Indiana State Department of Health

Indiana Refugee Health Program Annual Report

Federal Fiscal Year 2019

Date Issued: February 26, 2020

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Overview

Refugee resettlement in the United States is a collaborative effort between the U.S. Department of State Bureau of Population, Refugees, and Migration (PRM); the U.S. Department of Health and Human Services Office of Refugee Resettlement (ORR); national and local resettlement agencies; and state governments (or designated replacement organizations). Ensuring the health and well-being of refugees so that they can flourish in their new home is a key component of refugee resettlement. Each refugee who arrives to the U.S. is eligible for a domestic refugee health assessment, which should occur within the first 90 days of arrival.

Accomplishing the goal of offering a health assessment to every new refugee in Indiana cannot happen without strong partnerships and good communication between all of the agencies involved in refugee resettlement. The Indiana State Department of Health (ISDH) works closely with the Centers for Disease Control and Prevention (CDC), the three Indiana refugee resettlement agencies (Catholic Charities Fort Wayne-South Bend, Catholic Charities Indianapolis, and Exodus Refugee Immigration, Inc.), and local health departments to ensure refugees receive a domestic refugee health assessment upon resettlement in Indiana.

Definitions

Persons eligible for a domestic refugee health assessment are defined by ORR, which is currently the funding source for all Indiana Refugee Health Program (IRHP) activities. Those eligible for ORR-funded services include refugees, asylees, Cuban/Haitian entrants or parolees, special immigrant visa (SIV) holders, Amerasians, and certified Victims of Human Trafficking. These will be collectively referred to as "refugees" throughout this report.

A brief definition of each is below.

A **refugee** is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. This status is granted *before* the person comes to the U.S.

An **asylee** is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. This status is granted *after* the person comes to the U.S. Once granted, an asylee can petition to have their immediate family members, who are still overseas, reunite with them in the U.S. Those family members are called follow-to-join (V92) asylees.

A **Cuban/Haitian entrant or parolee** is a national of Cuba or Haiti granted parole status or other special status and is not the subject of exclusion or deportation proceedings under the Immigration and Nationality Act.

A **special immigrant visa (SIV) holder** is someone who performed a service for the U.S. government in Iraq or Afghanistan and is determined to be eligible for resettlement by the U.S. Department of State.

An **Amerasian** is an individual fathered by a U.S. citizen and born in Vietnam after January 1, 1962, and before January 1, 1976.

A **certified Victim of Human Trafficking** is a person who has been granted protection due to being a victim of sex trafficking or labor trafficking.

Another important distinction is between primary and secondary refugees. A **primary refugee** is someone who was initially designated to resettle in Indiana. However, once they are in the U.S., refugees may move, and some do in order to reunite with family and existing cultural communities or to seek job opportunities in another state. A **secondary refugee** is a refugee who initially resettles in another state, but then moves to Indiana. Although secondary refugees are an important part of Indiana's refugee communities, this report will only address primary refugees.

International Refugee Crisis

The number of people forced to flee their home due to armed conflict and persecution continues to increase. According to the United Nations Refugee Agency (UNHCR), in 2018 there were 70.8 million forcibly displaced people as a result of persecution, conflict, violence, or human rights violations worldwide.[1] This is an increase of 2.3 million people from the previous year and a record high. Of those, there were a record 25.9 million refugees and 3.5 million asylum-seekers living outside of their country of origin, with the rest being people who are internally displaced in their home countries. Newly registered refugees and asylum seekers in 2018 primarily came from Syria, Venezuela, South Sudan, and Democratic Republic of the Congo, as these are places of large-scale and ongoing conflict or state-sanctioned violence.

Many refugees have spent several years in protracted refugee situations. In 2018, more than two-thirds of all refugees (67%) came from five countries: Syria, Afghanistan, South Sudan, Burma, and Somalia, and half of all refugees were children. Only 92,400 refugees were resettled to a third country, such as the United States. That is only 0.4% of the global refugee population.

Each year the President of the United States, in consultation with Congress, sets a ceiling for refugee admissions for the upcoming federal fiscal year. This dictates the maximum number of refugees permitted to come to the U.S. and does not include additional allocated slots for SIV holders. For federal fiscal year (FFY) 2019, the refugee ceiling was 30,000, which was the lowest ceiling set since Congress authorized the Refugee Act of 1980. The number of refugees actually resettled in the United States during FFY 2019 was exactly 30,000, with an additional 7,774 Afghani and Iraqi SIV arrivals.[2]

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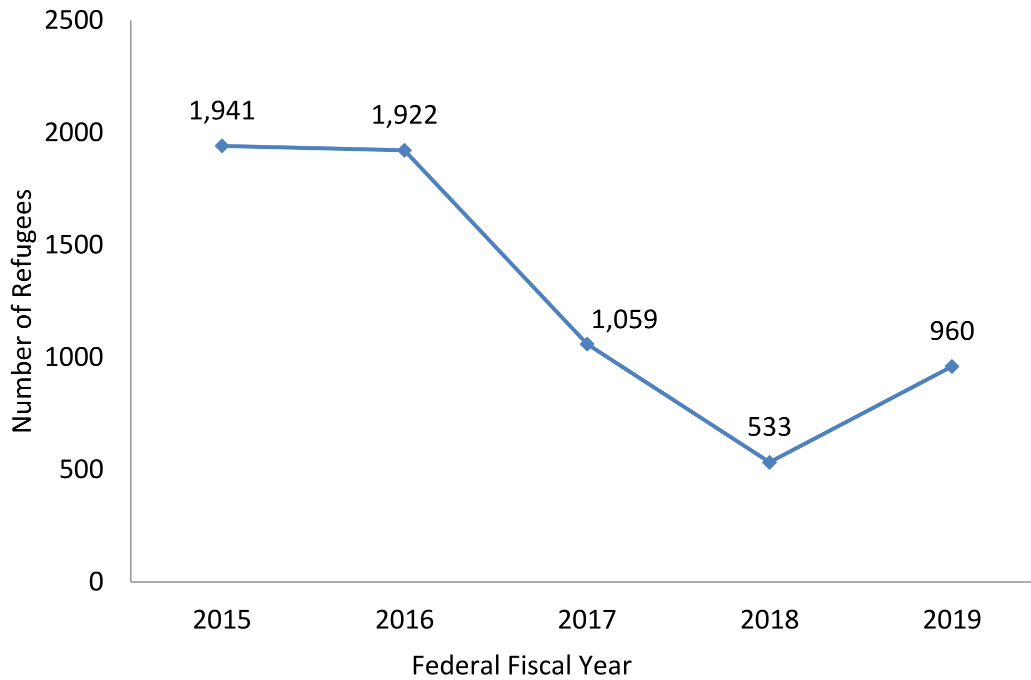
[1]UNHCR, "Global Trends: Forced Displacement in 2018," published June 19, 2019, accessed January 29, 2020, https://www.unhcr.org/en-us/statistics/unhcrstats/5d08d7ee7/unhcr-global-trends-2018.html.

[2] FY 2019 Arrivals by Region and FY 2019 SIV Arrivals reports, U.S. Department of State Refugee Processing Center, accessed January 29, 2020, www.wrapsnet.org.

Indiana Refugee Health Program

The Indiana Refugee Health Program (IRHP) at ISDH receives funding each year from ORR via the Indiana Family and Social Services Administration (FSSA) to operate a refugee medical screening program. ISDH contracts with local health departments to perform domestic refugee health assessments according to national and state guidelines and then enter results into the state refugee screening database, ITARA. For FFY 2019, this program served 960 new primary refugees to Indiana, an increase from the previous year but still lower than the previous five-year average (Figure 1).

Figure 1. Number of primary refugees, Indiana, FFY 2015-2019

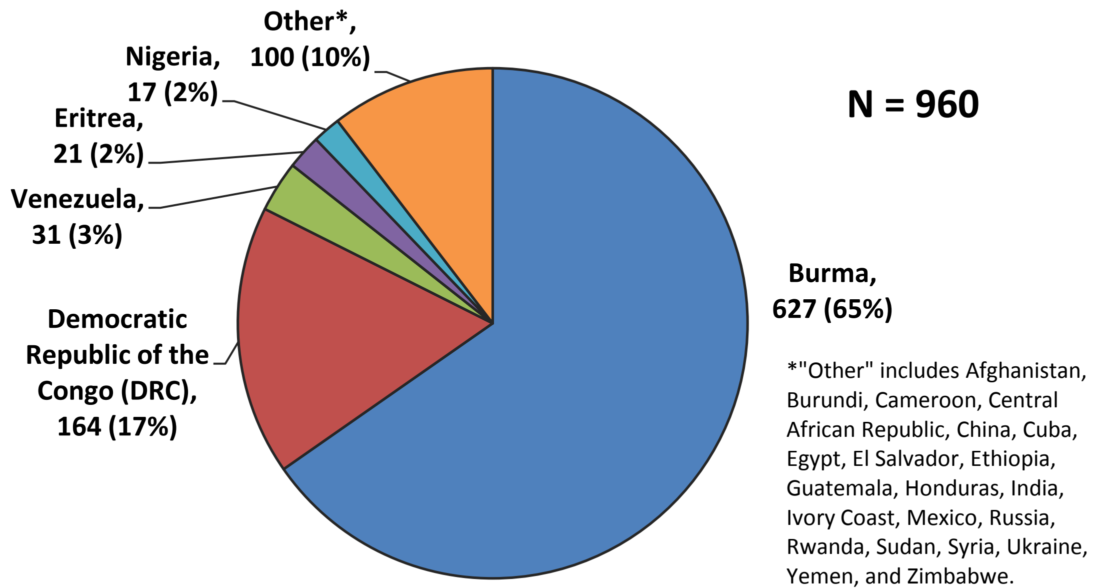


Demographic Data

Country of Origin

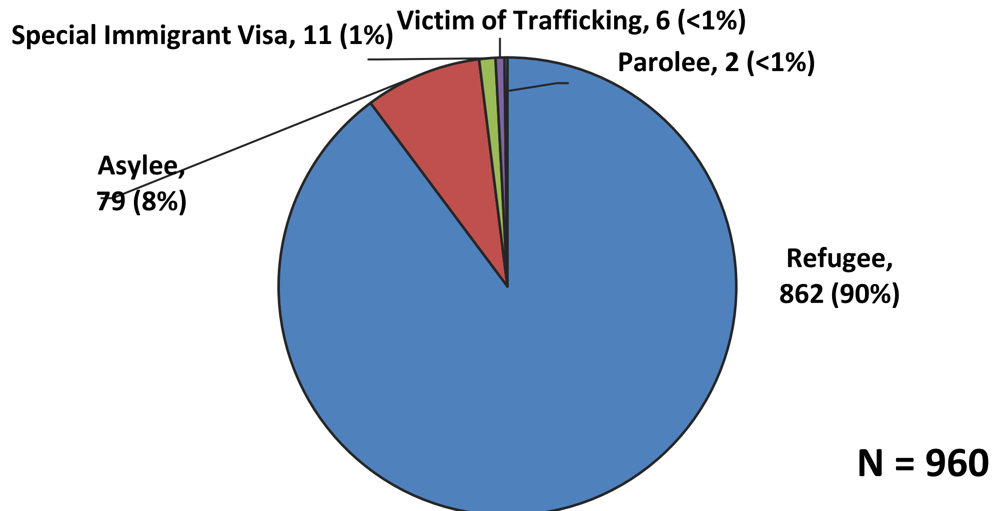
The refugees served by the IRHP came from 26 different countries. The largest number of refugees were from Burma (65%), followed by Democratic Republic of the Congo (17%), Venezuela (3%), Eritrea (2%), and Nigeria (2%) (Figure 2). The remaining 100 people came from 21 other countries. Historically, refugees from Burma have been the largest group to resettle in Indiana, but there is still a rich diversity in Indiana's refugee community.

Figure 2. Primary refugees by country of origin, Indiana, FFY 2019



Visa Type

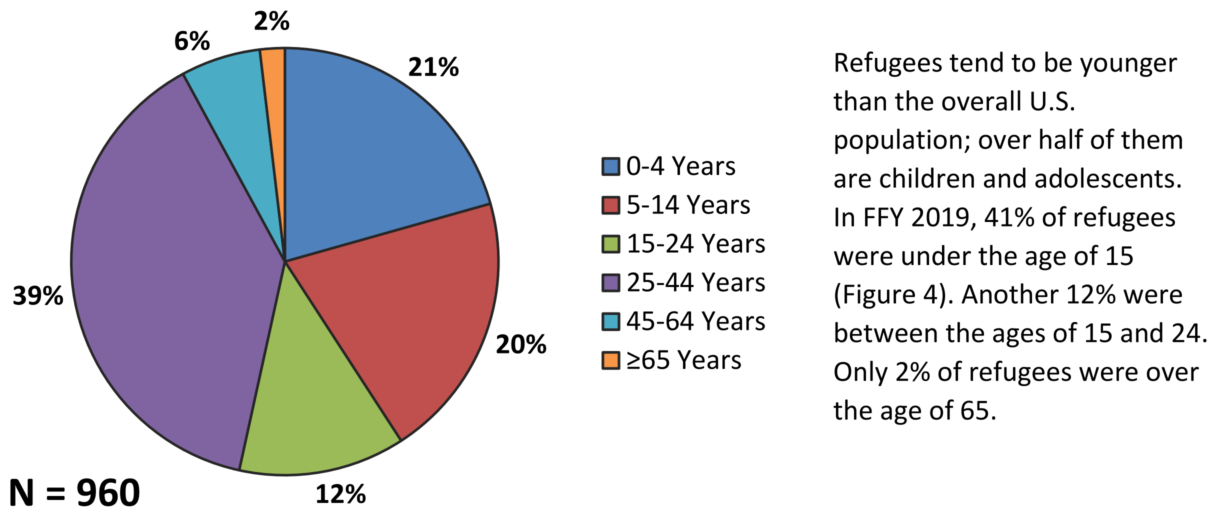
Figure 3. Primary arrivals by visa type, Indiana, FFY 2019



While the IRHP serves all ORR populations, most (90%) of people served came to the U.S. on refugee visas (Figure 3). Asylees were the second-largest visa category at 8%, with 20% of those being follow-to-join asylees and the other 80% having asylum granted after their arrival in the U.S. Eleven people came on special immigrant visas, six were certified Victims of Trafficking, and two were Cuban/Haitian entrants or parolees.

Age and Gender

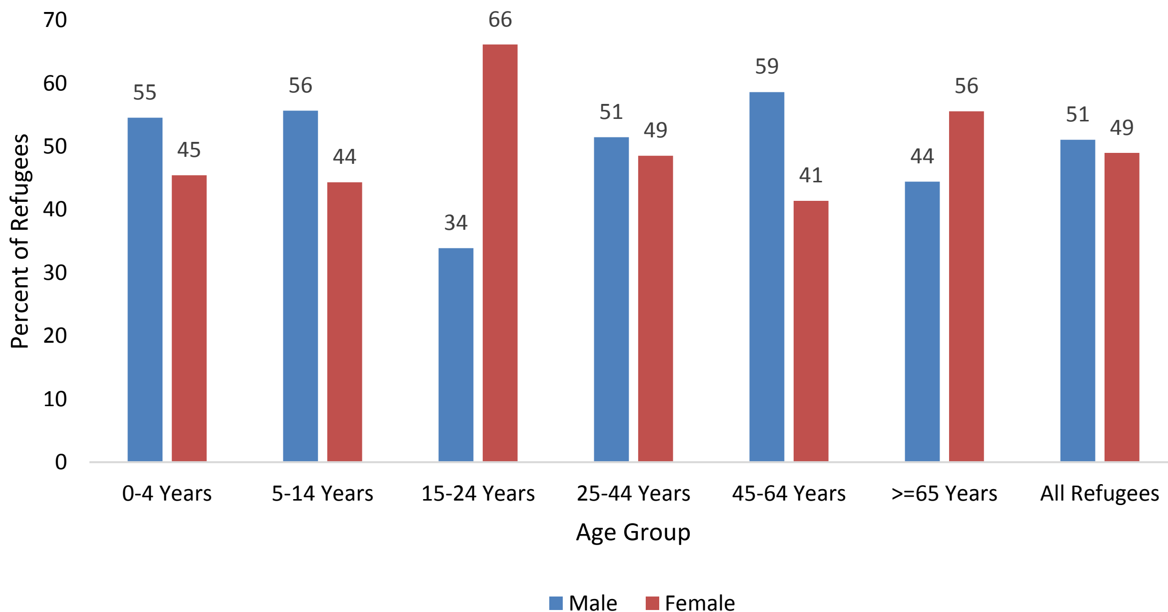
Figure 4. Primary refugees by age group, Indiana, FFY 2019



Refugees tend to be younger than the overall U.S. population; over half of them are children and adolescents. In FFY 2019, 41% of refugees were under the age of 15 (Figure 4). Another 12% were between the ages of 15 and 24. Only 2% of refugees were over the age of 65.

Overall, 51% of refugees were male (Figure 5). The gender split differed by age group. Children younger than 15 years had a higher percentage of males, and those over 65 years had a higher percentage of females.

Figure 5. Primary refugees by age group and gender, Indiana, FFY 2019



County of Resettlement

Table 1. Primary refugees by county of resettlement, Indiana, FFY 2019

County	Number of Refugees	Percent
Marion	703	73%
Allen	193	20%
Hamilton	36	4%
Elkhart	15	2%
Other	13	1%
Total	960	100%

Refugee resettlement agencies have a contract with one of nine national refugee resettlement organizations. These organizations work with the Department of State to determine where a refugee will be resettled in the U.S. In making these determinations, a number of factors are considered, the most important one being the city where the refugee already has a family member who is willing to receive and assist them with adjusting to life in the U.S. In 2019, over 80% of refugees in Indiana already had a family member living in the state.

Other factors that are considered when determining where a refugee will be resettled include the availability of affordable housing, existing cultural communities, and availability of jobs. In 2019, the majority of refugees (73%) were resettled in Marion County (Table 1), which is also home to two refugee resettlement agencies. The third resettlement agency in Indiana is in Allen County, which received 20% of all refugees.

Health Assessment Outcomes

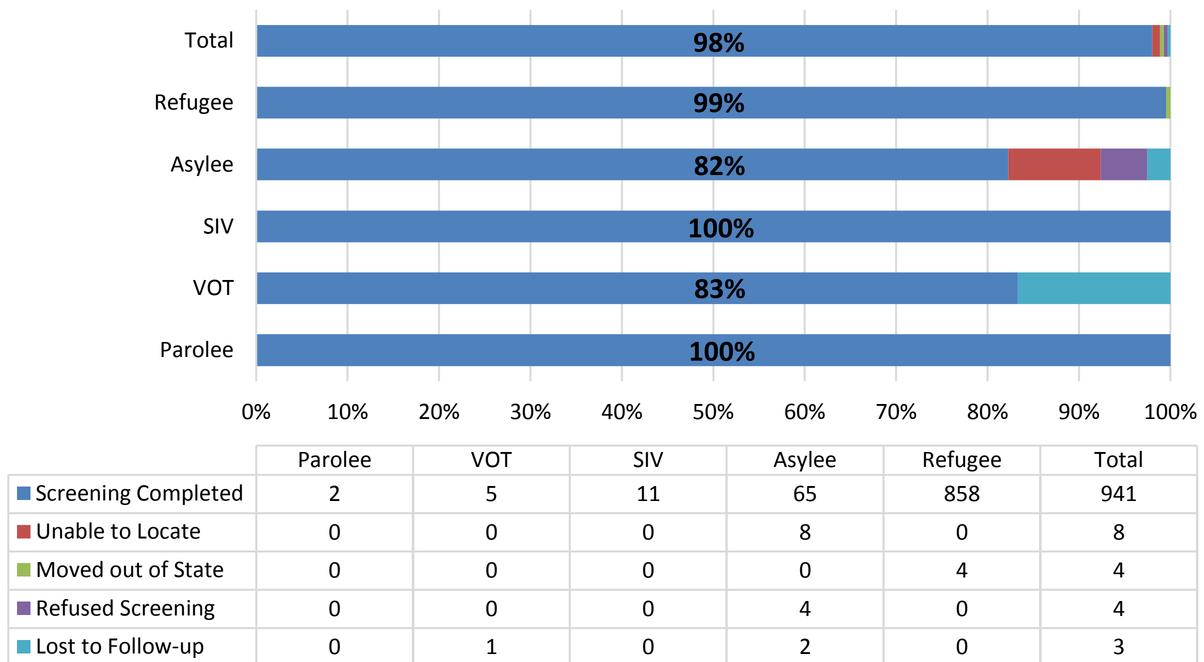
Health Assessment Completion Rate

Overall, 98% of refugees completed a domestic refugee health assessment (Figure 6) in 2019 after their arrival in Indiana, an increase from last year's overall completion rate of 95%. This is an impressive achievement and is a testament to the hard work of all the partners involved in the process.

The majority of persons who were not screened were asylees. Unlike refugees and SIVs who are assigned case managers and receive services from one of the resettlement agencies, asylees can be harder to locate as they must seek services on their own. They are only eligible for a health assessment for the first 90 days after their asylum is granted. Asylees do not have a case manager to help them navigate the health care system or sign up for benefits, and the contact information provided by the federal government for follow-to-join asylees may be outdated or inaccurate. Eighty-two percent of asylees reported to the IRHP completed a health assessment.

The health assessment rate for those with refugee visas was 99%. All SIVs and parolees were screened, and all but one certified Victim of Trafficking was screened. Among those persons who were not screened, eight could not be located, four moved out of state before a health assessment could be started, four refused a health assessment, and three were lost to follow-up.

Figure 6. Health assessment outcome of primary arrivals by visa type, Indiana, FFY 2019



	Parolee	VOT	SIV	Asylee	Refugee	Total
Screening Completed	2	5	11	65	858	941
Unable to Locate	0	0	0	8	0	8
Moved out of State	0	0	0	0	4	4
Refused Screening	0	0	0	4	0	4
Lost to Follow-up	0	1	0	2	0	3

Health Assessment Clinic

Table 2. Health assessment clinic of refugees with a completed health assessment, Indiana, FFY 2019

Health Assessment Clinic	Frequency	Percent
Marion County Health Department	731	78%
Allen County Health Department	189	20%
Other	21	2%
Total	941	100.0%

In order to remove barriers to accessing a health assessment, refugees are not charged for services; costs are either billed to Medicaid or paid for by Refugee Medical Assistance dollars. Because ISDH provides funding to Marion and Allen County Health Departments to conduct health assessments, these clinics serve refugees who live in their county as well as those who live in surrounding counties. Of those refugees who completed a health assessment, 78% of them were screened by Marion County Health Department. An additional 20% were screened by Allen County Health Department.

Occasionally, refugees are resettled in an area where traveling to Marion or Allen County for a health assessment, which is two to three separate appointments, is burdensome. These refugees are screened at other private clinics across the state after consultation with the IRHP.

Time to Health Assessment

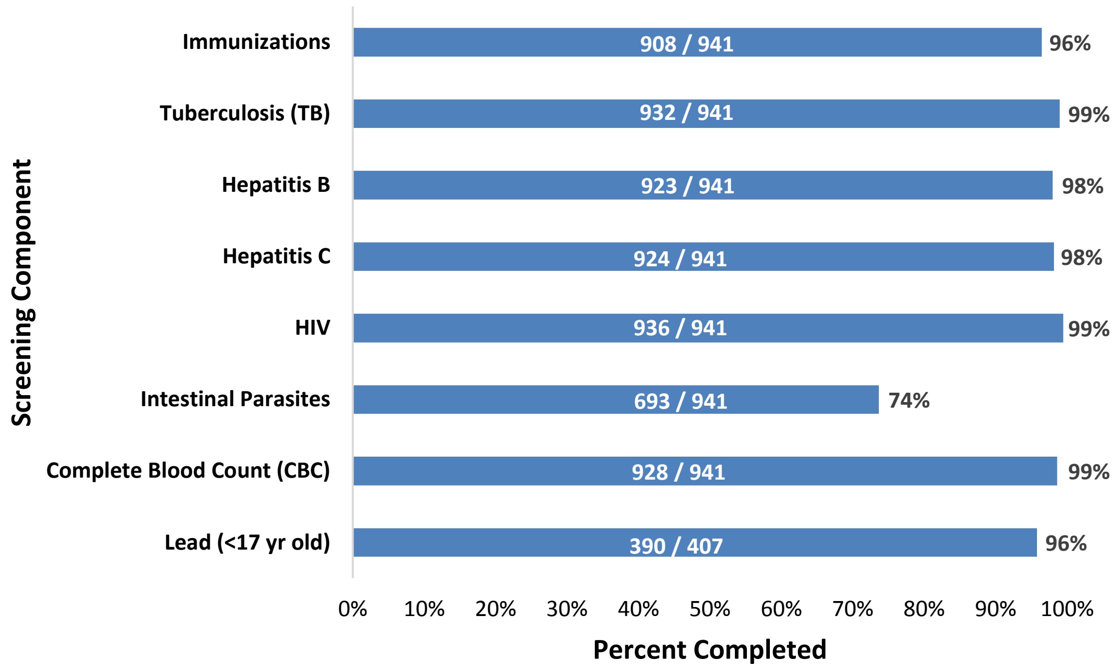
ORR recommends that domestic refugee health assessments begin within 30 days of U.S. arrival, although they can be completed as late as 90 days. This ensures that any urgent needs can be addressed as quickly as possible and that the process is complete before the case is closed by the resettlement agency. Among those refugees who initiated a health assessment, 94% were started within 30 days. Among all completed health assessments, 95% were completed within 90 days. The median number of days to initiation of the health assessment was 18 days, and the median number of days to completion was 33 days. No refugees received only a partial health assessment.

Health Assessment Components

CDC guidelines for the domestic refugee health assessments have several components, and recommendations that vary by age and gender. Testing for infectious diseases and providing treatment, if necessary, is a key part of the assessment, but addressing the refugee’s other physical and mental health needs is important as well. This is often a refugee’s first encounter with the U.S. health care system, so it is important that a trusting relationship is established between the refugee and the provider and that the refugee feels comfortable. As a part of the assessment, referrals should be made to address any health need identified, including referrals to primary care to help the refugee establish a point of access for ongoing health care in the United States. Additionally, refugees are provided a summary of their results to take with them to their primary care appointment.

While it is important to continue to strive to improve the overall health assessment rate, it is also important to look at individual health assessment components to help assess whether refugees are receiving quality assessments according to guidelines. Figure 7 shows a few of the individual component screening rates for refugees who completed a health assessment. Screening rates were high for many components, demonstrating that refugee health assessments in Indiana are of high quality. The IRHP continues to evaluate the quality of health assessments and identify areas for improvement.

Figure 7. Screening rates by component among refugees with a completed assessment, Indiana, FFY 2019



Health Assessment Results

Immunizations

Before U.S. arrival, refugees may not have had regular access to health care due to crowded living conditions with poor health infrastructure as they fled conflict. Because of this, refugees are not required to have any immunizations before U.S. arrival, although CDC and its partners have developed several immunization programs in refugee locations around the world. As part of the domestic refugee health assessment, providers should evaluate the refugee's immunization status and administer needed vaccines according to the Advisory Committee on Immunization Practices (ACIP) guidelines.

In FFY 2019, 96% of refugees who completed a health assessment received at least one vaccine during the process. The median number of vaccines given during the health assessment was three.

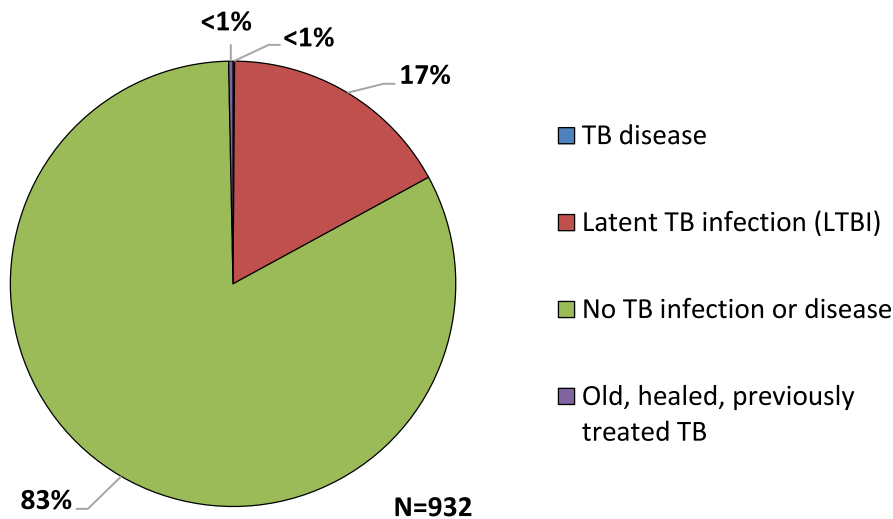
There are several reasons why a refugee may not receive any vaccines during the refugee health assessment. For example, they may be currently up to date or the vaccines that are due may be medically contraindicated for that individual. Data on reasons why refugees did not receive any vaccines was not available for FFY2019 but will be available next year.

Immunizations are an important part of the health assessment and should not be deferred unless medically necessary, as refugees must demonstrate that they are up-to-date on all the required vaccines when they apply to adjust their status after one year in the U.S. and receive their green card. They should be completed while they are fully covered as part of the health assessment; otherwise the refugee may end up paying out of pocket for their adjustment of status vaccines.

Tuberculosis (TB)

While refugees receive some TB screening overseas to ensure they are not infectious with TB disease before traveling, CDC guidelines recommend that every refugee receive a full domestic TB evaluation and treatment for any TB conditions found. In FFY 2019, 99% of all refugees who completed a health assessment received a full TB evaluation. The majority of refugees were found to have no TB infection or disease (Figure 8). Only one refugee was diagnosed with TB disease, and 17% were diagnosed with latent TB infection (LTBI). Local health departments offer treatment to all refugees who are diagnosed with TB disease or LTBI. The IRHP does not collect treatment outcomes for refugees; however, the ISDH TB Program receives reports for all persons in Indiana diagnosed with TB disease or LTBI.

Figure 8. TB diagnoses among refugees with a complete TB evaluation, Indiana, FFY 2019



Refugees who have abnormal findings on their overseas TB exam, but are not infectious, are given a TB Class designation and are noted for follow-up upon U.S. arrival. The ISDH Refugee Health and Tuberculosis Programs work closely together to ensure that all refugees with a TB Class designation receive appropriate follow-up in the U.S.

In FFY 2019, 85 refugees entered the U.S. with a TB Class designation. All 85 (100%) received a full TB evaluation as part of their refugee health assessment.

Hepatitis

Chronic infection with hepatitis B or hepatitis C puts people at high risk for chronic liver diseases, including cirrhosis and cancer. CDC guidelines for the domestic refugee health assessment recommend a full hepatitis B panel for adults: hepatitis B surface antigen (HBsAg), hepatitis B core antigen (anti-HBc), and hepatitis B surface antibody (anti-HBs). For children less than 18 years old, CDC guidelines recommended at minimum HBsAg.

CDC has expanded HBsAg testing at many panel physician sites overseas, and refugees arriving to Indiana increasingly have an HBsAg result documented on their overseas records. If a refugee has a negative HBsAg documented on their overseas records, retesting is not required but can be done based on clinical judgment of risk and vaccination status. Clinicians performing refugee health assessments in Indiana frequently chose to retest for hepatitis B as part of a comprehensive hepatitis panel.

Table 3. HBsAg result among those refugees tested, Indiana, FFY 2019

HBsAg Result	Frequency	Percent
Negative	906	98%
Positive	17	2%
Total	923	100%

In FFY 2019, 98% of all refugees who completed a health assessment received an HBsAg test.

Of those, 2% tested positive (Table 3). Refugees with Hepatitis B are referred to a specialist for ongoing medical management. Household contact testing and prophylaxis is managed by the local health department.

For hepatitis C, CDC guidelines for testing during the domestic refugee health assessment are to test those with risk factors and consider testing all refugees from countries with high (> 5%) or high moderate (2% to 5%) prevalence of hepatitis C. Health assessment clinics in Indiana choose to test most refugees for hepatitis C infection with an anti-HCV screening test since treatment for Hepatitis C is becoming more widely available. A positive anti-HCV test requires confirmatory testing with an HCV RNA test.

Table 4. Hepatitis C result among those refugees tested, Indiana, FFY 2019

Hepatitis C Result	Frequency	Percent
Negative	916	99%
Positive Anti-HCV, Positive HCV Confirmatory	5	<1%
Positive Anti-HCV, Negative HCV Confirmatory	2	<1%
Indeterminate	1	<1%
Total	924	100%

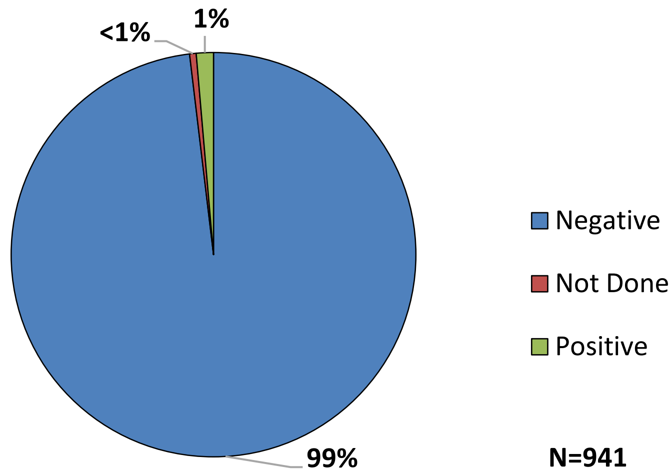
In FFY 2019, 98% of all refugees who completed a health assessment received an anti-HCV test. Of those, seven (1%) tested positive (Table 4). All seven received confirmatory testing, with five refugees determined to have chronic HCV infection. Refugees diagnosed with Hepatitis C are referred to a specialist for ongoing medical management and discussion of treatment.

HIV

CDC guidelines recommend HIV testing for all new refugees in an opt-out format. Now with proper treatment, people with HIV can live long and productive lives; consequently in 2010, HIV was removed from the list of inadmissible health conditions for U.S. immigration purposes. At that time overseas testing for HIV ended, and CDC began recommending that all refugees receive an HIV test as part of the domestic refugee health assessment.

In FFY 2019, 99% of all refugees who completed a health assessment received an HIV test (Figure 9). Of those, 13 (1%) tested positive. All 13 received a referral to an infectious disease specialist for treatment and ongoing care.

Figure 9. HIV outcomes among those with a completed health assessment, Indiana, FFY 2019



Syphilis

Syphilis is one of the inadmissible conditions for U.S. immigration, and refugees ages 15 and older receive a syphilis screening test on their overseas exam. Refugees who test positive for syphilis must be treated before they are allowed to immigrate. CDC guidelines for the domestic refugee health assessment recommend syphilis screening in refugees age 15 and older, unless there is documentation of a negative overseas result.

Table 5. Syphilis outcome, refugees age 15 and older at screening, Indiana, FFY 2019

Syphilis Screening Result	Frequency	Percent
Positive	3	<1%
Negative	182	33%
Not Done	369	67%
Total	554	100%

In FFY 2019, 33% of refugees age 15 and older who completed a health assessment received a syphilis test.

Of those, 3 (<1%) tested positive for syphilis (Table 5).

In order to improve how the quality of syphilis screening is assessed, data collection on reasons syphilis testing was not done was changed from free text to a limited menu of options during this past year. As a result, data quality on reasons syphilis testing was not done in FFY 2019 is poor and of limited utility.

Analysis on syphilis screening for next year will be able to take into account whether a refugee has a documented negative overseas syphilis test result.

Chlamydia and Gonorrhea

Sexually transmitted infections (STIs) are major causes of acute illness and infertility worldwide. These infections are often asymptomatic. CDC recommends that female refugees less than 25 years old who are sexually active or female refugees 25 years and older who have risk factors be screened for chlamydia and gonorrhea, along with any refugee (male or female) who has symptoms. However, in

Indiana males and females are screened at similar rates, and clinics aim to test all refugees ages 15-44 years.

Refugees tend to have low rates of STIs. In FFY 2019, 99% of refugees ages 15-44 who completed a health assessment were tested for chlamydia (Figure 10) and gonorrhea (Figure 11). Of those, only one (<1%) tested positive for chlamydia and one (<1%) tested positive for gonorrhea.

Figure 10. Chlamydia outcomes by gender, refugees ages 15-44 at screening, Indiana, FFY 2019

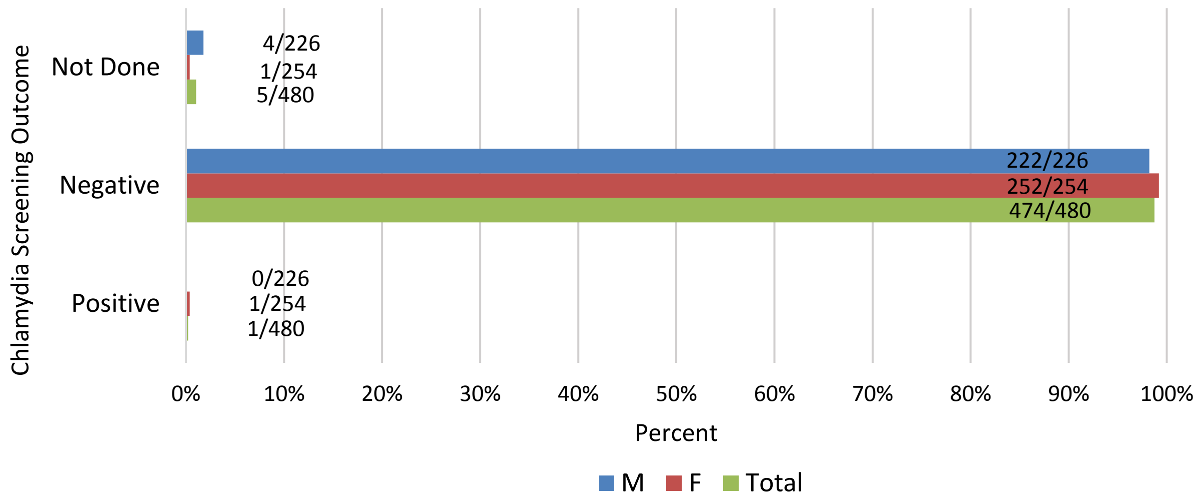
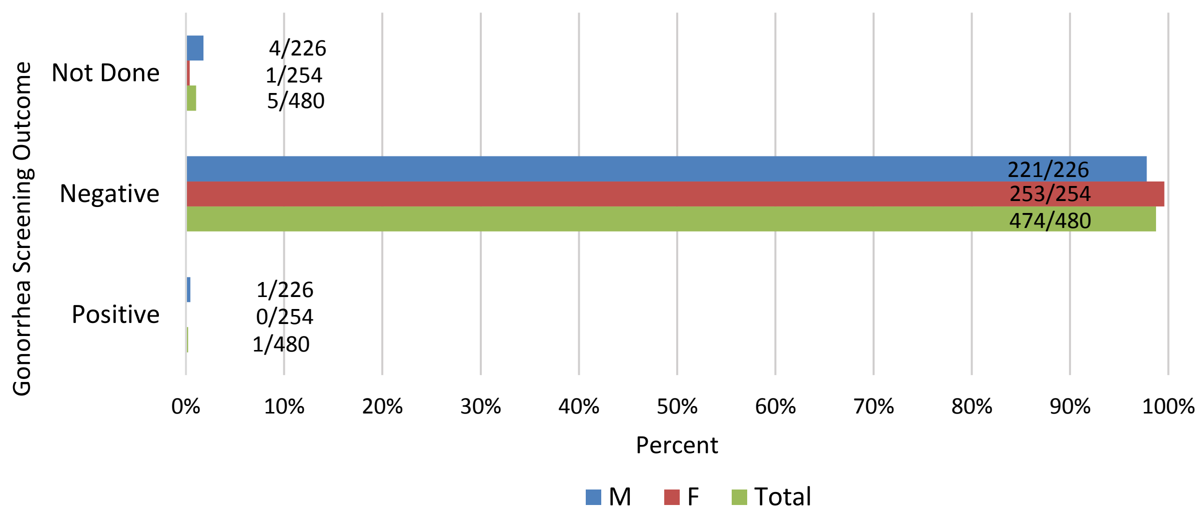


Figure 11. Gonorrhea outcomes by gender, refugees ages 15-44 at screening, Indiana, FFY 2019



Pregnancy

Females of reproductive age should receive a pregnancy test as part of the domestic refugee health assessment so that pregnant refugees can be referred quickly to an obstetrician for prenatal care. In FFY 2019, 24 (9%) of female refugees ages 15-44 at the time of screening had a positive pregnancy test. Only three female refugees in that age range (1%) were not tested. The remaining 227 refugees (89%) had a negative pregnancy test.

Newborn Screening

All infants less than one year old at the time of the refugee health assessment should receive a newborn screening panel, which screens for various genetic and metabolic conditions that are better treated, and potentially mitigated, if caught early. In FFY 2019, there were 18 infants eligible for a newborn screening panel, and 14 of them (77%) received one. The IRHP does not collect the newborn screening panel test results.

The reason the other four did not receive a newborn screening panel was not collected. Plausible reasons include that the child was close to their first birthday and thus the timeline for submission was short or that the refugee health assessment was performed at a private clinic without a method of reimbursement for the newborn screening panel. Indiana Medicaid does not reimburse for newborn screening panels for infants who were not born in the United States. The IRHP covers the costs of the newborn screening panel for refugee infants through contracts with the county health departments who perform refugee health assessments.

Malaria

CDC guidelines around malaria screening for refugees focus on those from Sub-Saharan Africa, and most refugees from that region are presumptively treated for malaria before departure to the U.S. CDC recommendations state that those who received the recommended anti-malarial pre-departure treatment do not need further evaluation or treatment for malaria unless they have symptoms. Malaria is no longer commonly seen in Indiana, and access to testing to assess for sub-clinical malaria is a challenge for clinics outside of the hospital setting.

Table 6. Malaria screening outcomes among refugees who completed a health assessment, Indiana, FFY 2019

Malaria Screening Outcome	Frequency	Percent
Negative	1	<1%
Not Applicable	743	79%
Not Done	197	21%
Total	941	100%

In FFY 2019, only one refugee was screened for malaria. Not applicable means the refugee did not depart from Sub-Saharan Africa. Over the past year, the IRHP has worked to improve the data collection around malaria screening, including a refugee's presumptive treatment status for malaria. Next year the IRHP should be able to better evaluate the impact of presumptive treatment on the need for malaria testing during the health assessment.

Intestinal Parasites

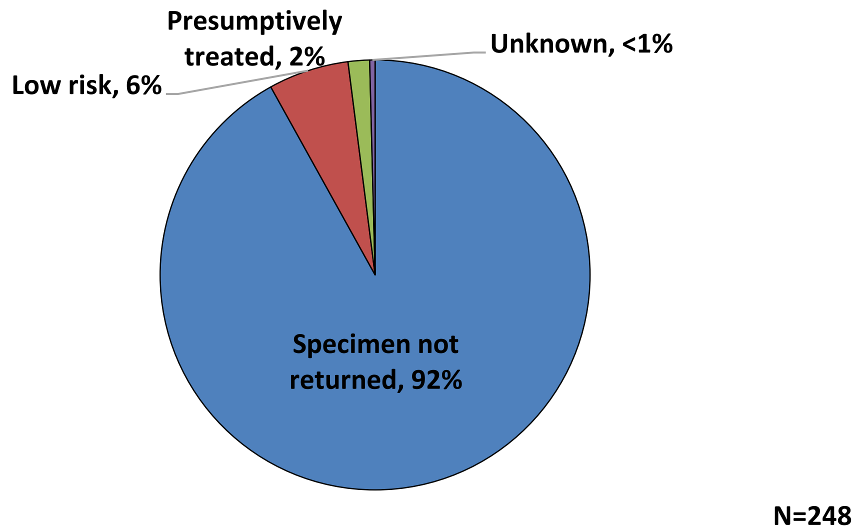
CDC recommendations for intestinal parasite evaluation during the domestic refugee health assessment follow a complicated algorithm based on refugee departure country as well as what pre-departure

medication they received. CDC has several programs in place to presumptively treat refugees for certain parasites shortly before they depart for the U.S. Over the past year, the IRHP has worked to implement changes to parasite screening data collection to include information about a refugee's presumptive treatment status as well as collect parasite screening serology results. This will allow to IRHP to comply with new ORR reporting requirements as well as better evaluate whether the CDC algorithm is being followed. This information will be available for FFY 2020.

In FFY 2019, 74% of refugees who completed a health assessment were evaluated for intestinal parasites with stool ova and parasite testing.

Figure 12 describes reasons that refugees were not evaluated for intestinal parasites with stool ova and parasite testing. The primary reason was that the stool specimen was not returned. The second most common reason was that the refugee had low risk for intestinal parasites based on their last country of residence.

Figure 12. Reasons refugees were not screened for intestinal parasites, Indiana, FFY 2019



Among those who did receive a stool ova and parasite testing, 581 (84%) were found to have no parasites, 88 (13%) were found to have at least one pathogenic parasite, and 24 (3%) were found to have non-pathogenic parasites.

Table 7. Pathogenic parasites found in refugees screened for intestinal parasites, Indiana, FFY 2019

Parasite	Frequency*	Percent among those screened for parasites
Blastocystis**	56	8%
Strongyloides	16	2%
Giardia	15	2%
Schistosomiasis	4	<1%
Dientamoeba fragilis	3	<1%
Entamoeba	1	<1%

*Not mutually exclusive.
**There is scientific debate as to whether Blastocystis is pathogenic or non-pathogenic.

Table 7 lists the pathogenic parasites found in stool testing along with the proportion of infection among all refugees screened for parasites.

The most common pathogenic parasite found was Blastocystis, followed by Strongyloides and Giardia. Refugees testing positive for pathogenic parasites are offered treatment or are referred for ongoing medical management as appropriate.

As part of the domestic refugee health assessment, CDC recommends that each refugee have a complete blood count (CBC) with differential performed. A high eosinophilia count can sometimes be an indication of a parasitic infection. Refugees with an abnormal eosinophilia count should either be tested or presumptively treated for parasites if they did not receive such treatment overseas. For all refugees with an abnormal eosinophilia count, the CBC with differential should be repeated in 3-6 months.

In FFY 2019, 928 (99%) of refugees who received a health assessment had a CBC with differential done. Of those, 104 (11%) had an abnormal eosinophilia count.

Anemia

Anemia is a common finding in refugees of all ages and ethnicities. Common causes of anemia in refugees include iron deficiency, inherited hematologic abnormalities, and infectious diseases.

In FFY 2019, 99 (11%) of the 928 refugees who had a CBC with differential done had a low hemoglobin level and may be anemic. World Health Organization hemoglobin level cut-offs by age and gender[3] were used to determine whether a refugee could be considered anemic. (Pregnancy status was not taken into account.) A finding of anemia during the refugee health assessment prompts follow-up testing and referral to determine the underlying cause.

Lead Poisoning

Refugee children are at higher risk than the general U.S. population for having elevated blood lead levels upon arrival as well as ongoing exposure risk, since they often settle in neighborhoods with older housing. Exposure to lead can come from many sources, including lead-based paints; contaminated soil, foods, and candies; and traditional therapies. Malnutrition and iron deficiency can also increase intestinal lead absorption. CDC recommends that all children less than 17 years old have their blood lead

[3]WHO. Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity. Vitamin and Mineral Nutrition Information System. Geneva, World Health Organization, 2011 (WHO/NMH/NHD/MNM/11.1) (http://www.who.int/vmnis/indicators/haemoglobin.pdf, accessed December 27, 2018).

level checked as a part of their domestic refugee health assessment. The cut-off for value for recommended action is a blood lead level ≥ 5 mcg/dl.

In FFY 2019, 390 (96%) of refugee children who received a complete health assessment and were under the age of 17 at the time of screening received a blood lead level test. Of those, 43 (11%) had an elevated blood lead level ≥ 5 mcg/dl.

Currently, Indiana law only requires public health lead case management services for children with a blood lead level ≥ 10 mcg/dl, although some counties do provide services to children whose test result is in the 5-9.9 mcg/dl range. Otherwise recommended follow-up testing should be performed by the primary care provider. The IRHP is partnering with the ISDH Lead and Health Homes division on an evaluation of follow-up lead testing results in refugee children; results should be available in FFY 2020.

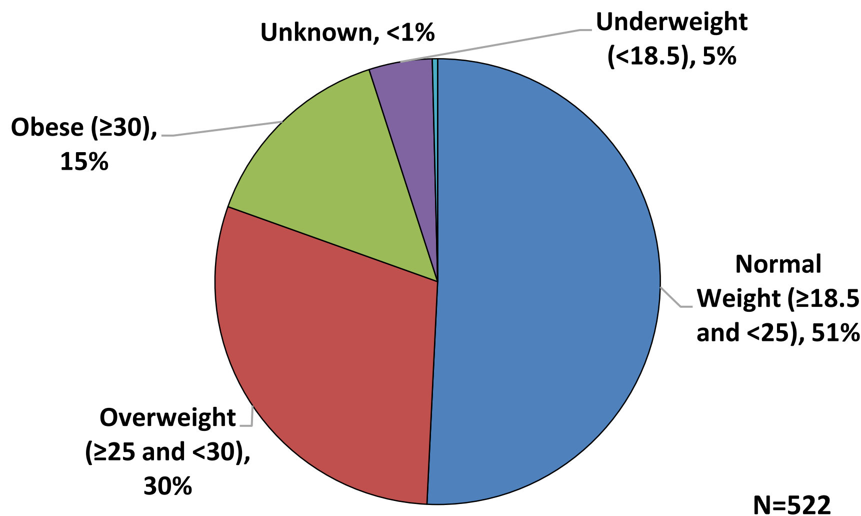
Vitals

Chronic disease is no longer primarily an issue for populations in economically wealthy countries; refugees are also at risk for metabolic diseases such as diabetes and high blood pressure. Adult refugees with risk factors receive testing for blood sugar, cholesterol, and blood pressure. If there are indications of an underlying condition, refugees are referred to primary or specialty care for follow-up.

Figure 13 shows the Body Mass Index (BMI) of refugee adults who completed a health assessment.

In FFY 2019, 45% of refugee adults were either overweight or obese, putting them at risk of metabolic diseases. However, this is lower than the general Hoosier adult population (66%).[4] Two refugees who completed a health assessment (1%) did not have a reliable height and/or weight available.

Figure 13. Body Mass Index of adult refugees with a completed health assessment, Indiana, FFY 2019



[4] 2018 Indiana Behavioral Risk Factor Surveillance System Report, Indiana State Department of Health, accessed February 26, 2020, https://www.in.gov/isdh/25194.htm.

Figure 14. Systolic blood pressure of adult refugees with a completed health assessment, Indiana, FFY 2019

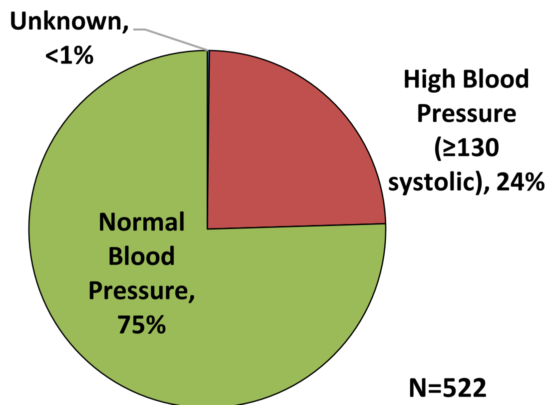


Figure 14 shows the systolic blood pressure of refugee adults who completed a health assessment.

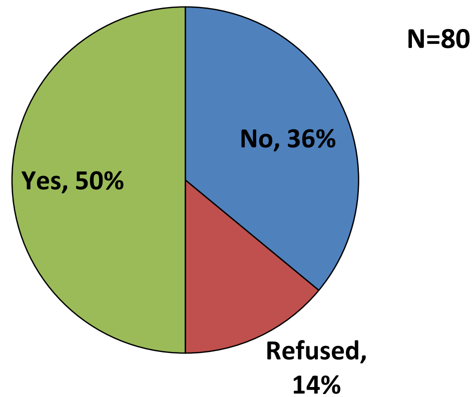
In FFY 2019, 24% of refugee adults had a systolic blood pressure reading of ≥130 mmHg, although further testing is needed to determine if they have chronic high blood pressure. These results are given to the primary care provider for follow-up. One refugee who completed a health assessment (<1%) did not have a reliable blood pressure value available.

Mental Health

Over the past several years, mental health screening has been the subject of much research and is increasingly emphasized in the field of refugee health. Many refugees have a history of trauma, and a prevalence of mental health disorders like depression and post-traumatic stress disorder. Adjusting to a new life and culture is difficult, and it is often not what the refugee expects. CDC recommends that all refugees age 14 and older receive some type of mental health screening; however, CDC does not specify how that screening should occur. Refugee health assessment clinics in Indiana use a mental health screening tool called the Refugee Health Screener-15 (RHS-15), which contains 15 questions to help detect a range of emotional distress. Refugees with a positive screening result on the RHS-15 should be offered a referral to a mental health specialist for further evaluation. While the RHS-15 is a validated tool, clinical judgment plays an important role. A referral should be made in instances where the RHS-15 gives a negative result but the clinician feels a referral is in the best interest of the refugee.

In FFY 2019, 546 (95%) of refugees age 14 years and older received a mental health screening. Of those, 80 (15%) had a positive result. Among those with a positive result, 40 (50%) were referred for further evaluation (Figure 15). An additional 15% were offered a referral but refused. It is unknown why the remaining 36% were not offered a referral.

Figure 15. Referral status for refugees age 14 or older with a positive mental health screening, Indiana, FFY 2019



Referrals

Successful referrals help connect refugees to care to address their more complicated or ongoing health needs. In addition, all refugees are referred to primary care to give them an entry point as they learn to access health care in the U.S. on their own. Resettlement agencies assist refugees with primary care appointments and help ensure their referrals to specialists are successful. Table 8 lists the top ten referrals that refugees were given in FFY 2019 as part of the health assessment.

Table 8. Top ten referrals given to refugees with a completed health assessment, Indiana, FFY 2019

Referral	Frequency*	Percent of refugees referred among those screened
Primary Care	941	100%
Dental	499	53%
Public Health Nurse**	299	32%
Vision	55	6%
Mental Health	44	5%
Infectious Disease	17	2%
Hematology	10	1%
Hearing	10	1%
Physical Medicine	9	1%
OB/GYN	5	<1%

*Not mutually exclusive.

**This is a referral for other public health department services; for example, TB services or lead program services.

Indiana Refugee Health Program Year in Review

Successes

2019 included several successful efforts to move the Indiana Refugee Health Program forward:

- **Data quality improvement efforts**: The IRHP worked with the Marion County Public Health Department and the Allen County Health Department to improve the quality and accuracy of health assessment data. The IRHP provided summary of health assessment components and results for each clinic for the first time since the program began. Trainings were also provided on key issues discovered regarding data quality. Additionally, schedules for auditing data were developed for each clinic based on individual needs and process. A data dictionary for ITARA was created and distributed, and the User Guide was updated. These efforts have resulted in more timely data entry of health assessment results as well as higher quality health assessment data.
- **ITARA database improvements**: The IRHP worked with a developer to make several enhancements to the refugee health screening database, ITARA. Changes were made to several variables to enhance data quality and accuracy. Several new variables were added to meet new ORR reporting requirements for FFY 2020. A new report was created to track pending parasite screening results, and changes were made to several reports to improve their utility. Finally, CDC started providing electronic chest X-ray files in EDN this past year, so the ability to attach these files to each record was added to ensure access by the clinics.
- **Multistate refugee health surveillance network**: A data sharing agreement between ISDH and the CDC-funded Colorado Center of Excellence in Refugee Health was signed in June. Indiana is now participating in a network of pooled refugee health assessment data. This allows for standardization of data across states to: 1) help identify and respond to the changing landscape of refugee health in real-time and 2) provide a mechanism to describe what refugee health looks like in the U.S. Indiana will be sending de-identified health assessment data on a quarterly basis to the Colorado Center of Excellence in Refugee Health. The first data transmission is expected in FFY 2020.
- **Refugee health data intern**: The IRHP hosted an intern during the summer of 2019. The intern worked on cleaning and organizing old health assessment data into a more usable format. She also wrote a report which summarizes the content of the old health assessment data along with assessing the utility and quality of the data.
- **Health assessments for refugees in northern Indiana**: The IRHP developed a protocol with the resettlement agencies to address how to manage health assessments for refugees resettled in counties that are far from the contracted public health clinics. The assessments occurred in private clinics. This protocol was used for several families and overall was successful.
- **Transportation to health assessment appointments:** Transportation to the first health assessment appointment became an issue last year after a Medicaid policy change that no longer allowed refugees with Medicaid applications pending to be transported by Medicaid contractors. In the interim, the resettlement agencies were transporting clients to their first health assessment appointment. With the support of ORR, the IRHP will provide reimbursement at Medicaid rates to resettlement agencies starting FFY 2020 for transporting refugees to this appointment.
- **Medicaid systems navigation**: Positive partnerships with FSSA are key to ensuring that refugees and service providers understand refugee Medicaid benefits and can navigate the system and

maintain their health insurance. The IRHP made connections with individuals working in FSSA's Division of Family Resources to help troubleshoot Medicaid eligibility issues. The IRHP also facilitated trainings in June 2019 for the resettlement agencies on the Healthy Indiana Plan's Gateway to Work program. Additionally, the Refugee Health Coordinator worked with one of the Medicaid managed care companies to expand parasite treatment medications included on their formulary.

- **Internal ISDH collaborations**: The IRHP has made an effort to connect with other ISDH programs to raise the profile of refugee health within the department and ensure refugees are considered in program planning. This included starting an evaluation project with the Lead and Healthy Homes Division, participating in the Maternal and Child Health Title V needs assessment steering committee, participating in anti-racism and cultural competency trainings put on by the Office of Minority Health, and connecting with the HIV and Viral Hepatitis divisions on outreach efforts.
- **Mental Health First Aid training**: The IRHP collaborated with ORR and the Burmese American Community Institute to host a Mental Health First Aid training in July 2019. Eighteen community members became certified to provide mental health first aid when they encounter someone in crisis.
- **Refugee Health Promotion grant:** In August 2019, the IRHP was awarded a third year of funding of a three-year project period for the Refugee Health Promotion grant from ORR. These funds are given to the three Indiana resettlement agencies to provide health education for refugees and assist them with health systems navigation.

Challenges

2019 was not without its challenges, including:

- While the IRHP worked with resettlement agencies in 2019 to address access to health assessments for refugees that live far from contracted clinics, this is still a key issue for asylees. Asylees do not have the case management support services that refugees have to help arrange appointments. Access to health assessments for asylees that cannot travel to Allen County or Marion County is still an ongoing issue.
- A small but significant number of refugees resettling in Indiana have complex medical needs that are beyond the scope of the refugee health assessment. The resettlement agencies and the public health nurses work to address those needs as timely and as completely possible. However, there are many barriers that make it difficult to navigate the systems and ensure these needs are met.
- Partners continued to express frustration with Medicaid transportation, as it is a confusing system with many language and cultural barriers that are difficult for new refugees to navigate.
- There has been increased uncertainty and changes to the refugee resettlement program at the national level. On September 26, 2019 the President signed Executive Order 13888 Enhancing State and Local Involvement in Refugee Resettlement, which requires affirmative consent in the form of a letter from governors and local government in order to resettle refugees in that location. This along with continuing cuts to the refugee admissions ceiling has made it essential for the IRHP to focus time and energy on sustaining the network of partnerships and expertise that have been built over many years.

Despite these changes and challenges, the program achieved a 98% health assessment rate for new refugees, which is a testament to the strength of the relationships between ISDH, the county public health departments, the resettlement agencies, and other community partners.

2020 Plans

In addition to regular program activities, the Indiana Refugee Health Program for 2020 will focus on continuing data quality and process improvement initiatives and strengthening partnerships.

In 2020, the IRHP aims to:

- Finalize Indiana Medical Screening Program Objectives and monitor progress towards those objectives. Proposed objectives can be found in Appendix A. This will include finalizing a routine schedule and content for the auditing of data entered in ITARA.
- Redesign the public IRHP website with a focus on facts and transparency, especially around data and statistics. This will include both updated and new content.
- Continue to utilize interns to work on meaningful projects and expand the capacity of the program.
- Explore developing a series of cultural sensitivity workshops and pilot them with the TB/Refugee Health team.
- Participate in agency-wide health equity efforts and provide leadership where appropriate.
- Continue to network with other ISDH divisions to raise the profile of the IRHP within the agency.
- Continue to strengthen partnerships with FSSA and refugee service providers with a focus on sharing knowledge gained about Medicaid eligibility, benefits, and services as it relates to refugees. This will allow service providers to better advocate for their clients and can help identify process issues for possible intervention.
- Gather more information about current processes, strengths, barriers, and challenges to addressing complex medical needs for newly arrived refugees and explore possible solutions.
- Explore methods to be able to provide reimbursement for a health assessment for asylees who cannot access the currently contracted health assessment clinics due to distance.
- Collaborate with the Colorado Center of Excellence in Refugee Health by sending de-identified health assessment data each quarter and participating in manuscript review and other network activities.
- Provide leadership for national refugee health groups, including the Association of Refugee Health Coordinators and the Electronic Disease Notification (EDN) Workgroup.

Indiana Medical Screening Program: 2020 Objectives

The following objectives will be used to evaluate the Indiana Medical Screening Program for FFY 2020.

Please note that the term refugees includes refugees, asylees, entrants/parolees, special immigrant visa holders, Amerasians, and certified victims of trafficking, unless otherwise specified.

Objective 1: 95% of newly arrived refugees will complete a health assessment within 90 days of arrival or status grant date.

Objective 2: 90% of newly arrived refugees who initiate a health assessment will have their first health assessment appointment within 30 days of arrival. (Refugees and Special Immigrant Visa holders only.)

Objective 3: 90% of refugees who complete a health assessment and are due for and medically able to receive vaccine will receive at least one vaccine as a part of their refugee health assessment.

Objective 4: 95% of refugees who complete a health assessment will receive a complete tuberculosis evaluation including diagnosis.

Objective 5: 97% of refugees who complete a health assessment will receive a HBsAg test or have a documented HBsAg result on their overseas records.

Objective 6: 97% of refugees who complete a health assessment will receive an HIV test.

Objective 7: 80% of refugees who complete a health assessment will receive stool O&P testing or have documentation of presumptive antihelmenthic treatment for parasites.

Objective 8: 97% of refugees who complete a health assessment will receive a Complete Blood Count with differential.

Objective 9: 90% of refugees under 17 years old at time of screening who complete a health assessment will be tested for lead poisoning.

Objective 10: 90% of refugees age 14 and older at time of screening who complete a health assessment will be screened for mental health concerns using the RHS-15.