MINNESOTA'S STATE PLAN FOR REFUGEE RESETTLEMENT

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

DEPARTMENT OF HUMAN SERVICES
RESETTLEMENT PROGRAM OFFICE

AUGUST 31, 2023

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I. Administration

A. Organization.45.CFR 400.5

1. State Agency Designee
   The Minnesota Department of Human Services is designated as the State agency responsible for services designed to meet the resettlement needs of refugees funded through the US Health and Human Services Office of Refugee Resettlement. The Commissioner of the Minnesota Department of Human Services has delegated the responsibility for developing the Refugee Resettlement State Plan, and supervising the administration of the plan to the State Refugee Coordinator.

2. State Refugee Coordinator Designee
   Ms. Rachele King is designated as the State Refugee Coordinator (SRC) 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 within the Office of the Commissioner of the Minnesota Department of Human Services.

3. State Refugee Health Coordinator Designee
   Ms. Blain Mamo is designated as the State Refugee Health Coordinator (SRHC), through interagency agreement with the Minnesota Department of Health.

4. Organizational Structure
   The Minnesota's Resettlement Programs Office is responsible for administering the US Refugee Program in the State. The person designated State Refugee CoordinaotrDepartment of Human Services.

5. Quarterly Meetings
   At least quarterly meetings are convened in partnership with local resettlement agencies the three regions of the state where primary resettlement occurs. This includes the Twin Cities Metro region, the St. Cloud region, and the Rochester region. These meetings include local resettlement affiliates, local governance, school systems, public safety, the state health coordinator, local public health, and other local service providers. Additional monthly meetings are convenend by the State Coordinator to provide updates and consultation specifically across state agencies.

6. Fiscal and Program Oversight
   Program and fiscal oversight of Refugee Cash Assistance, Refugee Medical Assistance and Medical Screening, and Refugee Support Services (RSS), and RSS Set-Aside programs are overseen through coordinated reporting and monitored activities will specialization of contract, program and fiscal oversight. Real-time data and outcome tracking are reviewed monthly with program grant recipients. A comprehensive casefile review is conducted annually along with a fiscal and administrative review and formal report.

7. Verifying Client Eligibility

   The Minnesota Refugee Information System (MRIS) is used for program enrollment and reporting by all program providers. All program participants are enrolled into the MRIS system prior to receiving services. Enrollment includes uploading of immigration documentation, which is then reviewed by State staff to verify program eligibility.

8. Safeguarding Client Information

   The MRIS system undergoes regularly comprehensive security reviews by State IT staff to ensure technology and business processes are in place to protect client data. Users are required to complete comprehensive data privacy and security training prior to being approved access and at least annually thereafter. State staff are required to complete extensive training related to data privacy annually as a condition of employment.

9. Data System

   The MRIS system is used to collect and maintain records necessary for federal monitoring. Information is entered by service providers and is available for review in real time. A data manager serves as system administrator and oversees data collection and integrity as well as ORR reporting. Data is currently exported and filtered to meet reporting requirements. This year, additional reporting functionality will be built in to ensure consistency and efficiency of federal reporting.

10. Office Location

    State Resettlement Programs Offices are located in Saint Paul, Minnesota.

11. Procurement

    Procurement processes to acquire services supports a transparent (1) merit-based selection of sub recipients, and (2) distribution of funding between sub recipients based upon objective factors. This is achieved through community review panels, and formula based allocations based on caseloads and performance matrix. To ensure timely implementation of programming for arrivals through Operation Allies Welcome and Uniting for Ukraine, some targeted programming has/will used/use emergency authority outlined in ORR Policy letters 22-15 and 22-03 to bypass standard procurement guidelines regarding competition given the continuing need to facilitate the provision of services to eligible populations and quickly as possible to meet immediate needs for Afghan and Ukrainian arrivals (45C.F.R 75.329 (f)(2)).

B. Assurances. 45 CFR 400.5

The Department of Human Services has the responsibility to:

1. Comply with Title IV, Chapter 2 of the Refugee Act (8 USC 1522) and official issuances of the Office of the 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 Director, as needed.

5. Ensure assistance and services funded under this plan are provided to all ORR-eligible populations without regard to race, religion, nationality, sex, or political opinion.

6. Convene, not less often than quarterly, meetings where representatives of local resettlement agencies, local community service agencies, and other agencies that serve refugees meet with representatives of state and local governments to coordinate the appropriate services for refugees in advance of the refugees' arrival. Such meetings shall include outreach and invitation to, at a minimum, public school officials, public health officials, welfare and social service agency officials, and police or other law enforcement officials, for jurisdictions in which refugees resettle.

7. Act in accordance with 45 CFR §§ 75.351-75.360 and 400.22(b) (2) with regard to sub recipient monitoring and management.

8. Act in accordance with 45 CFR §§ 75.371-75.380 for remedies for sub recipient noncompliance.

II. Assistance and Services

A. Cash and Medical Assistance Coordination – 45 CFR § 400.5

1. All Cash and Medical Assistance (CMA) programming is implemented with support services to promote employment and encourage economic self-sufficiency for ORR-eligible populations.

2. ORR-funded services are implemented through four regional resettlement networks. All service providers track enrollment, outputs and outcomes through the Minnesota Refugee Information System (MRIS) which is both a data tracking and coordination tool for providers. Clients enrolled in employment services are required to send regular updates to county employment and assistance providers or RCA workers with updates on employment plan and employment status. The State reviews data in the MRIS on a monthly basis with sub recipients.

3. ORR-eligible populations residing in the Minnesota have reasonable access to ORR cash assistance and services. Four regional networks are designed to ensure access through in person or remote services as part of the contracted requirements.

4. ORR-eligible populations who receive cash benefits through TANF are enrolled in the Minnesota Family Investment Program (MFIP), which is state supervised and administered by 87 Minnesota counties. Families are enrolled in MFIP are connected to an array of county services including child care and other support programs for families transitioning to employment or new to employment

through a county-designated employment counselor. In addition, Minnesota has a robust network of adult basic education programs, to support language acquisition and GED services.

5. Any person receiving cash benefits in the state of Minnesota, either through MFIP or RCA are required to participate in language and/or employment services as a condition of receiving ongoing benefits or meet criteria for exemption.

6. The state is prepared to continue services to the highest level possible in an emergency. The state has in place continuity planning which is activated in the case of emergency in collaboration with state emergency response teams and protocols.

B. Refugee Cash Assistance (RCA) and Employment Services 45CFR Part 400 subparts E and F

1. Refugee Cash Assistance is administered through Public-Private Partnership in some locations and through a county administered-state supervised model in other locations.

2. The PPP model is used in twelve counties (Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, Washington, Stearns, Benton, Kandiyohi, Sherburne) where local resettlement affiliates are in close proximity. Refugee Cash Assistance is publicly-administered by county human services under state supervision in the remaining 75 counties.

3. In accordance with 45 CFR 400.55, all agencies who implement the RCA program have LEP plans to ensure language access for all program participants. All participants have an interview to determine eligibility and provide program orientation in their own language. All forms and notices, if not available in the language of the participant, include a language block of how to access information in other languages.

4. The Minnesota Family Investment Program (MFIP) is the state's Temporary Assistance to Needy Families program for low-income families with children. Reception and Placement Cash assistance is not counted when determining eligibility for TANF and payment levels.

5. The state follows the mediation and fair hearing standards and procedures outlined at 45 CFR 400.83.

6. Criteria for Exemption from Employment Services:
   Each Refugee Cash Assistance participant is required to enroll in available Employment Services within 30 days after Refugee Cash Assistance is approved. Once enrolled, participants are required to develop and comply with an employment plans unless he/she meets one 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 family member who is ill or disabled (with medical authority verification)
- Experiencing a personal or family crisis, as determined by the agency (re–assessed monthly)
- Emergency determined by local, State, or Federal government policy.
- Are considered a non-employable entrant by virtue of their immigration status as outlined in ORR PL-19-06.

As a condition for the receipt of Refugee Cash Assistance, 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

7. Eligibility and payment levels for the publically administered RCA program:
    a. The RCA program aligns with the state TANF program in all areas unless in conflict with federal RCA policy.

    b. The date an application is submitted is used as the start date for Refugee Cash Assistance benefits. Employment status and income are assessed monthly. In PPP locations, participants meet with RCA eligibility coordinators virtually or in person on a monthly basis to discuss any chanes or updates that may impact program eligibity prior to issuance of RCA benefit. In non-PPP sites, participants are required to report any change in income, household composition, or basis of eligibility within 10 days of the change.

    c. See chart below for TANF assistance levels by number of individuals in household.

Payment standards by household size		
Household size	**Minnesota Family Investment Program payment standard as of 10/1/2023**	**Refugee Cash Assistance payment standard as of 10/1/2023**
1	$515	$515
2	$731	$731
3	$841	N/A
4	$943	N/A
5	$1,031	N/A

    d. Resources and income are considered as outlined at 45 CFR 400.66(b)-(d).

8. Notification to Local Resettlement Affiliate. 45 CFR.68

    a. In county-administered locations, local resettlement affiliates connect directly with counties to assist primary refugee arrivals with RCA applications while other eligible people access benefits directly through the county.

b. All refugee employment service providers are required to report any change in employment status within 10 days of the change and to report at least monthly a participant's compliance with the employment plan, including any offers of employment.

9. Eligibility and Payment Levels. 45 CFR §§ 400.56-400.63 and ORR's Guidance for Public-Private RCA Programs

a. Determination of eligibility for Refugee Cash Assistance is based on income and asset verification prospectively for the first two months, and retrospectively for months three through twelve. Refugee Cash Assistance income and asset eligibility follows Minnesota Family Investment Program policy, including disregarding the first $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. Counted assets must not exceed $10,000 to be eligible for Refugee Cash Assistance.

b. RCA assistance levels in Minnesota mirror TANF assistance levels for both the PPP and county administered regions of the state to ensure consistency across the RCA program in Minnesota.

c. RCA PPP payment levels

Household size	**Minnesota Family Investment Program payment standard as of 10/1/2023**	**Refugee Cash Assistance payment standard as of 10/1/2023**
1	$515	$515
2	$731	$731
3	$841	N/A
4	$943	N/A
5	$1031	N/A

The Public-Private Partnership model provides additional transportation assistance to participants who are actively seeking employment and are engaged with their employment provider. Job search activities are verified on a monthly basis to ensure compliance prior to issuance of transportation assistance. Vouchers are purchased to support monthly travel costs for job search activities, based on the local transit system in PPP sites.

d. The state follows public/private RCA program requirements related to financial eligibility and consideration of resources and income.

e. N/A

f. The date an application is submitted is used as the start date for Refugee Cash Assistance benefits. Employment status and income are assessed monthly. In PPP locations, participants meet with RCA eligibility coordinators virtually or in person on a monthly basis

to discuss any chanes or updates that may impact program eligibity prior to issuance of RCA benefit. In non-PPP sites, participants are required to report any change in income, household composition, or basis of eligibility within 10 days of the change.

g. The State annually develops budgets for direct assistance and administration costs of the Public-Private Partnership model for Refugee Cash Assistance, which are monitored to ensure spending is within approved limits. RCA expenses submitted as a part of the Cash and Medical Assistance estimate are based on projected number of primary, secondary, SIV and asylee arrivals and the average number of months on assistance for each enrollee. Because there is little variance in assistance levels, if arrival projections are within the projected amount, the estimate will be in line with projected expenses. The administrative costs for RCA stay consistent across arrival patterns as long as they are within the funded service capacity. This year budgeted amounts have increased due to significant increased arrival projections.

h. Quarterly case reviews are conducted by the RCA coordinator. Where there are discrepancies found, they are reconciled and action taken to bring issuance into compliance. In alignment with state TANF program administration, any discrepancies that are due to agency error are not recouped from participants.

10. Refugee Cash Assistance Program Administration. 45 CFR 400.13

a. In the counties receiving the highest number of refugee arrivals, Refugee Cash Assistance eligibility is completed through a Public-Private Partnership with local resettlement affiliates. The remaining counties have county (public) administered Refugee Cash Assistance.

b. Eligibility determinations are made by local resettlement affiliates in PPP locations, and by county workers in other locations. Counties are subject to time studies for division of work, including RCA program activities. Reimbursement for time is made to counties on a quarterly basis based on these time studies.

c. Refugee Cash Assistance benefit checks are issued by the state in all counties. Participants who meet certain criteria and are employment exempt may opt to receive benefits via Electronic Benefits Transfer (EBT). In the twelve counties listed above which are Public-Private Partnerships, assistance payments may be issued through vouchers sent to contracted local resettlement affiliates or through Electronic Benefit Transfer (EBT) to participants. In all other counties, payments are issued directly to Refugee Cash Assistance participants through the EBT system.

d. At the state level, there is one staff person responsible for oversight and implementation of Refugee Cash Assistance programming. This individual is responsible for the coordination of the Public-Private Partnership and RCA policy implementation statewide, and serves as a resource and policy advisor for refugee access to all county administered cash and food

programs. Staff at the five local resettlement affiliates in the Public-Private Partnership total 14.05 FTEs. This year staffing levels have increased to put into place infrastructure to meet projected increases RCA-eligible arrivals. In addition, one full time eligiblty coordinator is added at the state level to provide back up and fill in across agencies if/when arrivals surges occur or there are staffing transitions at PPP agencies or impacted counties. Counties who administer Refugee Cash Assistance do time studies on a regular basis to report time spent on Refugee Cash Assistance activities. Based on these studies, the Resettlement Programs Office is billed quarterly for Refugee Cash Assistance related activities for county eligibility workers.

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

C. Refugee Medical Assistance (RMA) 45CFR 400 Subpart G

1. RMA Program Administration. 45 CFR 400.13
   Refugee Medical Assistance administration costs include staffing with the Minnesota Department of Human Services to ensure policies and systems are aligned with federal and state regulations, conduct outreach and training to counties, and trouble-shoot application issues. In the coming year, Minnesota will continue efforts to strengthen RMA program administration, prioritizing updates to the health care programs manual, policy updates to increase RMA income eligibility from 100% to 200% FPG, and outreach and training to county providers to ensure accurate RMA program implementation. The Refugee Health Specialist within the Minnesota Department of Human Services works with the health care administration to move these priorities forward. In coordination with MDH, this position will continue work to improve access to other mainstream health programs administered within the Department of Human Services, including managed health care programs. This happens in coordination with MDH. Because the Refugee Health Coordinator is based within the Minnesota Department of Health, they do not directly participate in the administration of the Refugee Medical Assistance program.

2. Applications, eligibility determinations, and furnishing medical assistance
   a. Process for determining eligibility for Medicaid and CHIP: Medical Assistance 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.

      All Minnesotans, including people with refugee status, who apply for health care coverage through MNsure (the state health care exchange) are screened for eligibility for MA, state subsidized health insurance, and Refugee Medical Assistance. Minnesota's exchange includes Medicaid expansion as of 1/1/2014, expanding eligibility for all Minnesotans.

   b. A "Designated Application Process for New Arrivals to the United States" streamlines health care application processing for primary refugee arrivals assigned to local resettlement

affiliates in Minnesota. This process began in July of 2014 as a result of the Affordable Care Act and the state exchange which combined applications for all health programs onto one platform. Applications are screened first for eligibility for Medicaid. If ineligible for Medicaid based on income, refugee applicants are screened for eligibility for other local health insurance programs, such as RMA. This year the State will add one full time eligibility coordinator position to expand this designated process to ORR-elligible arrivals who arrive through new and emerging pathways such as Welcome Corps, educational pathways, and Humanitarian Parole pathways.

3. Eligibility for RMA. 45 CFR 400.100 Through 400.104
    a. The financial eligibility standards for Refugee Medical Assistance is currently 100% of the federal poverty level. Since all refugees are screened first for Medical Assistance eligibility, all refugees who would qualify for Refugee Medical Assistance should also qualify for Medical Assistance. The methodology used to determine income eligibility is MAGI.

    b. The state considers income and resources as outlined at 45 CFR 400.102.

    c. The state provides continued coverage of recipients as required by 45 CFR 400.104.

4. Scope of Medical Services. 45 CFR 400.105 and 400.106
    a. Refugee Medical Assistance will cover at least the same services in the same manner and to the same extent as Medicaid on a fee for service basis.

    b. RMA is delivered on a fee-for-service basis. Services follow Medicaid services, including coverage for transportation and interpretation.

    c. For eligible populations without health coverage or whose health insurance does not cover the refugee health screening, a flat-fee reimbursement for the cost of the refugee health screening – if completed within the first three months after date of arrival in the US or of eligible status grant - is charged to RMA. The Minnesota Department of Health oversees this process as a part of health screening administration.

D. Medical Screening 400 CFR 400.107; 45 CFR 400.5(f)

1. Coordination of the Medical Screening Program
    a. The Minnesota Department of Human Services implements the Refugee Medical Screening program through an interagency agreement with the Minnesota Department of Health. Under the leadership of the Refugee Health Coordinator, staff engage in a broad array of activities including the following:
        - Provide clinical consultation, administrative guidance and training to local public health agencies and private health care providers which provide medical screening;
        - Ensure standard implantation of the Office of Refugee Resettlement and Centers for Disease Control and Prevention medical screening guidelines across the state;

- Identify health care entry points, systems and specialists to ensure refugees with acute and chronic health conditions are linked to care in a timely manner;
- Maintain 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;
- Provide assistance to local resettlement agencies and other contracted agencies in identifying refugees needing medical treatment or observations at the time of resettlement as needed and requested;
- Provide medical care coordination for primary arrivals with acute or complex health care needs upon arrival;
- Facilitate positive working relationships between health screening providers, health care systems and plans, local public health, local resettlement affiliates and community partners;
- Serve as subject matter expert on issues related to health needs of newly arrived refugees;
- Coordinate disease outbreak and prevention efforts for newly-arrived refugees, and consult on the state's emergency preparedness (all-hazards response and recovery) plans;
- Analyze and summarize health screening data to identify trends and outcomes;
- Complete federal reporting requirements related to health screening activities;
- Monitor and assess health screening implementation statewide;
- Develop and implement health education for new arrivals in coordination with program partners; and,
- Administer the flat fee reimbursement program to cover refugee medical screenings and related services.

b. The Minnesota Department of Health coordinates the Refugee Medical Screening program and works with local refugee resettlement agencies, local public health offices, community - based agencies and DHS to identify newly arrived primary and secondary refugees in need of care.

   Local resettlement agencies and other contracted agencies directly refer each new primary arrival to a designated local public health contact in the county of residence along with biodata forms and any medical information received from overseas, with a copy sent to the Minnesota Department of Health. Referrals for secondary migrants come to the Minnesota Department of Health from various sources including local resettlement affiliates, local public health departments, private clinics, local service providers, and other states. The Minnesota Department of Health monitors screening results and timelines. Follow up is initiated with local public health contacts to offer support or appropriate interventions, as needed.

   The Minnesota Department of Health has developed a process to receive arrival notifications for humanitarian parolees and privately sponsored refugees not coming through local resettlement agencies. Humanitarian parolees, privately sponsored refugees

or their respective sponsors are able to directly refer newcomers through a HIPAA-protected RedCap Referral form (https://redcap.health.state.mn.us/redcap/surveys/?s=NLPW8DLT8JFTT443). Once the Minnesota Department of Health receives these arrival notifications, it records the information in eSHARE and starts medical coordination with local public health agencies.

c. The Minnesota Department of Health is designated as the single point notification entity for CDC's Electronic Database Notification system (EDN). The Minnesota Department of Health completed the enhancements to eSHARE, the state refugee health database to enable attachment of medical records and overseas digital chest x-rays. Starting February 2019, all 87 local public health agencies have been given access rights to eSHARE to view and download overseas medical records for residents of their respective counties; eSHARE is also designed to allow clinic level access however clinics have opted to receive records from local public health. Hard copies of the medical records or digital chest x-rays may be mailed to local public health or clinics if sites are unable to access records. The eSHARE system continues to be updated with revised or newly-issued CDC refugee screening guidance. MDH will work with DHS to update our respective data systems to automate secure data reporting and transfers between the two agencies. We will develop a data sharing agreement to facilitate data exchange.

   Health care practitioners rely on the medical records to apply appropriate screening protocols based on demographic and medical history, including age and risk factors. Follow up referrals are made based on conditions identified on the overseas health information or during the screening.

d. The Minnesota Department of Health receives funding through federal Cash and Medical Assistance funding to coordinate activities related to refugee health screenings. A public health nurse contact in each of the 87 county health departments in Minnesota works with the Department of Health to implement screenings state-wide. Local Public Health contacts establish relationships with select private clinics or public health clinics and provide training to clinicians providing the screening. Counties with high volumes of screenings receive funding through CMA to support coordination and scheduling of screenings.

e. Refugees in Hennepin and Olmsted Counties receive health screenings within public health clinics. All other counties utilize private clinics to deliver refugee health screenings. All refugees who need active TB or latent TB follow-up receive services at local public health TB clinics.

2. Operation of Medical Screening Program

Minnesota requests approval to bill RMA for health screenings when an individual is not eligible for MA, and does not have other health coverage to pay for the screening expense. In these cases, RMA

is billed a flat rate equal to the MA rate for the same services. In recent years, fewer than ten screenings have been billed to RMA each year.

3. Scope of Medical Screening Services. 45 CFR 400.107
    a. Minnesota assures that the Medical Screening program is operated in accordance with the requirements prescribed by the Director.

    b. Medical Screening cost reimbursement is comparable to Medicaid rates.

    c. All aspects of the Medical Screening checklist are billed to Medicaid, when available. If an individual is not eligible for MA, the screening is billed, as a flat rate, to RMA.

    d. The Minnesota Department of Health regularly monitors the screening status of all new arrivals to ensure that screening is initiated within 90 days of arrival (or status grant for US granted asylees and victims of human trafficking). The Minnesota Department of Health also monitors the completeness of the screening. Local Public Health contacts are called and reminded if health screenings are delayed and are offered support or appropriate interventions.

    e. See "Attachment A" for description of service elements of the Refugee Health Screening covered by Medicaid, including services provided based on age and risk factors.

    f. All medical screening items are billed to Medicaid.

    g. Transportation is provided for refugee medical screenings for all arrivals.

    h. Interpretation services are available for refugee medical screenings. If clinics are unable to locate interpreters for rare languages because it's a new community in our State, a flat fee may be offered to offset the clinics' interpretation service costs.

    i. Two additional services, secondary arrival administration and complex care coordination, are outlined below. In addition, systems coordination for medically complex cases and secondary/humanitarian parole arrival administration ensures access and support to every ORR-eligible resident in Minnesota.

        - The Minnesota Department of Health has integrated health systems coordination to assist with care plans for refugees with acute or complex health care needs into its core activities. To accomplish this task, a medical social worker (Health Systems Coordinator) works with local refugee resettlement agencies to develop and set-up care protocols and assure initial health care services for cases with significant health conditions prior to arrival. The Minnesota Department of Health medical social worker identifies resources and communicates with Local Public Health, primary care providers and referral specialists to inform of the refugee's health status, and forwards overseas relevant medical records to the appropriate health care facilities. To provide additional support and medical coordination for recently arrived Afghan newcomers and Ukrainian

Humanitarian Parolees, two additional temporary staff will manage clinic assignment and coordination of screening, managing outgoing and incoming health-related data.

- Coordination of refugee health screening for secondary arrivals and other ORR-eligible populations: the Minnesota Department of Health, with RPO, has established referral and linkage to health care protocols to assist secondary migrants, SIV holders, U.S.-granted asylees and ORR-eligible humanitarian parolees to health care. Through the established referral mechanisms, local public health agencies, community-based organizations or resettlement agencies refer these newcomers to the Minnesota Department of Health. If available, program staff request overseas medical records from the primary arrival state or CDC for secondary migrants or SIV holders; the documents 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 these eligible populations. The health screening budget supports screening coordination in the counties most impacted by secondary arrivals, asylees, ORR-eligible humanitarian parolees, and SIV holders.

j. There are no services beyond those outlined in ORR's medical screening checklist which are included as part of health screening.

E. Refugee Supportive Services (RSS). 45 CFR 400 Subpart I

1. Supportive services provided to refugees within criteria outlined at 45 CFR 400.154 and 400.155.

   Funding supports social services within Office of Refugee Resettlement prioritization criteria. Beginning October 2019, four Regional Resettlement Networks and service hub locations were established in Minnesota. Regional Resettlement Networks incorporate the following underlying values:

   - QUALITY: Every person should have access to the highest-quality services available. Service components funded prioritize provider expertise in each service area.
   - A WHOLE FAMILY APPROACH: Individual and family wellbeing are interdependent. Resettlement Networks use a Family Wellbeing Inventory to take a two-generation approach in assessing wellbeing. All providers use this inventory as a tool to identify additional resources that may be of interest to a family, and to track family progress over time. Training will be provided by the State on the use of this tool, which is a requirement for all funded providers.
   - MEANINGFUL CONNECTIONS: People need connections to the right service(s) at the right time(s). Meaningful connection to appropriate services is an integral part of the Resettlement Network service delivery model. With the first point of contact for any Resettlement Network service funded by the State, a Family Wellbeing inventory is completed and agencies work with families to ensure meaningful connections to other experts within the Resettlement Network. The State will provide education on network resources and networking opportunities to build connections between the four service components (Immigration, Employment, Community Orientation and Family Supports) to support this goal.

- COORDINATED SERVICES: Individuals and families experiencing difficulty should be supported by helping systems. People who need assistance can have multiple barriers that prevent their ability to visit a multitude of agencies for different types of support. In the Resettlement Network, services should be coordinated and consolidated to maximize efficiency for the participant in order to increase family wellbeing. The State provides a centralized database, Minnesota Refugee Information System (MRIS), which will track services to participants across the Resettlement Network to support and enhance agency communication and facilitate coordinated services. MRIS system training provided by the State.
- ACCESSIBLITY/MOBILITY: Service locations should be accessible and convenient for participants. Resettlement Networks include service Hubs at a location(s) of community significance where people are comfortable seeking assistance. Funded agencies must offer services at these Network-identified Hubs, in addition to any other location(s) proposed, to allow participants to access all funded services in one location.
- COLLABORATION: Interagency communication and collaboration is necessary to provide the most effective service. The regional Resettlement Networks are funded through a consortium model to facilitate partnerships that, together, offer the most effective and comprehensive service to people with an eligible status.
- ADAPTABILITY: Services should meet the needs of participants. The Resettlement Network model is designed for flexibility to adapt to the current changing landscape of resettlement in Minnesota. As populations change and service needs shift, a network of agencies can be more responsive to change than individual agencies. For example, specialized service expertise can be brought to new populations, locations can be adjusted to meet geographic needs, and services can be tailored to meet the need of people served.

Each of the four Regional Resettlement Network are comprised of six service components:

- **Family Support Services:**
  - *Family Assisters* work with families to resolve immediate needs and connect them to a wide array of community resources.
  - *Family Coaches* provide longer-term support and utilize a Check and Connect model to support progress towards multi-step academic and career/vocational goals for students, youth or adults.
- **Immigration Services** help people to apply for work authorization and progress on a path to become U.S. Citizens.
- **Employment Placement Services** assist people to secure and maintain employment and job upgrades.
- **Community Orientation Workshops** provide education about integration topics encountered during the first 5 years in the U.S., such as employment readiness, how to utilize public transit, financial literacy, navigating the public education system, understanding healthcare in the U.S., buying a home, ways to volunteer and get involved in your new community, and other relevant topics identified by community partners.
- **Community Health Worker Services** provide direct assistance to people with ongoing medical needs to access services and supports needed to manage their health conditions.
- **Refugee Cash Assistance (PPP)** provide cash assistance and connection to resources for up to 12 months to people within their first year of arrival who are not eligible for other cash support.

Funded providers are required to implement the following service elements as a part of service provision:

- Family Wellbeing Inventory:
  - ✓ Standardized tool to identify needs and service connections.
  - ✓ Completed at the first point of contact within the network and updated every 3-6 months.
- Network Connections
  - ✓ Upon completion of the Family Wellbeing Inventory, providers make connections to the appropriate network resources for the needs identified.
- Centralized Service Documentation:
  - ✓ Agencies use the MN Refugee Information System (MRIS) to complete Family Wellbeing Inventories and to track service outputs and outcomes. Information in MRIS will help identify service needs, support coordinated service delivery, and measure changes in family wellbeing over time.
- Mobile Services Offered at Network-identified Service Hubs:
  - ✓ Specialized services (Immigration, Employment, Community Orientation, and Family Coaches) offered at Hub locations or locations most accessible to the participant.

These networks provide coordinated, quality, family-centered service delivery structure for all ORR state formulary funds. Within Resettlement Networks, DHS funds specialized service components which include the following activities:

- Employment Placement and Job Upgrade services
- Social Adjustment Services
- Outreach
- Information and referral services
- Case management and service navigation
- Transportation
- Translation/Interpretation services
- Citizenship and naturalization preparation services (services offered do not include any resources for fees paid to the United States Citizenship and Immigration Services (USCIS)Assistance applying for EAD

2. Regional Resettlement Networks use the Family Wellbeing inventory, which is embedded in the Minnesota Refugee Information System (MRIS) as a condition of enrollment. This inventory brings providers through a series of questions to identify family needs resulting in a service directory for providers to follow up upon. The MRIS system also allows providers to make referrals based on that assessment to other network providers. All providers are required to conduct follow up inventories every six months until a family ages out of services or asks providers to stop contacting them. In this way, providers are proactive in following up with clients and assessing needs over a continuum of integration over time.

   The MRIS system cues for providers when a follow up inventory is due for follow up. There are also incentives for providers in the form of service outputs that can be claimed against contract goals for completing this inventory each six months.

3. Set-Aside Services
    a. STUDENT SERVICES and YOUTH MENTORING: RSS set-aside funding is used to support refugee students and youth and is awarded to support student mentoring and coaching utilizing the evidence-based Check and Connect model used to support students to improve academic success and social wellbeing.

    Key Components of Family Coach Role:

    - Targets <u>one or more</u> of the following three populations:
        i. At-risk kids in grades 1-12 who are struggling school.
        ii. Youth ages 15-24 transitioning out of high school, who may benefit from mentorship towards post-secondary education, vocational pathways or employment goals.

    - Focuses on individual progress toward educational or vocational goals over time
        i. Educational & vocational goals are identified through the Family Wellbeing Inventory, which may be completed by any Resettlement Network provider.
        ii. When educational or vocational goals are identified, Resettlement Network providers will connect participants to a Family Coach who will work with the individual to develop a goal plan.
        iii. Coaches build relationships with individuals and pro-actively mentor individuals towards their longer-term goals.

    - Builds relationships and uses a family-centered mentorship model support families over an extended timeframe
        i. Coaching services include a whole-family perspective in goal setting and progress measurement.
        ii. Families identify and accomplish tangible steps toward longer-term goals.
        iii. Coaching services work to build relationships within families and mentor families in their progress across various benchmarks of progress.

    - Uses the "Check and Connect" mentorship framework. The "Check" component refers to coaches systematically monitoring individual progress markers toward goal benchmarks. Progress markers will vary by target population. A core set of markers will be provided by state prior to start of program as part of Check and Connect documentation tools and training. Some examples of measurable progress markers include information such as attendance records, grades, ELL level, and course completion. The "Connect" component refers to coaches providing regular, in-person connections with each participant to discuss progress markers, identify barriers that prevent progress, and provide timely interventions to help resolve challenges, and mentoring individuals' progress toward their goals. Information about the "Check and Connect" mentorship framework is available at: http://checkandconnect.umn.edu/.

b. ELDERLY SERVICES: RSS funding is used to support elderly refugees, application supports for adjustment of status and citizenship applications and connections to other support services.

c. REFUGEE HEALTH PROMOTION SERVICES (RHP): RHP services are used to implement a community health worker model for health education and promotion for new arrivals.
   - Program structure: Beginning in 2023, a community health worker model was established to meet the needs of new arrival populations. The model includes recruitment, training and supervision leading to licensure of CHWs from new arrival communities. The goals are three-fold. The first goal is to expand health promotion services through CHW model blending cultural and medical expertise. The second goal is to support development of culturally competent services through combining training and supervision leading to licensure of new practioners while they are gaining on the job experience. Third, building providers capacity to support ongoing services that are billibable to Medical Assistnace (MA) with a goal of transition to reimbursable service provision through licensed, trained, culturally competent CHWs from new arrival communities to continue and expand service provision.
   - Roles of contracted providers: Contracted partner will recruit, train, and supervise community health workers and integrate them into Resettlement Network services. They will develop and bill MA for services as appropriate and base CHWs in locations most accessible to communities.
   - Geographic service area(s) projected: Statewide through in person and virtual service provision.
   - Target populations: New arrival populations including Ukrainian, Afghan, Karen, Somali, DRC, Cuban and others.
   - Activities: Health education and health self-management services, in home, virtual and group settings.
   - Describe how these set-aside services complement services provided under RSS base funding. These services will be embedded in the Resettlement Network service structures, allowing for cross referrals and service coordination through regular meetings, and a shared information system. There are no other services currently funded that support health navigation for individuals. This service will be built into the family wellbeing inventory to help flag participants that would benefit from the service.

   In addition, funding is being set aside for additional community driven initiatives open to community based organizations through 2024 and for potential interpretation support for health services beyond medical screening for rare languages (on case by case basis) and development of structure for distribution of first aid kits to new arrivals.

d. MENTAL HEALTH funding has been obligated to augment family coaching services programming with a new consortium partner with expertise in mental health to build direct service connections and provide expertise to the service area.

   In addition, there are currently community conversations underway to support community driven initiatives to support wellbeing.

4. The State strategically uses Afghan Supplemental Appropriation (ASA) funds to expand existing service structures, augment programming with new essential services, and fill short term service needs. Investments for 2024 are twofold. Ongoing investments are listed below. Additional investments will be guided by results of community needs assessment and resource mapping project commissioned by the State. Results of this evaluation will be released in September of 2023.

    a. Housing: Long-term housing stability: The Afghan Housing Stability Program provides services and subsidies to Afghans whose housing expense exceeds 45% of their income. This program provides shallow rental subsidies and intensive case management services focused on increasing income and/or decrease housing expense to ensure long-term housing stability. This program is a new service component of Minnesota's statewide Resettlement Network Services, allowing for coordination of this program with other ORR funded services such as student success, employment services, community orientation and more by using the centralized collaboration tool of Minnesota Refugee Information System (MRIS).

    b. Legal Services: ORR-Afghan Legal services, private resources, and local preferred legal service allocations are pooled into a coordinated service delivery system to ensure all Afghans are connected to legal representation towards permanency. A contract is in place with The Advocates for Human Rights to coordinate this effort. They oversee recruitment, training, and oversight of pro-bono attorneys matched to Afghan families. The legal path for each family is mapped and matched with appropriate representation, with partners focusing expertise within the different pathways.

    c. Employment Services: Resettlement Network Services service expansion has been maintained to continue services for Afghans through the coordinated services structures, including job upgrades.

    d. Community Orientation Services: Resettlement Network Community Workshops offer enhanced services to Afghans including:
        - Housing rights and responsibilities
        - Financial literacy
        - Other priorities defined by community and agency partners

    e. Ongoing Service Navigation: Resettlement Network Family Assister Services that were expanded in the Twin Cities Metro area maintain expanded service capacity to address immediate needs.

    f. AmeriCorps:

- The State launched the Minnesota Resettlmeent Corps in partnership with ServeMN (AmeriCorps administrative agency in Minnesota) to allocate up to 22 full time AmeriCorps members to be placed at Resettlement Network Service providers in the areas of housing stability, Legal assistance and family coaching services for Afghans. The State pays the placement fee for members placed.

5. ASA set-aside funding enhance and expand programs and ensure culturally relevant and accessible services are available to ORR-eligible Afghans.
    a. Youth mentoring and Student Success funding, supports Minnesota's Family Coaching services. Past expansion of the consortium to include a Afghan Mutual Assistance Association has been continued and further expanded as needed.
    b. S2S funding supports direct funding to school districts and the Minnesota Department of Education to develop and implement supports for Afghan students and the educators serving them.
        - Direct funding two impacted school districts, Minneapolis Public Schools and St. Paul Public Schools to support a staff person to bridge district resources, connect to family coaching programming, and support family connection in schools is continuing through 2024.
        - An interagency agreement with the Minnesota Department of Education is in place to support a statewide New Americans Workgroup for district staff to develop and implement supports for districts serving Afghans, and oversees funding to support district-driven initiatives supporting student success.
    c. Health Promotion. ASA Health Promotion funding supports a Community Health Worker network for ongoing health education and navigation for ORR-eligible Afghans with chronic issues. This includes training and employment opportunities for training and career pathways for individuals with health care background. Please see II.E.3.c for additional detail. ASA funding will support the recruitment, hiring and implementation of CHW services targeted to meet the health and health education needs of Afghans.

6. A coordinated service delivery strategy takes into account all federal and local resources to support people arriving through the Uniting for Ukraine program (U4U) including ORR funding directed to local resettlement agencies to prevent duplication and ensure continuity of services. The State has worked with local resettlmenet affiliates to implement Ukrainian Navigation Services as an essential first point of access to screening for all ORR funded services connection to new arrivals. A needs assessment was conducted in 2023 which continues to inform investments.

    The State funds additional outreach and engagement activities through a contract with the Ukrainian American Community Center (UACC) who coordinates across the Ukrainian Community and provides a location to host various community services provided by other organizations such as Ukrainian Navigatoin Services and other and RSS funded services such as community orientation workshops.

    Additional direct-service investments include:

- Continued and augmented funding to support use of the Ukrainian Center outreach and engagement which has become a service hub for service provision of other organizations.
- New Ukrainian Emergency fund to provide emergency supports (anticipated launch October 2023)
- Implementation of a state-wide Help Line (anticipated October 2023 launch), with Ukrainan speaking navigator to support menaningful navigation and connection to supportive services statewide.
- Dollars set aside for community initiated projects.
- Expansion of Family Support Services networks to include Ukrainian Mutual Assistance Association:
  - *Family Assisters* work with families to resolve immediate needs and connect them to a wide array of community resources.
  - *Family Coaches* provide longer-term support and utilize a Check and Connect model to support progress towards multi-step academic and career/vocational goals for students, youth or adults.

F. Unaccompanied Refugee Minors (URM) Program. 45CFR 400 Subpart H

1. Administrative Structure and State Oversight: Minnesota does not currently operate an Unaccompanied Refugee Children program. Children in need of protection are referred to child protective services for assessment and referral to available interventions.

Minnesota's State Plan for Resettlement submitted by Rachele King, Minnesota State Refugee Coordinator.

Signature: 

Date: *8/31/2023*

ATTACHMENT A

Service Elements of the Refugee Health Assessment

Minnesota follows the Office of Refugee Resettlement's 2012 refugee screening guidelines, along with Centers for Disease Control and Prevention refugee screening guidance. 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 Office of Refugee Resettlement, Centers for Disease Control and Prevention and Minnesota Department of Health refugee 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 Electronic Disease Notification system 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 B0 TB – active TB disease treated overseas by panel physicians
    - Class B1 TB – evidence of pulmonary or extra pulmonary TB disease, sputum smear-negative; includes "old healed TB", and previously treated TB
    - Class B2 TB – Latent TB infection (LTBI) if TST ≥ 10 mm or positive interferon-gamma (IGRA)
    - 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. Draw an interferon-gamma (IGRA) blood assay for all refugees ≥2 years and older 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 and recommended for use in anyone ≥2 years of age. Administer a tuberculin skin test (TST) for all refugees six months to < 2 years old. 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 B1 conditions, (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 IGRA results or TST (≥10mm induration) **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, sputum specimens should be collected for bacteriologic examination and a "TB suspect" reported to the Minnesota Department of Health TB Prevention and Control Program. Providers need to remember to consider extra pulmonary TB disease, which is also reportable to the Minnesota Department of Health. 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 IGRA or TST 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 Minnesota Department of Health 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, any records brought by the refugee or in the state immunization information system (MIIC). The Minnesota Department of Health electronically transmits overseas immunization records into MIIC for newly arrived primary refugees in the state. All previous vaccinations should be recorded if not already captured in MIIC. 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, D 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, and 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; those who initiated vaccines overseas should continue to receive the necessary doses to be up-to-date. Pregnant women identified as carriers should have test results forwarded to their prenatal care provider for appropriate follow-up for their infant. The Minnesota Department of Health collaborates with hepatitis surveillance and perinatal hepatitis B prevention program to share all screening and demographic information to ensure follow-up.

Adult refugees 18 years and older and pregnant women should routinely be screened for hepatitis C (anti-HCV and confirmatory). Those < 18 years old may be screening if the present with risk factors.

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
    - If partially treated, screen or treat presumptively
    - Routine eosinophil count
    - Screen for giardiasis using stool antigen for those with symptoms

    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 (consider contraindications)

    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. Sexual and reproductive health and follow-up:
    Universal testing of HIV for arrivals from mid-high HIV prevalence regions

    - Screen for HIV if 13-64 years and from non-endemic region; screening all family members, regardless of age is encouraged
    - Syphilis
        - Rescreen those 15 and older for syphilis according to clinic protocol, confirm (we're currently reviewing the new CDC syphilis screening guidance to update the guidance)
        - Screen those 15 and under if risk factors are present according to clinic protocol (being revised)
    - Gonorrhea and chlamydia
        - Screen 18 to 24 years if they don't have pre-departure testing for GC/Chlamydia or if symptomatic.
        - Screen those <18 or >24 if symptomatic
    - Female genital cutting/mutilation: Screen women and girls from countries where FGC/M is practiced.

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

- Screen all pregnant or lactating women and girls
- Refer to Public Health and medical follow up if BLL ≥5 µg/dl.

11. Pregnancy test should also be performed for all women of childbearing age and pubescent adolescent girls.

12. Additional components include:
    - Basic metabolic panel, if indicated (especially if screening if occurring in a primary clinic setting)

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 Local Public Health 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.

    Local Public Health provides most of this education, but providers in private clinics provide this education as well. Minnesota Department of Health provides technical assistance, resources or guidance as requested. The program is currently working with various partners across the U.S. to vet and update relevant health orientation materials. Resources and tools will be shared widely via the department's website.