Caring for Immigrant Children

Future of Pediatrics
CME Program
June 21, 2017

Jennifer Chapman, MD, FAAP, Megan Gray, MD, MPH, FAAP
Children’s National Health System
Conflicts

- Jennifer Chapman, uptodate.com
Goals & Objectives

• Describe the journey of an unaccompanied child from their home country to the DC area
• Formulate a care plan for an office-based visit of a newly-arrived immigrant pediatric patient
It’s a busy Tuesday in clinic.
You open the door to the next exam room to see:
WHO IS AN IMMIGRANT CHILD?

- Child here via legal immigration
- Child with illegally-arrived parent
- Unaccompanied child
- Trafficked child
- Refugee child
Who is an immigrant?

- **Undocumented/Unauthorized** –
  - Entered the US without inspection by US Immigration
  - Or had legal status, but expired/terminated

- **Refugee** –
  - Persecuted in home country
  - Status granted while OUTSIDE the US.
  - Legal permanent resident status 1 year after entering the US.

- **Asylee** –
  - Persecuted in home country
  - Status granted while INSIDE the US.
  - Legal permanent resident status 1 year after entering the US.

- **Immigrant children** –
  - Foreign-born children OR children born in U.S. who live with at least 1 foreign-born parent  
    (AAP Policy statement in Pediatrics: June 2013)
What is an unaccompanied child (UC)?

• No lawful immigration status in the United States
• < 18 years of age
• No parent or legal guardian in the United States, or no parent or legal guardian in the United States available to provide care and physical custody

Children and Immigration

• Immigrant children:
  • Fastest growing segment of US population
  • Accounted for most of pediatric population growth in 2000s
• 1 in every 4 children in US lives in an immigrant family (18.4 million children)
• 89% of these children are born in the U.S. and are U.S. citizens.

Children of Immigrants: Growing National and State Diversity. The Urban Institute; 2011
Latinos in DC

- 9.1% of DC population is Latino (2010)
- Latinos are the fastest growing ethnic minority in DC
- 46.3% live in Ward 1
  - Mt Pleasant, Adams Morgan, Columbia Heights
- Many Salvadorans initially arrived as asylees after the Salvadoran Civil War (1979-1992)
  - Political violence
  - Deteriorating economy
Latinos in DC

- 9.1% of DC population is Latino (2010 census)
  - Largest Latino groups: 30% Salvadoran, 16% Mexican

Source: US Census Bureau, 2009; Data Created by DC Office of Latino Affairs
Latinos in DC

Latinos in MD

- 8.2% of MD population is Latino (2010 census)
  - Largest Latino groups: 26.3% Salvadoran, 18.7% Mexican

Office of Minority Health and Health Disparities,
Maryland Department of Health and Mental Hygiene, May 2013
Latinos in VA

• 7.9% of VA population is Latino (2010 census)

• Between 1990-2010 the Latino population nearly quadrupled
Where are children in our region coming from?

Country of Origin:
FY2016
- 1) Guatemala (40%)
- 2) El Salvador (34%)
- 3) Honduras (21%)
Why do children travel unaccompanied

“PUSH” factors
• Gender-based violence
• Abuse, neglect with little authoritative intervention
• Gang violence

“PULL” factors
• Educational opportunity
• Financial opportunity
• Only 1/3 cite family reunification as reason

Journey from “My Country” to US
Journey from “My Country” to US

• Many children take trains, buses, or walk into the US
• Journey of several weeks
• Subject to dehydration, exposure, sexual assault, injuries, trauma
At the Border

- Majority of UC apprehended at US ports or US/Mexico border
  - ~80% apprehended in Rio Grande Valley by Customs & Border Patrol (CBP)
- Less common: apprehended in interior of country, found to be unaccompanied juvenile
  - Immigration & Customs Enforcement (ICE) processes these cases
At the Border

- Taken to CBP Processing Center for triage: transfer to Office of Refugee Resettlement (ORR) within 72 hours by law
  - identify child
  - assess risk:
    - perceived risk: detention center
    - low risk: ORR shelter
  - health screening: “visible and obvious health issues”
    - scabies, lice, varicella (+/- pregnancy)
  - must be considered “fit to travel” before moved from the border patrol station to an ORR shelter
Legal Standards

• 1996: Flores Settlement: standards for treatment
• 2008: Trafficking Victims’ Protection Reauthorization Act: each child must “be promptly placed in the least restrictive setting that is in the best interest of the child.”
  
  *8 U.S.C. § 1232(b)(2)*
HHS Shelters- Temporary Custody

• HHS operates ~ 150 shelters in US
  • Nonprofit group homes contract with Office of Refugee Resettlement (ORR)
• Temporary custody for unaccompanied children prior to release to sponsors; constant supervision
• Average length of stay <35 days
• Wide variation in shelter quality and capacity, most <50 children
• HHS provides all services: **chief focus: reunification**
  • Food
  • Clothing
  • Education
  • Medical care
  • Placement services that facilitate safe & timely release to family members or other sponsors
HHS Shelters- Medical Services

- Routine medical and dental care
- Family planning services: pregnancy tests, access to medical reproductive health services, emergency contraception
- Emergency health services
- Complete medical examination (including screening for infectious diseases) within 48 business hours of admission
- Immunizations
- Administration of prescribed medications and special diets
- Appropriate mental health interventions (including individual/weekly therapy)
Release to Sponsor

• Released from federal custody to an appropriate sponsor:
  • Order of priority: parent, then legal guardian, then adult family member
  • Screened by shelter case managers: interview, background check, fingerprinting
  • Must commit to safely care for child while immigration case proceeds
• Sponsors given copy of child’s medical/immunization records from time in HHS custody
• Post-release services limited
  • “safety and well-being follow-up call” 30 days after release
Resettlement Figures 2014-2016

- In 2016: **32% < age 14**, 37% ages 15-16, 31% age 17
- April 2017 updated figures: surge continues
  - 85% children are reunified with their families (FY 2014)

DMV area: Total number unaccompanied minors released to sponsors:

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Educational Services

• US Law: School access
• After arrival to US: US Dept Health and Human Services provides educational services for unaccompanied children within HHS shelters
• After release from federal custody to a sponsor: children have the right under federal law to enroll in public schools
Many unaccompanied children may qualify as a protected class: eligible for special visas
- SIJS (special immigrant juvenile status)
- T visa- trafficking
- U visa- victims of crimes

www.immi.org resource for navigating status

Patients worried about deportation:
- Can direct patients to complete power of attorney
WHO IS AN IMMIGRANT CHILD?

- Child here via legal immigration
- Child with illegally-arrived parent
- Unaccompanied child
- Trafficked child
- Refugee child
What are your next steps to meet this child’s needs?

MENTAL HEALTH

CLINICAL

EDUCATIONAL

IMMIGRANT CHILD’S NEEDS

LEGAL

SOCIAL
Current Guidelines

- AAP Red Book: Medical Evaluation of Internationally Adopted Children, 2006
- DC AAP Immigrant Health Committee: 2016
Council on Community Pediatrics

Immigrant Child Health Toolkit

This toolkit was designed to provide practical information and resources for pediatricians to address common matters related to immigrant child health.

Introduction
This section includes key facts about immigrant children and families. Learn about the development of the toolkit and the toolkit contributors.

Key Facts
This section includes interesting facts on demographics, access to care, socioeconomic status, and health disparities.
Local Resources

• **DC AAP Immigrant Health Toolkit:**
• **CASE 1:**

A 4 yo girl presents to the office for a physical. Her parents arrived in the US 6 months ago from Honduras but have not seen a doctor until today. She does not speak more than 5 words in English or Spanish.
Issues: Language

• How do you communicate with the family?
  • What languages do your patients speak? Read? Write? Understand?

• Interpreter Services
  • Always document that you used an interpreter and give as much information about that person as possible – ID#, name, etc.
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* En Jornada Nacional de Vacunación
** En Campanas de Seguimiento

[http://www.immunizationcards.org/hnd-honduras](http://www.immunizationcards.org/hnd-honduras)
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Resource: CDC PinkBook
Issues: Developmental Delay

• High rates of speech and language delay
  • Lack of early education
  • Lack of books
  • Lack of appropriate stimulation
  • Illiteracy

• Vision/Hearing
  • Undiagnosed vision or hearing problems contribute to developmental delays
Clinical Case

• **CASE 2:**

A 12 y.o. girl who arrived from El Salvador 2 months ago presents to the office for a routine school physical. Her mother states that she has shortness of breath and chest pain with exercise. She states that she has a history of a “heart operation” that was done when she was about 8 years old but does not know why and has had no cardiac follow-up since then. Her PE reveals normal vital signs, no murmur, with a large sternal scar.

She has not yet enrolled in school- her local school told her they were “full.”
Issues: Records/access

- What do you do?
- Can the family obtain her records?
- Specialist referral? – Insurance, Language issues
- Sports clearance?
- School access?
Social Issues - Insurance

- Patients need insurance for –
  - Specialty referrals
  - Medications
  - Lab work
- Patients do not need insurance for –
  - Vaccines
Federal Medicaid and SCHIP Immigrant Eligibility Restrictions

- Undocumented and temporary immigrants are generally ineligible for Medicaid and SCHIP.
- Most adult legal immigrants are barred from Medicaid and SCHIP for the first five years they reside in the U.S.
  - Exception: refugee/asylee status
  - CHIPRA 2009- immigrant children allowed access without wait
- Emergency Medicaid is available to undocumented, temporary, and recent legal immigrants who meet other program eligibility requirements.
- States have the option to use SCHIP funds to provide prenatal care to pregnant women regardless of immigration status.

Kaiser Family Foundation: Summary: Five Basic Facts on Immigrants and Their Health Care, March 2008
DC Safety Net

- DC HealthCare Alliance (Alliance):
  - medical assistance to needy District residents who are not eligible for federally-financed Medicaid benefits
  - qualified aliens who do not meet the immigration requirements needed to be eligible for Medicaid and non-qualified aliens
  - Include Amerihealth, MedStar, and Trusted plans
  - Members must go to DHS every 6 months to prove eligibility
Health Insurance in DC: 
*Immigrant Children’s Program*

- **Services:** mirrors Medicaid
- **Eligibility:**
  - < age 21
  - School attendance not required
  - No citizenship requirement but must be DC resident
  - Not eligible for Medicaid
  - Income < 200% Poverty or $47,700 family of 4
- **Eligible child is automatically assigned to managed care plan:**
  - AmeriHealth DC, MedStar Family Choice, Trusted Health Plan, HSCSN
Health Insurance in MD

• Eligibility for full Medicaid or Maryland Children’s Health Program coverage:
  • Immigrant children < 21 must be lawfully-present
  • Not subject to 5 year waiting period
FQHCs in MD

- Community Clinic Incorporated (CCI)
  - Serves Montgomery and NW PG Counties- largest FQHC
  - Sliding fee pay scale for uninsured patients
  - Largest WIC provider in MD

- Mary’s Center
  - Sliding fee pay scale for uninsured patients
Health Insurance in VA

- Eligibility for VA Medicaid or FAMIS coverage:
  - Immigrant children < 19 must be lawfully-present, meet residency requirements
  - Not subject to 5 year waiting period
Services in VA

• Fairfax Co: Medical Care for Children Partnership (MCCP)
  • non-profit/public partnership for medical and dental care
  • Network of member pediatricians and dentists
  • serves uninsured children <19 not eligible for Medicaid
  • covers up to 250% federal poverty level; citizenship not required

• Arlington: Arlington Pediatric Center
  • medical care
  • serves uninsured children < 19 not eligible for Medicaid
  • covers up to 200% federal poverty level; must be resident of Arlington County
School access

• Real barriers
• False barriers
• Don’t allow the confusion to keep families from accessing services
  • Reach out to other orgs for guidance: cold-call local organizations
• Resources:
  • Maryland or Virginia: CASA works with immigrant residents, and on community education in a range of other areas - http://wearecasa.org/
  • DC: Children’s Law Center 202-467-4900, option 3. Helpline is staffed by attorneys M-F from 9-5.
Legal issues: using the toolkit

• DC AAP Immigrant Health Toolkit:
Clinical case

• **CASE 3:**

• You are the screening medical officer working at a detention center in Baytown, Texas. You see a mother with her 18 month male infant who have newly arrived from El Salvador.
• Mom states that he appears paler than usual, and is not eating as well lately.
• 1%ile for weight
• What is on your differential diagnosis?
Clinical Issues: Nutrition

- Malnutrition: stunting and physical growth delay
  - Dietary history
  - Anthropometric indices: weight, height, head circ
- Rickets
- Iodine deficiency
- Anemia
  - Iron deficiency most common
  - Also hemoglobinopathies or G6PD deficiency: esp African, Southeast Asian, Hispanic or Mediterranean background
- **Recommended treatment:**
  - Multivitamins for all children aged 6 months to 5 years
Clinical Issues: Growth

• Short stature and growth problems
  • Chronic intestinal infections
  • Lack of nutritious foods
  • Anemia
  • Chronic Diseases
• CDC Growth Charts not developed on samples of immigrant children
• Significant catch-up growth in 1st year – follow closely
Clinical issues: using the toolkit

- DC AAP Immigrant Health Toolkit:
CASE 4:

16 y.o. girl from El Salvador comes to the clinic for her first appointment.
- Newly arrived
- Weight gain: 10 lbs
- Living situation
- Limited history
Clinical case

CASE- Continued

Mother-daughter conflict

3 months later she comes back in for an appt and she is pregnant.
Issues: Reunification

• Children left behind
• Reunification in this country
• Food as connection
• Teenage vulnerabilities
Mental Health: National Child Traumatic Stress Network

- Core Stressors overview:

- Social Support
- Environment
- Family Relationships
- Language Learning
- Acculturation
- Cultural Learning
- Trauma
- Emotion Regulation
- Discrimination
- Isolation
- Loneliness
- Alienation
- Resettlement
- Basic needs
- Legal
- Financial
- Healthcare
Mental health issues: using the toolkit

- DC AAP Immigrant Health Toolkit:
Mental Health: Assets/Resiliencies

- DC Public Schools: International Academy at Cardozo HS
Limitations of guidelines/resources

- AAP toolkit – very broad, lots of content, US audience (not local)
- DC AAP toolkit: resources limited by insurance access
- Mental health resources limited
- Connections to other community resources limited
- Patient experience will be different at different providers across country, even across DC area
  - Fragmented care: detention centers, outpatient clinics, EDs
  - No central recordkeeping/ vaccination registries not up to date
Current Policy

• AAP Statement on Protecting Immigrant Children: Fernando Stein, Jan. 2017
  • “Children do not immigrate, they flee”
• Risk of new federal policies:
  • increased deportation and detention
  • restriction of travel
  • restricted access to public benefits
  • increased fear/anxiety: prolonged exposure to toxic stress
Next steps

• Protecting Immigrant Children now a top priority for AAP
• Know your immigrant community – each ethnic group has unique social and medical needs

• Build your team:
  • Social work
  • Community resources for immigrant children and families

• Never underestimate the strains on immigrant children and families
• Be curious—ask questions!
• No matter where you work: immigrants will be part of your practice!
References

- Tiffany Nelms, LSW: Associate Director, Home Study and Post Release Services, U.S. Committee for Refugees and Immigrants