG, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator
45337	Sigmoidoscopy, flexible; with decompression of volvulus, any method
45340	Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyps(s), or other lesions(s) by snare technique
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyps(s), or other lesions(s) by hot biopsy forceps or bipolar cautery
45332	Sigmoidoscopy, flexible; with removal of foreign body
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
V0105	Eye examination, including history, visual acuity determination
V0110	Eye examination, including history, visual acuity determination
V0100	Eye examination, including history, visual acuity determination

Children's Preventive

ICD-9 Code	Code Description
V20.0 - V20.2	Health supervision of infant or child
V21.0, V21.3, V21.8, V21.9	Constitutional states in development
V29.0 - V29.3, V29.8, V29.9	Observation and evaluation of newborns for suspected condition not found
V71.81	Observation and evaluation for abuse and neglect

CPT Code	Code Description
99431	History and examination of the normal ne
99432	Normal newborn care in other than hospital
99435	History and examination of the normal neonate
99438	Infant care to one year of age, with a m
90465	Immunization administration under 8 year
90466	Immunization administration under 8 year

CPT Code	Code Description
90467	Immunization administration under age 8
90468	Immunization administration under age 8
90755	Infant care to age one year
90757	Newborn care, in other than hospital setting
99381	Initial check up screening
99382	Initial check up screening
99383	Initial check up screening
99384	Initial check up screening
99385	Initial check up screening
99391	Periodic check up screening
99392	Periodic check up screening
99393	Periodic check up screening
99394	Periodic check up screening
99395	Periodic check up screening

Women's Health Care

ICD-9 Code	Code Description
V24.0 - V21.2	Postpartum care and examination
V25.0 - V25.9	Contraceptive management
V26.0 - V26.9	Procreative management
V72.3	Gynecological examination
V76.2	Routine cervical Papanicolaou smear
V73.81	Screening for human papillomavirus (HPV)
V73.88	Screening for other specified chlamydial diseases
V73.89	Screening for other specified viral diseases
V02.7	Carrier or suspected carrier of gonorrhea
V02.8	Carrier or suspected carrier of other venereal diseases
090-099	Syphilis and other venereal diseases
V01.6	Contact with or exposure to venereal diseases

CPT Code	Code Description
86592	Syphilis test; qualitative (EG, VDRL, RPR, ART)
86593	Syphilis test; quantitative
86781	Antibody; treponema pallidum, confrmatory test (EG, FTA-ABS)
59430	Postpartum care only (separate procedure)
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (Quadrivalent), 3 dose schedule, for intramuscular use
T5907	Postpartum examination; office follow-up
76088	Mammary ductogram or galactogram, multiple
76089	Mammary ductogram or galactogram, multiple
77054	Mammary ductogram or galactogram, multiple
76087	Mammary ductogram or galactogram, single
76086	Mammary ductogram or galactogram, single
77053	Mammary ductogram or galactogram, single
76096	Mammographic guidance for needle placement
77032	Mammographic guidance for needle placement
77056	Mammography; bilateral
76091	Mammography; bilateral
77055	Mammography; unilateral
76090	Mammography; unilateral

Conditions

Parasites	
CPT Code	**Code Description**
87177	Ova and parasite examination
85048	Eosinophil count
Pharmaceutical Treatment	
Generic	**Brand Name**
Ivermectin	Stromectol
Albendazole	Albenza
	Eskazole
	Zentel
Praziquantel	Biltricide
	Cesol
	Cysticide
High Cholesterol	
CPT Code	**Code Description**
80061	Lipid panel
82465	Cholesterol, serum or whole blood, total
83721	Lipoprotein, direct measurement, LDL cholesterol
83719	Lipoprotein, direct measurement, VLDL cholesterol
83718	Lipoprotein, direct measurement, high density cholesterol
84478	Triglycerides
ICD-9 Diag Codes	**Code Description**
v81.0	Screening for cardiovascular conditions as appropriate
v81.1	Screening for cardiovascular conditions as appropriate
v81.2	Screening for cardiovascular conditions as appropriate
v77.91	Screening for lipoid disorders
272.0	Pure hypercholesterolemia
272.1	Pure hyperglyceridemia
272.2	Mixed hyperlipidemia
272.3	Hyperchylomicronemia
272.4	Other and unspecified hyperlipidemia
272.5	Lipoprotein deficiencies
272.6	Lipodystrophy
272.7	Lipidoses
272.8	Other disorders of lipoid metabolism
272.9	Unspecified disorder of lipoid metabolism
Pharmaceutical Treatment	
Generic	**Brand Name**
Aorvastatin	Lipitor
Fluvastatin	Lescol
Lovastatin	Mevacor
Pravastatin	Pravachol
Rosuvastatin calcium	Crestor

Simvastatin	Zocor
Ezetimibe	Zetia
Cholestyramine	Questran
	Questran Light
	Cholybar
Colestipol	Colestid
Colesevelam	Welchol
Niacin, Nicotinic Acid	Niacor
	Nicolar
	Slo-Niacin
	Niaspan
Niacin + Lovastatin	Advicor
Gemfibrozil	Lopid
	Jezil
	Gen-Fibro
Fenofibrate	Tricor
	Lofibra
	Lipanthyl
Clofibrate	Atromid-S
Simvastatin + Ezetimibe	Vytorin
	Inegy
Hepatitis A	
ICD-9 Diag Codes	**Code Description**
070.0	Viral hepatitis A with hepatic coma
070.1	Viral hepatitis A without mention of hepatic coma
070.4	Other specified viral hepatitis with hepatic coma
070.5	Other specified viral hepatitis without mention of hepatic coma
070.6	Unspecified viral hepatitis with hepatic coma
070.9	Unspecified viral hepatitis without mention of hepatic coma
CPT Code	**Code Description**
80074	Acute hepatitis panel
86709	Hepatitis A antibody (HAAB); IGM antibody
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBSAG)
Hepatitis B	
ICD-9 Diag Codes	**Code Description**
070.2	Viral hepatitis B with hepatic coma
070.3	Viral hepatitis B without mention of hepatic coma
070.4	Other specified viral hepatitis with hepatic coma
070.5	Other specified viral hepatitis without mention of hepatic coma
070.6	Unspecified viral hepatitis with hepatic coma
070.9	Unspecified viral hepatitis without mention of hepatic coma
CPT Code	**Code Description**
80074	Acute hepatitis panel

86705	Hepatitis B core antibody (HBCAB); IGM antibody
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBSAG)
Pharmaceutical Treatment	
Generic	**Brand Name**
Alfa Interferon	Intron a
	Infergen
	Roferon-a
Lamivudine	Epivir-HBV
	Zeffix
	Heptovir
	Epivir
Adefovir dipivoxil	Hepsera
Entecavir	Baraclude
Abnormal Urinalysis	
CPT Code	**Code Description**
81002	Dipstick or tablet reagent urinalysis
87086	Culture, bacterial; quantitative colony count, urine
87088	Culture, bacterial; with isolation and presumptive identification of isolates, urine

Appendix B

Affirmative Asylum Grant Rate			
	Grants	Cases Adjudicated	Grant Rate
FY 2003	13374	39107	34%
FY 2004	12952	31582	41%
FY 2005	11737		
FY 2006	12851		
FY 2007	12317		
FY 2008	12187		

*2004 Yearbook of Immigration Statistics

Defensive Asylum Grant Rate			
	Grants	Denials	Grant Rate
FY 2003	13379	22411	37%
FY 2004	13022	20866	38%
FY 2005	11705	19028	38%
FY 2006	13300	16477	45%
FY 2007	12832	14888	46%
FY 2008	10743	13199	45%

*EOIR Statistical Yearbook FY2007 (for years 2003)

*EOIR Statistical Yearbook FY2008 (for years 2004,2005,2006,2007,2008)

Appendix C

Conditions Identified in the Domestic Health Screening by Country of Origin

The table below provides frequencies as well as the percentages depicted in Figure 15.

Country	Condition														
	High Cholesterol			Hepatitis B			Hepatitis A			Urinary Abnormality			Parasites		
	# Tested	# Positive	% Positive	# Tested	# Positive	% Positive	# Tested	# Positive	% Positive	# Tested	# Positive	% Positive	# Tested	# Positive	% Positive
Burma	19	8	42.1%	199	11	5.5%	85	72	84.7%	107	1	0.9%	122	33	27.1%
Colombia	1,147	620	54.1%	2,659	79	3.0%	615	349	56.8%	2,074	147	7.1%	2,702	345	12.8%
Cuba	42,107	22,430	53.3%	62,200	641	1.0%	22,368	14,517	64.9%	56,768	8,211	14.5%	64,546	6,587	10.2%
Haiti	399	176	44.1%	1,853	154	8.3%	419	307	73.3%	1,649	129	7.8%	1,957	503	25.7%
Liberia	47	5	10.6%	361	61	16.9%	37	30	81.1%	152	4	2.6%	359	99	27.6%
Peru	14	4	28.6%	26	1	3.9%	5	1	20.0%	19	1	5.3%	33	2	6.1%
Russia	9	3	33.3%	145	5	3.5%	79	42	53.2%	57	8	14.0%	69	14	20.3%
Ukraine	51	16	31.4%	157	10	6.4%	40	19	47.5%	175	20	11.4%	190	58	30.5%
Venezuela	356	149	41.9%	689	29	4.2%	193	84	43.5%	566	40	7.1%	708	67	9.5%
Vietnam	34	6	17.7%	154	33	21.4%	81	44	54.3%	101	5	5.0%	139	16	11.5%

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