

Duval County Refugee Health Care Utilization Process
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Health

By

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Duval County Refugee Health Care Utilization Process

Introduction

Florida received approximately 24,000 refugees/entrants in federal fiscal year 2005-2006, more than any other state. Approximately 89% of the new arrivals were provided a domestic health examination by a county health department. Among these arrivals, there were more than 100 countries of origin represented including Cuba, Colombia, Haiti, Venezuela, Russia, Vietnam, Uzbekistan, and Ukraine.¹ These individuals originated from all regions of the world, bringing the unique cultures and languages of their countries of origin. This diversity necessitates the delivery of quality health care services in a culturally appropriate manner. Such care is important for two reasons. First, providing appropriate and necessary care, especially accurate detection and treatment of communicable diseases, protects public health in Florida. Second, encouraging and providing preventive health care among these new residents will enrich their lives and protect limited health care resources.

Throughout this report, the word refugee will be used to refer to all of the following groups:

- A refugee – Any person who is outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution.
- An asylee – An alien in the United States (US) or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality or seek the protection of that country because of persecution or a well-founded fear of persecution.
- A Cuban or Haitian entrant – Cuban or Haitian nationals who have entered the US and have been granted parole status for permanent residency consideration, have applied for asylum, or have a final order for deportation but have not yet left the US.
- Other persons entitled to the same health benefits as refugees.

References to the Department of Health will generally mean the Refugee Health Program in Florida's Department of Health.

Purpose of this Report:

This report is a qualitative evaluation of refugee health care in Duval County Florida. It reviews the federal mandates for that care. Based on interviews with Duval County system participants,

¹ Immigration statuses eligible for refugee health services include: refugee; asylee; Cuban and Haitian entrants; certain Amerasians; certified victims of human trafficking. For simplicity, this document will use the term "refugee" to describe persons eligible for federal refugee health benefits, regardless of their particular immigration category.

it compares the Duval County system with the federal mandates and provides suggestions for improvement of the system in Duval County and possibly other counties in the state.

Regulatory mandates related to refugee health and health care

Federal regulations guide the medical screening requirements and/or health benefits for refugees entering the United States. For instance:

- Before entering the United States, most refugees must obtain an overseas medical screening (physical and mental) as part of the visa application process.²
- Within 90 days of arrival, refugees are eligible for and encouraged to receive a domestic health examination and/or immunizations at no charge.^{3,4}
- Refugees are eligible for either health care through Medicaid with the same restrictions as any other Medicaid recipient or Refugee Medical Assistance (RMA) for eight months after the date of entry or the date asylum is granted.

Overseas medical screening

Figure 1 summarizes the intended process for evaluating refugee health status and for the provision of health care to this population. The blocks in the figure are color coded based on the party primarily responsible for overseeing implementation. Blue blocks are completed primarily by voluntary resettlement agencies (VOLAGs), red blocks by the county health department Refugee Health Clinic (RC), green blocks by the Department of Children and Families (DCF) Medicaid Enrollment Staff, and yellow blocks by the Agency for Health Care Administration (AHCA) Medicaid Field Staff. Federal codes and regulations that apply to each step of the process are indicated in black print below each block when applicable.

Generally, each refugee must have an overseas medical screening before entering the US (Block 1); this screening cannot predate entry by more than twelve months. The refugee is given a form summarizing the findings of the overseas health screening.

When the refugee immigrates to the US, a representative of the Centers for Disease Control (CDC) reviews the form summarizing the overseas medical screening (Block 2). Most refugees are met upon entry by a VOLAG paid by the US Department of State to ensure that the refugee is provided with resettlement services. The VOLAG that is resettling the refugee is provided a copy of the overseas medical screening results.

The CDC sends a copy of the overseas medical screening results to the state Department of Health (DOH) (Block 3), who then forwards the form to the county health department that will be responsible for the domestic health examination (Block 3a).

When the refugee is met at the port of entry by the VOLAG, the VOLAG examines the overseas medical screening form to determine if any Class A health conditions exist⁵ (Block 4). If such a

² 42USC252 (Note: the requirement for an overseas medical examination does NOT apply to some asylees and Cuban and Haitian entrants)

³ 45CFR400.107

⁴ Voluntary agencies (VOLAGS) have agreements with the Department of State to arrange their clients' domestic health screenings within 30 days of arrival. However, not all refugees have VOLAG sponsors.

⁵ A Class A condition is an excludable condition (such as, infectious tuberculosis, HIV infection, Hansen's disease, physical or mental disorders that may pose a threat, and drug abuse or addiction); a waiver may be granted to enter

condition exists, based on mandates in its cooperative agreement with the US Department of State, the VOLAG must help the refugee obtain appropriate treatment within seven days of entry (Block 5). VOLAG responsibilities dictated by these cooperative agreements bear the acronym CA above the block on the flow chart. Generally, refugees with Class A conditions are not permitted to enter the country without a waiver. To obtain a waiver, a physician must send a letter to the CDC indicating that he or she will provide treatment for this condition upon arrival; the County Health Department is required to validate that the letter is from a physician with skills to treat the condition. In fact, if it is a TB case, according to DOH policy, (see Appendix 1) the county health department is responsible for:

- Contacting the refugee with the Class A condition for evaluation within three days of receiving information regarding the arrival of the refugee.
- Perform the appropriate examination to verify the condition.
- Coordinate and track the treatment for the condition.
- Provide services in a culturally and linguistically appropriate manner.
- Complete and return the CDC 75.17 form and return it to the Refugee Health Program.

VOLAGs have many responsibilities regarding resettlement of refugees. Part of the services they provide is a general orientation of refugees to the health care system in Florida (Block 6); another responsibility is to ensure that each refugee have a domestic health examination, including the immunizations needed to apply for permanent residency (Block 7).

Orientation and Medicaid coverage

As part of the orientation to the health care system, VOLAGs assist refugees in completing their on-line applications for Medicaid coverage (Block 6a). The Medicaid eligibility determination process is depicted on the second page of the flow chart. Refugees are entitled to free health insurance through Medicaid if they qualify (for as long as they qualify) or through Refugee Medical Assistance (RMA) for eight months after the date of entry or the date asylum was granted. Based on the information in their completed applications and verification of refugee status, the Department of Children and Families (DCF) determines if each refugee meets the qualification standards for Medicaid (Blocks 6b). If he or she does qualify, AHCA reimburses providers for medical care from Medicaid funds (Block 6d). If not, the refugee does not receive health care coverage (Block 6c). There is one exception. Adults without children do not meet the criteria for Medicaid coverage on technical grounds unless they are disabled, elderly, or pregnant. So, adult refugees without children and some families can qualify for RMA covering health care services for eight months, if assets and income criteria are met. However, once a refugee qualifies for Medicaid coverage, he can receive health care benefits from Medicaid until he no longer qualifies because earned income exceeds the criteria for Medicaid eligibility (Block 6e). If the refugee receives Medicaid tied to cash assistance for three months or more before earned income exceeds the level set to qualify for Medicaid, he qualifies for Transitional Medicaid for up to twelve more months (Blocks 6f and 6g). However, if earned income surpasses the Medicaid qualification level before benefits have been paid for three months,

the United States. The waiver process generally includes assurance, from a private medical provider or an appropriate public health agency in the United States, that necessary medical or psychological follow-up services will be provided upon arrival.

subsequent health care will be covered by RMA (Block 6h). When refugee health care is paid out of RMA, coverage terminates 8 months after the date of entry or granting of asylum (Block 6i). The Department of Children and Families notifies such refugees that coverage is about to terminate during the eighth month of residency via a letter to the refugee (Block 6j). DCF also explores other possible sources of coverage and notifies the refugee that he may qualify for another category of Medicaid coverage. If he does qualify (Block 6l), he is reenrolled in Medicaid under the same constraints as any other Medicaid recipient (Block 6m).

Domestic health examinations

Part of each VOLAG's resettlement activities is the scheduling of a domestic health examination with the county health department in the county where the refugee resides (Block 7). In order for the cost of the domestic health examination and immunizations to be covered by Refugee Medical Assistance funds, the examination must be completed within 90 days of entry (Blocks 7a, b, and c) (45 CFR 400.107). The Department of State prefers that domestic health examinations occur within 30 days of arrival. Therefore, they require that VOLAGs send a written explanation of the reason any examination is delayed beyond 30 days of arrival (Blocks 7d and 7e). If the domestic health evaluation reveals the presence of a communicable disease or any other condition in need of treatment, the county health department must refer the refugee for treatment (Block 7g). The VOLAG is responsible for ensuring that the necessary treatment is provided (Block 7h).

Figure 1: Flow Chart – Refugee Health Services

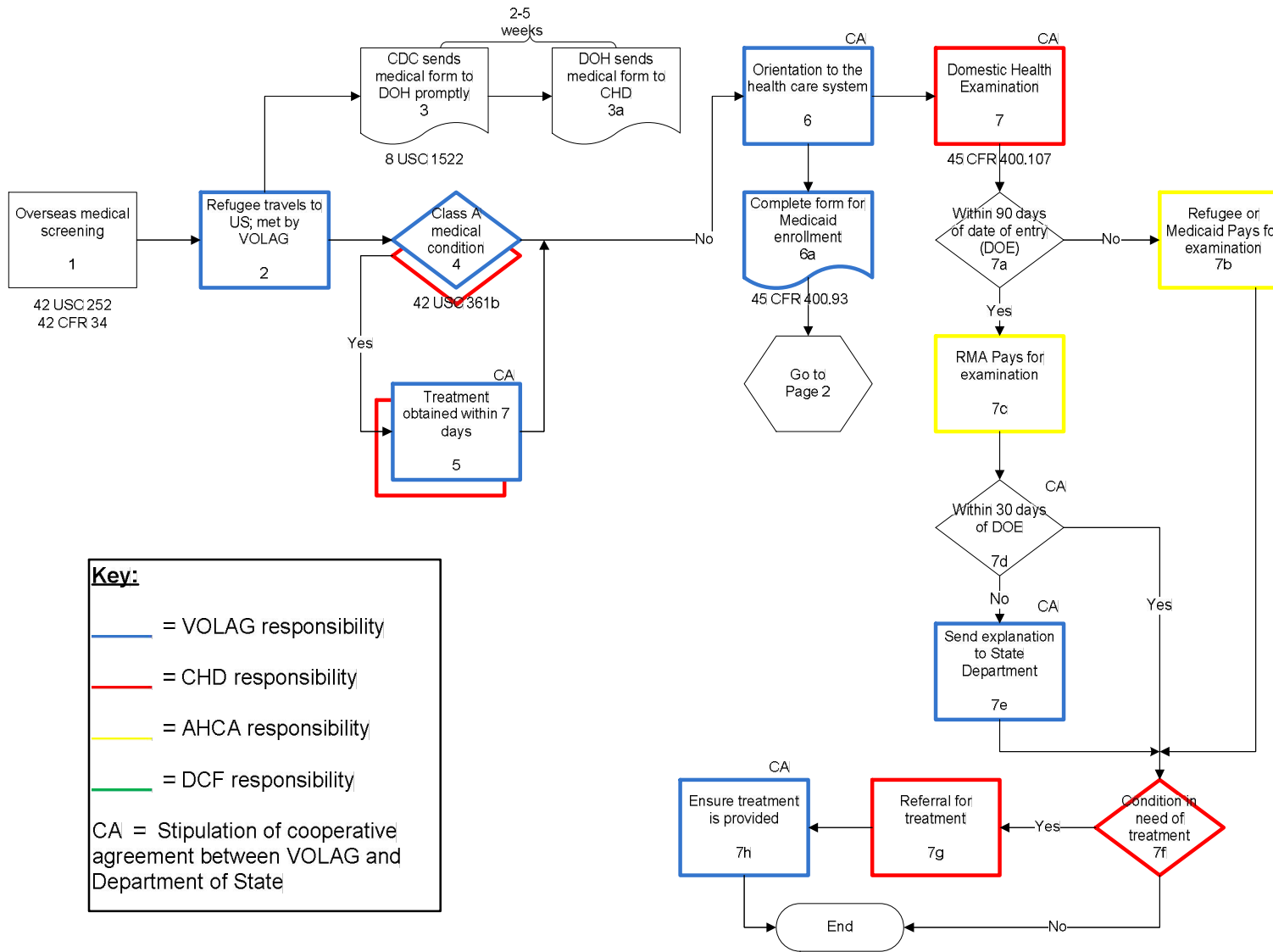
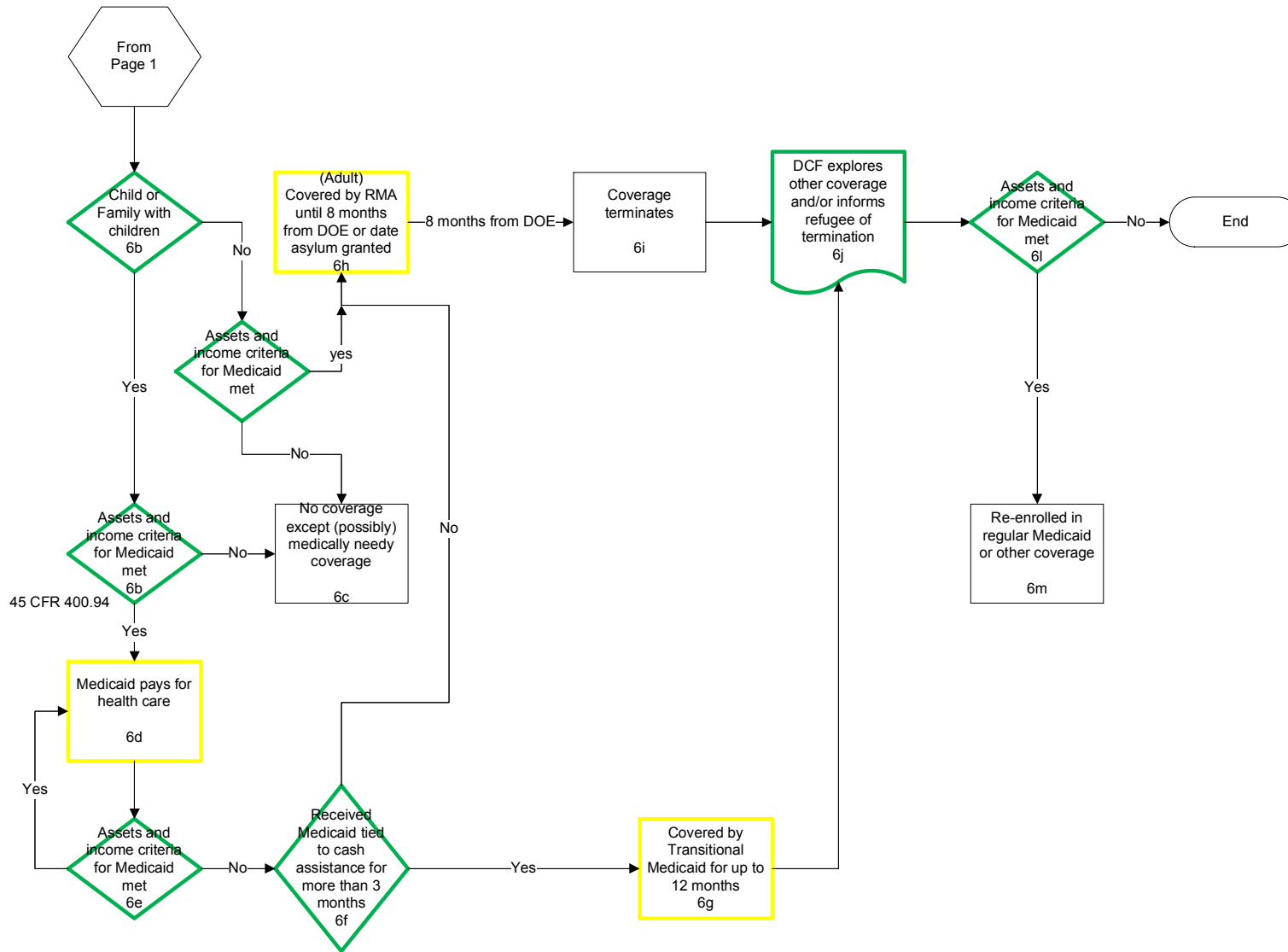


Figure 1: Flow Chart – Refugee Health Services (continued)



Method for documenting the Duval County processes

As a county that regularly receives immigration of a diverse group of refugees, Duval County was selected for in-depth qualitative interviews to determine how closely a local process adheres to federal guidelines for the provision of health care services to refugees. A questionnaire was developed for face-to-face interviews with the spectrum of providers involved with the evaluation of health status and the provision of health care for refugees (see Appendix 2 for a sample questionnaire). Because physicians could devote a limited time to the interview process, the questionnaire was abbreviated for interviews with health care providers. Between March 12 and March 14, 2007, interviews were conducted with the following individuals:

- Representatives of all three VOLAGS providing resettlement services to refugees in Duval County: Lutheran Social Services of North Florida; United States Conference of Catholic Bishops Resettlement Program at Jacksonville, Florida; and World Relief
- Two administrative employees of the Refugee Health Clinic of the Duval County Health Department (RC)
- One medical provider in the RC
- Two AHCA employees involved with providing assistance to Medicaid recipients in the selection of a health plan
- Two DCF employees involved with determining eligibility for Medicaid
- Two private health care providers known to provide care to refugees
- One DOH administrator of refugee health programs in Tallahassee

When interviewees brought up new issues late in the interview process, previously interviewed participants were contacted by telephone to clarify the participants' experiences. Two central topics of these follow-up phone calls were: obtaining treatment for Class A conditions within seven days of entry and defining the exact procedures for obtaining domestic health examinations and immunizations.

To seek clarification of the Medicaid eligibility criteria, DCF Refugee Services staff in Tallahassee was interviewed.

Description of the Duval County process

Arrival

All three VOLAGs reported meeting refugees upon entry and obtaining copies of their Overseas Medical Screening forms (Figure 1: Block 2).

Treatment for Class A Conditions

According to VOLAG representatives, there are very few refugees entering Florida with Class A medical conditions indicated on their Overseas Medical Screening form. However, for the few Class A cases, VOLAGs consistently report that the requirement of obtaining treatment for such conditions within seven days of arrival is not being met. RC staff reports that, if a VOLAG calls them about such a condition, an attempt is made to schedule the initial examination earlier than would normally be done. No one, however, claims that there is an effective process in place to obtain treatment for these conditions in the seven-day time frame set by the State Department (Figure 1: Blocks 4 and 5). Apparently, VOLAGs are not generally using the waiver information

that accompanies the medical form to contact the doctor who has committed to provide treatment. Although the CDC is moving towards notifying county health departments electronically, through state departments of health, with the data on the overseas medical screening form, they have not begun doing so in Duval County. The information is sent by US mail to DOH who then forwards it to the RC. Therefore, the RC has no timely way of knowing if a refugee has arrived with a Class A condition unless a VOLAG contacts them with the information.

Orientation to the health care system

VOLAGs differ regarding the type of orientation they provide about the health care system (Figure 1: Block 6). Most offer some information during group sessions. Case workers are ready to answer any questions refugees may have. No VOLAG claims to provide extensive orientation to the health care system.

Health care coverage – Medicaid or RMA

All the VOLAGs believe that 100% of refugees apply for Medicaid and report that, in recent months (February and March 2007), the application and approval process has improved significantly. VOLAG staff either takes the responsibility for completing or work with each refugee in completing the on-line application for Medicaid (Figure 1: Block 6a). They report that, with some exceptions, it normally takes two to three weeks for refugees to obtain Medicaid cards after application. Since refugees must meet strict assets, earnings, and technical criteria to qualify for Medicaid coverage and, once those criteria are met initially, qualified refugees are guaranteed health care coverage for at least an eight-month period, it is important that this on-line application process be completed before refugees secure employment (and, as a result, may not meet the earnings requirement). All VOLAG staff is aware of this aspect of the system, and VOLAGs complete the application process shortly after the refugee arrives in the state.

Healthy adult refugees without children do not meet the technical criteria to qualify for Medicaid; so, if they meet the assets and income criteria, they are covered by Refugee Medical Assistance (RMA) for the first eight months they are in the country. For families and children, after being determined eligible for Medicaid, if a refugee begins to earn an income that exceeds the criteria for continued Medicaid coverage, the refugee's medical expenses can be covered by RMA (if the refugees received Medicaid for less than three months) or by Transitional Medicaid (if the refugee received Medicaid for more than three months).

According to Duval County DCF staff, the turnaround time has shortened in the past few months because they have changed their process. Instead of randomly assigning applications for processing among the entire eligibility determination staff, whenever an application is received from a refugee, it is assigned to one staff member who is knowledgeable about refugee eligibility standards. Eligibility is determined, based on the information in the application, by a computer-based algorithm and is checked by the specialist reviewing the case.

Duval County is participating in the Medicaid Reform Pilot Project, which uses a spectrum of approved local health plans. AHCA provides choice counselors to help Medicaid enrollees select a plan that is appropriate for them; AHCA has a contract with Albers to provide interpreters to assist non-English-speaking enrollees with the selection process. VOLAGs also try to help refugees select appropriate plans based on proximity of providers to public transportation and/or the refugee's residence and the availability of a person in the provider's

office that can serve as an interpreter. However it is difficult to identify health care providers who will be culturally sensitive to the needs of refugee groups.

A serious problem also arises when RMA coverage terminates. Refugees are only provided RMA for eight months after the date of entry or date asylum is granted (Figure 1: Block 6i). After that, they may qualify for Medicaid, have private insurance, or go without health insurance. According to DCF staff, during the eighth month after entry, refugees covered by RMA receive two letters, in English, Spanish, or Haitian Creole (depending upon language preference stated during the application process) (Figure 1: Block 6j). The first letter explains that health insurance will terminate at the end of the month; they may qualify for other forms of coverage; and children may qualify for Florida KidCare. The second letter informs them of other types of available Medicaid coverage. These letters are sent to each refugee at the last known address. There are several obstacles to continued health insurance coverage engendered in this process:

- Refugees often have unstable living conditions and may move one or more times during their first eight months in Florida. So, they may not receive the letters informing them of their change in status.
- Receiving two separate notification letters decreases the probability that a refugee will understand the action that must be taken for continued coverage and the consequences of inaction.
- Before a refugee's eighth month in Florida, resettlement agencies have reached the end of the timeframe during which they provide intensive resettlement services. Therefore, there is no agency designated to provide refugees the kind of assistance they need to interpret the letters they receive and to navigate the Medicaid reapplication process.
- For many refugees, English, Spanish, and Haitian Creole are not the primary language.
- Some refugees may have experienced difficulty finding physicians willing to treat Medicaid patients. Therefore, they may decide that reapplying for Medicaid is not worth the trouble.

AHCA staff indicated during their interview that each month more than 2,000 persons (out of all Medicaid enrollees) fall off the Medicaid rolls, a testament to the challenges involved in the reapplication process. Those challenges are magnified for refugees with limited capacity in English and a lack of familiarity with Florida's health care system.

Domestic medical examination

VOLAGs have the responsibility to ensure that refugees under their care are offered Domestic Health Examinations (Figure 1: Block 7). All VOLAGs interviewed complete the paper work required by RC, deliver the completed forms to the RC, serve as the point of contact for scheduling the appointment, and bring refugees in to the RC for their physical examinations.

In some instances, refugees reside in one of the surrounding counties. When VOLAGs attempt to schedule domestic health examinations in the county of residence, the county health department staff may not be knowledgeable about the required procedures for examinations, immunizations, and reimbursements.

The completed documents that the Duval RC requires VOLAGs to submit in order to schedule the domestic health examination and the reason each is required are summarized in Table 1.

Table 1: Forms Required for Scheduling Domestic Health Examination

Form	Rationale
<i>Overseas medical screening form:</i> Completed at time of overseas medical screening; contains information about refugee health status.	Identifies conditions that will need treatment. This form is sent directly to the RC by DOH but may not arrive in time for use at the domestic health examination, which should occur within the first thirty days after entry and must occur within the first ninety days of entry for the RC to receive reimbursement from RMA funds. When DOH did a data query, they found that, in 2006, more than 90% of these forms arrived at the Duval County Health Department within thirty days after date of entry. Most of them arrive within the first two weeks.
<i>Screening form:</i> Completed by the VOLAG	Provides demographic data and serves as invoice for DOH; The reason the demographic section of this form must be completed by the VOLAGs is because RC may not receive the overseas medical screening form containing the needed demographic information from DOH until after domestic health examinations need to be complete.
<i>I-94:</i> Provided to refugee in the refugee camp before leaving for the US; Validates refugee status; Some Cuban and Haitian entrants and asylees do not have I-94 forms because they do not arrive from refugee camps.	Verifies that date of entry is less than 90 days before the examination, serves as a picture ID, and documents immigration status.
<i>A picture ID:</i> Sources: I-94; passport; driver's license	Verifies that the person being screened is the same as the person on the I-94.
<i>Release of information forms:</i> Completed by VOLAG and signed by refugee.	Grants permission for medical information to be provided to VOLAG.

Within two days of receiving documentation from a VOLAG, RC staff tries to schedule appointments for examinations to be conducted within two weeks. The RC is staffed by one full time Licensed Practical Nurse (LPN), who conducts the examinations and provides immunizations, and one clerk, who schedules appointments.

VOLAGs need to have written documentation of the scheduled appointment for their files. The RC reports that it faxes appointment dates and times to VOLAGs, but many appointments are scheduled over the telephone, which does not provide the necessary documentation.

One concern VOLAGs report regarding the scheduling of timely appointments for examinations is that the RC does not generally schedule appointments on days that either the clerk or the LPN in the Refugee Health Clinic will be out. Clinic staff has back-ups for each position, but there

have been appointment scheduling delays because these back-up positions are seldom used to fill in the gaps.

Because there are limits to the number of examinations the RC LPN can complete in one day, RC limits the number of examinations in a day to ten. While VOLAGs attempt to make appointments for refugees in order of entry date, to meet the 30 day time frame established in their cooperative agreements with the State Department, the ten-person limit sometimes creates a need to break up a family so some family members are examined on one day and others are examined at a later date.

Scheduling timely make-up dates when a refugee misses his or her appointment for a domestic health examination is a reportedly labor-intensive experience for VOLAGs. RC staff requires that they complete and hand deliver a new screening form for billing and accounting purposes. Make-up appointments are often scheduled weeks after the original appointment, jeopardizing the timeliness of the examination and immunizations. When asked about this requirement, Department of Health, Refugee Health staff said that the official record for billing is the electronic data system. Therefore, it is acceptable for RC staff to write the rescheduled appointment date on the original paper invoice form when they reschedule an appointment, eliminating the requirement for document resubmission.

Generally, with the exceptions listed below, refugees receive their first series of immunizations during the health examination. These immunizations are required for refugees to apply for permanent residency status after being in the US for one year. As long as the health examination occurs within 90 days of arrival and the first set of immunizations occurs within eight months of entry, the second set can also be provided free of charge to the refugee any time before the permanent residency application process (Figure 1: Block 7a, 7b, and 7c). The RC will not provide immunizations to refugees if they have high blood pressure, high blood sugar, or HIV. They require that these conditions be treated by a physician before immunizations can be given. Therefore, the RC requires a note from the treating physician indicating that treatment is being provided before they will immunize these refugees. If this communications process breaks down, a refugee risks not obtaining the first set of immunizations within eight months of entry and, therefore, having to pay for the immunizations.

The RC schedules health examinations on Mondays, Tuesdays, and Wednesdays. They schedule examinations for each VOLAG on separate days. Two Thursdays a month are devoted to providing second immunizations, while Fridays are reserved for paper work. The activities occurring on the other two Thursdays of each month were not reported.

VOLAGs differ with respect to whether the case manager stays with the refugee throughout the physical examination. One drops off all the refugees scheduled for examinations and picks them up when the examinations for the day are completed; another stays with the client and serves as an interpreter. The benefits of the case manager staying at the RC with the refugees are: 1) they can serve as interpreters during the examination, which is appreciated by RC staff. If a qualified interpreter is not provided by the VOLAG, RC staff uses the telephone interpreter services contracted for by DOH; and 2) they can guide refugees to other offices if needed, for instance, if

children need to go to the Children’s Health Unit for immunizations or if a refugee needs immediate medical attention in another unit or at Shands Hospital.⁶

The current immunization policy and process creates some challenges for refugees:

- The RC automatically sends anyone under 19 years of age to the Children’s Health Unit at the Duval County Health Department (CHD) for immunizations. The reason provided is that the Children’s Health Unit provides free immunizations. There is a net cost to the RC for the immunizations they provide because DOH reimburses RC at a lower rate than their costs. The Children’s Health Unit reportedly will only provide free immunizations to children that will be attending school. They will not immunize 17 and 18 year olds who will not be attending school. Therefore, this group is not being served.
- The Children’s Health Unit reportedly will not immunize children who are already covered by Medicaid. They require the family to find a private practice physician to provide the immunizations. This practice postpones immunization unnecessarily, causing children to miss school and placing a burden on refugee parents or caregivers who have minimal comprehension of how to navigate Florida’s health care system.
- If a refugee misses a scheduled appointment for second immunizations, it is very difficult to obtain a make-up date, which is understandable if second immunizations are only provided twice a month.

Health care seeking behavior

There are two phases during which refugees may need acute or preventive health care:

- Before they are enrolled in Medicaid
- After Medicaid enrollment

Before Medicaid enrollment, it is difficult to find a provider that will treat refugees because reimbursement is not guaranteed. For refugees with an immediate need for health care, some VOLAGs can call on a limited number of physicians, who have agreed to provide care before the refugee has received a Medicaid card.

It is important for the health of refugees and the general public for refugees to seek care for conditions identified during the overseas and domestic health examination and for preventive health care. The RC provides both the refugee and the VOLAG with referrals for conditions needing treatment that were identified during the domestic health examination. Treatment of tuberculosis (TB), hepatitis, and sexually transmitted diseases is provided at the county health department. Appointments with private practice physicians are used for treatment of other conditions. In Duval County, possibly because of the Medicaid Reform Pilot Project, the RC provides referrals for identified conditions without specifying the anticipated treating physician.

VOLAGs differ both in philosophy and practice with respect to the degree of assistance they provide to refugees seeking health care. The cooperative agreements require that they ensure treatment for conditions identified during the domestic health examination. All VOLAGs make appointments for refugees to obtain such treatment. All want to educate refugees to be

⁶ However, the Department of Health and Human Services, in guidelines published in 2003 (HHS, 2003), requires that the County Health Department, as a recipient of federal funds, must “take reasonable steps to provide [limited English proficiency] LEP persons with meaningful opportunity to participate in HHS-funded programs.” Therefore, it is the responsibility of the RC to provide appropriate language assistance measures.

independent of the VOLAG as quickly as possible. The method used varies from VOLAG to VOLAG. Some encourage independence by telling the refugee about the appointment and giving them information about public transportation (and bus tickets); the refugee must find his own way to the appointment and do his or her best to interpret the doctor's instructions. Other VOLAGs will accompany the refugee to the doctor's office and serve as an interpreter during the appointment. In either case, physicians generally only provide interpreters if they or one of their staff speaks the refugee's preferred language. Medicaid will not reimburse physicians for the cost of interpreters; and private physicians do not have access to the telephonic interpreter services under state contracts.

None of the interviewees believes that refugees are adequately prepared to derive the most benefit from the health care system. Most also feel that few if any physicians are adequately prepared to provide culturally sensitive care to refugees. There is much room for improvement in the preparation of both groups to create an effective health care environment for this vulnerable group. All individuals interviewed agreed that refugees are not adequately prepared or encouraged to seek preventive health care.

Both physicians that were interviewed seemed willing to see more refugee patients. Both were immigrants themselves and were especially interested in providing care for refugees from their countries of origin.

Common obstacles to refugees receiving follow-up and preventive care that were identified by interviewees include:

- Providers don't have interpreters available.
- Transportation is an obstacle. Medicaid will pick refugees up to take them to a doctor's appointment, but there is a three page form that has to be completed to qualify for the ride. It may have to be completed each time they need a ride. There is a phone number they have to call three days before the appointment. And, to complete the application, you must have a SSN, but Cuban and Haitian entrants don't get SSNs until they get their Employment Authorization Documents which takes three months.
- Not all plans provide transportation; those that do don't always communicate well about how to secure transportation.
- It is difficult for refugees to set up medical appointments on their own.
- There is a lack of communication about health care options – e.g., what they are eligible for.
- They don't know how to get prescriptions filled.
- There is a long wait to see specialists, sometimes as much as four to five months.
- Some refugees cannot come in during regular office hours due to work.
- Before reforms, there was a lack of specialists who would treat Medicaid patients.
- Refugees only seek care if there is a health crisis.
- Some services are not covered by Medicaid – like dental.
- In some cultures it is not acceptable for a woman to be cared for by a man.
- Refugees are not educated about health care and the health care process.
- Poor nutrition can be a deterrent.

Recommendations for process enhancements

The following recommendations were derived from the interviews conducted by Chiles Center staff. DOH staff helped identify state and federal written policies that were supportive of the recommendations.

The recommendations are organized as they relate to the steps in the refugee health care process describe in the “Regulatory Mandates” section of this report.

Treatment for Class A conditions:

The local county health department should meet with local VOLAGS to determine if treatment for Class A conditions is being provided within seven days of arrival for refugees in their communities. If not, a process should be established to ensure that such treatment is made available. Providers should be identified, interpreter services need to be available, and a payment method should be established. Two possible mechanisms are:

Before the CDC begins sending overseas health information electronically to the RC:

- VOLAGs simultaneously contact the doctor who signed the waiver to make an appointment to bring the refugee in for care and inform the RC immediately upon arrival of a refugee with a class A condition. The doctor will have to report the treatment to the RC after seeing the refugee.
- For the rare occasion that there is no signed waiver form, develop a list of providers in the community who agree to provide such services, organizing the provider list according to conditions each agrees to treat. This list of providers will be available to all VOLAGs, who will then take the responsibility to call a provider for an appointment. The VOLAG will then take responsibility to ensure the refugee arrives for treatment and to communicate about the type of interpreter that is needed.
- Educate the providers’ staff regarding billing procedures.

After the CDC begins to send overseas health information electronically to the RC:

- As soon as the RC is notified, they need to contact the VOLAG to see if the VOLAG has already taken the refugee for treatment.
- If the VOLAG has not taken the refugee for treatment, the RC needs to discharge its duties as described in Appendix 1, if it is a TB condition.

Orientation to the health care system

All Duval County providers seem to agree that refugees are not sufficiently oriented to get the maximum benefit from Florida’s health care system. Some VOLAGs provide relevant information during orientation, but all believe that more is needed. Some ways to improve this circumstance are:

- Someone from the county health department, like a medical case manager, could provide health care orientation for all refugees.

- AHCA choice counselors could meet regularly with new groups of refugees to educate them about health benefits and how to choose a plan that is suitable.
- Each health plan can have one person who specializes in orienting new foreign-born enrollees.
- Medical case managers can serve as an information resource for VOLAGs and refugees to provide continuous education to refugees until each is ready to seek health care independently.

Health care coverage – Medicaid or RMA

Initial enrollment in Medicaid or RMA

The eligibility determination/enrollment process seems to be working efficiently and effectively in recent months. Good features include:

- VOLAGs are voluntarily completing the DCF forms on line for refugees and assisting with the selection of a Plan.
- DCF using a refugee specialist to determine refugee eligibility has also improved the process, ensuring that refugees are enrolled as soon as possible.

Refugees may not, however be availing themselves of medical care because of a lack of understanding of the system. If the suggestions to improve orientation to the system described in the preceding section are followed, it may encourage better utilization.

Other suggestions regarding Medicaid enrollment are:

- If there were a specific choice counselor who worked with all refugees, it would facilitate the plan selection process. This person would be familiar with challenges refugees often face and with their special needs.
- Since language is such an important aspect for refugees accessing health care, it would be immensely helpful for refugee plan selection if plans provided information about languages spoken in each doctor's office. This would require an additional piece of data for AHCA to collect from each participating physician.

Re-application for Medicaid after eight months

Refugees covered by RMA need assistance navigating the Medicaid re-enrollment process.

Some strategies that might be helpful would be:

- The medical case manager (recommended above) could guide each refugee through the re-enrollment process. This person would have to be copied on the letter sent to refugees about benefit termination. This will make it more likely that the refugee will actually be informed of the opportunity for continued coverage.
- DCF should consider sending refugees a single letter providing all the necessary information about the reapplication process.
- With the trend to providing Medicaid care through capitated arrangements with defined health care plans, there is a natural incentive for health care plans to keep refugees enrolled in Medicaid after their initial eight-month enrolment period. A win-win situation could be created for the refugee and the plan if DCF could be informed of the

plan in which each refugee is enrolled. They then could set up a system informing the plan of the impending termination date for the refugee, and the plan could then work with the refugee to assist with the re-enrollment process.

Domestic medical examination:

The RC should have written procedures that are shared with VOLAGS. The written procedures should include actions that need to be taken and anticipated timelines. Procedures should address:

- Obtaining treatment within mandated time frames for refugees with Class A conditions on their overseas health evaluations.
- Making appointments for initial health examinations.
- Timeframes for scheduling appointments.
- Defining method for communicating appointments in a written format.
- A list of necessary forms to be submitted before appointments can be scheduled, including acceptable alternatives in the event that the refugee does not have an I-94 or an overseas medical screening form.
- A written plan on language assistance (as required by HHS Guidelines, 2003) including how trained medical interpreters will be available during every refugee visit to the county health department.
- Obtaining immunizations.
- Re-scheduling missed appointments.
- The process for evaluating the results of TB tests, including the point at which the TB Clinic will become involved.
- Reporting treatment for identified conditions to DOH
 - Conditions found during the domestic medical examination that were not identified during the overseas health screening; conditions with public health significance should be reported immediately
 - Treatment for conditions identified during the domestic medical examination

A process needs to be established and communicated so that VOLAGs, health care providers, and CHD staff each understand their roles in this reporting process.

Scheduling appointments

- All RC appointment times should be communicated to VOLAGS in writing. Fax and e-mails are acceptable.
- All refugees should be able to have a health screening within 30 days of arrival.
- The appointment scheduling process should be both more timely and more flexible:
 - The procedures for scheduling appointments should be provided in writing and applied consistently.
 - Both Cuban and Haitian entrants and asylees may not have an I-94 at the time of scheduling an examination. If the VOLAG does not have that form or another source of identifiable picture ID, RC staff should be prepared to take a picture of the refugee for the official medical record. Lack of picture ID should not delay the scheduling of an examination.

- While it is convenient to the VOLAGs to bring in all their clients on the same day, the RC should, when a full day of appointments with refugees from one VOLAG is not scheduled be willing to schedule appointments for a second VOLAG on that same day. This would permit refugees to have examinations at the earliest possible date.
- Perhaps one group could be scheduled earlier in the day and one later.
- It would be advisable to schedule approximate appointment times as well as appointment days.
- Opportunities for second immunizations should be available more than two times in a month. As refugees become self-sufficient, they are less available to come in for an appointment on demand.
- Rescheduling missed appointments should be timely and not require the resubmission of documents already provided by the VOLAG.
- It should be possible for VOLAGs to perform the scheduling of appointment function during any working day. Appointments should be available during every week of the year, using back-up clerks and nurses when necessary, both to allow RC staff to take needed vacations and sick time and to ensure that examinations can occur in a timely manner.

Domestic medical examination

- Examinations should be conducted, at a minimum, by a Registered Nurse.
- The CHD must provide a qualified interpreter, in person or telephonically, during all medical encounters unless the refugee speaks fluent English. If the refugee request to have his or her own interpreter, the CHD is still responsible for having a qualified interpreter present. Health and Human Services (HHS) Guidelines published in August of 2003 (HHS, 2003) require this of all recipients of federal funds.
- VOLAG case workers should remain with refugees at health examinations and medical appointments to serve as interpreters, if qualified, and to guide refugees through the process.
 - It should be understood that such activities are purely voluntary. In fact, the federal guidelines (2003) recommend that anyone serving as an interpreter be trained to interpret and be familiar with the vocabulary of the medical environment. So, unless the VOLAG employee has been so trained, he or she should not be relied upon by the RC as an interpreter.
 - According to the HHS guidelines (2003), the RC clinic is responsible for determining the qualifications of a proposed interpreter and, in all cases where the proposed interpreter is not trained, they should use the telephonic interpretive services provided for by DOH.
- To conform with federal guidelines (HHS, 2003), the RC should post notification to inform refugees of the availability of language assistance and instructions about how to request such assistance.
- The process for evaluation of the results of TB tests should be modified. The RC should read the skin tests and only send refugees with positive skin tests to the TB clinic for further tests and treatment.
- One VOLAG suggested that the LPN at the RC could make good use of an assistant.

- Another VOLAG suggested the RC should reinstitute full physicals; they used to have a physician do all the screenings; now they have less thorough examinations.
- RC staff suggested that asylees should be screened earlier.
- The LPN would like to be able to request an HIV test if the refugee has not already had one. Right now, they only get reimbursed for tests for syphilis and hepatitis. According to DOH, they do provide reimbursement for HIV testing.
- The CHD must provide a qualified interpreter, either in person or telephonically, during all medical encounters unless the refugee speaks fluent English or requests not to have a trained interpreter.
- DOH should ensure that county health departments have the tools and knowledge to provide appropriate services – e.g., background and health information on clients.

Immunization

- The RC should provide immunizations for all refugees, regardless of age, health status, or health care coverage. Or, alternatively, the Children’s Health Unit of the CHD should agree to fill in the gaps, immunizing all refugees too young to be immunized in the Refugee Health Clinic, including minors not attending school and refugee children already covered by Medicaid. This recommendation is consistent with Florida Department of Health policies regarding reduction of missed opportunities for immunization (see Appendices 2, 3, 4, and 5), which emphasizes taking advantage of any opportunity to assess a patient’s immunization status and to provide immunizations without delay.
- The RC would like to have access to overseas records of immunizations. Burma provides immunization records but other camps do not. An example given regarding why this would be desirable is: RC staff reports that 75% of refugees are testing positive for TB which requires them to go on preventive medication and have chest x-rays. This is probably because they have been immunized before arrival. If all overseas health screening forms recorded immunization history, the refugees could avoid the inconvenience and the state could avoid the expense.

While access to immunization records would be beneficial, a 1996 MMWR (ACET 1996) published by the CDC indicates that use of the Bacillus of Calmette and Guerin (BCG) vaccine is of questionable efficacy. In fact, the report indicates that “The presence or size of a post-vaccination tuberculin skin-test reaction does not predict whether BCG will provide any protection against TB disease.” Therefore, it is prudent to provide chest x-rays and preventive medication to all refugees testing positive for TB, even if there is a record of BCG vaccination.

Reporting information to DOH in Tallahassee:

- As soon as VOLAGs consider resettling refugees in a county without a designated refugee clinic, they should contact DOH Refugee Health staff to inform them of their plans. In this way, DOH can provide technical assistance to CHD staff in the new county to prepare them to conduct domestic health examinations.
- RCs should regularly report conditions they find that were not identified in the overseas evaluation to DOH Refugee Health Program.

- DOH should be informed about follow-up care for conditions identified at the domestic medical examination.
- The RC should report all active TB cases to DOH Refugee Health Program per state disease reporting requirements.

Other suggestions:

- It might help if DOH headquarters were consulted about recommended staffing structure.
- DOH headquarters should analyze the data they receive from RCs monthly to identify problems and trends.

Health care seeking behavior:

Prior to Medicaid coverage:

- Someone needs to take the responsibility (or have the responsibility delegated to them) to maintain a list of health care providers willing to provide health care to refugees before they receive Medicaid cards. Medicaid coverage is retroactive to the date of entry into the US, so it shouldn't be too difficult to find primary health care providers and specialists, who ordinarily serve Medicaid recipients, who would be willing to provide care to refugees before they are officially enrolled in a particular plan.
- Such a list could be revised quarterly and distributed to all VOLAGs.

After Medicaid enrollment:

One suggestion that was made by many system participants was to have a medical case manager, possibly housed in the county health department. The person or persons in this position could play several roles, including but not limited to:

- Monitoring the communication among health care providers, VOLAGs, and the county health department to ensure refugees avail themselves of follow up care and that the care is reported back to the county health department.
- Accepting the responsibility to provide needed assistance with health care and mentoring the refugee until he or she is ready to use health care independently, after the first three months of resettlement services are provided by a VOLAG and if the VOLAG feels that a particular refugee needs additional assistance with the health care system.
- Serving as a health care resource by working with VOLAG staff during the first three months of resettlement to ensure that all refugees receive information about how the health care system works.
- Capitalizing on the cultural diversity of physicians in Florida to develop and maintain a list of local physicians by specialty group and location who have the capacity to provide qualified in-office interpreters for specific languages.
- Serving as a guide through the process of reapplication for Medicaid after the initial eight months of coverage for all refugees covered by RMA. DCF would have to send a copy to the case manager on all notification letters sent to refugees.
- Providing orientation sessions for physicians interested in providing culturally sensitive care for refugees.

Care for identified conditions

It is important for the health of refugees and the general public for refugees to seek treatment for conditions identified during the domestic health examination and for preventive health care.

To protect public health and safety, it is imperative that all refugees with health conditions receive proper treatment. To ensure the provision of such treatment:

- A feedback system needs to be devised and adhered to that will ensure that conditions identified during either the overseas medical screening or the domestic health examination are treated correctly and in a timely manner. This system requires active participation of the state DOH, VOLAGs, Refugee Clinic staff, and physicians. Roles need to be clearly defined and the process needs monitoring.

Refugees enter this country with a spectrum of communications capabilities. Some are quite proficient communicating in English; such refugees need minimal guidance in obtaining follow-up or preventive care. However, many refugees are neither proficient in English nor grasp the complexities of available health care. While some refugees have family or community members that are happy to serve as linguistic interpreter and as interpreters of the US health care system, using friends and relatives as interpreters is not recommended by the HHS Guidelines (2003), both because they are not trained in medical interpretation and their involvement may raise confidentiality issues. Low English proficient refugees need a great deal of assistance in obtaining appropriate quality care.

Especially since they are responsible contractually for follow-up care after the domestic health examination, VOLAGs should offer to accompany refugees to follow-up appointments.

Interpreters

To provide refugees quality health care, it is imperative that they are understood by the health care provider and they understand what the provider is telling them. This mutual understanding would be greatly facilitated if the provider spoke the refugee's native tongue or if someone were present during office visits to serve as a trained interpreter. There are four possible ways to accomplish this end:

- The provider speaks the language in question
- Someone on staff with the provider can serve as a qualified interpreter for that language
- Free interpretive services, either face-to-face or telephonic, are provided upon request through an organization
- Physicians are reimbursed through Medicaid for providing interpretive services, either in the office or telephonically, when requested.

The last two possibilities are not likely in the current environment because, in Florida, there is no funding stream to cover the cost of interpretive services in physicians' offices. Therefore, AHCA staff has suggested that

- An additional data field be added to the file for each health care provider in every plan: languages spoken by office staff. If such data were available for every provider's office, staff could be trained in medical interpretation, and refugees could be guided to enroll in plans where their preferred language is spoken in a provider's office.

Although Florida Medicaid does not currently permit physicians to be reimbursed for interpreter services, the federal government does provide matching funds to states to help cover this cost of

interpreter services for limited English proficiency (LEP) clients who are Medicaid and SCHIP recipients. Currently, twelve states and the District of Columbia have programs to utilize these funds and several other states have pilot programs or are planning to implement such reimbursement plans (Connecticut Health Foundation, 2007). With Florida's status as a major recipient of refugees, the state has every reason to avail itself of this funding for interpreter services. Medicaid can pay for interpreter services through contracts with language service agencies, reimbursement of providers for hiring interpreters, direct reimbursement of interpreters, or provision of access to a language line (National Health Law Program, 2007). The statewide parties responsible for ensuring refugees receive quality services, Department of Health, Department of Children and Families, and the Agency for Health Care Administration, should collaborate to ensure that interpreter services are included in Florida's State Medicaid Plan and that CMS approval is obtained, if needed.

In fact, the federal guidelines require all physicians accepting payments derived from federal funds to provide qualified interpreter services. The only specific exemptions from this requirement are for physicians who only receive federal funding through **Medicare Part B**. Therefore, to be consistent with federal guidelines, Florida's Medicaid Plan should reimburse physicians for the use of interpreters (see National Health Law Program, 2003).

When they make a physician appointment for a refugee,

- VOLAGS need to tell physicians' staff that an interpreter will be needed for the refugee. This will allow the physician to plan for the availability of an interpreter if possible.

Refugees seeking preventive health care

Most refugees are so overwhelmed in their new environments that education on the advisability and availability of preventive health care is not considered a priority to refugees themselves or even to those providing essential resettlement services. Although some information may be provided during orientation sessions, the information is most likely lost in the noise. It is more likely that refugees will be more open to hearing information about prevention after they have been in the country for a while. To ensure refugees are exposed to information about preventive health care when they are receptive:

- VOLAGs, DOH, and county health department staff could collaborate to develop a health care curriculum for refugees to be offered after refugees have been here for three months. In fact, county health departments have educators that they send out to provide prevention educations. These people could be instrumental in leading the curriculum development and delivery efforts.

Preparing refugees and physicians for an effective health care environment

- Refugees that continue to need assistance accessing medical care after the standard three-month resettlement process, should be assigned to a medical case manager who will be responsible for continuing refugee orientation to the health care system and educating them to be independent of assistance as early as possible.
- When refugees become independent, they should still have access to the case manager for answers to questions that may arise or as an advocate when they experience road blocks in the system.
- The medical case manager can also provide regular orientation sessions for physicians that wish to provide care to refugees.

Summary

This report reviews the federal mandates related to refugee health status and health care. Information derived from interviews of Duval County providers is used to describe the Duval County refugee health access process. Suggestions made by interviewees regarding facilitation of refugee health care are summarized for consideration by process participants.

References

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Connecticut Health Foundation. Seeking Solutions: State Approaches to Covering Medical Interpreter Services in Medicaid and SCHIP Programs. *Policy Brief*. April 2007.

Department of Health and Human Services. Guidance for Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficiency Persons, *Federal Register*, August 8, 2003, Volume 68, Number 153, pages 47311-47323.

National Health Law Program. Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency. 2003.

National Health Law Program. Show me the Money: How Medicaid Can Pay for Language Services. 2007.

Appendix 1:

TECHNICAL ASSISTANCE: TB 10
October 1, 2002

Class A/B Tuberculosis (TB) Notification

I. TYPE OF STANDARD: Service

II. OUTCOMES:

Prevention of tuberculosis through testing of selected foreign-born persons entering the United States (U.S.) who are at high risk for tuberculosis disease; and the appropriate treatment of persons identified from this testing who have latent TB infection (LTBI) or active TB disease.

During the last several years, TB in the U.S. has been characterized by substantial declines in both the number of reported cases of TB among U.S.-born persons and in the case rate for U.S.-born persons. Concurrently, the number of cases among foreign-born persons has been relatively stable while the case rate has declined only modestly. Most cases of TB among foreign-born U.S. residents probably result from infection with *M. tuberculosis* while living in the person's country of birth. Consequently, the strategy adopted by the Centers for Disease Control and Prevention (CDC) and the Bureau of TB and Refugee Health is to mount an aggressive program to evaluate and, when necessary, provide prompt and complete treatment of persons found to have LTBI or active TB disease.

III. PERSONNEL:

Administrator, Refugee Health Program; County Health Department (CHD) Refugee Program Coordinator; TB Program Supervisor; Area TB Program Manager/Coordinator; Area TB Surveillance Officer; Field Services Staff, Bureau of TB and Refugee Health.

Each discipline will perform activities within the constraints of their respective practice acts, job descriptions, and protocols.

IV. GOALS AND OBJECTIVES:

The goal of this program is to ensure the evaluation and treatment, as appropriate, of all referred immigrants and refugees who are identified to have LTBI or active TB disease.

TA-TB 10-p. 1

TECHNICAL ASSISTANCE: TB 10
October 1, 2002

V. DEFINITIONS:

CDC 75.17: A form used by the Centers for Disease Control and Prevention to report Class B conditions to state health departments.

CDC 75.18: A form used by the Centers for Disease Control and Prevention to report Class A conditions to state health departments.

Class A Condition: A determination that is based on tests given abroad indicating finding consistent with a specific disease that is infectious.

Class B Condition: A determination that is based on tests given abroad indicating findings consistent with a specific disease; however, the disease was not infectious.

B-1: Tuberculosis, clinically active, not infectious

B-2: Tuberculosis, not clinically active, not infectious

Evaluation: An evaluation consists of a physical examination, x-ray, sputum or other specimen culture, and other measures to verify information presented in the DS-2053, CDC 75.17, and 75.18 forms.

DS-2053: Report of Overseas Medical Examination conducted by a physician under contract with the U.S. Government to examine persons, applying for residency in the U.S., for freedom from communicable diseases.

Immigration Statuses:

Alien: A generic term for non-citizens of the U.S. that include, among others, persons classified by the U.S. Immigration and Naturalization Service as refugees, immigrants, and asylees.

Asylee: An alien who has received permission to remain in the U.S. based on a "well-founded fear of persecution" should the alien return to the native land. A prospective asylee applies for this permission from U.S. soil, unlike a refugee, who applies from abroad. They must demonstrate that they meet the statutory definition of "refugee."

Immigrant: An alien admitted to the U.S. as an actual or prospective permanent resident; an alien with the right to eventually obtain citizenship, i.e., an alien living here permanently.

Refugee: An alien defined by the Immigration and Nationality Act, Section 101(a)(42) as: (a) any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, or (b) in such circumstances as the President after appropriate consultation (as defined in section 207(e) of this Act) may specify, any person who is within the country of such person's nationality or, in the case of a person having no

nationality, within the country in which such person is habitually residing, and who is persecuted or who has a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The term "refugee" does not include any person who ordered, incited, assisted, or otherwise participated in the persecution of any person on account of race, religion, nationality, membership in a particular social group, or political opinion.

If the client has one of the following immigration statuses: Amerasian; Asylee; Cuban/Haitian Asylum Applicant; Cuban/Haitian Entrant; Cuban/Haitian Parolee; or Refugee, the PPD and chest x-ray are reimbursable through the Refugee Health Program, if performed within 90 days of arrival in the U.S.

Treatment: Refers to the treatment of latent TB infection or active TB disease consistent with Technical Assistance Guideline TB 3 - Targeted Testing and the Treatment of Latent Tuberculosis (TB) Infection and Technical Assistance Guideline TB 6 - Treatment of Tuberculosis Disease.

VI. SPECIFIC AREAS OF RESPONSIBILITY:

Administrator, Refugee Health Program

General Discussion of Responsibilities:

Establish and manage a system to transmit, track, and assure proper assessment of persons referred by the CDC to the Bureau of TB and Refugee Health for evaluation and treatment, if necessary.

Specific Tasks Included in Responsibilities:

- Notification of the county health department within one day of receipt of a report (CDC 75.17 or CDC 75.18) of an alien with a Class A/B TB condition.
- Transmission of a copy of the Overseas Medical Exam (DS-2053) and the CDC 75.17 or CDC 75.18 within one day of receipt from CDC based on one of the following circumstances:
 - If the alien is a **refugee in a county with a CHD Refugee Program Coordinator**, the original local CHD copy of CDC 75.17 or 75.18 is sent with the DS-2053 and cover letter to the CHD Refugee Program Coordinator in the appropriate county and copies of the CDC form, the DS-2053 and cover letter are sent to the area TB Program Manager/Coordinator.
 - If the alien is a **refugee, but there is no CHD Refugee Program Coordinator in the county**, the original local CHD copy, the DS-2053 and cover letter are sent directly to the Area TB Program Manager/Coordinator for initiation of follow up action.
 - If the alien is an **immigrant**, the original local CHD copy, the DS-2053 and cover letter are sent to the Area TB Program Manager/Coordinator, who is responsible for coordinating the evaluation of the client.

- Input of data from the State Health Department Copy of CDC 75.17 or CDC 75.18 into the “Class A/B” database and filing of the State Health Department Copy, by county, along with a copy of the DS-2053 and the cover letter sent to the CHD.
- Marking returned CDC 75.17 or CDC 75.18 reports with the date received and making a copy.
- Mailing the original and a cover letter to the data manager at CDC.
- Input of information regarding the evaluation into the “Class A/B” database. Also, verification that the county name is correct/updated in the database. Filing the copy of the Local Health Department Copy and the copy of the cover letter sent to the CDC data manager, by county, with the original.
- Producing a “Class A/B 45 Day Reminder” report monthly and distributing it to the appropriate Area TB Program Manager/Coordinator with copies to the Director of Field Services. (Report will be sorted by class, arrival date, and age.) No client will be taken off the “Class A/B 45 Day Reminder” report until the CDC 75.17 or CDC 75.18 has been returned either complete with the evaluation information or marked as “alien did not report.”

CHD Refugee Program Coordinator or TB Program Supervisor

General Discussion of Responsibilities:

- The Refugee Program Coordinator is responsible for clients with immigration statuses that are eligible for reimbursement, as identified in Definitions. The TB Program Supervisor is responsible for clients with all other immigration statuses.
- Receive referrals of refugees/immigrants with Class A/B conditions and make contact with the client within three working days to schedule an examination.
- Perform or supervise the performance of appropriate examinations to verify information contained in the CDC 75.17.
- Coordinate and track any treatment of active TB disease or LTBI identified in the examination. (CHD Refugee Program Coordinator will refer clients to TB Program Supervisor, as appropriate.)
- Provide all services in a culturally and linguistically appropriate manner.
- Return the completed Forms CDC 75.17 to the Refugee Health Program, or the area TB Program Manager/Coordinator, as appropriate within 60 days showing the results of the examination.

Specific Tasks Included in Responsibilities:

- Client Contact. Locate the client, schedule for evaluation, conduct or arrange the evaluation as specified on the CDC 75.17, and refer to the TB Control Program for any follow up treatment identified.
- Complete the CDC 75.17. This includes checking the appropriate block in the box marked “Local Health Officer” in the top right corner of the form, obtaining the physician’s signature on the form, and writing the name of the county health department in the appropriate space. A copy of

the CDC 75.17 can be returned if the original cannot be located. All forms should be edited for completeness before being returned.

- If client is located and evaluated: Return completed CDC 75.17 to the Refugee Health Program for clients who are located and evaluated. **All blanks must be filled in.** Paperwork accompanying the CDC form should be filed in the client's record.
- If client is not located: Complete and return the CDC 75.17 to the Refugee Health Program. Shred or retain the accompanying paperwork at the CHD's option. If the client has moved but new location is unknown, process the CDC form in the same manner as that of a client who cannot be located, including checking the block, signing the form, and writing in the name of the health department. Also, indicate that the client has moved to an unknown location, and return the CDC form. **All appropriate blanks must be filled in.** The accompanying information can be shredded or filed.
- Client moved to another state: Write the new address on the CDC 75.17, if known, and follow the instructions for completing the CDC 75.17 as if the client could not be located, including checking the block, signing the form, and writing in the name of the health department. Prepare a Florida Confidential Interstate/Intrastate Referral Form (consistent with TB Interstate/Intrastate Notification guideline), in as much detail as possible, and send it with the CDC 75.17 and all accompanying paperwork to the Refugee Health Program. The Refugee Health Program will clear its record of the client and forward the information to the Field Services Section for forwarding to the client's new state of residence.
- Client moved to another county in Florida: Write the new address on the CDC 75.17, forward all information to the new location and send a copy of the CDC 75.17 with the new address to the Refugee Health Program.
- Case Management. Clients identified to require treatment for LTBI or active TB disease should be referred to the TB Control Program for case management. No additional follow-up to the Refugee Health Program concerning the outcome of this referral is required at this time.
- Pregnancy Special Case Instructions.
 1. In a few instances, the overseas evaluation of a pregnant female immigrant or refugee cannot be completed. Such individuals are often referred to the CHD for evaluation without a CDC 75.17. These cases are not tracked by the Refugee Health Program in the same manner as regular referrals. Typically, in such cases, the tuberculin skin test (TST) will be positive and active TB disease ruled out, but treatment may be delayed by the provider until after delivery. In these cases, the CHD should hold the referral letter until conclusion of the pregnancy at which time the evaluation can be completed.
 2. If the x-ray is negative, manage the client per CHD protocol, but do not return the referral to the Refugee Health Program. If the x-ray is abnormal, manage the client per CHD protocol and complete a blank CDC Form 75-17 to return to the Refugee Health Program.

Area TB Program Manager/Coordinator; Area TB Surveillance Officer

General Discussion of Responsibilities:

The Area TB Program Manager/Coordinator or Surveillance Officer is responsible to receive, track, and report on the status of all referrals for counties in his or her area of responsibility. The area TB Program Manager/Coordinator or Surveillance Officer is also responsible for assuring that all forms from CHDs in his/her area are complete before they are returned to the Refugee Health Program.

For Class A conditions: Ensure completion of CDC 75.18 by private physician. Have the local health officer endorse the form and return it to the Refugee Health Program.

Field Services Staff, Bureau of TB and Refugee Health

General Discussion of Responsibilities:

Assists the Refugee Health Program by providing follow-up services to ensure timely and complete processing of all referrals.

Specific Tasks Included in Responsibilities:

- Reviews “Class A/B 45 Day Reminder” reports on a monthly basis and contacts appropriate Area TB Program Managers/Coordinators to ensure receipt of the report.
- Checks the “Class A/B” database after 10 working days of notification to see if overdue evaluations have been entered into the database. Contacts the Area TB Program Manager/Coordinator regarding those that remain overdue.
- If the notification paperwork for a Class A/B has been lost, the Area TB Program Manager/Coordinator or CHD works with the Refugee Health Section to recreate the paperwork and resend to the Area TB Program Manager/Coordinator.
- Forwards CDC 75.17 and CDC 75.18 forms to the appropriate state, for refugees/immigrants moving out-of-state.
- Assures that a discussion of the efforts made by CHDs regarding Class A/Bs is included in Quality Improvement reports. The review should measure CHD performance against the state goal of 85% of Class A/Bs receiving a complete evaluation and 100% of the CDC 75.17 and CDC 75.18 forms being returned to the Refugee Health Section.

VII. Confidentiality: All forms, reports and other documents containing client identities are subject to the Department of Health, Bureau of TB and Refugee Health, and local CHD security procedures. All reports, that are mailed, will be sent by traceable mail in double envelopes marked “Confidential” on the outside. If fax is used, established security procedures will be followed.

VIII. Reporting: Evaluations conducted under these guidelines may be reported in the Project category in the Targeted Testing Report.

5. On average, how soon after arriving do refugees actually have their health evaluations?
6. What percent of refugees do you think have health evaluations?
7. If a need for treatment is indicated in the health evaluation, how are refugees referred for treatment?
8. If a communicable disease is identified during the initial health screening, how is care for that condition provided?
9. In an ideal world, how do you feel the system for refugee health evaluation should work?
10. Does anyone in Duval County make any attempt to follow-up a refugee's efforts to seek treatment or to obtain medical care of any kind? If so, what is the process that is used?

11. Does anyone in Duval County make an effort to communicate prevention information to refugees? Who? What do they do?

12. What is the process for enrolling refugees in Medicaid?

13. What obstacles exist to refugees seeking healthcare?

14. What are the reasons refugees leave Medicaid enrollment?

15. Do you think today's refugees are adequately prepared to get the most from the healthcare that is available to them?

16. Do you think healthcare providers are adequately prepared to provide appropriate and culturally sensitive healthcare to refugees?

17. In an ideal world, what do you think the system should look like to follow-up on refugee health care and health status?

Appendix 3:

INTERNAL OPERATING POLICY: IMMUN 3

Reduction of Missed Opportunities for Immunization

Policy: County health department (CHD) staff will routinely assess the immunization status of clients aged 0-18 years and other children in the household, regardless of the purpose of the visit, and provide all medically indicated immunizations to those present. The highest priority will be given to children 0-2 years old. Reduction of missed opportunities for childhood vaccine is based on the recommendations found in the Standards for Pediatric Immunization Practices, U.S. Department of Health & Human Services.

In addition, all adults receiving comprehensive primary care services at the CHD should be assessed for needed immunizations and vaccine should be offered if indicated. Reducing missed opportunities for adults is based on the Standards for Adult Immunization Practice, which is encouraged by the National Coalition For Adult Immunization and endorsed by the Centers for Disease Control and Prevention.

Authority: Section 381.0011, F.S.

Effective Date: April 1, 2002 (Reviewed August 2006)

_____(Signature on file)_____

____ 4/01/02 _____

Bonita J. Sorensen, M.D., M.B.A.

Date

Deputy State Health Officer

For technical assistance on this policy, see TA-IMMUN 3 and TA-IMMUN 7

Appendix 4:

INTERNAL OPERATING POLICY: IMMUN 1

Vaccine Eligibility

Policy: The DOH State Health Office Bureau of Immunization will provide certain vaccines and immune globulin at no cost to DOH County Health Departments (CHDs). These products will be available at no cost to eligible CHD clients 0-18 years of age regardless of income status. Eligibility is based on recommendations of the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Services Centers for Disease Control and Prevention and the availability of the vaccine or immune globulin through the DOH State Health Office Bureau of Immunization.

Authority: Section 381.0011, F.S.

Effective Date: April 1, 1998 (Reviewed August 2006)

State Health Officer

Date

For technical assistance on this policy, see TA-IMMUN 1.

P-IMMUN

Appendix 5:

TECHNICAL ASSISTANCE: IMMUN 3
OCTOBER 1, 2004

Reduction of Missed Opportunities for Immunization

I. Adoption of the Standards for Child and Adolescent Immunization Practices

A. The Standards for Child and Adolescent Immunization Practices are recommended by the National Vaccine Advisory Committee, approved by the United States Public Health Service, and endorsed by the American Academy of Pediatrics.

B. Adoption of the standards will assist county health departments (CHD) in identifying needed changes to enhance childhood immunization practices, and in removing all barriers to the immunization process, and in reducing missed opportunities and eliminating disparities in immunization coverage between minority and non-minority population groups.

C. The current Standards for Child and Adolescent Practices can be accessed at the following Center for Disease Control and Prevention (CDC) Internet site: <http://www.cdc.gov/nip/recs/rev-immz-stds.htm#childlist>.

D. The Quality Improvement site visit and the annual site visit include an evaluation of the implementation of these Standards at each CHD site.

II. Adoption of the Standards for Adult Immunization Practice

A. The Standards for Adult Immunization Practices are encouraged by the National Coalition for Adult Immunization and endorsed by the Centers for Disease Control and Prevention (CDC) and major medical groups nationwide.

B. The Standards for Adult Immunization Practices can be accessed at: <http://www.cdc.gov/nip/recs/rev-immz-stds.htm#adult>.

C. Adoption of the Standards that are appropriate for CHDs will assist in identifying needed changes to enhance adult immunization policies and practices, and in removing all barriers to adult immunization process and in reducing missed opportunities for immunization and eliminating disparities in immunization coverage between minority and non-minority adult population groups.

Vaccine Eligibility

I. Eligible Immunizations, VFC Eligibility/Screening, and Documentation:

The Department of Health (DOH) Bureau of Immunization will provide certain vaccines and immune globulin to county health departments (CHD) without charge. These products will be made available free of charge to eligible CHD clients under 19 years of age regardless of income status, subject to availability.

A. **Eligible Immunizations:** CHDs will make available, free of charge, the following vaccines to all eligible clients under 19 years of age:

1. All vaccines recommended by the Recommendations of the Advisory Committee on Immunization Practices (ACIP).
2. All immunizations necessary for admittance and attendance in Florida schools (public or private), child care facilities or family day care homes, in accordance with sections 1003.22, 402.305, and 402.313, Florida Statutes; and Rules 64F-16.004 , 64F-16.005 ,64D-3.011, 65C-22, and 65C-20, Florida Administrative Code.

B. VFC Eligibility/Client Screening:

1. CHD clients less than 19 years of age should be screened to determine Vaccines For Children (VFC) eligibility type by referring to the following criteria:

M = Medicaid (client is enrolled in Medicaid)

N = No insurance (client does not have any health insurance)

U = Underinsured (client has health insurance that does not cover immunizations)

A = American Indian or Alaskan Native (check if client indicates he/she is an American Indian or Alaskan Native)

O = Other (client does not meet one of the above VFC eligibility categories)

2. Clients presenting to the CHD and enrolled/covered by health insurance should be encouraged to request immunizations from their health care provider. However, in order to avoid a missed opportunity, appropriate vaccines should be offered at that contact. These children should be entered as VFC Screening code "O" in the Immunization Module. The CHD should provide the immunization documentation to the parent/guardian to give their health care provider.

C. Documentation of VFC Eligibility:

1. A client's VFC eligibility status should be indicated by noting the appropriate code (refer to paragraph I.B.1.) in the space provided on the client's Immunization Clinic Record/Signature Card (Form DH 687).

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2. A client's VFC eligibility status should also be recorded in the Immunization Module/Florida SHOTS of the Public Health Management System (PHMS).

II. Vaccines:

The following vaccines or their combinations will be provided at no cost to CHDs for clients aged 0-18 years, subject to availability.

A. Routine Childhood Vaccines:

1. Diphtheria, tetanus, and a cellular pertussis
2. Inactivated polio
3. Measles, mumps, and rubella (1st and 2nd doses)
4. *Haemophilus influenzae* type b Conjugate Vaccine
5. Hepatitis B
6. Varicella
7. Pneumococcal conjugate
8. Influenza for recommended age range

B. Other Vaccines and Immune Globulin Recommended by the ACIP For High-Risk Groups or For Special Circumstances:

1. Pneumococcal polysaccharide
2. Influenza
3. Hepatitis A
4. Diphtheria and tetanus (For children less than 7 years of age for whom pertussis vaccine is contraindicated)
5. Hepatitis B Immune Globulin (HBIG) [Refer to the Detection and Prevention of Perinatal Hepatitis B/Perinatal Hepatitis B Registry (Internal Operating Policy: IMMUN 7 and Technical Assistance: IMMUN 7)]

C. Hepatitis A and B Vaccines for Adults (under the following special circumstances):

1. **Sexually-Transmitted Disease (STD) Clients:**
Refer to Internal Operating Policy (IOP): STD 14 Hepatitis A and B Vaccine for High-Risk STD Clients and Technical Assistance (TA): STD 20 Guidelines for Providing Hepatitis-B Vaccine for High-Risk STD Clients.
2. **Contacts of a Pregnant HBsAg-Positive Women:**
Refer to IOP: STD 10 Hepatitis-B Follow-Up Among Pregnant Women and Their Sexual, Needle Sharing, and Household Contacts and TA: STD 16 Perinatal Hepatitis B Follow-Up.