Screening Guidance and Protocol

Key Points

- Review overseas medical documents, including vaccinations and screening for communicable conditions of public health importance.
- Work with a qualified medical interpreter who speaks the patient's preferred language.
- During the initial screening appointment, address immediate health concerns/priority needs and obtain a detailed history, including aspects unique to refugees (e.g., travel history).

Screening Guidance

CBC: Complete blood count with differential. Report conditions identified (such as anemia), further tests needed, and plans for follow-up. If the hematocrit is less than 30%, a malaria smear is recommended for persons from regions where it is endemic (i.e. tropical areas in general, such as Sub-Saharan Africa, the Indian subcontinent, East Asia, Central America, Tropical South America, Middle-East.). See CDC General Clinical Guidance for the Evaluation and Interpretation of Complete Blood Count, Hemoglobin Electrophoresis, Thyroid Function, and Newborn Screening in Refugee Populations for more information.

Hepatitis B: Screen all newly arriving refugees from high or intermediate endemicity countries. Serologies for hepatitis B should include HBsAg, hepatitis B surface antibody (anti-HBs), total hepatitis B core antibody (anti-HBc), and IgM antibody to hepatitis B core antigen (IgM anti-HBc). Those who do not have HBV infection should be offered hepatitis B vaccination series according to the ACIP-recommended schedule. Reportable to Vermont Department of Health.

Hepatitis C: Universal hepatitis C screening should be implemented for all new adult arrivals (≥18 years of age). Screening is recommended for all pregnant women during each pregnancy.

HIV screening: Current CDC guidelines for the United States recommend HIV screening in health-care settings for all persons 13-64 years of age. Screening of all refugees 13-64 years of age is recommended in accordance with this policy. Screening of all refugees on arrival, including those ≤12 years and ≥64 years of age, is also encouraged. Screening should be performed on all refugees unless they decline (opt out).

Lead screening: Test all refugee infants and children under 16 years old at entry to the US. Test all pregnant and lactating women and adolescent girls. Capillary screening results at or above 3.5 µg/dL should be confirmed with blood drawn by venipuncture. Check for lead sources in children with an elevated blood level ≥ 3.5 µg/dL. (For more information, see DHHS Notification: Updates to the domestic lead screening guidance for newly arrived refugees). Perform a follow-up screening at 3-6 months after arrival for all refugee children under 6 years, regardless of initial screening result. Test refugees older than 18 years of age if there is a high index of suspicion, or clinical signs/symptoms of lead exposure. Check for lead sources and provide appropriate follow-up care when blood lead level is ≥ 3.5 µg/dL. See Screening for Lead during the Domestic Medical Examination for Newly Arrived Refugees for additional information. VDH Lead Program will provide in-home, follow-up management to individuals identified with elevated BLL.

Malaria testing: Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pregnant, lactating, infant < 5 kg). Refugees from areas other than sub-Saharan Africa are not routinely presumptively treated or tested, unless specifically directed.

Mental health screening: Assess patient's general orientation to date/place/time. An age appropriate and culturally responsive mental health screening should be utilized (see below for available screening tools). Focus screening on perceived level of stress (e.g., symptoms related to PTSD, anxiety or depression). If appropriate, ask if patient has substance use concerns. Questions on sensitive issues such as torture, rape, or family violence should be reserved for trained experts in a setting of a trusting relationship, but providers should help refugees access these services through appropriate referrals. See CDC Guidance for Mental Health Screening during the Domestic Medical Examination for Newly Arrived Refugees for more information. Potentially appropriate screening tools include the following:

a. Ages 14 and above: Refugee Health Screener – 15 (RHS-15)
b. Ages 3-17: Strengths and Difficulties Questionnaire
c. Parental screening: Edinburg Postnatal Depression Scale; Patient Health Questionnaire-2

Physical assessment: Use additional sheets if necessary. The physical examination should include:

- **Physical:** Basic evaluation, general condition (including heart, lungs, ENT, skin evaluation, blood pressure patients 5 years and older). Height, weight, head circumference (if less than 3 years old). Note that children of different ethnic groups may not follow the growth pattern represented on standard US growth charts.
- **Vision:** Gross evaluation. Tumbling E or Landolt C charts may be used for vision screening of
- persons who use a different alphabet.
- **Dental:** Gross evaluation. Check for decay, white spot lesions on teeth, poor oral health habits,
- bottle feeding in bed (infants). Refer as indicated.
- **Developmental screening:** Age-appropriate developmental screening may be initiated during the domestic medical screening for both children and adults.

Parasitic infection screening: Review overseas records to determine whether any overseas presumptive treatments were provided and whether any contraindications to treatment exist. Depending on country of origin and whether overseas presumptive treatment was provided, determine whether any additional presumptive treatment or "test and treat" via stool sample assessment is appropriate. Determine whether the following screenings/presumptive treatment are appropriate:

1. **Schistosomiasis:** Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pre-existing seizures; under age 4 years) that are not resolvable should be tested rather than treated. Serologic testing is an acceptable alternative. Presumptive treatment is only recommended in refugees from sub-Saharan Africa. Currently all sub-Saharan refugees without contraindications are receiving pre-departure treatment
2. **Stool O&P:** Stool test for ova and parasites. Two tests must be conducted, collected at least 24 hours apart. Only report as "Positive" if finding is a pathogenic organism.
3. **Strongyloidiasis:** Most refugees receive overseas pre-departure treatment with ivermectin before departure unless contraindicated (e.g., pregnant; <15kg). All individuals who did not receive pre-departure presumptive treatment should have serologic testing or presumptive treatment after arrival. Refugees who have lived in a Loa loa-endemic country should be tested for the presence of Loa Loa microfilaremia BEFORE being treated with ivermectin. See Presumptive Treatment and Screening for Strongyloidiasis, Infections Caused by Other Soil-Transmitted Helminths, and Schistosomiasis among Newly Arrived Refugees.

Syphilis Test: Recommended for age 15 and over. Report the result of the RPR test. If positive, report on history of syphilis and treatment to facilitate interpretation.

TB (Tuberculosis): IGRA (Interferon Gamma Release Assay) is the preferred screening tool for some people ages 5 and older. For more information on when to use IGRA and how to interpret results visit: CDC IGRAs Fact Sheet. **The tuberculin skin test (TST)** is the preferred screening test for use in people

under 5 years old regardless of BCG history. The measurement of what is considered positive is dependent on several conditions and factors. For more information on TST use and how to interpret results, please visit: CDC Tuberculin Skin Testing Fact Sheet. **Chest x-ray (CXR)** is indicated for any refugee who has a positive TST or IGRA, a Class B TB status, or signs and symptoms of TB. A chest x-ray may also be indicated in screening for TB disease among individuals with a known HIV positive status. **Suspicion of active TB** is an immediately notifiable condition to the Vermont Department of Health (802-863-7240)**. Sputum samples** are clinically indicated when a refugee has an abnormal chest x-ray or signs and symptoms of TB disease. Sputum samples may also be indicated in screening for TB disease among individuals with a known positive HIV status. For more information: CDC Guidance for Screening for TB Infection. When it is indicated to collect sputum samples for microscopy/bacteriology to diagnose or rule out active TB, the Vermont Department of Health can help arrange for the appropriate selection of tests, sputum collection and lab processing. Contact VDH at 802-863-7240. **Latent TB Infection** is also a reportable diagnosis. Please notify VDH. **Medications for the treatment of active and latent TB** can be provided through the state TB program if needed, contact VDH at 802-863-7240.

Immunizations

Guidance for Evaluating and Updating Immunizations during the Domestic Medical Examination for Newly Arrived Refugees

US-Bound refugees are offered some vaccines overseas through the Vaccination Program for US-Bound Refugees. Refugees who undergo repeat medical examinations before departure may receive additional vaccine doses. Vaccinations administered through this program are documented on the DS-3025 (*Vaccination Documentation Worksheet*). Age-appropriate historical vaccinations with valid documentation are also recorded on the DS-3025 in the "Vaccination Record" column.

Note that US-bound refugees, unlike immigrants, are not required to receive vaccinations before arrival in the United States. It is also not uncommon for refugees to arrive without immunization records due to the circumstances of their travels from their country of origin. Therefore, many may not be fully up to date with Advisory Committee on Immunization Practices (ACIP)-recommended immunizations at time of arrival. If only partial records or no immunization records are available at the time of the health screening appointment(s), provider should initiate the immunization series according to ACIP guidelines. Titers can also be drawn to determine protection. Partial overseas records may be available and can be incorporated into the catch-up administration of vaccines. Note that available records must include actual dates of administration, not just a check mark. These guidelines may be accessed at CDC Immunization Schedules, or by calling the Vermont Immunization Program at 1-800-640-4374 (VT only).

Hepatitis B instructions: Vaccinate all children 11-12 years of age who did not receive the primary series as infants. Vaccinate household contacts of persons whose surface antigen test is positive (HbsAg). Screen all pregnant women for HbsAg; If at risk, repeat screening closer to term.

MMR: Vaccine is provided at no cost by the Vermont Department of Health. Please note trivalent vaccines may not be available abroad and refugees may not be fully immunized.

Contact Information

Refugee Health Program: Allie Perline, Program Coordinator, Allison.Perline@vermont.gov.
Vermont Department of Health: Infectious Disease Reporting and Data
Call by phone for all immediately reportable findings: Infectious Disease Program at 802-863-7240 or 1-800-640-4374 (within Vermont only) from 7:45 a.m. through 4:30 p.m. on business days. An epidemiologist is available 24/7 for diseases that require prompt public health follow-up or consultation.