REFUGEEHEALTH TECHNICAL ASSISTANCE CENTER

Domestic Refugee Health Screening Models and Clinical Guidelines Webinar
Wednesday, October 26, 2011
Questions and Answers

During the "Domestic Refugee Health Screening Models and Clinical Guidelines" webinar, participants had the opportunity to submit questions to the presenters, Dr. Paul Geltman and Dr. William Stauffer. Due to time constraints, not all questions were answered during the webinar. Questions and presenters' responses are provided here for those questions that were not covered during the webinar. The webinar can be viewed on the Refugee Health Technical Assistance Center (RHTAC) website www.refugeehealthta.org. For further questions or comments, please contact RHTAC by email at refugeehealthTA@jsi.com.

Part 1: Public Health Models for Refugee Health Screening
Speaker: Dr. Paul Geltman

Q: In your experience, which model provides the most benefit to the refugee?

I am somewhat biased toward the mixed public-private model as we have developed it in Massachusetts for over the past 15 years. Such a model affords uniformity of care following a fixed protocol across multiple sites, fixed costs with a standard rate set by the state health care financing agency, opportunity for high rates of initiation and completion, and, most importantly, sites of clinical care that can be located in communities with concentrated refugee resettlement as needed. In addition, such a model provides the opportunity to cultivate local clinicians as "experts" in refugee health for their clinics and communities, medical practitioners who become invested and supportive of the program, what are termed "provider champions" in quality improvement models. In reality, though, as I stated during the webinar, states must craft public health screening models that will work best given their respective clinical capacity and public and private health care infrastructures. In many states, that will mean utilization of existing local and county health departments and their clinics. For Massachusetts, this was not an option as we do not have the same county health infrastructure and so we worked with private partners, primarily federally qualified community health centers, to implement our program.

Q: The three models for medical health screening seemed to have been focused on funding models and less on the actual health screening processes, which are being paid by three or more funding sources. I'm particularly interested in the health screening process because ORR is requiring us to monitor health screening and we want to make sure that we do it effectively, and in ways that add value to a refugee's health.

It is very difficult to monitor concrete clinical outcomes of individual refugees without engaging in a formal and well-funded research project. However, I will say that the clinical content should approximate the guidelines elaborated by Dr. Stauffer in the second part of the webinar and available on the CDC's website. My purpose was to describe infrastructure models for the public health screening process. This focus was also intended to imply, with my mention of the example of recent developments in

Philadelphia and Pennsylvania, that states without well-structured, public refugee health programs should be moving in that direction. Within that context, there are different ways to approach ensuring quality of the process. In Massachusetts, we review all reporting forms to look for missing data or discrepancies. We will withhold payment for significant lapses or errors. In addition, we conduct annual site visits and chart audits to ensure that our sites are following clinical protocols. Part of this process also serves as a reminder to our sites that they should be following up on abnormalities detected and serving as a bridge into primary care. We emphasize a team approach to care for refugees with regular meetings of the team to ensure quality of care. Also, we place a heavy emphasis on the transition into primary care. In the latter context, we are looking to targeted testing that will help in the transition to primary care. An example of this might be testing for glycosylated hemoglobin in patients with diabetes. We are also able to monitor and report on timeliness of referrals by resettlement agencies, responses by clinical sites, initiation of first appointments, and completion of second appointments. Regardless of the system in place in your state, it is imperative to design a system of monitoring of the process and care that is being provided.

Q: I'm thinking about the Reception and Placement Cooperative Agreement ensuring that every refugee has a health assessment within 30 days of arrival. Your interpretation seems to indicate that the requirement means a linkage with a health clinic within 30 days. Is this an official DOS interpretation of 8.c.4.k of the cooperative agreement?

The language in the Department of State, Bureau of Population, Migration and Refugees (PRM) Cooperative Agreement for Reception and Placement services is clear with regard to the 30-day time frame for medical screening. Because many refugee medical screening protocols involve more than one encounter (visit), it is our understanding that the 30-day objective would reference initiation of the process (first visit). Note: Opinions presented by the RHTAC are not necessarily those of PRM.

Q: Are there any state practices for screening refugees for functional disabilities and sharing/communication of this information so the affected individuals can be connected with appropriate follow-up services?

I am not aware of any formal programs for this. It is something, though, that most experienced medical clinicians will be considering. In research projects we have used what is the standard functional health screening questionnaire, the SF-12 of the Medical Outcomes Study, but it is probably not necessary to use a formal questionnaire. Regarding communication, this was also a theme highlighted in both parts of the webinar. It is critical for clinicians to establish relationships with referring resettlement agencies as many have case management support. As we increasingly see refugees with complex medical conditions, states may be well-served to encourage local clinics to establish regular care coordination meetings for both pre- and post-arrival discussion of complex medical cases. This is a new process that, again, states will need to structure to meet their own needs.

Q: Are there state health screening models that include behavioral symptoms, not necessarily a mental illness diagnosis, as part of the domestic health screening that are specific for child, adolescent and adult?

States will have different approaches to the inclusion of screening for behavioral symptoms as part of the refugee health assessment. New Mexico currently uses a symptom-based, functional assessment process which their relatively low volume permits. Colorado uses a similar system but is able to do so because resettlement is geographically concentrated. States with larger volumes or more dispersed resettlement may struggle with such an approach (which I have advocated for some time). The problem with some behavioral symptoms is that they can be very non-specific and are too prevalent to be used for screening, e.g. somatic complaints. CDC guidelines include a simple one- or two-question assessment of violence exposure, assessment of physical and emotional trauma, physical exam focused on signs of physical trauma, and assessment of mental status. The guidelines also discuss a variety of common screening instruments for depression and PTSD. The Technical Assistance Center is collaborating with Dr. Michael Hollifield of the Pathways to Wellness project and Pacific Institute for Research & Evaluation to promote use of a newly developed screening questionnaire, the RHS-15 which is specific for PTSD, Depression, and Anxiety. Dr. Hollifield will be giving a webinar on this topic on January 25, 2012.

Q: While some guidelines are complete, they are not specific enough, especially for mental health. What are your thoughts on this?

As noted above, the Technical Assistance Center is promoting the use of the RHS-15. For more information, please join us for our January webinar on this topic.

Q: I am interested in integrating mental health screening into a full screening package/protocol. Beth Farmer from [Pathways to Wellness] Seattle has been very helpful. Do you have any further suggestions and resources?

(Dr. Stauffer) There is a section on mental health screening in the guidelines with some references listed. See www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html. The Center for Victims of Torture or the Harvard Program in Refugee Trauma have additional information on mental health screening. As noted above, the Technical Assistance Center is promoting the use of the RHS-15. For more information, please join us for our January webinar on this topic.

Q: How do you educate the clinicians in community health centers regarding refugee health needs?

You can use a variety of approaches. In Massachusetts over the years, we have held state-wide CME conferences, email journal clubs, and monthly case discussion and topical conference calls. We also conduct individual orientation for physicians or midlevel providers new to the program. Lastly, we regularly send email updates to clinic practitioners and administrators regarding relevant updates on a variety of health-related and resettlement-related topics. (A medical librarian can help you stay on top of current

research publications that might be worth disseminating to your clinicians). You might also encourage clinicians to sign up for the Refugee Health Technical Assistance Center listserv for regular updates by visiting our website, www.refugeehealthta.org.

Q: Are the [medical screening] guidelines for parolees the same as those for refugees? I ask because it seems to take much more time for parolees to get onto Medicaid than people in other groups such as asylees and refugees.

I think the questioner is referring to Haitian or Cuban parolees (aka Entrants) as this category of arrivals is eligible for federal refugee benefits and programs, including medical screening, but do not arrive with the organizational support of a resettlement agency and Reception and Placement services.

While the recommendations were developed for refugees being resettled from overseas, in practice they may be applied to other populations that are covered by the federal refugee program, including asylees, victims of trafficking and Iraqi and Afghani special immigrants. As Dr. Geltman noted in his talk, funding options may be limited when services are delayed.

Part 2: Pre-departure Presumptive Treatment, Domestic Medical Screening and Creating a Smarter & More Responsive System
Speaker: Dr. William Stauffer

Q: Should a provider assume that refugees have received appropriate presumptive therapy even when there is no documentation from overseas?

It is reasonable to make the assumption that a refugee has received therapy if s/he is from a group that is currently receiving presumptive therapy prior to departure. CDC has found very high compliance rates in populations that are supposed to be getting treated (despite the difficulty in getting documentation to the clinicians in the U.S.). Current populations that are receiving treatment are listed at: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html.

This link, which is in the section labeled **Information on presumptive therapy received**, will be kept up to date with any changes.

Q: If the rates of STDs are so low among arriving refugees, why is screening for syphilis and other STDs recommended?

Routine screening for GC and Chlamydia is not recommended. The exception is that refugee women 15-25 years of age who are sexually active should routinely be screened for Chlamydia. This recommendation is consistent with the general US guidelines. At this point there are not enough data in refugees to differ from the general US guidelines. The refugee screening guidelines are available at: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html.

The historic (and current) screening for syphilis can be traced to regulatory purposes. While there has been some reassessment of the domestic screening for syphilis, at this

point it is still recommended for those refugees over 15 years of age (and some special groups).

HIV testing is no longer done before departure, but post-arrival screening is highly encouraged.

Q: Is there any thought to vaccinate all refugees in the camps for these parasites regardless of whether they will be traveling to the US or not?

I think this is two questions. There is no vaccine for parasites (except the newer malaria vaccine that seems to have some efficacy).

There are programs in certain refugee populations for mass vaccination campaigns as well as some for mass parasitic presumptive treatment. The major impediment to implementing these programs is funding. They are typically carried out by UNHCR and/or NGO's. Ideally, these would be available to all refugees, regardless of whether they are destined for the U.S.

Q: Many of our Bhutanese refugees have their documented immunization records from the camps. Can suggestions be made that those records are acknowledged at the pre-departure IOM exams?

Due to regulatory purposes, the vaccines received in the camps cannot be included on the DS forms. However, IOM is encouraged to have refugees bring their camp cards with them to the US. When the refugee has a legitimate vaccine card from the camp, the vaccines recorded and in compliance with ACIP guidelines, they may be (should be) accepted toward the routine vaccine series.

Q: Regarding HBV screening for newly arrived refugees...our state lab performs HBsAg and anti-HBc total plus Anti-HBc-IgM if HBsAg is positive all of which identify acute and carrier cases. Anti-HBs is not performed to determine immunity. Do you feel Anti-HBs is a worthwhile test to perform on refugees? Or is it best to just vaccinate? Thank you.

This is controversial. I think most experts would recommend anti-HBc, anti-HBs and HBsAg as screening tests (but you must know how to interpret). Anti-HBc alone, without anti-HBs is more difficult to interpret. See question #15 below.

Q: What are your recommendations for clients that test HBV Core antibody positive?

This is a very complicated question. The full hepatitis guidelines will be issued shortly and will have a lengthy discussion on this issue. In general for anti-HBc:

Anti-HBc appears at the onset of symptoms or when liver function test abnormalities appear in acute HBV infection; it persists for life. In certain persons, total anti-HBc is the only detectable HBV serologic marker. Isolated anti-HBc positivity can represent:

- resolved HBV infection in persons who have recovered but whose anti-HBs levels have waned, most commonly in high-prevalence populations;
- chronic infection in which circulating HBsAg is not detectable by commercial serologic assays, most commonly in high-prevalence populations and among persons with HIV or HCV infection (HBV DNA has been isolated from the blood in <5% of persons with isolated anti-HBc);
- false-positive reaction. In low-prevalence populations, isolated anti-HBc may be found in 10%-20% of persons with serologic markers of HBV infection, most of whom will demonstrate a primary response after hepatitis B vaccination. Persons positive only for anti-HBc are unlikely to be infectious except under unusual circumstances in which they are the source for direct percutaneous exposure of susceptible recipients to substantial quantities of virus (e.g., blood transfusion or organ transplant). Keep in mind that anti-HBc is NOT a marker of immunity to HBV. A positive test for anti-HBs indicates immunity.

Q: Thank you for the wonderful overview. I'm curious to know if there any plans to provide additional resources or shared best practices for chronic disease screening? Our academic primary care center runs a refugee health program (including screening and ongoing primary care) in partnership with a resettlement agency. We recently found that half of adults and 30% of children have at least one chronic condition. Our VOLAG partner spends a significant amount of time and effort on medical case management. Thanks.

It is recognized that this is a very important and expanding area in refugee health. I believe there are many groups working on best practices in this area. If you haven't seen the textbook by Barnett and Walker, Immigrant Medicine, this would be a worthwhile reference. I think you will see more coming out in the literature.

Q: What is your thought on the CDC option of domestic presumptive treatment for intestinal parasites rather than stool and serology screening?

Domestic presumptive treatment can be more cost-effective and is reasonable. It depends on how your system is set up: some clinics do the screening, some do the presumptive treatment. One exception, I would personally test refugees who come from Loa loa endemic areas (much of sub-Saharan Africa) for strongyloides before treatment just because the high dose of albendazole isn't very conducive to presumptive treatment. Be sure to be aware of what populations are already being treated as in question #9.

Q: How do you define non-Loa Loa areas? Is there a reliable set of countries? If not, how do you suggest approaching presumptive treatment when we cannot get serology (due to expense and lack of availability)?

This information is included in the guidelines (www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/intestinal-parasites-overseas.html). There is a table that defines Loa loa endemic countries. Alternative treatments are available (such as higher dose albendazole), but personally, I would do testing for strongyloides for people from Loa loa endemic areas and treat those that are

positive due to the high dose of albendazole needed (and rates of strongyloides are lower in these populations).

Q: What tests are recommended for strongyoildes and schistosomiasis screenings?

Please see the full section of parasitic screening: www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html.

Testing (for symptomatic patients) can be complicated and it depends what type of infections you suspect and where you think the infection is – you can look at stool and, for schistosomiasis, can look in the urine or other areas. For screening, you can pick up in stool (or urine) but this is not very sensitive, so most people will use serological studies for both of these. There is extensive discussion in the guidelines.