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Abstract:

In the United States, 1 in 4 children lives in an immigrant family. State and national policies have historically precluded equitable access to health care among children in immigrant families. More recently, increasingly restrictive policies, political rhetoric, and xenophobic stances have made immigrant families less able to access health care and less comfortable in attempting to do so, thus increasing the likelihood that patients will present to the emergency department. Once in the emergency department, language, cultural, and health literacy barriers make providing high-quality care potentially challenging for some families. Emergency care professionals can therefore glean critical insight regarding inequities from clinical work to inform advocacy and policy changes at institutional, community, regional, and national levels.

Keywords:

immigrant; immigration; emergency department; access to care; language barrier; health literacy

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Children in Immigrant Families: Advocacy Within and Beyond the Pediatric Emergency Department

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In the United States (US), 1 in 4 children (more than 18.4 million) lives in an immigrant family, meaning the child and/or at least 1 parent was born outside of the US.¹ Although the percentage of children in immigrant families continues to increase, the number of immigrant children (children who are foreign-born) in the US has declined since 2000.² Drivers of migration are complex and include political, socioeconomic, environmental, communication, religious, educational, and other community and personal circumstances.³ Such shifting demographics and policy changes are relevant to pediatric emergency medicine (PEM) through issues related to access to care, clinical presentations, patient outcomes, and emerging needs for systems-level innovation and transformation.

Despite the complexity of immigration policy, PEM physicians have an opportunity to connect clinical experiences with education and research to advance policy changes at multiple levels.^{4,5} Restrictive immigration policies, such as increased immigration enforcement leading to parental deportation, immigration detention, and family separation at the border, negatively impact the health and well-being of children in immigrant families (CIF).⁶⁻⁹ For instance, recent immigration policy changes have been associated with increased psychological distress, including anxiety and sleep disturbances, and physical effects such as blood pressure changes among adolescents.^{8,9} Xenophobia and racism have been associated with negative health effects and may be exacerbated by the rhetoric surrounding restrictive immigration policies.¹⁰⁻¹³ Additionally, being undocumented and/or in mixed-status families has been connected with poor health outcomes, particularly in high-risk scenarios such as child birth or after kidney transplant.¹⁴⁻¹⁶ Fear and uncertainty when accessing health care or participating in public programs, including through the public charge regulation, have also created barriers for CIF.¹⁷⁻²⁰ Increasingly restrictive border policies, including the Migrant Protection Protocol (MPP) and “metering” at ports of entry whereby officials limit the daily number of individuals allowed to enter the US (often at random), have increased the health and safety risks to immigrant families seeking safe haven.^{21,22} Unlike restrictive policies, inclusive immigration policies, such as Deferred Action for Childhood Arrivals and providing health coverage to unauthorized pregnant women and children, support health, well-being, and access to care.^{6,23-26}

Health insurance coverage greatly impacts access to care and health outcomes yet varies widely across states. As of January 2020, only 6 states (Washington, Oregon, California, Illinois, New York, Massachusetts) and the District of Columbia offered health coverage to immigrant children regardless of immigration status (Figure 1).^{27,28} More than half of states offer Medicaid or the Children's Health Insurance Program (CHIP) to lawfully residing children regardless of date of entry (Figure 1).^{27,28} Insurance coverage is intimately connected with having a usual source of care and with emergency department (ED) utilization.²⁹ Additionally, increased parental coverage is associated with increased utilization of preventive health care by their children.³⁰ However, despite improvements in insurance coverage after passage of the Affordable Care Act including through state Medicaid expansion, Latinx youth and non-Latinx black youth are less likely to be insured than non-Latinx white peers.³¹ Additionally, citizen children with an immigrant parent are still less likely than citizen children with a nonimmigrant parent to have health coverage.³² Such inequitable health coverage naturally translates into challenging inequities in the pediatric ED.

More recently, the novel coronavirus (COVID-19) pandemic has underscored existing inequities and revealed new ones for CIF.³³ Stark inequities by race, ethnicity, and language preference have been widely described and attributed to the impact of racism and structural inequities in communities across the nation.³⁴ Furthermore, like previous pandemics that have been associated with xenophobia and stigma,³⁵ COVID-19 has

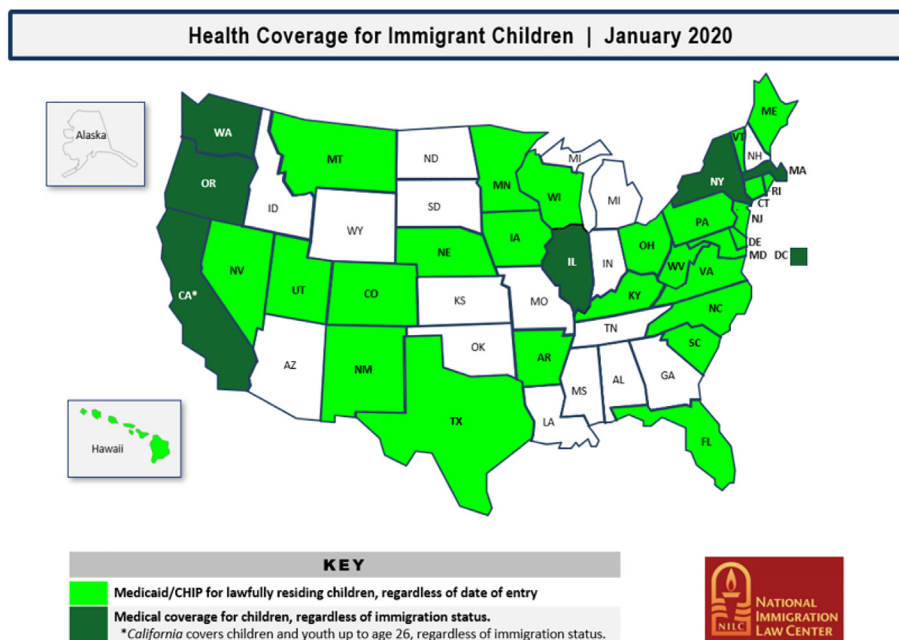


Figure 1. Health coverage for immigrant children. Reproduced with permission of the National Immigration Law Center.²⁸

led to anti-Asian xenophobia that has negatively impacted Asian Americans and people of Asian descent globally. Although children may be less likely to become symptomatic from COVID-19, the COVID-19 pandemic impacts other aspects of child health relevant to PEM physicians, including immunizations (and risk for serious infections), abuse, and mental health concerns.³⁶

PEM physicians can glean critical insight regarding immigrant health inequities from clinical work to inform research and advocacy at institutional, community, regional, and national levels. The subsequent article offers case-based examples to understand critical challenges and opportunities for improvement in the field.

CHILDREN OF IMMIGRANT FAMILIES PRESENTING TO THE ED

Case 1. A 3-year-old boy presents to the ED at 10 PM for concerns regarding his poorly controlled eczema. He was born in the US, but his parents are undocumented immigrants from Angola. He is uninsured and does not have a medical home.

Eligibility for Health Coverage

There are many reasons why patients of any background may present to the ED for the treatment of a nonemergent condition; however, many of these disproportionately impact CIF. As discussed above, health insurance coverage in most states is directly linked to immigration status, which in turn affects access to a medical home. In most states, immigrants have limited or no access to federally funded health care.³⁷ Ultimately, undocumented and “lawfully present” immigrants have significantly higher rates of being uninsured and decreased health care utilization and expenditures as compared to US citizens.³⁸⁻⁴² CIF subsequently have significantly diminished access to health insurance, health care, and mental health care.⁴³⁻⁴⁵


Barriers to Accessing Care

Many barriers impair access to care for CIF. For example, the complex laws that affect health care coverage are unclear to many, including those assisting immigrant families, leading to confusion over eligibility. As a result, many patients who are eligible for public programs are not aware and therefore are not registered.^{37,46,47} The application process is often difficult to navigate, and families may experience logistical barriers such as lack of financial resources and transportation. Health literacy challenges also affect ability to access care.^{4,48}

Racism and Xenophobia

Recently arrived immigrants may face xenophobia and racism premigration, during migration, and postmigration.⁴⁹ Both engender fear, leading to concern over the consequences of accessing benefits, mistrust of the health care system, and decreased utilization of medical care for CIF.¹³ Local immigration raids and deportations have also led to decreased participation in public programs, including Medicaid and Women, Infants, and Children (WIC).⁵⁰ This fear is not limited to those without legal documentation and can also affect immigrant families who may fear that they will be perceived as undocumented because of their race/ethnicity.³⁸ When states have enacted laws threatening immigrant families, such as with Arizona's SB1070 or Georgia's HB87, health care utilization among immigrant families decreased.^{51,52} Likewise, restrictive policies, statements, and attitudes toward immigrant families coming from the Trump administration also undoubtedly affect families' comfort level with seeking medical care⁵³ and willingness to trust the health care system with their personal information.⁴⁶ Most recently, the amended Public Charge rule caused confusion and fear among immigrant families, leading to decreased utilization of health care even by those not directly affected by the rule change.^{19,38,54-56} For example, some studies have demonstrated that children who are US citizens in mixed-status families, despite eligibility for federal and state programs, have comparatively low resource utilization and still make up a significant percentage of the uninsured child population.^{57,58} With more than 7 million mixed-status families in the US, it is crucial that emergency physicians acknowledge the effects of xenophobia on the health of immigrant populations.^{8,9,33} All of these factors, and more, influence the likelihood that families will have a regular source for preventive and illness health care needs, and the likelihood that they will present to an ED instead.

Opportunities for Advocacy

Emergency physicians should consider the relationships between immigration status, insurance status, race/ethnicity, and health care access in the context of health equity within the ED and beyond. In the case of CIF presenting to the ED for a nonurgent medical condition, opportunities for advocacy exist at the institutional, community, state, and federal levels. Advocacy in such cases begins with delivery of high-quality and compassionate care, including addressing nonemergent needs, identifying barriers to primary care, and referral to culturally relevant community-based resources. Many of these opportunities are in line with existing American Academy of Pediatrics policies.^{4,5,11,59-63} Suggested advocacy action items for ED physicians are included at the end of each section (Box 1). 

CONSIDERATIONS FOR CIF WHILE IN THE ED

Case 2. A newly arrived, 8-year-old Guatemalan child presents to the ED after a first-time seizure. He and his father prefer to speak Tz'utujil. Telephonic interpretation is not available for this indigenous language, so a family friend provides the interpretation. Hospital admission is ultimately recommended but declined by his father, as his friend is unable to stay to assist with ongoing communication.

Providing high-quality and compassionate care to CIF in the ED requires purposeful attention to mitigating barriers such as language, cultural discordance, and health literacy difficulties, and augmenting strengths such as community and family support.

Language Barriers

In 2018, 22% of people in the US (67 million) reported speaking a language other than English at home.² Of those, 62% reported speaking Spanish at home. Among

all CIF, 4% live in a home where neither the child nor parents have been in the US for greater than 5 years.⁶⁵ Without the use of professional interpretation, language barriers have a negative impact on treatment adherence, admission rates, resource utilization, repeat emergency visits, length of stay, medical errors, patient satisfaction, patient trust, and perceptions of received care.^{4,66-82} However, inclusion of professional interpreters is associated with improved understanding of diagnosis, treatment plan, and discharge instructions; increased filling of prescriptions; decreased return visits; decreased resource utilization; decreased admission rates; and reduction in medical errors. Interpreter use also improves patient satisfaction, perception of provider friendliness/respectfulness, and quality of care received.^{66,80,83-92} Despite this, pediatricians often rely on family members or nonprofessional interpreters, increasing the risk for negative outcomes.^{4,92-96} Addressing language barriers is a legal and ethical requirement and is essential to providing appropriate care to CIF.⁶⁶ Barriers can be overcome through utilization of best practices, development of programs and partnerships, and flexibility.⁹⁷

Box 1. Advocacy opportunities: advancing equitable access to care.

- | | |
|---------------|--|
| Institutional | <ul style="list-style-type: none"> · Clarify and develop processes for financial counseling and/or charity care when patients present to the ED without insurance or ability to pay · Develop processes to offer social work and/or community health worker referrals when patients register in the ED and are not able to identify a medical home · Offer ongoing education to physicians, nurses, trainees, and other team members regarding culturally relevant, accessible care for CIF · Offer ongoing education to physicians, nurses, trainees, and other team members regarding pertinent health care topics (eg, common health care conditions, neglected tropical diseases, social determinants of health, racism and bias, and human trafficking) |
| Community | <ul style="list-style-type: none"> · Engage with community organizations already serving local immigrant communities. Identify areas for partnership and potential referral sources for patients. This may include: <ul style="list-style-type: none"> · Medical-legal partnerships⁶⁴ · Organizations providing activities or mentorship · Mental health organizations · Organizations providing dental care and nutritional services⁴ |
| State | <ul style="list-style-type: none"> · Advocate for new or continued Medicaid expansion in all states · Advocate to end the 5-year waiting period for lawfully residing children in states that have not yet done so²⁸ · Work with state-level professional organizations and community partners to build a coalition to expand access to Medicaid/CHIP for all children, regardless of immigration status |
| Federal | <ul style="list-style-type: none"> · Work with professional organizations to support expansion of ACA programs to all immigrant families · Work with policy makers to encourage all federal, state, and local agencies that interact with CIF to develop policies that prioritize and protect the health, well-being, and safety of CIF · Advocate against any form of family separation and the detention of children as a form of immigration enforcement · Advocate against immigration enforcement activities in local communities, especially in sensitive locations such as schools and health care facilities, that have irreparable consequences to a child's health, a family's willingness or ability to access care, and community well-being |

Cultural Considerations

In caring for CIF, it is crucial to underscore protective cultural factors, including strength, resilience, and support from extended families and communities.^{4,43,48,98} Providing culturally relevant care is challenging, rewarding, and ultimately vital to advancing health equity. Failure to do so may lead to mistrust of the provider or health care system, decreased patient compliance, and poorer outcomes.


Effective communication often requires bridging cultural differences between patients, their families, and physicians. Each immigrant family comes from a unique cultural framework, informed by their life experiences, values, behaviors, beliefs, religions, languages, and understanding of illness and the role of the health care system. Therefore, to effectively communicate, physicians must approach their patients with cultural humility. This includes recognizing their own cultural assumptions and biases, the systemic and historical underpinnings to existing power differentials and health inequities, and their patient's cultural perspectives.³³ Physicians may have implicit racial biases that impede effective interpretation of patients' symptoms, decision making, and provider understanding of patients' ethnic and cultural disease models and expectations.⁹⁹ Failing to negotiate cultural divides may lead to improper diagnoses, improper pain management, underutilization of prescription medications, and challenges with obtaining informed consent. In the aforementioned case, the family's choice to decline admission likely encompassed factors beyond the language barrier. Additional considerations may have included the family's interpretation of the risks of declining further workup, their understanding of the disease process or treatment options, preferences regarding traditional vs Western therapies, fear of being mistreated, not having the culturally appropriate decision-making authority present, or any other number of factors.

Health Literacy

Health literacy is described as an individual's ability to "obtain, process, and understand basic health information needed to make appropriate health decisions."¹⁰⁰ It also reflects the complexity of the health care system with which the individual is interacting and the degree to which they are attempting to do so.¹⁰⁰⁻¹⁰² Health literacy affects a patient's or family's ability to understand written material and health-related information, communicate effectively, and make appropriate health related decisions.¹¹⁰ An estimated 1 in 3 patients/family members has low health literacy, therefore affecting most ED encounters.¹⁰³ Limited health literacy disproportionately affects people with lower socioeconomic status, minority groups, and those with limited English proficiency. Poor

health literacy has been associated with higher rates of ED visits for nonemergent care, higher rates of hospitalizations, and worse preventive care and health outcomes in children.^{101,103-105} Recognizing and addressing the complexities of poor health literacy are vital to appropriately and effectively treating children in the ED, continuing quality care after discharge, and connecting them to a medical home.

Opportunities for Advocacy

PEM physicians can work at institutional, community, state, and federal levels to develop systems-level approaches to advancing linguistically and culturally relevant care for CIF (Box 2). 

SPECIAL POPULATIONS: CHILDREN SEEKING SAFE HAVEN

Case 3. A 16-year-old adolescent boy from El Salvador who is residing in a local shelter for unaccompanied minors (UM) presents with a perirectal abscess that requires admission for surgical intervention and further evaluation for underlying medical conditions. Concerns are raised regarding a potentially incomplete history, ability to obtain informed consent, and language and cultural barriers.

Children and Families Seeking Asylum

The numbers of forcibly displaced people around the world have risen to alarming levels, reaching an estimated 70.8 million in 2018.¹⁰⁶ There are many ways by which a family might seek safe haven in the United States, including with temporary or special visas, applying for refugee status before traveling to the US, or requesting asylum on arrival.^{4,107} According to the US Customs and Border Protection, 851 508 people were apprehended on the Southern US border in Fiscal Year 2019 (October 2018-September 2019).¹⁰⁸ Although the criteria and legal definitions for this complex system are beyond the scope of this paper, families seek asylum and other forms of legal protection for complex reasons, including abject poverty, interpersonal and community violence, and lack of state protection.⁵ As described in a *Medecins San Frontieres* (Doctors Without Borders) report, 39% of migrants report direct attacks or threats to themselves or family, extortion, or gang-forced recruitment as their primary motivation for escaping. Forty-three percent have had a family member die because of violence in the preceding 2 years (notably, 56% of Salvadorans). As many as 75% report witnessing a murder or seeing a corpse in the preceding 2 years.¹⁰⁹ Continued violence is common during the arduous journey or even after arrival. In fact, 68% of migrants report being victims to violence

Box 2. A advocacy opportunities for advancing linguistically and culturally relevant care.

Institutional	<ul style="list-style-type: none"> · Explore opportunities to create welcoming spaces for CIF (eg signage, culturally appropriate nutrition options) · Ensure written materials are available in common languages for your community and written at an appropriate level. Consider audiovisual or other forms of information delivery · Educate ED physicians and staff on the importance and proper use of interpreters. Ensure the availability of in-person or telephonic interpretation. Discourage the use of family, friends, or other nonprofessional interpreters. Children should never be used as interpreters · Integrate prompts into the medical record system to remind physicians to ask families for their preferred language · Educate ED physicians on the importance of cultural humility and the complexities of cross-cultural communication with immigrant families · Partner with interpreters, social work, and community organizations to ensure patient care is being delivered in the most culturally sensitive manner · Make health literacy an integral part of the ED's mission and operations. It should be factored into planning, evaluation measures, patient safety, and quality improvement¹⁰¹ Educate ED physicians and staff on the importance of delivering diagnosis, health information, and discharge instructions to families with varying levels of health literacy · Design processes and assist patients to navigate the local health system. Provide easy access to navigation assistance¹⁰¹
Community	<ul style="list-style-type: none"> · Partner with local community-based organizations working with immigrant families to seek feedback on care provided in the ED · Offer community-based educational materials in multiple languages and in multiple platforms including signage, social media, radio, and local television
State	<ul style="list-style-type: none"> · Advocate for insurance coverage of medical interpretation through state Medicaid and CHIP
Federal	<ul style="list-style-type: none"> · Advocate for insurance coverage of medical interpretation through the Affordable Care Act

during their journey, and one third of women reported sexual abuse while in transit.¹¹⁰ Violence may be even worse in certain higher-risk populations such as UM or migrants who identify as lesbian, gay, bisexual, transgender, questioning, and/or intersex (LGBTQI).

Under the MPP instituted in 2019, most asylum seekers approaching the US from Mexico are returned to Mexico pending their immigration hearing, regardless of their country of origin. This has led to overcrowded and unsafe makeshift camps along the border, as asylum seekers from different countries and people groups—some who may have been fleeing the very people they are sent to Mexico with—are sent with limited legal protections and lack of access to counsel. Human rights organizations have documented high levels of violence, including kidnapping, rape, and murder in these camps. The MPP has also compelled Mexican authorities to increase their southern border and internal enforcement where many more health and safety concerns exist.¹¹¹

When caring for recently arrived asylum-seeking patients in the ED, one must consider that a patient has likely been a victim of or exposed to violence. Additional considerations include the toxic stress associated with detention and family separation.^{5, 112} Health sequelae include acute physical injuries acquired during their journey and mental health concerns, especially posttrau-

matic stress disorder.¹¹³ Although most are healthy, one must be thorough with newly arrived patients because they may present with previously undiagnosed disease, poorly managed chronic diseases, or chronic diseases that have decompensated during their journey.

Unaccompanied Minors

“Children do not migrate, they flee.”¹¹⁴ UM entering the US face added risks given their age and lack of family support. They are at high risk of having been witness or subject to physical and sexual violence, including human trafficking, rape, kidnapping, extortion, torture, and murder. According to Amnesty International, as many as 6 in 10 Central American women and girls are victims of sexual violence during their migration through Mexico.¹¹⁵ Based on previous experiences with violence, history taking and physical examination can be retraumatizing. In particular, extreme sensitivity should be used if a genital or rectal examination is required for any recently arrived patient.

Once in the US, UM are detained in Customs and Border Patrol processing facilities for up to 72 hours before being transferred to the Office of Refugee Resettlement (ORR) custody. From there, they are placed in ORR shelters for UM, often for several months,

pending reunification with a family or community sponsor or placement in the foster care system. It is important to note that not all UM arrive to the US alone. Children may be separated from their family members for reasons of detention, removal, or prosecution of the adult family member, thus exposing them to additional trauma.

For children coming to the ED from the ORR shelter, all should have had an initial medical evaluation within 72 hours of arrival to the shelter, and all children should have access to medical care after discharge. Most shelters have daily nursing staff and access to a medical home onsite, offsite, or at times via telehealth (particularly in the setting of COVID-19). Any discharge or follow up instructions should be clearly written for the receiving shelter medical staff. If the child requires subspecialty care, this should be expedited, if possible, as there may only be a short window before the child leaves the shelter. While in ORR custody, medical care is covered by ORR, and expedited follow-up may remove medical barriers for reunification.

As with any patient, if the child requires hospitalization or procedures, informed consent must be obtained. As the child is in ORR custody, ORR has the full legal authority to consent; however, the minor should be a full participant in medical discussions (as is age appropriate), and full assent should be sought by the medical team. Clinicians should also feel empowered to seek speaking to the patient's family, whether they are in the US or another country, assuming that contacting the patient's family would not compromise the child's safety. Although the parents do not have medical decision-making authority, obtaining a complete history and having their participation in the consent process are, in most cases, the right thing to do. By working together with the patient, the patient's family, and the ORR shelter, we can improve our ability to best care for the child while in our ED, after returning to the ORR shelter for UM, and after reunification.

Mental Health Concerns

Immigrants undergo an intense period of unfamiliarity and uncertainty throughout the migration experience, including in country of origin, during migration, and after arrival in the US. Postmigration, immigrant youth have high rates of posttraumatic stress disorder and depression. Up to 85% of refugee youth experience bullying.¹¹⁶ In fact, when compared with nonimmigrant youth, immigrant youth are more likely to present to the ED rather than other medical facility with their first mental health crisis.¹¹⁷ The ED practitioner should offer trauma-informed care, addressing psychosocial needs when possible. ED physicians can also emphasize inherent strengths that may provide a protective benefit to our patients, including extensive community and extended

family support.⁶³ For instance, CIF often have strong cultural identification but yet are able to maneuver between the dominant US culture and that of their family and home country.^{43,49} The ED approach therefore should be holistic, understanding that addressing the child's family and support network may be an important component of doing what is best for the patient.

LGBTQI-Specific Concerns

The subset of child immigrants who identify as part of the LGBTQI community has unique health care access challenges that the PEM practitioner should be aware of. They are more likely to use the ED, to report financial barriers to medical care, and to experience difficulties accessing mental health care.¹¹⁸ Data on sexual minority immigrant youth are sparse, but nonimmigrant sexual minorities have more unmet health care needs and less routine care compared to their heterosexual counterparts.¹¹⁹ This is likely compounded by the additional barriers to health care immigrants' experience. LGBTQI youth may be stigmatized or considered lower class.¹²⁰ Many report bullying and victimization.¹²¹


In the setting of limited access to care and social ostracism, physicians caring for LGBTQI immigrant youth must recognize that an ED visit may be one of the few contacts the patient may have with the health care system. Sexual minority youth express need for privacy, confidentiality, inclusivity of language, and increased physician comfort with topics of LGBTQI-related health issues.¹²² As such, PEM physicians must work to establish trust and promote safety, recognize the complexities of their mental health challenges, and be introspective about one's own implicit biases.¹²³

Human Trafficking Concerns

Children who are immigrants or undergoing migration are at increased risk of labor and sex trafficking.¹²⁴ They are uniquely vulnerable to exploitation and human rights violations because of the same risk factors (eg, poverty, persecution, fear) that caused them to migrate in the first place.¹²⁵ ED physicians should educate themselves on red flags for trafficking and coercion, such as reluctance to give a history without deferring to the accompanying person, injuries out of proportion to stated history, lack of control of documents and identification, multiple sexually transmitted infections or multiple partners, etc. The National Human Trafficking Hotline (1-888-373-7888) offers basic protocols and various screening tools for trafficking that are undergoing validation for the pediatric ED.⁵⁹ Victims of human trafficking may be eligible for a protective visa if they work with law enforcement and other authorities. Social services in the pediatric ED should be aware of this and know how to link victims with

appropriate legal assistance in pursuing a T-visa when applicable.

Opportunities for Advocacy

Special populations, including immigrant families seeking safe haven, UM, CIF with mental health difficulties, CIF who identify as LGBTQI, and victims of human trafficking, face unique challenges within the broader population of CIF. PEM physicians have opportunities to advocate for policy changes to support the unique health and wellness needs of CIF who are part of special populations (Box 3). 

SPECIAL CONCERNS DUE TO COVID-19

Case 4. A 3-year-old girl presents to the ED with distal finger cellulitis that began during the SARS-CoV-2 outbreak. Her mother prefers to speak Vietnamese, had lost her job, and harbored significant fear of both

accessing health care and contracting COVID-19. She treated the finger with home remedies for 2 weeks until the infection continued to spread, causing intractable pain and severe swelling. The child was found to have severe osteomyelitis and underwent intravenous antibiotic therapy and distal fingertip amputation.

A pandemic such as COVID-19 places additional strain on immigrant families already facing a myriad of social and economic challenges, exposing gaping inequities in our system.¹²⁶ Many factors contribute to inequitable outcomes for CIF during the pandemic, including diminished access to care from language barriers or limited health literacy, insufficient health coverage, or decreased access to medical homes. Immigrant families may also be less likely to enroll in nutritional assistance or other social support programs.³³ In addition, immigrant children are more likely to live in multigenerational households and therefore unable to limit social contacts. Adults may have fewer financial resources and be required to work to make ends meet, or they may be

Box 3. Advocacy opportunities to advance health equity for special populations of CIF.

Institutional	<ul style="list-style-type: none"> · Develop processes to provide trauma informed care in the ED · Educate ED staff and learners on the needs of special populations of CIF who may present to the ED, such as offering Safe Zone training (https://thesafezoneproject.com/about/what-is-safe-zone/) to support CIF who are also LGBTQI · Develop processes to identify and respond to human trafficking and/or domestic violence when caring for CIF (http://www.polarisproject.org) · Encourage appropriate communication with the families of UMs, even when they are located in other countries, except in situations where it may potentially cause harm
Community	<ul style="list-style-type: none"> · Develop relationships with local ORR shelters <ul style="list-style-type: none"> · Remove barriers to caring for their patients and improve communication with shelter medical staff. · Remove barriers to seeking subspecialty care within your institution. Develop a process to expedite their appointments · Explore opportunities to fill in any gaps to care that the ORR shelter might not be able to provide · Collaborate with local community-based organizations who offer services to LGBTQI youth and ensure that linguistically and culturally relevant resources are available in the ED · Partner with community-based organizations to expand linguistically and culturally relevant mental health services for referral when mental health challenges arise in the ED · Partner with and advocate for organizations providing postrelease services for those children who were previously detained and/or newly arrived to the community.
State	<ul style="list-style-type: none"> · Advocate for the expansion of public funding for mental health services accessible to CIF through school-based health centers and/or community-based organizations · Advocate against state-level policies that unravel protections for LGBTQI individuals · Advocate for “safe harbor” laws that recognize trafficked children as victims rather than perpetrators and that prevent them from being prosecuted for prostitution
Federal	<ul style="list-style-type: none"> · Advocate for policy makers to create an inclusive immigration policy that protects the health, well-being, and safety of all CIF, especially those requiring special protections as outlined above · Attend to guidance from professional organizations and encourage others regarding comments on rule changes that negatively affect immigrant health, such as new asylum regulations, public charge regulations, and efforts to prolong detention for immigrant families (https://www.federalregister.gov)

more likely to be in frontline, essential jobs and therefore faced increased infectious exposure.

Increasing xenophobia has also been all too present. At the start of COVID-19, Twitter was inundated with xenophobic messaging targeting Asian communities, amplified by messages of fear and anger worldwide.¹²⁷ The Asian Pacific Policy and Planning Council reporting center documented nearly 1500 reports of verbal harassment, physical assault, and civil rights violations against Asians within 4 weeks of its inception.¹²⁸ Considering that one quarter of Asians are immigrants and this population is growing, xenophobia against Asians affects the pediatric immigrant population profoundly.¹²⁹ Xenophobia in the setting of the pandemic may also contribute to fear to seek medical care.


Although there is not yet sufficient research to investigate delays to care, emerging data suggest that some are experiencing harm because of this delay. A small case series in Italy demonstrated that even children who are not immigrants experience COVID-19 fear-related delays to care, sometimes at significant morbidity and mortality cost.¹³⁰

Policy solutions are critical to mitigate the inequitable impact of COVID-19 on CIF.^{33,131} In a pandemic where public fear is already elevated, physicians can advocate for immigrants by lobbying for expanded access to care and for multilingual and culturally relevant messaging to help immigrant families navigate the changes in the medical system without fear, and by supporting federal mandates to ensure that undocumented immigrants and people experiencing poverty are included in public services and not have to fear deportation if they access services.

SUMMARY

PEM physicians often have the privilege of caring for CIF during some of the most challenging moments in their lives. With that privilege comes a responsibility to engage in advocacy to advance health equity for CIF through systems-level and policy change. Such advocacy is motivated through compelling interactions with children and families. When cases present in the ED that demonstrate inequities in policies or practices, PEM physicians can consider seeking permission from the family to share the story in a deidentified way to motivate change. Through a combination of narratives to tell the story, data to describe the impact, and policy-level solutions, PEM physicians can contribute to advancing health equity for CIF.

CONFLICTS OF INTEREST

The authors have no conflict of interest. 

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