



Report

¿Cómo Están los Niños? The Health of Latino Children and Families in California

Prepared By



The Child and Adolescent Health Measurement Initiative



ABOUT CAHMI: The Child and Adolescent Health Measurement Initiative (CAHMI), founded in 1997, is a research and policy group based at Oregon Health & Science University that focuses on the development, implementation, and strategic dissemination of data based on measures of child and adolescent health and health care quality. The CAHMI is committed to advancing patient-centered innovations by putting children, youth and families at the center of quality measurement and improvement.



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Support for this research was provided by the Lucile Packard Foundation for Children's Health. The views presented here are those of the authors and not necessarily those of the Lucile Packard Foundation for Children's Health or its directors, officers, or staff.

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Table of Contents

	Acknowledgements
7	Executive Summary
	Context
	Objective
	Main Findings
	Conclusions and Recommendations
12	Introduction
	Notes on the Data
14	Demographics
	Acculturation and Language
	The “Immigrant Paradox”
	Children of Undocumented Immigrants
	“Mixed Status” Families
	Household Income and Financial Disparities
20	Health Status of Latino Children in California
	Children with Special Health Care Needs
	Asthma
	Air and Water Quality
	Emotional, Behavioral, and Developmental Problems
	Neonatal Outcomes
	Overweight/Obesity
	Oral Health
	Mortality
27	Health Care Access and Quality
	Barriers to Health Insurance Coverage
	Comprehensive and Family-Centered Health Care
	Quality of Health Care
	Community Clinics and Health Centers
36	Family, Community and School
	Family and Home Environment
	School Environment
45	The Whole Child
47	Conclusions and Policy Recommendations
49	References

Figures

Page

- 8 Percent of California White and Latino Children Age 0-17 Years Who Experience Minimum Standards for Health Care, Home Environment, and School/Neighborhood Safety
- 14 Figure 1: Percent of California Children Age 0-17 Years by Ethnicity, 1990-2010
- 15 Figure 2: Latino Children Age 0-17 Years in California by Region, 2013
- 16 Figure 3: Health Effects of Acculturation
- 18 Figure 4: Citizenship and Immigration Status of California Latino Children Age 0-17 Years and Their Mothers
- 19 Figure 5: Household Income of Families of California White and Latino Children Age 0-17 Years
- 20 Figure 6: Percent of California White and Latino Children Age 0-17 Years Whose Parents Consider Their Child's Health Excellent or Very Good
- 21 Figure 7: Percent of California White and Latino Children Age 0-17 Years Who Have Special Health Care Needs
- 22 Figure 8: Most Common Health Conditions Experienced by California White and Latino Children Age 0-17 Years
- 24 Figure 9: Neonatal Outcomes for Whites and Latinos, Rates per 1,000 Live Births, California, 2010
- 27 Figure 10: Type of Health Insurance Among California White and Latino Children Age 0-17 Years
- 28 Figure 11: Percent of California White and Latino Children Who Are Uninsured
- 29 Figure 12: Percent of California White and Latino Children Age 0-17 Years Meeting Medical Home Criteria
- 30 Figure 13: Percent of California White and Latino Children Age 0-17 Years Receiving the Components of a Medical Home
- 31 Figure 14: Percent of California White and Latino Children Age 0-17 Years Who Receive Family-Centered Care
- 31 Figure 15: Components of Family-Centered Health Care Experienced by California White and Latino Children Age 0-17
- 32 Figure 16: Preventive Health Care Services Received by California White and Latino Children Age 0-17 Years
- 33 Figure 17: Percent of California White and Latino Children Age 0-17 Years who Received Health Care Meeting All 3 Quality of Care Criteria
- 34 Figure 18: Usual Source of Health Care for California White and Latino Children Age 0-17 Years

- 36 Figure 19: Positive Home Environment Factors Experienced by California White and Latino Children Age 0-17
- 38 Figure 20: Physical and Emotional Health of Parents of California White and Latino Children Age 0-17
- 39 Figure 21: Prevalence of Adverse Childhood Events Experienced by California White and Latino Children Age 0-17 Years
- 40 Figure 22: Percent of California White and Latino Children Age 6-17 Years Who Experience All 3 Factors Promoting School Success
- 41 Figure 23: Education Attainment and School Outcomes Among California White and Latino Children
- 42 Figure 24: Neighborhood Support and Safety Among California White and Latino Children Age 0-17 Years
- 43 Figure 25: Amenities in Neighborhoods Where California White and Latino Children Age 0-17 Years Live
- 44 Figure 26: Factors Promoting Resilience Experienced by California White and Latino Children Age 6-17 Years
- 44 Figure 27: California White and Latino Children Age 6-17 Years Who Have At Least One Adult Mentor
- 46 Figure 28: Percent of California White and Latino Children Age 0-17 Years Who Experience Minimum Standards for Health Care, Home Environment, and School/Neighborhood Safety

Acknowledgements

The report was produced by staff at the Child and Adolescent Health Measurement Initiative (CAHMI) at Oregon Health and Science University, including:

- Susan Carson, MPH; *CAHMI Research Associate*
- Katharine Zuckerman, MD, MPH; *Assistant Professor, Department of Pediatrics, School of Medicine*
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The report was commissioned and funded by the Lucile Packard Foundation for Children's Health. The following foundation staff contributed to the report:

- Edward L. Schor, MD; *Senior Vice President, Programs and Partnerships*

The following experts served as key informants and reviewers:

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- Carmela Castellano-Garcia, esq; *President and CEO, California Primary Care Association*
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- Michael A. Rodriguez, MD, MPH; *Professor and Vice Chair for Research in the Department of Family Medicine at the David Geffen School of Medicine at UCLA, Director of the Network for Multicultural Health & Healthcare Research and Associate Director of the UCLA Primary Care Research Fellowship*

Executive Summary

Context

The health of Latino children and families is of increasing importance to California and the nation. The factors affecting Latino children's health today will have lifelong consequences for their own health, and for the future well-being of California's population and economy. Assuring that Latino children and their families have access to high-quality health care and the resources necessary for them to benefit from that care may require new policies and approaches.

Recognizing that children's health and well-being rest upon a foundation built not only on their access to quality medical care, but also on their home environment and neighborhood context, is vital to viewing a child as a whole person. This "whole child" approach is used to inform policy to support healthy development.

Objective

This report is intended to be used by policymakers, community, consumer and family leaders, health care professionals, educators and families themselves to identify opportunities to leverage strengths and address risks of Latino children and families to ensure a healthier future for California.

Data Sources

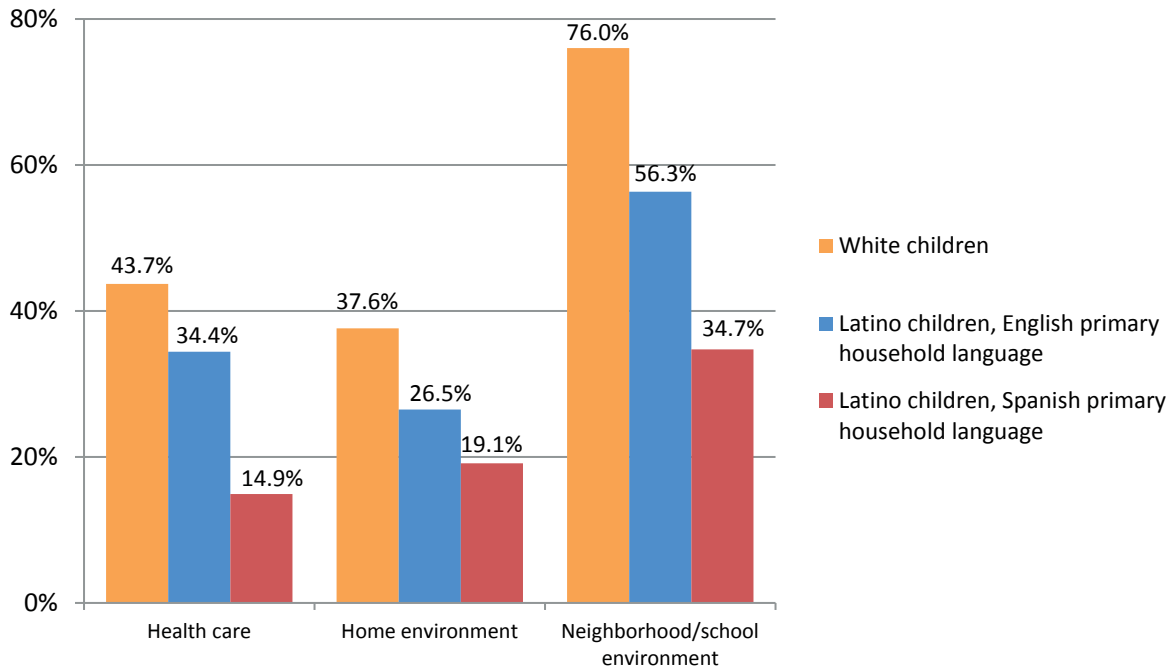
The 2011/2012 National Survey of Children's Health, 2009/2010 National Survey of Children with Special Health Care Needs, the 2012 California Health Interview Survey, and other population-based surveys, supplemented with published and gray literature and expert advisor input.

Main Findings

The presence of individual risk factors and protective factors is less important to overall well-being than their combined influence, and it is useful to present data by combining both positive and negative factors into summary measures. Summary measures were used to describe some complex issues, including a minimum quality standard for basic health care, a protective home environment, and a community that is likely to promote children's health, development and well-being.

Fewer California Latino children than white children experience a minimum standard of basic health care, family, and community factors, and this is especially true for Latino children living in Spanish primary language households:

Percent of California White and Latino Children Age 0-17 Years Who Experience Minimum Standards for Health Care, Home Environment, and School/Neighborhood Safety



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2552&r=6>; <http://childhealthdata.org/browse/survey/results?q=2556&r=6&g=456>; <http://childhealthdata.org/browse/survey/results?q=2369&r=6&g=456>;

Demographics

More than 4.5 million Californians are Latino children under age 18. Latinos make up 37.6 percent of California's total population, but 51.2 percent of the child population. Most California Latino children were born in the state, but 45.7 percent of their mothers were born outside the US. Over 30 percent of California children live in households in which the primary language spoken is Spanish.

Financial stress is a significant burden for many Latino families in California, even when parents are employed full time. More than half of Latino children from Spanish primary language households live below the federal poverty level (\$23,050 per year for a family of 4 in 2012), and over 30 percent live in a "working poor" household, in which parents have incomes of less than 100 percent of the federal poverty level despite being employed full time.

Even when they, themselves, are citizens, children of undocumented immigrant parents face significant disadvantages. They are more likely to live in poverty, with parents who face barriers to health care and other social services. They may live in unhealthy environments, some associated with their parents' poor working conditions, and experience the constant stress and instability from knowing that members of their family may be subject to deportation. These stresses likely affect their health and well-being in the present time and on into adulthood.

Health Status

Many California Latino children have parents who report they are in very good or excellent health, but the story is different for Latino children in Spanish primary language households. In those families nearly half of the children are reported to experience less than excellent or very good health. Higher rates of poverty and its associated stressors are at least partially responsible for the poorer reported health status of these children. Latino families, in general, seem less inclined to report that their children have chronic health conditions and special health care needs, and when those are reported they tend to be more complex and result in limitations in daily activities.

Health Care Access and Quality

While most California Latino children are US citizens and qualify for publicly funded insurance based on their family income, disparities in health insurance coverage remain, and more than 370,000 Latino children in California have no health insurance. Over 10 percent of children from primarily Spanish-speaking households are uninsured, which is more than twice as high as white children or Latino children with homes where English is the primary language.

More than half of Latino children from Spanish primary language households live below the federal poverty level.

Out-of-pocket health care expenses are an added burden to already struggling families. These expenses are obviously substantial in the absence of health insurance, and they are also common when employer-funded health insurance has limited benefits, a common situation for low-income workers. Families with public insurance tend to have lower out-of-pocket expenditures; among those with publicly funded insurance, 71.7 percent say their out-of-pocket costs are usually or always reasonable, compared to 47.0 percent of similar families with private sector health insurance. Reported out-of-pocket expenditures are higher for families whose children have special health care needs.

An essential source of care for many vulnerable Latinos are the more than 900 Community Clinics and Health Centers located throughout California, making support of these clinics essential to the health of Latino children. In California, 57.7 percent of Latino children from Spanish-speaking households use a community or government clinic or a community hospital as a usual source of care, a much higher rate of use than white children (15.3 percent) or Latino children from English-speaking households (17.9 percent).

More than 370,000 Latino children in California have no health insurance.

One way in which quality of care is ascertained is determining whether a child receives care in a setting that meets the definition of a medical home—care that is accessible, continuous, comprehensive, family-centered, compassionate and culturally effective. Despite comprising the majority of children in California, Latino children are nonetheless significantly less likely than white children to receive care in a medical home.

A minimalistic health care quality summary measure was developed assessing whether children in California have adequate health insurance, receive care in settings that meet criteria for being a “medical home,” and have had at least one preventive health care visit in the past 12 months. Using this measure, it is clear that California can do better for all children—only 31.7

percent of California children overall met this minimum quality of care criteria—but the results were substantially lower for Latino children. Only 14.9 percent of children from households in which the primary language is Spanish receive care that meets all three quality criteria.

Family

Several indicators address whether children live in a home environment that promotes and protects their development and health. In California, Latino children fare as well or better than white children when it comes to family habits and practices that promote and protect their child’s health. Most Latino children in California have parents who themselves report excellent or very good physical, emotional/mental health, and low levels of difficulty parenting their children. Still, many parents, especially those in Spanish-language households, report difficulties parenting their child. More than 18 percent of California Latino children live with a parent who reports “usually” or “always” feeling stress from parenting (i.e., the parent reported feeling that their child was much harder to care for than other children, they were often bothered a lot by their child’s behavior and/or they were often angry with their child). California children from Spanish primary language households have parents who report this kind of parenting stress nearly 3 times more often than do white children (22 percent vs 8 percent).

Latino children fare as well or better than white children when it comes to family habits and practices that promote and protect their child’s health.

Community

Amenities and social support within their own neighborhoods are lacking for many Latino families in California. Latino children are less likely than white children to live in a neighborhood that has certain resources that contribute to child health and well-being, such as parks, recreation centers, sidewalks and libraries. In addition, California Latino children are less likely than white children to have parents who report living in a supportive neighborhood (75.3 percent vs 90.8 percent). Latino children are also less likely than whites to have parents who feel that their neighborhood is usually or always safe.

School

Data show that California Latino children and their parents value education and place high importance on success in school. Being engaged in school, participating in extracurricular activities, and feeling safe at school are important factors that promote academic success, but only 52.3 percent of California Latino students experience all three of these school-success factors, compared to 72.2 percent of white children.

Conclusions and Recommendations

This report highlights several key opportunities to promote the health of California’s Latino children and families. Pressing needs include improving the quality of health care available to Latino children in California, addressing language and cultural barriers to health care, and mitigating the harmful health effects of poverty and poor neighborhood conditions. Recommendations based on

the data presented here and developed in partnership with expert advisors, focus on the following areas:

- Improve access to and quality of health care, and improve health care system performance;
- Address language and cultural barriers to health care; and
- Help children build resilience against the harmful health effects of poverty and unsafe neighborhoods.

Introduction

The changing demography of the United States is nowhere more evident than in California where, today, the majority of children are Latino, and over 90 percent of Latino children are US citizens. Over the next several decades, as these children age, Latinos will comprise an ever larger portion of California's workforce. For that workforce to contribute successfully to the state's economy and leadership, it is essential that their childhood offers them not only the opportunity for a sound education, but also ready access to high-quality, effective and appropriate health care so they enter adulthood healthy.

Latino children have the same potential for health and well-being as other children, but they may face barriers to achieving that potential not experienced by other children. The goal of this report is to help identify those barriers, as well as particular strengths of the Latino community in order to guide proactive strategies to ensure that the health of California's Latino children and their families is optimized.

The majority of California children are Latino.

In summarizing the most recent data on the health status of California's Latino children and families, this report is intended to be used by policymakers, community, and family leaders, health care professionals, educators and families themselves to identify opportunities and target areas for intervention to ensure a healthier future for California.

Although this report focuses on Latino children, it is important to note that California can do better for all its children. A previous report found that California lags behind most other states in providing quality health care to children.¹ In particular, California ranks poorly compared to other states on numerous measures of quality health care for children with special health care needs (CSHCN), including adequacy of insurance, provision of basic preventive care, and meeting minimal criteria for having a medical home (ongoing, comprehensive, coordinated, and family-centered care).

Notes on the Data

When reporting data on the health of Latinos, it can be difficult to separate the effects of language and cultural factors from the effects of poverty and socioeconomic status. More than one-third of California Latino children live below the federal poverty level, and the many ways that poverty affects them are reflected in this report. In order to put the data in perspective, we use comparison groups when reporting data on Latino children. In this report, the comparison group used most frequently is California white children. For most indicators, we report the Latino child data by subgroups according to the child's primary household language. Previous research on the health of Latino adults shows disparities based on country of nativity (i.e., US-born Latinos or foreign-born). It is not possible to separate most child health data according to parents' place of birth, so primary household language is used as a marker for parents' place of birth and acculturation.

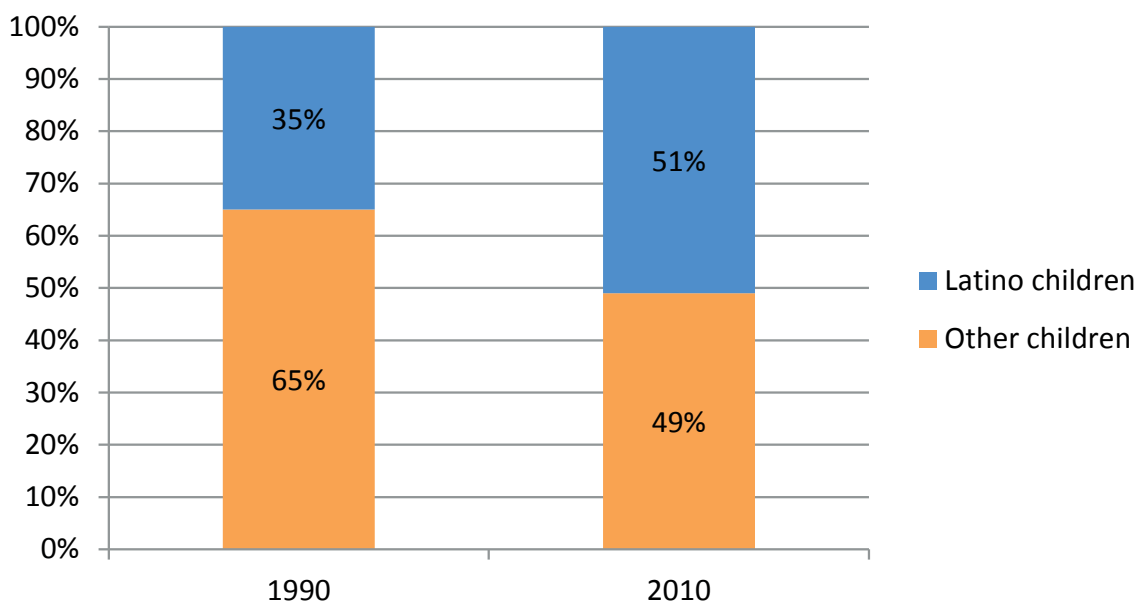
¹ Bethell C, Zuckerman K, Stumbo S, et al. Children with Special Health Care Needs in California: A Profile of Key Issues. The Lucile Packard Foundation for Children's Health. January 2013. Available at: <http://lpfch-cshcn.org/publications/research-reports/children-with-special-health-care-needs-in-california-a-profile-of-key-issues/>.

Throughout this report, we use the term “Latino” to mean people of Latin American descent. For most of the data reported, this designation is self-reported on surveys such as the National Survey of Children’s Health, the California Health Interview Survey or the US Census. Unless otherwise specified, the term “white” when used in this report means non-Latino white.

Demographics

More than 4.5 million Californians are Latino children under age 18. Latinos make up 37.6 percent of California's total population, but 51.2 percent of the child population. The population of children under age 18 who are Latino has increased steadily over the last 20 years, from about 35 percent of the child population in 1990 (Figure 1).² This growth is expected to stabilize over the next 20 years because of falling birth rates and decreased migration to the US. By 2030, it is projected that 52.5 percent of California children under age 10 and 53.4 percent of those ages 10 to 17 will be Latino.

Figure 1: Percent of California Children Age 0-17 Years by Ethnicity, 1990-2010

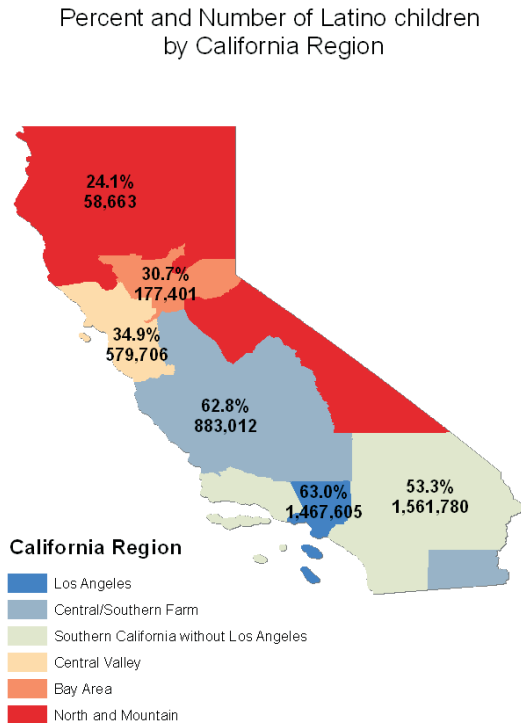


Data source: Pastor M, Marcelli EA, Carter V, Sanchez J. What's at stake for the state: Undocumented Californians, immigration reform, and our future together. 2013

² Pastor M, Marcelli EA, Carter V, Sanchez J. What's at Stake for the State: Undocumented Californians, Immigration Reform, and our Future Together. May 2013. Center for the Study of Immigrant Integration (CSII). University of Southern California. Available at: http://csii.usc.edu/documents/whats_at_stake_for_the_state.pdf.

The California regions with the greatest concentrations of Latino children are the Central/Southern farming regions and Los Angeles County (Figure 2).

Figure 2: Latino Children Age 0-17 Years in California by Region, 2013



Data source: California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, 2010-2060 (May 2013); U.S. Census Bureau, Current Population Estimates, Vintage 2012 (June 2013). Accessed at: <http://www.kidsdata.org/data/demographic/dashboard.aspx?dem=17>

Latinos are often referred to as a single group, but differences in country of origin, length of time in the US, area of residence, and economic circumstances mean Latinos in California are a diverse group with different health strengths and risks. California Latinos come from more than 20 different countries in Central and South America, the Caribbean and Europe. Children of Mexican descent are the largest group (43.1 percent of California children), followed by children of Central American (3.3 percent) and South American descent (0.7 percent).³

Acculturation and Language

Acculturation is the process by which immigrants acquire the culture, values and norms of their new country. The effect of acculturation on the health of Latinos in the US is complex and not well understood. Researchers have identified both positive and negative effects, and results vary based on how acculturation is measured (Figure 3).⁴

³ Myers D. California's diminishing resource: Children. January 2013. Lucile Packard Foundation for Children's Health (USC, Sol Price School of Public Policy). Available at: http://www.usc.edu/schools/price/research/popdynamics/pdf/2013_Myers_Californias-Diminishing-Children.pdf.

⁴ Lara M, Gamboa C, Kahramanian MI, Morales LS, Bautista DE. Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annu Rev Public Health*. 2005;26:367-97.

Figure 3: Health Effects of Acculturation

Positive health effects of acculturation	Negative health effects of acculturation
<ul style="list-style-type: none"> ● Higher rates of health insurance coverage ● More use of preventive health services ● Better satisfaction with care and perceived health ● Fewer barriers to care, even after controlling for poverty, transportation and other factors 	<ul style="list-style-type: none"> ● Increased drug use in adults and adolescents ● Alcohol use in women ● Smoking ● Worse birth and perinatal outcomes ● Smoking, alcohol and drug use during pregnancy ● Poorer diet and nutrition

Data source: Lara M, Gamboa C, Kahramanian MI, Morales LS, Bautista DE. Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annu Rev Public Health*. 2005;26:367-97.

Acculturation can be measured in many ways, one of which is by the primary language spoken at home (the measure of acculturation used for most outcomes in this report). Latinos who primarily speak Spanish are likely to be more recently arrived in the country and live in communities with a larger Latino population, promoting retention of the culture of origin. Although language measures have been shown to be reliable markers of acculturation, there are degrees of acculturation not captured by dividing Latinos into subgroups of English or Spanish speakers.

Over 30 percent of California’s school-age children live in households in which the primary language spoken is Spanish. There are many advantages to growing up bilingual, including retention of ethnic identity, access to community networks, and on some measures, increased academic success and cognitive performance. One in four Spanish-speaking households in California is considered “linguistically isolated” however, meaning no one in the household age 14 or older is conversant in English.³ Parents of young children who have limited English proficiency may have difficulty navigating and engaging in their community, their child’s school and the health care system, resulting in increased health risks for their children.

The “Immigrant Paradox”

The “immigrant paradox” or “healthy immigrant phenomenon” are terms used to describe the observation that although Latino immigrants have higher poverty rates, lower education levels and less access to health care on average than US-born Latinos and whites, they have more positive health outcomes on several measures than these other groups.⁵ For example, infant mortality rates and the prevalence of low birth weight infants are lower in Mexican immigrants than US-born Mexican Americans and whites. One possible explanation for this is that the cohesion and connection provided by family and community promote positive health behaviors, and this support acts as a buffer to mitigate the detrimental effects of poverty and other risk factors.^{5,6} More research is needed to identify the specific positive family, cultural, and community factors that protect against the significant health risks faced by immigrants. A better understanding of these mitigating factors may lead to interventions to improve the health of all children.

5 Mendoza FS. Health disparities and children in immigrant families: A research agenda. *Pediatrics*. 2009;124(Suppl 3):S187-95.

6 Flores G, Fuentes-Afflick E, Barbot O, et al. The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *JAMA*. 2002;288(1):82-90.

Children of Undocumented Immigrants

Over 94 percent of Latino children in California were born in the US, though many have one or both parents who are undocumented immigrants. It is estimated that 1 in 6 children in California (including non-Latinos) has at least one parent who is an undocumented immigrant² and 85 percent of undocumented immigrants in California are Latino.

Children with undocumented parents face significant disadvantages. They are more likely to live in poverty, to have parents who face barriers to health care and other social services, and who may be disengaged from their communities and children's schools because of limited English proficiency and fear of identification and deportation.²

Over 30% of California's school-age children live in households in which the primary language spoken is Spanish.

- In California, 67 percent of children with an undocumented immigrant parent live below 150 percent of the federal poverty level (\$23,050 for a family of 4 in 2012), compared to 42 percent of those with a parent with legal residency status and 25 percent of those with a US-born parent.
- Median annual income of undocumented immigrants who work full time is \$20,000, less than half that of US-born full-time workers.
- 47 percent of undocumented immigrants in California age 25 and older have had no schooling beyond the elementary grades, and only 33 percent are high school graduates. In contrast, 85 percent of documented immigrants have graduated from high school.
- 42 percent of undocumented immigrants in California speak English well, compared with 61 percent of non-citizen documented immigrants.

A large proportion of undocumented immigrants live in substandard housing; 69 percent are considered "burdened renters" (those who spend more than 30 percent of household income on rent) and 19 percent live in overcrowded housing (more than 1.5 people per room in a household).

The undocumented status of a parent can have negative consequences for children, including separation, or fear of separation, from the parent, psychological distress of parents due to low wages and poor working conditions, and unstable family situations in the event that a parent is deported.⁷

The stress faced by children of undocumented immigrants is significant and is likely to affect them into adulthood.

The stress faced by children of undocumented immigrants is significant and is likely to affect them into adulthood. Research has shown that early adversity and persistent stress in childhood can lead to later impairments in learning, behavior, and both physical and mental well-being.⁸ Parental distress has been associated with lower child cognitive development.⁷ Because of their vulnerability, and because these adverse childhood experiences have effects across the life span, it is important that early intervention and supports are directed toward children who have an undocumented immigrant parent. In addition

⁷ Yoshikawa H, Kholoptseva J. Unauthorized immigrant parents and their children's development: A summary of the evidence. 2013.

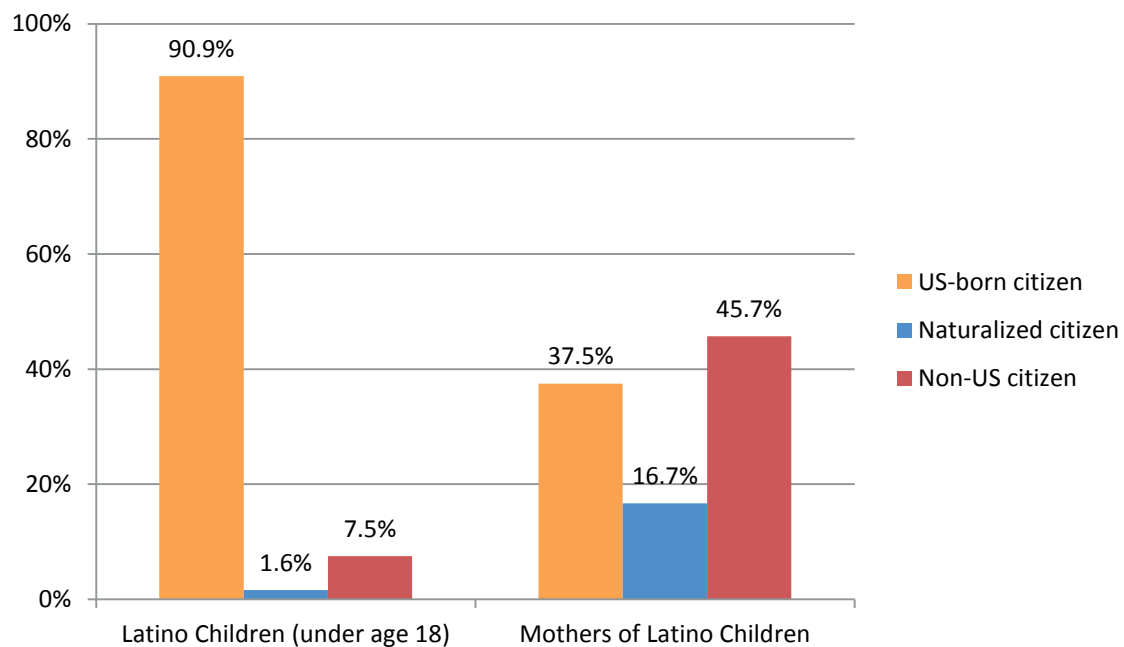
⁸ Shonkoff JP, Garner AS. The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption and Dependent Care, and Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1).

to addressing the root causes of these adverse childhood experiences through immigration reform, efforts can focus on fostering resilience in children by building on the strengths of their families and communities.

“Mixed Status” Families

As of 2011-12, almost 97 percent of California Latino children under age 12, and 83 percent of those ages 12-17, were born in the US. While most California Latino children are US-born, 45.7 percent of their mothers were born outside the US (Figure 4). Many of these households are “mixed-status”, meaning children are US citizens but parents are not, including those families with parents or siblings who are undocumented immigrants. Low income children who are citizens are eligible for government assistance programs, including health insurance, but parents may be unaware of these programs or reluctant to enroll their children due to language and cultural barriers, fear of exposure and deportation if they are undocumented, or if their mixed citizenship status allows one child to be eligible and another not.

Figure 4: Citizenship and Immigration Status of California Latino Children Age 0-17 Years and Their Mothers

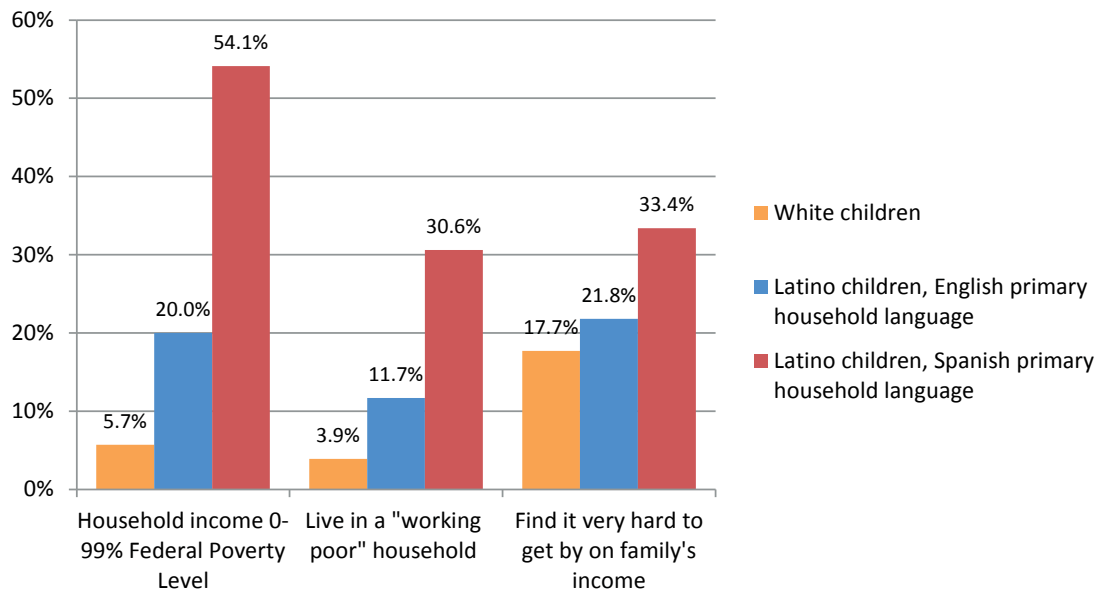


Data source: California Health Interview Survey 2010; accessed at: <http://ask.chis.ucla.edu/main/DQ3/topic.asp?page=first>

Household Income and Financial Disparities

Financial stress is a significant burden for many Latino families in California, even when parents are employed full time (Figure 5). More than half of Latino children from Spanish primary language households live below the federal poverty level (\$23,050 per year for a family of 4 in 2012). Over 30 percent of Latino children from Spanish primary language households live in a “working poor” household, with parents who have incomes less than 100 percent of the federal poverty level despite being employed full time.

Figure 5: Household Income of Families of California White and Latino Children Age 0-17 Years



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2280&r=6&g=457>

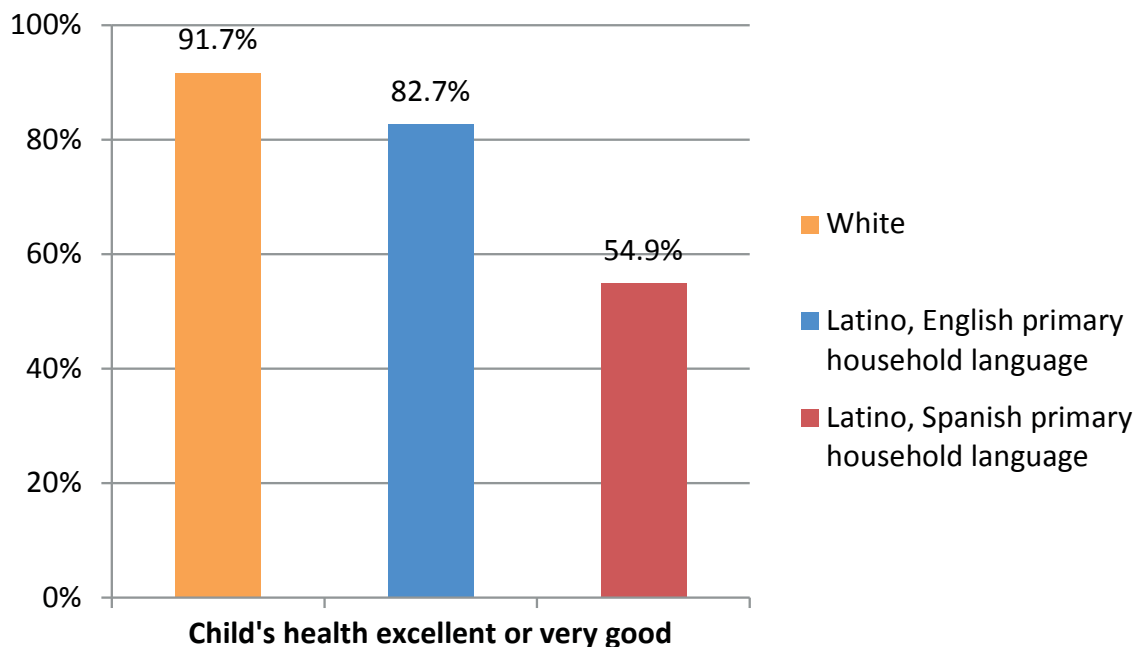
The effects of poverty can vary depending on other supports available. Families will be less burdened if their basic needs for food, shelter, and other resources are met, but one-third of children living in Spanish-speaking households, and 28.3 percent of California Latino children overall, live with parents who report that it is hard to get by on the family's income. Low income Latinos in California (those with incomes below 200 percent of the Federal Poverty Level) are significantly more likely than low-income whites to be “food insecure,” reporting they are not able to afford enough food (46 percent vs 36 percent).⁹ Food insecurity is even higher in Spanish-speaking households. Over half of Spanish-speaking, low-income adults in California are food insecure.

⁹ California Health Interview Survey 2011-2012. Accessed at: http://ask.chis.ucla.edu/main/DQ3/output.asp?_rn=0.9656183

Health Status of Latino Children in California

Although a majority of Latino children in California experience overall health that is reported to be very good or excellent, they are in poorer health than white children. In the 2011/12 National Survey of Children's Health, only 66.8 percent of Latino children have parents who report that their child is in excellent or very good health, compared to 91.7 percent of white children. The difference is primarily driven by Latino children in Spanish primary language households; only 54.9 percent of Latino children in Spanish primary language household are in excellent or very good health (Figure 6).

Figure 6: Percent of California White and Latino Children Age 0-17 Years Whose Parents Consider Their Child's Health Excellent or Very Good



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2456&r=6&g=457>

Reasons for the relatively poorer health status of Latino children are complex. Poverty and its associated stressors have significant impacts on a child's overall health.¹⁰ These factors are more likely among Latino families with Spanish primary language. In addition, multiple studies suggest that Latino children may have more adverse environmental exposures than white children, due to poorer housing and parental working conditions that may lead to higher incidences of diseases such as asthma. Food insecurity and living in unsafe neighborhoods or neighborhoods lacking amenities such as parks may also impact health. Finally, Latino children, especially those with Spanish primary language, have poorer access to quality health care services that might improve their health.

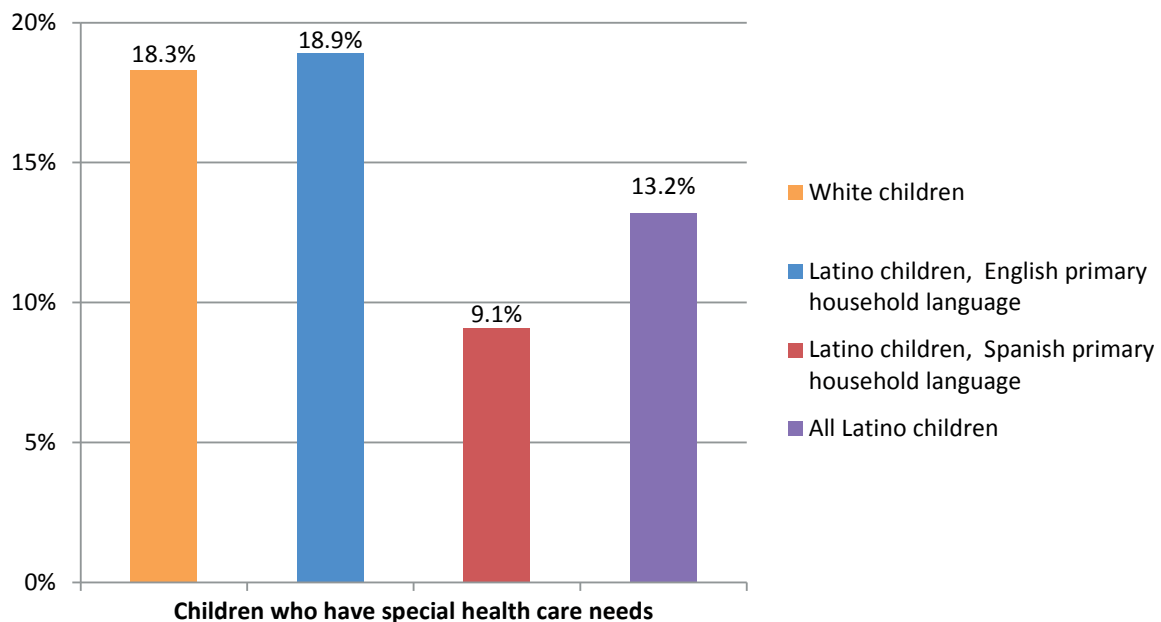
¹⁰ Stevens GD. Gradients in the health status and developmental risks of young children: The combined influences of multiple social risk factors. *Matern Child Health J.* 2006;10(2):187-199.

Children with Special Health Care Needs

The Federal Maternal and Child Health Bureau defines Children with Special Health Care Needs (CSHCN) as those who “have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related service of a type or amount beyond that required by children generally.”¹¹ Prevalence of children who currently have special health care needs status (not including the at-risk component) is assessed using the CSHCN Screener, a validated, non-condition-specific, consequences-based measure.¹²

In California overall, a lower percent of Latino children are reported by parents to qualify as having a special health care need than white children (Figure 7). However, Latino children with Spanish primary language are significantly less likely to meet standardized criteria for having a current chronic condition and special health care need, with rates less than half the rate of white children.

Figure 7: Percent of California White and Latino Children Age 0-17 Years Who Have Special Health Care Needs



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2625&r=6&g=457>

The fact that Latino children are more likely to have poor health, but are less likely to have a reported special health care need, has been a consistent national finding.¹ National and state level CSHCN prevalence for Latino children from Spanish-language households has been estimated to be less than half that of Hispanic children from English-language households. While Latino children living in Spanish-speaking households are less likely to be identified as CSHCN, there is no

11 McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998;102(1 Pt 1):137-140.

12 Bethell CD, Read D, Stein RE, Blumberg SJ, Wells N, Newacheck PW. Identifying children with special health care needs: Development and evaluation of a short screening instrument. *Ambul Pediatr*. 2002;2(1):38-48.

evidence that access to care or parental knowledge about their child's health influences identification of CSHCN overall.^{13,14}

When Latino children are identified as having special health care needs, however, those needs are more likely to have a greater impact on their daily activities and functioning and to require more complex services. For instance, among CSHCN, 33.6 percent of Latino children have conditions that “consistently and often greatly affect their daily activities” compared to 25.1 percent of white children. One hypothesis is that Latino children with milder conditions are less likely to be identified by their parents as having a special health care need.

The 2011/12 NSCH asks families whether their child has one of 18 common health conditions of childhood. Overall, about 14.1 percent of Latino and 25.3 percent of white children in California has at least one of the 18 conditions. Many children have multiple conditions: 5.1 percent of Latino children and 10.4 percent of white children have at least two of the conditions asked about in the survey. Figure 8 shows the prevalence of these health conditions among Latino and white children in California.

Figure 8: Most Common Health Conditions Experienced by California White and Latino Children Age 0-17 Years

Condition	White children	Latino children
Learning Disability (age 3-17 years)	7.5%	9.5%
Asthma	5.6%	7.8%
Stuttering or Other Speech Problem	5.2%	3.5%
Attention Deficit Hyperactivity Disorder	4.2%	6.4%
Behavior/Conduct Problems	3.0%	1.3%
Developmental Delay	2.7%	2.9%
Bone, Joint, or Muscle Problems	2.1%	2.0%
Vision Problems	2.0%	1.3%
Autism or ASD	1.9%	1.9%
Depression	1.8%	1.1%
Anxiety	1.6%	2.0%
Intellectual disability	1.1%	1.4%

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey?q=2625&r=6>

13 Blumberg SJ, Read D, Avila RM, Bethell CD. Hispanic children with special health care needs from Spanish-language households. *Pediatrics*. 2010;126:S120.

14 Read D, Bethell C, Blumberg SJ, Abreu M, Molina C. An evaluation of the linguistic and cultural validity of the Spanish language version of the Children with Special Health Care Needs Screener. *Matern Child Health J*. 2007;11(6):568-585.

Similar to white children, the most prevalent chronic conditions among Latino children are learning disabilities and asthma. As the data show, some conditions, such as behavior or conduct problems and speech problems, are slightly less likely to be reported for Latino children when compared to white children. Other conditions, such as learning disabilities and asthma, are slightly more prevalent. Since Latinos are overall less likely to have a usual source of health care, it is possible that some conditions are under-diagnosed in Latinos. In addition, Latinos may be less likely to disclose that their child has some conditions (particularly mental health conditions) due to concerns about stigmatization.¹⁵

Asthma

Asthma is one of the most common health conditions among all California children. Data from the 2010 California Health Interview Survey suggest that the prevalence of asthma is slightly lower among Latino children than white children; these findings are consistent with national data on asthma prevalence. Overall, asthma severity also varies by national origin.¹⁶

Despite the lower prevalence, asthma hospitalizations and Emergency Department visits have been shown to be higher in Latino children than in white children, suggesting that many Latino children with asthma are less likely to be identified until their symptoms are severe, or have not received medical attention that included sufficient patient education and access to appropriate medication.¹⁶

Air and Water Quality

Children are especially vulnerable to the harmful health effects of air pollution. Air pollution increases the frequency and severity of asthma in children, and California Latino children are more likely than white children to live in counties that have serious problems with particle air pollution. The six most polluted counties in the entire nation are located in California, and these counties all have a high percentage of Latino children.¹⁷

Vehicle emissions coming from highways also increase the risk of lung problems, and living near a highway or busy road may be especially harmful to health. According to the American Lung Association, air quality monitors are lacking near many major highways. Expanded monitoring near major highways, where people are more likely to breathe higher levels of pollution, would increase the ability to track levels of harmful air pollution.¹⁷ In California, Latino children are more likely to live in areas of high traffic density than white children. Research has shown that when Latino children in California live near highways, their asthma is more likely to be uncontrolled.¹⁸

Latino children living in rural areas adjacent to farmlands are more likely to experience adverse air quality from pesticide and other farm chemical drift and particulate matter. Water quality in rural areas is also sometimes linked to health problems such as gastrointestinal disturbance and heavy

15 Zuckerman KZ, Mattox KM, Sinche BK, Blaschke GS, Bethell C. Racial, ethnic, and language disparities in early childhood developmental/behavioral evaluations: A narrative review. *Clin Pediatr*. 2013 [Epub ahead of print];Sep 10.

16 Davis AM, Kreutzer R, Lipsett M, King G, Shaikh N. Asthma prevalence in Hispanic and Asian American ethnic subgroups: Results from the California Healthy Kids Survey. *Pediatrics*. 2006;118(2):e363-e370.

17 American Lung Association. State of the Air 2013. Accessed at: <http://www.lung.org/associations/states/california/assets/pdfs/sota-2013/sota-2013-full-report.pdf>.

18 Gunier RB, Hertz A, Von Behren J, Reynolds P. Traffic density in California: Socioeconomic and ethnic differences among potentially exposed children. *J Expo Anal Environ Epidemiol*. 2003;13(3):240-246.

metal ingestion.¹⁹ The majority of California children in places with poor community water quality are Latino.²⁰

Emotional, Behavioral, and Developmental Problems

Emotional, behavioral, and developmental problems can include anxiety, depression, substance abuse, learning disabilities, developmental delay, intellectual disability, autism, attention deficit hyperactivity disorder, and other conditions. Overall, these problems are reported among Latinos at slightly lower rates than among whites.

Current data from the 2011/2012 NSCH suggest that 2.8 percent of Latino CSHCN and 4.7 percent of white CSHCN have “an ongoing emotional, behavioral, or developmental problem that requires treatment or counseling.” These findings are consistent with national data on Latino CSHCN and may reflect a lower recognition of this type of condition in the Latino community, due in part to less access to health care, or possibly a stronger family support system for these children.

Neonatal Outcomes

Neonatal outcomes are a health strength of the Latino community (Figure 9). Nationally, Latinos have similar or lower rates of adverse neonatal outcomes compared to whites, and rates are often lower than in other underserved groups.²¹ This effect, which is particularly pronounced in mothers of Mexican origin, is thought to be due to the fact that many Latina mothers are young and have fewer adverse health behaviors such as smoking. In addition, Latina women may receive high levels of informal social support during pregnancy, leading to better health outcomes.

Figure 9: Neonatal Outcomes for Whites and Latinos, Rates per 1,000 Live Births, California, 2010

	Low Birth Weight	Infant Mortality	Teen Birth
Latinos	63	4.7	48
Whites	64	4.4	13

Data Source: KIDS Count Data Center, Annie E. Casey Foundation; accessed at: <http://datacenter.kidscount.org/data#CA/2/0>

One perinatal risk factor for which Latino girls are not an exception is teen birth, which is known to be associated with poorer child developmental outcomes. Nearly half of Latino births are to teen mothers, but the teen birth rate among California Latinos has been declining in recent years.

19 Harter T, Lund JR, Darby J, et al. Addressing nitrate in California’s drinking water with a focus on Tulare Lake Basin and Salinas Valley groundwater. 2012. Report for the State Water Resources Control Board report to the legislature. *Center for Watershed Sciences, University of California, Davis* Accessed at: <http://groundwaternitrate.ucdavis.edu>.

20 Balazs C, Morello-Frosch R, Hubbard A, Ray I. Social disparities in nitrate-contaminated drinking water in California’s San Joaquin Valley. *Environmental Health Perspectives*. 2011;119(9):1272.

21 McGlade MS, Saha S, Dahlstrom ME. The Latina paradox: An opportunity for restructuring prenatal care delivery. *Am J Public Health*. 2004;94(12):2062-2065..

Overweight/Obesity

The Centers for Disease Control defines overweight at 85-95 percent Body Mass Index (BMI) for the age and gender of the child, and obesity as Body Mass Index of 95 percent or more for age. Overweight and obese children are at risk for a large variety of problems including diabetes, cardiovascular disease, and social risk such as lower self-esteem. In addition, they are more likely to be overweight as adults, and have a higher risk of premature mortality.

Latino children, both nationwide and in California, are more likely to be overweight and obese than white children. The Centers for Disease Control and Prevention projects that half of Latino children born since 2010 will develop diabetes in their lifetime, due largely to the same factors fueling the obesity epidemic. Rates of overweight and obesity from the National Survey of Children's Health suggest that 17.7 percent of Latino children age 10-17 in California are overweight, compared to 10.9 percent of white children. Similarly, 21.1 percent of Latino children age 10-17 are obese, compared to 9.2 percent of whites.

More research needs to be done about why Latino children are at increased risk for unhealthy weight. They may have less access to physical activity due to poorer-quality neighborhoods and schools. Latino children also are exposed to more TV and other media than white children, which increases exposure to marketing of unhealthy food and beverages and may limit physical activity. Finally, due to poverty, lack of available food resources and neighborhood exposure to vendors of unhealthy food and beverages, Latino children may have less access to healthy foods.²² Additional factors may include increases in stress, unsafe neighborhoods or lack of neighborhood recreational or sports resources as well as cultural norms related to diet, food and exercise.

Oral Health

Dental caries are by far the most common disease of all children in California. Dental pain can lead to poorer school performance and can be associated with problems eating and speaking. Poor dental hygiene can also lead to poor self-esteem among children. Adequate oral health in childhood is important since children with dental problems are more likely to have dental problems as adults.

In California, Latino children have dental problems more often than white children: only about 50 percent of Latino children have teeth that are in excellent or very good condition, compared to more than 80 percent of white children.²³

Latino children are also much more likely to have had an oral health problem in the past 12 months, compared to white children (25.4 percent vs 14.8 percent).²³ Disparities in oral health may be related in part to access to dental insurance or available providers. In addition, many Latino adults have less knowledge about oral health, and view obtaining dental care as less necessary than whites,²⁴ which may lead to more dental problems among their children.

22 Salud America! The RWJF Research Network to Prevent Obesity among Latino Children. Accessed at: <http://salud-america.org/research>.

23 Data Resource Center (DRC). National Survey of Children's Health 2011/2012. <http://childhealthdata.org/browse/survey/results?q=2488&r=1&r2=6&g=457>.

24 Hispanics open up about oral health care: A collaboration between the Hispanic dental association (HDA), Crest® and Oral-B®. Accessed at: http://www.dentalcare.com/media/en-US/events/HDA-MiniReport-English_10-27-11.pdf.

Mortality

Overall, childhood mortality rates are similar among California's Latinos and non-Latinos.²⁵ This is consistent with national data about mortality among Latino children and youth.²⁶ The leading cause of death among Latino and white children in California is unintentional injury, or accidents such as car accidents or falls, but recent evidence suggests that the rate of death due to unintentional injury is slowly decreasing.²⁷ Other causes of death are homicide, suicide, cancer, heart disease, and congenital abnormalities.

25 KIDS COUNT Data Center, Annie E. Casey Foundation. Accessed at: <http://datacenter.kidscount.org/data#CA/2/0>.

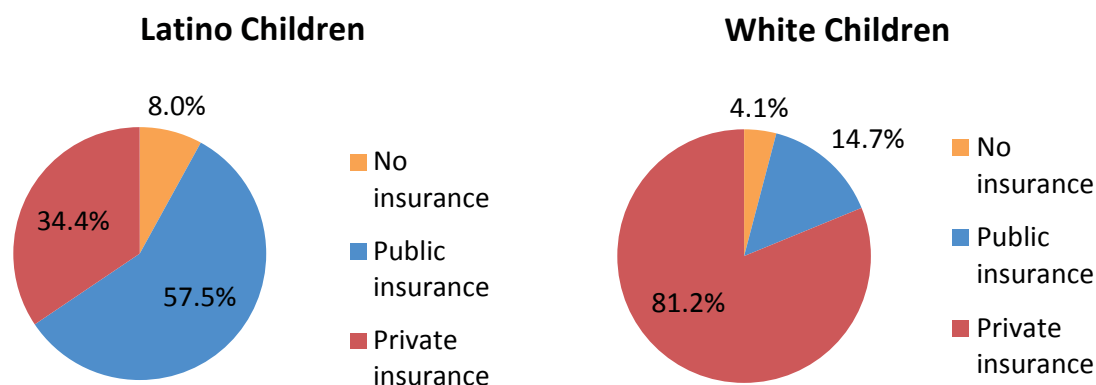
26 Child Trends Data Bank. Infant, child, and teen mortality. Accessed at: <http://www.childtrends.org/?indicators=infant-child-and-teen-mortality>.

27 KidsData.org. A program of the Lucile Packard Foundation for Children's Health. Accessed at: <http://kidsdata.org/demographic/17/latinohispanic-children/results#ind=&grp=92,85&say=>.

Health Care Access and Quality

Among children who are insured, California Latino children are more likely than white children to have publicly financed health insurance; those with public coverage are more likely than those with private insurance to report adequate coverage and lower out-of-pocket costs (Figure 10). This finding is true nationwide and in California.

Figure 10: Type of Health Insurance Among California White and Latino Children Age 0-17 Years



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2490&r=6&g=456>

Still, out-of-pocket health care expenses are more of a burden for Latino families than white families in California. When Latino children from Spanish-speaking households are covered by private health insurance, their parents consider their out-of-pocket health care expenses “reasonable” only half the time. This is likely due to the disproportionate burden of out-of-pocket costs to families with lower incomes.

Public health insurance for children generally offers more comprehensive benefits than do private insurance policies, so having public health insurance greatly reduces the out-of-pocket burden for Latino families from Spanish-speaking households. Among those with publicly funded insurance, 71.7 percent say their out-of-pocket costs are usually or always reasonable, compared to 47.0 percent of similar children with private-sector health insurance.

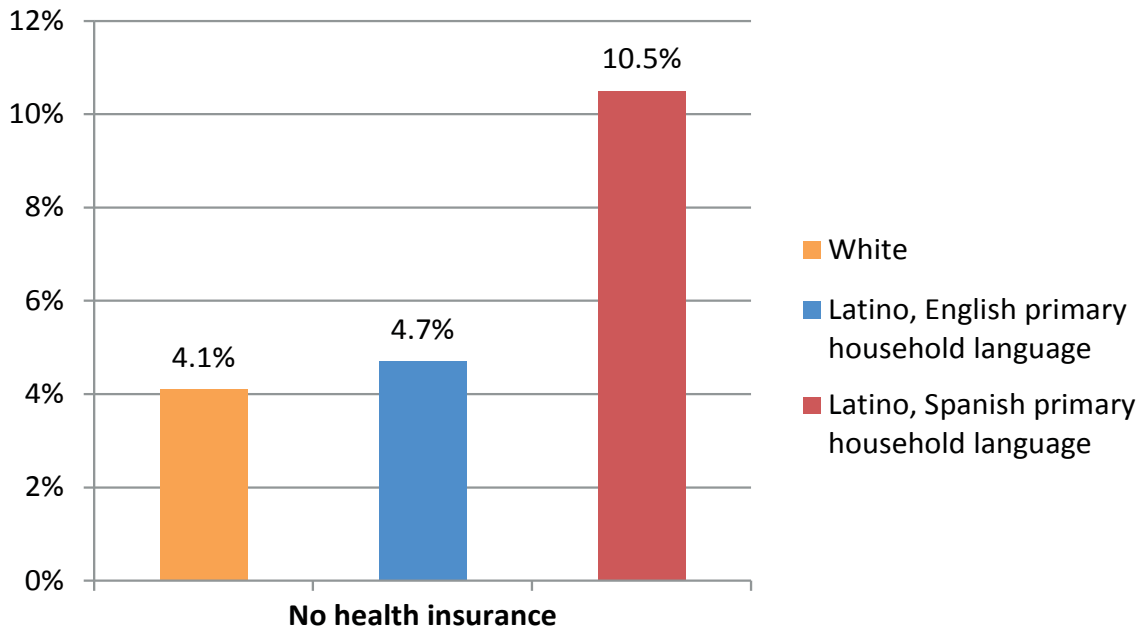
Barriers to Health Insurance Coverage

Most California Latino children are US citizens and can qualify for publicly funded insurance based on their family income, but disparities in health insurance coverage remain.

- Over 370,000 Latino children in California have no health insurance.
- The rate of uninsurance among Latino children from English-speaking households is similar to that of white children (Figure 11), but Latino children from households in which the primary language spoken is Spanish are more than twice as likely to be uninsured than Latinos from

English-speaking households or white children.⁷ Over 280,000 children from Spanish primary language households in California have no health insurance.

Figure 11: Percent of California White and Latino Children Who Are Uninsured



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2488&r=6&g=457>

Expanded coverage under the Affordable Care Act will not address two important barriers to insurance coverage for many Latino families: undocumented immigrant status and under-enrollment despite eligibility. Undocumented immigrants will remain ineligible for Medicaid and tax credits and will be prohibited from purchasing coverage through an exchange even at full cost.²⁸

Several barriers to enrollment in public health insurance programs among children of undocumented immigrants are frequently cited, but research in this area is lacking. Undocumented immigrants may avoid enrolling their children in programs out of fear their immigration status will be discovered in the process.⁷ Limited English proficiency may also contribute to a lack of knowledge or understanding about eligibility and the enrollment process, although this may be less of a problem in California than in states with fewer translation services. Even with translation services, however, enrollment paperwork may be extensive, making access to insurance more difficult for parents with lower literacy or understanding of the complex processes required to register.

Because only a very small number of California Latino children (those who are undocumented immigrants) are currently ineligible for health insurance, expanded eligibility under the Affordable Care Act (ACA) will not directly affect most of them. Some parents who are low-income workers and either citizens or legal residents will be newly eligible for health insurance coverage which may lead to better health for the family overall.

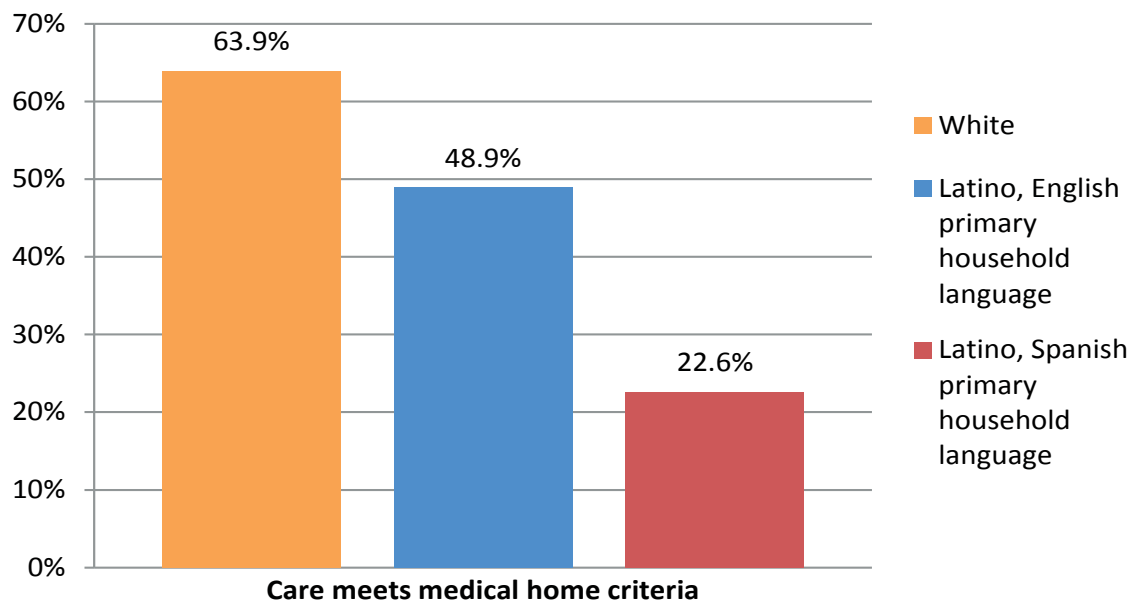
²⁸ Stephens J, Artiga S. Key facts on health coverage for low-income immigrants today and under the Affordable Care Act. March 2013. Kaiser Commission on Medicaid and the Uninsured. Accessed at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf>.

Comprehensive and Family-Centered Health Care

The medical home is an approach to delivering primary care that is accessible, continuous, comprehensive, family-centered, compassionate and culturally effective. The American Academy of Pediatrics recommends that physicians strive to attain a medical home for every child, and supports reimbursement policies that promote this model.²⁹ The NSCH assesses medical home based on whether a child has a primary doctor and usual source of care and whether the care they receive is coordinated with schools and other service providers, is family-centered, and supports referrals to needed services.³⁰

Latino children in California are significantly less likely than white children to receive care within a medical home as measured by the NSCH (Figure 12). Only 22.6 percent of Latino children from Spanish primary language households receive this standard of care.

Figure 12: Percent of California White and Latino Children Age 0-17 Years Meeting Medical Home Criteria



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2507&r=6&g=457>

29 American Academy of Pediatrics Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110(1):184-186.

30 The Child and Adolescent Health Measurement Initiative (CAHMI). Measuring medical home for children and youth: Methods and findings from the National Survey of Children with Special Health Care Needs and the National Survey of Children's Health. A Resource manual for child health program leaders, researchers and analysts. U S Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics. May 2009; CDC PO #300614801-01. Available at: http://childhealthdata.org/docs/medical-home/mhmanual-_body_sept2009-cb-edit-1-pdf.pdf.

On every component of this multi-component indicator of medical home, Latino children fare worse than white children, and Latino children in Spanish primary language households fare the worst (Figure 13).

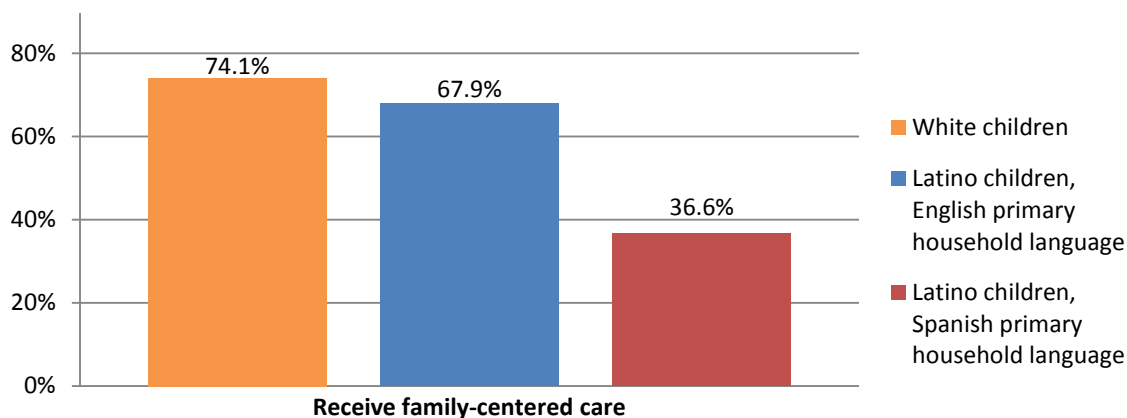
Figure 13: Percent of California White and Latino Children Age 0-17 Years Receiving the Components of a Medical Home

Measure	White children	Latino children, English primary household language	Latino children, Spanish primary household language
Personal doctor or nurse	94.3%	84.8%	80.5%
Usual source of sick care or advice	95.2%	91.2%	76.9%
Received family-centered care	74.1%	67.9%	36.6%
Received referrals when needed	82.6% (among 16.2% who needed referrals)	56.5% (among 18.8% who needed referrals)	53.3% (among 12.4% who needed referrals)
Received care coordination when needed	71.9% (among 42.3% of children who require 2+ types of services)	55.6% (among 36.8% of children who require 2+ types of services)	53.7% (among 44.9% of children who require 2+ types of services)

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey?q=2507&r=6>

One component of a medical home on which Latino children often lack quality care is Family Centered Care (Figure 14). In the 2011/12 NSCH, Family Centered Care is measured according to parental responses to five questions. Parents are asked whether their child's health care provider spends enough time with the child, listens carefully, is sensitive to the family's values or customs, gives needed information, and if the family feels like a partner in the child's health care. To qualify as having family-centered care responses to all five questions must be either "Usually" or "Always".

Figure 14: Percent of California White and Latino Children Age 0-17 Years Who Receive Family-Centered Care



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2510&r=6&g=457>

On all five individual components of family-centered care, children from Spanish-speaking households fared worse than children from English-language households and white children (Figure 15). For instance, fewer than half of children from Spanish-language households had parents who felt their doctor spends enough time with their child.

Figure 15: Components of Family-Centered Health Care Experienced by California White and Latino Children Age 0-17

Indicator (Usually/always)	White children	Latino children, English primary household language	Latino children, Spanish primary household language
Doctors spend enough time with child	84.3%	81.4%	46.7%
Doctors listen carefully to parents	92.4%	88.4%	76.5%
Doctors are sensitive to family culture and values	93.7%	88.9%	70.5%
Doctors provided information specific to child's health	85.3%	82.8%	71.6%
Parents feel like partners in child's care	88.1%	87.3%	76.5%

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey?q=2507&r=6>

Latino children in California receive most preventive health services at about the same rate as white children. Latino children from Spanish-speaking households have higher developmental screening rates and lower vision screening rates, however (Figure 16).

Figure 16: Preventive Health Care Services Received by California White and Latino Children Age 0-17 Years

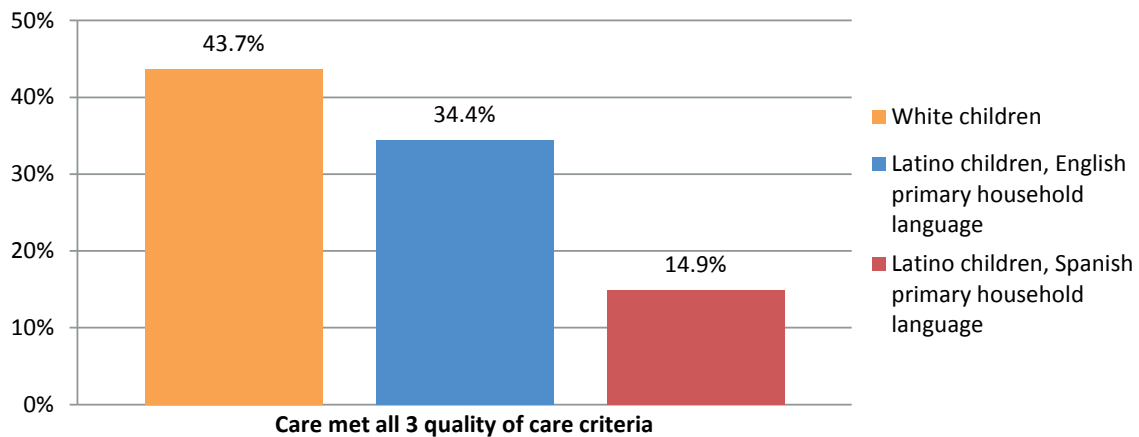
Preventive Health Care Service	% of children who received the service		
	White children	Latino children, English primary household language	Latino children, Spanish primary household language
Any medical care in past 12 months	87.8	86.4	80.3
Physical exam or well child visit in past 12 months (ages 1 to 17 years)	80.0	84.3	76.9
Any dental care visit in past 12 months	79.2	77.9	70.0
Both preventive medical and dental care in past 12 months	66.2	69.1	59.4
Vision screening in past 2 years	67.1	65.5	50.1
Developmental screening during a health care visit (ages 10 months to 5 years)	27.5	31.8	33.1

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2494&r=6>

Quality of Health Care

Having health insurance does not always mean having access to care or to high-quality health care. Latino children in California are significantly less likely than white children to receive quality health care, as measured by an index composed of three system performance indicators: having adequate insurance, receiving ongoing and coordinated care within a medical home, and having at least one preventive health care visit in the past 12 months.¹ California can do better for all children—only 31.7 percent of California children overall met all quality of care criteria—but Latino children in California are even less likely than white children to receive care that meets all quality criteria, and only 14.9 percent of children from households in which the primary language is Spanish receive care that meets all quality criteria (Figure 17).

Figure 17: Percent of California White and Latino Children Age 0-17 Years who Received Health Care Meeting All 3 Quality of Care Criteria



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2552&r=6&g=457>

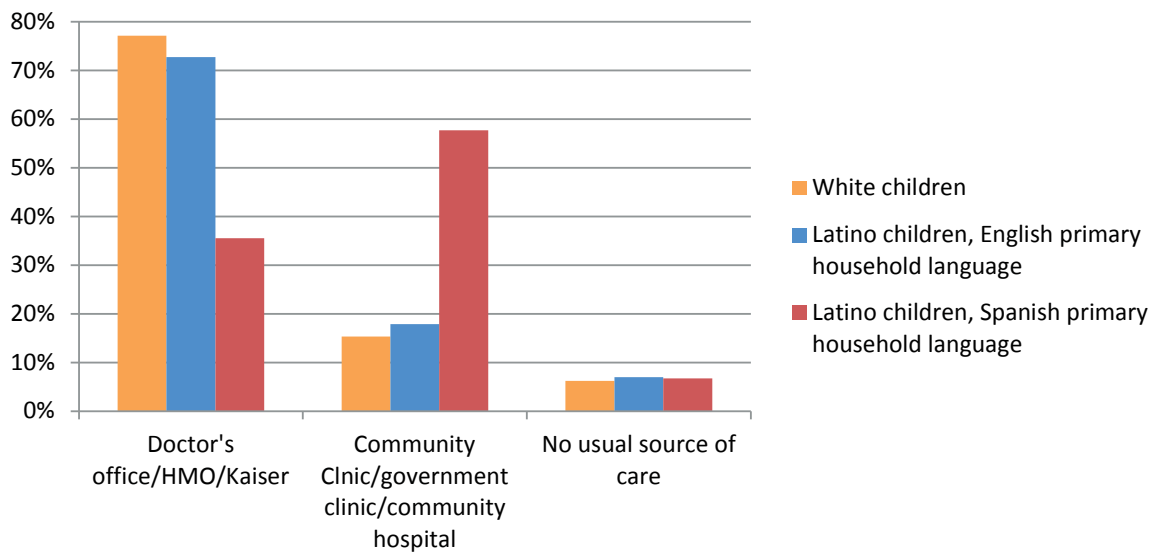
Additional barriers to quality of care for Latinos include:

- Limited transportation to medical visits
- Undersupply of Spanish-speaking health professionals
- Under-representation of Latinos in medicine and other health professions
- Undersupply of primary care health professionals, especially in remote rural areas often populated by Latinos

Community Clinics and Health Centers

In California, 57.7 percent of Latino children from Spanish-speaking households use a community or government clinic or a community hospital as a usual source of care, a much higher rate of use than white children or Latino children from English-speaking households (Figure 18). (Note that this measure differs from NSCH medical home item which asks if the child has a personal doctor or nurse.)

Figure 18: Usual Source of Health Care for California White and Latino Children Age 0-17 Years



Data Source: 2011-2012 California Health Interview Survey; accessed at: <http://ask.chis.ucla.edu/main/DQ3/topic.asp?page=first>

An essential source of care for many vulnerable Latinos are the more than 900 Community Clinics and Health Centers (CCHCs) located throughout California. These include Federally Qualified Health Centers (FQHCs), FQHC Look-Alike sites, and Rural Health Centers. Because these Centers are required to provide care to all regardless of ability to pay, they provide an essential safety net for the uninsured and for low income Californians who may have difficulty finding health care providers who will accept public health insurance.

In addition to the medical care they provide, CCHCs can help address health disparities among Latino children in California by linking a wide variety of services to address the social determinants of health. FQHCs are required to design culturally and linguistically appropriate health services programs for underserved populations in their communities and to collaborate with other health care providers and social service agencies. They are especially important to Latino farmworkers and undocumented immigrants. In addition, the health center's governing board must be "composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex." CCHCs are also mandated to routinely assess and improve quality. These requirements ensure that those directing the health center are truly invested in its quality and in the community it serves.

In 2012,

- Over half of the patients served in CCHCs in California were Latino.
- 30 percent of patients served by a CCHC were uninsured.
- 35 percent were covered by Medi-Cal.
- 42 percent reported a language other than English as their primary language.
- CCHCs served over half a million migrant or seasonal farm workers.

Recently, the Institute of Medicine recommended that health care providers address health equity by assuring that children receive health care in medical homes that are actively engaged in efforts to address the social determinants of health.³¹ Similarly, the concept of the “health neighborhood” has been recommended as a way to promote health by providing community-based, non-medical services in the medical home. The health neighborhood model includes identification of patient needs, care coordination, co-location of services on site, and a centralized access point for services. One of the California Primary Care Association’s three “bold steps” in its 2011-2013 Strategic Plan is to assist every CCHC in becoming a recognized patient-centered health home. CCHCs are uniquely positioned to address the social determinants of health among California Latino families by serving as health neighborhood sites. CCHCs, as providers of comprehensive health care and enabling services, are natural fits and early adopters of the patient-centered health home model.³²

31 Wong W, Anderson KM, Dankwa-Mullan I, Simon MA, Vega WA. The patient-centered medical home: A path toward health equity? 2012. Accessed at: <http://iom.edu/Global/Perspectives/2012/PatientCenteredMedicalHome.aspx>.

32 Leesha K, Hoilette AK, Blumkin CD, Baldwin KF, Szilagyi PG. Community health centers: Medical homes for children? *Academic Pediatrics*. 2013;13(5):436.

Family, Community and School

Family and Home Environment

About two-thirds of California Latino children live with both parents who are married, and 1 in 5 live in a female-headed, single parent household.³³

In California, Latino children fare as well or better than white children when it comes to family habits and practices that are indicators of a home environment that promotes and protects their child's health (Figure 19). For example, Latino children from Spanish primary language households eat meals together with their family every day more often than white children, and are more likely to live in a household where no one smokes.

Figure 19: Positive Home Environment Factors Experienced by California White and Latino Children Age 0-17

	White children	Latino children, English primary household language	Latino children, Spanish primary household language
Family eats meals together at least 4 days per week	80.4%	80.2%	79.7%
Family eats meals together every day	42.5%	44.4%	58.1%
No one in house smokes tobacco	80.8%	79.7%	92.4%
Read together every day (age 0-5)	62.9%	39.8%	20.9%
Sing or tell stories together every day (age 0-5)	63.1%	50.5%	33.4%

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey?q=2507&r=6>

Reading to young children at home is one of the most important ways to promote literacy, but Latino children, especially those with limited English proficiency, are read to less often than white children; only 21 percent of children from primarily Spanish-speaking households are read to every day by a parent or caregiver.

³³ KidsData.org. A program of the Lucile Packard Foundation for Children's Health. Accessed at: www.kidsdata.org/topic/539/families-with-children-type-race10/table.

An example of a successful intervention to improve literacy is the “Reach Out and Read” program. Implemented in the pediatric primary care setting, the program promotes literacy by providing bilingual books and educational materials, and encouraging parents to read aloud to their children. Low-income Latino parents who had access to the program increased the amount of time they read to their children and reported more enjoyment of reading together with their children.³⁴

Health of Parents

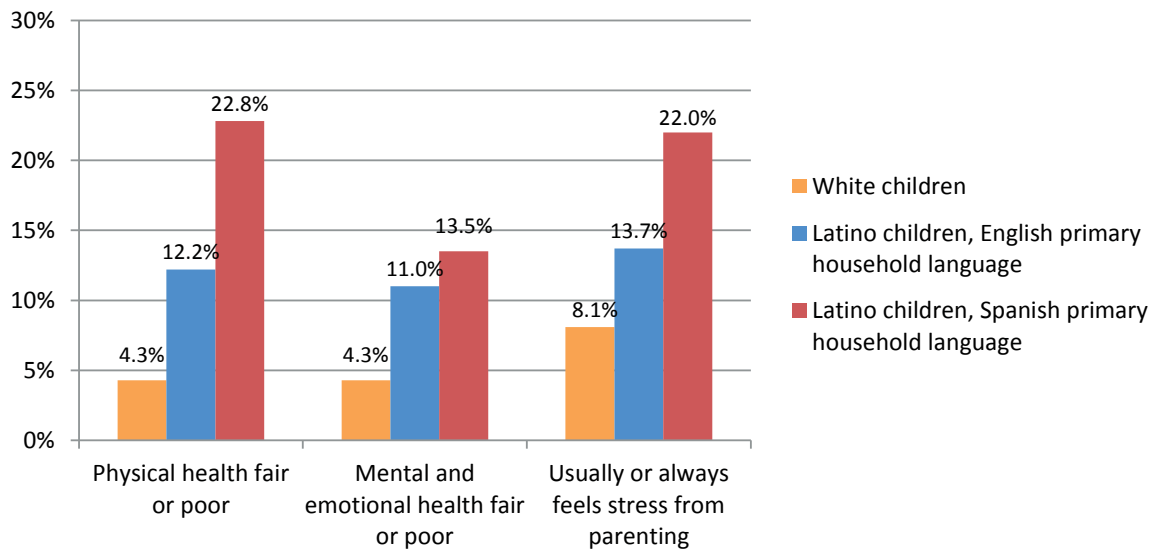
The health and health behaviors of parents is an important determinant of the health of children in the family. This is the case because healthy parents are more likely to give birth to healthy children, and healthy parents are also most likely to give children an environment conducive to optimal health.

Although the majority of Latino children in California have parents who report excellent or very good physical, emotional/mental health, and low levels of difficulty parenting their children, many have parents who are struggling with persistent parenting challenges. Overall, Latino children have mothers who rate their physical and mental health status as only “fair or poor” more often than white children (Figure 20), and fewer than half have mothers who say they are in “excellent” or “very good” physical health. Latino children also have mothers who report worse mental health than white children. Similarly, Latino children more often have fathers who report poor physical and mental health than white children.

More than 18 percent of California Latino children live with a parent who reports “usually” or “always” feeling stress from parenting (i.e., the parent reported feeling that their child was much harder to care for than other children, they were often bothered a lot by their child’s behavior and/or they were often angry with their child). California children from Spanish primary language households have parents who report this kind of parenting stress nearly 3 times more often than do white children (22 percent vs 8 percent).

³⁴ Golova G, Alario A, Vivier PM, Rodriguez M, High PC. Literacy promotion for Hispanic families in a primary care setting: A randomized, controlled trial. *Pediatrics*. 1999;103(5):993.

Figure 20: Physical and Emotional Health of Parents of California White and Latino Children Age 0-17



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2246&r=1&r2=6&g=457>

Adverse Childhood Experiences

Adverse experiences in childhood (ACEs) have been found to affect health and well-being many decades later, and there is a strong dose/response effect based on the number of ACEs experienced. In the 2011/2012 NSCH, parents were asked whether their child had experienced any of 9 adverse childhood events (Figure 21). There are several positive points to be made about these data. Latino children from Spanish-speaking households experience many ACEs less frequently than white children, and are somewhat less likely to have experienced two or more adverse childhood events (15.9 percent vs 18.4 percent). Only 9.8 percent of Latino children have lived with a parent who divorced or separated, compared to 22.4 percent of white children. Latino children from Spanish-speaking families are also less likely to have lived with someone who abused drugs or alcohol, or who was mentally ill. On the other hand, Latino children from Spanish language households are more likely to have parents who find it hard to get by on the family's income and Latino children are more likely to have been a victim of or witness to neighborhood violence.

Figure 21: Prevalence of Adverse Childhood Events Experienced by California White and Latino Children Age 0-17 Years

Adverse Childhood Event	White children	Latino children, English primary household language	Latino children, Spanish primary household language
One or more adverse childhood experience	43.6%	44.6%	47.7%
Two or more adverse childhood experiences	18.4%	21.2%	15.9%
Hard to get by on family's income	17.7%	21.8%	33.4%
Lived with parent who got divorced or separated	22.4%	15.6%	9.8%
Lived with a parent who died	3.5%	1.6%	0.9%
Lived with a parent who served time in jail or prison	4.0%	9.4%	3.8%
Witnessed domestic violence	6.1%	7.4%	6.6%
Victim or witness of neighborhood violence	4.7%	9.0%	9.3%
Lived with anyone who was mentally ill or suicidal	7.3%	6.3%	3.3%
Lived with anyone who had a problem with alcohol or drugs	15.6%	13.0%	7.1%
Child treated or judged unfairly because of his/her race or ethnic group	2.0%	2.8%	4.1%

Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2257&r=6&g=457>

These data show that many Latino children in California are challenged by poverty and living in unsafe neighborhoods, but most have strong family support. These positive family experiences and

relationships are vital to help children build resilience against the negative health effects of adverse childhood experiences.

When certain positive factors, such as caring relationships, high expectations, and meaningful participation are present, children and youth are less likely to engage in health-risking behaviors, including drug and alcohol use, and violence. These factors can mitigate the harmful effects of adverse childhood experiences, and they are modifiable. By increasing their presence in the lives of at-risk children and youth, resilience against persistent stress can be built.

School Environment

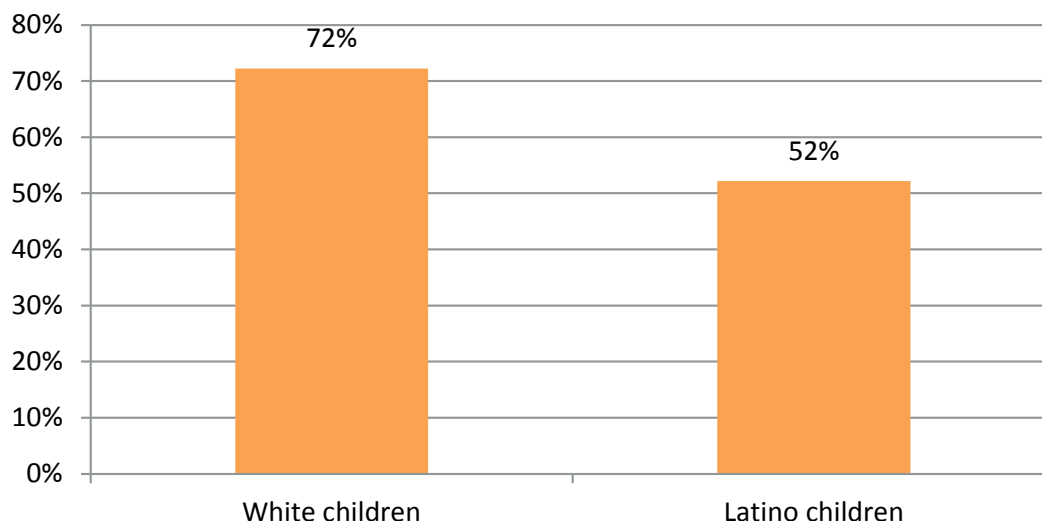
In 2012, 52 percent of California public school students were Latino and 18.9% of public school students were Latino English learners. About 18% of California public school teachers were Latino.

Data show that California Latino children and their parents value education and place high importance on success in school. Success in school is related to factors that can affect health throughout the course of a person's life. The Promoting School Success Index³⁵ combines 3 indicators that may promote school success:

- Usually/always engaged in school
- Participated in extracurricular activities
- Usually/always felt safe at school

Nationwide, 60 percent of all children experience all three factors. According to the 2011/2012 NSCH, 52.3 percent of California Latino students experience all 3 factors, vs 72.2 percent of California white children (Figure 22).

Figure 22: Percent of California White and Latino Children Age 6-17 Years Who Experience All 3 Factors Promoting School Success



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2446&r=6&r2=1&g=461>

³⁵ Centers for Disease Control and Prevention. The association between school based physical activity, including physical education, and academic performance. Atlanta, GA: U.S. Department of Health and Human Services; 2010. Accessed at: http://www.cdc.gov/healthyyouth/health_and_academics/pdf/pa-pe_paper.pdf.

Latino children from Spanish-speaking households are less likely than either white children or Latino children from English-speaking families to participate in organized activities outside school or to have at least one adult mentor at school, in their neighborhood or their community. Children from Spanish-speaking households are less likely to have parents who report they feel their child is safe at school than white children in California (82.3 percent vs 95 percent).

Latino students score lower than white students on several measures of academic achievement. This gap is evident as early as kindergarten and disparities increase in the later grades, with 18.2 percent of California Latino students dropping out of high school, compared to 8.9 percent of white students (Figure 23).

Figure 23: Education Attainment and School Outcomes Among California White and Latino Children

	White children	Latino children
Repeated one or more grades since kindergarten	5.6%	9.3%
Third grade students scoring proficient or higher on English Language Arts CST	64%	33%
High school graduates completing college preparatory course, 2011	43.9%	26.7%
Students scoring proficient or higher on Algebra I CST	43%	24%
Tenth grade students passing the high school exit exam in math, 2012	91%	78%
High school dropouts	8.9%	18.2%

Data sources: California Department of Education and 2011/12 National Survey of Children's Health; accessed at: <http://www.kidsdata.org/data/topic/dashboard.aspx?cat=21> and <http://childhealthdata.org/browse/survey/results?q=2515&r=6&g=457>

School discipline policies take a greater toll on Latinos. School expulsion rates at every level are higher for Latinos. School absence rates at every grade level, for illness, truancy, and expulsion (discipline), are much higher for Latino than white kids. Frequent /chronic absence leads to falling behind academically, social exclusion, and higher drop-out rates.

Nutrition in school is important to Latino children's health. School meals are a main source of nutrition for more than half of Latino children in public schools. Schools improving the healthfulness of the food and drinks that they offer are contributing to children's better health and lifelong eating habits of children.

Students who spend more time on physical activity are healthier, and there is no evidence that this activity has an adverse impact on academic performance. Some studies suggest that academic performance improves with regular physical activity³⁵ In some Latino neighborhoods, school grounds are the only safe facilities for physical activity.

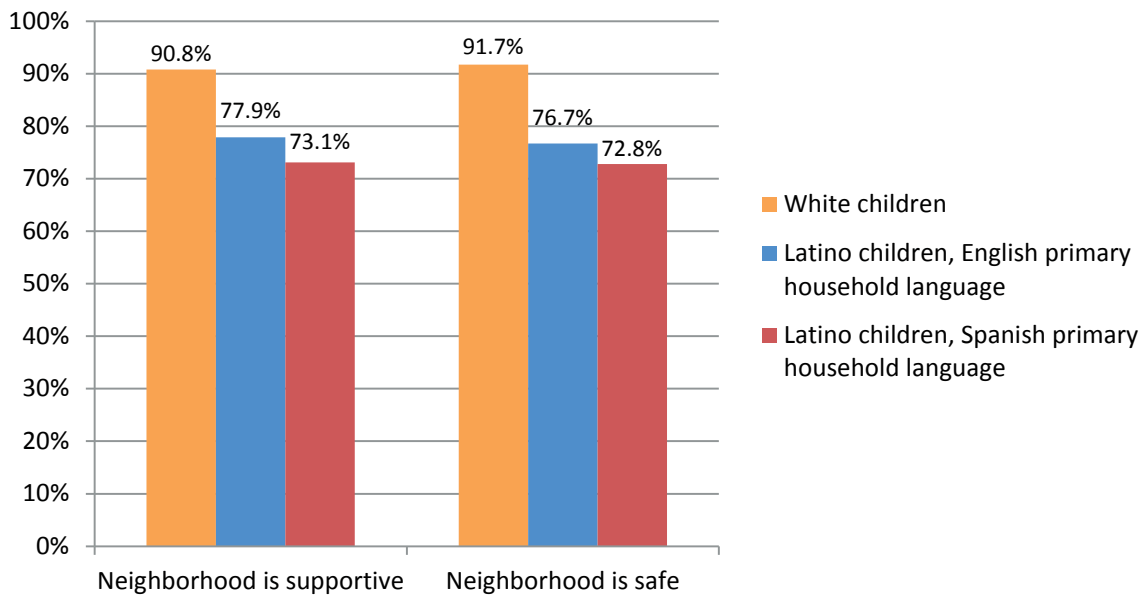
Communities and Neighborhoods

Although the presence of strong community ties is a frequently cited strength among Latinos, support within their own neighborhood is lacking for many Latino families in California. The National Survey of Children’s Health (NSCH) measures how supportive a child’s neighborhood is (sometimes called “neighborhood cohesion”) by asking parents whether they agree with at least three of the following items which are considered indicators of a supportive neighborhood:

- People in my neighborhood help each other out
- We watch out for each other’s children in this neighborhood
- There are people I can count on in this neighborhood
- If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child

California Latino children are less likely than white children to have parents who report living in a supportive neighborhood (75.3 % vs 90.8 %), and Latino children from Spanish-speaking households are slightly less likely to live in a supportive neighborhood than Latino children from English speaking households (Figure 24). Latino children are also less likely than white children to have parents who feel that their neighborhood is safe for their child, and again those speaking Spanish as the primary household language are less likely to report that their neighborhood feels safe.

Figure 24: Neighborhood Support and Safety Among California White and Latino Children Age 0-17 Years



Data source: 2011/12 National Survey of Children’s Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2523&r=6&g=457>

Neighborhood Amenities

Latino children are less likely than white children to live in a neighborhood that has certain amenities— parks, recreation centers, sidewalks or libraries – that can contribute to children’s health and well-being (Figure 25). Just over half (50.5 percent) of California Latino children from Spanish-speaking households live in a neighborhood that contains all 4 of these amenities, compared with 73.2 percent of white children and 71.3 percent of Latino children from English-speaking households.

Figure 25: Amenities in Neighborhoods Where California White and Latino Children Age 0-17 Years Live

Neighborhood Amenity	White children	Latino children, English primary household language	Latino children, Spanish primary household language
Neighborhood has sidewalks or walking paths	87.3%	89.8%	71.0%
Neighborhood has a park or playground area	93.3%	92.3%	89.3%
Neighborhood has a recreation center, community center, or Boys'/ Girls' Club	85.0%	79.9%	61.9%
Neighborhood has a library or bookmobile	94.8%	90.7%	82.0%
Neighborhood has all 4 amenities	73.2%	71.3%	50.5%

Data source: 2011/12 National Survey of Children’s Health; accessed at: <http://childhealthdata.org/browse/survey?q=2562&r=6>

Safety factors such as community transportation, crosswalks, animal control, and lighting have all been found to be deficient in many low-income Latino neighborhoods, and can have an adverse impact on health.

Community Connectedness

In the 2008-2010 California Healthy Kids Survey only 35.6 percent of Latino children reported they experienced meaningful participation in their community, and only 56.6 percent experienced all three community connectedness factors (Figure 26).

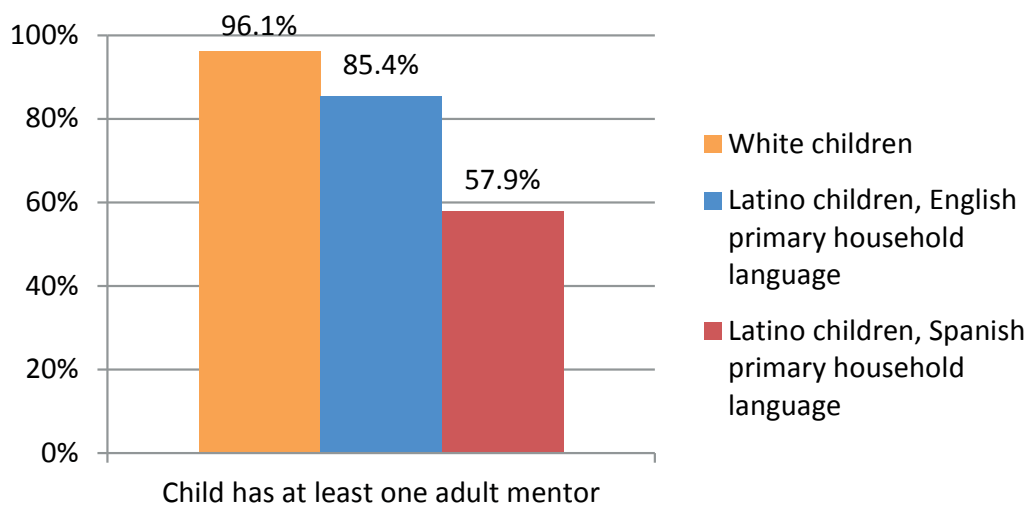
Figure 26: Factors Promoting Resilience Experienced by California White and Latino Children Age 6-17 Years

Protective factor	White children	Latino children
Presence of a caring adult in the community	73.0%	60.8%
High expectations from adults in the community	74.3%	61.6%
Meaningful participation in the community	59.5%	35.6%
Total community assets (presence of all 3 factors)	75.7%	56.6%

Data source: 2008-2010 California Health Kids Survey; accessed at: <http://chks.wested.org/indicators>

Similarly, the 2011/2012 NSCH found that Latino children are significantly less likely than white children to have an adult mentor in their school, neighborhood or community. Only 57.9 percent of Latino children from Spanish-speaking households had a mentor (Figure 27).

Figure 27: California White and Latino Children Age 6-17 Years Who Have At Least One Adult Mentor



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2528&r=6&g=457>

The Whole Child

This report has presented data on the health and health care of California's Latino children and youth and the many factors that affect them. The presence of individual risk factors and protective factors is less important to overall well-being than their combined influence, and it is useful to present data by combining both positive and negative factors into summary measures. This view takes a "whole child" approach to addressing health. Summary measures were used to describe some complex issues including a minimum quality standard for basic health care, a protective home environment, and a community that is likely to promote children's health, development and well-being.

Health Care System Performance Summary Measure

- Access to a medical home
- Health insurance that is adequate to meet their medical needs
- At least one preventive visit in the previous 12 months.

Home Environment Summary Measure

For children age 0-5:

- Have 4 or more family meals per week
- Are read or sung to every day
- Were ever breastfed
- Watch 2 hours of television per day or less (for children 1 year or older)
- Experience no household tobacco smoke exposure

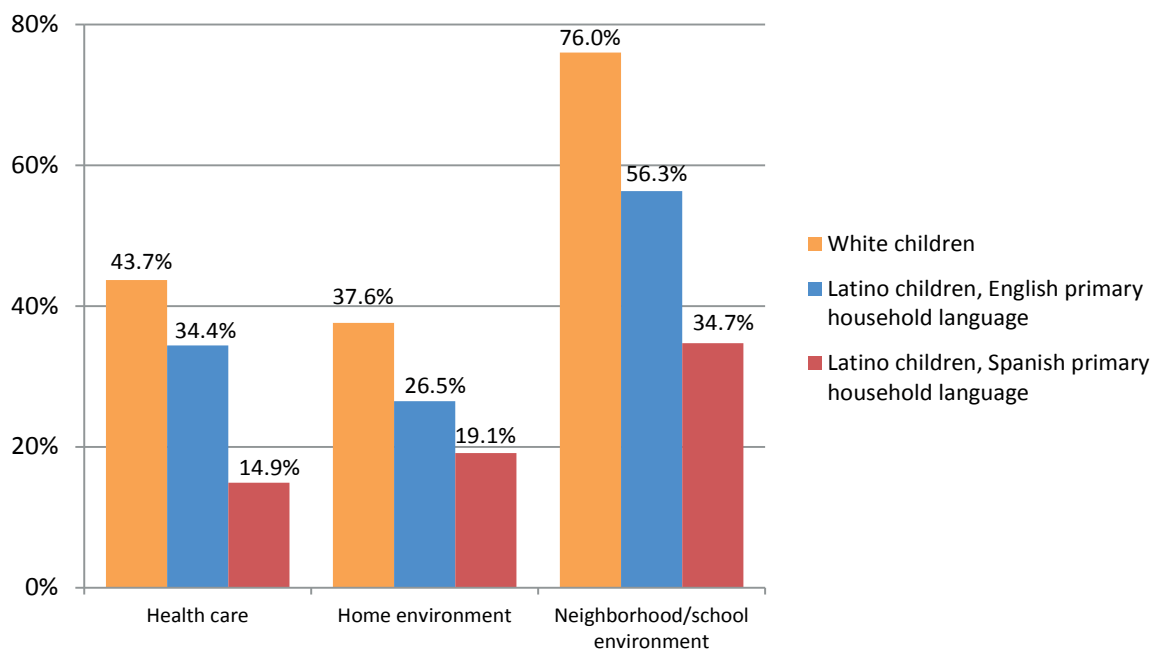
For children age 6-17:

- Have 4 or more family meals per week
- Have no television in their bedroom AND watch 2 hours of television per day or less
- Parents have met all or most of their friends
- Usually or always do all required homework
- Experience no household tobacco smoke exposure

Community/Neighborhood Summary Measure (Calculated only for children ages 6-17 years)

- Are usually or always safe in their community or neighborhood
- Live in a supportive neighborhood, defined as responding "usually/always" to all of the following:
 - "People in my neighborhood help each other out."
 - "We watch out for each other's children in this neighborhood."
 - "There are people I can count on in this neighborhood."
 - "If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child."
 - Parent feels child is usually/always safe at school.

Figure 28: Percent of California White and Latino Children Age 0-17 Years Who Experience Minimum Standards for Health Care, Home Environment, and School/Neighborhood Safety



Data source: 2011/12 National Survey of Children's Health; accessed at: <http://childhealthdata.org/browse/survey/results?q=2552&r=6>; <http://childhealthdata.org/browse/survey/results?q=2556&r=6&g=456>; <http://childhealthdata.org/browse/survey/results?q=2369&r=6&g=456>;

Figure 28 shows that substantially fewer California Latino children than white children experience these minimum standards of basic health care, family, and community factors. Fewer than half of all California children meet the minimum standards for health care and a positive home environment, for example— but Latino children are especially vulnerable and at risk for poor health outcomes.

Conclusions and Policy Recommendations

Many of today's California Latino children are at risk for long-term health problems because of exposure to adverse experiences. The most serious health risk factors experienced by California Latino children—poverty, language and cultural barriers, and unsafe or unhealthy environments—will not be eliminated in the short term. But steps can be taken now to increase access to the resources limited by poverty, reduce cultural barriers to services and health care, improve access to safer physical environments in which children can play, and build resilience in children by increasing their access to positive factors. It is in the interest of all Californians to take measures now to increase the chances of today's Latino children to experience a healthy future.

This report highlights several key areas for focus. Most pressing needs include improving the quality of health care available to Latino children in California, addressing language and cultural barriers to quality health care, and mitigating the harmful health effects caused by poverty. Actionable policy recommendations, based on the data presented here and developed in partnership with experts and stakeholders, are listed below.

Improve access to and quality of health care and improve health care system performance

- Increase support for community health centers in Latino communities, especially for undocumented immigrants, who will remain uninsured under the ACA, and for many of the previously uninsured Californians as they become newly eligible for public insurance.
- Increase enrollment of all eligible children in school nutrition programs, WIC, food stamps, MediCal and Covered California, including eligible children of undocumented immigrants.
- Support Community Health Centers, Public Health Departments, and Family Resource Centers to help Latino families connect with and benefit from education, social and health care services, especially to improve prevention, early identification and early intervention of health problems. Support establishment of patient-centered medical homes staffed by multi-disciplinary teams that are language and culturally competent, provide care management, and are connected to a variety of community services. Thus organized, health professionals are well situated to play an active role in addressing the social determinants of health by facilitating linkage to housing, legal services, nutrition, literacy, and other social service programs at the point of care.
- Support payment reform that enables health care providers and non-licensed professionals such as health educators, patient navigators, care coordinators and community health workers to provide comprehensive and seamless clinical care and community interventions to improve health.

Address language and cultural barriers to health

- Support literacy programs and adequate translational services to improve health outcomes for children by increasing their parents' ability to navigate the health care system.
- Use research about culture-sensitive health behaviors and Latino community health promotion programs to inform policies affecting the health of Latino children and families.
- Reform immigration to resolve issues of family separation, unequal treatment, low program participation, and barriers to trust that threaten the health of millions of Latino children.

- Encourage changes to health profession schools' admission policies to increase Latino enrollment and potentially increase access to health care services in underserved communities.

Help children build resilience against the harmful health effects of poverty and unsafe neighborhoods

- Support early childhood education for every Latino child as a pathway to school readiness, educational success and better health. Integrate evidence-based parenting and resiliency training programs.
- Support youth development programs that focus on connecting Latino children with caring adult mentors, raising expectations for school success, and providing meaningful participation in the community.
- Encourage schools to play a key role in development efforts as a vehicle to increase academic success.
- Provide neighborhood services and resources such as parks and safe playgrounds, access to healthy foods, enrichment programs, after-school academic activities, and volunteer experiences for youth in areas that currently lack them to promote community connectedness, neighborhood cohesion and ultimately better health and well-being.
- Create employment opportunities for young Latinos to provide income, stability, and career opportunities. Especially create opportunities for jobs as a career ladder to the health professions.

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