

Safe Haven: Providing Compassionate, Evidence Based care to Young Immigrants

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Disclosure

I have no financial relationships to disclose

Learning Objectives

To recognize the immigrant children in our care

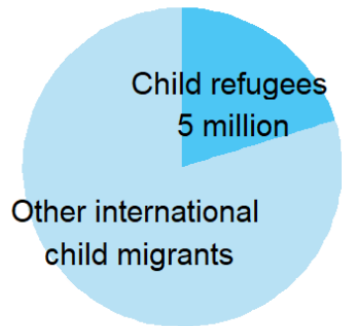
To understand the rationale for and approach to conducting a migration health history

To understand the evaluation of and approach to common conditions in new immigrant children including malnutrition, developmental delays, and endemic infections

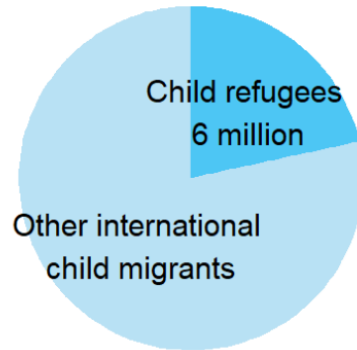
Considerations for trauma informed care

Displacement

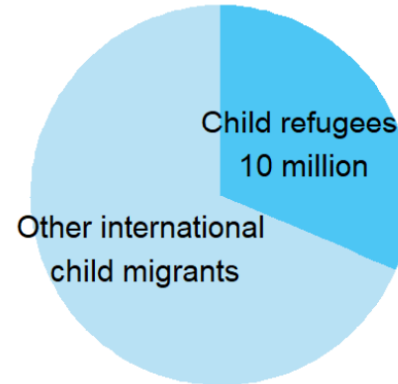
2005 - total 25 million



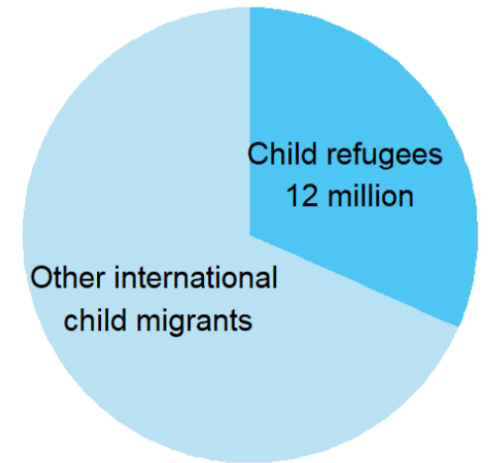
2010 - total 27 million



2015 - total 30 million



2020 - total 36 million



Graph courtesy of UNICEF

*“These children may be refugees,
internally displaced or migrants, but
first and foremost, they are children:
no matter where they come from,
whoever they are, and without
exception.”*

-Unicef-Uprooted Executive Summary

Caring for Children in Immigrant Families: Are United States Pediatricians Prepared?

Blake Sisk¹, Andrea Green², Kevin Chan³, Katherine Yun⁴

Nine percent of Utah residents are
immigrants

Nine percent are native born citizens
with at least one immigrant parent

Identifying and Defining Immigrant Children

Foreign born parent

Legal permanent resident

Refugee

Asylee

Special immigrant visa holder

Undocumented/Unauthorized immigrant

Unaccompanied immigrant

Unaccompanied refugee minor

- **Refugees:** individuals outside of their country who are unable or unwilling to return home because they fear serious harm, and are outside the US when they seek protection
- **Asylees:** individuals who fit the definition of a refugee, however, they seek protection at a point of entry or once they are within the US
- **Unaccompanied children (UAC):** individuals under age 18 without lawful legal status in the US and without a legal guardian in the US to provide care or physical custody
- **Unaccompanied refugee minors (URM):** refugee children under age 18 years old meeting definition above of 'refugees' without a parent or guardian and living with foster family with
 - protection of the Office of Refugee Resettlement (ORR)
- **Undocumented immigrant children:** children without lawful legal status in the US with a legal guardian in the US
- **Special Immigrant Visa:** qualifies for a green card (permanent residence) under the United States Citizenship and Immigration Services (USCIS) special immigrant program (most often Afghani and Iraqi families that worked for the US military)
- **Immigrant Visa holders:** other children with various legal visa status' including green cards obtained through 'family-based' program and 'green card' lottery"

Welcoming Immigrant Children into Our Care

Create

- Create Welcoming Environment

Avoid

- Avoid the Continuum of Confusion

Approach

- Approach to Migration Health



The Continuum of Confusion



Approach to Clinical Care

Migration History

+

Preventive Health Services

=

Migration Health Maintenance



Proposed Patient Care and Follow-up Plan

Timing	First provider visit	~4 weeks after first provider visit	2 months after second provider visit
Goals	<ul style="list-style-type: none"> • Introduce family to clinic and health care system (ie when to call clinic, how to call, when to go to ER, interpretation use) • Elicit Migration History • Collect PMHx, Family Hx, Physical Examination • Review prior records including screening labs and overseas medical examination information for refugees* • Prescribe presumptive treatment (prn) • Connect with SW, nutrition, MLP (prn) • Referrals (medical subspecialty, Head Start, etc) 	<ul style="list-style-type: none"> • Discuss adjustment for child and family • HEADSSS for adolescents • Developmental screening • Ensure enrolled in school and necessary forms completed • Dental varnish and referral • Follow-up concerns from Visit 2 	<ul style="list-style-type: none"> • Discuss adjustment for child and family • Follow-up concerns from Visit 2
Labs	Recommended list*	If unable to do at Visit 1	Consider repeat Lead (3-6 months after arrival)
Meds	Presumptive treatment	If necessary based on labs	
Imms	Initiate catch-up	Continue catch-up	Continue catch-up
Follow-up/Note	Code Z11.9 & change display as "Migration health maintenance": use 'newimmigrantproblemlist'	Update "Migration health maintenance" list	Update "Migration health maintenance" list

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Migration History

Location of birth

Number of years in the US

Nationality

Preferred Language

Immigration status*

Migration path to the US

Health care access

Education access

Family

Migration Health Maintenance

Introduction to
Preventive
Health

Screening Labs

Growth

Developmental
Screening

Mental Health
Screening

Immunizations

Screening Labs & Presumptive Treatment

New Immigrant Screening and Care at Harborview Pediatrics

New Immigrant Laboratory Screening

1. Identify if refugee, **YES** ☐ **NO** ☐ → If Yes, Contact SKCPH, Refugee Screening Clinic, call Debbie or Shayla RN, 206-477-8315 (Fax: 206-296-3140), to determine if testing done

Standing Labs

Lab	Information
CBC/Diff	Follow-up if AEC >400
ZPPH	Follow clinic protocol
Hep B S Ag	Potential for vertical or horizontal transmission
Lead	Ages 6 mos-16 years Repeat in 3-6 months
HIV ELISA (HIV 1 & HIV 2)	If child is <18 months old order HIV PCR
Quantiferon (or TST)	TST if <2 years old; *DO NOT place TST on Thursday
Syphilis EIA	≥13 years
U GC/CT	≥13 years
Newborn Metabolic Screen	Children <6 months old can have one time newborn screening panel; MA must complete paperwork for NBS. WA DOH will run sample for older child with concern for developmental delay

Non-Standing Labs

Lab	Information
Urine BHCG	
Hemoglobin electrophoresis	To evaluate for Hgb SS, Hgb SC, Hgb S trait and thalassemias in high risk populations
G6PD	Consider screening males from high risk areas or with family history
Hepatitis C (Hep C Antibody)	Individuals with concern for high risk: blood transfusion, surgery overseas, tattoo, IV drug use, maternal history
TSH	6 mos-3 yo children w/ growth concerns
Giardia stool antigen	Diarrhea +/- growth concern
Stool O&P x 3	If not giving presumptive treatment, see Pathogenic and non-pathogenic stool samples for interpretation
Strongyloides IgG	If not giving presumptive Ivermectin treatment
Schistosomiasis IgG	If not giving presumptive Praziquantel treatment
Vitamin B12	Bhutanese ethnicity, dietary risk factors
25 OH Vitamin D	Dark skin, covered, dietary risk factors
Malaria Smears/Malaria RDT	Clinical suspicion

*Approach modified and attributable to: AAP Immigrant Tool Kit Creators, WA DOH Refugee Tool Kit Creators, Denver Health Immigrant and Refugee Health Assessment Team

Harborview Pediatrics Clinic

For questions or comments please contact: eedh@uw.edu

Careref

1. Demographics

Select the state where the refugee patient resides *

Select the refugee's departure or host country *

Select the refugee's country of birth *

Enter the refugee's date of birth *

January	1	2021
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Select the refugee's sex at birth *

☐ Male ☐ Female

Do you have the records from the refugee's pre-departure medical exam? *

☐ Yes ☒ No

Recommendations

Cancel

Careref

CDC alerts

Screening labs

Physical Exam

Immunizations

Mental Health

Health Profiles

CDC Health Alerts for U.S.-Bound Refugees

- News/Updates: Operation Allies Welcome (OAW) (notification issued 2021-10-29)

[Show more](#)

- Interim Hepatitis B Virus Domestic Medical Screening Examination Recommendations for Afghan Evacuees (notification issued 2021-11-08)

[Show more](#)

- Interim guidance for predeparture COVID-19 testing and domestic clinical considerations for COVID-19 (notification issued 2021-11-09)

[Show more](#)

- Update Alert: Confirmed Cases of Hepatitis A Virus Infection Among Newcomers from Afghanistan (notification issued 2021-12-14)

[Show more](#)

- Update Alert: Interim Clinical Guidance for Providers Caring for Newcomers from Afghanistan (notification issued 2021-12-20)

[Show more](#)

- Updates to the domestic lead screening guidance for newly arrived refugees (notification issued 2021-11-08)

[Show more](#)

- Interim COVID-19 Vaccination and Testing Guidance for Newly Arrived Refugees (notification issued 2021-05-05)

[Show more](#)

Presumptive Treatment for Parasitic Disease

- Identify if patient is a **refugee**
- YES?-> Received treatment overseas
- **NO-> proceed with presumptive treatment**

* DO NOT give Albendazole or Praziquantel to individuals with concern for Neurocysticercosis, if a child has a history of seizures or neurologic deficits of unknown cause, do not treat until further evaluation completed.

Global Region	Soil-transmitted helminths: Albendazole	Strongyloidiasis: Ivermectin or high-dose albendazole	Schistosomiasis: Praziquantel
Asia, the Middle East/North Africa, Latin America and Caribbean	12-23 months of age: 200 mg orally for 1 day. >23 months: 400 mg orally for 1 day Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200mcg/kg/day orally once a day for 2 days. ^b Should not be used presumptively if <15 kg or from Loa loa-endemic country ^c	Not recommended
Sub-Saharan Africa	12-23 months of age: 200 mg orally for 1 day. >23 months: 400 mg orally for 1 day Presumptive therapy is not recommended for any infant less than 12 months of age.	Ivermectin, 200 mcg/kg/day orally once a day for 2 days Should not be used presumptively if <15 kg or from Loa loa-endemic country ^c	Praziquantel, 40 mg/kg (may be divided and given in two doses for better tolerance). Children < 4 years of age should not receive presumptive treatment with praziquantel

^aAdapted from CDC Domestic Screening Guidelines for Parasitic Disease

^bSee New Immigrant Screening Guideline Appendix for helpful weight range Ivermectin dosing.

^c Countries with endemic Loa loa; therefore, do not use ivermectin for presumptive treatment for strongyloidiasis (this could cause die off of microfilariae → encephalopathy). Countries include: Angola, Cameroon, Chad, Republic of Congo, Democratic Republic of Congo, Equatorial Guinea, Gabon, Nigeria, South Sudan

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Eligibility for Government Funded Programs based on Immigration Status in UT

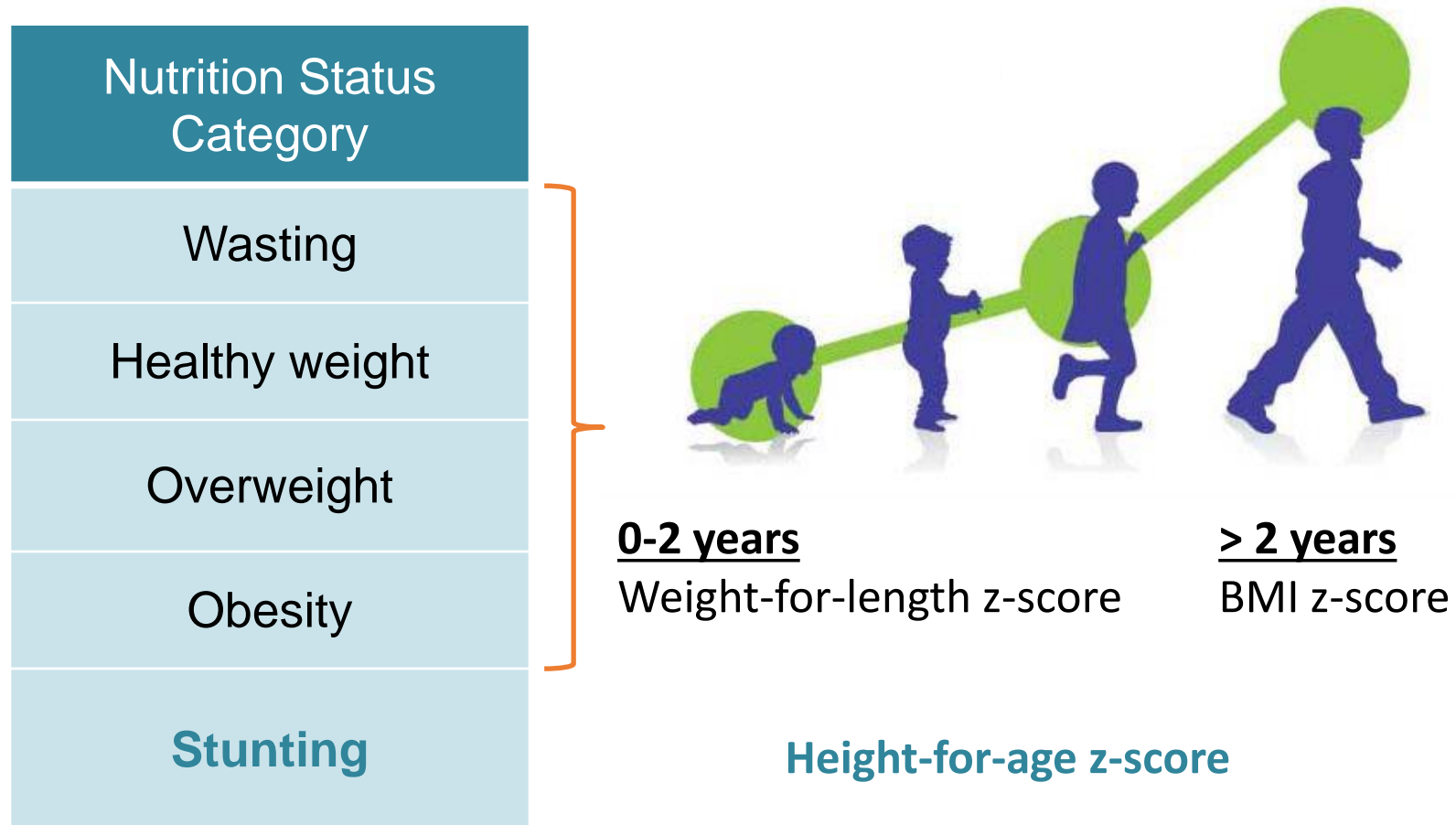


	Refugee/Asylees	Accompanied and Unaccompanied Immigrant Children	Undocumented Immigrant Children	US born child with an undocumented immigrant parent
Free/reduced priced school meals	Yes	Yes	Yes	Yes
WIC	Yes	Yes	Yes	Yes
Public Health Insurance	Yes	Yes	No	Yes
SNAP	Yes	Yes	No	Yes
TANF	Yes	No	No	Yes
DDI/Head Start	Yes	Yes	Yes	Yes
Foster Care	Yes	Yes, with caveats	No	Yes
SSI	Yes	No	No	Yes
Childcare Subsidy	Yes	No	No	No



Common Concerns: Malnutrition

Anthropometrics



Etiologies of Malnutrition

- Repeated bouts of diarrhea
- Giardia
- Metabolic disorders
- Food scarcity
- Feeding aversion



A large orange circle with a thin white border, serving as a background for the text.

Common Concerns: Developmental Delay & Mental Health

“Many children may have experienced a disruption in what we call the “scaffolding of childhood”—the basic experiences we expect to be in place for children to develop and thrive, such as access to schools, health care, adequate food and water, safe neighborhoods, and intact families”

-Refugee Health Technical Assistance Center



Setting the Stage

- Global rates of pediatric developmental disability range from 5-20%
- Prevalence in pediatric immigrant and refugee populations are unknown
- No word for “development” in primary language of many immigrants and refugees
- Limited awareness of developmental milestones

How Common Are Mental Health Concerns?

Refugee Children

- PTSD-
 - 11% if some exposure to adverse events
 - 38% if severe exposure

Almqvist, 1997

Immigrant Children

- 32% PTSD
- 16% Depression

Jaycox, 2002

Unaccompanied Refugee Minors

- 38.3% Anxiety
- 44.1% Depression
- 52.7% PTSD

Vervliet, 2014

Trauma Informed Approach: Universal Principles



TRAUMA INFORMED
CARE



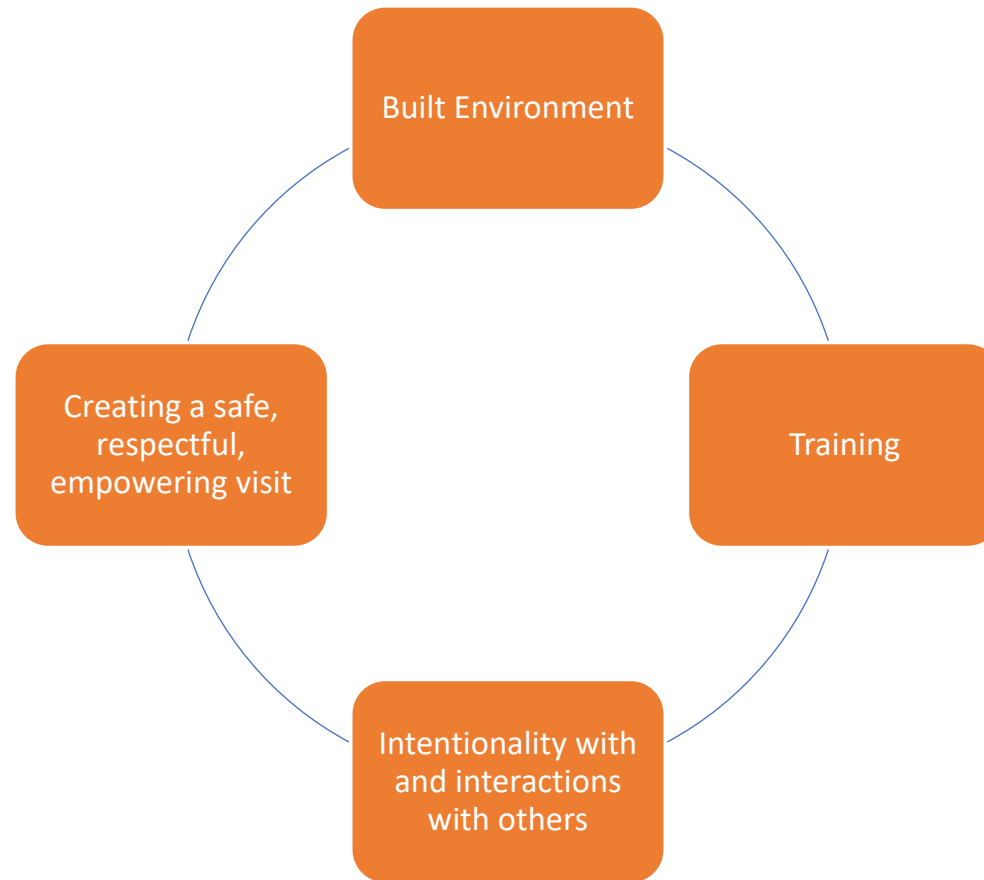
CARE APPROACH



CELEBRATING LANGUAGE

Slide adapted from Dr. Beth Dawson-Hahn

Trauma Informed Care



Training & Intentionality

“I imagine you may have been through a lot in your journey, I am going to ask you a few questions to help me take better care of you. You are welcome to share more if you would like to.”



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Celebrating Language

Identify preferred language

Consider in-person interpretation

Introduce interpreter and interpretation

Set clear expectations

Partnering with interpreters

- Shared mental model
- Debriefing

Slide adapted from Dr. Beth Dawson-Hahn



Self Care



Questions?

Contact: anisai@uw.edu

Social Media

-twitter handle @anisai



Resources

- [https://downloads.aap.org/AAP/PDF/cocp toolkit full.pdf](https://downloads.aap.org/AAP/PDF/cocp_toolkit_full.pdf)
- <https://www.frameworksinstitute.org/issues/immigration/>