Utah Department of Health & Human Services

Refugee Health Program

Health Screening Provider Resource Guide

March 2025

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I. Introduction

The domestic medical screening program was established as part of the Refugee Act of 1980. The screening gives clinicians a chance to follow up on or identify new health concerns that may work against successful resettlement and self-sufficiency, to promote well-being, and to connect refugees with routine and specialty care. A patient-centered approach to refugee screening is critical in evaluating initial health needs and to make sure that each refugee is linked to appropriate ongoing care.[1]

The purpose of the medical screening is to:

1) Follow-up on medical issues identified in the overseas medical screening
2) Identify individuals with communicable diseases of potential public health significance
3) Give refugees a chance to successfully resettle by identifying health conditions that threaten their well-being
4) Refer clients to primary care providers or specialists for ongoing healthcare[2]

The goals and objectives of the Utah refugee health program include:

1) The Refugee Health Program (RHP) will collaborate with resettlement agencies to make sure that at least 90% of newly arriving refugees begin health screening within 30-90 days of arrival.
2) The RHP will monitor health screenings to make sure 90% are completed no later than 45 days after the initial screening date.
3) The RHP will collaborate with resettlement agencies to make sure that at least 90% of refugees ≥ 14 years old attend a health orientation.
4) The RHP will monitor health screening results to make sure that 90% of individuals screened establish a medical home/primary care provider within 30 days after the screening is completed.
5) The Program will monitor resettlement agencies to make sure that 90% of individuals screened establish care with a health screening provider, no later than 90 days after they arrive.
6) The Program will monitor resettlement agencies to make sure that 90% of refugees attend their establish care appointment, no later than 90 days after they arrive.
7) The Program will monitor resettlement agencies to make sure that at least 50% of all referrals identified from the health screening are completed, no later than 90 days from arrival.
8) The Program will work with resettlement agencies to make sure that 90% of

individuals referred for a TB-related chest x-ray obtain the x-ray within 30 days of receiving chest x- ray order.

9) The Program will work with resettlement agencies to make sure at least 95% of all refugees with a positive TB screening or who arrived with B1/B2 status complete a TB intake.

RESOURCES

1) CDC Domestic Health Screening Guidelines found here
2) Office of Refugee Resettlement information found here

II. Overseas medical examination and pre-departure screening

Immigrants and refugees will receive an overseas medical examination and pre-departure screening to promote healthy resettlement. The screening will be done before they leave for the U.S. by physicians from the International Organization for Migration (IOM) or a local panel of physicians approved by the CDC.[1]

The CDC, along with other international partners, has also put overseas health intervention programs in place to improve health during travel, reduce travel delays, and decrease associated health and cost burden on receiving communities.

The overseas medical examination findings and interventions are documented on the OS medical forms. The OS forms and digital chest x-ray are uploaded to the CDC Electronic Disease Notification (EDN) system. State and local health department officials, as well as clinic staff who treat refugees, have access to information for their own arrivals.

The overseas medical examination and pre-departure screening includes:

1) Medical history and physical. https://www.cdc.gov/immigrant-refugee-health/hcp/panel-physicians/medical-history-physical-examination.html

2) Tuberculosis (TB) screening. A complete screening for TB is done overseas by panel physicians before the refugees come to the U.S. The following information was implemented overseas as of October 1, 2024 and should not be confused with domestic (Utah) TB screening. It is for your information only:
   a) All refugees 2 years of age and older will have an IGRA (QFT or T-SPOT) in countries with a WHO-estimated high TB incidence rate (≥20 cases per 100,000 population). (Children in these countries have been required to receive IGRA testing since 2018).
   b) Refugees in all countries ≥15 years old must have chest x-ray.
   c) Refugees, <2 years of age with signs and symptoms of TB or with known HIV infection will get an IGRA; chest x-ray; and sputum samples.
   d) Check EDN to find records of your patient's overseas medical exams.

3) Age-appropriate vaccinations (if available). Information found here.

4) Mental health evaluation.
   a) The required examination includes evaluation of physical and mental disorders with associated harmful behaviors and substance use disorders. Inadmissibility based on a physical or mental disorder is limited to applicants who have associated harmful behavior or potentially harmful behavior. The Immigration and Nationality Act (INA) provides three grounds of inadmissibility related to substance addiction or abuse, or physical or mental disorders that affect behavior. (Link here). They are:
      i) Current physical or mental disorder with associated harmful behavior.
      ii) Current physical or mental disorder with a history of associated harmful behavior if the harmful behavior is likely to recur or lead to other harmful behavior in the future.
      iii) Drug (substance) abuse or addiction (medically identified as a "substance use disorder") of any of the substances listed in Section 202 of the Controlled Substances Act (Appendix C).

5) Testing for gonorrhea to include medical history, physical examination, and laboratory testing (NAAT).
   a) All applicants aged 18-24 years must be tested for evidence of gonorrhea. CDC Guidelines can be found here.
   b) Applicants younger than 18 years or older than 24 years must be tested if there is a reason to suspect infection with gonorrhea.
   c) The gonorrhea nucleic acid amplification test (NAAT) must be ordered by the panel physician at the time of the immigration medical examination. Tests performed elsewhere, or before the panel physician's examination of the applicant, are not acceptable.

6) Serologic test for syphilis.
   a) All applicants aged 18 years to those younger than 45 years must be tested for evidence of syphilis. CDC Guidelines can be found here
   b) Applicants younger than 18 years or 45 years old or older must be tested if there is reason to suspect infection with syphilis.
   c) Nontreponemal and treponemal laboratory tests must be ordered by the panel physician at the time of the immigration exam and these tests must be performed on the same blood sample. Tests performed elsewhere, or

before the panel physician's examination are not acceptable.
   d) People who have positive results are required to undergo treatment before they leave for the U.S.; physical exam for evidence of other STDs.

7) Physical exam for signs of Hansen's disease. Refugees who have laboratory-confirmed Hansen's disease are placed on treatment for 7 DAYS before they are eligible for travel to the U.S. Generally, treatment must be continued in the U.S. CDC guidelines can be found here

Departure of refugees with communicable diseases that keep them from entering into the U.S. (syphilis, gonorrhea or Hansen's disease) may be delayed until appropriate treatment is started, and the person is no longer infectious. Based on the examination, an person's medical status is assigned a classification. These classifications include:

1) Class A: Conditions that prevent a refugee from entering the U.S. include communicable diseases of public health significance, mental illnesses associated with violent behavior and/or drug addiction. Class A conditions require approved waivers for entry and immediate follow-up upon arrival. Examples of Class A conditions are:
   a) Chancroid, gonorrhea, granuloma inguinate, lymphogranuloma venereum, and syphilis.
   b) TB: active and infectious
   c) Hansen's disease (leprosy)
   d) Mental illness with associated harmful behavior
   e) Substance abuse

2) Class B: Physical or mental abnormalities, diseases or disabilities of significant nature; require follow-up soon after arrival.
   a) TB: active, not infectious; extrapulmonary; old or healed TB; contact with an infectious case patient; positive tuberculin skin test (TST)
   b) Hansen's disease, not infectious
   c) Other significant physical disease, defect or disability

3) Class B TB:
   a) Class B0 TB, pulmonary
   b) Class B1 TB, pulmonary

c) Class B1 TB, extra pulmonary
d) Class B2 TB, LTBI evaluation
e) Class B3 TB, contact evaluation

Resources

CDC Technical Instructions for Panel Physicians can be found here.

III. Domestic refugee health screening in Utah

The Utah Department of Health and Human Services Refugee Program collaborates with various local medical clinics to provide comprehensive two-visit refugee health screenings to newly arrived refugees and other eligible immigrants. We also work closely with the local resettlement agencies (AAU, CCS, CRIC, IRC, and Utah Valley Refugees) responsible for scheduling the health screening appointments within 30-90 days of arrival in Utah. They arrange transportation and interpretation for the patients, and support, prepare, and champion these new community members in their transition to their new, successful lives here in the US.

The two-visit refugee health screening consists of 2 medical appointments the refugee attends with one of our contracted health screening medical providers.

The first visit follows the CDC Domestic Refugee Screening Guidelines and focuses on a review of overseas medical records (if provided), a physical exam, any pertinent lab work, and age-appropriate immunizations (if needed).

The second visit of the health screening allows the medical provider and patient to build on the new relationship they established during the first meeting. The 2 of them can review the lab results and identify any worsening/new symptoms the patient may have forgotten to mention the first time around. The provider might also take this opportunity to suggest any age-appropriate preventive health recommendations for the patient.

We hope giving the medical provider and refugee two chances to interact around the health screening creates a collaborative approach to the patient's healthcare. It also gives the provider the chance to follow up on any tests/labs they ordered at that first visit and strengthens the provider/patient bond. It also helps educate the patient on how to interact with their new medical system here in the US.
Each Utah Refugee Health Screening adheres closely to the CDC guidelines found here along with some Utah-specific standards (2).

Refugee health screening process in Utah

On July 1, 2022 The Utah Department of Health (UDOH) and Department of Human Services (DHS) officially became the Utah Department of Health and Human Services (DHHS). This provider manual was created before the consolidation and references some improvements/changes done while under the UDOH.

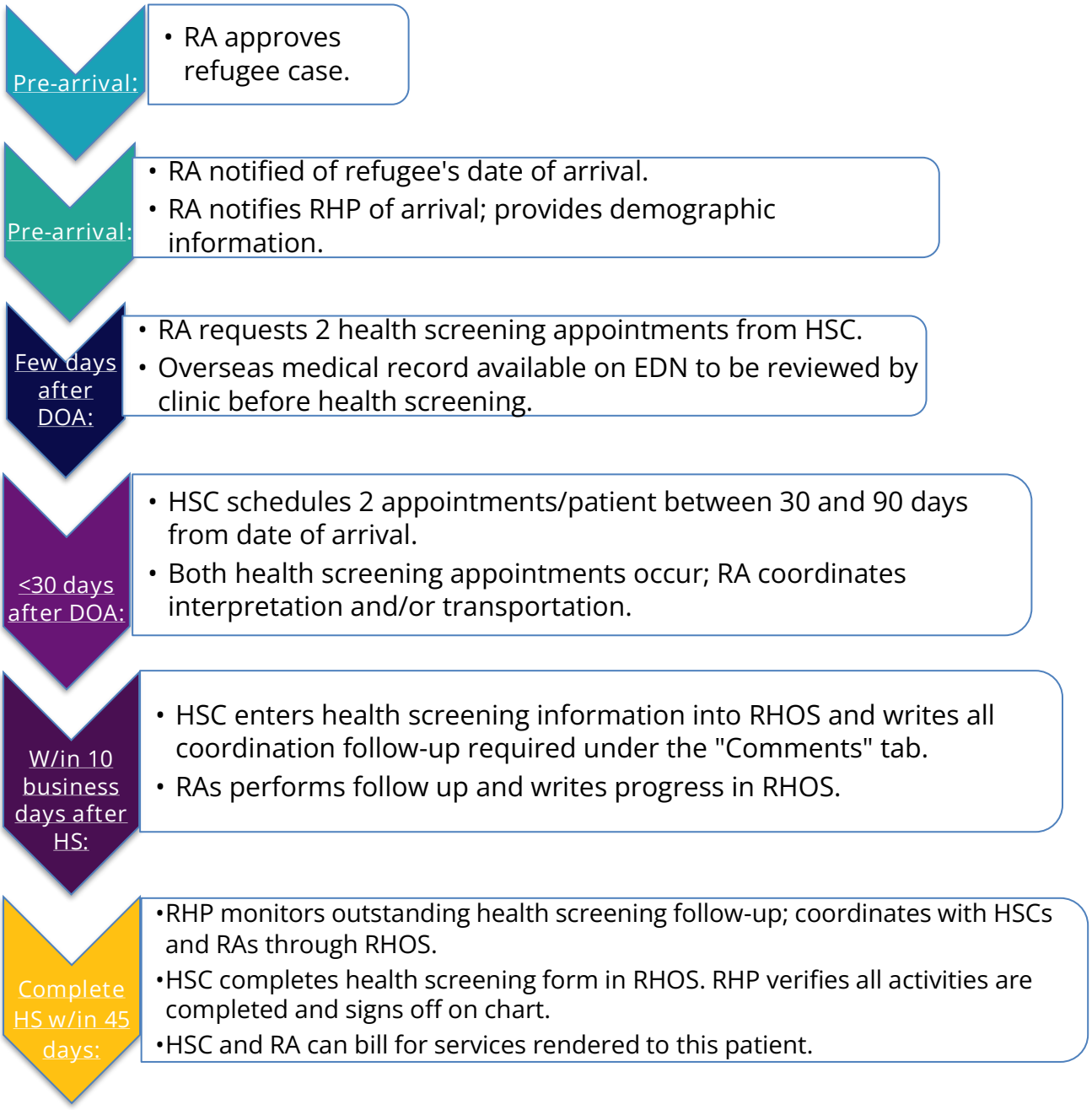
The Utah Department of Health Refugee Health Program converted data collection of all health screening information from a paper form to an electronic collection system in October 2019 through a database known as the Refugee Health Online System (RHOS; www.health.utah.gov/rhos/). This change was made to provide more collaborative and streamlined care between the Utah Department of Health, resettlement agencies, and health screening clinics to make sure the health needs of all newly arrived refugees are met.

The screening clinics may still use the Utah refugee health screening form as a guide during the appointment but are still required to enter all the data into fields in RHOS. The system can also auto-generate a completed health screening form using the patient data entered in RHOS if needed. The RHOS system is being upgraded in 2025 to make it even more robust and functional than before.

The DHHS Refugee Health Program team may help access RHOS and support health clinics and resettlement agencies as you work to understand this new way of collecting data.

Figure 1: Utah domestic refugee health screening coordination

ACRONYMS: RA: resettlement agency; DOA: date of arrival; HS: health screening HSCs: health screening clinics RHP: Utah Department of Health Refugee Health Program; RHOS: Refugee Health Online System



IV. Schedule and coordination with resettlement agencies

Guidelines

1) The resettlement agency coordinates with a contracted medical clinic to schedule both health screening appointments (the second appointment should be at least one week after the first).
2) The clinic and resettlement agency makes sure that both health screening appointments are scheduled and take place within the first 30-90 days in Utah.
3) Priority is given to people who have B1 and B2 TB status; they should be seen for health screening within 2 weeks of arrival in Utah.
4) Resettlement agency coordinates the following for the appointment:
    a) Interpreter (if needed).
        i) If unable to provide, the resettlement agency will request that the clinic provide an interpreter through one of Medicaid's contracted services; prior approval by DHHS is required for use of outside interpreter(s) for health screening appointments.
    b) Transportation (if needed).
    c) Copy of the overseas medical report, including immunization record (if available).
        i) These records can also be accessed directly by the clinic with EDN.
        ii) Some aspects of the record are imported into RHOS under a patient's "EDN" tab for clinics to review before the screening.
    d) Provide arrival and demographic information to RHP to be imported into RHOS.

Reporting

1) Reportable conditions should be reported under the appropriate tab in the client's case file in RHOS (https://rhos.dhhs.utah.gov/) and reported to the appropriate state/local authority.

Coordination/follow-up

1) Clinics will enter health screening information into the client's case file in RHOS and select "Completed HSF (Clinic)" if all health screening requirements are met. RHP will review all completed HSFs and put any additional information in the "Comments."

2) Completed health screening information is to be uploaded to RHOS within 10 business days of the initial health screening date.
3) Document screening provider comments under the “Demographics” tab.
4) Please communicate any urgent follow-up needs directly to the appropriate resettlement agencies via phone call, secure email, or text, and note in RHOS under the “Comments” tab.
5) For any questions/assistance, call or email:

DHHS/Refugee Health Program
Michelle Grossman
Phone: 801-888-4789
Email: magrossman@utah.gov

RESOURCES

1) Utah Refugee Health Screening Form (Attachment 1)
2) Utah Refugee Health Screening Checklist (Attachment 2)
3) Find CDC Domestic Health Screening Guidelines here

V. General laboratory tests

Testing recommendations

1) Complete blood count (CBC) with red blood cell indices, white blood cell differential, and platelet count for ALL newly arrived refugees of all ages and ethnicities.
2) HIV. Screening should be performed on ALL refugees unless they decline (use opt-out).
    a) Children <13 years of age should be screened unless negative HIV status for the mother of the child can be confirmed and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as previous blood product transfusions, early sexual activity, or history of sexual violence or abuse). In most situations, complete risk information will not be available; thus, most children <13 years of age should be screened.
3) Hepatitis B. Screen ALL refugees for active hepatitis B.
4) Hepatitis C. Screen adult refugees aged 18 to 79 years for screening for hepatitis C virus (HCV) infection according to USPSTF recommendations.
5) Urinalysis. Collect a urine sample from every newly arrived refugee ≥7 years of age.
6) Lead. Lead exposures among newly arrived refugees may include environmental and occupational exposures, as well as household and personal items. Serum blood lead testing should be done on:
    a) All refugee infants and children ≤16 years of age.
    b) Refugee adolescents >16 years of age if there is a high index of suspicion or clinical signs and symptoms of lead exposure.
    c) All pregnant and lactating women/girls.
7) Intestinal parasites. Most refugees are presumptively treated for Strongyloides, Trichomonas, and Schistosoma, possibly even malaria, depending on what country they came from. This information can be found on the patient's pre-departure exam form in EDN. If this information is not available, or if the patient is symptomatic, refer to the CDC Website for the most up-to-date information.
8) Newborn screening. Since routine screening is not performed in the majority of countries from which refugees emigrate, a newborn screening panel should be conducted according to state guidelines.

9) Clinicians can consider screening for Hemoglobinopathies in people who come from high prevalence areas. Screening should include hemoglobin electrophoresis, particularly in people with anemia, red blood cell abnormalities, and/or morbidity suggestive of disease.
10) TSH and free T4. Congenital and iodine-deficient hypothyroidism should be considered in ALL infants and children <6 years of age.
11) Cardiovascular and lipid disorders. Screen with a lipid profile in accordance with the U.S. Preventive Services Task Force (USPSTF) guidelines:
    a) Men aged 35 years and older
    b) Women aged 45 years and older who are at increased risk for coronary heart disease (CHD)
    c) Men aged 20 to 35 years who are at increased risk for CHD
    d) Women aged 20 to 45 years who are at increased risk for CHD
12) Pregnancy testing. Conduct a urine pregnancy test on ALL refugee females ages 13-50.
13) Diabetes. Conduct diabetes screening for all refugees with risk factors. Please refer to U.S. Preventive Services Task Force guidelines for reference and use the provider's best judgment.
14) Cancer screening. According to the CDC Domestic Refugee Screening Guidelines, "Refugees, as with all U.S. populations, should receive preventive screening according to USPSTF Cancer Screening Guidelines. The new-arrival medical screening examination may not be the ideal time to perform invasive medical screening examinations (e.g., prostate exam, pelvic exam), since many refugees have experienced sexual assault or other traumatic events. However, if an appropriate environment can be created, trust can be established, cultural norms respected, and the risk of additional trauma to the refugee minimized, the visit does present a possible opportunity to provide these services, or to make referrals for preventive care exams such as colonoscopies and mammograms as long as they are also fully explained and the patient understands what will happen during the exam."

Refer to this link for more specifics on laboratory testing.

VI. Tuberculosis

All refugees should receive a comprehensive domestic medical screening within 30-90 days after they arrive. The goal of this domestic screening for TB is to find individuals with latent tuberculosis infection (LTBI), individuals who may have developed TB disease since having an overseas medical examination, and to make sure they get prompt treatment and prevent transmission.

Domestic TB testing recommendations are based on signs and symptoms of TB and the results of screenings refugees received overseas, if available.

Tuberculosis testing guidelines

1) ALL refugees MUST be screened for tuberculosis. Closely review all pre-departure medical records for the refugee. Get a thorough medical history after they arrive. In addition to current signs or symptoms of TB disease (weight loss, night sweats, fever, cough), specific information may help recognize individuals who might have TB disease or LTBI:
   a) Previous history of TB
   b) Prior treatment suggestive of TB treatment
   c) Prior diagnostic evaluation suggestive of TB
   d) Family or household contact with a person who has or had TB disease, treatment, or diagnostic evaluation suggestive of TB
2) Refugees ≥2 years of age:
   a) IGRA (QFT, T-Spot) is the preferred method of testing and should be used with refugees ≥2 years.
   b) If no IGRA was completed overseas (or the IGRA result was indeterminate*), and there are no signs or symptoms of TB disease upon physical examination, conduct IGRA.
   c) If IGRA was negative overseas (within the last 6 months), and there are no signs or symptoms of TB disease upon physical examination, no further domestic evaluation is needed.
   d) If the overseas IGRA was negative but performed ≥6 months before the domestic examination, repeat IGRA.
   e) If the overseas IGRA was positive (within the last 6 months)and the chest x-ray (CXR) was negative (within the last 6 months) treatment for LTBI should be offered after TB disease is ruled out (if there are no contraindications).

f) If the overseas IGRA was positive and is dated more than 6 months ago—do not repeat domestically (never repeat a positive IGRA). Use this test result and proceed. If the patient had a CXR done overseas and the CXR is dated more than 6 months ago from the date of the HS—repeat the CXR.

3) Refugee children <2 years of age:
   a) A TST (PPD) is the preferred method of testing (IDSA Guidelines) and should be used with refugees in this age group.
   b) Do not place a TST on Thursdays (must be read 48–72 hours).
   c) If no TST was completed overseas (or result was indeterminate*), and there are no signs or symptoms of TB disease upon physical examination, conduct TST.
   d) If TST was negative overseas (within the last 6 months), and there are no signs or symptoms of TB disease upon physical examination, no further domestic evaluation is needed.
   e) If the overseas TST was negative but performed ≥6 months before the domestic examination, and there are no signs or symptoms of TB, conduct TST.
4) Positive QFT OR TST: Order a CXR for the patient to be completed ASAP, attach it in RHOS and let the resettlement agency know.
5) Refugees identified as Class B1 or B2 are given priority; for testing, follow the guidelines outlined in the Class B1-B2 Protocols (Attachment 3).
6) *An indeterminate QFT result should be repeated. If the second QFT result is indeterminate, place a TST.

*** If any vaccines containing live virus have been given to the patient, wait at least 29 days to repeat any TB testing.***

Reporting

1) If a patient tests positive for TB:
   a) Clinic will update the TB Tab in RHOS by adding the CXR order date.
   b) Clinic will upload CXR order form and lab results under the "Attachments" tab in RHOS within 7 business days.
   c) Clinic will make a comment in the "Comments" section in RHOS stating that the patient has a positive TB test and needs a CXR ASAP. Also inform the resettlement agency by email or another secure message as RHOS does not automatically alert them.
   d) The resettlement agency will make a comment in their section of the "Comments tab" stating when and where the CXR is scheduled for the patient to make it easier for the clinic to locate the CXR if it isn't sent directly to them after it is completed.

e) The clinic will update the TB tab with the date the CXR was performed, where it was performed, and the outcome (once the CXR report is received). The report should then be attached to the Attachments tab in RHOS, along with a copy of the CXR from EDN (if available) for comparison.
f) The clinic will also attach a referral to SLCoHD where the patient will be offered LTBI treatment after TB disease has been ruled out.

2) For questions/assistance, fax/email:

DHHS/Refugee Health Program—Michelle Grossman
Phone: 801-888-4789
Email: magrossman@utah.gov

Coordination/follow-up

1) Utah DHHS will work with the resettlement agency to make sure the CXR is completed in a timely fashion; standard is 30 days from day of CXR order.
2) The results will be sent to the physician/clinic listed on the order form. The resettlement agency will also document where they took the patient to have the CXR done in RHOS.
3) The screening clinics will upload the CXR results to RHOS.
4) If the screening clinic is not able to locate the CXR, leave a note under the "Comments" tab in RHOS and contact the resettlement agency to find out where they took the patient to get the CXR done if it hasn't been documented.

RESOURCES

1) Class B1-B2 protocols (Attachment 4)
2) Positive Quantiferon protocol (Attachment 5)
3) Find the CDC Domestic Health Screening Guidelines here

VII. HIV screening

HIV screening guidelines

1) ALL refugees should receive an HIV test as part of the health screening using the "opt-out approach."
2) Children <13 years of age should be screened unless negative HIV status for the mother of the child can be confirmed and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as previous blood product transfusions, early sexual activity, or history of sexual violence or abuse). In most situations, complete risk information will not be available so most children <13 years of age should be screened.
3) The identification and treatment of HIV-infected pregnant women can prevent HIV infection in their infants. All refugee women who are pregnant should undergo routine HIV screening as part of their post-arrival and prenatal medical screening and care.

Reporting

1) Report HIV results under the "Labs" tab in the client's case file in RHOS.
2) If the results are positive, document screening provider comments under the "Demographics" tab. Enter all required coordination follow-up under the "Comments" tab so RHP and RA are aware of required next steps.

Coordination/follow-up

1) The screening clinic will work with the resettlement agency to schedule the patient to return to the clinic so the provider can discuss the lab results with the patient in person.
2) The screening clinic and resettlement agency will work together to make sure the patient (adults are referred to Clinic 1A, while children are referred to Clinic 6, both at the University of Utah Hospital) gets the appropriate referrals for treatment and care.
3) Clinic 1A and/or clinic 6 may serve as the patient's primary care provider.

Resources

1) Find the CDC Domestic Health Screening Guidelines here

VIII. Sexual and reproductive health

Overview

Review local confidentiality laws with all adult and adolescent patients and explain how confidentiality covers sexual and reproductive health histories, examinations, and testing.

Urine pregnancy test

1) A urine pregnancy test should be performed on all women of childbearing age and girls age 8 and older.

Family planning/contraceptives

1) Discuss family planning and available contraceptive methods, including accessibility, efficacy, and cost. Condoms should be offered to avoid unintended pregnancy and sexually transmitted infections (STIs).

Sexually transmitted diseases

1) Conduct an evaluation for STIs (medical history, physical examination, and disease-specific testing as recommended).
2) Consider testing any refugee (including children) who has a history of sexual assault (including incest or underage marriage).

Female genital mutilation FGM/C

1) The CDC has specific guidance to address female genital mutilation. Guidance is as follows:
    a. “Screen women and girls from countries where female genital mutilation/cutting (FGM/C) is practiced for possible FGM/C-associated medical complications, including chronic pain, recurrent urinary tract infections, and OB related issues.”
    b. “Clinicians should inform refugees that FGM/C is considered child abuse, and that it is illegal to perform FGM/C on a child in the US or to take a child out of the country to undergo the procedure ("vacation cutting").”
    c. “Clear documentation of FGM/C in the medical record soon after US arrival, including a description of physical findings and ICD-10 coding, may help protect against future suspicions of "vacation cutting" and abuse accusations.”

Resources

1) Find CDC Guidance on Sexual & Reproductive Health Screenings here

Syphilis

Syphilis testing guidelines

1) All refugees between the ages of 18-45 have been tested overseas for syphilis before coming to the US.
   a) If you have documented evidence they were tested overseas before travel, and it is dated within 6 months of their health screening, there is no need to retest. Otherwise, test at HS.
   b) Men who have sex with men or persons with HIV infection may benefit from screening at least annually or more frequently (every 3 to 6 months) if they continue to be at high risk.
2) Screen using a VDRL or RPR and if positive, confirm with TP-PA test.
3) A positive syphilis test requires mandatory reporting. The clinic will contact the local health department (LHD) to verify patient history and confirm the appropriate steps. Salt Lake County Health Department: Lynn Beltran: 385-468-4185

Physical exam

1) If the history or serologic tests are suggestive of syphilis, a physical examination may be warranted that should include an evaluation for oral signs of syphilis, including mouth sores (chancres) or mucus patches, or rashes on the body, particularly on the palms of the hands or soles of the feet (a characteristic of syphilis infection that is unusual in other conditions).
2) An external genital examination is not required and must not be performed unless the applicant has laboratory confirmation of diagnosis.
3) Provide a gown or sheet to allow privacy, and a chaperone MUST be present, regardless of the applicant's gender, if external genital and rectal exams are needed. The chaperone must be a staff member of the gender the patient feels most comfortable with and not a family member. However, family members may be present for the exam if the applicant requests.

Gonorrhea

Gonorrhea testing guidelines

1) All individuals aged 18 to 24 must be tested for gonorrhea.
2) Individuals aged <18 years or >24 years with a reason to suspect infection must be tested.
3) Chlamydia is not a required test—but many test kits include tests for both chlamydia and gonorrhea.
4) Conduct a physical exam for other signs consistent with gonorrhea such as pharyngeal discharge, rash, ocular symptoms, and abdominal tenderness. However, a genital exam must not be performed for the gonorrhea portion of the medical exam. If you suspect a genital infection, proceed with laboratory testing.
5) Use a NAAT (nucleic acid amplification test) urine specimen test. Use clinical judgement when you determine if a different specimen type is more appropriate for testing based on risk factors, etc. (oral or rectal swabs).

Except the routine testing for syphilis and chlamydia, no data supports the routine testing for other non-HIV STIs in refugees. Testing for other STDs may be completed at the discretion of the screening physician.

Reporting

1) Acknowledge that overseas STD results were reviewed in RHOS by selecting "Yes."
2) If overseas STD results are complete, there is no need to retest, unless the patient has possibly been exposed to new STD infection.
3) Report domestic STD results under the "STD/RPR" section in the "Labs" tab in RHOS. Enter all required coordination follow-up under the "Comments" tab so RHP and RA are aware of required next steps.

Coordination/follow-up

1) As of February 4, 2014, the diagnosing physician assumes responsibility for treatment.

Resources

1) Find a copy of the CDC Guidelines here

IX. Blood lead level

Lead is a known neurotoxicant and exposure can result in elevated blood lead levels which can cause many health risks. Around the world, including many countries where refugees originate or seek asylum, environmental lead hazards are common.

Lead testing guidelines

1) Test ALL refugee infants and children ≤ 16 years of age.
2) Test individuals > 16 years of age if there is suspicion or clinical signs/symptoms of lead exposure.
3) All pregnant and lactating women and girls.

Follow-up testing within 3–6 months from first testing

1) The CDC considers a blood lead level of 3.5 or greater to be elevated.
2) All refugee children ≤ 6 years should have f/u testing, regardless of the initial screening result.
3) Children between 7-16 years with an elevated blood lead level at the initial health screening, and any child older than 7 years old who has a risk factor (a sibling with elevated blood lead, environmental risk factors) regardless of the initial test result.
4) Pregnant or lactating children <18 years of age who had elevated blood lead levels at initial HS.

Reporting

1) Report BLL results, especially elevated blood lead results ≥ 3.5 ug/dL, by updating the "Labs" section in the client's case file in RHOS.
2) Document screening provider comments under the "Demographics" tab.
3) Enter all required coordination follow-up under the "Comments" tab so RHP and RA are aware of the required next steps.

Coordination/follow-up

1) The screening clinic and resettlement agency will work with the refugee's family to make sure the patient is referred to the Salt Lake County Health Department for treatment and education.

Resources

1) CDC Domestic Health Screening Guidelines for Screening for Lead (updated May 2024) is here

X. Hepatitis B

Hepatitis B testing guidelines

1) Screen ALL refugees for hepatitis B surface antigen (HBsAg) AND
2) Vaccinate all refugees for hepatitis B as indicated.

Reporting

1) Update the "Labs" tab in a client's case file in RHOS to report a hepatitis B current infection (positive HBsAg) result. Enter all required coordination follow-up under the "Comments" tab as necessary so RHP and RA are aware of required next steps.
2) Report the hepatitis B immunity (+ or – titer) result in RHOS and vaccinate the client if they are not already immune. Make a note of client's hepatitis B immunization status under the "Immunizations" tab in RHOS. If required, make note of necessary coordination follow-up under the "Comments" tab so the RA and RHP are aware of next steps.

Coordination/follow-up

1) The screening clinic will work with the resettlement agency to make sure the patient is referred to the appropriate specialist for treatment if they are infected with a viral form of hepatitis.
2) The screening clinic will also push the patient's immunization results to the Utah Statewide Immunization Information System (USIIS) so these will be available statewide and in Docket. The clinic will give the patient a printed copy of their immunizations and/or titers if requested.

Resources

1) Refugee health screening form (Attachment 2)
2) MMWR immunization management issues: Hepatitis B
3) World Health Organization: Hepatitis B fact sheet
4) Minnesota refugee health screening guidelines: Hepatitis B
5) CDC Domestic Health Screening Guidelines: Hepatitis screening
6) CDC Yellowbook on Hep B
7) CDC Domestic Health Screening Guidelines: Immunizations

XI. Hepatitis C

Hepatitis C testing guidelines

1) Universal hepatitis C screening should be implemented for ALL new adult arrivals (≥18 years old) and any children with risk factors.
2) Hepatitis C screening is recommended for ALL pregnant women during each pregnancy.
3) Hepatitis C screening is not routinely recommended for children < 18 years old but is recommended for unaccompanied refugee minors. Testing is recommended for children who have risk factors.

Reporting

1) Update the "Labs" tab in a client's case file in RHOS to report a hepatitis C positive result. As necessary, enter all required coordination follow-up under the "Comments" tab so RHP and RA are aware of required next steps.

Coordination/follow-up

1) Report any follow-up required in RHOS and the resettlement agency will make sure the patient attends their referral.

Resources

1) Find the CDC Domestic Health Screening Guidelines here
2) CDC 2013 Clinical Care of Hepatitis C link is here
3) Find the Refugee Health Technical Assistance Center here
4) World Health Organization: Guidelines for the screening, care and treatment of persons with hepatitis C infection found here
5) CDC Hepatitis C Testing Recommendations found here
6) AASLD: HCV Guidelines found here

Additional reading

Suraj Sharma, Manuel Carballo, Jordan J. Feld, Harry L.A. Janssen, Journal of Hepatology, Volume 63, Issue 2, August 2015, Pages 515-522, "Immigration and viral hepatitis," Link

XII. Intestinal parasites

Intestinal parasite testing guidelines

Utah follows the CDC guidelines to screen and treat intestinal parasites. These guidelines were updated on May 15, 2024, and can be found on the CDC's website at this link.

Per CDC, providers can assume that refugees from certain countries are receiving presumptive anti-parasitic treatment before they leave even without overseas documentation (CDC letter issued January 15, 2014).

Refer to the CDC Treatment Schedule for Presumptive Parasitic Infections here.

Refugees who have certain conditions are excluded from presumptive treatment. Access the following link to find a list of these conditions.

Reporting

Update the "Parasite" tab in a client's case file in RHOS to report *Giardia* and other parasitic infections. (Only *Giardia* needs to be reported to Salt Lake County Health Department.)

Coordination/follow-up

1) Document screening provider comments under the "Demographics" tab. Enter all required coordination follow-up under the "Comments" tab so RHP and RA are aware of required next steps.
2) The resettlement agency, screening provider, and SLCoHD (when required) will coordinate follow-up treatment as indicated.

Resources

1) 2024 CDC Guidance for Overseas Presumptive Treatment of Strongyloidiasis, Schistosomiasis, and Soil-Transmitted Helminth Infections for Refugees Resettling to the United States found here.
2) CDC Domestic Health Screening Guidelines-Intestinal Parasites found here
3) Mass. Refugee Health Program interactive parasite help tool found here

XIII. Immunizations

Immunization guidelines

1) Review immunization history, including hard copy records and electronic records in the Electronic Disease Notification (EDN) system.
2) Children: provide immunizations according to the CDC/ACIP schedule; make sure that school-aged children receive the necessary immunizations to enroll in school.
3) Adults: provide immunizations according to the CDC/ACIP schedule; make sure the patient is on track to meet the green card requirements.

Reporting

1) Acknowledge that all immunizations given overseas were reported to USIIS. On or about July 1, 2024, the CDC began automatically transferring refugee overseas immunizations directly into USIIS. Double-check to make sure this is happening throughout the year.
2) Document all immunizations given at the health screening visit under the "Immunizations" tab in the client's case file in RHOS.
    a) *If immunizations are not given, document the reason and record any required coordination follow-up under the "Comments" tab so RA and Utah DHHS RHP are aware of required next steps.*
3) Document all immunizations in patient's chart; provide client(s) with copy if requested.
4) Enter HS immunization information into the USIIS. Double-check to make sure overseas immunization information has pulled over into USIIS from EDN.

Coordination/follow-up

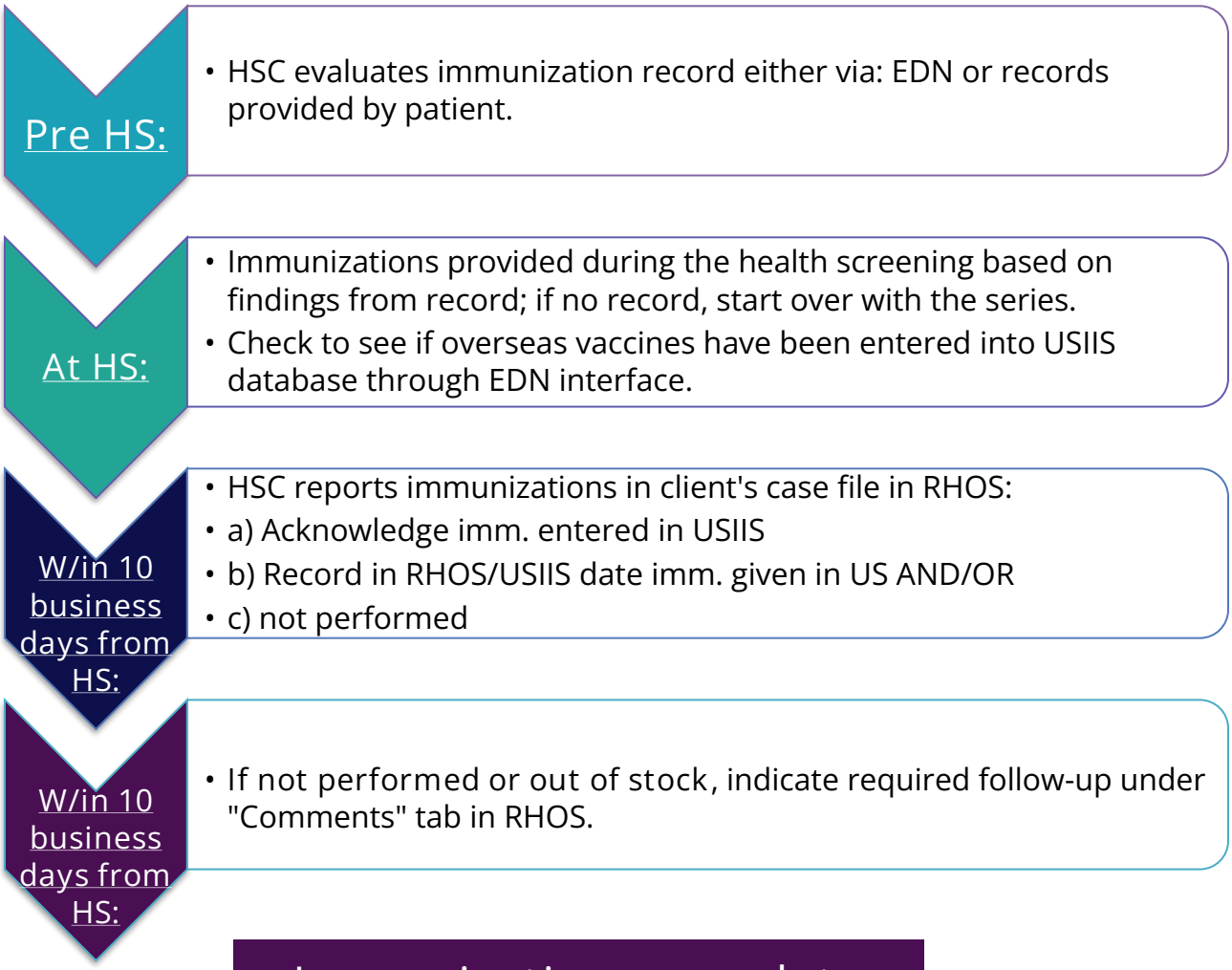
1) Communicate directly with RA under the "Comments" tab in RHOS if, for whatever reason, the patient was unable to receive required immunizations.

Resources

1) Find CDC Aid to Translating Foreign Immunization Records here
2) Find CDC Evaluating Vaccine Records here
3) Find the CDC Vaccine Schedules here
4) Find the Current Vaccination Criteria for U.S. Immigration here
   Immunize.org Terms in Multiple Languages found here
5) Utah School and Early Childhood Immunization Requirements found here

Figure 2: Utah refugee health screening—immunizations process

ACRONYMS: RA: resettlement agency; HS: health screening; HSCs: Health screening clinics; RHP: DHHS Refugee Health Program; RHOS: refugee health online system; EDN: electronic disease notification system; USIIS: Utah statewide immunization information system.



XIV.Mental health screening (RHS-15)

Mental health screening guidelines

All newly arrived refugees should be screened for their mental health needs while they are in the clinic for their first health screening. Patients are split into 2 different age groups to be screened using 2 different tools:

1) Age ≥14 years of age, use the RHS15 MH screening tool.
2) Age <14 years of age, use 1 yes/no question asked to the patient's parent or guardian.

Patients ≥14 years of age

1) The RHS-15 is used to assess the mental health needs of ALL newly arrived refugees ≥14 years old.
2) The RHS-15 (Appendix I) was designed as a simple tool that can be used during the initial health screening and/or in the primary care setting.
3) The RHS-15 in English is provided as Attachment 8. If you need more translated RHS-15 screeners, you can find a library here.
4) The 15 questions address symptoms associated with depression, anxiety, trauma, and overall well-being.
5) The RHS-15 is not a diagnostic tool; it is a predictive tool.

Patients < 14 years of age

1) All newly arrived refugees <14 years will be screened indirectly.
2) Parents or guardians will then be asked the following question: "*Do you think your child has difficulties with emotions, concentration, behavior, or getting along with other people?*"

Reporting

1) Screening physician/clinic updates the "Mental health" tab in the client's case file in RHOS to report mental health screening results.
2) If a client screens positive at the initial health screening, and *accepts a referral,* the healthcare professional who provides the screening enters this information into RHOS. This information will include:
   a) Screening done (Y/N)
   b) RHS-15 scores (For ≥14 years) OR <14 indirect screening question.
   c) Check mark any of the following conditions as identified:
      i) Anxiety (signs/symptoms)

ii) Depression (signs/symptoms)
iii) History of torture/violence
iv) Clinician's discretion.

d) MH other—Provide any comments and additional information about client's mental health concerns here.
e) Severity (if applicable, select 1 of the following)
   i) Mild
   ii) Moderate
   iii) Severe
f) Initial MH referral accepted (Check mark if client accepts MH referral)
g) If initial MH referral was rejected, why?
   i) Regardless of whether a client screens positive, answer this for all clients, with an acknowledgement that a client rejects MH referral or services.
h) Referral agency
   i) Providers select which clinical MH agency to refer the client to based on history/signs/symptoms and attach the referral under the "Attachments" tab in RHOS.

3) Indicate any referrals made or if the client refuses the referral.
   a) If client is not screened, document reason why under the "Mental Health" tab.

Coordination/follow-up

1) The mental health (MH) coordinator at 1 of the resettlement agencies will check RHOS to identify any clients who screened positive and accepted a referral at the initial health screening to coordinate the mental health referral.
2) Refer to Attachment 7 for additional information related to *mental health screening, referral, and treatment protocol in Utah*.

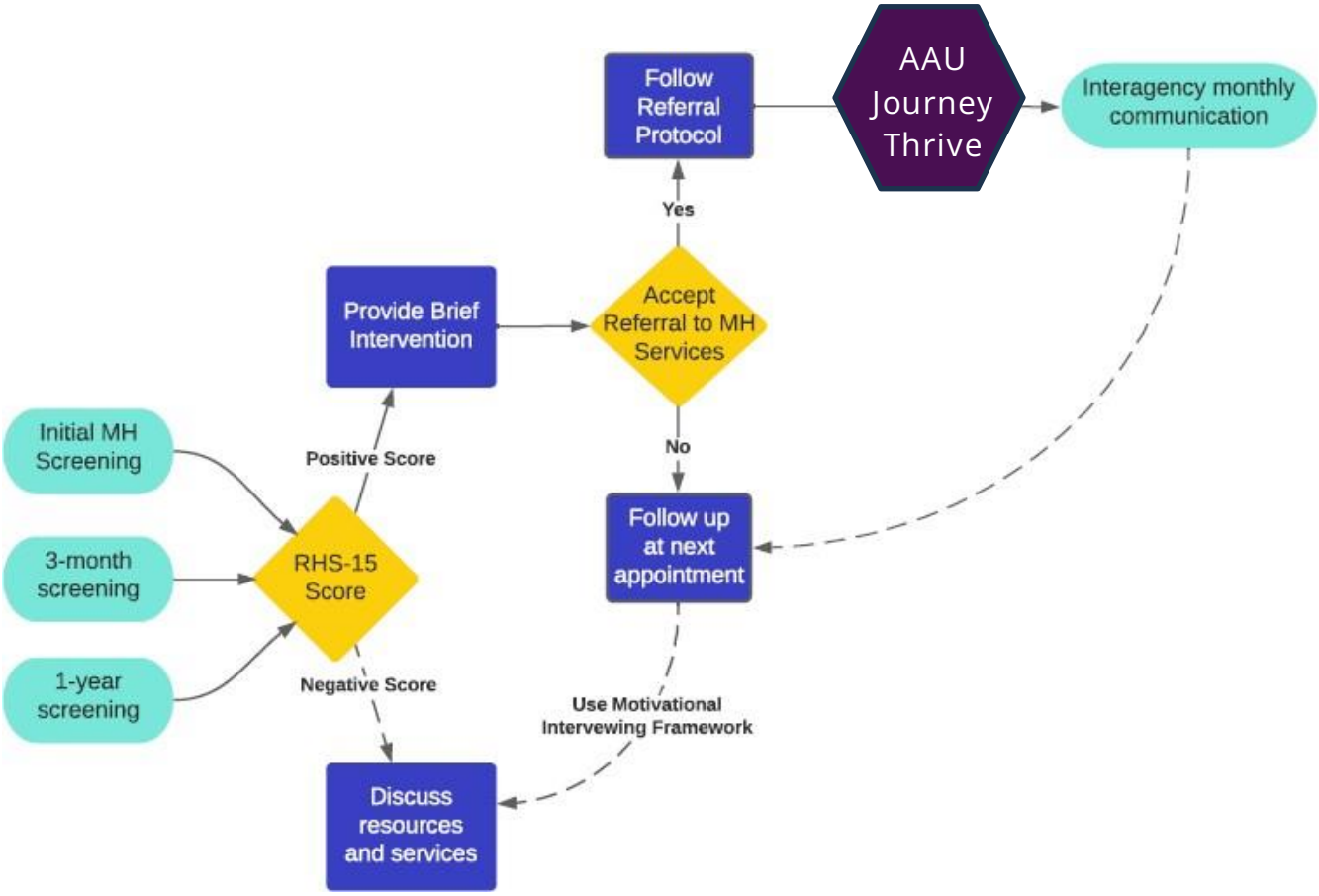
Resources

1) Utah Refugee Health: Mental health screening, referral, and treatment protocol (Attachment 7)
2) Refugee Health Screening Tool - 15 (RHS-15) English (Attachment 8). For additional languages, go here.
3) RHS-15 user manual (Attachment 9)
4) CDC Quick Guide for Mental Health Screening can be found here

Figure 3: General refugee mental health screening process flow

The diagram below outlines the general process of the mental health screening process flow for refugee clients who are 14 and older. This process flow closely outlines the order of the screening(s), and appropriate referral to clinical agencies.

Note: The order of activities may vary depending upon a client's understanding and willingness to attend mental health treatment.



XIV. Completing the health screening in RHOS

Instructions to complete and submit the health screening results in RHOS

1) Go to the RHOS database (https://rhos.dhhs.utah.gov/)
2) Look up the client's case file and enter information into each section as described below.
3) For more detailed instructions, read through Attachment 10: SOP: How to enter health screening results in RHOS.

Health screening sections	Instructions
Demographics	Completed by resettlement agency and Utah DHHS before health screening appointment. Clinic staff enters patient address.
General exam	Clinic staff indicates findings for basic physical examination (height/weight/BP/visual acuity etc.)
TB	Report TB test results here. If positive, enter date of CXR order here and attach under "Attachments" tab. Report results of CXR here and attach copy of results under "Attachments."
Parasite	Indicate whether screening occurred, client was treated overseas, or if N/A to screen based on country the client is arriving from.
Labs	Indicate whether screening occurred; if yes and appropriate, include date of screening and the lab results.
Immunization	Record all immunizations administered during health screening and make sure overseas immunizations were entered into USIIS.
Mental health	Record if screening was completed and

	note any referrals made during the appointment.
Medical conditions	Select all medical conditions identified during the health screening and if a referral is required. Attach referrals under “Attachments.”
Comments	Note all findings and follow-up required for the patient here.
Attachments	Include all relevant attachments here such as: CXR order, lab results, SOAP notes, and specialist referrals.

*Note: When making a referral, a referral needs to be attached under “Attachments” in either “Referral #1” and/or “Referral #2” (referrals can be combined in these spots) and make sure you check the corresponding conditions under “Medical conditions.”

Final steps to complete health screening in RHOS

1) After you complete all sections, determine if the health screening has met all requirements. If it has, select “Completed HSF (Clinics)” under the “Demographics” section to indicate to RHP that the health screening is complete. This will act as the clinic/physician signature signing off the chart.
2) The RHP will review all completed health screenings on a weekly basis and provide feedback, if required.

XV. Referring to primary care

Process to refer patients to primary care

It is strongly encouraged that the health screening provider continues to serve as the primary care physician (PCP) to promote continuity of care. However, there may be circumstances where this is not feasible; in these situations, follow the steps below to refer patients to other primary care providers.

1) All follow-up health needs (including immunizations) should be documented under the “Comments” section so the RA and RHP are aware of required next steps for the patient, regardless of whether the health screening provider continues as the PCP.
2) The resettlement agency will schedule an establish care appointment with PCP; reports name of provider to RHP and it is entered into RHOS.
3) Resettlement agency coordinates with the health screening provider/clinic to make sure health screening results are shared with PCP.

XVI. Health screening payment

Medical clinic payments for health screenings

Refugee health screenings are billed to Medicaid; however, the DHHS Refugee Health Program has some funding to provide payment for:

1) Applicable patient co-pays.
2) Provider consultation.
3) Refugee patients who are eligible for health screenings but do not qualify for Medicaid health coverage.

To receive payment for these services, the provider must:

1) Sign an annual provider agreement with DHHS RHP.
2) Submit a monthly invoice and supportive documentation using the approved template and format.
3) Recognize that a completed health screening in RHOS must be received by the DHHS Refugee Health Program before payment is rendered.

Utah REFUGEE HEALTH SCREENING FORM

Date of Arrival: ____ /____/____ Screening Clinic: _____ Screen Date: ____ /____/____

Last Name: _____ First Name: _____ Foster Care: ☐

Address: _____ DOB: ____ /____/____ Sex: M F Alien ID: _____ Resettlement Agency: _____

Place of Birth: _____ Arrive From: _____ Nativity/Culture: _____ Language: _____ USPHS Class: B1 ☐ B2 ☐

PHYSICAL EXAM:

Weight:_____ Height:_____ BP:_____BMI:_____	Visual Acuity: Y N Referral needed: Y N	Tobacco user: Y N

TB SCREENING:

Tuberculosis Test: PPD QFT Date: ____ /____/____	Results: _____mm Pos Neg Indeterminate Date: ____ /____ /____	X-ray Results: Normal Abnormal Date: ____ /____ /____

LAB TESTS: (ALL) WBC: RBC: Hemoglobin: Eosin: H-Pylori:

Anemia Screened (All): Y N Hct: MCV:	Diabetes Screened (All): Y N Results:	Urine Analysis (All): Y N Findings:_____
HIV (All) Tested: Y N Results:	RPR Tested (≥15 years): Y N Results:	Treponemal Test:
Chlamydia Tested (high risk): Y N Results:	Gonorrhea Tested (high risk): Y N Results:	B 12 Tested (Bhutanese, risk factors): Y N Results:
HBsAg (All) Tested: Y N Results:	Hep C (18+, at risk) Tested: Y N Results:	Blood Lead (≤ 16ys): Y N Results: _____µg/dl:

PARASITES Pregnancy Test (females, child-bearing ages): Total cholesterol: HDL: LDL:

Soil Transmitted Helminths:	**Schistosomiasis:**	**Strongyloides:**
Treated overseas: Y N Screened at HS: Y N Results: (+ / –) _____	Treated overseas: Y N Screened at HS: Y N Results: (+ / –) _____	Treated overseas: Y N Screened at HS: Y N Results: (+ / –) _____
Albendazole at HS: Y N Dose:	Praziquantel at HS: Y N Dose:	Ivermectin at HS: Y N Dose:

IMMUNIZATIONS:

Malaria: Treated overseas: Y N
Screened at HS: Y N RX @ HS: Y N

Vaccines (date given) COVID-19 Vaccine: Y N Type: Date 1: Date 2:

DTaP/TD/Tdap	IPV	HIB	Meningococcal	Hepatitis B	MMR	Varicella	Pneumococcal	Hepatitis A	HPV	Influenza
___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Serology (+ / –)										

MENTAL HEALTH: How was RHS-15 administered: _____ Self _____ Provider assisted _____ Interpreter assisted

≥ 14 yrs: RHS-15 Score 1: _____ (≥12 = positive) RHS-15 Score 2: _____ (≥4 = positive) < 14 yrs: Ask parent, "Do you think your child has difficulties with their emotions, concentration, behavior, or getting on with other people?" Y N	Torture/Violence: Y N "In this clinic we see many patients who have been forced to flee their homes because of violence or threats to their health and safety. Were you (or any of your family) a victim of violence and/or torture in your home country?"	All ages: Anxiety: Y N Depression: Y N Other: Y N Describe: _____

MH Referral Accepted: Y N	Referral Agency: AAU UHHR Other _____	MH Severity: ☐ Mild ☐ Moderate ☐ Severe

OTHER HEALTH CONDITIONS: check category if PRESENT, circle condition or write in space

☐	Cardiovascular:	HTN	↑ BP without HTN	Heart Murmur				
☐	Dental:	Caries	Calculus	Decay	Pain			
☐	Dermatology:	Dermatitis	Scabies	Tinea				
☐	Endocrinology:	Diabetes	Thyroid					
☐	ENT:	Impacted Cerumen	Perforated TM	<Hearing				
☐	Genitourinary:	Dysuria/BPH	Nocturia	UTI				
☐	GI:	Abdominal Pain	Constipation	Diarrhea				
☐	Hematology:	Eosinophilia	Macrocytic anemia	Microcytic anemia				
☐	Musculoskeletal:	Arthritis	Low back pain	Loss of Limb	Other Pain			
☐	Neurology:	Headaches	Neuropathy	Seizures				
☐	Nutrition:	Short stature	Underweight	Overweight	Obesity			
☐	Obstetrics/GYN:	Dysmenorrhea	Menorraghia	Depo due _____				
☐	Ophthalmology:	Corneal opacity	<Vision					
☐	Pulmonology:	Asthma	COPD	Hx of TB				

COMMENTS:

Screening Physician: _____ Physician Signature: _____

Original: Utah Department of Health, Refugee Health and TB Control Program, Box 142104, Salt Lake City, UT 84114-2104 Fax: (801) 237-0770 Canary: Resettlement Agency HSF entered _____ (9/2021)

Utah Domestic Refugee Health Medical Screening Guidelines Checklist* (as of 5-13-2025)

Activity	All	Adults	Children	Complete?
History & Physical Exam				
History (includes review of overseas medical records)	✔			
Physical Exam & Review of Systems (includes mental health, dental, hearing, and vision screening; nutritional, reproductive assessment; health education and anticipatory guidance, etc.)	✔			
Height, weight, BP	✔			
Visual Acuity Results		✔ All adults	✔ All children able to be screened	
Social History (Tobacco or Alcohol Use)	✔			
Mental Health	✔	Screened with RHS-15 (14+)	Screened via questions and discussion between provider and guardian.	
Laboratory Tests				
Complete Blood Count with Differential and Platelets	✔			
Diabetes Screening (PGL test for diabetes or marked “Low Risk” in RHOS)		✔ Screen if the patient is at high risk for diabetes and/or in accordance with the US Preventive Services Task Force guidelines.	✔ Screen if the patient is at high risk for diabetes and/or in accordance with the US Preventive Services Task Force guidelines.	
Urinalysis (if old enough to provide clean-catch urine specimens)	✔			
Cholesterol & Lipid Disorder Screening		✔ In accordance with the US Preventive Services Task Force guidelines		
Pregnancy Testing		✔ Women of childbearing age; using opt-out approach	✔ Girls of childbearing age; using opt-out approach or with consent from guardian	

*For specifics, see CDC guidelines at: https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/index.html these *screening* guidelines are for *asymptomatic* refugees. Refugees with signs or symptoms should receive diagnostic testing and refer to overseas medical screening notes from EDN regarding follow-up at final destination. Or utilize CareRef, which is a tool to determine screening tests recommended.

Utah Domestic Refugee Health Medical Screening Guidelines Checklist* (as of 5-13-2025)

Activity	All	Adults	Children	
HIV Testing	✔ Opt-out approach			
Hepatitis B Testing	✔			
Hepatitis C Testing		✔ All adults 18+	✔ Children with risk factors (e.g., hepatitis C -positive mothers, etc.)	
Blood Lead Level		✔ Pregnant or Lactating mothers	✔ All children and infants (16 years old or younger)	
Syphilis Testing (read more here)		✔ Screen adults 18-45 years old. Adults over 45 years old with risk factors FYI -Domestic Syphilis testing is not required if there's an overseas negative result.	✔ Children under 17 years old with risk factors (if there isn't a negative overseas result)	
Syphilis Confirmation Test[1]		✔ Individuals with positive VDRL or RPR tests	✔ Children with positive VDRL or RPR tests	
Chlamydia and GC Testing (read more here)		✔ Women ≤ 25 years who are sexually active or those with risk factors and do not have documented pre-departure testing.	✔ Girls under 18 years old who are sexually active or those with risk factors and do not have documented pre-departure testing.	
Newborn Screening Tests [2]			✔ Within the first year of life	
Preventive Health Interventions & Other Screening Activities				
Tuberculosis Screening [3]	✔			
Immunizations [4]		✔ Individuals with incomplete or missing immunization records upon review of overseas records OR Serology results.	✔ Children with incomplete or missing immunization records upon review of overseas records ~~OR Serology results.~~	
Review & Enter Overseas Immunizations into USIIS, acknowledge in RHOS.	✔			

[1] Note: False-positive nontreponemal test results can be associated with multiple medical conditions and factors unrelated to syphilis, including other infections (e.g., HIV), autoimmune conditions, vaccinations, injecting drug use, pregnancy, and older age (*566*,*569*). Therefore, people with a reactive nontreponemal test should always receive a treponemal test to confirm the syphilis diagnosis (i.e., traditional algorithm). See CDC Sexually Transmitted Diseases Treatment Guidelines.

*For specifics, see CDC guidelines at: https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/index.html these *screening* guidelines are for *asymptomatic* refugees. Refugees with signs or symptoms should receive diagnostic testing and refer to overseas medical screening notes from EDN regarding follow-up at final destination. Or utilize CareRef, which is a tool to determine screening tests recommended.

Utah Domestic Refugee Health Medical Screening Guidelines Checklist* (as of 5-13-2025)

Activity	All	Adults	Children	
Stool Ova and Parasite Testing [5,8]		✔ Refer to EDN and CDC guidance. Individuals who had contraindications to albendazole at pre-departure (e.g., women in the first trimester of pregnancy) Those who weren't screened overseas should be screened domestically and/or provided presumptive treatment based on results.	✔ Refer to EDN and CDC guidance. Children who had contraindications to albendazole at pre-departure (e.g., under 1 year) or who weren't screened overseas should be screened domestically and/or provided presumptive treatment based on results.	
Strongyloides Testing and/or Presumptive Treatment [5, 6, 8]		✔ Refer to EDN and CDC guidance. Individuals who did not receive pre-departure presumptive treatment or testing should be screened domestically and/or provided presumptive treatment based on results.	✔ Refer to EDN and CDC guidance. Individuals who did not receive pre-departure presumptive treatment or testing should be screened domestically and/or provided presumptive treatment based on results.	
Schistosomiasis and/or Presumptive Treatment [5, 7, 8]		✔ Refer to EDN and CDC guidance. Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pre-existing seizures) that are not resolvable should be tested rather than treated.	✔ Refer to EDN and CDC guidance. Children from sub-Saharan Africa who had contra-indications to presumptive treatment at pre-departure (e.g., under 4 years) should be tested domestically.	
Malaria Testing [5, 7, 8]		✔ Refer to EDN and CDC guidance. Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pregnant, lactating)	✔ Refer to EDN and CDC guidance. Children from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., < 5 kg)	
Vitamins		✔ Individuals with clinical evidence of poor nutrition	✔ Individuals with clinical evidence of poor nutrition	
RHOS Data Entry				
Screenings Results Entered?	✔			
Screening Provider Comments	✔			
Referrals Attached / Follow-Up Noted in RHOS	✔			

[2] *According to state standards; see: https://newbornscreening.utah.gov/*

[3] *Tuberculosis screening may include IGRA or TST/PPD testing and/or chest x-ray*

[4] *Serological testing is an acceptable alternative*

[5] *Presumptive treatment is an acceptable alternative to testing, provided the contraindication has resolved*

[6] *Ivermectin is the drug of choice, but is contraindicated in refugees from Loa loa endemic areas of Africa. In African refugees from Loa loa endemic areas, presumptive treatment is more expensive and complicated (e.g. high dose albendazole) and it may be more feasible to conduct serologic testing with treatment of those found to have infection*

[7] *Presumptive treatment is only recommended in refugees from sub-Saharan Africa. Currently, all sub-Saharan refugees without contraindications are receiving pre-departure treatment.*

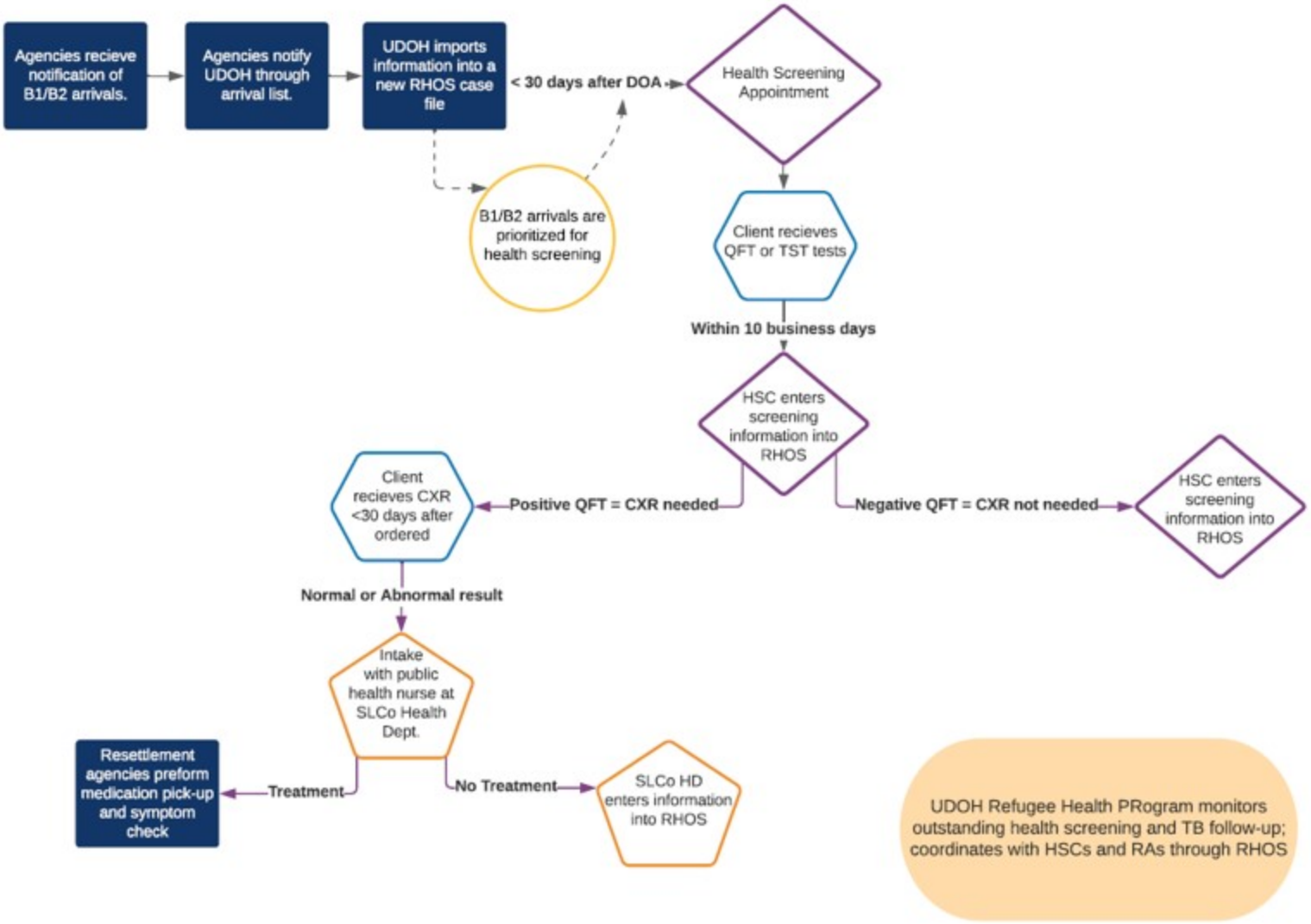
[8] *For additional support navigating the domestic parasite screening guidance, please refer to an interactive tool created by the Mass. Refugee Health Program: https://mdphgis.maps.arcgis.com/apps/MapSeries/index.html?appid=d3b4242937a447fe9b9fe7c137276085*

*For specifics, see CDC guidelines at: https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/index.html these *screening* guidelines are for *asymptomatic* refugees. Refugees with signs or symptoms should receive diagnostic testing and refer to overseas medical screening notes from EDN regarding follow-up at final destination. Or utilize CareRef, which is a tool to determine screening tests recommended.

General Refugee Tuberculosis Screening Process Flow

The diagram below outlines the general process of the tuberculosis (TB) screening process flow for refugee clients. This process flow closely outlines the order of the screening(s), and appropriate referral to the Salt Lake County Health Department (SLCo HD).

Note: The order of activities may vary depending upon a client's understanding and willingness to attend TB treatment.



A. Refugee Tuberculosis Screening

Before departure for the United States, all refugees must undergo an overseas medical examination that focuses on inadmissible conditions, including TB disease. TB disease should be encountered infrequently during the domestic medical screening examination because all new arrivals have been screened for TB disease prior to departure. Clinicians should be aware that the overseas medical exam is aimed at diagnosing pulmonary TB disease and may fail to detect extrapulmonary disease.

All refugee applicants must be assigned one or more TB classifications. TB classification is determined by screening results, and treatment, if required. **(See page 3: *Tuberculosis Classifications*)**

A.1 Guidelines for TB Testing

1. All refugees MUST be screened for Tuberculosis.
2. Interferon Gamma Release Assay, IGRA (Quantiferon (QFT), T-Spot) is the preferred method of testing and should be used with refugees ≥2 years.
3. Children <2 years should have a Tuberculin skin tests (TST) placed.
4. Do not place a TST on Thursdays (must be read 48–72 hours).
5. Refugees identified as Class B1 or B2 are given priority; for testing, please follow the guidelines outlined in the Class B1-B2 Protocols ***(Section A.2)***
6. An indeterminate QFT result should be repeated. If the second QFT result is indeterminate, place a TST.
7. If vaccines containing live virus have been given, wait at least 4-6 weeks to repeat any TB testing.
8. If a client tests positive – upload Chest X-ray (CXR) order form, and lab results under the "Attachments" tab in RHOS within 7 business days. Please follow guidelines outlined in Positive TB Screening ***(Section A.3)***
    a. Also, update CXR findings under the "TB" tab as soon as the CXR report is received.

A.2 B1 & B2 Protocol

1. Resettlement agencies will email the UDOH Refugee Health Program weekly with updates on arrivals who have any TB related bio-data.
2. The TB Epi Program at UDOH will keep pending refugee arrivals with B1/B2 status in a report in RHOS and will forward the referral, arrival information, and CDC paperwork to SLCo HD through UT-NEDSS when notified of their arrival by CDC.
    a. TB Epi creates case in UT-NEDSS and assigns to SLCo HD
    b. SLCo HD assigns a Public Health Nurse (PHN) to the case
    c. PHN contacts resettlement agencies to set up an intake
3. Resettlement agencies will schedule a health screening appointment within 30 days after the arrival date and inform the screening clinic of the clients' status giving priority to B1/B2 cases.
4. Resettlement agencies will coordinate with PHN to schedule an intake
5. TB Epi at UDOH will export intake, treatment, and outcome information from UT-NEDSS into RHOS at a bi-weekly interval.

B1 Specifics

1. Health Screening Clinics (HSCs) will see client for health screening and draw the Quantiferon Test (QFT).
2. HSCs will report results of QFT to the Refugee Health Program at UDOH and attach lab reports in RHOS.

3. The PHN will complete intake within two weeks of the health screening and request sputum sample from refugees with B1 status.
    a. IRC/CCS will deliver sputum to SLCo HD two days later.
4. PHN will schedule a Chest Clinic appointment within 90 days of refugee's arrival and inform client at intake.
5. Resettlement agencies will bring client to Chest Clinic appointment
    a. If Chest Clinic is missed, IRC/CCS will reschedule to the following Chest Clinic at SLCo HD.
6. SLCo HD will complete and upload CXR from Chest Clinic to RHOS.
7. HSCs will finalize and upload the updated health screening forms to RHOS.
8. Clients recommended for treatment will be enrolled into the LTBI program.

B2 Specifics

1. Resettlement agencies will request CXR order from SLCo HD.
    a. Point of contact:
2. Resettlement agencies will complete CXR within 30 days of CXR order date at Primary Children's Medical Center (PCMC).
3. Resettlement agencies will discard any duplicate CXR orders from Health Screening Clinics.
4. SLCo HD will assign PHN and contact IRC/CCS to schedule intake.
5. SLCo HD will complete intake and education within two weeks of health screening.
6. Clients recommended for treatment will be enrolled into the LTBI program.

A.3 Positive TB Screening

1. The screening clinic will upload the lab results with the positive IGRA (QFT, T-Spot) indicated on it to RHOS under the "Attachments" tab.
2. For every positive TB screening, the screening clinic will upload a chest x-ray order to RHOS under the "Attachments" tab.
3. Utah Department of Health - Refugee Health Program will work with the agency to make sure the patient completes a chest x-ray within 30 days of the chest x-ray order date.
4. The resettlement agencies will update the "Agency Comments" on RHOS with the CXR date and location.
5. The screening clinic will upload the CXR results to RHOS for the Salt Lake County Health Department for follow-up.
6. The Salt Lake County Health Department will get the completed CXR from RHOS.
7. The coordination between the Utah Department of Health, Resettlement Agencies, Screening Clinics and Salt Lake County Health Department should happen on the corresponding "Comments" section in RHOS, however, questions could be directed via secure email:
    a. UDOH Refugee Health Program Email: rhprogram@utah.gov

A.4 Coordination and Follow-up

1. UDOH will work with the resettlement agency to ensure the CXR is completed in a timely fashion; standard is 30 days from day of CXR order.
2. Once the CXR is complete; the results will be sent to the physician/clinic listed on the order form.
3. Upon receiving the CXR results, the screening clinics upload the CXR results to RHOS.
4. If the screening clinic is not able to locate the CXR, please leave a note under the "Comments" tab on RHOS.

Refugee Tuberculosis Screening

Overseas what people receive
Domestic what people receive / when

https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html

For refugees aged ≥15 years: If IGRA was not done overseas or a negative IGRA was documented >6 months prior, an IGRA is recommended at the domestic examination.

Referral to Tuberculosis Treatment

LTBI Coordination

Reducing the likelihood of progression from latent TB to active TB is a main focus of the UDOH TB Control Program. The Salt Lake County Health Department (SLCoHD) provides services to control the spread of TB in the Salt Lake valley through three main components of TB control:

1. Identify and treat TB disease;
2. Identify, evaluate and treat the newly infected contacts of infectious TB cases; and,
3. Screen and treat high-risk populations for TB infection. Since refugees are considered a high-risk population, SLCoHD works closely with resettlement agencies to evaluate, educate and treat refugees identified with LTBI.

Results from the refugee health screening are input into the clients RHOS file. This ensures that appropriate follow-up care and coordination is provided by the resettlement agencies. The expectation of the program is that each refugee will be assigned a Primary Care Provider (PCP) and receive timely follow-up care (within 30 days of completing the health screening).

Resettlement agencies are strongly encouraged to establish care with the initial health screening provider, thus improving the continuity of care. Care and coordination are facilitated by the resettlement agencies, as needed, for primary care, specialty care, and other health-related services.

Contact Information

Salt Lake County Health Department
Tara Scribellito
PHN Lead
tscribellito@slco.org
385-468-4276

Madison Clawson
PHN Lead
mclawson@slco.org
385-468-4277

Utah Department of Health
Sarah Bates
Refugee Health Program Specialist
sbates@utah.gov
801-538-9310

Rachel Ashby
TB Epidemiologist
rashby@utah.gov
801-538-9315

Hayder Allkhenfr
Refugee Health/TB Program Manager
hallkhenfr@utah.gov
385-259-5204

Appendix I: LTBI Screening Questions

Administer questions to client every month when ready for LTBI medication pick-up. Inform client that the resettlement agency will pick-up medication and deliver it to their home.

Client Name: _____

Nurse Name: _____

Due Date: _____

Problem List

☐ Fatigue
☐ Jaundice
☐ Loss of Appetite
☐ Rash/Bruising
☐ Dark Brown Urine
☐ Pregnant

Symptoms of TB:

☐ Productive Cough
☐ Chest Pain
☐ Weight Loss
☐ Fever / Chills
☐ Night Sweats

☐ **Other Symptoms:**

_____

☐ **Comments:**

_____

- How many pills do you have remaining? #_____
    - This is used to determine if the client is taking medication correctly

- If last month of medication, inform client that:
    - After this month, the medication will be finished. An envelope will come with a "treatment completion card".
    - Keep this card safe with your Medicaid card. If any employer askes about TB you can show that you have been fully treated for LTBI.

Medication Drop-off Date/Time: _____

☐ INH Month: _____ / _____
☐ RIF Month: _____ / _____
☐ Vitamin B

Afghan Arrivals

Oct – Dec

Afghans arriving with paper medical records, scanned and input to RHOS

Most are being screened on base for TB (QFT) – 2 of 8 bases are just doing CXR

Health Clinics are very backlogged with inputting data into RHOS. Sometimes clients who screen positive for TB/LTBI are not input

EMR's are being received for afghan medical records now – but it is very messy and require individual pdf review. The data needs to be reviewed and input

- Sarah has access to a CDC portal: DGMQ Newcomer Health SDX

Each arrival client has a folder with PDF data/medical records. This will require manual data entry of 900+ individuals into RHOS

Is the CDC expecting us to filter the Afghan arrivals as B1 or will these be people considered 'refugee status' who test positive for LTBI

- If someone has a positive QFT (from the base) they will not be in EDN (because people will be having paper based medical records)
- UDOH needs to ensure that clients are being evaluated and connected to care
- Before a LHD can offer treatment they need
    - QFT results (if done in-state, this information is in EpiTrax)
        - Taylor can start doing the data merge for EpiTrax and RHOS more frequently
    - CXR results
    - Signs/symptoms

For clients who are doing health screenings outside of SLCo, have those health clinics contact UDOH directly to then be connected to a LHD regarding LTBI follow-up/treatment.

Health screening that is happening on military bases is equivalent to what would be happening during the overseas screening. People are being identified as positive (domestically) when it would have typically been happening overseas.

NDR case (active TB) – the doctor wants to get an EKG now, but have coverage questions – need to confirm if the Medicaid application has been submitted. Sarah will confirm with CCS to see if this has been submitted. Need effective and policy date for approval.

Continue to state that we are treating these individuals like any other refugee who is identified with LTBI upon arrival – instead of Class B

Goal to get all EDN records into RHOS – prioritize those who are in RHOS but not in EpiTrax

Tuberculosis Screening for Applicants in High Tuberculosis Burden Countries*

Tuberculosis screening for applicants <2 years of age in high-burden countries

For all applicants <2 years of age

- Medical history
- Physical examination

For those with signs or symptoms of tuberculosis or known HIV infection

- IGRA or TST
- Chest x-ray
- Three sputum specimens for smears and culture plus molecular testing of the first specimen

For those with positive cultures

- Drug susceptibility testing

Tuberculosis screening for applicants ≥ 2 years of age in high-burden countries

For all applicants ≥ 2 years of age

- Medical history
- Physical examination
- IGRA

Chest x-ray required for:

- All applicants ≥ 15 years of age regardless of IGRA result
- Those <15 years of age with a positive IGRA, or signs or symptoms of tuberculosis, or known HIV infection

For those with a chest x-ray suggestive of tuberculosis, or signs or symptoms of tuberculosis, or known HIV infection

- Three sputum specimens for smears and culture plus molecular testing of the first specimen

For those with positive cultures

- Drug susceptibility testing

* Countries with a World Health Organization-estimated tuberculosis disease incidence rate ≥20 cases per 100,000 population

IGRA = Interferon-gamma release assay

TST = Tuberculin skin test

Accessible version (URL):
https://www.cdc.gov/immigrantrefugeehealth/panel-physicians/TB-flowchart-high.html

CS297106-B

Centers for Disease Control and Prevention
Division of Global Migration Health

Treatment

Since new arrivals are at an increased risk for developing active TB disease, treatment of LTBI is strongly recommended. The SLCoHD is responsible for conducting an intake appointment with Class B1/B2 arrivals and those with a positive IGRA QFT. At the intake appointment the public health nurse (PHN) will consult with the client and provide education regarding TB/LTBI treatment options. With the client's consent, the SLCoHD will prescribe medication and the client will be enrolled in a treatment program. Treatment regimens are client-specific and should be well documented in RHOS and EpiTrax. Upon completion of treatment, the SLCoHD will educate the client on future TB testing and issue a Certificate/card of Completion.

Follow Up

SLCoHD is responsible for regularly following up with clients that have initiated treatment to screen them for any potential medication side-effects and connecting clients to additional care, as needed. SLCoHD currently meets with the clients once per month as well as performs liver function tests prior to clients starting medication and one month after initiating treatment. Refer to Appendix II: Medication Pick Up Questionnaire for RHP side-effect review requirements.

Process Flow

New Arrivals

1. HSCs will evaluate and test clients for TB at the DRHS within 90 days of arrival.
    a. IGRA QFT* or T-Spot should be used with refugees ≥2 years of age.
        i. Children <2 years of age should have a TST placed.
            1. TSTs should be read by the HSC with the RA as a back-up option only.
            2. Try to avoid placing a TST on Thursdays (it must be read within 48–72 hours) as RAs are not available to support on the weekends.
        ii. An indeterminate QFT result should be repeated. If the second QFT result is indeterminate, place a TST.
        iii. If vaccines containing a live virus have been given, wait at least 4-6 weeks to repeat any TB testing.

1. RAs should avoid taking new arrivals for their immunizations prior to the health screening visit.

2. HSCs will report QFT/TST results to the RHP and upload client lab results to RHOS under the "Attachments" tab.
    a. If a client tests *negative*, no further TB follow up is required once the results are uploaded to RHOS.
    b. If a client tests *positive,* SLCoHD will be notified of the results in EpiTrax and assign a PHN to the case.
        i. The HSC's lab of choice is required to report positive QFT results to the state and results should be available in EpiTrax for DHHS and LHD access.
3. The SLCoHD PHN will initiate contact with the RA to notify the Case Manager (CM) or LTBI point of contact (POC) they are assigned to the case and have reviewed the QFT/TST results.
    a. If a client tests *positive*, the HSC will upload a CXR order form under the "Attachments" tab in RHOS within 7 business days of the positive TB test result and update the CXR Order Date in RHOS under the "TB" tab.
        i. RAs should disregard any duplicate CXR orders.
4. RAs will make sure the patient completes a CXR within 30 days of the CXR order date by providing transportation and interpretation for the client.
    a. RAs will help the client complete a CXR at any location that's closest to the client or takes their insurance. Most RAs opt to take clients to a University of Utah location if a client was seen by a University of Utah provider for ease of sharing electronic medical records.
5. RAs will update the CXR Date and CXR Location fields in RHOS under the "TB" tab or in the agency-designated TB/LTBI Google Drive Tracker.
6. Once the CXR is complete, the results will be sent to the physician/HSC listed on the order form.
7. HSCs will upload the CXR results to RHOS under the "Attachments" tab and update the CXR Results field under the "TB" tab in RHOS as soon as the report is received.
    a. If unable to locate the CXR results, please leave a note under the "Comments" tab in RHOS and/or reach out to the RA's LTBI point of contact (POC) or CM, who will investigate.
8. RAs will contact the assigned PHN, notify them of CXR completion, and provide the client's CM contact information.

9. Once SLCoHD reviews the CXR results, the PHN will contact the RA CM to schedule an intake appointment with the client within two weeks of the CXR results.
    a. RA will coordinate transportation and interpretation for the client's appointment.
10. After the intake appointment is complete at SLCoHD, clients recommended for treatment will be enrolled into the LTBI program and initiate treatment.
11. If a client enrolls in treatment, RAs will help coordinate medication pick up and drop off, as needed.
12. SLCoHD will continue to monitor the client for any potential medication side-effects until the client completes treatment.
13. Upon completion of treatment, SLCoHD will provide the client with a Certificate of Completion and reeducate the client on future IGRA testing.
14. RAs may continue to support the client as needed with treatment completion questions or concerns.
15. DHHS will continually monitor the screening and care coordination services to ensure they're completed within the appropriate timeframes.

*The QuantiFERON-TB Gold test (QFT-G) is the preferred testing method of the Utah RHP as it offers increased specificity and sensitivity.

Class B Arrivals

The RH and TB Program is notified of Class B TB arrivals through the RA's arrivals lists and by the Centers for Disease Control and Prevention (CDC) Electronic Disease Notification (EDN) system. Refugees assigned Class B1 and Class B2 TB status are prioritized to have a DRHS within 30 days of arrival and an intake appointment within two weeks of the positive IGRA. For additional guidance and information refer to Appendix III: Class B Domestic Follow-Up Recommendations.

Class B1 Specification:

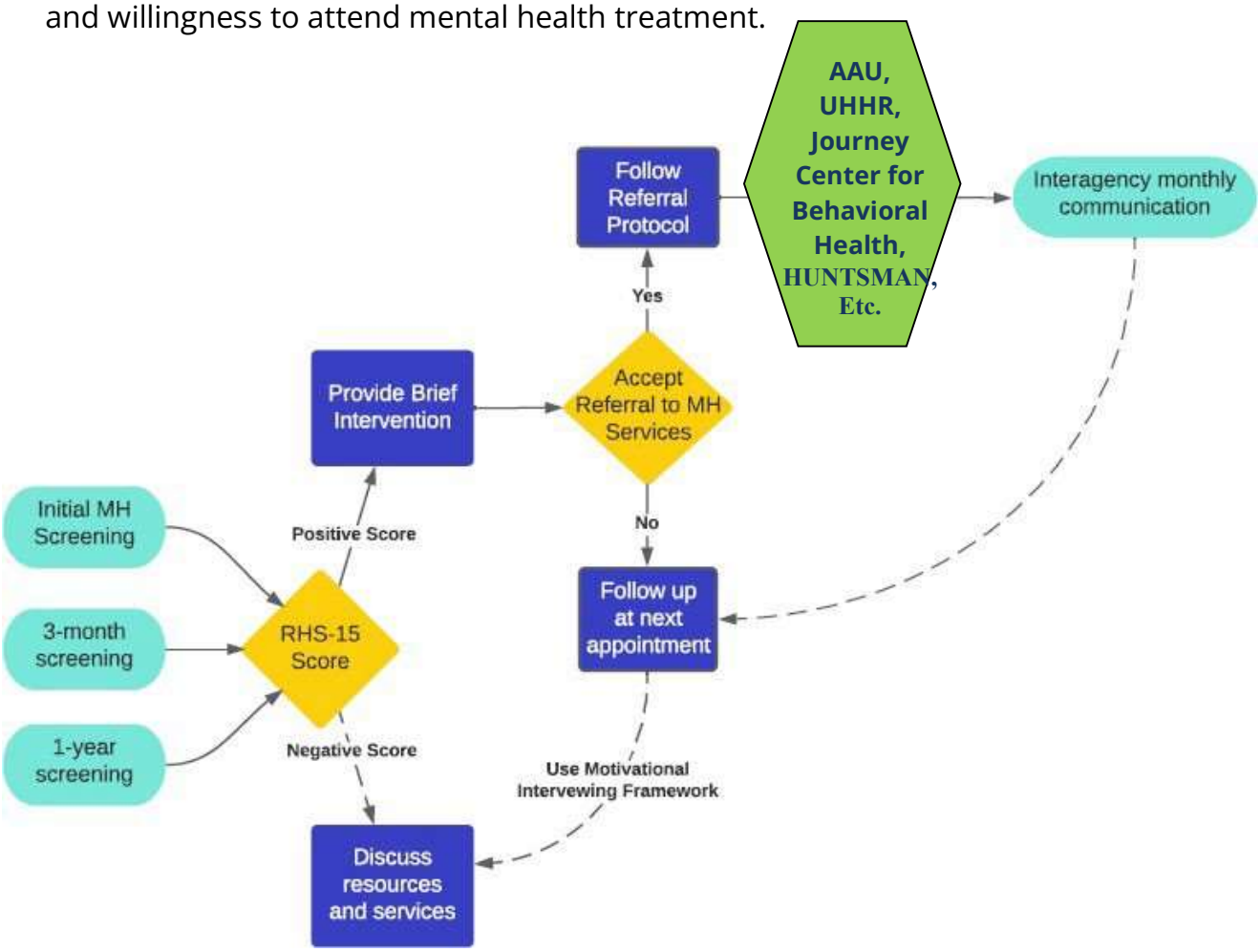
1. RA and DHHS will notify SLCoHD of Class B TB arrivals at least 24 hours in advance or within 24 of arrival via encrypted email.

Additional resources are provided in *Appendices I, II* and *III* for screening tools, referral and communication forms. The General Refugee Health Screening Process Flow serves as a visual guide of the comprehensive process of providing ongoing care, and care coordination to refugees and as an aid in navigating this protocol. If you have questions about this protocol or would like additional support, please contact the Refugee Wellness Specialist via phone (412-559-1852) or email (tmorsillo@utah.gov).

General Refugee Mental Health Screening Process Flow

The diagram below outlines the general process of the mental health screening process flow for refugee clients. This process flow closely outlines the order of the screening(s), and appropriate referral to clinical agencies.

Note: The order of activities may vary depending upon a client's understanding and willingness to attend mental health treatment.



A. Refugee Mental Health Screening (≥14 years)

WHO SHOULD BE SCREENED

The following clients should be provided a mental health screening:

Initial screening:

- All newly arrived refugees should receive a mental health screening at the initial health screen.

3-month screening

- Refugee clients who did not have an initial mental health screening score;
- Refugee clients who had a negative initial mental health screening score.

1-year screening

- All refugee clients.

Refugees who screened positive at the initial mental health screening, but declined a referral to mental health services will be provided mental health education or wrap around support services at 3-months post-arrival.

The RHS-15 is used to assess the mental health needs of newly arrived refugees ≥14 years old. The RHS-15 (Appendix I) was designed as a simple tool that can be used during the initial health screening and/or in the primary care setting.

The 15 questions address symptoms associated with depression, anxiety, trauma, and overall well-being; the tool has been translated and validated in a number of refugee languages.
Refugees scoring ≥12 on questions one through fourteen or ≥5 on the distress thermometer are identified as someone who may benefit from mental health

services. The RHS-15 is *not a diagnostic tool*, it is a predictive tool.

A.1 Administering the Refugee Health Screen (RHS-15)

Trained professionals involved in patient care are able to administer the RHS-15 (health care worker, case manager, mental health clinician, etc.).

A Note:
Transition to life in the United States is difficult for most refugees. The addition of the RHS-15 as a tool to better identify individuals who may be facing significant challenges within this process does not change this fact, nor does a negative RHS-15 score indicate a seamless adjustment.

1. Introduce the RHS-15: When the trained professional introduces the screen, they can explain the following:
    a. *"Part of what we'll talk about today is how you are feeling in your body and mind. We'll use something called the Refugee Health Screener 15 to talk about different symptoms and feelings."*

   b. The screening may occur in-person, over the phone, or via telehealth appointment.

2. If the client is literate and the screening tool has been translated into an appropriate language, it may be self-administered.
   a. If interpretation is needed, or if the client is pre-literate, the screen may be administered orally.

3. Reintroduce the RHS-15: Before handing out the RHS-15, state that each person (14 years old and over) will be asked questions about sadness, worries, body aches and pain, and other symptoms that may be bothersome to them.
   a. *"Some refugees have mind and body symptoms because of the difficult things they have been through, and because it is very stressful to move to a new country. The questions we are asking help us find people who are having a hard time and who might need extra support. The answers are not shared with employers, USCIS, teachers, or anyone else without your permission."*

4. Normalize the RHS-15: Tell clients that many refugees and asylees have a hard time because of the difficult things they have been through, and because it is very stressful to move to a new country.
   a. *"Many of the people we work with have different feelings or symptoms because of the difficult things they have been through, or because of the stress that comes with moving to a new country. We see people every day that have trouble sleeping, or think too much, or have aches that won't go away. We talk to all of our clients about how they feel to see if we can help them with services to feel better."*

5. Explain the RHS-15 Instructions: For clients who choose to self-administer, trained professionals can state:
   a. *"Using the scale beside each symptom (show the scale), please place a mark in/circle the degree to which the symptom has been bothersome to you over the past month/30 days including today. For example, in the past 30 days, you may have been crying every day, a few times, or not at all. We are asking you to place a mark, or circle, in the column that shows how much you have been having that experience in the last month or 30 days."*

   b. If a client prefers to have the screen read to them, the trained professional can read aloud the instructions with appropriate interpretation.

Remember to:

- Repeat the symptom items, read out loud, and speak slowly.
- Check for understanding by asking if anyone has any questions.
- If the tool is administered in a group setting (i.e., all family members at one time), remind each person to answer their own questions individually.

A.2 Administering Screening for Adolescents (<14 years)

1. Introduce the indirect adolescent screening.

2. When the trained professional introduces the screen, they can explain the following:
    a. *"Part of what we'll talk about today is how your child has been feeling within their body and mind. We will ask one question about how things are doing."*

3. Parents or guardians will then be asked "Do you think your child has difficulties with emotions, concentration, behavior, or getting on with other people?"
    a. If the parent/guardian responds with a "No" the health professional will document this.

A.3 Scoring the RHS-15

1. The trained professional administering the screen, collects and calculates the RHS-15 score.
    a. If items 1-14 score 12 or more, this is considered a **positive screen**. Proceed to **B.1**.

    a. If the distress thermometer is greater than 5, this is considered a **positive screen**. Proceed to **B.1**.

    b. If the client does not screen positive on the RHS-15, proceed to B.2.

2. Scores should be calculated and then entered into the client's **RHOS file**, along with the accompanying date for the screen (initial, 3-month, 1-year).

B. Conducting Brief Interventions with Clients

It is important to emphasize to all parties involved in administration of the tool, including clients, that this is *not a diagnostic tool*, but a predictive one. The results, as well as the process of administering the tool and discussing the results, are intended to support clients in accessing needed services.

The following are some strategies for using client-centered communication to discuss a positive screening score to treatment options. It is helpful to utilize motivational interviewing techniques (outlined in B.3) during this discussion to increase the likelihood of initiating treatment.

B.1 Reviewing and Connecting Screening Scores to Treatment Options

1. After calculating and entering the screening score into the client's electronic file, the trained professional begins the process of explaining a positive RHS-15 score.

2. The trained professional can review the reason for the screening tool with the client.
    a. *"From your answers to the questions, it seems like you are having a difficult time. You are not alone. I work with many people who experience [list the specific symptoms being experienced - crying easily, fast heartbeat, too much thinking, etc.] that may be causing some problems for you."*

3. The trained professional can offer support to the client by referring to some of the symptom items on the RHS-15 that were indicated in the client's score.
    a. *"Lots of people experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. There is support in our community for these symptoms you are having."*

4. The trained professional can normalize a client's experiences that contribute to a positive score.
    a. *"Lots of people who have been through what you went through (insert specific client information if applicable) have these symptoms. Sometimes people need extra support to help them through a difficult time."*

5. The trained professional can educate and emphasize the importance of mental health support, discuss specific modalities, and the clinical options that are available in Utah.

a. *"In the United States, people who experience these types of feelings/symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them. A counselor in the United States is a type of healthcare worker who will listen to you and provide help*

and support."

b. *"Therapeutic arts groups are meetings where people come together to sing, dance, or make art together while sharing their struggles and accomplishments with each other; ESL classes would give you a chance to increase your language skills which will help your adjustment to the United States, while meeting new people)."*

6. Give control and power for individuals to make an informed choice.
    a. *"Are you interested in being connected to these services? I recommend that you see what they are all about. If you would like to seek services, I can help you schedule the first appointment."*

If a client responds with **YES,** they are interested in being connected to mental health services:

1. The MH Coordinator at IRC/CCS will complete a referral request to AAU or UHHR depending on the specific therapeutic needs. These steps are outlined in the referral protocol C.1 or C.2.
    b. *"I would like to refer you to (name specific service and again describe the tangible benefit of the service). Is this OK with you? Someone will call you in your language and describe the type of support they can offer you."*

If a client **declines** a referral to mental health services, proceed to **B.2**.

B.2 Negative Screen or Denial of Treatment Services

If a client **screens negative** or **declines** a referral to mental health services:

1. Resettlement agencies can provide continued education and additional support services to the client (i.e. – community-based activities, support groups) and can discuss treatment options during follow-up visits and conversations using motivational interviewing tools outlined in **B.3**.

a. The continuation of active available referral options is an essential component of the case management period.

A Note on Client Declined Referrals

Some clients with identified MH symptoms may not feel ready to engage in treatment. If a client declines referral to further assessment and/or treatment:

- **Make a detailed note in the client's record describing the symptoms/RHS-15 score use and record the client's refusal.**
- **Provide the client with contact information and other information/resources for when the client feels ready for treatment; and**
- **Discuss the client's MH symptoms and treatment options at the next appointment using motivational interviewing techniques.**

B.3 Motivational Interviewing Tool – POLAR*S

If a client **declines services** to mental health treatment, a trained professional can utilize the following framework to guide a conversation.

POLAR*S is a motivational interviewing framework to help promote behavioral change. This framework can help a trained professional conduct a brief intervention to learn more about a client's knowledge and comfort around mental health, aid in identifying appropriate treatment options, and support a referral to needed care.

a. **Permission:** Ask permission to discuss your client's screening results, and treatment options.

b. **Open-ended Questions:** Ask open-ended questions to elicit important information about your client's knowledge about and comfort discussing mental health.

c. **Listen Reflectively:** Listen reflectively by repeating information your client told you to convey that you heard and understood. Listen for signs of ambivalence and things your client values.

d. **Affirmation:** Affirm your client's thoughts and feelings. This can help your client build confidence and realize that feelings like hesitancy, fear, and frustration is normal. Note that acknowledging a behavior, thought, or feeling is not the same as promoting it.

e. **Roll with Ambivalence:** Understand that your client may not be ready to engage in mental health treatment for various reasons. When these thoughts or feelings of ambivalence arise, examine the reasoning behind these thoughts and feelings with the client. Then, explore other options (community groups, wellness courses, etc.) or smaller steps your client can take towards accepting a treatment referral.

f. **Summarize:** Review the conversation with your client. If you both agreed on a plan to meet again, review the plan or goals that were set. Write down this plan for your client and document it in their record to follow up at the next appointment.

C. Referral to Mental Health Treatment

IRC Mental Health Coordinator: Oversees all mental health-related efforts for newly arrived refugees resettled by IRC-SLC including implementing mental health screening and referral for newly resettled refugees, coordinating intakes and follow-ups, facilitating staffing meetings with mental health providers, and acting as the primary reference point within the IRC office for mental health related activities and concerns.

CCS Mental Health Coordinator: Coordinates, oversees and manages mental health services for the Refugee Resettlement program. Reviews the mental health assessments performed during the initial health screening; conducts assessments three months and one year after arrival. Refers clients to and schedules clients with the appropriate mental health provider. Educates and trains medical interpreters and other CCS staff about mental health services and trauma-informed care. Manages all record-keeping aspects of mental health services.

C.1 Referral from Initial Health Screening - St Marks / Utah Health Clinic / Utah Partners for Health

1. If a client screens negative on the RHS-15 at the initial health screening, resettlement agencies (IRC/CCS) provide a 3-month RHS-15 to the client (**Section A**).

2. If a client screens positive on the RHS-15 at the initial health screening, but ***declines a referral*** to mental health treatment, the health clinics should report this in the clients RHOS file (**Section B.2**) and resettlement agencies (IRC/CCS) will provide a 3-month RHS-15 to the client (**Section A**).

3. If a client screens positive at the initial health screening, and ***accepts a referral***, the healthcare professional providing the screening will enter this information into RHOS. This information will include:
    a. Screening Done (Y/N)
    b. RHS-15 Scores (For 14+ years)
        i. For clients <14 years ask parent, "Do you think your child has difficulties with emotions, concentration, behavior, or getting on with other people"?
    c. Check mark any of the following conditions as identified:
        i. Anxiety (Signs/Symptoms)
        ii. Depression (Signs/Symptoms)
        iii. History of Torture/Violence
        iv. Dr. Discretion
    d. MH Other - Provide any comments and additional information

of client's mental health concerns here.

e. Severity (if applicable, select one of the following)
   i. Mild
   ii. Moderate
   iii. Severe

f. Initial MH Referral Accepted (Checkmark if client accepts MH referral)

g. If initial MH referral rejected, why?

i. Please answer this for all clients, with an explanation of why that client rejects MH referral or services.

h. Referral Agency

i. Screening clinics select which clinical MH agency to refer the client to, depending on history/signs/symptoms and attach the referral under the "Attachments" tab in RHOS.

4. The Mental Health Coordinator at CCS and IRC will assist in the referral coordination component.
(C.2 and C.3).

C.2 Referral to AAU

1. The Mental Health (MH) Coordinator at IRC/CCS will check the RHOS report under Agency - MH Dashboard to identify any clients who screened positively and accepted a referral at the initial health screening.

2. The Mental Health (MH) Coordinator at IRC/CCS will contact Amy Vu via encrypted email (Amy.Vu@aau-slc.org) with a referral request. This request should include:
    a. Client Name:
    b. Date of Birth:
    c. Gender:
    d. Alien ID:
    e. Country of Birth and US Date of Arrival:
    f. Medicaid (if applicable):
    g. Language:
    h. Address:
    i. Phone Number:
    j. RHS-15 Score and identified Mental Health Symptoms/Reason for Referral:
    k. Transportation Needs:
    l. Interpretation Needs:
    m. Other Information (client requests, etc.):

3. AAU has 5 business days to respond to the resettlement agencies with 2 MH intake date/time options.

4. After dates/time options are provided, IRC/CCS have 3 business days to work with the client to select an appropriate date.
    a. If the intake appointment needs to be rescheduled, IRC/CCS must alert AAU 2 days in advance, if possible.

5. AAU will provide email confirmation with the MH Coordinator at IRC/CCS that the MH intake date/time are scheduled.
    a. Upon confirmation, AAU will schedule interpretation services for the MH intake appointment, if needed.

6. The MH Coordinator at IRC/CCS will coordinate transportation needs for the client to the MH intake appointment, and for any ongoing MH treatment appointments.

7. On the day of the MH intake appointment, the MH Coordinator at IRC/CCS will provide a warm handoff confirmation via phone call, in-person, or telehealth conferencing with the client to help ensure

attendance.

8. After initial MH intake, AAU will have 3 days to alert the resettlement agency of follow-up/ongoing appointments.
    a. Resettlement agencies will aid in transportation coordination for continuing appointments during the duration of the 2-year active case management services, as needed.
    b. AAU will be responsible for coordinating needed interpretation services for continuing appointments.

9. AAU will provide monthly communication about client retention and needed support to the resettlement agency (i.e. assistance with reaching the client).

C.3 Referral to UHHR

1. The Mental Health (MH) Coordinator at IRC/CCS will check the RHOS report under Agency - MH Dashboard to identify any clients who screened positively and accepted a referral at the initial health screening.

2. Resettlement agency contacts UHHR via a referral website (https://www.uhhr.org/referral) with a referral request. This request should include:
    a. Client name, age, gender, ethnicity, country of origin, language
    b. Client contact information: address, phone number,
    c. Indication of referral agency (IRC/CCS)
    d. Client RHS-15 score, and any identified mental health symptoms.
    e. Other information, including interpretation and transportation needs.

3. UHHR has 5 days to respond to the resettlement agencies with 2 MH intake date/time options.

4. After dates/time options are provided, IRC/CCS have 3 business days to work with the client to select an appropriate date.
    a. If the intake appointment needs to be rescheduled, IRC/CCS must alert UHHR 2 days in advance, if possible.

5. UHHR will provide email confirmation with the MH Coordinator at IRC/CCS that the MH intake date/time are scheduled.
    a. Upon confirmation, UHHR will schedule interpretation services for the MH intake appointment, if needed.

6. The MH Coordinator at IRC/CCS will coordinate transportation needs for the client to the MH intake appointment, and for any ongoing MH treatment appointments.

7. On the day of the MH intake appointment, the MH Coordinator at IRC/CCS will provide a warm handoff confirmation via phone call, in-person, or telehealth conferencing with the client to help ensure attendance.

8. After initial MH intake, UHHR will have 3 days to alert the resettlement agency of follow-up/ongoing appointments.
    a. Resettlement agencies will aid in transportation coordination for continuing appointments during the duration of the 2-year active case management services, as needed.

   b. UHHR will be responsible for coordinating needed interpretation services for continuing appointments.

9. UHHR will provide monthly communication about client retention, and needed support to the resettlement agency (i.e. assistance with reaching the client).

Appendix I: RHS-15 Screening Tool and SDQ Impact Supplement Tool

The RHS-15 has 14 questions and a distress thermometer. The SDQ Impact Supplement is one initial question, asked to parents for refugees under the age of 14. If the response to the initial question is "*yes*", the individual providing

---

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODER-ATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

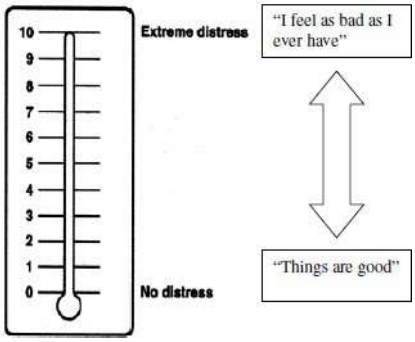
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

14. Generally over your life, do you feel that you are:

Able to handle (cope with) anything that comes your way 0
Able to handle (cope with) most things that come your way 1
Able to handle (cope with) some things, but not able to cope with other things.....2
Unable to cope with most things.....3
Unable to cope with anything 4

the screener will administer the four additional questions.

FIRST: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Appendix II: Referral and Communication Forms

AAU Referral:

To contact AAU send the following in an encrypted email to Amy Vu (Amy.Vu@aau-slc.org):

"To Whom It May Concern:

I am referring (clients name) for clinical services at AAU. (Clients Name) RHS-15 score and identified mental health symptoms indicate further clinical services would be beneficial. Please see below for further information regarding the client.

- *Age, gender, ethnicity, country of origin, language.*
- *Client contact information: address, phone number.*
- *Indication of referral agency (IRC/CCS).*
- *Client RHS-15 score, and any identified mental health symptoms.*
- *Interpretation needs.*
- *Transportation needs.*
- *Other information.*

I look forward to hearing from you regarding appropriate dates and times for a scheduled mental health intake appointment."

UHHR Referral

To contact UHHR, provide the following information via the referral website https://www.uhhr.org/referral

- *Age, gender, ethnicity, country of origin, language.*
- *Client contact information: address, phone number.*
- *Indication of referral agency (IRC/CCS).*
- *Client RHS-15 score, and any identified mental health symptoms.*
- *Interpretation needs.*
- *Transportation needs.*
- *Other information.*

Appendix III: Clinical Treatment Options

Asian Association of Utah (AAU):
AAU provides culturally and linguistically responsive mental health and substance use disorder services, case management, and medication management services to refugees, immigrants, asylees, and victims of human trafficking. Clinicians use evidence-based therapeutic approaches tailored to each client's unique needs. AAU works with clients with adjustment disorders, depression, anxiety, post-traumatic stress disorder, severe chronic illness, etc. AAU also provides counseling to survivors and perpetrators of domestic violence. A full list of services is below:

- Outpatient mental health, substance use, and domestic violence services
- Qualified clinical support using evidence-based methods.
- Language interpreting services
- Individual and group psychotherapy
- Individualized case management
- Medication management

Utah Health and Human Rights (UHHR):
UHHR is the only organization in Utah to provide co-located and highly specialized mental health, medical, legal, and case management services to refugees and asylum seekers who have survived torture and severe war trauma. UHHR's one-stop, wrap-around program model affirms the widely held belief that survivors of human rights abuses benefit most from low-barrier, integrated services. A full list of services is below:

- Individual psychotherapy
- Group psychotherapy and psychoeducation
- In-house psychiatric clinic
- Medical assessment and advocacy
- Case management
- Legal representation for torture survivors seeking asylum.

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

Refugee Health Screener-15 (RHS-15)

English Version

Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.

DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

_____ Gender: _____ Date of Arrival: _____

_____ Health ID: _____ Administered by: _____

_____ Date of Screen: _____

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

ID#

DATE

REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS

INSTRUCTIONS: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	*NOT AT ALL*	*A LITTLE BIT*	*MODERATELY*	*QUITE A BIT*	*EXTREMELY*
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

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ID# _____

DATE _____

REFUGEE HEALTH SCREENER-15 (RHS-15)

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

SYMPTOMS					
10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

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REFUGEE HEALTH SCREENER-15 (RHS-15)

ID#

DATE

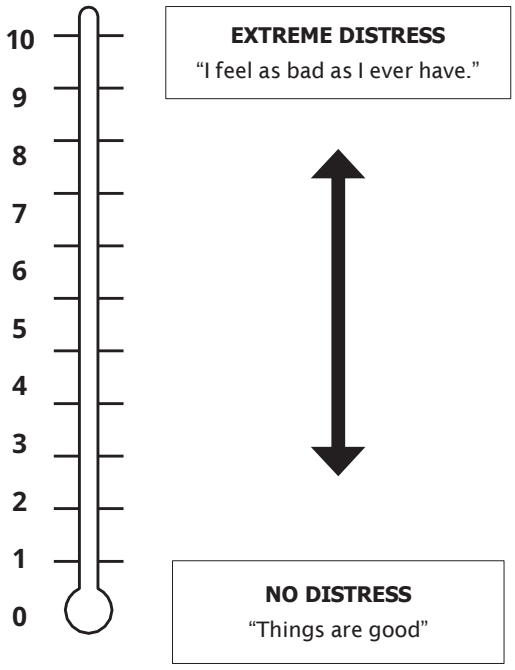
PATHWAYS TO WELLNESS

14. Circle the one best response below. Do you feel that you are:

Able to handle (cope with) anything	**0**
Able to handle (cope with) most things	**1**
Able to handle (cope with) some things, but not able to cope with other things	**2**
Unable to cope with most things	**3**
Unable to cope with anything	**4**

Add Total Score of items 1–14

15. Distress Thermometer



Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

SCORING SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

CHECK ONE: ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

HEALTH WORKER MANUAL: ADMINISTERING THE RHS-15

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.

Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

Table of Contents

This manual is designed for healthcare workers (health workers, doctors, support staff, social workers, humanitarian workers and interpreters) who will be administering the Refugee Health Screener-15 (RHS-15). The information in this manual should be viewed as general guidance and is

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intended to be adaptable to the local conditions and screening processes in your community.

History of the Pathways to Wellness Program

In King County, Washington, refugee service providers, resettlement agencies and community leaders, meet regularly to discuss issues and share resources. Over the years, the conversation frequently turned to refugee mental health. Given the trauma and loss refugees experience it was not surprising that many people around the table were seeing unmet needs in their clients and in their community, specifically around depression and traumatic stress. In 2009, a coalition formed between Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield to better address the mental health needs of refugees.

As refugee mental health continued to be discussed, there was a consensus that:

- Refugees with high distress needed to be found early before they were in crisis
- Any screening must consider the particular cultural understanding of mental health
- There should be rigorous evaluation so that it would provide a firm foundation for evidenced- based practice

Thus, *Pathways to Wellness: Integrating Refugee Health and Well-Being* was created. The vision of was to provide early screening and detection of emotional distress for newly arrived refugees.
Pathways created a culturally specific, short screening tool, the Refugee Health Screener-15 (RHS- 15), which detects symptoms of anxiety and depression in refugee populations from different countries.

The Refugee Health Screener-15 was developed in partnership with refugee communities and a renowned psychiatrist, and utilized a rigorous back-and-forth translation process to ensure that it asked the right questions in the right ways according to language and culture. The result is a culturally-appropriate, short screening instrument that detects symptoms of anxiety and depression in refugee

populations from different countries.

The RHS-15 was field-tested by public health workers in a community health setting. Currently the screener is available in Arabic, Karen, Burmese, Russian, Nepali, and Somali languages, representing some of the largest refugee groups currently being resettled into the United States (Iraqi, Burmese,

former Soviet Union, and Bhutanese). We have also produced Farsi, Amharic, Swahili, French, Cuban Spanish and Tigrinya versions.

The RHS-15 is just one component of the screening process. Pathways' also translated referral scripts in target languages to aide health providers in offering appropriate support. The RHS-15 is designed for refugees aged 14 and older and designed to be used in the target language.

TOPIC AREA: Setting the Context of the RHS-15

Please refer to the Clinic Script HANDOUT: 1 at the end of this manual.

Tips for Providers:
Setting the Context

- Let the patient know what to expect
- Discuss confidentiality in concrete terms
- Emphasize resources available
- Reassure patients that their answers will not impact their resettlement or immigration status

STEP-BY-STEP GUIDE FOR ADMINISTERING THE RHS-15

STEP 1: INTRODUCE THE RHS-15

- At the beginning of the health screening visit, the worker should explain what will happen during the visit, including any review of medical history, heights and weights, blood draws, immunizations, etc.

- The health worker should add that the last part of the visit also involves questions about how they are doing both in their body and in their mind.

The Health Worker states:

"In addition to blood draws, medical review, etc., your visit today will involve questions about how you are doing ***both in your body and in your mind.****"*

STEP 2: RE-INTRODUCE THE RHS-15

- When you get to the part of the visit where you will be administering the RHS-15, re-introduce it.

The Health Worker states:

"This is the part of the visit where we ask you questions about how you are doing both in your body and in your mind. Some refugees have mind and body symptoms because

of the difficult things they have been through, and because it is very stressful to move to a new country. The questions we are asking help us find people who are having a hard time and who might need extra support. The answers are not shared with employers, USCIS, teachers, or anyone else without your permission."

STEP 3: EXPLAIN THE INSTRUCTIONS

- Review the instructions by stating,

"On this paper is a list of symptoms. We are asking you to mark the degree that the symptom has been bothersome to you over the past month, or 30 days. Each question has a scale beside it that goes from "not at all" to "extremely." For example, in the past 30 days, you may have been crying every day, a few times, or not at all. We are asking you to place a mark in the column that shows how much you have been having that symptom in the last month or 30 days. Again, if the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

STEP 4: ADMINISTER THE RHS-15

- Only use the questions on the tool; don't make any additions or deletions.
- Don't comment on the patient's responses. You may affirm their statement by saying, "OK" or nodding.
- Reference the scale by pointing to the responses for both literate and non-literate patients. Re-explain the scale as necessary (for the first few questions you might have to list each answer as a possibility).
- Introduce question 14 by explaining that this question has different answers, and that the patient will need to listen to you read each possible answer before answering.
- While the patient is completing the questionnaire look for errors or non-completed items. If you find errors or non-completed items, wait until the patient has completed the questionnaire he/she is working on, and then ask them to complete unanswered questions, or make sure they understood the instructions.

Important Note: It is necessary that patients understand that they should do their best in answering, but that they also need to work through the questions rather quickly and not get too worried about having the "perfect" answer. It is also important that they understand that the questions on the RHS-15 should be completed in the order that they are given. After the patient has completed the questions and you have checked each one, proceed to scoring using the scoring box.

Key Discussion Points:

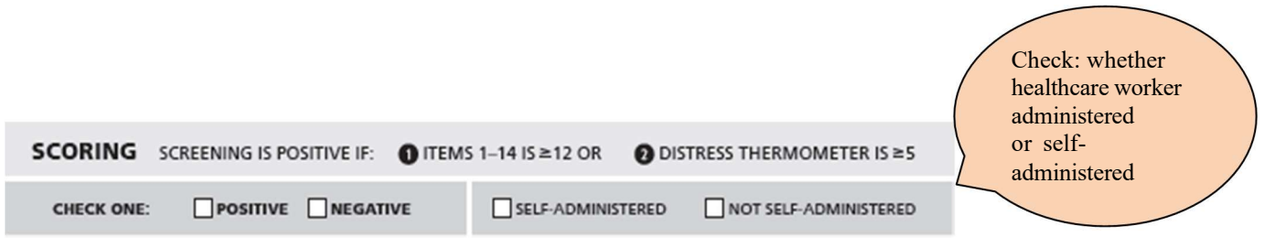
- ✓ *The healthcare worker reminds each person to answer the questions by themselves. However, they can ask for help from the healthcare worker and the interpreter if they cannot read them or find the answers confusing.*

- ✓ *Because of the high burden of traumatic experiences refugees face their experience and symptoms need to be normalized. It is common for refugees to experience these types of symptoms of emotional and physical health. This can be facilitated by referring back to common symptoms of emotional distress such as, crying easily, having too many thoughts, painful memories from the past, etc.*

- ✓ *The health worker explains that the answers to this health questionnaire, like all other components of their health visit will not be shared without their permission. Answering questions on the RHS-15 will not impact the patient's resettlement or immigration status.*

TOPIC AREA: Scoring the RHS-15

STEP 5: SCORE THE RHS-15



Directly after a patient completes the RHS-15 proceed to scoring the screener

- After the patient completes the RHS-15, score the answers in the scoring box on the last page of the RHS-15.

    1. **Total the item score for items 1-14. If they have a <u>score of 12 or greater</u>, they are considered "POSITIVE."**

    2. **<u>Note:</u> the number circled or marked for question 15.**
        - **If the client/patient circles a <u>5 or greater</u>, they are considered "POSITIVE." *A positive score means they may be experiencing symptoms of anxiety and/or depression and a referral is needed.***

    Then, circle if the patient's screen is **NEGATIVE** or **POS**

    IF POSITIVE, proceed to offering a referral

<u>Note</u>
<u>:</u>

- If a healthcare worker assisted with administering the tool check, "not self-administered"
- If the patient/client completed the tool without assistance you would mark, "self-administered."

- IF A PARTICIPANT HAS AN IMMEDIATE CLINICAL NEED, PROCEED TO THE CLINICAL PROTOCOL. INTERPRETERS MAY BE ASKED TO HELP MAKE A REFERRAL PHONE CALL OR IN PERSON OFFER.

- **IF SOMEONE IS CLEARLY EXPERIENCING PSYCHOTIC SYMPTOMS, PRESENTS AS VERY DISTRESSED (SOBBING, ETC.), OR HAS AN OVERSEAS MEDICAL EXAM NOTING MENTAL HEALTH CONCERNS, IT IS NOT NECESSARY TO ADMINISTER THE RHS-15. PROCEED DIRECTLY TO REFERRAL.**

If the score is negative: *"Your answers seem to show that you are not experiencing too much stress, sadness or worry right now. However, there are counselors available at* ***{X agency, CBO, healthcare center, etc.}*** *if you want to talk to someone about the symptoms you are experiencing. Is this something you would be interested in?"*

If client does not want to be referred: *"That is OK. Please know that the counselors are here if you change your mind. You can always ask your case manager or your doctor for help with getting connected to a counselor. "*

TOPIC AREA: Offering Referral Support

Please refer to Referral Script, HANDOUT: 2 at the end of this manual

*If someone has a **positive score on the RHS-15** (scored **12 or above** on the symptoms **OR** a **5 or greater** on the Distress Thermometer) on the RHS-15, refer him or her for additional emotional support.*

1. **Offer support by referring back to the symptom items on the RHS-15**
   "Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country."

2. **Normalize their experience**
   "Lots of people who have been through what you went through have these symptoms. Sometimes people need extra support to help them through a difficult time."

3. **Educate and re-emphasize**
   "In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy…….A counselor in the United States is a type of healthcare worker who will listen to you and provide help and support.

4. **Allow all decisions to be self-determined**
   "Are you interested in being connected to support services?"

Key Discussion Points

- ✓ *It may be challenging for refugee clients to accept support over the phone.*
- ✓ *Many persons are not used to telling problems to strangers and would prefer a relationship- based approach to knowing what services are available to them.*
- ✓ *For this reason, a healthcare worker may have to help them connect to a referral as opposed to giving them a sheet of paper or asking the patient/client to call a particular number.*

TOPIC AREA: Different Learning and Literacy Needs

The health worker or administrator of the screening instrument should work to identify any specific learning needs of the patient so as to deliver the most effective healthcare information and education possible.

Supporting Pre-literate Patients

- Repeat instructions, ***"How much in the last month or 30 days have the symptoms below been bothersome to you"…{symptom: crying easily, too much thinking, etc…}***

- Review the scale, "none, a little, moderately, quite a bit, extremely." It may be helpful to point to the numbers for the scale, and create a visual aid (see Appendix B) that shows patients the difference in the amount.

Health Providers Tips:
Pre-literate patients

- Speak slowly and clearly
- Position yourself close to the patient and read items out-loud
- Check that patient understands, ask if anyone has any questions
- Remind each family member to answer their own questions individually

Supporting Literate Patients

- Do not assume the patient does not want interpreter assistance, offer interpretive services at the beginning of the screening, and again if the client seems to be having difficulties

Do not assume that a patient is literate in his or her native language or the national language of his or her country of origin

- Review with the patient the instructions on the RHS-15 ***"How much in the last month or last 30 days have the following symptoms below been bothersome to you"***

- Review with the patient the scale on the RHS-15 "none, a little, moderately, quite a bit, extremely." It may be helpful to point to the numbers for the scale to emphasize frequency and the amount of how much the symptom has bothered them.

TOPIC AREA: Assuring Healthcare Workers

Healthcare workers can be assured that patients/clients who are experiencing emotional distress will not be harmed by completing this type of screening. The *Pathways* team highly recommends the use of the RHS-15 in settings where there are adequate resources to conduct and score the screening, and to develop a source and method of referral for further diagnosis and treatment.

REMEMBER:

1) Asking these questions can identify someone who needs support and help get them connected to needed care.

2) Screening is the **vehicle** that connects someone to a more comprehensive evaluation and treatment support.

3) The healthcare team is the **link** that connects the client to this resource.

It is very unlikely that asking about symptoms of anxiety, depression or PTSD will cause someone to decompensate or to be triggered emotionally to the extent that is would make it difficult for them to get through the questionnaire. However, health and community resettlement sites should have in place a protocol (community or clinically-based) for emergent care should someone need immediate healthcare in any area – whether it be mental or physical.

Key Points

- ✓ *Offering screening is not diagnostic---a screen with good psychometric properties is the first tier in the diagnostic process.*

- ✓ *When considering local conditions in your community, determine what available resources there are should someone need emergent care.*

- ✓ *In Pathways' experience, clients express relief about being asked about how they are doing. Some clients may cry or show distress, but do not decompensate to the point where this is an issue.*

- ✓ *It is a recommended to have a crisis referral in case a client does decompensate*

TOPIC AREA: Setting the Context
Different Case Scenarios

For this section please refer to HANDOUTS 3-5 at the end of this manual for scripted role plays.



Below are three common examples of incorporating mental health screening for new arrival refugees during their initial health screening exam in the United States. Health trainers are encouraged to facilitate the following examples as role play activities to enhance and optimize the learning experience for those administering the RHS-15. The scenarios can be used to elicit typical situations that may occur, guide health workers through suggestions with practice recommendations of how to best handle them.

All case scenarios are composed of fictional characters. All names and descriptions are for educational purposes only, and are not composed of real patients.

Case Study 1:
Family from Burma-Interpreter Assisted

A Karen refugee family of 9 from Burma is preparing to take the RHS-15. Five family members are aged 14 or older and the remaining are children. Three children are upset and crying from receiving immunizations. The family has difficulty in reading and writing in English or their native language. An interpreter speaking their Karen dialect is present for their screening.

Case Study 2:
Nepali Bhutanese Family-Self-Administered

Kanak and his family can read in the Nepali language.

CONSIDERATIONS

What is a good strategy to begin the session?

How may we address this in the time permitted?

What resources or tools are available?

His son Tarun can also speak some English. They come from Bhutan, where ethnic-Nepali people were forced from their homes and fled to neighboring countries as a result of ethnic cleansing by the Bhutanese government. The Nepali Bhutanese have spent almost twenty years in refugee camps in Nepal before being resettled into other countries such as the United States.

A family member is triggered emotionally-the patient wants to talk and starts to share with you a story about something traumatic that has happened to them. Other family members need assistance on questions that follow.

Case Study 3: Family from Somali-Non-literate client/ patient

Hawa and her family of 4 arrived last week from Kenya. It appears that two of the family members can read, but the others are not literate in their native language. Hawa can't read or write in English or her native language (Somali). The healthcare worker and the interpreter are having a hard time knowing how to get started. It is noted in their overseas IOM report that two of the children got separated from their mother when they were fleeing to the Kenyan border. They were eventually reunited at the refugee camp. Through the interpreter, you learn that their father was killed, and family members reported witnessing this event.

TOPIC AREA: Understanding An Interpreters Role in Administering the RHS-15

What is Interpretation?

Interpretation involves much more than the exchange of two languages. Interpretation entails creating a bridge between two or more cultures. Interpreters often see and understand best the differences in different cultural frameworks.

- ***Interpretation*** conveys the oral meaning behind language and culture, whereas ***translation*** coveys the written form of this expression.
- Interpretation is a cultural exchange as much as it is a language exchange.
- While there may be uniquely different individual, linguistic or cultural beliefs surrounding the meaning as it is expressed in a given language, interpreters are key to communicating an equivalent version of the original message.

The Role of an Interpreter

Interpreters support the healthcare team in delivering quality and culturally responsive healthcare. Interpreters maintain confidentiality by never discussing things spoken, observed, or heard during an interpreted encounter with other people, such as family, friends or community members. Just as with all health professionals, there are serious circumstances where confidentiality may need to be broken in order to support the patient. Interpreters are encouraged to seek ongoing consultation and confidential supervision with someone that understands cross cultural interpreting and ethical considerations.

There are four main roles interpreters often have interpreting in healthcare settings:

- **Conduit:** transmits everything as it spoken
- **Cultural broker:** providing the necessary framework for understanding the message being transmitted.
- **Clarifier:** changing the form of the message, in order to preserve the intent and meaning of the message
- **Advocate:** taking action on behalf of either the patient or the provider outside the bounds of the interpreted encounter

Note regarding Community Health Interpreting: Offering referral support may best come from those closest to the individual. Many interpreters are active in their

communities already providing traditional mechanisms to offer critical support services and may have developed language that is helpful in reducing stigma around entering mental healthcare. Similarly, interpreters may have very different views about mental health and mental illness in general. Stigma around accessing outside support may exist.

TOPIC AREA: Working with an Interpreter

Structuring the Interpreted Encounter

Taking time, before, during and after an interpreted session allows clinicians, health providers and interpreters the chance to collectively problem solve, creates avenues for adequate preparation and ongoing communication which can reduce greater chances of cross-cultural miscommunication.

- **Pre-session**- is a helpful way to inform the interpreter or health worker about what to expect.

    a. This allows the interpreter time to know what to anticipate for the visit.

    b. This allows the health worker the chance to obtain additional cultural information that could improve the relationship and complete the screening visit.

    c. If the interpreter knows the person or has a previous relationship this should be disclosed to the health worker.

HEALTH PROVIDER TIPS

- Always address the patient(s) directly.
- Speak in short clear sentences.
- Ask only one question at a time.
- Always allow enough time for the interpreter to interpret, and for the patients to answer.
- If you feel that more is being said or interpreted than what you wanted to convey, stop to clarify the side-conversation. Remind the interpreter to interpret everything that the family said or asked to you, too, even if the question was meant for the interpreter.
- Encourage the interpreter to use the “I”/”we” form when interpreting what the patient says.
- Be ready to reformulate what you said in different words to help everybody understand what you mean.

- **Screening Session-** Interpretation assistance during the screening visit entails supporting literate patients in self-administering the RHS-15 or supporting pre-literate patients with language assistance using the language as it has been translated on the bi-lingual or native language version of the RHS-15.

To avoid common pitfalls, the healthcare worker can prompt the interpreter to:

a. Position themselves next the patients to prevent having to "tennis match."

b. Discuss interpreter and healthcare confidentiality in detail.

c. Establish that anything that anyone says will be interpreted.

- **Post Session-** Taking time to debrief with the interpreter allows for additional cultural information that could have helped the patient. It is possible that the health worker may not be familiar with the physical symptoms the patient expressed, and how these may be connected to the patients' emotional wellbeing. In interpreter plays an important role in clarifying this information on behalf of the patient/client.

HANDOUT 1: CLINIC SCRIPT

HOW THE Refugee Health Screener-15 (RHS-15) IS INTRODUCED TO REFUGEE PATIENTS:

At the beginning of each health screening visit, the worker should explain what will happen during the visit, including any medical history review, height and weights, blood draws, immunizations, etc. The health worker should add that the last part of the visit also involves questions about how they are doing both in their body and in their mind. These questions are about sadness, worries, body aches and pain, and other symptoms that some people get that are related to bad experiences, stress at home, or travel to a new country.

It is important that this portion is seen as another part of the overall medical screening.

After immunizations have been administered, the worker hands out the RHS-15, and reminds the family that this is the last part of the visit and tells them that he would like each person (over 14 years of age) to answer the questions. The healthcare worker will assist in determining if the patient is able to self-administer, or if they will need assistance completing the RHS-15.

RHS-15 INTRODUCTION: (Suggested Script)

"Some refugees have mind and body symptoms because of the difficult things they have been through, and because it is very stressful to move to a new country. The questions we are asking help us find people who are having a hard time and who might need extra support. Your answers are not shared with employers, USCIS, teachers, etc."

The healthcare worker reminds everyone that each person will answer the questions by themselves, but that they can ask for help from the interpreter if they cannot read them or find the answers confusing. The healthcare worker explains how to answer the questions (only pick one number for each symptom, for example) and encourages everyone again to ask for help if they need it.

It is hoped that this approach puts the family at ease and normalizes the screening tool as a regular component to their

overall
health-
screening
visit.

HANDOUT 2: REFERRAL SCRIPT

This document may help you implement the Refugee Health Screener- 15 (RHS-15) in your health clinic.

TIMING
Referral for more support is offered directly after the health worker has completed the scoring of the RHS-15. If a patient has screened at or above the cut-off scores as indicated on the RHS-15, we recommend proceeding directly to completing a referral.

REFERRAL OFFER: (Suggested Script)"

"From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counselor. This is a type of healthcare worker who will listen to you and provide help and support. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?"

IF CLIENT AGREES TO SERVICES: (Suggested Script):

"Can we take a couple of minutes to complete our referral form? I will refer you to an agency and they will be contacting you, is this okay with you. Someone will call you in your language and describe the type of support they can offer you. They will call you in the next few days to give you the appointment date and location of the appointment so you can find out if it is the right service for you."

Notes from conversation: _____

_____

HANDOUT 3

CASE SCENARIO 1: KAREN FAMILY

This case scenario is composed of fictional characters. The names and descriptions are for educational purposes only, and are not composed of real patients and their experiences.

- A Karen refugee family of 9 from Burma is preparing to take the RHS-15. Five family members are aged 14 or older and the remaining are children. Three children are upset and crying from receiving immunizations.
- The family has difficulty in reading and writing in English or their native language.
- An interpreter speaking their specific dialect is present for their healthcare visit.

    - ***What is a good strategy to begin the screening session?***
    - ***How may address this in the time permitted?***
    - ***What resources or tools could help the situation?***

Characters:

- Health worker
- Interpreter
- Family of nine:
    - Father: Hte Bu Reh (43)
    - Mother: Di Di Paw (39)
    - Daughter: Ti Bu (17)
    - Son: Poe Reh (16)
    - Son: Sha Reh (15)
    - Daughter: Theh Mar (12)
    - Crying children: son: Heh Reh (5), daughters: Plar Mar (4) and Htoo Lar (2)

Health worker: ***Toward the end of our screening visit today we will ask you some questions about symptoms that some people get that are related to bad experiences, stress at home, or travel to a new country.***

Health worker: ***Our goal is to find out if you need help for any of these symptoms. Your answers are not shared with employers, USCIS, teachers, or others.***

Health worker: ***But before we start it, I see some little people here in need of some immediate comfort.***

Health worker: ***I have something for you, children, as a sign that you have been brave enough today to get your immunizations.*** (Interpreter assists the Health worker by translating and motioning for the children to remain calm and await something that the Health worker is bringing them).

Interpreter: interprets the same to the family/Health Worker after each party speaks.

Health worker brings over the sticker box/ small toy box of the office, says: ***Each of you can pick one of these (stickers/ toys). Heh, you may come over here and pick first.***

RATIONALE: As the older child Heh is more likely to have the courage and initiative to approach the health worker, and to model the right behavior for his younger sisters. Making it sound like a favor is apt to make the children more willing to take advantage of the opportunity. Children are curious, so they approach the box and forget about their tears in the search for the best prize. The younger ones may need an older person to accompany them, as they may be shy of grown-ups. The children may return to their parent's embrace/ lap, looking for comfort.

Health worker (addresses parents and older children)**:** ***In addition to your blood draws and physical exams, your visit today includes some questions of how you are doing both in your body and in your mind.***

[When it is time to administer the RHS-15, the health worker introduces it again]

Health worker: ***This is the last screening we do today, and it is meant only for those of you who are 14 years or older. The children are encouraged to play in the area near the books now.***

Health worker: ***Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country.***

Health worker: ***In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy.***

Health worker: ***Sometimes people need help through a difficult time. You can say yes or no to this support. Do you have any questions?***

Family nods and has no questions.

In order to help manage the younger children, the Health worker may suggest this: ***All of you who are younger can also help with this screening. You can either draw or look at books over at the children's area.*** (distributes blank paper and pencils/ crayons to the younger children). The health worker can provide a different space for the children to work, thus freeing up the parents for the upcoming mental health screening.

Health worker: ***Let's begin the screening. I will ask you one question at a time, and the interpreter will interpret it for you.***

Health worker: ***If you cannot write your own answer to this question, I will write down what the interpreter tells me you answered [***or**: **with your permission the interpreter will write down the answer you give him or her].***

Health worker: ***Please choose your very own answer to each question, as we want to be able to help all family members who need it.***

Health worker: ***Each of the questions I will ask you can have only one answer, and you can choose, where you feel you are, from "not at all"*** *(*points to the empty jar/ picture*)* ***to "very much/ extremely"*** (indicates overflowing jar*).* Health Worker gives more instructions about the scale on the screen, pointing to the chart and visually describing the same.

HEALTH PROVIDER TIP

Depending on your screening setting, it may be appropriate to separate family members (including spouses), or to keep them together during the screening. Importantly, because the RHS-15 is not designed for ages 14 and younger, it is recommended that arrangements for privacy for these family members are made while others complete the screening.

Health worker: ***All these questions are related to problems that may have been bothersome to you during the last month, including today***. (Interpretation).

Healthcare worker then administers the questionnaire. The screener repeats each question and waits for the interpreter to interpret and convey the meaning of the question to the family. Answers are written down after giving each individual the chance to express their own answer to that question.

During the screen, the mother describes the following symptoms: too many thoughts, heart beats fast, muscle aches and frequent headaches. The patient discloses that she has taken some medications for regulating her sleep.

Hte Bu Reh, the father, responded to feeling restless and sad, doing too much thinking, being jumpy, and only being able to cope with some things that come his way.

After administering the questionnaire/ reviewing the answers of the family, the Health Worker addresses the parents. **Health worker:** ***Di Di Paw and The Bu Reh, it seems you***

are going through some difficulties (may reiterate symptoms listed on the screen for each of the patients). ***Like I mentioned before, we have resources that can help you deal with the symptoms you are having***.

[The health worker and Interpreter refer to their referral script]

Health worker: ***From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country.***

Health worker: ***In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support.***

Health worker: ***This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time.***

Health worker: ***I would like to connect you to a counselor. This is a type of healthcare worker who will listen to you and provide help and support.***

Health worker: ***This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement.***

Health worker: ***Are you interested in being connected to these services?***

After a short time taken to confer among each other, the parents make a decision.

Father: ***Yes, please. Thank you for your help.***

The Health worker states: ***Can we take a couple of minutes to complete our referral form? I will refer you to an agency and they will be contacting you. Is this okay with you?***

Parents: ***Yes.***

Health worker (completes the referral form and says): ***Someone will call you in your language and describe the type of support they can offer you. They will call you in the next few days to give you the appointment date and location of the appointment so you can find out if it is the right service for you.***

HANDOUT 4

CASE SCENARIO 2: NEPALI BHUTANESE FAMILY

This case scenario is composed of fictional characters. The names and descriptions are for educational purposes only, and are not composed of real patients and their experiences.

- Nepali Bhutanese Family is completing a self-administered screen.
- Kanak and his son Tarun can also speak some English. A family member is triggered emotionally and he wants to talk and starts to tell you a story about something that has happened to his family. Other family members need assistance on questions that follow.

    - ***What is a good strategy to begin the screening session?***
    - ***How may you address this in the time permitted?***
    - ***What resources or tools could help the situation?***

Characters:

- Health Worker,
- Interpreter,
- Family of three:
    - Husband: Kanak Pradhan
    - Wife: Abhaya Pradhan
    - Son: Tarun Pradhan, 16 years old

Health worker: ***Toward the end of our screening visit today we will ask you some questions about symptoms that some people get that are related to bad experiences, stress at home, or travel to a new country.***

Health worker: ***Our goal is to find out if you need help for any of these symptoms. Your answers are not shared with employers, USCIS, teachers, or others.***

Interpreter: interprets the same to the family/Health worker after each party speaks.

Family nods and has no questions.

Health worker: ***Great! Let us start with the screen.***

Health worker: ***All of the questions I will ask you have one answer and are related to problems that may have been bothering you over the last month, including today.***

Health worker: ***Each of you will answer the questions by yourselves, based on your own experience. You can ask for help from the interpreter if you cannot read or if you don't understand the question.***

Health worker: ***Using the scale beside each symptom (show the scale), please indicate the degree to which the symptom has been bothersome to you over the past month including today.***

Health worker: ***Please place a mark in the appropriate column (show the options in the questionnaire). If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL" (point to questionnaire).***

Health worker: ***Just one more reminder. You should do your best to answer the questions quickly in the order that they are asked, but do not worry about if they are right or wrong. Do you have any questions?***

Family begins filling out the screening.

Kanak (husband) finishes first and hands to the Healthworker, who looks it over.

Abhaya (wife) (speaks to interpreter, then speaks in English)**:** ***I don't understand what this is (pointing to the distress thermometer).***

Tarun (son speaks in English): ***Is this to say how sick you are?***

Health worker *(to Abhaya and Tarun)****: I will address your questions in just a moment. I need to ask Kanak a question first.***

Health worker (to Kanak)**:** ***It appears from the screen that you are having some symptoms that are difficult for you.***

Interpreter (for Kanak): ***Yes, the way I feel makes it difficult to do things I need to do – like going to English class, riding the bus, etc….it is too much stress and worry right now……I think about all of this and I have to cry, and I can't think about anything else. This is when I am sweating and my heart is beating fast.***

Kanak puts his head in his hands. Family is now very silent and Abhaya is gazing down.

Health worker (to Kanak)**:** ***I am so sorry that happened to you. (Interpreter; silence allowed). Problems with sweating a lot and your heart beating fast are very difficult. I want you to know there is support for these symptoms you are having.***

Husband nods.

Health worker (to Kanak)**:** ***As I mentioned before, we have resources that can help you deal with the symptoms you are having.***

[The Health worker refers to the referral script]

Health worker (to Kanak)**:** ***From your answers on the questions, it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counselor. This is a type of healthcare worker who will listen to you and provide help and support.***
This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement. Are you interested in being connected to these services?

Husband speaks in Nepali

Interpreter: Yes, I'd like to have help to stop this from happening to me. It is coming in the way of my productivity.

Health worker: ***Can we take a couple of minutes to complete our referral form? I will refer you to an agency and they will be contacting you, is this okay with you.***

Health worker [completes the referral form]: ***Someone will call you in your language and describe the type of support they can offer you. They will call you in the next few days to give you the appointment date and location of the appointment so you can find out if it is the right service for you.***

Health worker (to Abhaya and Tarun)*:* ***Now, let's talk about how to complete the rest of the screening. Are you familiar with a thermometer that measures how hot it is in a room or outside? "Cold" is like there is no distress – things are good. "Hot" is like things are bad, and the highest "Hot" means "I feel as bad as I ever have."***

HANDOUT 5

CASE SCENARIO 3: SOMALI FAMILY

This case scenario is composed of fictional characters. The names and descriptions are for educational purposes only, and are not composed of real patients and their experiences.

HAWA and her family

- 37 y/o Somali female
- Arrived last week with her four children: Halima (20); Amina (18), Moulid (17), and Abdi (15)
- It is noted in their overseas IOM report that two of the children got separated from their mother when they were fleeing to the Kenyan border. They were eventually reunited at the refugee camp. Their father was killed, and family members reported witnessing this event.
- Hawa can't read or write in English or her native language (Somali).

  - ***What is a good strategy to begin the screening session?***
  - ***How will you address this in the time permitted?***
  - ***What resources or tools could help the situation?***

Characters:

- Health worker
- Interpreter
- Family of five: Mother (37), children (15, 17, 18 and 20 years-old)

Health worker: ***Toward the end of our screening visit today we will ask you some questions are about symptoms that some people get that are related to bad experiences, stress at home, or travel to a new country.***

Health worker: ***Our goal is to find out if you need help for any of these symptoms. Your answers are not shared with employers, USCIS, teachers, or others.***

Interpreter: Interprets the same to the family/Health worker after each party speaks.

Halima (mother): ***If I accept help, does that mean people will think I am crazy?***

Health worker (to Halima)**:** ***Absolutely not. Some refugees have these symptoms because of the difficult things they have been through, and because it is very stressful***

to move to a new country. These questions are to help us find out if someone is having a hard time and might need extra support. Your answers will not be shared with employers, USCIS (Immigration), teachers, or anyone else without your permission. Do you have any more questions?

Family: All members state that they have no more questions.

Health worker: ***Great! Let us start with the screen.***

Health worker: ***All of the questions I will ask you have one answer and are related to problems that may have been bothering you over the last month, including today.***

Health worker: ***Each of you will answer the questions by yourselves, based on your own experience. You can ask for help from the interpreter if you cannot read or if you don't understand the question.***

Health worker: ***Using the scale beside each symptom (show the scale), please indicate the degree to which the symptom has been bothersome to you over the past month.***

Health worker: ***Please place a mark in the appropriate column (show the options in the questionnaire). If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL" (point to questionnaire).***

Health worker: ***Just one more reminder. You should do your best to answer the questions quickly in the order that they are asked, but do not worry about if they are right or wrong. Do you have any questions?***

Family: ***No***

(Start RHS-15)

The Healthworker notices Hawa is not marking down her answers.
Health worker (to Hawa): ***I noticed you are not writing down your answers. Can we help you?***

Hawa (through interpreter) : ***Yes, please. I cannot read the numbers well.***

The health worker orients the interpreter to help Hawa in understanding the numbers and the scale by describing the amount of something as it would be contained in a jar or another container. The health worker then proceeds in recording the appropriate answers for Hawa after dialogue with the interpreter.

During the screen, both Hawa and Halima report being suddenly scared for no reason; feeling sad all the time, having muscle pain, and had the experience of reliving the trauma of watching their husband/father being killed.

Health worker (to Halima and Hawa)*: **It appears from the screen that you are going through some difficulties. You are not alone. Many refugees experience sadness, bad memories, and to much stress because of all you've been through on your journey here. This is a normal reaction to stressful events.***

Health worker(to Halima and Hawa)*: **In the United States, lots of people who are having these symptoms sometimes find it helpful to get extra support.***

Health worker (to Halima and Hawa)*: **This does not mean that something is wrong with them or that they are crazy. A counselor in the United States is a type of healthcare worker who will listen to you and help you through these difficult times. This person keeps everything you say confidential, which means they cannot by law share the information with anyone without your agreement.***

Health worker (to Halima and Hawa)*: **Are you interested in being connected to these services?***

Halima: ***Yes, I don't want to feel sad all the time.***

Hawa: ***Yes.***

Health worker: ***Can we take a couple of minutes to complete our referral form? I will refer you to an agency and they will be contacting you, is this okay with you.***

Health worker [completes the referral form]: ***Someone will call you in your language and describe the type of support they can offer you. They will call you in the next few days to give you the appointment date and location of the appointment so you can find out if it is the right service for you.***

APPENDIX A: ADMINISTERING THE RHS-15 STEP-BY-STEP

STEP 1: INTRODUCE THE TOOL AND ITS PURPOSE

"Some refugees have mind and body symptoms because of the difficult things they have been through, and because it is very stressful to move to a new country. The questions we are asking help us find people who are having a hard time and who might need extra support. Your answers will not be shared with employers, or immigration."

STEP 2: EXPLAIN THE INSTRUCTIONS AND SCALE

"I am going to ask you about some symptoms. Please let me know how much each symptom has been bothersome to you in the past month. Each question can have a possible answer on a scale. The
answers can be '**not at all**,' '**a little bit**,' '**moderately**,' '**quite a bit**,' or '**extremely**.'"

Pause for interpretation after each possible answer. Point to the picture depicting each answer.

STEP 3: ADMINISTER THE QUESTIONS

- Only use the questions on the tool, don't make any additions or deletions.
- Don't comment on the patient's responses. You may affirm their statement by saying, "OK" or nodding.
- Re-explain the scale as necessary (for the first few questions you might have to list each answer as a possibility).
- Introduce question 14 by explaining that this question has different answers, and that the patient will need to listen to you read each possible answer before answering.

STEP 4: EXPLAIN THE SCORE

If the score is negative: ***"Your answers seem to show that you are not experiencing too much stress, or sadness, and/ or worry right now. However, there are counselors available at XXX should you feel you need to talk to someone about stress in your life. Is this something you would be interested in?"***

If the score is positive**:** ***"From your answers to the questions it seems like you are having a difficult time. You are not alone. Lots of refugees experience sadness, too many worries, bad memories, or too much stress because of everything they have gone through and because it is so difficult to adjust to a new country. In the United States, people who are having these types of symptoms sometimes find it helpful to get extra support. This does not mean that something is wrong with them or that they are crazy. Sometimes people need help through a difficult time. I would like to connect you to a counselor. This is a type of healthcare worker who will listen to you and provide help and support.***

This person keeps everything you say confidential, which means they cannot by law share the things you tell them with anyone without your agreement. Are you interested in being connected to these services?"

If client accepts referral: *"I will be referring you to the XXX counseling program. The next step is…"*

***If client does not want to be referred**: "That is OK. Please know that the counselors are here if you change your mind. You can always ask your case manager or your doctor for help with getting connected to a counselor."*

APPENDIX B: PICTORIAL SCALE VISUAL AIDE

Please use the following pictorial images of the RHS-15 scale.

These may be helpful to assist patients that may need further explanation.

APPENDIX B: PICTORIAL SCALE VISUAL AIDE

Language	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
NEPALI	Psb d} gePs f]	clnslt dfq	;fdfGo lsl;dn]	w]/}g}	clt ;f/}
BURMESE	vHk;0r±i	tenf;i,	to;t w	enf;enf; m; r	tvGefrsm;
KAREN	eDwpJ;	wpJ;wrSJ;	zJt ·uX;	tgwpJ;	tg'd.r;
SOMALI	MAYA HABA YARAATEE	WAX YAR	SI DHEXE	YARA BADAN	XAD DHAAFAH
RUSSIAN	Совсем не беспокоил	Немного	Средне	Беспокоил достаточно сильно	Очень сильно

APPENDIX B: PICTORIAL SCALE VISUAL AIDE

AMHARIC	በፍጹም	ትንሽ	በመጠኑ	ከፍተኛ	ክፉኛ

APPENDIX B: PICTORIAL SCALE VISUAL AIDE

Language	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
FRENCH	PAS DU TOUT	UN TOUT PETIT PEU	ASSEZ	BEAUCOUP	EXTREMEMENT
TIGRINYA	ፈጺሙ	ቁሩብ	ብመጠኑ	ብርቱዕ	ብጣዕሚ ብርቱዕ
CUBAN SPANISH	NADA	UN POQUITO	MODERADA MENTE	BASTANTE	MUCHÍSIMO

APPENDIX B: PICTORIAL SCALE VISUAL AIDE

Language	EXTREMELY	QUITE A BIT	MODERATELY	A LITTLE BIT	NOT AT ALL
ARABIC	لا شيء على الإطلاق	قليلاً	معتدلا	كثيرا	إلى أقصى حد
FARSI	اصلا	كم	بطور متوسط	تا حدى	بسيار شديد

RESOURCES

Archived World Refugee Surveys (USCRI): *www.refugees.org/resources/refuge e- warehousing/archived-world-refugee-surveys/*

Bellevue/NYU Program for Survivors of Torture: *www.survivorsoftorture.org/*

Bhutanese Refugees: *www.bhutaneserefugees.co m/* **Bridging Refugee Youth & Children's Services**: *www.brycs.org/*

Center for Applied Linguistics: *www.cal.org/co/domestic/*

Center for Disease Control: *www.cdc.gov/eval/resources/index.ht m #stepbystep*

Center for Victims of Torture: *www.cvt.org*

Cultural Orientation Resource Center: *www.culturalorientation.net/resources- for- refugees/welcome-set*

Cross Cultural Healthcare Program: *xculture.org/*

ETHNOMED: *ethnomed.org/about*

Florida Center for Survivors of Torture: *gulfcoastjewishfamilyandcommun ity services.org/refugee/refugee-programs/florida-center-for-survivors-of- torture/*

Freedom from Torture: *www.freedomfromtorture.org/*

Harvard Program in Refugee Trauma: *hprt-cambridge.org/*

Heal Torture: *www.healtorture.org/*

Health and Human Services Global Health: *www.globalhealth.gov*

Healthy Roads Media: *www.healthyroadsmedia.org/*

MedLine PLUS: *www.nlm.nih.gov/medlineplus/*

Migration Information Source: *www.migrationinformation.org*

Minnesota Movie:

www.minnesotamovie.com/medbo

x- clip2.html

Office of Refugee Resettlement: *www.acf.hhs.gov/programs/orr/*

Refugee Council USA:

www.rcusa.org/index.php?pag

e= post-arrival-assistance-and-benefits

Refugee Health Technical Assistance: *www.refugeehealthta.org*

Refugees International: *www.refintl.org/*

Refworld UNHCR: *www.refworld.org/*

U.S. Committee for Refugees & Immigrants: *www.**r**efugees.org/*

U.S. States Bureau of Population, Refugees & Migration: *www.**state**.gov/j/prm/*

United States Department of Homeland Security:

www.dhs.gov/files/statistics/data/ **UNHCR. The UN Refugee Agency Statistics:**

www.unhcr.org/pages/49c3646c4d6.ht

ml **USA for UNHCR. (2013):**

www.unhcr.org/pages/49c3646c4d6.ht

ml **University of Minnesota, Working with**

Interpreters:*www.cehd.umn.edu/ssw/ContinuingEd/*

module5/default.html

University of Rochester, Mental Health Interpreting:

www.urmc.rochester.edu/deaf-wellness- center/products/mental-health-interpreting.cfm

SOP: How To Enter Health Screening Results in RHOS
As of 2.16.2024

This step-by-step guide to support screening clinic staff entering domestic health screening results into RHOS (Refugee Health Online System). RHOS was developed by Utah's Refugee Health Program as a way to electronically track domestic health screening results, monitor performance outcomes for contracted agencies and clinics, and provide more comprehensive data for larger scale reports related to health conditions identified in Utah's refugee population.

For a recorded step-by-step video for entering screening results in RHOS, please watch here.

1) From the RHOS home page, utilize one of the search boxes and filters to identify a patient's case file that needs screening results entered OR go to the report titled "Pending Health Screening" on the left side to find a list of patients that are missing the initial health screening results and are not marked as complete yet.

2) Select a patient's case file by clicking on the hyperlinked Alien ID #.

3) Once in their case file - you are in the "View" mode. In order to edit the results, you'll need to select "Edit" at the top to begin filling out the results.
    a) Note: some results are only viewable and not editable for patients. If you see discrepancies in data that's only viewable, please make a note of it in the screening comments and the RHP staff will fix it.

4) Once in "Edit" mode, begin by filling out the results and fields under each tab and sections within the tab

5) **Demographics tab**
    a) Demographics Section
        i) Fill in the patient's address
        ii) Nothing else is needed for clinic staff to complete in demographic section
    b) Refugee Health Screening Section
        i) Screening Date: Verify the screening date and fix if needed
        ii) Screening Clinic: The clinic assignment should already be listed as your clinic
        iii) Screening Location (if applicable to your clinic): Clinic location should already be listed as the assigned clinic location based on information from the RA.
        iv) Screening Physician: Select the provider who will perform the exam at the screening clinic

v) Screening comments - Copy provider notes/instructions here that require follow-up after the visit and that the next provider will need to know. Examples; problems or concerns identified, medications ordered, any follow-up information.
vi) Days to Screen: Autogenerated
vii) Primary Care Provider: Autogenerated from RA/RHP
viii) Primary Care Provider Location: Autogenerated from RA/RHP
ix) Date Assigned PCP: Autogenerated

c) Tracking Section

i) No screening needed: Autogenerated from RA/RHP
ii) Interpreters: RA will fill-in whether or not their agency can provide interpreter
iii) No Show: Select if the patient did not show up for their appointment.
iv) Completed HSF (Clinics): Select once ALL data has been entered, all referrals are attached, and any lab work is reviewed. This includes waiting for the CXR results to be uploaded before marking as complete, if applicable.
v) Completed HSF (State): Autogenerated from RHP
vi) HS Date Complete: Autogenerated from RHP
vii) Days to Complete: Autogenerated from RHP

6) General Exam tab

a) Physical Information Section

i) Height, Weight, BMI, Systolic BP, Diastolic BP: Enter results collected
ii) Wears Glasses: Select if the patient wears glasses currently
iii) Visual Acuity Screened: Select once completed
iv) Vision Acuity Results: Enter once completed. E.g. OD 20 OS 20 OU 20

b) Social History Section

i) Tobacco Use: Select if patient uses this substance
ii) Alcohol Use: Select if patient uses this substance

7) TB tab

a) Domestic TB Screening Section

i) Class A, B, B3: Select if applicable
ii) Class B1 and/or Class B2: Will already be selected if applicable per RHP. Patients receive this classification based on their history related to TB at the overseas medical exam.
iii) TB Test Date: Verify/enter previous testing date or enter date if completion at screening visit. (It is possible that is already completed overseas within 6 months of HS and we would just enter/verify the date instead of doing the screen at the domestic HS)

iv) TB Screened: Select if already completed and/or once completed by screening provider.
v) QFT: Select the test results if applicable. Mark as N/A if patient tested through PPD.

b) PPD Section

i) TST: Select the test results if applicable. Mark as N/A if patient tested through QFT.
ii) Induration in MM: Enter results collected if applicable.
iii) TST reading date: Enter results collected if applicable.

c) Repeated TB Test Section

i) Repeated TB Test: Select "Yes" if the TB test was repeated. Leave blank if not applicable.

d) CXR Section

i) CXR Order Date: Enter the date the screening provider ordered a Chest X-Ray due to patient testing positive on the screening
(1) Attach the CXR Order file under the "Attachments" tab in "CXR Order"
ii) CXR Date: Enter the date the Chest X-Ray was completed (This field may be filled in once results are received)
iii) CXR Results: Select the tests results applicable once received.
(1) Attach the CXR Result file under the "Attachments" tab in "CXR Report"
iv) Days from CXR order to CXR results: Autogenerated from RHP
v) Date CXR sent to SLCoHD: Autogenerated from RHP

e) TB Diagnosis Section

i) TB Diagnosis: Select result if patient needs LTBI or has TB diagnosis.

f) Special Instructions regarding TB

i) Patients should only be tested for TB by QFT or PPD, not both.
ii) All patients screening positive in a TB screening must be referred to LTBI services at Salt Lake County Health Department.
(1) Make a note in the 'clinic comment section' that "patient requires LTBI referral."
(2) RA will coordinate next appointment steps based off this recommendation.
iii) Clinics are able to track the LTBI treatment progress under the TB sub-tab of "LTBI Data" in RHOS

8) Parasites tab

a) Soil Transmitted Helminths Section (All 4 sub-sections requires same process)

i) Parasite (1-4) Treated Overseas: Select if treated overseas

ii) Parasite (1-4) Screened: Select if screened at screening visit
iii) Parasite (1-4) Results: Select applicable test results if completed at screening visit
iv) Medication at HS: Select if prescribed and provided at screening visit
v) Comments: Provide any pertinent information and follow-up instructions

b) Special Instructions regarding Parasites

i) Based on CDC guidelines for parasite screening, select whether a specific Parasite was treated overseas or if it was screened at the domestic screening.
(1) It will be noted on the overseas records, those who have been presumptively treated for parasites.
ii) Patients treated overseas do not need a repeat screening at the domestic screening visit.
iii) If the CDC/Care-Ref tool does not recommend the patient is screened, even if they have not been treated overseas, then you can skip this parasite section and leave those sections blank.
iv) For additional questions on screening requirements related to Parasites, please contact RHP's Sarah Bates: 801-538-9310 sbates@utah.gov

9) **Labs tab**

a) Enter all lab results in accordance with CDC guidelines.

b) HIV 1 Results Section

i) Select the result from the drop down

c) STD/RPR Section

i) Select the "Reviewed overseas STD results from EDN" if the patient was screened overseas and tested negative. Patients don't need to repeat the STD domestic screening if completed overseas and screened negative.
ii) Domestic Chlamydia Results: Select results if screened at the domestic screening as applicable.
iii) Domestic GC (Gonorrhea) Results: Select results if screened at the domestic screening as applicable.
iv) Domestic Syphilis Results: Select results if screened at the domestic screening as applicable.
v) Other STD Comments: Enter as needed

d) Hepatitis Section

i) Hep B Results: Select results if applicable.
ii) Hepatitis B test overseas: Select if the patient was tested for Hep B overseas.
iii) Hep C Results: Select results if applicable.

e) Blood Lead Section

i) BLL Results (ug/dl): Enter numeric blood lead results if applicable

f) B12 Section

i) B12 Results: Enter numeric B12 results if applicable

g) Diabetes Section

i) Low Risk for Diabetes: Select based on PGL results and clinical discretion
ii) PGL: Enter the numeric PGL results
iii) Diabetes Comments: Enter as needed

h) Lipid Disorder Screening Section

i) Total Cholesterol: Enter numeric results
ii) HDL Cholesterol: Enter numeric results
iii) LDL Cholesterol: Enter numeric results

i) Complete Blood Count Section

i) WBC: Enter numeric results
ii) RBC: Enter numeric results
iii) Hemoglobin: Enter numeric results
iv) Hct: Enter numeric results
v) MCV: Enter numeric results
vi) Eosinophils: Enter numeric results

j) Urine Analysis Section

i) Urine Analysis Results: Enter results. E.g. normal, trace protein or trace blood.

k) Helicobacter Pylori Section

i) H Pylori: Check mark if patient is positive for H Pylori
ii) H Pylori Test: Select type of test given from drop down options

10) Immunizations tab

a) In accordance with the ACIP schedule, enter all of the dates of when immunizations were provided at the initial health screening, including COVID-19 vaccination.
b) Important: select the "Reviewed overseas/base immunization and entered them in USIIS" to acknowledge that all overseas and base immunizations were entered into the state-side immunization tracking system.

11) Mental Health tab

a) All patients should receive a mental health screening

b) Initial RHS-15 Section

i) Select "Yes" from the "MH Screening Done" dropdown

c) < 14 years Section

i) If the patient is < 14 years old, please answer the question after reviewing the notes from the screening.

d) ≥ 14 years old Section

i) If the patient is ≥ 14 years old, enter the RHS-15 screening scores in "Initial RHS 1" and "Initial RHS 2" for the two different sections of

the assessment.

(1) Select from the dropdown with how the RHS was delivered

e) All Section

i) Select "Anxiety (Signs/Symptoms)" if identified based on the screening results/conversation at the screening.

ii) Select "Depression (Signs/Symptoms)" if identified based on the screening results/conversation at the screening.

iii) Select "History of Torture/Violence" if patient shares this or found in their history.

iv) Provide additional comments related to mental health, under "MH Other"

v) Utilize the dropdown "Severity" to mark the mental health concern severity for the patient

vi) Select "Initial MH Referral Accepted" if the patient accepted a referral to a clinical mental health agency for further support

vii) "If Initial MH Referral rejected, why?" use this box to write a note as to why the patient rejected the referral. E.g. patient felt unnecessary or not needed.

f) Mental Health Services After Positive Initial Screening

i) If a patient screens positive on MH screening, please from the "Referral Agency" dropdown so the resettlement agencies know where to connect the patient to MH follow-up care.

g) Special Notes on MH Section

i) If you'd like more information with regard to referral agencies for MH, please connect with Lida Rutz (lrutz@utah.gov) at RHP's Refugee Health Program.

12) Medical Conditions tab

a) This is where all conditions identified from the screening should be marked based on different sections e.g. Nutrition, Ophthalmology, Hematology, ENT, etc.

b) Each section has a comment section to enter other conditions not listed or other details that would be helpful if the patient were to establish care at a different PCP.

c) Select referral needed for a particular section if this is identified from the screening and the patient needs to see a specialist in that particular field.

i) E.g. If Cardiology issues are identified and the provider decides they need a specialist referral, you'd select the specific types of Cardiology concerns identified from check boxes and/or enter comments in the

"Cardiology Other" comment box. Finally, select the "Referral Needed" check box in the Cardiology section.

d) If other health issues were identified, at the bottom of this page, there's a comment box for other "Health Issues" to write in.

13) Comments tab

a) This is a section for screening clinics, agencies, and RHP to communicate on any follow-up or missing items for a particular patient's initial screening. You can see all the notes under "View"

b) When in "Edit" you can only add clinic comments. This is where you'd list out the different referrals and follow-ups that a patient needs.
   i) E.g. (1) PCP F/U - nutrition concerns (2) Dental (3) Eye exam

c) You can also communicate with the agencies in these comment boxes if any coordination is needed for a more pressing follow-up e.g. chest x-rays, vaccines, or stool kits.

14) EDN tab

a) No data entry required in this tab

b) RHP imports some data points from the EDN (Electronic Disease Notification) system at the CDC into RHOS so clinics can view some of the overseas medical exam results.

c) Sometimes there are delays in information on EDN or in the import into RHOS, so it's important to review in EDN versus relying on the information in RHOS.

d) If it's available, we will do our best to get the overseas medical information added into RHOS prior to the appointment to assist providers in knowing some of the basic concerns identified at the overseas exam.

15) Billing tab

a) Will show information if the clinic billed for the screening and if it was approved. Only there to provide some transparency.

16) Health Promotion tab

a) N/A to screening clinics

17) FINAL STEP

a) After all data is entered, all referral(s) attached, and pressing follow-up related to the initial exam are complete (i.e. CXR results), return to the "Demographics" tab and scroll down to the bottom to mark the HS as complete by selecting "Complete HSF (Clinics)"

b) Once completed, RHP will review and provide any comments if needed or approve as fully complete.

c) It is only after a HSF is fully approved by RHP that the consultation/co-payments may be paid to screening clinics.

Utah Refugee Health Screening Network

UDHHS, Epidemiology, Refugee Health/TB Program PO BOX 142104, 84114-2104 Cannon Bldg. 288 N 1460 W, SLC, UT 84116 Phone (801)538-6191 Epi Fax (801)538-9913 Refugee Health Program Fax (801)237-0770		
Rachel Ashby – Program Manager DHHS Refugee Health/TB Control Program	801-538-9315	rashby@utah.gov
Sarah Bates - State Refugee Health Coordinator, Refugee Health Program Manager	801-538-9310	sbates@utah.gov
Amanda Whipple - Refugee Health Promotion Coordinator	801-538-6834	awhipple@utah.gov
Lida Rutz – Refugee Wellness Specialist	801-538-9311	lrutz@utah.gov
Meghan Trout – Refugee Billing Specialist		meghantrout@utah.gov
Karla Jenkins – TB Nurse Consultant	801-538-6224	kmjenkins@utah.gov
Michelle Grossman - Refugee Health Screening Coordinator	801-538-6116	magrossman@utah.gov
Nava Azmak – Refugee Health Screening Assistant		nazmak@utah.gov

RESETTLEMENT AGENCIES

Cache Refugee and Immigrant Connection (CRIC) 1115 N 200 E #130, Logan UT 84341 435-915-6689		
Danny Beus - Executive Director		danny@cacherefugees.org
Danielle Rodriguez – Director of Resettlement Services		drodriguez@cacherefugees.org
Lorien Belton – Director of Finance & Operations		lorien@cacherefugees.org
Ashlee Wiser – Health Screening Coordinator		awiser@cacherefugees.org
Ariana Magana – Resettlement Manager		amagana@cacherefugees.org
Ben Randall - Health Promotions		brandall@cacherefugees.org
Amanda Anderson - HSCC/HP		aanderson@cacherefugees.org
Catholic Community Services (CCS) 745 E 300 S SLC, UT 84102 Phone (801)977-9119 Fax (801)977-9224		
Aden Batar – Migration & Refugee Services Director	801-428-1254	abatar@ccsutah.org
Randy Chappell – Basic Needs Director	801-428-1276	rchappell@ccsutah.org
Khalid Al Hachami, Refugee Case Manager Supervisor	(801) 428-1225	kalhachami@ccsutah.org
Jordan Kersten – Health Services Supervisor	385-409-1048	jkersten@ccsutah.org
Vanessa Masanka - Health Services Coordinator	385-343-6531	vmasanka@ccsutah.org
Leul Mengistu – Preferred Communities Lead	801-425-0673	lmengistu@ccsutah.org
Adison Cragun – Health Promotion Coordinator	385-409-1048	acragun@ccsutah.org
Brittany Steenhoek – Mental Health Coordinator	801-428-1247	bsteenhoek@ccsutah.org
Erica Astle - Refugee Foster Care Program Manager	801-428-1239	eastle@ccsutah.org

International Rescue Committee (IRC) **221 S 400 W, SLC, UT 84101** **Phone (801)328-1091 Fax (801)328-1094**		
Jesse Sheets- Acting Executive Director	435-260-9658	jesse.sheets@rescue.org
Jonessa White - Health Program Manager	801-694-7793	jonessa.white@rescue.org
Kaitlin Campbell – Health Promotion Supervisor	801-883-8475	kaitlin.campbell@rescue.org
Maha Elmashni – Health Promotion Coordinator (CHW)	801-883-8483	maha.elmashni@rescue.org
Hailee Smith – Health Access Supervisor	801-694-3811	Hailee.smith@rescue.org
Mazie St. Cin - LTBI Specialist	385-515-3477	mazie.st.cin@rescue.org
Annie Shaw – Women's Health Promotion Specialist	385-429-8652	Annie.shaw@rescue.org
Arwa Jundi—Mental Health Coordinator	385-320-1444	arwa.jundi@rescue.org
Sydney Lutnick – Mental Health Specialist	801-883-8464	Sydney.lutnick@rescue.org
Whitney Nguyen - Health Promotion	801-883-8465	whitney.nguyen@rescue.org
Refugee & Immigrant Center - Asian Association of Utah (AAU) 155 S 300 W, SLC, UT 84101 **Phone (801)467-6060 Fax (801)486-3007**		
Scott Cougill – Executive Director	801-990-9485	scott.cougill@aau-slc.org
Peter Frost – Director, Refugee & Immigrant Center	801-412-0578	Peter.Frost@aau-slc.org
Andrea Sherman – Director, Human Trafficking Support	801-990-9498	andreas@aau-slc.org
Tung Tran – Director, Interpreting Services	801-990-9498	tungt@aau-slc.org
Sarah Afridi - Health Services Coordinator	801-683-9162	sarah.afridi@aau-slc.org

LOCAL HEALTH DEPARTMENTS

Salt Lake County Health Department (SLCoHD) **610 S 200 E, Suite 2103 SLC, UT 84111** **Phone (385)468-4222 Fax (385)468-4232**		
Tair Kiphibane - Bureau Director & Nursing Supervisor	385-468-4276	mkiphibane@slc.org
Tara Scribellito - Nursing Supervisor	385-468-4275	TScribellito@slco.org
Madison Clawson - Nursing Supervisor	385-468-4277	mclawson@slco.org
Carlene Claflin - Public Health Nurse	385-468-4261	cclaflin@slco.org
Chantel Ikeda - Public Health Nurse	385-468-4259	cikeda@slco.org
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David Hernandez - Public Health Nurse	385-468-4262	dahernandez@slco.org
Jodi Neerings - Public Health Nurse	385-468-4263	jneerings@slco.org
Jeff Sanchez - Public Health Nurse	385-468-4208	jmsanchez@slco.org
Jason Lowry- Public Health Nurse	385-468-4224	jlowry@slco.org
TB Chest Clinic – SLC **Phone (385)468-4212** **Fax (385)468-4232**		
TB Clinic Physician	385-468-4213	
Weber-Morgan Health Department **477 23rd St. Ogden, UT 84401** **Phone (801)399-7250**		

MaryLou Adams-Nursing Director	801-399-7235	madams@co.weber.ut.us
Lori Gittings-Public Health Nurse	801-399-7232	lgittings@co.weber.ut.us

HEALTH SCREENING CLINICS

Hyrum Medical Clinic **26 W Main St. Hyrum, UT 84319** **Phone (435)245-6248 Fax (435)245-3637**		
Taylor Anderson, FNP-C	435-245-6248	tanderson@hyrumclinic.com
Caitlyn Jennings, CHA/PA-C, IBCLC	435-245-6248	cjennings@hyrumclinic.com
Peachtree Medical Clinic **893 E 9400 S Sandy, UT** **Phone (385) 335-7862**		
Lorena Cannon, FNP-C	385-335-7862	peachtreemedicalcare@gmail.com
Vanesa Judd, FNP-C		
St. Mark's Family Medicine **1250 E 3900 S # 260, SLC, UT 84124** **Phone (801)265-2000 Fax (801)265-2008**		
Karl Kirby, MD	801-265-2000 x110	kkirby@utahhealthcare.org
Diane Chapman, DNP, APRN, FNP-C	801-265-2000	dchapman@utahhealthcare.org
Katie Connolly, DNP	801-265-2000	kconnolly@utahhealthcare.org
Kayley Jordan - MA	801-265-2000	kjordan@utahhealthcare.org
University of Utah Redwood Clinic **(multiple locations throughout Salt Lake City)** **Phone (801)213-9500 – Scheduling Line (Care Navigation)**		
Marie-Chantal Taha - New American Services Program Coordinator	801-213-9700	Chantal.Taha@hsc.utah.edu
Krystal Bustamante – New American Support Coordinator	801-213-9700	krystal.bustamante@utah.edu
University of Utah Newcomer Clinic **168 N 1950 W #201, SLC UT 84116** **Phone (801)646-6388 Fax (801)646-6397**		
Peter Weir, MD – Chief Population Health Officer	801-230-1983 (cell)	peter.weir@utah.edu
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Emilse Peraza, PA	801-646-7698	Emilse.peraza@hsc.utah.edu
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Faviola Ortiz - MA	801-646-7698	Faviola.Ortiz@hsc.utah.edu

University of Utah Sugarhouse Clinic **1280 E Stringham Ave, SLC UT 84106** **801-213-8076**		
Hina Jhawer, MD		u6040989@utah.edu
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Utah Partners for Health **9103 S 1300 W #102, West Jordan UT 84088** **801-417-0131**		
Katie O'Brien, DNP		kboesen@upfh.org
Kandi Winsor		kwinsor@upfh.org
Debbie Turner - CEO		dturner@upfh.org
Wade Family Medicine **557 W 2600 S, Bountiful UT 84010** **801-298-9155**		
Wendy Smith – Billing Manager	801-298-9155	wendilyn7@yahoo.com
Antonina Callahan, MD	801-915-2289	callahana.md@gmail.com

MENTAL HEALTH CLINICS		
AAU Mental Health and Substance Abuse Services **Adults and Children 8 and older** **155 S 300 W, Suite 101, SLC, UT 84101** **Phone (801)467-6060 Fax (801)412-9926**		
Yvonne Mok, CMHC - Clinic Director, Behavioral Health		yvonne.mok@aau-slc.org
Megan Clark – Director of Operations, Behavioral Health	801-990-9441	megan.clark@aau-slc.org
Katelyn Payne – Mental Health Intake Coordinator		katelyn.payne@aau-slc.org
Utah Health and Human Rights (UHHR) **- Adults and Children 8-13 meeting agency criteria** **225 S 200 E, Suite 250, SLC, UT 84111** **Phone (801)363-4596 Fax (801)363-4596**		
Heidi Justice - Executive Director	801-494-5412	heidi.justice@uhhr.org
Mara Rabin, MD - Medical Director	801-363-4596	mara.rabin@uhhr.org
Xander Gordon - Clinical Director	801-494-5414	xander.gordon@uhhr.org
Dani Day – Associate Director	801-494-5412	dani.day@uhhr.org
Cami Berger - LCSW	801-494-5418	cami.berger@uhhr.org

Children's Center - Children under the age of 8 Services: Therapeutic Preschool Programs; Autism; Assessment and Evaluation; Medication Management; Family Therapy and Trauma Treatment		
Devon Musson Rose - Program Director, Trauma Program	801-582-5534	dmussonrose@tccls.org

05-28-2024

REFUGEE HEALTH SCREENER-15 (RHS-15)

Pathways to Wellness

Integrating Refugee Health and Well-being

Creating pathways for refugee survivors to heal

ENGLISH VERSION

DEMOGRAPHIC INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADMINSTERED BY: _____ DATE OF SCREEN: _____

DATE OF ARRIVAL: _____ GENDER: _____ HEALTH ID #: _____

Developed by the *Pathways to Wellness* project and generously supported by the Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, Seattle Foundation, and the Boeing Employees Community Fund.

Pathways to Wellness: Integrating Community Health and Well-being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Dr. Michael Hollifield. For more information, please contact Beth Farmer at 206-816-3252 or bfarmer@lcsnw.org.

REFUGEE HEALTH SCREENER (RHS-15)

Instructions: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODER-ATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

14. Generally over your life, do you feel that you are:

Able to handle (cope with) anything that comes your way 0

Able to handle (cope with) most things that come your way 1

Able to handle (cope with) some things, but not able to cope with other things.....2

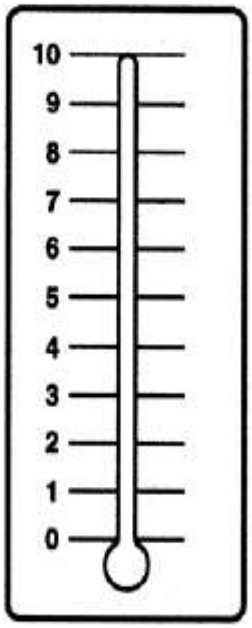
Unable to cope with most things.....3

Unable to cope with anything 4

15.

Distress Thermometer

FIRST: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Extreme distress

No distress

"I feel as bad as I ever have"

"Things are good"

ADD TOTAL SCORE OF ITEMS 1-14: ___

SCORING

Screening is POSITIVE

1. **If Items 1-14 is ≥ 12 OR**
2. **Distress Thermometer is ≥ 5**

Self administered: ____
Not self administered:____

CIRCLE ONE: **SCREEN NEGATIVE** **SCREEN POSITIVE REFER FOR SERVICES**

REFUGEE HEALTH SCREENER - 15 (RHS-15)

DISCLAIMER

The English Version of the RHS-15 is for informational purposes only. It is **not** intended for use in refugee populations. Bilingual versions of the RHS-15 have been translated by professional translations and with the participation of the community so that each question is asked correctly according to language and culture. Using the English version negates the sensitivity of this instrument.

If you would like to receive bilingual versions of the RHS-15, please contact Pathways to Wellness at bfarmer@lcsnw.org.

UTILIZATION REQUEST AND AGREEMENT

Pathways to Wellness

Integrating Refugee Health and Well-Being

Creating pathways for refugee survivors to heal

REFUGEE HEALTH SCREENER - 15 (RHS-15)

Pathways to Wellness is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Michael Hollifield, M.D. Generously funded by the Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, Seattle Foundation, and the Boeing Employees Community Fund

UTILIZATION REQUEST AND AGREEMENT

Date of Request:	**Name:**	
Institution:		
Department (if applicable):		
Your Position:		
Address 1:		
Address 2:		
City:	**State:**	**Zip:**
Country:	**Email:**	
Phone Number:		

INSTRUCTIONS **Please complete the fields below**			
Where did you hear about the RHS-15?	☐ In a journal publication *List:* _____	☐ From a colleague	☐ Other (please specify): _____
What is your intended use of the RHS-15?	☐ Clinical assessment	☐ Research	☐ Other (please specify): _____
If you plan to use the RHS-15 for research, please briefly describe your research or use:	Ethnic and/or language group(s): ☐ Arabic ☐ Russian ☐ Nepali ☐ Spanish ☐ Karen ☐ Somali ☐ Burmese	Age range ☐ 14-21 ☐ 21-64 ☐ 65-older	Context: (check all that apply) ☐ Refugees ☐ Asylum seekers ☐ Validity for Screening ☐ Comparison to another instrument
How many refugees do you screen a year?	☐ 25-50 ☐ 50-100	☐ 100-200	☐ 200 or more
What is the setting for administering the RHS-15?	Health setting ☐ Primary care ☐ Public health	☐ Resettlement agency	☐ CBO ☐ Other (please specify)
Funding source?	☐ Federal grant	☐ Foundation	☐ Intramural grant ☐ None

Is there other pertinent information about how your organization will utilize the RHS-15?	

UTILIZATION REQUEST AND AGREEMENT

Statement of Agreement

I understand that the purpose of this agreement is to improve the use and dissemination of the Refugee Health Screener – 15 (RHS-15). Any and all shared information and data between myself, or my institution, and *Pathways to Wellness* partners is to be utilized to improve the RHS-15. I also understand that I, and/or my institution, may negotiate with *Pathways to Wellness* partners how shared information and data will be used for institutional and/or scientific reports. I agree to utilize the Refugee Health Screener – 15 (RHS-15) in its current form and for its intended use unless otherwise specified in subsequent agreements.

(Please check the box that reflects your desired use of the RHS-15)

☐ I and/or my institution will use the RHS-15 for clinical purposes only. We do not have the capacity to engage in research, but agree to a qualitative interview to discuss challenges and successes with the RHS-15 so the tool can be further developed.

☐ I and/or my institution will use the RHS-15 for clinical purposes only. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

1. **The number of screenings conducted.**
2. **Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**
3. **Age, gender, and ethnic/language group, and screening score of participants screened.**

☐ I and/or my institution are interested in partnering with *Pathways to Wellness* partners on further evaluative projects about the RHS-15 and/or subsequent versions of the RHS-15. I/we understand that I/we will negotiate with *Pathways* how to proceed in such projects regarding lead, institutional review board approvals, data collection and management, and authoring of scientific reports. I/we agree to share with *Pathways to Wellness* partners the following information within a reasonable amount of time of a written request:

1. **The number of screenings conducted.**
2. **Time of screening administration during resettlement (i.e., six weeks after date of arrival in the U.S., one year after date of arrival in the U.S., etc.)**
3. **Age, gender, and ethnic/language group, and screening score of participants screened.**
4. **Clinical information regarding 1) the number of those screened referred to care, 2) the number of positive screened persons that went to care, and 3) treatment outcomes.**
5. **A summary of any other qualitative or quantitative evaluations about the utility of the RHS-15 (negotiable on execution of the agreement).**

UTILIZATION REQUEST AND AGREEMENT

Requestors' signature: _____Date: _____

Requestor's printed name: _____

Thank you for your interest in utilizing the Refugee Health Screener-15 (RHS-15). We are interested in your findings, recommendations for further use and development, and collaboration on research and development.

Please return the form to:

Pathways to Wellness
Beth Farmer, MSW
International Counseling & Community Services
4040 S 188th St., #200
Seattle, WA 98188
206-816-3252

You may fax to: **206-838-2680**

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REFUGEE HEALTH SCREENER - 15

Development and Use of the RHS-15

Early screening and intervention for emotional distress among newly arrived refugees is rarely conducted. Existing instruments are not designed for refugees or may be cumbersome to administer in health care settings. The RHS-15 was developed in a community public health setting to be an efficient and effective way to sensitively detect the range of emotional distress common across refugee groups.

Pathways to Wellness is a program of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. Generously supported by the Robert Wood Johnson Foundation, the Bill & Melinda Gates Foundation, United Way of King County, the Seattle Foundation, the Medina Family Foundation, and the Boeing Employees Community Fund.

Background

The United Nations High Commissioner for Refugees lists 16 million refugees and asylum seekers and 26 million internally displaced persons in the world as of mid-2009.[1] Over 1.8 million reside in the United States.[2] All refugees have experienced extremely stressful events related to war, oppression, migration, and resettlement. The best evidence shows that a large minority of refugees experience multiple, distressing somatic and psychological symptoms and poor mental health[3-11] that are associated with stressful events in a dose-dependent manner.[8,12-14]

Because this high burden of combined emotional and physical distress is often symptomatic of pre-existing or developing mental disorders, screening upon arrival in the host country is important. However, screening for mental disorders is not currently a standard practice in the majority of refugee resettlement programs in the U.S. Barriers to screening include time, cost, follow-up, refugees' health seeking behaviors, accessibility and availability of services, language, and cultural or conceptual differences in perceptions of health.[15] Another challenge to screening is that symptoms in refugees are most often not characteristic of single, western-defined psychiatric disorders.[16-26] Hence, instruments that effectively screen for distress in general, i.e., predictive of prevalent common mental disorders, have not been developed and tested in refugee populations. The value of such screening has also not been definitively established. Ovitt and colleagues examined refugee perceptions of a culturally-sensitive mental health screening in eight Bosnian refugees in the United States and suggested that screening is a necessary component of refugee resettlement.[15] Savin and colleagues (2005) analyzed data from the Colorado Refugee Services Program in Denver, and found that nearly 14% of the 1,058 refugees over the age of 18 screened positive for a psychiatric disorder using an instrument developed by an expert consensus process. Of those offered mental health services, 37% received such services and the remaining 63% declined.[26]

Developing an efficient and effective screening instrument

A screening instrument for refugees needs to be efficient and sensitive to a range of common psychiatric diagnoses. The two instruments that have been developed in refugee populations and could be considered screening instruments, the Harvard Trauma Questionnaire (HTQ) and the Vietnamese Depression Scale (VDS), are specific to posttraumatic stress disorder (PTSD) and depression, respectively.[27,28] The New Mexico Refugee Symptom Checklist-121 (NMRSCL-121), which was developed to assess the broad range of distressing physical and emotional symptoms in refugees,[5] is a reliable and a valid predictor of traumatic

events and mental health symptoms. However, it is long and comprehensive and was not intended to be a screening instrument.

Other scales developed for specific illness states in western populations have been adapted for use with refugees. For example, the Hopkins Symptom Checklist-25 (HSCL-25) has been adapted for several populations including Indochinese and Bosnian.[15,29] However, the HSCL-25 assesses clinically significant anxiety and depression, not PTSD, and was not intended for screening. A standard instrument that is effective and efficient in screening for emotional distress that is a common marker across psychiatric diagnoses in many ethnic groups would be helpful for resettled refugees.

Items used as a basis for developing an efficient screening instrument for emotional distress

PTSD, anxiety, and depression symptoms are the most common mental symptoms in refugees. Psychotic illnesses are relatively easy to detect by non-psychiatric providers. Thus, initial screening programs in two locales in the U.S. utilized instruments that have the best empirical support for assessing relevant symptoms. These included:

- *The New Mexico Refugee Symptoms Checklist-121 (NMRSCL-121)* assesses the broad range of persistently distressing somatic and psychological symptoms in refugees, and is reliable and a valid predictor of traumatic experiences, PTSD, anxiety and depression in both Kurdish and Vietnamese refugees.[5] The NMRSCL-121 is formatted for possible responses from 0 (not at all) to 4 (extremely), and may be scored as a sum or an item average.
- *The Hopkins Symptom Checklist-25 (HSCL-25)* assesses anxiety and depression symptoms, is valid for the general U.S. population and for Indochinese refugees,[30,31] and has transcultural validity.[32,33] The HSCL-25 is formatted for possible responses from 0 (not at all) to 4 (extremely), and is scored as an item average. Item-average cutoff scores of $\geq$1.75 for each scale predict "clinically significant" anxiety and depression in general U.S. and refugee samples and are valid as diagnostic proxies.[30,31]
- *The Posttraumatic Symptom Scale-Self Report (PSS-SR)* is a reliable predictor of the PTSD diagnosis in U.S. populations.[34] The 17 items on the scale, each scored from 0 to 3 for symptom frequency, are essentially DSM-IV PTSD diagnostic items. PSS-SR continuous scores and the diagnostic proxy were highly correlated with war-related trauma and anxiety and

depression in Kurdish and Vietnamese refugees,[13] and Cronbach's alpha in these samples was 0.95. The dichotomous proxy and the cutoff score were used for the current analyses.

The process of screening and assessing diagnostic proxies

For development of the Refugee Health Screener 15 (RHS-15), twenty-seven NMRSCL-121 items (each scored on a 0 to 4 severity scale) that were found to be most predictive of anxiety, depression, and PTSD in a refugee cohort were collectively utilized as the primary screening instrument. Six items were added to this screening based on clinical experience and empirical data about assessing emotional distress, including questions about family psychiatric history, personal psychiatric history, stress reactivity, coping capacity, and a distress thermometer. The HSCL-25 and the PSS-SR were used as diagnostic proxies to evaluate items that would comprise the RHS-15.

All instruments were translated into four languages using a rigorous, iterative back-and-forth participatory consensus process with refugees from each language group. This process ensured relevant language-specific semantics yielding accuracy and clarity of meaning. This phase of development is critical to obtain culturally-responsive items in each language. The four language groups were chosen because they are spoken by the highest number of refugees currently being resettled in King County, as well as in the United States.

Two-hundred fifty-one refugees 14 years or older in these four groups (93 Iraqi, 75 Nepali Bhutanese, 36 Karen, and 45 Burmese Speaking (including Karenni and Chin ethnic groups) coming for health screening at Public Health Seattle and King County (Public Health SKC) between April 2010 and November 2010 were screened by the *Pathways to Wellness* evaluation coordinator. Those screened were administered the diagnostic proxies usually within 2 weeks of screening. One hundred and ninety persons were administered the proxies. Those missed were due to shortage in available interpreters, out-migration, and other reasons (i.e. during time of diagnostic assessment, some participants had other medical concerns that warranted immediate attention). It is important to note that the development of the RHS-15 was an integral part of the overall *Pathways* mission, which included the integration of health services, outreach and education about refugee health, and an evaluation component. Stand-alone screening for emotional distress may not be useful if treatment services are not available or accessible.

Methods for evaluating the most valid set of items for screening

To establish the RHS-15, all items from the screening instrument and diagnostic proxy instruments (N=75 items) were analyzed together to improve on validity and efficiency of the initial screening instrument. Multiple exploratory methods were used, including initial correlations and general linear models using t-tests and analysis of variance. Three methods were then used and compared to establish the most useful and efficient set of items that would classify persons as most likely to have diagnostic proxy level anxiety, depression, or PTSD: discriminant analysis (DA), naïve Bayesian classification (BAY), and chi-square (CHI) for each item by diagnostic proxy. Diagnostic proxies used were (1) clinically significant anxiety, (2) clinically significant depression, (3) PSS-SR diagnostic PTSD, (4) moderate-severe PTSD or greater, and (5) any of the four previous diagnostic entities on Bayesian analysis.

Results of analyses

Most of the 75 items were significantly correlated with diagnostic proxies, reflecting their usefulness in the extant instruments. Some of the same and some different items were found to classify by diagnostic proxy when using each of the three classification methods. To establish the items that had the highest chance of correctly classifying a refugee with a likely diagnostic proxy, a grid of strength of association of item by classification method was constructed. Items that were high for classifying persons by at least 2 of the 3 methods were then subjected to BAY to maximize for classification sensitivity. Fourteen items were important for classifying by at least one of the 5 diagnostic proxies with sensitivity of at least .89 and specificity of at least .83. The table shows items included by BAY for each diagnostic proxy and the sensitivity and specificity of each item-group by proxy diagnosis. One item, HSCL 9 was not significant in other linear analyses, so was dropped from the final screening instrument. One item, HSCL 4 was significant in other BAY and CHI analyses so was added to the final instrument. Another item, HSCL 13, was significant in all 3 prior methods so was added to the final instrument. The distress thermometer was a significant predictor of each diagnostic proxy.

Table. Items selected for the RHS-15 by final Bayesian analysis

Items selected by BAY	PSS-SR ≥16	PTSD diagnosis	HSCL-25 Anxiety	HSCL-25 Depression	Any Proxy
NM 5_1	X		X	X	
NM 5_12				X	
NM 5_19				X	
NM 5_22					X
"Coping"			X		
PSS 3	X				
PSS 5				X	
PSS 11	X	X	X		X
PSS 17				X	
HSCL 1		X	X	X	X
HSCL 3			X		
HSCL 9	X				
HSCL 10	X				
HSCL 11				X	
Sensitivity	1.00	0.89	1.00	1.00	0.96
Specificity	0.94	0.83	0.91	0.93	0.86

"NM" is an item from the New Mexico Refugee Symptom Checklist
"PSS" is an item from the Posttraumatic Stress Symptoms-Self-Report
"HSCL" is an item from the Hopkins Symptom Checklist
The sensitivity and specificity values assume optimal scores to proxy diagnoses in BAY analyses

Current Recommendations for Scoring and Using the RHS-15

Past analyses of the initial screening instrument consisting mostly of NMRSCL-121 items determined that an item-average of 0.88 or greater was optimally associated with significant emotional distress (i.e., diagnostic level distress on proxy instruments). However, the RHS-15 now includes items from 3 different instruments, which had different instructions, response scales, and scoring. In particular, the PSS-SR items are rated more by frequency than severity on a scale from 0 to 3. The NMRSCL-121 and the HSCL-25 both have items rated from 0 to 4, but the instructions specify a different time frame of the symptoms. We have constructed the RHS-15 so that each item has the same response possibilities from 0 (not at all) to 4 (extremely).

Post-hoc analyses of the RHS-15 with items standardized to the current scoring scale were conducted to determine the optimal cut-off score to predict a positive case. One assumption of such analysis is that future

samples will score similar to our initial sample on the RHS-15 items and the diagnostic proxies. These analyses showed that an item-average of 1.18 may result in the most optimal sensitivity and specificity. However, a screening instrument is generally utilized to be highly sensitive, in order to identify all cases, particularly when missing any case would result in a significantly adverse outcome. An item-average of 0.88 and 1.18 on the 14 RHS-15 items translates to a total score of 12.32 and 16.52, respectively. Our data suggest that using the former cut score will result in identifying approximately 38% of refugees as positive for emotional distress. The latter cut score has not been tested in a separate or split sample, but we estimate it will result in identifying between 25% and 33% of refugees as positive for emotional distress. For now, we recommend that the item average of 0.88 (total $\geq$12) or higher be used to identify a positive case. Further evaluation is necessary to determine the sensitivity and specificity of the RHS-15 at various cut-off scores to find significant emotional distress, as well as other outcome measures that have yet to be investigated.

In the current analyses, a distress thermometer score of 5 or greater was 85% specific for being positive on any of the diagnostic proxies. The sensitivity of this cut score was .87, .85, and .66 for PTSD, depression, and anxiety, respectively. If a cut score of 6 or greater was used, then specificity increased to .93, but the sensitivity was below .50 for the three diagnostic proxies. Thus, to optimize for sensitivity and include cases that may be missed by the 13 symptom items plus the coping item, we recommend that a distress thermometer score of 5 or greater be considered a positive screen. Thus, our current recommendation is that a score of $\geq$ 12 OR a distress thermometer score of $\geq$ 5 is considered a positive case. We believe that the best process will eventually be to utilize the RHS-15 as a highly sensitive first screen, with intermediate scores (e.g., 12 to 16) warranting a second level, more specific screen. Early results from our second phase where the RHS-15 is integrated into routine health screening at Public Health SKC indicates that the administration time is approximately 5 minutes for those who are literate and self-administer the RHS-15, and up to 15 minutes for those who are administered the instrument regardless of literacy level. Public Health SKC has been forward-looking and innovative as a *Pathways* partner and by advocating for a pay-line for the time to administer the RHS-15.

We highly recommend the use of the RHS-15 in settings where there are adequate resources to conduct and score the screening, and to develop a source and method of referral for further diagnosis and treatment. Another decision point is about when in the course of resettlement is the best time to administer the RHS-15. While our premise is that it should be administered early in the course of resettlement, it is also clear in our work and from other studies that a significant proportion of newly arrived refugees will have a delayed onset of emotional distress. We are currently working on better understanding the proportion of refugees with distress on arrival, delayed distress, and factors that predict each.

Finally, the *Pathways* project invites collaborative work with other groups who wish to use and/or evaluate the effectiveness of the RHS-15. It is expected that the form and method of screening may vary from locale to locale, dependent on the health care setting, the population served, and the resources available. As of September 2011, the RHS-15 is available in English, Arabic, Burmese, Karen, Russian and Nepali (Bhutanese), with a Somali version soon available. We are beginning the process to have the RHS-15 also available in Spanish. Current development and evaluation of the RHS-15 has had institutional review board (IRB) approval and oversight at The Pacific Institute for Research and Evaluation. Any further collaborative evaluation and/or research will necessarily involve a discussion about how and where to obtain IRB approval to proceed with the work.

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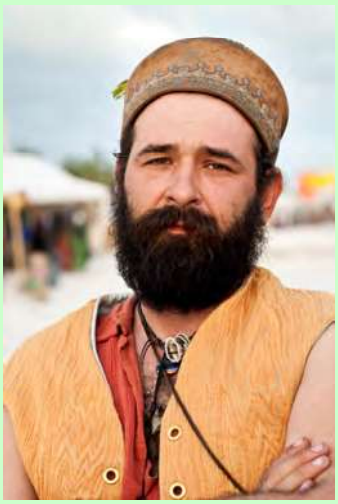
"It is so simple, but it makes such a huge difference."
~ Lisa Buckner, Registered Nurse



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Pathways to Wellness

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Pem came from a small country in Asia.

As a young mother, Pem fled her village when civil war broke out and soldiers began burning and looting homes. She spent over a month walking with her infant daughter to safety. For the next 13 years, Pem languished in a refugee camp. Fortunately, she was one of the lucky few that received an opportunity to come to the United States. When she arrived, Pem was given a required health screening that also looked for signs of depression and anxiety. Pem admitted to not being able to sleep at night and crying on an almost daily basis. Her body hurt, she said. "Too many thoughts. So many thoughts, I can not think well." Pem was immediately connected to support to help her with these symptoms, and is now thriving with a new job and new hope. Pem's assessment took less than 10 minutes, but it is not happening for most refugees.

Pathways to Wellness is a new approach to finding depression, anxiety, and traumatic stress in refugees and connecting them to the care they need to heal. We provide training for mental health providers to effectively deliver services to refugee populations, and partner with refugee communities to better understand and address mental health issues. *Pathways* is working with other cities across the United States to duplicate its success.

No refugee should suffer any more than they already have. Contact us to get more information on how *Pathways* can benefit your community.

Beth Farmer, Project Director
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Pathways to Wellness is a partnership project between Lutheran Community Services NW, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield of the Pacific Institute for Research and Evaluation.

SOP: How To Enter Health Screening Results in RHOS

As of 5-13-2025

This step-by-step guide to support screening clinic staff entering domestic health screening results into RHOS (Refugee Health Online System). RHOS was developed by Utah's Refugee Health Program as a way to electronically track domestic health screening results, monitor performance outcomes for contracted agencies and clinics, and provide more comprehensive data for larger scale reports related to health conditions identified in Utah's refugee population.

For a recorded step-by-step video for entering screening results in RHOS, please watch here.

1) From the RHOS home page, utilize one of the search boxes and filters to identify a patient's case file that needs screening results entered OR go to the report titled "Pending Health Screening" on the left side to find a list of patients that are missing the initial health screening results and are not marked as complete yet.

2) Select a patient's case file by clicking on the hyperlinked Alien ID #.

3) Once in their case file - you are in the "View" mode. In order to edit the results, you'll need to select "Edit" at the top to begin filling out the results.
    a) Note: some results are only viewable and not editable for patients. If you see discrepancies in data that's only viewable, please make a note of it in the screening comments and the RHP staff will fix it.

4) Once in "Edit" mode, begin by filling out the results and fields under each tab and sections within the tab

5) **Demographics tab**
    a) **Demographics Section**
        i) Fill in the patient's address
        ii) Nothing else is needed for clinic staff to complete in demographic section
    b) **Refugee Health Screening Section**
        i) Screening Date: Verify the screening date and fix if needed
        ii) Screening Clinic: The clinic assignment should already be listed as your clinic
        iii) Screening Location (if applicable to your clinic): Clinic location should already be listed as the assigned clinic location based on information from the RA.
        iv) Screening Physician: Select the provider who will perform the exam at the screening clinic
        v) Screening comments - Copy provider notes/instructions here that require follow-up after the visit and that the next provider will need to know. Examples; problems or concerns identified, medications ordered, any follow-up information.

vi) Days to Screen: Autogenerated
vii) Primary Care Provider: Autogenerated from RA/RHP
viii) Primary Care Provider Location: Autogenerated from RA/RHP
ix) Date Assigned PCP: Autogenerated

c) **Tracking Section**
i) No screening needed: Autogenerated from RA/RHP
ii) Interpreters: RA will fill-in whether or not their agency can provide interpreter
iii) No Show: Select if the patient did not show up for their appointment.
iv) Lost to Follow Up: Select if after **3** attempts to follow-up on outstanding items on the HS are unsuccessful. Proceed with selecting completion after that step.
v) Return to Initial HS Provider: Select if based on clinician's discretion, the patient should return to the initial HS provider to review labs, discuss treatment options, etc.
vi) Completed HSF (Clinics): Select once ALL data has been entered, all referrals are attached, and any lab work is reviewed. This includes waiting for the CXR results to be uploaded before marking as complete, if applicable.
vii) Completed HSF (State): Autogenerated from RHP
viii) HS Date Complete: Autogenerated from RHP
ix) Days to Complete: Autogenerated from RHP

6) **General Exam tab**
a) **Physical Information Section**
i) Height, Weight, BMI, Systolic BP, Diastolic BP: Enter results collected
ii) Wears Glasses: Select if the patient wears glasses currently
iii) Visual Acuity Screened: Select once completed
iv) Vision Acuity Results: Enter once completed. E.g. OD 20 OS 20 OU 20

b) **Social History Section**
i) Tobacco Use: Select if patient uses this substance
ii) Alcohol Use: Select if patient uses this substance

7) **TB tab**
a) **Domestic TB Screening Section**
i) Class A, B, B3: Select if applicable
ii) Class B1 and/or Class B2: Will already be selected if applicable per RHP. Patients receive this classification based on their history related to TB at the overseas medical exam.
iii) TB Test Date: Verify/enter previous testing date or enter date if completion at screening visit. (It is possible that is already completed on a military base and we would just enter/verify the date instead of doing the screen at the domestic IHS)

iv) TB Screened: Select if already completed and/or once completed by screening provider.
v) QFT: Select the test results if applicable. Mark as N/A if patient tested through PPD.

b) **PPD Section**
   i) TST: Select the test results if applicable. Mark as N/A if patient tested through QFT.
   ii) Induration in MM: Enter results collected if applicable.
   iii) TST reading date: Enter results collected if applicable.

c) **Repeated TB Test Section**
   i) Repeated TB Test: Select "Yes" if the TB test was repeated. Leave blank if not applicable.

d) **CXR Section**
   i) CXR Order Date: Enter the date the screening provider ordered a Chest X-Ray due to patient testing positive on the screening
      (1) Attach the CXR Order file under the "Attachments" tab in "CXR Order"
   ii) CXR Date: Enter the date of the scheduled Chest X-Ray (This field may be completed once results are received)
   iii) CXR Results: Select the tests results applicable once received.
      (1) Attach the CXR Result file under the "Attachments" tab in "CXR Report"
   iv) Days from CXR order to CXR results: Autogenerated from RHP
   v) Date CXR sent to SLCoHD: Autogenerated from RHP

e) **TB Diagnosis Section**
   i) TB Diagnosis: Select result if patient needs LTBI or has TB diagnosis.

f) ***Special Instructions regarding TB***
   i) Patients should only be tested for TB by QFT or PPD, not both.
   ii) All patients screening positive in a TB screening must be referred to LTBI services at Salt Lake County Health Department.
      (1) Make a note in the 'clinic comment section' that "patient requires LTBI referral."
      (2) RA will coordinate next appointment steps based off this recommendation.
   iii) Clinics are able to track the LTBI treatment progress under the TB sub-tab of "LTBI Data" in RHOS

8) **<u>Parasites tab</u>**
   a) **Soil Transmitted Helminths Section (All 4 sub-sections requires same process)**
      i) Parasite (1-4) Treated Overseas: Select if treated overseas
      ii) Parasite (1-4) Screened: Select if screened at screening visit
      iii) Parasite (1-4) Results: Select applicable test results if completed at screening visit

iv) Medication at HS: Select if prescribed and provided at screening visit
v) Comments: Provide any pertinent information and follow-up instructions

b) ***Special Instructions regarding Parasites***

i) Based on CDC guidelines for parasite screening, select whether a specific Parasite was treated overseas or if it was screened at the domestic screening.
(1) It will be noted on the overseas records, those who have been presumptively treated for parasites.
ii) Patients treated overseas do not need a repeat screening at the domestic screening visit.
iii) If the CDC/Care-Ref tool does not recommend the patient is screened, even if they have not been treated overseas, then you can skip this parasite section and leave those sections blank.
iv) For additional questions on screening requirements related to Parasites, please contact RHP's Sarah Bates: 801-538-9310 sbates@utah.gov

9) **Labs tab**

a) Enter all lab results in accordance with CDC guidelines.
b) **HIV 1 Results Section**
i) Select the result from the drop down
c) **STD/RPR Section**
i) Select the "Reviewed overseas STD results from EDN" if the patient was screened overseas and tested negative. Patients don't need to repeat the STD domestic screening if completed overseas and screened negative.
ii) Domestic Chlamydia Results: Select results if screened at the domestic screening as applicable.
iii) Domestic GC (Gonorrhea) Results: Select results if screened at the domestic screening as applicable.
iv) Domestic Syphilis Results: Select results if screened at the domestic screening as applicable.
v) Other STD Comments: Enter as needed
d) **Hepatitis Section**
i) Hep B Results: Select results if applicable.
ii) Hepatitis B test overseas: Select if the patient was tested for Hep B overseas.
iii) Hep C Results: Select results if applicable.
e) **Blood Lead Section**
i) BLL Results (ug/dl): Enter numeric blood lead results if applicable
f) **B12 Section**
i) B12 Results: Enter numeric B12 results if applicable
g) **Diabetes Section**
i) Low Risk for Diabetes: Select based on PGL results and clinical discretion
ii) PGL: Enter the numeric PGL results
iii) Diabetes Comments: Enter as needed

h) **Lipid Disorder Screening Section**
    i) Total Cholesterol: Enter numeric results
    ii) HDL Cholesterol: Enter numeric results
    iii) LDL Cholesterol: Enter numeric results
i) **Complete Blood Count Section**
    i) WBC: Enter numeric results
    ii) RBC: Enter numeric results
    iii) Hemoglobin: Enter numeric results
    iv) Hct (Hematocrit): Enter numeric results
    v) MCV: Enter numeric results
    vi) Eosinophils: Enter numeric results
        (1) Note: RHOS collects results that are in the unit cells/uL rather than the typical labs - so you need to multiply the k/uL number * 1000 for the cells/uL rate. E.g. 0.1*1000 = 100 cells/uL.
j) **Urine Analysis Section**
    i) Urine Analysis Results: Enter results. E.g. normal, trace protein or trace blood.
k) **Helicobacter Pylori Section**
    i) H Pylori: Check mark if patient is positive for H Pylori
    ii) H Pylori Test: Select type of test given from drop-down options

10) **Immunizations tab**
a) In accordance with the ACIP schedule, enter all of the dates of when immunizations were provided at the initial health screening.
b) Important: Select the "Reviewed overseas/base immunizations" button to acknowledge that all overseas immunizations were entered into USIIS, the Utah immunization tracking system.
c) At the second health screening visit, please give any immunizations found lacking per the titers drawn at the first health screening visit, and enter them in the correct spots in this tab..

11) **Mental Health tab**
a) All patients should receive a mental health screening
b) **Initial RHS-15 Section**
    i) Select "Yes" from the "MH Screening Done" dropdown
c) **< 14 years Section**
    i) If the patient is < 14 years old, please answer the question after reviewing the notes from the screening.
d) **≥ 14 years old Section**
    i) If the patient is ≥ 14 years old, enter the RHS-15 screening scores in "Initial RHS 1" and "Initial RHS 2" for the two different sections of the assessment.
        (1) Select from the dropdown with how the RHS was delivered
e) **All Section**
    i) Select "Anxiety (Signs/Symptoms)" if identified based on the screening results/conversation at the screening.

ii) Select “Depression (Signs/Symptoms)” if identified based on the screening results/conversation at the screening.
iii) Select “History of Torture/Violence” if patient shares this or found in their history.
iv) Provide additional comments related to mental health, under “MH Other”
v) Utilize the dropdown “Severity” to mark the mental health concern severity for the patient
vi) Select “Initial MH Referral Accepted” if the patient accepted a referral to a clinical mental health agency for further support
vii) “If Initial MH Referral rejected, why?” use this box to write a note as to why the patient rejected the referral. E.g. patient felt unnecessary or not needed.

f) **Mental Health Services After Positive Initial Screening**
   i) If a patient screens positive on MH screening and accepts a referral, please select from the “Referral Agency” dropdown so the resettlement agencies know where to connect the patient to MH follow-up care.

g) **Special Notes on MH Section**
   i) If you’d like more information with regard to referral agencies for MH, please connect with Lida Rutz (lrutz@utah.gov) at DHHS’s Refugee Health Program.

12) **Medical Conditions tab**
   a) This is where all conditions identified from the screening should be marked based on different sections e.g. Nutrition, Ophthalmology, Hematology, ENT, etc.
   b) Each section has a comment section to enter other conditions not listed or other details that would be helpful if the patient were to establish care at a different PCP.
   c) Select referral needed for a particular section if this is identified from the screening and the patient needs to see a specialist in that particular field.
      i) E.g. If Cardiology issues are identified and the provider decides they need a specialist referral, you’d select the specific types of Cardiology concerns identified from check boxes and/or enter comments in the “Cardiology Other” comment box. Finally, select the “Referral Needed” check box in the Cardiology section.
   d) If other health issues were identified, at the bottom of this page, there’s a comment box for other “Health Issues” to write in.

13) **Comments tab**
   a) This is a section for screening clinics, agencies, and RHP to communicate on any follow-up or missing items for a particular patient’s initial screening. You can see all the notes under “View”
   b) When in “Edit” you can only add clinic comments. This is where you’d list out the different referrals and follow-ups that a patient needs.

i) E.g. (1) PCP F/U - nutrition concerns (2) Dental (3) Eye exam

c) You can also communicate with the agencies in these comment boxes if any coordination is needed for a more pressing follow-up e.g. chest x-rays, vaccines, or stool kits.

14) **Attachments tab**

a) Attach all the necessary attachments after entering the health screening results.
b) Most importantly, provide an attachment for all referrals and CXR or Lab orders.
c) **Pre-HS Assessment**
   i) Agency to update this if possible.
d) **HSF Upload Days**
   i) N/A - automatically generated
e) **Health Screening Form**
   i) Attachment is not required in this section. HS information entered into RHOS will count as a health screening form.
f) **SOAP Note #1 and #2**
   i) Attach the SOAP notes from HS #1 and HS #2.
g) **Lab Results #1 and #2**
   i) Attach all Lab results from HS.
   ii) In RHOS there are two attachment spots for multiple lab results.
h) **CXR Order**
   i) Attach the CXR Order for positive QFT.
i) **CXR Report**
   i) Attach the CXR Result after it is received from the area chest x-ray provider.
j) **PPD reading**
   i) Attach PPD results if applicable.
k) **Referrals #1 and #2**
   i) In this section, attach all the HS referrals and lab orders.
   ii) In RHOS there are two attachment sections for referrals (Referrals #1 & Referrals #2). If a patient has more than two referrals, combine files together.
l) **Military Base Medical Record**
   i) N/A for clinics - for some Afghan parolees, it contains their military base medical record.

15) **EDN tab**

a) **No data entry required in this tab**
b) RHP imports some data points from the EDN (Electronic Disease Notification) system at the CDC into RHOS so clinics can view some of the overseas medical exam results.
c) Sometimes there are delays in information on EDN or in the import into RHOS, so it's important to review in EDN versus relying on the information in RHOS.

d) If it's available, we will do our best to get the overseas medical information added into RHOS prior to the appointment to assist providers in knowing some of the basic concerns identified at the overseas exam.

16) **Billing tab**
    a) Will show information if the clinic billed for the screening and if it was approved. Only there to provide some transparency.
17) **Health Promotion tab**
    a) N/A to screening clinics
18) **FINAL STEP**
    a) After all data is entered, all referral(s) attached, and pressing follow-up related to the initial exam are complete (i.e. CXR results), return to the "Demographics" tab and scroll down to the bottom to mark the HS as complete by selecting "Complete HSF (Clinics)"
    b) Once completed, RHP will review and provide any comments if needed or approve as fully complete.
    c) It is only after a HSF is fully approved by RHP that the consultation/co-payments may be paid to screening clinics.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

January 16, 2024

Helen McGuirk
Chair
Association of State Refugee Health Coordinators
Refugee Health Coordinator
Michigan Department of Health and Human Services

Dear Ms. McGuirk:

The 2024 Technical Instructions for Tuberculosis (TB TIs) for Panel Physicians have been posted on the Centers for Disease Control and Prevention (CDC) website and are effective as of January 24, 2024, with major changes to testing to be implemented no later than October 1, 2024.

The 2024 TB TIs define the requirements for panel physicians examining applicants overseas for infectious tuberculosis disease. These instructions are specific to the immigration medical evaluation overseas. They should not be used as guidance to test for or treat tuberculosis disease in other settings or as a clinical manual that defines detailed laboratory procedures or specific treatment regimens. CDC's Division of Global Migration Health (DGMH) developed these instructions in consultation with US tuberculosis subject matter experts and US panel physicians.

You can access the 2024 TB TIs for panel physicians at Tuberculosis Technical Instructions for Panel Physicians | CDC

Major revisions in the 2024 TB TIs that go into effect on October 1, 2024, include:

- Panel physicians must perform an interferon-gamma release assay (IGRA) on all applicants 2 years of age and older in countries with a World Health Organization (WHO)-estimated tuberculosis incidence rate of ≥20 cases per 100,000 population, to begin no later than October 1, 2024. Children in these countries have been required to receive IGRA testing since 2018. Note that applicants 15 years and older in these countries will continue to receive a chest x-ray regardless of IGRA results. Panel Physicians will now be allowed to use WHO-approved IGRA tests in addition to US Food and Drug Administration (FDA)-approved tests to improve availability and potentially lower costs.
- Panel physicians must perform a molecular test in addition to sputum smears and culture. The molecular test must be a nucleic acid amplification test (NAAT) and must be performed on the first respiratory specimen from all applicants requiring sputum collection for initial diagnosis. Panel physicians must begin using a molecular test no later than October 1, 2024.
- Please see TB TIs for other minor revisions.

Updates to the Civil Surgeon TB TIs for examination of applicants within the United States will be posted in the coming weeks, and additional information will be provided at that time. If you have any questions regarding the 2024 TB TIs for Panel Physicians, you may contact CDC QAP at cdcqap@cdc.gov.

Thank you for your support in this important public health matter.

Sincerely,

POSEY.DREW.LAWRENCE.1266056431

Digitally signed by POSEY.DREW.LAWRENCE.1266056431
Date: 2024.01.17 11:52:42 -05'00'

Drew Posey, MD, MPH
Chief
Immigrant and Refugee Health Branch
Division of Global Migration Health
Centers for Disease Control and Prevention

cc:
Margaret Brewinski-Isaacs, ORR, ACF, DHHS
Blain Mamo, Minnesota Newcomer Center of Excellence
Lori Kennedy, Colorado Newcomer Center of Excellence
Erin Mann, National Resource Center for Refugees, Immigrants, and Refugees
Sarah Clarke, Society of Refugee Healthcare Providers

Utah Refugee Health Screening Network

UDHHS, Epidemiology, Refugee Health/TB Program PO BOX 142104, 84114-2104 Cannon Bldg. 288 N 1460 W, SLC, UT 84116 Phone (801)538-6191 Epi Fax (801)538-9913 Refugee Health Program Fax (801)237-0770		
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RESETTLEMENT AGENCIES		
Cache Refugee and Immigrant Connection (CRIC) 1115 N 200 E #130, Logan UT 84341 435-915-6689		
(Open) – Executive Director		
Virginia Schmid – Interim Resettlement Director	435-534-1525	vschmid@cacherefugees.org
Lorien Belton – Director of Finance & Operations	435-770-2413	lorien@cacherefugees.org
Ariane Magana – Resettlement Manager	435-534-1919	amagana@cacherefugees.org
Ben Randall CHW - Health Promotions	435- 534-1618	brandall@cacherefugees.org
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Catholic Community Services (CCS) 745 E 300 S SLC, UT 84102 Phone (801)977-9119 Fax (801)977-9224		
Aden Batar – Migration & Refugee Services Director	801-428-1254	abatar@ccsutah.org
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Brittany Steenhoek – Health Services Supervisor		bsteenhoek@ccsutah.org
Vanessa Masanka - Health Services Coordinator	385-343-6531	vmasanka@ccsutah.org
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Sediqullah Noori – Health Services Team		snoori@ccsutah.org
Erica Astle - Refugee Foster Care Program Manager	801-428-1239	eastle@ccsutah.org
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International Rescue Committee (IRC) 221 S 400 W, SLC, UT 84101 Phone (801)328-1091 Fax (801)328-1094		
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Jonessa White - Health Program Manager	801-694-7793	jonessa.white@rescue.org
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Arwa Jundi—Mental Health Coordinator	385-320-1444	arwa.jundi@rescue.org
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Whitney Nguyen - Health Promotion	801-883-8465	whitney.nguyen@rescue.org
Teresa Hyatt – Billing Supervisor		Teresa.Hyatt@rescue.org
Refugee & Immigrant Center - Asian Association of Utah (AAU) 155 S 300 W, SLC, UT 84101 Phone (801)467-6060 Fax (801)486-3007		
Scott Cougill – Executive Director	801-990-9485	scott.cougill@aau-slc.org
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LOCAL HEALTH DEPARTMENTS		
Salt Lake County Health Department (SLCoHD) 610 S 200 E, Suite 2103 SLC, UT 84111 Phone (385)468-4222 Fax (385)468-4232 https://www.saltlakecounty.gov/health/infectious-disease/tuberculosis/		
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University of Utah Redwood Clinic 1525 W 2100 S SLC UT 84119 Phone (801)213-9500 – Scheduling Line (Care Navigation)		
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Krystal Bustamante – New American Support Coordinator	801-213-9700	krystal.bustamante@utah.edu
University of Utah Newcomer Clinic 168 N 1950 W #201, SLC UT 84116 Phone (801)646-6388 Fax (801)646-6397		
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MENTAL HEALTH CLINICS

Asian Association of Utah (AAU) – Refugee & Immigrant Center Mental Health and Substance Abuse Services and more Adults and Children 5 and older 155 S 300 W, Suite 101, SLC, UT 84101 Phone (801)467-6060 Fax (801)412-9926		
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THRIVE Center for Survivors of Torture (THRIVE) [formerly Utah Health and Human Rights (UHHR)] Adults who are survivors of violence and torture 225 S 200 E, Suite 250, SLC, UT 84111 Phone (801)363-4596 Fax (801)363-4596		
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Cami Berger – Clinical Director	801-494-5418	cami.berger@thrivesot.org
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The Children's Center Utah Children under the age of 8 Services: Therapeutic Preschool Programs, Autism, Assessment and Evaluation; Medication Management, Family Therapy and Trauma Treatment 3725 West 4100 South, Ste 250 West Valley City, UT 84120 Phone (801)582-5534		
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Sarah Robinson – SAHMSA Grant Project Coordinator	801-578-2331	sarah.robinson@tccutah.org
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**Katie Proffitt – Intake Coordinator		kproffitt@tccutah.org
**Jasmine Topete – Intake Coordinator		jtopete@tccutah.org
Journey - Center for Behavioral Health Adults and children 8 and older Referrals: info@journeyslc.org Services: Psychotherapy, medication management, wellness and psychoeducation groups. 1343 S. Main Street, SLC, UT 84115 Phone (801)232-7633 Fax(801)466-2377		
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**Zala Sanaullah – Intake Coordinator		zalas@journeyslc.org

03-13-2025