Minnesota Department of **Human Services**

October 21, 2016

Chandra Allgood-Foster
Regional Representative, Region V
Office of Refugee Resettlement
Administration for Children and Families U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 400
Chicago, Illinois 60601-5519

Dear Ms. Allgood-Foster,

Please find attached the revised Minnesota's FY 2017 State Plan for Refugee Resettlement. Please feel free to contact me directly if you have any questions or concerns about the information provided.

Thank you for your time and attention to this matter.

Rachele C. King

Rachele King
State Refugee Coordinator
Minnesota Department of Human Services

MINNESOTA'S STATE PLAN FOR REFUGEE RESETLEMENT

[45 CFR 400.5 (a) – (i) and State Letter #13-03]

DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
ECONOMIC ASSISTANCE AND EMPLOYMENT SUPPORTS DIVISION
RESETTLEMENT PROGRAM OFFICE

AUGUST 15, 2016

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Section I – Administration

A. Designation of Authority

1. The Minnesota State Department of Human Services (DHS) is designated as the State agency responsible for services contracted by the State of MN designed to meet the resettlement needs of refugees funded through the US Health and Human Services Office of Refugee Resettlement.

2. Ms. Rachele King is designated as the State Coordinator for Minnesota. The State Coordinator has the responsibility and authority to ensure coordination of public and private resources for refugee resettlement statewide. The State Coordinator manages the Resettlement Programs Office (RPO), within the Economic Assistance and Employment Supports Division.

3. Benefits are publically administered in all 87 counties of MN with the exception of 8 counties approved as public/Private Partnerships for Refugee Cash Assistance (RCA) only. These counties are: Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott and Washington.

B. Organization

1. The Commissioner of the MN Department of Human Services has delegated the responsibility for developing the Refugee Resettlement State Plan, supervising the administration of the plan and designation of the State Coordinator, to the Assistant Commissioner for Children and Family Services, (CFS).

   The Minnesota's Refugee Resettlement Programs Office is responsible for administering the US Refugee Program in the State.[1] The major responsibilities of the Office include:

   - Coordination of various public and private programs affecting refugees, asylees, Cuban and Haitian entrants, unaccompanied minor children, and victims of severe form of trafficking.[2] This includes business continuity planning to prepare for state and federal government shutdowns.
   - Communication with and organization of multiple partners in local sites to assess and address local capacities and resources needed to resettle and integrate refugees including such sites which are heavily impacted by arrivals from other states.
   - Administer and oversee development and implementation of programs funded through the Office of Refugee Resettlement including Refugee Social Services (RSS), Refugee Student Impact Grants (RSIG), Refugee Elders Program, and Cash and Medical Assistance grant.
   - Administration of the Public/Private Refugee Case Assistance programs in eight counties and the US Repatriation Program.[3]
   - Liaison with the Office of Refugee Resettlement (ORR) within the US Department of Health and Human Services; the Bureau of Population, Refugees and Migration (PRM) within the US Department of State; national resettlement agencies (VOLAGS)[4]; and other states.

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[1] In the Refugee Act of 1980, Pub.L. No. 96-212, Congress codified and strengthened the United States' historic policy of aiding individuals fleeing persecution in their homelands. The Refugee Act of 1980 provided a formal definition of "refugee" which is virtually identical to the definition in the 1967 United Nations Protocol relating to the Status of Refugees. This definition is found in the Immigration and Nationality Act (INA) at section 101(a)(42), In addition, the Act provided the foundation for today's asylum adjudication process and development of an Office of Refugee Resettlement (ORR) within the Department of Health and Human Services. ORR's mission is to assist refugees and other special populations, as outlined in ORR regulations (45 CFR Part 400), in obtaining economic and social self-sufficiency in their new homes in the United States.

[2] In future references, the term "refugees" is used to refer to refugees, asylees, Cuban and Haitian entrants, unaccompanied minor children, victims of severe form of trafficking and other populations defined in 45 CFR 400.43.

[3] Refugee Cash Assistance (RCA) is administered or operationalized by VOLAG affiliates in eight counties (Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, Washington.) In the 79 remaining counties, RCA is administered by county human services. The RCA policies are the same in all 87 Minnesota counties.

[4] In future references, the term "VOLAGS" is used to refer to the national resettlement agencies, "VOLAG affiliates" is used to refer to the local offices of VOLAGS. There are six local agencies which are affiliated with seven VOLAGS that are approved to

- Provide input on development of state policies and programs to fully integrate refugees.
- Ensure Refugee Health Screenings policies and procedures are in place to guarantee access to screening for all new arrivals.
- Conduct outreach and engagement activities to increase understanding about refugees in Minnesota

C. Assurances

The Department of Human Services has the responsibility to:

1. Comply with Title IV, Chapter 2 of the Immigration and Nationality Act and official issuances of the ORR Director.

2. Meet the requirements of 45 Code of Federal Regulations (CFR) Part 400.

3. Comply with all applicable Federal statutes and regulations in effect during the time that Minnesota is receiving grant funding.

4. Amend this plan as necessary to comply with the standards, goals, and priorities established by the ORR Director.

5. Ensure assistance and services funded under this plan will be provided to refugees without regard to race, religion, nationality, sex, or political opinion.

6. Convene meetings of public/private sectors at least quarterly unless exempted by ORR.

7. Use the same mediation/conciliation procedures as those for TANF for counties which have publically administered RCA program.

8. Use hearing standards & procedures listed in CFR 400.9 related to review of decisions on approval of the State plan and amendments.

9. Ensure refugee populations are included in the state emergency operational plans.

resettle refugees in the State. The local affiliates are: Catholic Charities of Archdiocese of Minneapolis/St. Paul, and Catholic Charities of the Diocese of Winona (affiliated with the United States Conference of Catholic Bishops); International Institute of Minnesota (affiliated with US Committee for Refugees and Immigrants); Lutheran Social Services (affiliated with Lutheran Immigration and Refugee Services); MN Council of Churches (affiliated with Church World Services and Episcopal Migration Ministries); and Arrive Ministries (affiliated with World Relief). The VOLAG affiliates are located in the metropolitan Twin Cities, Rochester and St. Cloud.

Section II – Assistance and Services

A. CMA Coordination

DHS administers an array of programs and services to help Minnesotans meet their basic needs so they can live in dignity and achieve their highest potential. Refugees are generally eligible for all programs and services under the same rules as US citizens.

With funding from the Office of Refugee Resettlement (ORR), DHS purchases additional services designed to complement mainstream services. These services provide additional help to refugees in their resettlement and integration – the initial steps refugees must experience on their road to achieving their highest potential.

Pursuant to the US Refugee Program's philosophy of immediate employment and economic self-sufficiency as quickly as possible, all procured services under this plan are designed to operationalize this philosophy. Additionally, RPO prioritizes services to refugees who are less than one year in the country and/or are receiving cash assistance. These priorities are upheld with contract and evaluation criteria stating at least 60% of outcomes must be for refugees less than one year in the country and weighting employment placements for participants receiving cash assistance higher than those not on assistance.

B. Language Training and Employment Service Certification

Language training and employment services made available to all refugees through the Minnesota Adult Basic Education system which provides English Language Learner (ELL) classes free of charge for adult learners who seek to improve their English skills in areas of speaking, reading, listening and writing. Under this system licensed adult education teachers deliver instruction to ESL students and monitor student performance using state-approved standardized English tests. Work readiness and economic self-sufficiency content are an important part of the ELL curricula. Programs are accessible statewide and are funded through a combination of state, federal and local resources. The state Adult Basic Education program is administered through the Minnesota Department of Education (MDE).

C. Refugee Cash Assistance (RCA) 45CFR Part 400.45

1. The Minnesota Family Investment Program or MFIP, is the state's Temporary Assistance to Needy Families (TANF) program for low-income families with children. MFIP helps families transition to economic stability. Parents are expected to work, and are supported in working. Most families can get cash assistance for only 60 months. The Refugee Cash Assistance or RCA is cash assistance available to refugees who are ineligible for TANF. In MN, RCA is utilized for single adults and childless couples to provide benefits for up to eight months after arrival to the US.

a. Determination of initial and on-going eligibility for RCA is based on income and asset verification prospectively for any refugee less than 8 months in the country not eligible for MFIP. RCA income and asset eligibility follow MFIP policy. RCA applies earned income disregards of the 1st $65 of earned income per wage earner plus 50% of the remaining earned income of the assistance unit, with a dollar for dollar reduction from benefit level for household size thereafter in determination of eligibility and budget. Counted assets must not exceed $10,000 to be eligible for RCA.

b. Assistance levels are based on the size of the assistance unit. Cash support levels are listed below for both MFIP and RCA participants. RCA applies a $65 standard disregard per wage earner plus a 50% disregard on remaining earned income in the assistance unit, with a dollar for dollar reduction in cash benefits thereafter.

Household size	**MFIP payment standard[5]**	**RCA Payment Standard[6]**
1	$360	$360
2	$547	$547
3	$642	N/A
4	$731	N/A
5	$807	N/A

c. Proration of shelter, utilities and similar needs for RCA are based on MFIP policy.

d. During the 2013 legislative session, a new MFIP benefit available to all MFIP-eligible families was established. The benefit was rolled out effective July 1, 2015. Households on MFIP receive an additional $110 Housing Grant monthly.

e. Assets do not include resources remaining in the applicant's country of origin for eligibility determinations.

f. Income and resources of an applicant's sponsor is only considered when they are a part of a family unit such as spouse, or child living in the same household.

[5] During the 2013 legislative session, a new MFIP benefit available to all MFIP-eligible families was established. The benefit payments began July 1, 2015. Households receive an additional $110 housing grant monthly. Payment levels listed represent the sum of two separate payments made to MFIP participants which are a cash support and housing grant payment made to recipients on a monthly basis.

[6] This payment standard will be implemented by 1/1/2017 or as soon as system modifications can be put in place to increase payment standard match MFIP assistance levels. Until that time, RCA payment standards are $250 for household size of 1 and $437 for household size of 2.

g. Cash grant received by applicant under the Federal resettlement program are not counted as income or assets for eligibility determination.

h. The date of application is used as the start date for RCA benefits.

i. Local resettlement agencies work with RCA provider, either through in-house eligibility coordinators, or county administered programs for application for RCA.

j. RCA employment service providers coordinate with RCA eligibility coordinators on at least a monthly basis related to job search activities and within 10 days of any offer of employment.

k. The State annually develops budgets for direct assistance and administration costs of the Public-Private partnership model for RCA which are monitored to ensure spending is within approved limits.

l. The PPP administered model provides transportation vouchers to participants who are actively seeking employment and engaged with their employment provider. Job search activities are verified on a monthly basis to ensure compliance prior to issuance of transportation voucher. The cost of these vouchers is paid for from RSS funds. Vouchers are purchased for $42.50 for unlimited one month rides (discounted 50% from $85 value).

m. RCA participants are required to enroll with Refugee Employment Services (RES) within 30 days of RCA eligibility approval. Each RCA recipient is required to develop and comply with RES employment plans unless he/she meets 1 of the following conditions:
    - Employed at least 30 hours per week
    - Age 60 or over
    - Temporarily or permanently ill or disabled (with verification from medical authority for any condition expected to last more than 30 days)
    - Responsible for the care of a spouse who is ill or disabled (with medical authority verification)
    - Experiencing a personal or family crisis, as determined by the agency (re–assessed monthly)

    As a condition for the receipt of RCA, a refugee who is not exempt must also:
        - Accept at any time, from any source, an offer of suitable employment
        - Comply with monthly reporting requirements if receiving earned income

n. The State meets the requirements regarding Limited English Proficient (LEP) Guidance in both public and private RCA programs for access to services.

2. RCA Program Administration

a. In the 8 counties receiving most RCA arrivals, eligibility is completed through a Public/Private Partnership with private refugee agencies. The remaining 87 counties have County (public) administered RCA.

b. RCA benefit checks are issued by the state in all counties. In the 8 counties listed above which are Public/Private Partnerships, assistance payments are sent to contracted private refugee agencies who meet monthly with RCA participants and distribute benefit checks in person. In all other counties, payments are issued directly to RCA participants.

c. At the state level, there is one staff person that is responsible for the oversight and implementation of RCA programming statewide. This individual is responsible for the coordination of the Public Private Partnership, and serves as a resource for all county administered programs and policy related questions.

d. Staff at the 6 private refugee agencies in the Public/Private partnership total 6.05 FTEs. All counties who administer RCA do time studies tracking time spent on RCA activities on a regular basis. Based on these studies, the RPO is billed quarterly based on time spent on RCA related activities for eligibility workers.

e. The state charges a 10% indirect rate on all direct expenses for which HHH is the cognizant agency

D. Refugee Medical Assistance (RMA)

1. Medical Assistance (MA) is a federal program established under Title XIX of the Social Security Act to provide health care to needy people. Funding is a combination of Federal and State monies. Individuals under 133 percent of the federal poverty level are eligible for MA with higher income thresholds for children and pregnant women.

a. A "Designated Application Process for New Arrivals to the United States" streamlines health care application processing for refugees who are newly arrived to the United States and who are resettled by affiliates in Minnesota. Since the start of this designated process in July of 2014 the average time for new arrivals to be approved for assistance is two weeks, and expedited requests are processed in 24 to 48 hours of submission.

Refugee Medical Assistance (RMA) is a program provided for in the Refugee Resettlement Act. It provides medical coverage for refugees without a basis of

eligibility for MA. Coverage is limited to the first eight months a refugee is in the US.

b. All Minnesotan's, including refugees, who apply for health care coverage through MNsure (the state health care exchange) are screened for eligibility for MA, state subsidized health insurance, and RMA. MN's exchange includes Medicaid expansion as of 1/1/2014 expanding eligibility for all Minnesotans as described in D.1 above.

2. Income Standards:
    a. The financial eligibility standards for RMA is currently 100% of the federal poverty level. Since all refugees are screened first for MA eligibility, all refugees who would qualify for RMA should also qualify for MA. For this reason, there are no circumstances in which a new refugee would be in-eligible for MA and still meet the income guidelines.
    b. In the coming year, program staff will explore the feasibility of increasing the income standard up to 200% of the federal poverty level for possible implementation in the next program year.
3. Eligible individuals who receive increased earnings from employment are ensured continued coverage under RMA up to 8 months in the country, based on their eligibility at the time of application.

4. RMA will cover at least the same services in the same manner and to the same extent as Medicaid. This is administered in MN on a fee for service basis for RMA recipients.

5. Additional Services: None to report.

6. Minnesota Department of Health (MDH), MDHRHP coordinates the medical screening of refugees and work with local refugee resettlement agencies to identify newly arrived refugees in need of care under an interagency agreement with the MN Department of Human Services. MDHRHP responsibilities include:
    - Serving as the single point notification for primary refugees to MN under the Reception and Placement program for electronic notification system managed by the Centers for Disease Control (CDC)
    - Providing clinical consultation, administrative guidance and training to local public health agencies and private health care providers which provide medical screening, ensuring standard implantation of the ORR and CDC refugee screening guidelines across the state.
    - Identifying health care entry points, systems and specialists to ensure refugees with acute and chronic health conditions are linked to care in a timely manner.
    - Maintaining a local public health nurse contact in each county health department who is responsible for coordination of health screenings for newly arrived refugees under their jurisdiction.

- Providing assistance to local resettlement agencies in identifying refugees needing medical treatment or observations at the time of resettlement as needed and requested.
- Maintaining and analyzing health screening data.

a. The MDHRHP has a centralized refugee screening management model. It has been designated as the single point notification source for new arriving refugees into the state under the reception and placement program. The Centers for Disease Control (CDC) notify the MDHRHP of all arrivals via the Electronic Disease Notification system or EDN. The basic arrival information includes names of all persons in the household, their alien registration numbers, dates of birth, gender, place of birth, sponsoring resettlement agency or other sponsor (e.g., relative), and the date on which they arrived in the U.S. Accompanying their arrival information is a report of each person's overseas medical examination on Department of State forms DS-2053, DS-2054, DS-3024-3026, pre-departure medical screening (PDMS) form and Special Medical Case (SMC) form. EDN notifications are available for primary refugees, derivative asylees, and parolees. Documentation for secondary refugee transfers is also available in EDN.

b. The MDHRHP oversees, plans and coordinates all aspects of the refugee medical screening to ensure refugee health screening policies are implemented statewide. Overseas medical records are reviewed by a nurse at the MDHRHP who highlights medical care needs and assists local refugee resettlement agencies to interpret medical information. Basic demographic information is then entered into the MDHRHP database (eSHARE). These services are federally funded through interagency agreement with the MN Department of Human Services and paid for through CMA funds.

   Local resettlement agencies directly refer each new arrival to the local public health contact in the county of residence with biodata forms and any medical information received and forward this information to MDHRHP. Once a county receives EDN notifications from MDHRHP, they move forward with the localized process for scheduling health screenings.

   Screening results and referral information are returned to and tracked by MDHRHP. The MDHRHP monitors the screening status of all new arrivals to ensure that all complete screening within 90 days. LPH contacts are called and reminded if health screenings are delayed and are offered support or appropriate interventions.

c. The MDHRHP has a local public health nurse contact in each of the 87 county health department throughout the state. These local public health (LPH) nurse contacts coordinate health screenings for all newly arrived refugees to their county. Refugees in Hennepin and Olmsted Counties are screened within their

LPH agency clinics. All other counties utilize private clinics to deliver refugee health screenings. LPHs have established relationships with these select private clinics and provide training to clinicians providing refugee health screenings. Refugee health screenings require at least two clinic visits. The first visit is with a nurse and the second is with a physicians, physician assistant or nurse practitioners depending on clinic staffing.

d. See "Attachment A" for description of service elements of the Refugee Health Screening covered by Medicaid.

7. RMA Costs
   a. RMA health insurance delivery is administered on a fee-for-service basis, including medical, interpretation, and transportation costs. The number of estimated monthly recipients/users (4 per month) of RMA on Line 2a in ORR-1 includes:
      - Adults without children with incomes at or above 133% of the federal poverty guideline (until 12/31/2013) or
      - Adults without children with incomes at or above 133% of the federal poverty guideline (after 12/31/2013) or
      - Adults without children who lose their MA eligibility due to earnings from employment

   b. No RMA administration costs are charged to the CMA budget.

E. Refugee Medical Screening Program (RMS)

1. MN only charges RMA for eligible populations without health coverage or whose health insurance does not cover the refugee health screening, a flat-fee reimbursement is be made within the first three months after arrival for the cost of the refugee health screening.

2. RMS is administered in accordance with ORR's 2012 refugee screening guidelines.
   a. All required screening services are covered under MA and RMA benefits.

   b. Additional services provided:
   See Attachment A #8 for a listing of additional medical components of the Refugee Health Screening.

   Complex Medical Systems Coordination: The MDHRHP has integrated health systems coordination to assist with care plans for refugees with acute or complex health care needs into its core activities through a medical social worker who works with local refugee resettlement agencies to develop care protocols and assure initial health care services for cases with significant health conditions are set up prior to arrival. The MDHRHP medical social worker identifies resources and communicates with LPH, primary care providers and referral specialists to inform of the refugee's

health status, and forwards relevant medical records to the appropriate health care facilities.

Coordination of refugee health screening for secondary arrivals: According to ORR report issued in June 2015, Minnesota had a net migration of over 3,000 secondary refugees in FFY14 making it the number one destination in the US for secondary refugees. In 2015, MDHRHP received 1013 referrals from secondary migrants 60% of whom had not had and were still eligible for a refugee health screening. With limited CDC funding, MDHRHP was able to develop a structured process for screening for secondary arrivals. Overseas medical records are transferred from primary arrival state and forwarded to local care providers, avoiding unnecessary repetition of screening or vaccinations. This coordinated approach has been embraced locally, but requires resources to support care access for secondary refugees who do not have the support of a local resettlement agency. Resources are built into the health screening budget to support screening coordination in the counties most impacted by secondary arrivals

c. RMA uses the same Medicaid reimbursement rate for the components of the health screening. This cost is included in the $640 average unit cost on Line 2a in the FY 2017 ORR-1.

d. The MDHRHP regularly monitors the screening status of all new arrivals to ensure that all complete screening within 90 days. LPH contacts are called and reminded if health screenings are delayed and are offered support or appropriate interventions.

3. Costs of the medical screening program are listed in the ORR1 CMA estimate.
    a. Most Refugee Medical Screening expenses are covered under MA or RMA. For eligible populations without health coverage or whose health insurance does not cover the refugee health screening, a flat-fee reimbursement is be made within the first three months after arrival for the cost of the refugee health screening

    b. All of the Medical Screening Administrative budget is paid to MDHRHP to coordinate the refugee health screening related activities state wide, as described in Section D and E.1&2 above.

F. Refugee Social Services (RSS)

1. Social services are provided to refugees consistent with ORR priorities and guidelines. DHS uses formula social services grants and targeted assistance program formula allocation grants[7] to fund social services meet the ORR prioritization criteria. Currently, these services include:

- Employment services
- Resettlement services for Secondary migrants

[7] Hennepin and Ramsey Counties are counties qualified to receive Targeted Assistance Program (TAP) grants. Through agreement with both counties, DHS administers TAP locally. TAP funding is used exclusively for refugee employment services

- Housing search
- Outreach
- Information and referral to mainstream social services
- Case management
- Information and referral
- Interpretation services; and
- Citizenship and naturalization preparation services (services offered do not include any resources for fees paid to the United States Citizenship and Immigration Services (USCIS).[8]

Services are limited to refugees who have been in the US for less than five years, with priority given to new arrivals within the first year here.[9] These services are equally available to women. DHS contracts with various consortia of providers. The consortia includes:

- Local resettlement agencies
- Mutual Assistance Associations
- Faith-based organizations
- School districts
- Social service agencies and legal aid agencies – all with significant experience and expertise in providing linguistically and culturally compatible services at the point of service transaction.

RPO establishes annual contract minimum outcome benchmarks to measure contract performance for each contract during the contract negotiation process. Contract performance indicators are reviewed on a quarterly basis. The RPO provides "Quarterly Report Cards" that indicate contract performance which are shared with all contracted agencies. In addition to the on-going performance outcomes monitoring, RPO conducts formal programmatic and fiscal reviews of all contracts annually.

G. Cuban Haitian Entrant Program: MN is currently not a site for Cuban/Haitian entrants

H. Unaccompanied Refugee Children (URM): MN does not currently operate an URM program. Children in need of protection may be referred to child protective services for assessment and referral to available interventions.

[8] In addition, several VOLAG affiliates operate The Matching Grant Program (MGP). MGP is an alternative to public assistance, designed to make refugees self-sufficient within four months after arrival in the US. This program requires a match of an agency's private funds or in-kind goods and services. During the refugees' first four months in the US, VOLAG affiliates which operate MGP are responsible for resettling refugees and assisting them to become self-sufficient through private initiative without recourse to public assistance.

[9] Citizenship and naturalization preparation services, referral and interpretation services are available to refugees who have been in the US more than 60 months.

ATTACHMENT A

Service Elements of the Refugee Health Assessment

Minnesota follows ORR's 2012 refugee screening guidelines. A Refugee Health Assessment consists of a series of two to three visits. Essential elements of the exam include a medical and physical assessment focused on the identification and treatment of infectious diseases and indicators of chronic conditions, according to standardized ORR, Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health screening protocols. The exam also includes treatment for any conditions identified or referral to appropriate follow-up care and basic health education.

The providers of initial health assessments are expected to provide the following medical services to each refugee:

1. History- Overseas medical records are reviewed for all newly arrived refugees and necessary follow-up are initiated.

2. Physical Exam and Review of Systems: Refugees receive a complete physical exam (with special attention to suspected signs of Hansen's Disease), including assessment of acute mental health concerns, dental, hearing, vision, height/weight, nutritional assessment (Vitamin B12, D) with necessary referrals

3. Complete blood count with differential to identify hematologic disorders

4. Tuberculosis screening and follow-up: Refugees are screened for tuberculosis (TB) prior to leaving their country of origin and the TB component of overseas evaluations are determined by the individual's age, the prevalence of TB in the local population, and the resources in that country to implement CDC's enhanced screening protocol developed in 2007. Those found to have TB-related conditions are given a "TB Class" which is then reflected in the EDN notification of that arrival and documented on their DS forms. These TB Classes are:
   - Class A TB – active pulmonary TB disease, sputum smear or culture positive; requires a waiver (i.e., on treatment and smear-negative prior to travel).
   - Class B1 TB – evidence of pulmonary or extrapulmonary TB disease, sputum smear-negative; includes "old healed TB", and previously treated TB
   - Class B2 TB – Latent TB infection (LTBI) if TST ≥ 10 mm
   - Class B3 TB – Contact of a known TB disease case
   - No Class – none of the above.

The *domestic TB screening* of newly arriving refugees includes the following:

a. Administer a tuberculin skin test (TST) for all refugees six months or older or draw an interferon-gamma (IGRA) blood assay regardless of the refugees' BCG history unless the person has a reliable history of previous treatment for TB or reliable documentation of a previous positive test. IGRA

testing is approved for use in anyone ≥5 years of age. For most refugees, the TST is positive if ≥10 mm induration. A 5 mm cutoff is used if: (1) HIV+, (2) recent close contact to infectious TB case, (3) arrivals with TB Class A or B1conditions, (4) chest X-ray (CXR) with fibrotic changes, (5) organ transplant, or (6) otherwise significantly immune-compromised.

b. Perform a chest x-ray for refugees with:
   - Positive TST (≥10mm induration) or IGRA results **or**
   - TB Class A or B1 designation from overseas exam, regardless of TST **or** IGRA results
   - Symptoms of tuberculosis, regardless of the TST or IGRA results.

c. Diagnose infection or rule out active/LTBI:
   - **Diagnosing TB disease, suspected or confirmed**: If the refugee arrives as a Class A TB, or the chest x-ray is abnormal and consistent with TB disease, or the individual has signs or symptoms of TB, regardless of the TST/IGRA results then sputum specimens should be collected for bacteriologic examination and a "TB suspect" reported to the MDH TB Prevention and Control Program. Providers need to remember to consider extrapulmonary TB disease, which is also reportable to MDH. Further diagnostic testing may be necessary to confirm or rule out TB disease. Treatment for TB disease should be initiated as soon as possible and directly observed therapy (DOT) is the standard of practice for treating active TB.
   - **Diagnosing Latent TB infection (LTBI):** If the TST or IGRA is positive and the chest x-ray is normal or abnormal but tuberculosis disease is ruled out, then treatment for LTBI should be initiated. For specific treatment regimens, providers consult the CDC guidelines available on the MDH TB Program website at: www.health.state.mn.us/tb.

5. Immunizations and follow-up: Clinics are advised to assess the immunization history of each refugee referring to the overseas records (if any) and any records brought by the refugee. All previous vaccinations should be recorded. Lab evidence of immunity may be obtained and recorded as is history of disease. All previous vaccinations are considered valid if they were given according to the Minnesota child or adult schedule.
   - If there is no documentation, assume the refugee is unvaccinated
   - All age appropriate vaccinations are given as recommended by the Advisory Committee on Immunization Practices (ACIP)
   - Documentation of all vaccination administrated is given to the refugee and entered into the state immunization information system (MIIC)

6. Hepatitis A, B, C and follow-up: All refugees receiving initial health assessments should be assessed for hepatitis B status with serologic screening for hepatitis B HBsAg, anti-HBs, anti-HBc. Household contacts of those identified as carriers of the virus (HBsAg) who are themselves HBsAg negative should have determination of their antibody status. All susceptible contacts should receive a three-dose series of hepatitis B vaccine. Pregnant women identified as carriers should have test results forwarded to their prenatal care provider for appropriate follow-up for their infant. The MDHRHP collaborates with MDH's hepatitis surveillance and perinatal hepatitis B prevention program to share all screening and demographic information to ensure follow-up.

Refugees may be screened for hepatitis C (anti-HCV and confirmatory), if indicated by risk of exposure. Routine screening for hepatitis A is not recommended for refugees

7. Intestinal Parasites and follow-up: Evaluation for significant parasitic disease or infestation followed by appropriate treatment:
    - Confirm pre-departure presumptive treatment
    - Routine eosinophil count

PLUS

If **no documented** pre-departure parasite treatment:

- Collect 2 stool specimens more than 24 hours apart for Ova and Parasites
- Strongyloides serology (all refugees)
- Schisotosoma serology for sub-Saharan Africans
- or presumptive domestic treatment

If **documented** pre-departure parasite treatment:

- *Single-dose* pre-departure with no praziquantel treatment requires strongyloides serology (all refugees) and schistosoma serology for Sub-Saharan Africans or presumptive domestic treatment
- *Single-dose* pre-departure with praziquantel treatment requires strongyloides serology (all refugees) or presumptive domestic treatment
- Eosinophilia with *high dose* pre-departure treatment requires either ova and parasite testing or a repeat eosinophil count in 3-6 months after arrival.

Treatment should be provided according to approved treatment schedules for any and all pathogenic parasites identified.

8. Malaria screening and follow-up:
    - Screen if symptomatic or suspicious history
    - Screen or presumptively treat if asymptomatic, from highly endemic areas (Sub-Saharan Africa) and **no documented** pre-departure therapy.
    - Obtain 3 thick and thin smears to screen or use PCR.

9. Sexually transmitted diseases screening and follow-up:

Universal testing of HIV and syphilis for arrivals from mid-high HIV prevalence regions

- Screen for syphilis with VDRL or RPR, confirm
- Screen for HIV if 13-64 years and from non-endemic region; screen all family members if person is positive, confirm
- Screen sexually active patients for other STIs, if appropriate, using urine testing for GC/Chlamydia, if possible.

10. Lead Screening:
    - Screen all children < 17 years old

- Refer to Public Health and medical follow up if BLL >10mg/dl.

11. Pregnancy test should also be performed when indicated

12. Additional components include:
    - Basic metabolic panel, if indicated (especially if screening if occurring in a primary clinic setting)
    - There is a bunch of stuff left out here… dental, height/weight, vision/hearing physical,

13. Refugee Health Orientation: It is also essential to help orient the new refugee arrival to the need for the domestic health assessment and how to access health care services here in the U.S. Examples of topics addressed by LPH with new refugee arrivals include;
    - knowing when to call the doctor
    - how to recognize an urgent medical problem
    - how to recognize a medical emergency
    - how to utilize the 911 system
    - how to ask for an interpreter
    - how to utilize Emergency Rooms
    - how to use prescription medications, etc.

LPH provides most of this education, but providers in private clinics provide this education as well. MDHRHP provides technical assistance, resources or guidance as requested. In collaboration with LPH, health care providers and local resettlement agencies, the RHP is assisting with the development of an orientation tool kit for newly arrived refugees.