

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Community Health Services

Providing Care For Immigrant, Homeless, and Migrant Children

ABSTRACT. This policy statement, which replaces the retired statements "Health Care for Children of Immigrant Families" (1997) and "Health Needs of Homeless Children and Families" (1996), is a broader discussion and addresses not only immigrant but also homeless and migrant child populations. It provides pediatricians with the necessary framework for addressing underserved children: those who face substantial barriers that limit access to appropriate health care services. This statement supports a community-based approach to health care delivery to ensure that underserved children have a medical home. *Pediatrics* 2005;115:1095-1100; *immigrant, migrant, homeless children, underserved communities.*

ABBREVIATIONS. SCHIP, State Children's Health Insurance Program; AAP, American Academy of Pediatrics.

INTRODUCTION

Children in underserved communities face multiple and often shared barriers to accessing comprehensive, affordable, and culturally and linguistically competent health care services. Some of these barriers include poverty, high mobility, limited English proficiency, and lack of insurance. In addition, they may encounter limited availability of health care because inadequate reimbursement prevents some health care professionals from accepting patients enrolled in publicly sponsored health care programs. Inadequate necessities, such as housing and food, and lack of information regarding previous medical care are some of the persistent challenges faced by these vulnerable families. For some, the fear of violence or immigration officials compounds their already fragile living conditions. Socioeconomic, financial, geographic, linguistic, legal, cultural, and medical barriers often impede these families from accessing even basic health care services.¹ Their pattern of health services utilization reveals that prevention is not a focus of their care, and the resulting care is fragmented, episodic, crisis oriented, and frequently reliant on emergency departments. Many children discussed in this policy statement may not have a regular source of care or coverage, but to the extent possible, health care professionals should make themselves aware of potential sources of coverage or alternate sources of

health care services and should care for these children.

Poverty, a strong determinant of child well-being, is closely linked to negative physical, developmental, and mental health-related outcomes.² A family's socioeconomic status has a direct effect on their ability to access high-quality health care services. In general, poverty rates in the United States have decreased, but the number of children living in families that are extremely poor remains virtually unchanged.³ As a result, the child poverty rate in the United States is among the highest in the developed world.³

Children of immigrant, homeless, and migrant farmworker families often are from racial or ethnic minorities that face health status disparities that exist as a function of complex and often poorly understood determinants, many of which are exacerbated by the children's life circumstances. Although these children have similar challenges with regard to poverty, housing, and food, significant physical, mental, and social health issues exist that are unique to each group.

IMMIGRANT AND REFUGEE CHILDREN

The 2000 US Census data⁴ highlight the growing numbers of immigrants who currently reside in the United States. However, despite efforts to report the US population accurately, census figures are likely to underreport immigrants, because immigrants often fear that participation may alert officials to possible illegal status.

In this policy statement, the term "immigrant children" refers to both legal and undocumented immigrants, refugees, and international adoptees.⁵ Some children in immigrant families may themselves be US citizens, eligible for government-sponsored and other health programs. However, the immigrant status of their families often influences whether and how these children access such programs. Under current law, there are, for example, health benefits restrictions for lawful immigrants who have arrived in the United States after 1996. These immigrants are barred for 5 years from receiving comprehensive health benefits under Medicaid and the State Children's Health Insurance Program (SCHIP), although their families pay taxes and contribute to society. More than 20 states currently provide health insurance coverage to legal immigrant children using state-only funds.

The uniqueness and complexity of each immigrant

experience must be emphasized, but certain overarching health issues are common in caring for immigrant families. Immigration imposes unique stresses on children and families, including:

- depression, grief, or anxiety associated with migration and acculturation;
- separation from support systems;
- inadequate language skills in a society that is not tolerant of linguistic differences;
- disparities in social, professional, and economic status between the country of origin and the United States; and
- traumatic events, such as war or persecution, that may have occurred in their native country.⁵

In addition, international adoptees also may face the challenge of being joined to families with whom they have no common language or physical similarities. As a result of these stressors, immigrant children may have difficulties adapting to school and may be at risk of depression, posttraumatic stress disorder, or conduct disorders.

Immigrant children may have diseases that are rarely diagnosed in the United States, such as malaria or schistosomiasis, or diseases that are more common in their country of origin, such as hepatitis A infection and amebiasis.⁶ During 1993–1998, the tuberculosis case rate was 32.9 per 100 000 population in foreign-born persons, compared with 5.8 per 100 000 population in US-born persons.⁷ Furthermore, immigrant children may not have been screened at birth for diseases such as congenital syphilis, hemoglobinopathies, and inborn errors of metabolism. Pediatricians in the United States may not be experienced in accurately evaluating, diagnosing, and treating some of these diseases, particularly when they first see patients in the later stages of illness. Appropriate screening and diagnostic protocols are available for use in evaluating foreign-born children and should be used routinely for all newly arrived immigrant children.⁸ Many foreign-born children have not been immunized adequately or lack documents verifying their immunization status; therefore, appropriate immunizations should be initiated immediately according to the recommended schedule for healthy infants and children.^{6,9}

Dental problems are common among immigrant children. In elementary school, immigrant children have been found to have twice as many dental caries in primary teeth as their US-born counterparts.¹⁰ Access to dental services should be facilitated by the pediatrician.

Immigrant children, especially international adoptees, have high rates of developmental delays. Screening for developmental delays should occur as part of the initial well-child assessment. School-aged children may require psychoeducational testing and possibly special education services in schools. Immigrant children often do not meet established height-for-age and weight-for-age measures at the time of entry into the United States. Although many experience significant catch-up growth within 1 year of arriving in the United States,^{8,11,12} these children should be monitored closely. When disturbances are

suspected, more comprehensive evaluations should be obtained expeditiously, and when necessary, appropriate services should be accessed.

Without being judgmental, the pediatrician should be aware of what other medications or interventions the child is receiving and what traditional medical beliefs the family has. Traditional beliefs that go unacknowledged may result in patient or family noncompliance with physician recommendations. Immigrant families may sometimes access traditional healers before seeking care from a pediatrician and may choose to use complementary remedies at any point in the US health care delivery continuum. Patients living in states near the Mexico-US border often travel into Mexico to seek medical care or to purchase medications. In one study, most US patients seeking low-cost health care and medications in Mexico were uninsured.¹³

HOMELESS CHILDREN

In defining the homeless population, the US Department of Housing and Urban Development includes those who are currently living on the streets or in shelters as well as those who are at risk of being homeless. Included in the latter group are those who are (1) in the process of terminating a stay in an institutional setting, (2) in situations in which they have insufficient prospects or resources, or (3) in precarious but conventional housing arrangements, including an increasing number of children living in poverty or in single-parent families, children who are recent immigrants, and children caught in the complicated web of urban decay and conflicting housing and social policies.¹⁴ Families with children are the fastest growing subgroup of the homeless population nationally and represent more than half of the homeless population in many cities.¹⁵

It is estimated that 1.6 million youth are homeless each year in the United States,¹⁶ and the number is growing. Some studies have shown a disproportionate rate of homelessness among minorities. Multiple societal problems (such as lack of affordable housing; decreases in the availability of rent subsidies; unemployment; personal crises such as divorce and domestic violence; cutbacks in public welfare programs; substance abuse; deinstitutionalization of the mentally ill; and increasing rates of poverty) contribute to the increasing rate of homelessness.¹⁷

Homelessness has been found to be an independent predictor of poor health status and high service use among children. In 1 study, after controlling for potential explanatory factors, homeless children remained more likely to experience fair or poor health status.¹⁸ Homeless children have a higher incidence of trauma-related injuries, developmental delays, sinusitis, anemia, asthma, bowel dysfunction, eczema, and visual and neurologic deficits. Obesity and hunger are also common among homeless children. School-related problems are common among homeless children and include sporadic attendance or nonattendance, grade repetition, and below-average performance. Furthermore, runaway youth or young people living on the streets are at significant risk of violence and victimization, substance abuse, preg-

nancy, and sexually transmitted diseases, including HIV infection and AIDS.¹⁷

A substantial number of homeless children do not have a regular source of health care.¹⁹ Health becomes a lower priority as parents struggle to meet the family's daily demands for food and shelter. Integration of health services with services provided by other agencies may improve access to care for children and adolescents who are living in shelters and do not have a medical home.^{20,21} Shelters and drop-in centers may act as gateways to other services and offer significant intervention potential for these families.²² Systems for tracking these children, such as portable medical records, need to be devised as a means of ensuring at least basic health care. Pediatricians who care for homeless patients must be cognizant of their patients' living environments and resource limitations. Medications that require refrigeration, for example, should not be prescribed for families that may not have consistent access to a refrigerator. Special arrangements may be needed to address lack of transportation, child care, and communication (eg, telephone) resources.

MIGRANT FARMWORKER CHILDREN

Migrant and seasonal farmworkers constitute a major portion of the labor force in the US agricultural industry. The Federal Migrant Health Program defines a migrant as one who, in the preceding 24 months, had principal employment in agriculture on a seasonal basis and who moved to seek such employment. It is estimated that there are between 3 and 5 million migrant farmworkers and their dependents in the United States, most being of Hispanic origin. In addition to the linguistic barriers faced by many monolingual Hispanic people, they also may have difficulty with written health education information because of low educational level and the prevalence of regional dialects and communication patterns. Because of their income level, lack of insurance, and mobile lifestyle, families of migrant farmworkers often find that comprehensive child health care is unavailable. They live in conditions characterized by poverty, unstable and overcrowded housing, poor sanitation, unreliable transportation, and social and cultural isolation.²³

Migrant farmworkers' children of all ages are at increased risk of respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, dental problems, lead and pesticide exposure, tuberculosis, poor nutrition, anemia, short stature, undiagnosed congenital anomalies, delayed development, intentional and unintentional injuries, occupational injuries, and substance abuse.²⁴ Adolescents, who constitute 5% to 10% of migrant farmworkers, often travel without guardians and face the aforementioned conditions as well as routine adolescent health issues, exacerbated by reluctance to access the health care system at a critical time in their physical and emotional development.²⁵

ROLE OF THE PEDIATRICIAN

The need for a community-pediatrics approach²⁶ is nowhere more acute than in working with children

in underserved populations. The pediatrician is instrumental in facilitating the health and general well-being of children in these populations. Pediatricians fulfill a unique professional role in understanding and addressing the complex health challenges faced by these populations and in ensuring their general health and well-being.

By providing a medical home for children in underserved populations, the pediatrician can serve as a key source of information to connect children and families with local resources to address their basic subsistence needs. Because children in underserved populations often access multiple agencies to meet their health and health-related needs, the pediatrician can act as a central coordinator of care, coordinating services to assure the maximum benefit for children and families and advocating on their behalf. As such, it is incumbent on pediatricians not only to maintain their fund of knowledge regarding the basic and unique health needs of underserved children but also to expand their scope to include a basic understanding and facility with community resources to support the maintenance of healthy growth and development.

RECOMMENDATIONS

1. Pediatricians should be aware of and sensitive to the onerous financial, educational, geographic, linguistic, and cultural barriers that interfere with achieving optimal health status for underserved children.
2. Pediatricians should be knowledgeable of the special mental and physical health problems faced by homeless, migrant, and immigrant children. Appropriate screening to identify family, environmental, and social circumstances, as well as biological factors, should be incorporated into routine pediatric assessments.
3. Pediatricians should try to provide compassionate and culturally and linguistically effective health care²⁷ services to all children and adolescents residing in the United States regardless of their immigration or socioeconomic status. They should inquire respectfully about housing circumstances, traditional healing practices, and medication use while obtaining a patient's medical history.
4. Pediatricians should have access to information regarding federal, state, and community programs that can serve as resources to at-risk children and their families.
5. Pediatricians and American Academy of Pediatrics (AAP) chapters should advocate on behalf of underserved children at local, state, and national levels. Advocacy efforts should address outreach efforts for children who are potentially eligible for Medicaid and SCHIP but not enrolled, simplified enrollment for both programs, and state funding for those who are not eligible for Medicaid or SCHIP. The Medicaid reciprocity model, which allows Medicaid recipients in 1 state to qualify for services in another state without reestablishing eligibility, is an example of a model that enables underserved families to access health benefits more easily.

6. Collaborations with legislators, families, and organizations representing underserved populations may increase the effectiveness of advocacy efforts.
7. Comprehensive, coordinated, and continuous health services provided within a medical home should be integral to all efforts on behalf of homeless, migrant, and immigrant children; this is especially critical for children with chronic health care needs and mental health problems.
8. Knowledge, attitude, and skill development in cultural and linguistic competence should be a part of every pediatrician's professional agenda.

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REFERENCES

1. Flores G, Vega LR. Barriers to health care access for Latino children: a review. *Fam Med*. 1998;30:196–205
2. National Research Council and Institute of Medicine, Committee on Integrating the Science of Early Childhood Development. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Shonkoff JP, Phillips DA, eds. Washington, DC: National Academy Press; 2000
3. Annie E. Casey Foundation. *Kids Count Data Book*. Baltimore, MD: Annie E. Casey Foundation; 2003
4. US Census. Available at: www.census.gov. Accessed March 10, 2004
5. American Academy of Pediatrics, Committee on Community Health Services. Health care for children of immigrant families. *Pediatrics*. 1997;100:153–156
6. Talbot EA, Moore M, McCray E, Binkin NJ. Tuberculosis among foreign-born persons in the United States, 1993–1998. *JAMA*. 2000;284:2894–2900
7. Hostetter MK, Iverson S, Thomas W, McKenzie D, Dole K, Johnson DE. Medical evaluation of internationally adopted children. *N Engl J Med*. 1991;325:479–485
8. American Academy of Pediatrics. Medical evaluation of internationally adopted children for infectious diseases. In: Pickering LK, ed. *Red Book: 2003 Report of the Committee on Infectious Diseases*. 26th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2003:173–180
9. American Academy of Pediatrics, Advisory Committee on Immunization Practices, American Academy of Family Physicians. Recommended childhood and adolescent immunization schedule—United States, 2005. *Pediatrics*. 2005;115:182–186
10. Pollick HF, Rice AJ, Echenberg D. Dental health of recent immigrant children in the newcomer schools, San Francisco. *Am J Public Health*. 1987;77:731–732
11. Miller LC, Kiernan MT, Mathers MI, Klein-Gitelman M. Developmental and nutritional status of internationally adopted children. *Arch Pediatr Adolesc Med*. 1995;149:40–44
12. Schumacher LB, Pawson IG, Kretchmer N. Growth of immigrant children in the newcomer schools of San Francisco. *Pediatrics*. 1987;80:861–868
13. Macias EP, Morales LS. Crossing the border for health care. *J Health Care Poor Underserved*. 2001;12:77–87
14. The Urban Institute. *Alternative Methods to Estimate the Number of Homeless Children and Youth*. Washington, DC: US Department of Education; 1991
15. Bolland JM, McCallum DM. Touched by homelessness: an examination of hospitality for the down and out. *Am J Public Health*. 2002;92:116–118
16. Robertson MJ, Toro PA. Homeless youth: research, intervention and policy. In: Fosburg LB, Dennis DL, eds. *The 1998 National Symposium on Homelessness Research*. Washington, DC: US Department of Housing and Urban Development, US Department of Health and Human Services; 1999
17. American Academy of Pediatrics, Committee on Community Health Services. Health needs of homeless children and families. *Pediatrics*. 1996;98:789–791
18. Weinreb L, Goldberg R, Bassuk E, Perloff J. Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics*. 1998;102:554–562
19. Simms MD. Medical care of children who are homeless or in foster care. *Curr Opin Pediatr*. 1998;10:486–490
20. Klein JD, Woods AH, Wilson KM, Prospero M, Greene J, Ringwalt C. Homeless and runaway youths' access to health care. *J Adolesc Health*. 2000;5:331–339
21. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110:184–186
22. De Rosa CJ, Montgomery SB, Kipke MD, Iverson E, Ma JL, Unger JB. Service utilization among homeless and runaway youth in Los Angeles, California: rates and reasons. *J Adolesc Health*. 1999;24:449–458
23. American Academy of Pediatrics. *Guidelines for the Care of Migrant Farmworkers' Children*. McLaurin J, ed. Elk Grove Village, IL: American Academy of Pediatrics; 2000
24. American Academy of Pediatrics, Committee on Community Health Services. Health care for children of farmworker families. *Pediatrics*. 1995;95:952–953
25. Veta-Acosta M, Lee B, eds. *Migrant and Seasonal Hired Adolescent Farmworkers: A Plan to Improve Working Conditions. Recommendations From the National Adolescent Farmworker Occupational Health and Safety Advisory Committee*. Marshfield, WI: Marshfield Clinic. Available at: www.marshfieldclinic.org/nfmc/farmworkersreport. Accessed March 10, 2004
26. American Academy of Pediatrics, Committee on Community Health Services. The pediatrician's role in community pediatrics. *Pediatrics*. 1999;103:1304–1307
27. American Academy of Pediatrics, Committee on Pediatric Workforce. Culturally effective pediatric care: education and training issues. *Pediatrics*. 1999;103:167–170

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Resources that provide access to health care

Centers for Medicare and Medicaid Services: administer the federal component of key government programs serving this population, including Medicaid, SCHIP, and the Rural Health Clinics program.

7500 Security Blvd
Baltimore, MD 21244
Telephone: 410-786-3000
Web site: www.cms.hhs.gov

State and local health and human service agencies: administer the state component of key government health programs (eg, Medicaid and SCHIP) as well as state-only sponsored health programs. These agencies typically coordinate outreach and enrollment activity for health-related programs.

National Association of Community Health Centers: the national trade association of nonprofit clinics that provide free health care and/or low-cost health services to medically underserved populations.

1330 New Hampshire Ave
Suite 122
Washington, DC 20036
Telephone: 202-293-5518
Fax: 202-659-8519
Web site: www.nachc.com

Vaccines for Children program (VFC): a federally funded program that provides free vaccines to eligible (traditional and safety net) health care professionals for the purpose of immunizing children and youth who are uninsured, enrolled in Medicaid, or participating in Indian Health Service programs. Each state or region has a designated VFC coordinator who can be identified through the appropriate health and human service agency.

National Immunization Hotline: 800-232-2522
Web site: www.cdc.gov/nip/vfc

Migrant Clinicians Network: a national organization of health care professionals who promote the health of migrant farmworkers. Education, resources, and advocacy are priorities.

PO Box 164285
Austin, TX 78716
Telephone: 512-327-2017
Fax: 512-327-0719
Web site: www.migrantclinician.org

Resources that establish standards for health care

AAP: a professional association of pediatricians in the United States. The AAP establishes the basic content and periodicity of well-child (health supervision) visits, develops policies regarding the provision of health care to all children, and administers programs to expand access to care for underserved populations (eg, the Breastfeeding Promotion in Pediatric Office Practices Program II, the Community Access to Child Health program, and the Healthy Tomorrows Partnerships for Children program). A set of resources for child health care professionals titled *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 2nd edition, is available through the AAP; and *Guidelines for the Care of Migrant Farmworkers' Children* was published by the AAP in 2000.

141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098
Telephone: 800-433-9016
Web site: www.aap.org

Centers for Disease Control and Prevention: the lead federal agency responsible for the health and safety of the population. It provides grants to support the development of health promotion and disease-prevention programs and related research, establishes guidelines and credible information for the prevention and treatment of numerous infectious diseases (including immunization standards), and provides national focus for health promotion and education activities.

Telephone: 800-311-3435
Web site: www.cdc.gov

Food and nutrition resources

United States Department of Agriculture: administers a number of food and nutrition services for vulnerable populations, including the federal food stamp program, the emergency food assistance program, national school nutrition program, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs, as well as a number of housing programs for rural families.

14th Street and Independence Avenue, SW
Washington, DC 20250
Telephone: 202-720-4323
Food Stamps (toll free): 800-221-5689
Web site: www.fns.usda.gov/fns

WIC: provides vouchers for specific supplemental foods, nutrition education, and referrals to health care and social service agencies for low-income women, infants, and children up to 5 years of age who are at nutritional risk.

Web site: www.fns.usda.gov/wic

National School Lunch program and School Breakfast program: provide free breakfast and lunch to school-aged children in families with incomes less than 130% of the federal poverty line and reduced-cost breakfast and lunch to school-aged children in families with incomes between 130% and 185% of the federal poverty line.

Web site: www.fns.usda.gov/cnd

America's Second Harvest: a national hunger-relief organization that distributes food through a nationwide network of more than 200 food banks and food-rescue programs.

Web site: www.secondharvest.org

Housing resources

US Department of Housing and Urban Development (HUD): administers public housing programs, which provide subsidized housing for indigent families. Local public housing authorities are available through the HUD Web site.

451 7th St SW
Washington, DC 20410
Telephone: 202-708-1422
Web site: www.hud.gov

National Low Income Housing Coalition: provides education, advocacy, and coalition building to ensure decent and affordable housing for everyone.

1012 14th St NW, Suite 610

Washington, DC 20005

Telephone: 202-662-1530

Fax: 202-393-1973

Web site: www.nlihc.org

Cash assistance resources

Office of Family Assistance: located within the US Department of Health and Human Services and administers the federal component of several cash and employment assistance programs for low-income children and their families. These services include the Temporary Assistance to Needy Families program and the Earned Income Tax Credit program.

Administration for Children and Families

370 L'Enfant Promenade SW

Washington, DC 20447

Web site: www.acf.hhs.gov

Legal resources

A variety of public-interest law programs have been established to provide free or low-cost legal services, policy analysis and advocacy, technical assistance, and training on behalf of individuals and/or segments of vulnerable populations. These programs use the law to protect vulnerable populations from the harms caused by poverty, immigrant status, and other vulnerabilities.

National Center for Youth Law

405 14th St, 15th Floor, Suite 1500

Oakland, CA 94612

Telephone: 510-835-8098

Fax: 510-835-8099

E-mail: info@youthlaw.org

Web site: www.youthlaw.org

National Health Law Program

National Web site: www.nhelp.org

2639 S La Cienega Blvd

Los Angeles, CA 90034-2675

Telephone: 310-204-6010

Fax: 310-204-0891

E-mail: nhelp@healthlaw.org

or

1101 14th St NW, Suite 405

Washington, DC 20005

Telephone: 202-289-7661

Fax: 202-289-7724

E-mail: nhelpdc@healthlaw.org

National Immigration Law Center

3435 Wilshire Blvd, Suite 2850

Los Angeles, CA 90010

Telephone: 213-639-3900

Fax: 213-639-3911

E-mail: info@nilc.org

Web site: www.nilc.org

National Law Center on Homelessness and Poverty

1411 K St NW, Suite 1400

Washington, DC 20005

Telephone: 202-638-2535

Web site: www.nlchp.org

These resources are provided to assist the pediatrician in addressing the health needs and basic subsistence needs of children and families who are poor and underserved. These resources are not intended to be comprehensive but include a representation of key government and nonprofit programs and services for these populations.