Chapter 9
Hispanic Children and Integrated Care

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Introduction

More than 20 % of US children meet criteria for a mental health diagnosis (Van Landeghem & Hess, 2005). The age of onset of major mental illness can be as young as 7 years of age, and predictors of mental health problems are sometimes seen in preschoolers (National Center for Children in Poverty, 2006). The consequences of childhood mental illness can be devastating. Half of high school-aged youth with a mental illness drop out of school and 70 % of juvenile justice-involved youth have a mental illness (National Institute of Mental Health, 2006). Furthermore, suicide is the third leading cause of death among youth aged 10–24 (Pearson, Stanley, King, & Fisher, 2001).

Unfortunately, 75–80 % of children who need mental health services do not receive them (Van Landeghem & Hess, 2005). Parents often seem willing to follow through with referrals to meet with a psychologist/behavioral health provider (BHP) during pediatric visits but frequently fail to follow through. Integrated pediatric primary care may be a solution to this problem, as most parents report a preference to meet with BHPs at their primary care office over an outside agency (Kolko, Campo, Kilbourne, & Kelleher, 2012).

Compared to other ethnic groups, Hispanic youth are the least likely to receive needed mental health care (Kataoka, Zhang, & Wells, 2002). This is particularly

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concerning given national estimates that suggest Hispanic adolescents may be one of the most vulnerable groups with higher rates of suicidal thoughts, suicide attempts, and symptoms of depression and anxiety (Kataoka et al., 2002). They also tend to have higher rates of dropping out of high school, substance use, driving when drinking alcohol, unsafe sex, overweight and obesity, and unhealthy eating habits (Chapman, Laird, Ifill, & KewalRamani, 2011; Eaton et al., 2012). Integrated primary care may be part of the solution in creating healthcare equality. Comparable utilization rates and clinical outcomes have been demonstrated between Hispanics and non-Hispanic White patients in adult integrated care settings (Bridges et al., 2014), suggesting that integrated care may reduce some of the barriers to quality healthcare for Hispanic youth.

Barriers to Quality Healthcare

Knowledge and Training

Many symptoms presented to pediatric primary care providers (PPCPs), such as sleep difficulties, toileting problems, tantrums, abdominal pain, and mealtime struggles do not have a biological cause. Approximately 50 % of pediatric primary care visits are associated with emotional, behavioral, and educational problems (Pidano, 2007). Routine behavioral health screening in primary care is necessary, but is not common practice. This is a missed opportunity to address mental health problems early, before they become chronic and debilitating conditions.

Simply making behavioral health screens a routine procedure of well-child visits is not the solution. PPCPs are inaccurate at identifying developmental and mental health problems, with sensitivities below 54 % (Sheldrick, Merchant, & Perrin, 2011). In addition, PPCPs may be attempting to address mental health concerns without adequate training. The majority of PPCPs report not having enough knowledge and training to recognize and treat mental health problems in children (Nasir, Watanabe-Galloway, & DiRenzo-Coffey, 2014; Pidano, Kimmelblatt, & Nease, 2011). In a survey of PPCPs, more than 90 % of respondents reported seeing at least one patient per month with a diagnosed mental health problem, but only 10 % felt they were well-prepared to diagnose and treat these problems (Davis et al., 2012). Many PPCPs identified lack of communication and consultation with mental health providers as a barrier to quality care.

PPCP's lack of expertise may be noticeable to parents. Some parents have reported that their PPCPs initially normalized their concerns when they first presented them to their PPCPs (Brown, Girio-Herrera, Sherman, Kahn, & Copeland, 2014). Others report receiving little feedback from their PPCPs about how to address behavioral health problems in their children. Instead, caregivers are routinely given referrals to go elsewhere, but may not have a clear understanding of why there are being referred or what to expect from the referral services.

Financial Cost and Logistical Issues

Healthcare is costly for families and could present a significant barrier to following through with referrals and interventions. This may be a particularly salient barrier for Hispanic families. With the signing of the Patient Protection and Affordable Care Act in 2010, more Americans have access to health insurance. However, Hispanic children continue to be disproportionately uninsured. In 2013, 12.1 % of Hispanic children were uninsured compared to 5.4 % non-Hispanic White children, 7.5 % of Black children, and 8.4 % of Asian children (Smith & Medalia, 2014). Hispanic households also have one of the lowest median incomes and highest rates of poverty. In 2013, the poverty rate for Hispanics in the US was 23.5 %, compared to only 9.6 % for non-Hispanic Whites (DeNavas-Walt & Proctor, 2014). Mental disorders were the most costly condition ($13.9 billion) for youth in 2012 (Center for Financing, Access, & Cost Trends, 2012) and the average annual cost per child is highest for mental disorders ($2195). In addition, families with Medicaid typically have limited options for mental health services.

In traditional pediatric primary care, parents report spending 11–20 min with their PPCP (Halfon, Stevens, Larson, & Olson, 2011). This may not provide parents with enough time to adequately get their needs met. Longer visits are associated with more anticipatory guidance, and more psychosocial risk and developmental assessment. Parents are also more likely to report feeling respected and understood during longer appointments. This is evidence that pediatric well-child visits are not structured in a way to adequately meet the needs of families. This may be particularly relevant for Hispanic families who already have cultural barriers to feeling respected and understood.

There are several logistical barriers that are particularly salient for low-income families. The cost of transportation, lack of transportation options, inability to take time off work, lack of time, lack of childcare, and a higher incidence of day-to-day stress have all been identified as barriers to accessing healthcare for children from low-income households (Bringewatt & Gershoff, 2010; Santiago, Kaltman, & Miranda, 2013).

Cultural

A caregiver's culture will shape their perception of their child's emotional and behavioral problems. Hispanics tend to respond to psychological distress with somatic complaints. As a result, they are more likely to present to primary care for mental health problems (Bridges et al., 2014). Some Hispanic groups may have different views about when to seek professional assistance or feel unsure about when their children are in need of services.

Some parents feel uncomfortable discussing emotional issues because they view them as private family matters. A fragmented health care system makes this

barrier even more prominent, as parents will prefer to speak with a provider with whom they have already established trust. Indeed, the quality of the therapist–family relationship is one of the most important factors associated with premature drop-out in community mental health centers (Stevens, Kelleher, Ward-Estes, & Hayes, 2006). The perceived relevance of treatment is another major factor associated with treatment attrition rates. Low expectations of the usefulness of referrals may make it less likely caregivers will follow through with treatment recommendations.

The use of home remedies is common among some Hispanic groups (Risser & Mazur, 1995). Some Hispanic caregivers report using a combination of pharmaceutical and herbal remedies to treat illnesses such as asthma, fever, and infections. Curanderos, or folk healers, are highly respected in some Hispanic cultures. Parents' beliefs about folk remedies and healers will affect how much faith they put into medical explanations and interventions. Culturally competent clinicians will be better able to effectively explain treatment rationales in a way that takes the family's cultural beliefs into consideration and makes it relevant to the family's perceived needs.

Miscommunication between caregivers and providers is a common reason for treatment nonadherence. Miscommunications are likely if providers cannot speak with families in a language they can understand. Parents may rely on a limited understanding of English, creating another barrier for quality healthcare. While most Hispanic children speak English very well, more than half of Hispanic children who live with both parents have at least one parent who does not speak English well (Murphey, Guzman, & Torres, 2014). Unfortunately, bilingual and ethnic minority providers are lacking. Approximately 25 % of the US population under the age of 18 is of Hispanic origin (Colby & Ortman, 2014). In contrast, only 2.8 % of US physicians identified as Hispanic in 2004 (Castillo-Page, 2006). Fortunately, physicians are becoming more diverse, as 8.5 % of medical matriculants identified as Hispanic in 2011 (Castillo-Page, 2012). There is also a lack of diversity among BHPs. It has been estimated that approximately 90 % of behavioral health professionals are non-Hispanic White (Annapolis Coalition, 2007).

When providers lack cultural competence in working with Hispanic families, their biases can act as a barrier to treatment. If providers and support staff lack cultural sensitivity to specific values, common stressors, and potential barriers to treatment for a family's specific Hispanic culture, inaccurate assumptions and misinterpretations are possible. Providers may be quick to label patients as "difficult" and make assumptions about their attitudes about treatment, possibly making fewer attempts to reach a family for follow-up after a missed appointment.

There are also limited options for culturally sensitive assessment and treatment. Families from some Hispanic cultures may want to include other family members, spiritual healers, or teachers in their child's treatment team. The Latino value of *familismo* suggests some Hispanic families will expect family members to take an active role in treatment and family-based interventions may be preferred.

Stigma and Fear

Many Hispanic individuals have experienced discrimination, making them feel uncomfortable in unfamiliar settings. Hispanic individuals living in the US often report feeling misunderstood, or even maltreated (Santiago et al., 2013). These experiences can lead to distrust of other ethnic groups. In addition, Hispanic immigrant families without proper documentation may experience fear associated with their immigration status and fear of deportation, making them reluctant to access care for their children.

There are several potential fears that may prevent caregivers from utilizing services. Hispanics and other low-income groups have reported a fear of losing custody of their children if they admit to having difficulty caring for their children or managing behavioral problems. An alarming number of minority children have been relinquished to child welfare agencies so that they can receive needed mental health services (Children's Defense Fund, 2009). Fear associated with not being able to afford services and what might happen if they cannot afford services may keep some caregivers from following through with referrals.

Further, there continues to be a stigma associated with needing mental health services. Some Hispanic families may fear disapproval from relatives and community members, or that others and providers will blame them for their problems with their child. They may also receive feedback that discourages them from following through with mental health referrals. Some families may prefer to seek help through informal sources over traditional mental health settings.

Integrated Care

Traditional healthcare has failed to address the many barriers to quality healthcare faced by many Hispanic families and integrated care may be the solution. There is no clear definition of integrated care but there are models of collaborative care with varying levels of integration. Often the terms coordinated care, co-located care, and integrated care are used interchangeably, making it difficult to interpret the existing literature. In coordinated care, medical and mental health services occur in different settings. There is a referral relationship between PPCPs and BHPs, as well as other community resources. There is limited integration in this model and the majority of the aforementioned barriers still exist. In a co-located model, medical and behavioral health services are located in the same facility, but there is still a referral process for medical cases to be seen by BHPs. Co-located practices are rare and do not guarantee enhanced communication between providers (Guevara, Greenbaum, Shera, Bauer, & Schwarz, 2009).

In integrated care, there is one treatment plan for both medical and behavioral health components of care. Primary care and behavioral health are usually co-located. The treatment plan is delivered by staff that closely work together. Teams usually consist of a physician and some combination of physician's assistants, nurse

practitioners, nurses, social workers, case managers, family advocates, psychologists, or behavioral health therapists. Ideally, there would be more than one BHP for each PPCP, so that while one is performing treatment the other is available for "warm handoffs." Evidence suggests that the ideal ratio of PPCP to BHP is 1:6 (Cummings, O'Donohue, & Cummings, 2009).

In a fully integrated pediatric primary care practice, behavioral health is part of routine medical care which includes direct patient care, as well as screening and prevention services. There is a holistic approach to healthcare that appreciates all aspects of an individual's health, including culture. Integrated pediatric primary care programs typically offer psychoeducation, medication, psychotherapy, and care management strategies. Pharmacological interventions are monitored collaboratively by all team members. BHPs in primary care tend to have larger caseloads and more flexible session time limits than in traditional outpatient mental health settings (Stancin, Perrin, & Ramirez, 2009). They also tend to use briefer, short-term interventions, use less-extensive documentation, and have flexible treatment plans. Interventions tend to be skills-based and patients may be taught self-management strategies to increase health knowledge and self-efficacy. Informal "curbside" consultations are common. The role of a BHP may extend beyond psychotherapy, and include patient education, physician education, case management, telephone monitoring, and skill coaching. BHPs may provide training to physicians on improving cultural competence and communication with families.

Integrated care also provides an important opportunity for developmental screening, promotion of healthy parent–child interactions, and detection of parental mental health problems and child maltreatment (Stancin et al., 2009). Assistance from other team members will help ensure that children who need additional services are not missed and allow PPCPs to focus their time on procedures for which they are better trained. Barriers to care are openly addressed and some programs may provide additional resources, such as transportation assistance, childcare, or meeting with children while they are at school.

Integrated care is associated with improved access to mental health services, greater patient satisfaction, higher quality care, improved patient compliance to treatment, greater provider satisfaction and perceived skill, better clinical outcomes and follow-ups, and a reduction in medical costs (Blount, 2003; Cummings et al., 2009; Hwang, Chang, LaClair, & Paz, 2013). The "warm handoff" in integrated models results in up to 90 % of patients entering mental health treatment, compared to 10 % through a traditional referral system (Cummings et al., 2009). These findings provide convincing evidence that integrated care is the way to eliminate the aforementioned barriers to quality healthcare that are often experienced by Hispanic families.

Implementation Challenges

The more integrated a program, the more likely it will be successful. However, there are several challenges when it comes to integrating care. It would likely take time to develop the infrastructure to support this system. There is also a lack of adequate

payment options and many complex coding and billing issues (Stancin & Perrin, 2014). In integrated care, families will often attend joint or sequential appointments with pediatricians and BHPs. Unfortunately, some payers will not pay for more than one service per day for the same diagnosis and there is no mechanism available to pay BHPs to facilitate parent education groups in a pediatric practice. Therefore, integrated models will not be sustainable without changes in policy, and the management of billing and repayments. A crucial component of the future of integrated care is education. Many training programs are training psychologists and other mental health professionals to work in this fast-paced setting.

Special Topics in Treating Hispanic Youth

Integrated care provides opportunities for regular assessment and early intervention of childhood mental health disorders while reducing barriers for Hispanic families. It is also the ideal setting to coordinate care for children with chronic physical and mental health problems. Mental health is interconnected with physical health and both should be addressed concurrently. Below are examples special topics relevant to the health of Hispanic youth and examples of how integrated care can help reduce disparities in these areas.

Attention-Deficit/Hyperactivity Disorder

The prevalence and heritability of attention-deficit/hyperactivity disorder (ADHD) is similar across different cultural groups (e.g., Rohde et al., 2005). However, Hispanic youth are less likely to receive an ADHD diagnosis compared to White youth, even when they present with the same symptoms (Morgan, Staff, Hillemeier, Farkas, & Maczuga, 2014). This is especially the case in non-English-speaking families. This means that many Hispanic children are not being properly assessed and diagnosed, and not receiving needed treatment. Likely, a result of the many barriers to treatment described above. ADHD is highly comorbid with other mental health disorders, such as depression, anxiety, and substance-use disorders. It is also associated with an increase in risk taking behaviors and poor school performance. A recent study found that there is a high prevalence of ADHD symptoms among Hispanic prison inmates (González, Vélez-Pastrana, Ruiz Varcárcel, Levin, & Albizu-García, 2015).

Evidence-based interventions for ADHD include pharmacological management and behavioral treatment (Daly, Cohen, Carpenter, & Brown, 2009). In traditional pediatric settings, children are prescribed psychostimulant medications by their PPCP and given a referral for behavioral treatment through a BHP. The aforementioned barriers often keep families from following through with needed behavior modification interventions and parent training. An integrated care model is ideal for

treating ADHD because collaboration between PPCPs, BHPs, and school personnel is the gold standard. Collaborative care is an effective model for treating Hispanic youth with ADHD (Myers, Vander Stoep, Thompson, Zhou, & Unützer, 2010).

Violence

Hispanic adolescents are involved in physical altercations more often than White adolescents, with approximately one-quarter engaged in fighting (Shetgiri, Kataoka, Ponce, Flores, & Chung, 2010). Homicide is the second leading cause of death for Hispanics adolescents (Center for Disease Control and Prevention, 2010). Oppositional defiant disorder and conduct disorder are often risk factors for later violence. Early identification and intervention of these problems is crucial for reducing risk for later violence. Being a bully and being a victim of bullying are both associated with physical altercation injuries (Glew, Fan, Katon, & Rivara, 2008). Involvement in bullying is linked to negative psychological outcomes such as anger, depression, and suicidal ideation (van der Wal, de Wit, & Hirasing, 2003), and to a higher likelihood for criminality by early adulthood (Renda, Vassallo, & Edwards, 2011).

PPCPs are well positioned to take preventative action for youth at-risk for violence involvement. However, children are infrequently screened about current involvement in violence, or risk of future violence perpetration at routine visits. In fact, one study demonstrated that 76 % of practitioners never or rarely asked adolescents about involvement in physical fighting (Borowsky & Ireland, 2004). In general, pediatricians are not comfortable addressing issues of violence with their patients (Chaffee, Bridges, & Boyer, 2000; Finch, Weiley, Ip, & Barkin, 2008).

Violence-prevention strategies can be integrated into pediatric practice. Both the American Medical Association (AMA) and the AAP have strongly encouraged PCPs to screen youth for violence-related involvement and link at-risk youth to necessary intervention and follow-up services (AAP, 2009; Knox, Lomonaco, & Elster, 2005). This process would include appropriate screening for a history of injuries associated with violence and risk of retaliatory violence (Whiteside & Cunningham, 2009). Some key questions to assist in determining risk of future violence include school attendance and achievement, witnessing of violence, previous physical fights, bullying, substance use, and access to firearms (Borowsky & Ireland, 2004).

Many effective violence-prevention strategies and interventions are available that can easily be implemented by BHPs in primary care. Connected Kids (AAP, 2006) is a freely available strength-based prevention program designed for use in primary care that has demonstrated reductions in both fighting and related injuries in a randomized controlled trial (Borowsky, Mozayeny, Stuenkel, & Ireland, 2004). Parent–child Interaction Therapy (PCIT; Zisser & Eyberg, 2010) is a parent training intervention for children between the ages of 2 and 7 with disruptive behavior disorders. Abbreviated versions that have been adapted for primary care have shown improvements in child behavior through increased effectiveness of parenting strategies for child behavior management (Berkovits, O'Brien, Carter, & Eyberg, 2010).

Substance Abuse

Hispanic adolescents are disproportionately affected by substance use (Chen & Jacobson, 2012). Identification and treatment of substance use in Hispanic adolescents is inadequate and inconsistent (Saloner, Carson, & Lê Cook, 2014). Hispanics experience higher severity substance use and more severe consequences later in life as a result of early onset substance use (Hingson & Zha, 2009), and an increased likelihood of experiencing co-occurring mental health disorders (Chisolm, Mulatu, & Brown, 2009). Untreated substance use in Hispanic youths is also associated with problem behaviors such as unsafe sexual behavior (Prado et al., 2006), conduct problems, and delinquency (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006).

Routine substance use screening of adolescents is recommended by the AAP (Levy, Kokotailo, & Committee on Substance Abuse, 2011). Screening, Brief Intervention, and Referral to Treatment (SBIRT; Babor et al., 2007) is a research-supported approach for this purpose that has been effective in adult populations. SBIRT is intended to identify current substance use along a spectrum and implement appropriate intervention at every health care visit in primary care (see Levy et al., 2011 for intervention goals based on level of substance use). Those in need of extensive substance abuse treatment are typically referred to outside providers, but within an integrated model this would be unnecessary. An exception would be if the adolescent was in need of inpatient or detoxification services. A number of outpatient evidence-based treatments exist for adolescent substance abuse, including ecological family therapy, multidimensional family therapy, brief motivational interventions, and cognitive behavioral therapy (Hogue, Henderson, Ozechowski, & Robbins, 2014). Family-based interventions are the gold standard and can be incorporated into primary care.

Overweight and Obesity

Childhood obesity is linked to serious medical conditions such as type 2 diabetes and cardiovascular disease (Weiss et al., 2004). Diabetes diagnosed before the age of 20 can reduce life expectancy by up to 27 % (Mayer-Davis et al., 2009). Childhood obesity places children at risk to a number of psychosocial consequences including depression, anxiety, impulsivity, and ADHD (Kalarchian & Marcus, 2012). Obese youth often have low self-esteem and negative body image, and face social discrimination and bullying (Puder & Munsch, 2010).

Although being overweight is directly related to the imbalance of caloric intake and physical activity, the current obesity epidemic proves to be more complex. Hispanic youth have higher rates of overweight and obesity than children of other ethnicities (Ogden, Carroll, Kit, & Flegal, 2014). Although there is a strong genetic component disproportionally predisposing certain racial and ethnic groups to diabetes, complex cultural and socioeconomic barriers place Hispanic youth at greater

risk. Factors such as parental obesity, lack of time for meal preparation, higher cost of healthy foods, lack of access to healthy foods, meals traditionally higher in fat and carbohydrates, and caregivers using sugary foods as rewards have all been implicated in the high rate of obesity in Hispanic youth (He et al., 2013; Snethen, Hewitt, & Petering, 2007). Factors associated with decreased physical activity in the Hispanic community include limited time, lack of transportation, sedentary activities (e.g., watching television, playing video games), lack of safe options for recreational activities, racism from other ethnic groups or police, and the cost of organized athletic activities. Lack of parental health knowledge may also be an important contributing factor and a reasonable target for intervention.

The provision of educational materials is a common obesity intervention in pediatric primary care; however, this often leaves Hispanic families with more questions than answers., Hispanic parents were more likely than White parents to rate the quality of advice received regarding nutrition and physical activity at their most recent primary care visits as poor or fair (Taveras, Gortmaker, Mitchell, & Gillman, 2008). Many primary care offices now have educational information in Spanish about metabolism, nutrition, healthy snacks, portion size, and fitness (Stacia et al., 2010). However, there is a strong need for skilled health educators to provide culturally competent nutritional education that respects Hispanic heritage and beliefs about diet and potential barriers to regular physical activity. Family-based interventions are likely to be the most effective and acceptable method for working with Hispanic families.

Rather than relying on visual appearance, which is only noticeable when children are already obese, all children should be screened for overweight and obesity and risk factors. This can be accomplished by calculating the Body Mass Index (BMI) of each child at every well child visit (Barlow & Expert Committee, 2007). Regardless of BMI percentile, all children should receive a medical and behavioral assessment of risk factors for obesity, as well as an assessment of attitudes that affect lifestyle and habits. Children with a BMI below the 85th percentile and no evidence of health risk should get continued screening, prevention messages, and reinforcement for maintaining a healthy lifestyle. Those with a BMI at the 85th percentile or higher should get different stages of intervention depending on their level of risk. For some, prevention counseling will be sufficient, while others will require more active forms of treatment. In most cases, a multidisciplinary team consisting of social workers, psychologists, other BHPs, registered dietitians, exercise specialists (e.g., physical therapist), and community resources are only utilized in more severe cases. BHPs' expertise in behavioral change makes them well-suited to assess behavior and attitudes, teach behavioral-change strategies, as well as address the psychosocial consequences of overweight and obesity. In integrated primary care, BHPs can be involved in the prevention stage, possibly mitigating the need more intensive interventions.

Obesity interventions may be more effective when they extend beyond the primary care setting. Interventions that incorporate both primary care and community resources may help combat risk factors unique to Hispanic and low-income families. For example, *Healthy Living Today*! is a family-centered, culturally sensitive

intervention that focuses on nutrition, physical activity, and stress management. It is effective and well tolerated by Hispanic families (Arauz Boudreau, Kurowski, Gonzalez, Dimond, & Oreskovic, 2013).

Asthma

Asthma is the most common chronic illness among children in the US. It is a chronic inflammatory disorder of the airways that is characterized by variable and recurring airflow obstruction and bronchial hyperresponsiveness (National Institutes of Health [NIH], 2007). Physical symptoms include difficulty breathing, wheezing, coughing, and mucus secretions. The severity of asthma exacerbations can vary from mild to fatal.

Asthma is currently conceptualized as a disorder with genetic, environmental, and psychological factors. Asthma disproportionately affects low-income and urban communities, likely due to various environmental factors, such as higher exposure to indoor and outdoor pollutants, as well as psychosocial stressors (Canino et al., 2006). While Hispanic children as a whole tend to have lower rates of asthma compared to other ethnic groups, a large disparity exists between different Hispanic subgroups. Puerto Rican youth have the highest prevalence of asthma than any other US racial or ethnic group, even after controlling for known risk factors (Lara, Akinbami, Flores, & Morgenstern, 2006). US born Hispanic youth tend to have higher rates of asthma compared to foreign-born Hispanic youth, with higher prevalence of asthma in later generations (Balcazar, Grineski, & Collins, 2015).

Maternal distress during pregnancy may disrupt fetal lung development and immunomodulation (Wright et al., 2010). Continued exposure to maternal distress and parenting difficulties into infancy and early childhood may negatively impact immune functioning and contribute to how infants learn to regulate physiological and emotional stress (Klinnert et al., 2001; Kozyrskyj et al., 2008). Stress and emotions are common triggers for many children with asthma, especially when exposed to stressful life events (McQuaid & Abramson, 2009).

Hispanic children have very poor adherence to prescribed asthma regimens, with less than half of Hispanic families adhering to the treatment recommendations described by the NIH (Acevedo-Nieves, 2008). Failing to fill prescriptions, incorrect dosage, inaccurate dosing intervals, and premature discontinuation of asthma medications are all common, especially if medications are expensive, have unpleasant side effects, are difficult to take, or if the benefits are not seen immediately. A major contributor to noncompliance with prescribed regimens among Hispanic families may be lack of asthma awareness. Hispanic caregivers are less likely to receive adequate training on how to control their child's asthma than non-Hispanic White caregivers (Inkelas, Garro, McQuaid, & Ortega, 2008). Hispanic parents report that they need more help understanding asthma and how to use medications to control it, which may contribute to a reliance on folk remedies (Mosnaim et al., 2006).

There are several ways an integrated approach can reduce barriers to adequate asthma care for Hispanic families. Several asthma educational programs for patients and families have been developed (McQuaid & Abramson, 2009). The most successful programs provide information about asthma and incorporate behavioral-change strategies. BHPs can also assist with physician training programs. The Physician Asthma Education program consists of teaching communication techniques and reviewing asthma guidelines with physicians (Cabana et al., 2014). It has been associated with higher adherence to guidelines by physicians, improved communication with patients, and better patient outcomes.

BHPs can identify psychosocial barriers to asthma management and provide interventions to address these barriers. One purpose of psychosocial interventions is to improve the family's autonomy in the self-management of asthma. Interventions may include self-management training, problem-solving techniques, family-based interventions, motivational interviewing, relaxation training, and biofeedback (McQuaid & Abramson, 2009). As the patient ages into adolescence, the focus of self-management training shifts from the caregivers to the child. Patients are taught to appropriately take medications and may be taught stress-management strategies to reduce autonomic arousal and emotional distress during an asthma exacerbation. A culturally adapted, family-based, asthma educational program called CALMA was found to improve patient outcomes and caregiver confidence in treating asthma in island and mainland Puerto Rican families (Canino et al., 2008).

School-Readiness and Literacy

Hispanic youth have lower levels of educational attainment and academic achievement than non-Hispanic White youth (Garcia & Miller, 2008). Children who attend high-quality preschool programs evidence greater school readiness; however, the long-term benefits are unclear. Hispanic families often do not have access to affordable, high-quality programs, which puts the pressure solely on parents to prepare children for school. Unfortunately, Hispanic caregivers are less likely than White caregivers to read daily to their young children (Murphey et al., 2014). The AAP recommendations that PPCPs promote early literacy with caregivers beginning when children are in infancy (High, Klass, & Council on Early Childhood, 2014). National programs, such as Reach Out and Read (ROR) are designed for PPCPs to teach the caregivers of preschoolers about the importance of reading aloud, teach book-reading strategies, and provide caregivers with developmentally appropriate books for their children during each well-child visit. Caregivers in ROR are more likely to read regularly with their children and children in the program evidence significantly improved language development at 24 months of age (High et al., 2014). This program has demonstrated to be efficacious with Hispanic populations (Sanders, Gershon, Huffman, & Mendoza, 2000).

Including other providers into primary care may enhance these outcomes. Programs such as Healthy Steps (Zuckerman, Parker, Kaplan-Sanoff, Augustyn,

& Barth, 2004) and the Video Interaction Project (VIP; Mendelsohn et al., 2007) utilize child development specialists to teach caregivers about child development, assess caregiver emotional health, reframe negative parental attributions about their child, and model positive interactions during well-child visits. Healthy Steps has been associated with greater adherence to well-child visits and better parenting. Caregivers in VIP meet with child develop specialists to discuss caregiver expectations and concerns about the child's development. They are videotaped while playing together with their child for several minutes. The video is watched and the specialist reinforces parenting strengths and teaches caregivers how to engage children and navigate disruptive behavior. VIP is associated with lower levels of parenting stress, greater likelihood of normal cognitive development, and lower likelihood of developmental delays in children. It has been implemented with both English- and Spanish-speaking families.

Conclusion

Mental health problems are prevalent in children, but the majority of these children do not receive needed services. Hispanic children are less likely to receive these services than children of other ethnic groups, likely due to barriers associated with physician training and knowledge, financial cost and logistical issues, culture, and stigma and fear. Integrated care has been shown to reduce these barriers and provide a setting for a higher quality, culturally competent, and holistic approach to healthcare.

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