Refugee Health Quarterly

A Refugee Health update from the Minnesota Department of Health

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Greetings from the Refugee and International Health Program

Working in refugee health continues to be an incredible journey. In 2016, nearly 3200 refugees made Minnesota home. Their successful resettlement and refugee health screenings wouldn't have been possible without the tireless work of family, friends, neighbors, local public health agencies, health care providers, and the community at large.

From October through December 2016, 25,671 refugees entered the U.S. (893 in Minnesota). For this federal fiscal year, the national admissions cap has been reduced to 50,000 refugees, and the refugee resettlement program has been suspended for four months. We are waiting to hear from our federal partners on refugee arrival numbers for the remainder of the year. Despite the uncertainty, our resolve is to continue to provide the best possible support to our partners, local public health agencies, resettlement agencies, and clinics.

On January 25, we hosted our tenth Local Public Health and Resettlement Agency forum. This annual event provides an opportunity for our key partners to meet in person, network and share ideas and resources for promoting refugee heath. Our theme for this year's forum is "Building Bridges: Refugees, Health Care, and Resources," and these verses from "Step by Step" sang by Pete Seeger describe our work so well:

Step by step the longest march

can be won, can be won.

Many stones can form an arch,

Singly none, singly none.

And by union what we will

Can be accomplished still

Drops of water turn a mill,

Singly none, singly none.

We look forward to continuing our collaborative work in 2017!

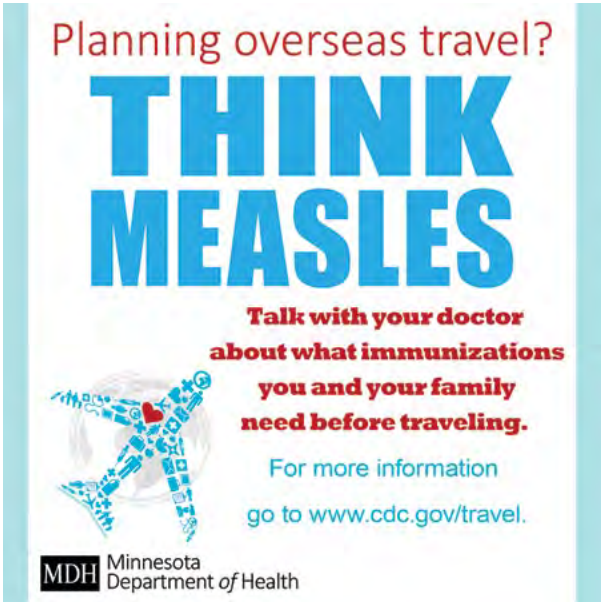
LPH and VOLAG Forum

The Tenth Annual Local Public Health and Resettlement Agency forum was held on Wednesday, January 25, 2017. This year's theme was "Building Bridges: Refugees, Health Care, and Resources." Attendees networked, generated ideas, and shared their knowledge to address the ongoing health-related needs of our new refugee arrivals!

Discussions and presentations focused on how to help connect refugees to important health resources and services. The forum addressed respectful and effective ways to work with diverse communities and with a range of partners of varied perspectives. Topics included language access, housing law, chemical dependency, and more. The day also included a session on leadership and self-care in cross-cultural work, building on last year's popular session.

More detail is available on the Local Public Health and VOLAG Forum (www.health.state.mn.us/divs/idepc/refugee/forum.html) webpage. Presentations will be posted soon.

If you have questions, please call 651-201-5414 and ask for someone from the Refugee and International Health Program.



Ad from the February diverse media campaign. Versions of this ad have been translated into Amharic, Hmong, Somali, and Spanish.

MDH Minnesota Department of Health

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Community Health Workers: Bridging Community and Clinic

For over 30 years, Hennepin County Public Health Clinic (HCPHC), has served as the primary refugee screening clinic for residents in the largest county in Minnesota. During 2011-2015, the clinic saw an average of 2,300 primary and secondary refugees annually. We interviewed public health nurse (PHN) Ingrid Attleson and community health worker (CHW) Omar Hassan about Omar's role at HCPHC.

How long has Omar been at HCPHC?

Our CHW, Omar, joined the Public Health Clinic in January 2016, as part of the Emerging Profession Integration Grant Program (MDH/DHS State Innovation Model funding), to work with new arrivals receiving refugee screening. He worked intensively with a mentor PHN during the initial nine-month grant period and is now in a two-year, full-time and benefited position.

What was it like to add a CHW to the team? What has changed?

Omar has been an invaluable addition to our clinical team. His training, language abilities, and cultural sensitivity are clearly appreciated by our majority Somali patients and significantly improve the efficiency of referrals and care plan adherence. As a result of Omar's work with refugee clients on health education and health system navigation, the PHNs have increased capacity to focus on the case management needs of more medically complex patients. Our program also has increased capacity to assist patients in establishing primary care. This is particularly helpful for our secondary refugees, who do not have the support of a resettlement agency.

What are some challenges and successes? How does having a CHW on the team impact your patients?

The main challenge has been high demand for CHW services and only one Omar! Happily, we were able to transition the grant-funded position into a more permanent position at the clinic, so we will continue to integrate Omar and his work into our refugee health team.

Omar helps to clarify complex concepts during screening visits. In particular, he assists the PHN and nurse practitioner (NP) with explaining chronic diseases, such as hepatitis B infection. This infection, along with its recommended care, is often misunderstood due to several issues: translation (there is no Somali word for hepatitis B, and the commonly used word, "cagaarshow," is more directly understood as "jaundice"), stigma (hepatitis B can be associated by new refugees with sexual transmission and promiscuity, rather than the more common mother-to-baby transmission), and the need for continued monitoring even in the absence of symptoms. Omar is able to catch interpreters' use of the common translation, identify the specific areas of confusion for the patient, and spend time after the visit reviewing the provider's plan of care.

Explain the collaboration between Omar and other staff.

Our refugees are screened at our clinic over two separate visits. The initial visit is by a PHN and includes a health history and blood tests. The second visit is by a NP and includes an exam and a review of testing results. Omar sits in on both visits, whenever possible, and collaborates with the clinical staff after the visit to create a care plan for the identified patient needs. Additionally, the NPs create referrals for Omar's services for all patients who would benefit from non-urgent assistance with primary care or dental resources.

Are there any changes you would like to see happen? Do you have any recommendations to other clinics or LPH who might be considering adding a CHW?

We do not yet have a system for billing for CHW services, which we understand to be a common barrier for other clinics as well. Our program and staff have benefited greatly from the addition of a CHW to our team, and we would recommend any refugee health program consider adding this type of position.

Omar, what do you enjoy most about your position as a CHW at HCPHC?

As a CHW, I act as a bridge between the refugee community and the public health clinic. I am able to provide information to clients while being respectful of their cultural beliefs. I connect clients to both social and health care services.

Every day is an interesting day at my job. What I find most interesting is when I am able to help clients with services they didn't know were available to them. I know as a former refugee how confusing it can be for new refugees and I am so happy that I am able to help in the resettling process.

Provider Update: Immunizations and Refugees

Immunizations are an important part of public health for all communities. The documented immunization history for most refugees begins in the refugee camp prior to US arrival. While some may have received vaccinations prior to that, documentation is often not available. More than 80 percent of refugees arriving in Minnesota have at least one vaccination (Table 1) documented in their medical records from overseas (the DS-3025 and the Pre-Departure Medical Screening Form). Which vaccinations are given depend on the resources and protocols of the camp, as well as the age and medical considerations of individual.

At the Refugee Health Assessment (RHA) visit, providers should assess written documentation of a refugee's previous vaccinations and follow the Advisory Committee on Immunization Practices (ACIP) guidelines to determine which vaccines should be given. Required vaccinations are only a subset of the ACIP recommendations, and it is important that providers offer all immunizations that are medically appropriate. All vaccinations due at the RHA should be given. Missed opportunities generally result in incomplete vaccination. If the person needs further doses or additional vaccinations, providers should discuss when those vaccines are due and help the patient plan where to go to receive those immunizations.

RIHP tracks the immunization rates at the RHA (Table 2). Immunization is a core outcome of the RHA process, and rates are reported to counties and the federal Office of Refugee Resettlement annually. The goal is for at least 90 percent of refugees to receive immunizations at the RHA, acknowledging that some may not be due for a vaccine,

(continued on Page 3)

Table 1. Primary Refugee Arrivals to Minnesota with Documentation of Overseas Immunizations, January 2015 – June 2016

Age at US Arrival (years)	2015		Jan-Jun 2016	
	Total Number of Arrivals	Number (%) with Documentation of Overseas Immunizations	Total Number of Arrivals	Number (%) with Documentation of Overseas Immunizations
Under 5	343	310 (90%)	190	177 (93%)
5 – 17	721	647 (90%)	427	382 (89%)
18 and older	1,180	932 (79%)	724	597 (82%)
Total	2,244	1,889 (84%)	1,341	1,156 (86%)

(continued from Page 2)

may have contraindications, or may defer. RIHP staff are available to clinics and counties interested in training and technical support on the RHA process, including vaccination.

Additional immunization assessment guidance:

- Overseas vaccinations for primary refugees are automatically uploaded into the MIIC (Minnesota Immunization Information Connection) immunization registry. RIHP creates MIIC profiles for primary refugees with at least one documented vaccination in their overseas medical paperwork. Documentation of diseases, serology results, BCG vaccination, varicella history, and mother's maiden name are not included the upload. Local public health and clinics are encouraged to add this information as they are able.
- If local public health or a provider sees an error in vaccine documentation on the overseas paperwork, such as an immunization date before the client's date of birth, please inform RIHP.
- Be aware that immunization practices may be different across countries, so the patient may have a different expectation about what being "up to date" means.
- Only written documentation is acceptable proof of vaccination. If the documentation is not in English: 1) check the Foreign Language Terms (https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/foreign-products-tables.pdf) appendix in CDC's Pink Book; 2) bring in a translator to assist in reading the record; or 3) check the Vaccine Information Statement for similar terminology. If the clinic is unable to determine the vaccines documented, revaccination is recommended.
- Serology may be an option for certain vaccines, but it is generally most cost effective to revaccinate. Laboratory evidence of immunity is acceptable for the following diseases: measles, mumps, rubella, hepatitis A, hepatitis B, polio, and varicella. Guidance regarding what type of serology is recommended can be found in the General Recommendations at Immunization of the Advisory Committee on Immunization Practices (https://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf).
- Details about the immunization programs in refugee camps can be found at the Vaccination Program for U.S.-Bound Refugees (https://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/interventions/immunizations-schedules.html).
- Details about the immunization requirements for the I-693 Adjustment of Status Form (required for the "green card") can be found in the Requirements for routine vaccination of adjustment of status applicants who are not fully vaccinated or lack documentation (https://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html#tbl1) table.
- When pneumococcal conjugate vaccine 10-valent (PCV10) is given, it should be treated like PVC7 (i.e., children under age five years need to receive one or more doses of PCV13). Record PCV10 doses as PCV7 doses in MIIC (MIIC does not have a PVC10 option). Children age two to five years who only received PCV10 doses as the vaccination series should receive one supplemental dose of PCV13. Children who have started the PCV series with PCV10 can complete the series using PCV13.
- Only documentation showing receipt of trivalent oral polio vaccine (tOPV) is proof of vaccination for polio. Because this is usually not specified in the overseas health document, most persons up to age 18 years should receive age-appropriate inactivated poliovirus vaccine (IPV) according to the catch-up schedule. While serology can be substituted, serologic testing for type 2 antibodies requires live virus and is becoming increasingly unavailable. A positive antibody for type 1 and type 3 poliovirus does not provide evidence of immunity to type 2 poliovirus.
- Also note, when both tOPV and IPV are administered as part of a series, a total of four doses are needed. Regardless of the number of doses previously received, the final dose needs to be given on or after the fourth birthday and at least six months from the previous dose.

Table 2. Receipt of Immunizations after US Arrival, Primary Refugee Arrivals to Minnesota, 2015-June 2016

Age at US Arrival (years)	2015		Jan-Jun 2016	
	Total Number of Arrivals to Receive RHA*	Number (%) Received Immunizations after US Arrival	Total Number of Arrivals to Receive RHA*	Number (%) Received Immunizations after US Arrival
Under 5	337	316 (94%)	181	168 (93%)
5 - 17	699	662 (95%)	413	380 (92%)
18 and older	1,132	1,034 (91%)	683	563 (82%)
Total	2,168	2,012 (93%)	1,277	1,111 (87%)