IMPROVING UNACCOMPANIED REFUGEE MINORS QUALITY OF LIFE IN VIRGINIA

Prepared by:
Oriana Figueroa Chacin
Master of Public Policy Candidate
Frank Batten School of Public Policy and Leadership
University of Virginia
2023

Prepared for
Eva P. Stitt, PhD,
Refugee Behavioral Health State Coordinator Manager

Virginia Department of Behavioral Health & Developmental Services

University of Virginia | Frank Batten School of Leadership and Public Policy

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Mandatory Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Acknowledgements

I would like to thank Eva Stitt, PhD, at the Virginia Department of Behavioral Health and Developmental Services for allowing me the privilege of doing research on the topic of unaccompanied refugee minors mental health, a topic that is becoming more relevant by the day. Her patience, guidance, mentorship, and feedback were instrumental for the creation and finalization of this report so that it reached its fullest potential. It's been an honor to receive mentorship and feedback from someone that cares so deeply about the topic and works daily to ensure unaccompanied refugee minors are receiving the care they deserve.

I would also like to thank Professor Kirsten Gelsdorf and Professor Chrisopher Ruhm for all the help and insight that they have offered over the most arduous academic year of my life. You both have spent countless hours ensuring that my work has gone above and beyond my expectations and I both want to both thank you and express my admiration for your work.

I would also like to thank my parents and my sister, as well as my friends, for all the support they have offered me over the last year, which made this report possible.

Finally, I want to acknowledge Jonathan Dove, Allison Edwards and Owayne Owens for the help they have offered me regarding the APP this semester.

Executive Summary

The levels of displacement caused by conflict or natural disasters are increasing at an alarming rate. Many of those who have been forcibly displaced by tragedy, conflict or coercion are children, and many of those children are traveling without any adult supervision, and thus fall into the category of unaccompanied refugee minors once they reach the United States and are put in the custody of the Office for Refugee Resettlement (Office of Refugee Resettlement, n.d.2). In less than a decade, the United States saw an increase of almost 100,000 unaccompanied refugee minors entering the country, from the initial estimate of 27,840 back in 2015 to 127,447 unaccompanied refugee minors in 2022 (Office of Refugee Resettlement, n.d.1). The drastic increase is concerning by itself, but considering that 90 percent of Unaccompanied Asylum-Seeking Children are victims of exploitation at some point of their journey to safety, it is essential to begin working on possible pathways to ensure that the unaccompanied refugee children that have been released to sponsors in the state of Virginia are being given all the resources they need to integrate into American society (Rodriguez & Dobler, 2021).

This report delineates the background and possible consequences of a failure to integrate into American society, as well as examining four policy options that Eva Stitt and the Office of New Americans could consider implementing to ensuring unaccompanied refugee minors' wellbeing is safeguarded. The alternatives presented are the following:

- Retain the Status Quo.
- Establish Community Groups Solely for Unaccompanied Refugee Minors.
- The creation of Instructional Videos regarding Language Resources for Sponsors and Practitioners affiliated with the Office of New Americans.
- Improve current Cultural Trainings Opportunities available for Healthcare Providers.

The four alternatives will be evaluated on three criteria: cost (scored as a measure of financial feasibility), effectiveness (scored as a measure of take-up rates estimated from similar programs), equity (scored as a measure of the cultural range that could theoretically be included within each of these alternatives).

The final recommendation is that of the creation of Instructional Videos regarding Language Resources for Unaccompanied Refugee Minors' sponsors and health practitioners affiliated with the Office of New Americans, as it is an option that rates high in effectiveness, cost and equity and would allow to easier access to resources currently available. However, other alternatives also scored highly and should be considered if the Office of New Americans has the budget to implement them.

Acronyms

Unaccompanied Asylum-seeking Children – UASC

Unaccompanied Refugee Minor – URM

U.S. Department of Health & Human Services - DHHS

Virginia - VA

Office of Refugee Resettlement – ORR

Unaccompanied Refugee Minor Foster Care - URMFC

Virginia Department of Social Services – VDSS

Virginia Department of Behavioral Health and Developmental Services – VDBHDS

Office of Refugee Resettlement Unaccompanied Refugee Minor Program – ORR URM Program

Problem Statement

Over the last ten years, the numbers of Unaccompanied Refugee Minors (URMs) entering the U.S. has increased by nearly 100,000. Among all US states, Virginia (VA) ranks as the seventh state with the most URMs released to sponsors, as VA saw an increase of almost 5,000 URMs released to sponsors in the state in less than ten years (Office of Refugee Resettlement, n.d.1). **As the Office of Refugee Resettlement (ORR) settles a growing number of unaccompanied refugee minors in Virgnia, a priority must be made in ensuring their well-being and adjustment to the state and the country to ensure they have a proper quality of life (Office of Refugee Resettlement, n.d. 2).** Placement of URMs is primarily left to the Virginia Department of Social Services (VDSS) which offers two foster care programs for URMs located in Richmond and in Fairfax, but it mostly relies on the federal Unaccompanied Refugee Minor Foster Care (URMFC) program for most resources offered (Virginia Department of Social Services, n.d.1).

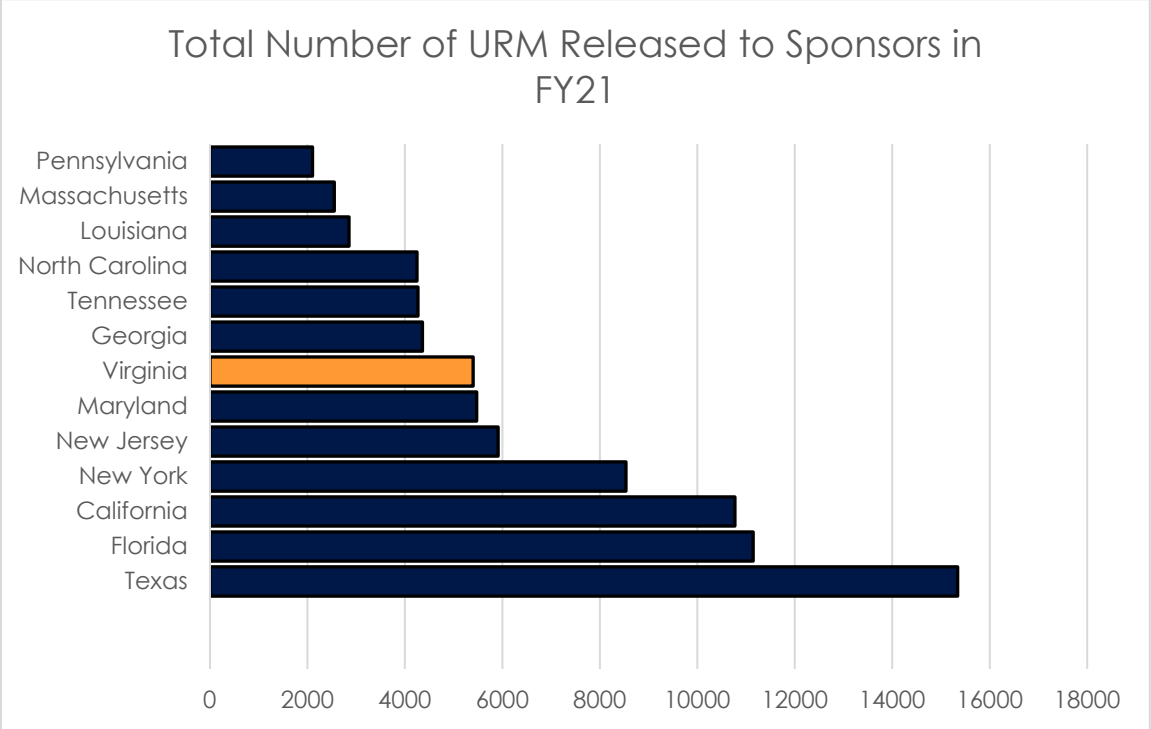

Figure 1: Top 13 States with the Most URMs released to sponsors by State (Office of Refugee Resettlement, n.d.1)

Background

Scale of Unaccompanied Asylum-seeking Children worldwide

According to the United Nations High Commissioner for Refugees, as of 2022 there are 89.3 million forcibly displaced people worldwide, with an estimated 41 percent (36.5 million) of them being children below the age of 18 (United Nations High Commissioner for Refugees). This estimate is concerning as 90 percent of Unaccompanied Asylum-seeking Children (UASC)— whose numbers include URMs— worldwide have been subjected to exploitation during their flight from peril, making them particularly vulnerable to mental health issues even once they have been granted asylum (Rodriguez & Dobler, 2021). Specifically, studies show that around 41-69 percent of UASCs report mental health problems and 64 percent meet the criteria necessary to be diagnosed with post-traumatic stress disorder (PTSD), among other mental illnesses as well as physical issues (Rodriguez & Dobler, 2021).

Scale of Unaccompanied Refugee Minors in the United States and in Virginia

The number of URMs in US first saw a spike after the federal fiscal year of 2015 (FY15), which runs from October 2014 to September 2015. In FY15, the number of total URMS released to sponsors by state in the US was 27,80. Seven years later, in federal fiscal year 2022 (FY22), which ran from October 2021 to September 2022, the number of URMs released to sponsors by state during the federal year increased to 126,447(Office of Refugee Resettlement, n.d.1). Virginia has reflected this sudden influx of URMs in that period. In FY15 Virginia received 1,694 URMs released to sponsors within the state while seven years later in FY22 the number of URMs released to sponsors in Virginia increased to 6,213 URMs (Office of Refugee Resettlement, n.d.1). This jump has drastically increased the state's needs for resources directed to URMs specifically as Virginia is now the state with the seventh largest population of URMs in the country (Office of Refugee Resettlement, n.d.1).

Client Mandate

Unaccompanied refugee minors (URMs) are under fall under the purview of the Office of Refugee Resettlement (ORR), an office within the U.S. Department of Health & Human Services (DHHS) in the federal scale (Stitt, 2022). As the DHHS oversees the foster care system, they are also given temporary guardianship of URMs during the period it takes the federal government to find sponsors for them within the country (Stitt, 2022). On the state level, the DHHS partners with the Virginia Department of Health and Behavioral Services (VDHBS) and the Office of New Americans (ONA) to settle URMs throughout the state and to provide resources as needed (Stitt, 2022).

In a recent initiative to improve refugee conditions, the VDHBS recently implemented the Virginia Refugee Healing Partnership (VRHP), a "statewide initiative to establish sustainable

public-private collaboration to ensure refugee access to mental healthcare, to develop pathways to support behavioral health providers prepared to serve refugees and to strengthen refugee mental wellness and capacity building measures" (VDBHDS). According to Eva Stitt, the client of this report and the coordinator of the Virginia Refugee Healing Partnership (VRHP), the mandate of the VRHP includes providing tools for refugees to integrate to American society, therefore putting this topic under the partnership's domain of influence (Stitt, 2022). This is particularly crucial now, as the great number of URMs in Virginia has made it essential for the VDHBS, and specifically the VRHP, to further develop their services to allow for the integration of URMs within the state to prevent future negative developments based on the children's inability to feel at home in the United States. This is because while many of their current resources might be beneficial to URMs, URMs might lack the knowledge of how to access them or are intimidated due to being children in new environments (Stitt, 2022).

Mental Health Issues

With the increase of URMs reaching the United States over the last decade, it is crucial to consider the psychological impacts being an URM has on children. Data suggests that about 75 to 80 percent of unaccompanied minors arriving to the United States are victims of human trafficking (Ataiants et al., 2018), an experience that exacerbates the trauma that drove these minors to leave home in the first place. The traumatic experiences faced by URMs include political violence, combat situations, loss of family, famine, sexual exploitation, and abuse (Rodriguez & Dobler, 2021).

Compared to accompanied refugee minors, research shows that URMs are more likely to develop higher levels of psychological distress due to having to face traumatic experiences alone and unprotected during their travels (Müller et al., 2019). Further division within this subgroup is presented when throwing gender into the equation, as it has been found that there is a possibility that female URMs are more likely to experience symptoms of depression on top of the PTSD symptoms that have become commonly attributed to the refugee experience across studies (Mohwinkel et al., 2018). Altogether, mental health issues are a barrier that URMs need to clear to integrate meaningfully into American society.

Mental Health Access

There is growing literature regarding refugee's access to mental care in the United States, that has found that refugees hailing from non-Western cultures (who resettle within a Western culture distinct from their own) face both "functional and social barriers to the effective use of healthcare" (Puentes, 2017). Although the ORR provides health services as soon as URMs are placed in their custody– including overall health services–these services are not sufficient. In fact, once these minors are released to their sponsor's care, there are few follow-up avenues for the URMs (Stitt, 2022). From a functional standpoint, the lack of accessible social integration resources for URMs and their sponsors often disincentives these individuals from following up

with mental health service options (Stitt, 2022).

There are additional social barriers that stop URMs from accessing mental health resources. These are multifaceted, as they tend to be a mix of both cultural prejudices and barriers, as well as mental healthcare practitioners' failure to consider a refugee's unique situation and how that could affect the way they interact with others (Shannon et al., 2015). A crucial reason is that URMs tend to refuse the offer to access mental health care due to preconceived cultural notions regarding therapy if trust is not built previously between the person offering the referral and the URM (Misra et al., 2021). It is true that those resources are available and accessible in shelters, schools, and community services if needed, but culture clashes and the minors' beliefs tend to cause hesitancy amongst many to reach out for help (Misra et al., 2021). This lack of access, or reluctance to access the resources, can lead to the exacerbation of the mental health issues plaguing the URMs if they do not have a proper network of support, and in some cases even when a support network has been established, the trauma the URMs have been exposed to is too overwhelming for them to be able to cope without professional help (Rodriguez & Dobler, 2021).

This is not to say that the situation is incorrigible, as counties and cities in Virginia have begun taking steps to bridge the gap between practitioners and patients through partnerships with the VRHP. These counties and cities have begun implementing programs meant to increase the engagement of refugee minors through partnerships with schools and communities' centers. Although these programs— such as the Charlottesville Refugee Mental Health Referral System, which has been recognized statewide as an excellent program— have multiple shortcomings that prevent full participation and limit the programs full potentials, they still improve the refugee minors experience in the United States (Puentes, 2017). Even though these programs are tremendously helpful, they tend to focus on refugee minors, rather than in specific subdivisions. This has led them to not differentiate between those who have come to the country with their family and those who are unaccompanied. Considering the difference in experience between these two groups, then, it can be inferred that there are gaps within the mental healthcare given to *unaccompanied* refugee minors.

Consequences

The lack of cultural awareness to mental health approaches and resources for unaccompanied refugee minors tends to have unintended consequences on the URMs in the long term. The following must be taken into consideration throughout this section: each of these consequence chains do not exist in isolation, on the contrary, and URMs might be experiencing more than one of these consequences at once.

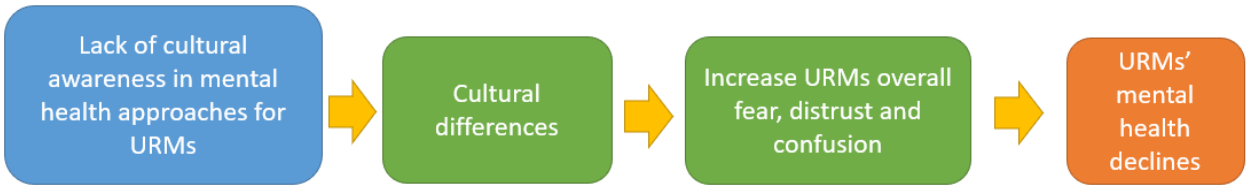

Figure 2: Consequence Chain #1

Figure 3: Consequence Chain #2

When it comes to healthcare, cultural differences and prejudices create a solid barrier for refugees of all types. Cultural differences create doubts on the URMs' side regarding the medical practitioners' capabilities as they act in ways they are not used to. On the medical practitioners' side, it causes irritation and confusion at the misunderstandings (Morris et al., 2009). This lack of communication leads many URMs to only reach out for help once the situation becomes dire. When narrowing the focus to mental health, it is also found that many cultures stigmatize mental health or describe it as specific issues rather than something that everyone needs to pay attention to, therefore making URMs less likely to seek help when it comes to dealing with their trauma (Morris et al., 2009).

Children under eighteen become contested sites of cultural clashes once they are submerged within new cultures, usually battling to integrate their own cultural ideas with those of their new environments (Renzaho et al., 2017). Renzaho's research delves on general immigration, but the weight of these cultural crashes likely affects URMs the same way as it does to the children of immigrants, if not more due to the isolationist experience that is being an URM in a foreign country (Renzaho et al., 2017). There is further evidence that a lack of understanding of cultural differences, practices and prejudices by mental health practitioners might increase the URMs overall sense of fear, distrust, and confusion, causing their mental health to decline (Shannon et al., 2015). Furthermore, many URMs worry about negative reactions from their cultural peers—specifically regarding how others will view their attempts to seek help (Shannon et al., 2015) Being a URM is already a particularly isolating situation, and

cultural stigmas surrounding mental health may lead URMs to lose their support networks if they reach out for help, which can lead to a failure to integrate to American society.

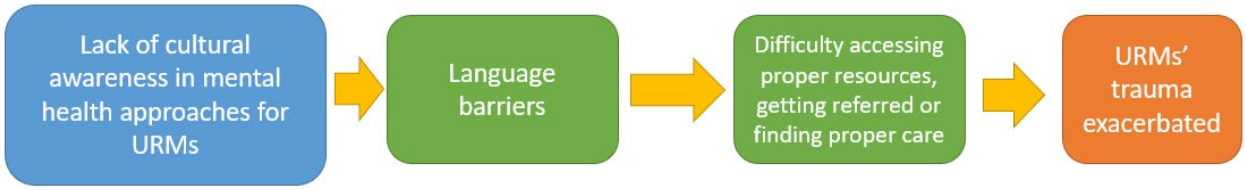

Figure 4: Consequence Chain #3

When it comes to lack of cultural awareness in health outreach for URMs', one of the biggest issues is that of language barriers and how they can cause a disruption to the URMs' ability to access healthcare. Language barriers are not simply contained within a doctor-patient interaction but are extended to every level of the health care system including pharmacies, scheduling, and billing. This leads to an extra layer of burden on URMs and their sponsors (Saechao et al., 2011). Lack of easily accessible instructions on their language of choice tends to have two effects in refugees: they either choose to give up on attempting to get care, or they receive improper care due to improper communication facilitated by the language barrier (Morris et al., 2009). On top of that, cultural prejudices play a significant role in whether an URM will attempt to access mental healthcare or not. When socio-cultural practices are paired with the issues surrounding language barriers, the trauma faced by URMs is often exacerbated.

Evidence for Promising Alternatives

The following section will synthesize the current scholarship on promising alternatives to the current status quo regarding programs targeting URMs in Virginia. A range of international research and national research has been consulted to create data-based approaches that will be tailored to the state of Virginia and the Office of New Americans (ONA).

Community Groups

The use of community-based health programs is a common means of treatment for long-term issues such as diabetes and addiction. Over the last few decades, the number of research projects regarding the benefit of community-based mental health programs have steadily increased. Examples of community-based health programs include Alcoholics Anonymous and Sexual Assault Survivors Groups, yet these programs tend to target older demographics. Targeting URMs might prove to be essential as there is an expanding body of evidence and research on the connection between the sense of community and social support and the way it leads to individuals feeling more satisfied with their life while lessening the symptoms of mental health issues (Hombrados-Mendieta et al., 2019; Kogstad et al., 2012; Riza et al., 2020; Tyrer & Fazel, 2014; Weine, 2011). In refugee communities, peer-lead community groups – specifically those who focus on Health Promotion – are known to increase a community's satisfaction with life while allowing the organizers to build social capital in the form of trust and authority. Social capital is a vital step in encouraging groups who have cultural bias against mental healthcare to change their mindset (Im & Rosenberg, 2015).

An example of a community-based health program in the United States is the *promotora* program which helps immigrant Latina woman connect to a community health worker and has shown results of decreasing their levels of depression and stress through the connections they have established on the program (Tran et al., 2013). A literature review regarding community-based practices written by Riza et al. examined over 129 published articles regarding refugee and immigrant welfare in new countries (Riza et al., 2020). According to their findings, out of the fifteen highly assessed best practices in refugee and immigrant help, seven of those were mental health related and five of those seven emphasized the importance of community building when it comes to the improvement of mental health and the treatment of mental illnesses within immigrant and refugee communities (Riza et al., 2020).There is an emphasis on the importance of school-based interventions for children, which is a type of community-based intervention allowing children to form bonds within their new community. These bonds have been found to increase their satisfaction of life and sense of belonging, while facilitating a social support network (Tyrer & Fazel, 2014).

The research available regarding community-based mental health interventions has a strong methodology and has been explored for over twenty years. The research articles cited seem to have ample samples and those who run regressions account for possible errors in the

date. At first glance, the rigor and applicability of the research also supports the data. While there is a recently published article that ran RCTs regarding the effectiveness or acceptability of community-based interventions for child and adolescent refugees and asylum seekers in high-income countries that states that there is low correlation between community-based interventions and improvements in this group's mental health (Soltan et al, 2022), one article does not override the findings of previous literature. As the results have not yet been reproduced, the Soltan et al. article does not undo the previous body of literature that extends over 20 years.

Language Support

There is worldwide trend that places growing emphasis on the use of language support when it comes to refugee, immigrant and asylee assistance, explaining that the issue of language accessibility is becoming key when it comes to helping these groups integrate into their new communities (Swartz et al., 2013; Tribe & Lane, 2009; Thomson et al., 2015). Yet, despite the growing acknowledgment of the importance of language accessibility as a means to lower the hardship and risks immigrants, refugees and asylees face; the availability of appropriate language resources remains a concern (Schwebel & Brezausek, 2008; Ortega et al., 2021) In the cases in which languages accessibility efforts have been implemented, there is evidence of a clear increase in the uptake of mental health resources for those whom English is not their preferred language (McClellan et al, 2012). Despite the growing availability of language support, provides with access to such resources do not tend to do the effort to access them, and patients have difficulty accessing said resources as the process is cumbersome at best (Brisset et al., 2013; Graves et al., 2020). A case study in Montreal shows that of all health practitioners within the study, 35.4 percent had access to linguistic resources through their institutions, but only 23.9 percent of all participants solicited an interpreter when they knew they needed one (Brisset et al., 2013). Language support can be crossed through counseling in the same language as the individual in need of the resources or the use of interpreters during the counseling session, and research suggests that both types of language support would equally benefit the individual in need of assistance (Schiphorst et al., 2022).

Although there is strong evidence of the need for language support, as well as its success by increasing the take-up rate of health services worldwide, there seems to be more articles about the necessity of language support than articles judging the effectiveness of established programs with language support. The evidence found shows a strong trend in improvement due to currently available language support, but there are gaps in the research as it is limited. Additionally, most organizations nowadays have language support resources available, so connecting them to the medical practitioners might be worth it even if there isn't a solid research base.

Cultural Awareness Training for Provider

The need for cultural awareness within the healthcare system has been observed as early as 2003, with multiple United States government-based agencies providing articles and possible next steps to take to diminish the gap that cultural unawareness causes on the up-take of resources by racial and ethnic minorities (Holden et al, 2014; Murray et al., 2010). There is an increasing body of evidence that creates a direct link between an increase in cultural awareness from health providers and improvement in health from their patients that belong to ethnic or racial minorities (Murray et al., 2010; Bhattacharyya & Benbow, 2012) The sort of program that trains providers has become progressively available over the last decade and has caused a positive impact on how providers interact with their refugee patients (Fondacaro & Harder, 2014; Bäärnhielm et al., 2014; Nigar & Stein, 2016).

The evidentiary chain regarding the concept of cultural awareness training for providers of mental health resources has a strong methodology with studies from both within the United States and abroad. There is a great deal of applicability of the research, and an emphasis on how to train providers for the needs of refugees which is crucial to the focus of this report. However, the rigor is in question at times, as not all the research provided a considerable sample and the programs suggested showed improvement over a short period of time, rather than containing a long-term analysis. Regardless, the evidence does seem to suggest that cultural awareness programs would be a helpful addition to any refugee settlement program.

Alternatives

The next section provides a brief synopsis of the possible policy responses to begin addressing the matter of URM integration into American Society.

Alternative 1: Status Quo

The Commonwealth of Virginia currently has resource centers for immigrants and refugees alike spread out throughout the state which offer job training, placement and similar skill development and essential aid for new arrivals to the country, such as free interpreting programs (Stitt, 2023). Although URMs are amongst the people they are meant to serve, few programs other than foster programs run by Christian-based organizations and other local providers are targeted to them specifically (Virginia Department of Social Services, n.d.1)[1].

The Office of Refugee Resettlement URM (ORRURM) Program provides a more specific list of current resources offered to URMs such as: indirect financial support, social worker case management, healthcare options, educational training vouchers and cultural orientation and social adjustment (Office of Refugee Resettlement n.d.2.)[2]. The list contains a broad number of resources offered to URMs, but they are not explained in depth what their cultural orientation entails, and as the two main providers of services are Christian organizations that work with local affiliates, it is likely there are gaps on their cultural orientation programs (Office of Refugee Resettlement, n.d.2). As with the Status Quo, this alternative is already being implemented and will remain in implementation until there is a drastic change in policy which would change the resources, or the budget attributed to ONA.

Alternative 2: Establish Community Groups Solely for Unaccompanied Refugee Minors

Alternative 2 focuses on community building by bringing URMs from the same national origin together and giving them a support group. While the plan is open for expansion, the alternative first suggests the creation of two community groups targeting Afghan URMs, two community groups targeting Honduran URMs and two community groups targeting El Salvadorian URMs. Alternative 2 suggests that one group targeting each national origin mentioned should be opened in the Richmond and Fairfax area as they are the areas where the main URMs program coordinators are located (Virginia Department of Social Services, n.d.2). Alternative 2 is suggested to run for a five-year period, and then to be revaluated based on the

[1] There is a lack of specification on the VDSS Refugee Services webpage regarding what programs are offered towards refugees in general, aside from links directing to affiliate organizations such as the International Rescue Committee and various Christian-based organizations. For the URMs resources, the VDSS Refugee Services directs the reader to the Office of Refugee Resettlement URM Program Overview Page which leads to a broken link (Virginia Department of Social Services, n.d.1.).

[2] This is not an extensive list, as all the resources offered are given in a general description rather than referring specific programs.

results on whether the program should be continued or stopped. If the program proves beneficial in the long term, further expansion should be considered.

As such, if this alternative is chosen it is recommended that after it has been picked, two months are taken to find appropriate facilitators, to determine where the groups are going to meet, and to ensure the information of the groups launch is disseminated amidst Unaccompanied Refugee Minors of the targeted national origins, before the community groups begin meeting by the third month, at which point the program will run for a five-year trial period. The goal of this alternative is for the unaccompanied refugee minors to build connections with each other based on their shared national origins, as well as confront cultural bias by showing them that everyone struggles and seeking help is not detrimental. The alternative will target both old and new unaccompanied refugee minors as it will create a more tightly established network of bonds, and it would seek facilitators from the same national origin as the children.

Alternative 3: An Instructional Video for Unaccompanied Refugee Minors' Sponsors & Health Care Providers in the Office of New Americans Network

The third alternative is to increase the accessibility to language support resources for both the unaccompanied refugee minors and their sponsors. This alternative is offered as despite the current development of language accessibility happening throughout the country, there is evidence that URMs and their sponsors remain concerned regarding the availability of appropriate resources as they are not aware how to access them (Schwebel & Brezausek, 2008; Ortega et al., 2021). Clear access to language resources will inherently increase medical take-up for non-native English speakers, but due to the lack of uptake of language resources already in place for both healthcare providers, URMs and their sponsors, the issue of language accessibility remains a priority (McClellan et al, 2012; Brisset et al., 2013; Graves et al., 2020). The purpose of this alternative would seek the creation of an instructional video for unaccompanied refugee minors and their sponsors regarding language support resources available for medical and educational provides to increase the uptake of these resources. The video would focus on giving the URMs' sponsors detailed instructions on how to access translation resources, as well as request translators for medical services and how to request help for similar issues.

A similar instructional video or seminar would be sent to providers within the VDSS ONA health provider network so that they become aware of the resources that could make their appointment more efficient and positive such as translation and transcribing resources meant to facilitate understanding between the two parties. The general timeline for the creation of videos is around two months, so it is recommended that the staff of the ONA takes another month before the beginning of the production to collect information and write a preliminary script (Johnston; Admin, 2021). As a video only needs to be shot once and then it has an infinite number of uses, the duration of the implementation of this alternative would only entail the

shooting of the video. Afterwards, the video can be made available for anyone who wants it through the ONA website or through requests.

Alternative 4: Improve Cultural Awareness Training for Health Providers

The last alternative is to improve cultural awareness training for health providers working with URMs. The need for cultural awareness within the healthcare system has been observed as early as 2003, with multiple United States government-based agencies providing articles and possible next steps to take to diminish the gap that cultural unawareness causes on the up-take of resources by racial and ethnic minorities (Holden et al, 2014; Murray et al., 2010). There is an increasing body of evidence that creates a direct link between an increase in cultural awareness from health providers and an improvement in health from their patients that belong to ethnic or racial minorities, including but not limited to refugees (Murray et al., 2010; Bhattacharyya & Benbow, 2012; Kerrigan et al., 2020).

Using a study ran in 2020 as guideline, the program based on this alternative would consist of a 25-minute web-based module and a 1.5-hour live interaction session (Parker et al., 2020). The program would be single session and the participation would be on volunteer basis, although the ONA could make the programs be either **strongly encouraged** or **mandatory** depending on how they decide to approach the issue, both which would increase the number of health providers signing up. It would take approximately a month and a half to research different providers of cultural awareness programs and pick one to hire, after which it is recommended that four of these sessions are offered a year for a five-year period, before the results are evaluated. The session rate would be one session per three months.

Evaluative Criteria

The range of the scoring will go from zero to three in intervals of 0.5. The definitions of each criterion and their corresponding scoring systems are explained below. The Cost criteria is weighted 40 percent of the final score, as it is essential to ensure that the final recommendation can be implemented by the client, and that will only be possible if it's financially feasible. The Effectiveness criteria is weighted at 40 percent of the final score as the primary goal is to provide a recommendation that is not only financially feasible, but that will create a meaningful change for URMs. The weight of the Equity criterion is 20 percent as equity is not necessary for the implementation of any of the final recommendations, but it is encouraged.

Cost

The cost criteria will focus primarily on the financial feasibility of the alternatives on a five-year period through comparing estimates of the final costs of the alternatives against a budget increase of $7,500,000 given to the Department of Social Services Office of New Americans in the Virginia General Assembly session of 2022 (LIS State Budget VA). To adequately estimate the total cost of the alternative, I will be using the projected inflation estimates for the next five years and a primary discount factor of 3 percent. The discount factors of 5 and 7 percent will be used for sensitivity testing of the final recommendation. The CPI estimates used for these calculations were taken from the Congressional Budget Office's projections and are the following: 3 percent inflation rate in 2024, 2.2 percent inflation rate in 2025, 2.1 percent inflation rate in 2026 and 2027 and 2.3 percent inflation rate in 2028 (Congressional Budget Office, 2023). The costs of each alternative will be measured against this increase in funding, and it will be analyzed whether it would be feasible for the Office of New Americans to implement the alternative in the long term (over a span of five years), this measure will include the total cost of the program as a measure of what percentage of the budget increase is it using.

- **Three (3)**: The measure of Three (3) will indicate both that the program is highly financially feasible, and that it costs less than five (5) percent of the budget increase given to the Office of New Americans.
- **Two (2):** The measure of Two (2) will indicate both that the program is moderately financially feasible, and that it costs less than ten (10) percent of the budget increase given to the Office of New Americans.
- **One (1)**: The measure of One (1) will indicate both the program is not very financially feasible and that it costs more than fifteen (15) percent of the budget increase given to the Office of New Americans.

Effectiveness

The effectiveness criteria will focus primarily on predictions on the take-up rate of resources before and after the alternative is implemented. Research on this area does not tend to focus on exact percentages of take-up rate, however, as the measurements tend to be more qualitative in nature (Riza et al., 2020; Jacobs et al., 2001; Jacobs et al., 2004; Parker et al., 2020; Holden et al, 2014). The common qualitative descriptors used on research papers on this area are the following: ***significant*** substantive improvement, ***moderate*** substantive improvement, or ***no change*** (Riza et al., 2020; Jacobs et al., 2001; Jacobs et al., 2004; Parker et al., 2020; Holden et al, 2014). Therefore, this phrase will be used to judge this criterion. In this scenario, the zero point five (0.5) intervals will allow for more freedom of interpretation if results are mixed.

- **Three (3):** If the alternative can increase the take-up rate of health services ***significantly*** in a substantive manner.
- **Two (2)**: If the alternative can increase the take-up rate of health services ***moderately*** in a substantive manner.
- **One (1):** If the alternative ***does not increase*** the take-up rate of health services or ***affects it negatively***.

Equity

This criterion focuses on the incorporation of the national origin of the unaccompanied refugee minors into the alternatives presented. In an ideal world, all national origins would be included in each alternative, however that is not feasible in the long term. To set realistic standards, we focus on the data from the Virginia Refugee Statistics spreadsheet and from the Social Worker Supervisor of the Virginia Branch of the Lutheran Social Services which determines that the most common national origins of unaccompanied refugee minors in Virginia is Afghan and Central American national origins (Rippeto, 2023; Virginia Department of Social Services). As such, the following national origins will be the focus of this criterion: Afghan, Guatemalan, El Salvadorian, Nicaraguan, Honduran, Belizean, Costa Rican, Panamanian. Emphasis on these national origins, rather than in general cultural or national origin training, is placed as a primary goal as focusing the alternatives on these national origins will allow a wider audience to be reached, and therefore it will be helpful for the biggest number of URMs.

- **Three (3):** The alternative incorporates resources targeting two of the most common national origins of Unaccompanied Refugee Minors in Virginia (Afghan and/or a Central American national origin).
- **Two (2)**: The alternative incorporates resources targeting one of the most common national origins of Unaccompanied Refugee Minors in Virginia (Afghan or a Central American national origin).
- **One (1):** The alternative incorporates resources targeting none of the most common national origins of Unaccompanied Refugee Minors in Virginia (Afghan or a Central American national origin).

Evaluation of Alternatives

Alternative 1: Status Quo

Cost Score: 3

Maintaining the current status quo refers as maintaining the current resources available for all New Americans while not placing a special emphasis on unaccompanied refugee minors. This alternative will not alter the current spending of the Virginia Department of Social Services Office of New Americans. As the budget amendment passed back in 2022, the funding for the Office of New Americans increased by $7,500,000, which makes maintaining the current types of resources financially feasible (LIS State Budget VA). For this alternative, I calculated the total accumulated worth of the budget increase in the 2023-2028 period. The full calculations can be found in Appendix 1, Table A1 & A2. The initial net present value using a 3 percent discount rate when adjusted for inflation for 2023 is $7,500,000 and due to inflation, every year the cost is going to rise. The Congressional Budget Office offers different estimates for inflation per year, and the full calculations for inflation can be found in Appendix 1, Table A1. Using my primary discount factor of 3 percent, the total net present value of this alternative over the next five years will be an additional $44,393,307 in budget. As this alternative sees a budget increase rather than a subtraction due to costs, the score of 3 is given as it is financially feasible.

Effectiveness Score: 1

According to the Social Worker Supervisor for the Virginia branch of the Lutheran Social Services, unaccompanied refugee minors can be assigned to their services by the state government, and they provide resources for them (Rippeto, 2023) As this is an action taking place concurrently, the likelihood of a moderate increase in take up rate is low, as one of the current issues the state is facing is a low substantive take-up rate for the available resources offered to Refugees and Unaccompanied Refugee Minors (Stitt, 2023)

Equity Score: 1

Information given by Marilyn Rippetoe suggests that there are no specific programs that specifically target prioritized national origins (Afghan or Central American) within the social services organizations working with the Office of New Americans, but that unaccompanied refugee minors are encouraged to keep in contact with members of their family in other countries origins which is not a meaningful intervention (Rippeto, 2023).

Alternative 2: Establish Community Groups Solely for Unaccompanied Refugee Minors

Cost Score: 1.5

For a community group to be beneficial two things, aside from participation, are required: a location and a facilitator. As the beneficiary of these alternatives are children under the age of eighteen, it would be ideal for the group to meet either in a public-school gymnasium or a public rec center. Depending on the school district, the fee may be variable, but as both public schools and public recreation centers are managed by the county, they tend to have similar costs when it comes to renting. A public recreation center in Fairfax costs between $55 to $110 dollars an hour (Fairfax County VA). If the community groups were one hour and met biweekly, that would be around 26 meetings that are an hour long per year, making the renting cost an approximate cost of between $1,430 and $2,860. The next requirement is a facilitator. A Denver pilot program that used community health workers to create community support groups to target men from undeserved communities had a cost of $6,229 per month in 2006 and saw a drastic success on the uptake of their resources (Whitley et al., 2006). The modern equivalent of $6,229 in 2006 is $9,481 (CPI Inflation Calculator). Community health workers would be an ideal facilitator, as they are trained to help people who have survived traumatic experiences, which many unaccompanied refugee minors have had. Over a span of a year, that would mean that the total program cost would be around $149,496. A similar program, however, had a slightly higher cost prediction with a yearly cost of $420,348 per three community health workers leading these groups, making the total cost for six groups $840,696 in 2013 (Mirambeau, Wang, Ruggles, & Dunet, 2013). The modern equivalent of $420,348 in 2013 is $55,965 and the modern equivalent of $840,696 in 2013 is $1,101,929 (CPI Inflation Calculator). Using the higher cost estimates to allow room for error, the final yearly cost of this alternative would be $1,104789.

For further analysis, in this alternative, I calculated the total accumulated cost of the community groups in the 2023-2028 period. The full calculations can be found in Appendix 1, Table B1 & B2. The initial net present value using a 3 percent discount rate when adjusted for inflation for 2023 is $1,104,789. The Congressional Budget Office offers different estimates for inflation per year, and the full calculations for inflation can be found in Appendix 1, Table B1. Using my primary discount factor of 3 percent, the net present value of this alternative over the next five years will accrue a total cost of $6,381,079 spread over this five-year period. Further sensitivity testing using the 5 percent and 7 percent discount rate can be found in Appendix 1, Table B2. When comparing the total net present value of this alternative ($6,381,079) to the total net present value of the budget increase seen in Appendix 1, Table A2($44,393,307), we find that the total net present cost of this alternative amounts to a 14.37 percent of the total increase of the budget over the next five years. As the program costs more than 10 percent of the total budget increase given to the Office of New Americans but less than a 15 percent of the total budget increase, the score of 1.5 is given as it is not a financially feasible option.

Effectiveness Score: 2.5

A research paper by Tyrer & Fazel describes how community-based interventions, such as community groups for children, focused on children cause take up rate of other services on a substantive range from ***moderate*** to ***significant*** (Tyrer & Fazel, 2014). Furthermore, a literature review regarding community-based practices written by Riza et al. has similar mixed results which determine that community groups increase substantive take up rate in a ***moderate***-to-***significant*** way (Riza et al., 2020). Based on these findings, this alternative scores 2.5.

Equity Score: 3

The initial phase of this alternative includes six community groups focusing on three of the national origins delineated on the scoring criteria. Furthermore, it spreads out the location of these groups with three in the Richmond area and three in the Fairfax area. Although equity is always a criterion that can be further improved, for the scoring purposes of this report, this alternative meets standards for a score of 3.

Alternative 3: An Instructional Video for URMs Sponsors & Health Care Providers in the Office of New Americans Network

Cost Score: 3

Using estimates from FLearning Studio, a filmmaking studio specializing in corporate training that could be used to create the sponsor and healthcare provider training videos, a training video costs anywhere between $300-$2000 per minute based on the desired effects used in said video. As most training videos tend to be around one hour in hopes of maximizing retained information, that would mean a range of costs from $18,000-$120,000 (F.Learning, 2022). An initial phase would require three videos narrated in Pashto, Persian and Spanish respectively as they are the main languages spoken by the cultural groups that have a highest population density in Virginia. Three videos in different languages plus the additional video targeting healthcare providers would cost between $72,000 and $480,000. Using the higher estimate, the cost is 6.4% of the budget increase allocated in 2022 for the Office of New Americans (LIS State Budget VA). As the creation of these videos is associated with a sunk cost, there are no long-term calculations included for this alternative. The video creation is a one-time event, meaning that once the initial cost has been accrued there is no further cost in a five-year period. Furthermore, when comparing the higher estimate for the total sunk cost of this alternative ($480,000) to the total net present value of the budget increase seen in Appendix 1, Table A2 ($44,393,307), we find that the total net present cost of this alternative amounts to 1.081% of the total increase of the budget over the next five years. As the program costs less than 5% of the total budget increase given to the Office of New Americans, the score of 3 is given as it is a financially feasible alternative in the long term.

Effectiveness Score: 2.5

Two research articles published in the National Library of Medicine conduct an in-depth analysis of the effectiveness of language services when it comes to increasing the use of healthcare services. The first one mentions a ***significant*** increase on use of ***three*** **out of the** ***six*** **metrics** when translation resources are used, and the second one mentions a 5 percent increase in use of care when compared to the control group, naming it a ***significant*** substantive increase (Jacobs et al., 2001; Jacobs et al., 2004).

Equity Score: 3

To ensure that the videos are beneficial to all Afghans, it is necessary to focus on Pashto and Persian, and as Spanish is the most spoken language in Latin America, that language had to be chosen. While Pashto and Persian would only be targeting Afghan unaccompanied refugee minor sponsors, Spanish increases accessibility for members of multiple Latin American cultures. By choosing to focus the Instructional Videos on this three languages, Unaccompanied Refugee Minors from Afghan and Central American national origins, and their sponsors, will have access to vital information.

Alternative 4: Improve Cultural Awareness Training for Health Providers

Cost Score: 3

According to a BioMed paper, overall cultural awareness program costs were $5,754.19. The average program cost per participant was $139 (Parker et al., 2020). Let's assume that the ONA establishes four of said programs a year, once every three months, the total yearly cost would be an estimate of $23,016, which would fall below one percent of the budget amendment increase of $7,500,000 allocated to the Office of New Americans in 2022 granting them a high score on this metric (LIS State Budget VA).

For further analysis, in this alternative, I calculated the total accumulated cost of the cultural awareness training in the 2023-2028 period (see Appendix 1 Section C). The initial net present value using a 3 percent discount rate when adjusted for inflation for 2023 is $23,016 and due to inflation, every year the cost is going to rise. The Congressional Budget Office offers different estimates for inflation per year, and the full calculations for inflation can be found in Appendix 1, Table C1 & C2. Using my primary discount factor of 3 percent, the net present value of this alternative over the next five years will accrue a total cost of $132,937 spread over the five-year period. Further sensitivity testing using the 5 and 7 percent discount rate can be found in Appendix 1, Table C2. When comparing the total net present value of this alternative ($132,937) to the total net present value of the budget increase seen in Appendix 1, Table A2 ($44,393,307), we find that the total net present cost of this alternative amounts to 0.29 percent of the total increase of the budget over the next five years. As the program costs less than 5 percent of the total budget increase given to the Office of New Americans, the score of 3 is given as it is a financially feasible option.

Effectiveness Score: 2.5

The Parker et al. paper explained that while there were certain measurements of effectiveness that saw a significant increase, there were others that say no change or merely a moderate change, and it concluded that the final takes up rate was ***moderately*** substantive rather than significant (Parker et al., 2020). Further articles on the topic mention a substantially ***significant*** increase on patient follow-up and ***moderate*** substantive increase on overall primary visits (Holden et al, 2014).

Equity Score: 1.5

Cultural awareness training can be tailored to specific national origins, or they can be training focused on general advice that applies to multiple cultures. However, as the ONA will likely focus on overall cultural awareness training in hopes of reaching a wider audience and thus missing crucial cultural distinctions, the score will be set as a 1.5. This score is subject to change based on ONA's decisions, but for now this is the score given due to a higher likelihood of the client implementing general cultural awareness.

Outcomes Matrix

	Cost (40%)	Effectiveness (40%)	Equity (20%)	Final Score
Alternative 1: Status Quo	**3** (Weighted score: 1.2)	**1** (Weighted score: 0.4)	**1** (Weighted score: 0.2)	**1.2+0.4+0.2=** **1.8**
Alternative 2: Establish Community Groups Solely for Unaccompanied Refugee Minors	**1.5** (Weighted score: 0.6)	**2.5** (Weighted score: 1)	**3** (Weighted score: 0.6)	**0.6+0.8+0.6=** **2.2**
Alternative 3: An Instructional Video for Unaccompanied Refugee Minors Sponsors & Health Care Providers in the Office of New Americans Network	**3** (Weighted score: 1.2)	**2.5** (Weighted score: 1)	**3** (Weighted score: 0.6)	**1.2+1+0.6=** **2.8**
Alternative 4: Improve Cultural Awareness Training for Health Providers	**3** (Weighted score: 1.2)	**2.5** (Weighted score: 1)	**1.5** (Weighted score: 0.3)	**1.2+1+0.3=** **2.5**

Table 2: Outcome Matrix for Alternatives

Final Recommendation

Each alternative has its benefits and addresses different issues affecting URMs' ability to fully utilize the resources provided for them by the state and federal government, as well as affiliates. Alternative 4, for example, scored highly on both cost and effectiveness. However, once the scores on the matrix above are weighed and those results are added together, we see that Alternative 3 has the highest scoring.

While Alternative 3 and Alternative 4 have similar scoring, **Alternative 3: An Instructional Video for Unaccompanied Refugee Minors Sponsors & Health Care Providers in the Office of New Americans Network** is much more equitable which makes the difference between the two. As such, it is recommended that the ONA creates instructional videos for sponsors of unaccompanied refugee minors and sponsors alike. While the cost is 6.4 percent of the budget increase, the budget increase is only a portion of the ONA budget which gives some leeway on the financial feasibility angle. The ability to tailor these instructional videos based on language and culture, as well as the significant increase in the use of healthcare resources it provides, this alternative is worth exploring as it has potential for a great positive impact for URMs.

Although the tradeoff for this alternative is that it merely makes the status quo resources more accessible, it still provides a marked improvement in current conditions. It is important to note, though, that if the status quo changes and the number of language support resources decreases, this alternative will be affected and become less effective overall, and as such this alternative must be paired with the current status quo and not be implemented independently. Furthermore, it is recommended to also consider Alternatives 2 & 4 as their scores prove that they might be beneficial to URMs.

Implementation

Alternative 3 requires a considerable amount of work to be implemented. Although it is very possible to create instructional videos in the office, they tend to be lower quality than those professionally shot. The concept of job training videos is not new, but there is no common reference to base the dialogue of the video or the information that needs to be provided. Before contacting a film-making company to help with the creation of the video, a great deal of research and work must be done to ensure the alternative is implemented smoothly.

To begin with, there are multiple stakeholders that are going to be involved with the implementation of this alternative and it's necessary to keep them all in mind throughout the different steps in the process. Those in charge of the project within the ONA need to take into consideration the audiences they want to reach when gathering the information necessary to begin the process, as well as take into consideration the film-making company they will be hiring to shoot and edit the training video to operate smoothly. In this case, the workers of the ONA as well as the workers of film-making company are going to be stakeholders playing the role of producers of content, while the sponsors and the healthcare providers are going to be the recipients of the work.

For the recommended alternative to be implemented there are multiple steps that need to be taken. The very first challenge is to determine the content of each video. Although the video targeting URM sponsors will initially be available in three languages, the information delivered will be the same. The first step is to find a film company to hire to film and edit the video. Then it is to write out the information which each video is meant to provide and write a script for both the video addressed to sponsors and the one addressed to providers. Afterwards, the script of the video addressed to sponsors must be translated to Pashto, Persian and Spanish, which will require the help of translators, and later of fluent speakers to voice the instructions on the video to ensure that the instructions are understood. Then there are the usual video-making stages: strategy and preparation, creative development, pre-production and postproduction (Johnston). According to two different companies that specialize in making instructional videos and commercials, the estimated timeline of the process once it starts is around two months (Johnston; Admin, 2021).

Once that is completed, however, the videos will be ready for distribution to both sponsors and healthcare providers. After that is just a matter of using the data ONA possesses to create a mailing list for Pashto, Persian and Spanish speaking sponsors and sending the respective instructional video to them and to send an email to healthcare providers affiliated with the office offering the educational video if they ask for it.

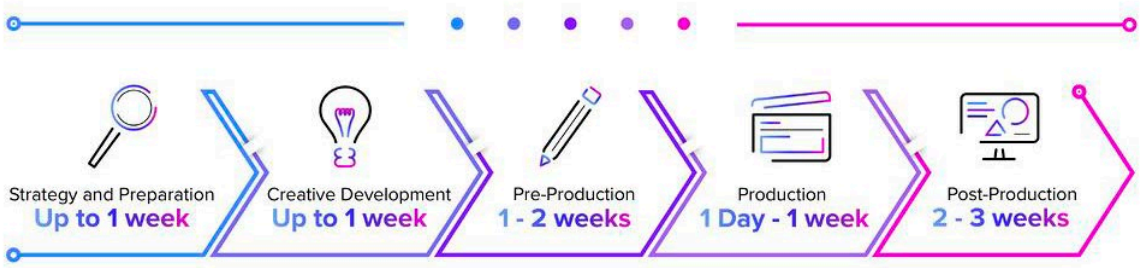

Figure 5: Video Production Timeline by VMG Studios (Johnston).

Additionally, it is important to think of the stakeholders when thinking of implementation. Although the instructional video will help sponsors save time and money on later times, it is possible that many sponsors won't take the time or effort to watch them, as even if there is particular emphasis put into how the videos will help them access better resources on a later date, they might consider the lost time to watching the video too much of a burden. As such, it is particularly important not only to emphasize to the sponsors of the importance of watching the video but try to create occasions in which they would want to watch the instructional video such as holding viewing events for the videos and providing with food, as those tend to be excellent motivators for people. Healthcare providers might react negatively at the offer of the instructional video, as they might see it as an attack to their professionalism and effectiveness, so care must be put into the email which will be offering the access to these resources in order to emphasize that this is not a slight against them, just a reminder of tools they can use if they so please.

Every step of the implementation process is essential to ensure the final product— the informational videos for both sponsors and healthcare providers— achieves the goal in mind, and as such it is necessary to take particular attention to each step to ensure all the key information remains in the videos throughout the process and it is not edited out.

Appendix 1: Inflation and Discount Rate Calculations

Section A: Status Quo

Year	Pre Inflation Budget Increase	Estimated Annual CPI	Percentage Increase based on Inflation Estimates	Inflation Factor	Annual Budget Increase Post Inflation
2023	**$7,500,000**				$7,500,000
2024	**$7,500,000**	3	3.0%	1.03	$7,725,000
2025	**$7,500,000**	2.2	2.2%	1.022	$7,894,950
2026	**$7,500,000**	2.1	2.1%	1.021	$8,060,744
2027	**$7,500,000**	2.1	2.1%	1.021	$8,230,020
2028	**$7,500,000**	2.3	2.3%	1.023	$8,419,310
Total					$47,830,024

Table A1: Inflation Calculation for Budget Increase Using the Congressional Budget Office Estimates (Congressional Budget Office, 2023)

Year	Annual Budget Increase Post Inflation	Discount Factor 3%	Discount Factor 5%	Discount Factor 7%	Net Present Value 3%	Net Present Value 5%	Net Present Value 7%
Original Budget Increase	$7,500,000.00						
2023	$7,500,000	1	1	1	$7,500,000.00	$7,500,000.00	$7,500,000.00
2024	$7,725,000	0.971	0.952	0.935	$7,500,000.00	$7,357,142.86	$7,219,626.17
2025	$7,894,950	0.943	0.907	0.873	$7,441,747.57	$7,160,952.38	$6,895,755.09
2026	$8,060,744	0.915	0.864	0.816	$7,376,722.59	$6,963,173.70	$6,579,968.17
2027	$8,230,020	0.888	0.823	0.763	$7,312,265.79	$6,770,857.47	$6,278,642.53
2028	$8,419,310	0.863	0.784	0.713	$7,262,570.78	$6,596,749.71	$6,002,851.69
Total:	$47,830,024				$44,393,306.75	$42,348,876.11	$40,476,843.64

Table A2: Discount Rate and Net Present Value calculations for the Budget Increase using a 3%, 5% and 7% Discount Rate

Section B: Alternative 2

Year	Pre Inflation Cost	Estimated Annual CPI	Percentage Increase based on Inflation Estimates	Inflation Factor	Annual Cost Post Inflation
2023	**$1,104,789**				**$1,104,789**
2024	**$1,104,789**	3	3.0%	1.03	$1,104,789
2025	**$1,104,789**	2.2	2.2%	1.022	$1,129,095
2026	**$1,104,789**	2.1	2.1%	1.021	$1,152,806
2027	**$1,104,789**	2.1	2.1%	1.021	$1,177,015
2028	**$1,104,789**	2.3	2.3%	1.023	$1,204,086
Total Cost					$6,872,580

Table B1: Inflation Calculation for Cost of Alternative 2 Using the Congressional Budget Office Estimates (Congressional Budget Office, 2023)

Year	Annual Cost Post Inflation	Discount Factor 3%	Discount Factor 5%	Discount Factor 7%	Net Present Value 3%	Net Present Value 5%	Net Present Value 7%
Original Budget Increase	$1,104,789						
2023	$1,104,789	1	1	1	$1,104,789.47	$1,104,789.47	$1,104,789.47
2024	$1,104,789	0.971	0.952	0.935	$1,072,611.14	$1,052,180.45	$1,032,513.52
2025	$1,129,095	0.943	0.907	0.873	$1,064,280.18	$1,024,122.30	$986,195.16
2026	$1,152,806	0.915	0.864	0.816	$1,054,980.64	$995,837.02	$941,032.95
2027	$1,177,015	0.888	0.823	0.763	$1,045,762.36	$968,332.95	$897,938.92
2028	$1,204,086	0.863	0.784	0.713	$1,038,655.24	$943,432.96	$858,496.74
Total:	$6,872,580				$6,381,079.02	$6,088,695.15	$5,820,966.77

Table B2: Discount Rate and Net Present Value calculations for the Cost of Alternative 2 using a 3%, 5% and 7% Discount Rate

Section C: Alternative 4

Year	Pre Inflation Cost Increase	Estimated Annual CPI	Percentage Increase based on Inflation Estimates	Inflation Factor	Annual Cost Post Inflation
2023	**$23,016**				**$23,016**
2024	**$23,016**	3	3.0%	1.03	$23,016
2025	**$23,016**	2.2	2.2%	1.022	$23,522
2026	**$23,016**	2.1	2.1%	1.021	$24,016
2027	**$23,016**	2.1	2.1%	1.021	$24,521
2028	**$23,016**	2.3	2.3%	1.023	$25,085
Total Cost					$143,176

Table C1: Inflation Calculation for Cost of Alternative 4 Using the Congressional Budget Office Estimates (Congressional Budget Office, 2023)

Year	Annual Budget Increase Post Inflation	Discount Factor 3%	Discount Factor 5%	Discount Factor 7%	Net Present Value 3%	Net Present Value 5%	Net Present Value 7%
Original Budget Increase	23,016						
2023	$23,016	1	1	1	$23,016.00	$23,016.00	$23,016.00
2024	$23,016	0.971	0.952	0.935	$22,345.63	$21,920.00	$21,510.28
2025	$23,522	0.943	0.907	0.873	$22,172.07	$21,335.47	$20,545.33
2026	$24,016	0.915	0.864	0.816	$21,978.34	$20,746.20	$19,604.47
2027	$24,521	0.888	0.823	0.763	$21,786.29	$20,173.21	$18,706.70
2028	$25,085	0.863	0.784	0.713	$21,638.23	$19,654.47	$17,885.00
Total:	$143,176				$132,936.56	$126,845.35	$121,267.78

Table C2: Discount Rate and Net Present Value calculations for the Cost of Alternative 4 using a 3%, 5% and 7% Discount Rate

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