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FAMILY FACTORS AS DETERMINANTS OF REPRODUCTIVE HEALTH OUTCOMES FOR YOUTH

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Purpose: To provide an updated review of published research examining the influence of family factors (family connectedness, parental monitoring, general parent-child communication, and parent-child communication about sexual health) on adolescent reproductive health (ARH).

Methods: We conducted a systematic review of observational research published between 1985 and 2007 in eight online databases and from bibliographies of recent relevant review articles. The search strategy was adapted from one previously established by Catalano et al. (1998). Inclusion criteria included examination of the association between a family factor and an adolescent sexual/reproductive health outcome(s), use of multivariate analyses, a sample size of > 100 for significant results, and 200 for non-significant results, and publication in a peer-reviewed journal. Direct effects were coded as protective, risk, or no association and indicated as longitudinal (L), cross sectional (CS), or indirect effect (IE). Coding was validated by a second researcher. We counted the number of studies as well as the number of findings. The presence of two longitudinal studies for at least one outcome was considered an indication of adequate evidence; one longitudinal study was considered an indication of promising evidence.

Results: Studies included 87 for family connectedness (L = 36; CS = 51; IE = 12), 45 for parental monitoring (L = 21; CS = 24; IE = 6), 27 for general parent-child communication (L = 6; CS = 14; IE = 7), and 60 for parental communication about sexual health (L = 10; CS = 39; IE = 16). Findings for family connectedness and general parental communication indicated a protective association: 28 findings from 14 longitudinal family connectedness studies and 6 findings from 3 general communication longitudinal studies were protective; none indicated a risk association. For parental monitoring, 22 findings from 12 longitudinal studies indicated a protective association, while 3 findings from 3 longitudinal studies indicated a risk association (greater negotiated unsupervised time or parental over-control). For parental communication regarding sexual health, 10 findings from 6 longitudinal studies were protective, while 5 findings from 2 longitudinal studies indicated risk association.

Conclusions: There is adequate evidence to support protective associations between family factors and ARH, although selected findings indicated a risk association. Further study regarding the nature of and interaction between these family factors and their combined influence on ARH would be informative. Inclusion of parental education components in adolescent sexual health programs and youth development interventions may have a positive impact on ARH outcomes.

Sources of Support: This study was supported by the US Centers for Disease Control and Prevention.

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ARE MOMS OF DAUGHTERS WITH CHRONIC ILLNESSES TALKING ABOUT SEX AND SUBSTANCE USE AND IF SO, WHAT ARE THEY SAYING?

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Purpose: Female adolescents with chronic medical conditions (CMCs) engage in health risk behaviors with equal or greater

frequency than their healthy counterparts. Parent-adolescent communication has been shown to be protective against health risk behaviors among healthy female adolescents, but data is still needed for female adolescents with CMCs. The current study examined patterns of communication over the past 3 months among mother-daughter dyads in order to document the frequency and dyadic agreement of discussion of sexual activity and substance use issues.

Methods: Forty-three dyads were surveyed regarding communication about health risk behaviors. Female teens ranged in age from 14-19 years M (SD) = 16.2 (1.63) and had been diagnosed with a CMC for at least one year. Dyads completed questionnaires at an outpatient appointment including a validated 28-item index of frequency of communication about sexual behavior and substance use. Response patterns of mothers and daughters were grouped to examine concordance in mother-daughter perceptions of frequency of communication at the item level. Three categories were created: Low Frequency Concordance Group (dyad agreed that they infrequently discussed the topic), High Frequency Concordance Group (dyad agreed that they frequently discussed the topic), and Discordance Group (dyad disagreed about frequency of discussion). Frequency analyses examined the percentage of dyads in each group for each item.

Results: Dyads agreed on discussing substance use issues more often than sexual activity issues. Over 1/3 of dyads agreed on frequently discussing risks of substance use, frequency of other teens' substance use, peer opinions about teen substance use, and risks of driving under the influence. In contrast, over 1/3 of dyads agreed that they had not discussed paternal opinions about teen sexual activity, peer opinions about teen sex, risks associated with multiple sex partners and unprotected sex, what the act of sexual intercourse is, safe sex practices, or decision-making about readiness for sexual activity. The majority of the sample reported discordance in perceptions of frequency of discussion of the remaining 13 items, 10 of which focused on sexual activity.

Conclusions: Health care providers should encourage communication about health risk behaviors, especially sexual activity, for females with CMCs. Families may benefit from learning effective communication strategies regarding these sensitive topics. Health care providers may be in a unique position to model effective communication strategies and to counsel parents in strategies for discussing these sensitive topics.

Sources of Support: None.

SESSION II (THURSDAY): POLICY

67.

YOUTH PERSPECTIVES ON HEALTH & WELLNESS: A FOCUS GROUP STUDY

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Purpose: Youth are often the targets of health policy, but are rarely consulted during policy formation. As part of the development of a state health plan for Indiana adolescents, we conducted focus groups to identify health issues relevant to youth and solicit their solutions.

Methods: After IRB approval, six groups of 6 - 10 adolescents each were recruited from existing community groups across the state. Led by a trained moderator, focus groups lasted 1 hour and were conducted in a private room at each group's regular meeting place. The semi-structured interview guide included questions such as

“What makes a teenager healthy?”, “What are teenagers’ health concerns?”, “Who do you trust most for health information or advice?”, and “What solutions would you recommend to help solve the health issues affecting others your age?” Focus groups were audio recorded and transcribed. We developed four preliminary codes from an initial reading of the transcripts: physical health, psychological health, social support, and health communication. Preliminary codes were selected, closely read, and key concepts that spanned groups were identified. These key concepts were organized into a model.

Results: Groups were recruited from five different cities or small towns across Indiana, and included an urban youth leadership group, Future Farmers of America, a Latino student group, an alternative high school group, parenting adolescents, and university freshmen. The 49 participants ranged in age from 14–24, included males (26) and females (23), and included White (32), African American (10), and Latino (7) ethnicities. Participants described three levels of health; individual, relational, and environment. Participants listed stress and fatigue, obesity, tobacco, alcohol, sexual health, and access to care as key health issues. While acknowledging an individual’s responsibility for their own health behaviors, they placed these behaviors in the context of relationships and environment. Relationships with parents and other caring adults were viewed as critical supports. Supportive adults were someone they could talk with, respectful of emerging skills, and remained positive and non-judgmental. Physical environments included buildings, roads, green space, sidewalks, and violence; financial environments included family financial stressors and the need to have a job; Informational environments included access to complete and truthful health information. These environments could either support or hinder healthy decision-making. The themes of supportive relationships and environments were consistent across geographic locations, demographics, and life circumstance.

Conclusions: Adolescents viewed health as a shared responsibility between adolescents and the adults in their lives. Supportive relationships and healthy physical, financial, and informational environments were viewed as necessary to healthy behaviors and outcomes.

Sources of Support: ISDH, Indiana State Dept. of Education, K23HD049444-01A2, MCH T71MC00008.

68.

WHO WILL PAY WHEN I GET OUT? INSURANCE STATUS OF YOUTH IN SECURE DETENTION CENTERS

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Purpose: Youth who are detained or committed in a public institution are in jeopardy of losing Medicaid (MA) benefits due to federal and state legislation and regulations. This poses a problem for these youth when they return to the community, as they may be forced to requalify for benefits. To better understand the extent of this problem in Maryland, we studied the prevalence of MA funding as a source of health insurance. We determined the number of youth in detention facilities who have MA and compared this with youth in the general population. We also identified factors associated with the prevalence of Medicaid. We hope that data like this will be used for analysis of current Medicaid policies relating to youth in detention centers.

Methods: This study is a descriptive cross-sectional study of youth in Maryland’s secure detention facilities. Demographic

information, placement status, and length of stay (LOS) were obtained from the ASSIST database (2008) on all youth ages 13–18 ($n = 434$) identified from a 1 day population count (October 24, 2007). The Medicaid Management Information System (2008) was used to check for presence of Medicaid health insurance. Health insurance status of the general population was derived from the 2007 Current Population Survey. Rates of Medicaid between study subjects and same aged youth in Maryland were compared. Comparisons were also made on the basis of placement status, LOS, gender, ethnicity, and utilizing the presence of a social security number as a surrogate marker, documented or undocumented immigrant status. A stratified analysis using χ^2 tests was used to assess associations between variables.

Results: Youth in detention centers were more likely to have had Medicaid health insurance than other state youth (69.6% vs. 12.7%, $p < 0.001$). Youth who were adjudicated were more likely to have MA than pre-adjudicated youth (77.5% vs. 65.4%; $p = 0.009$). There were no demonstrable differences according to gender or LOS. African-Americans (72.7%) and Whites (61.4%) were more likely to have had Medicaid than Latino youth (30.8%, $p = 0.006$). Not surprisingly, 94.9% of youth with no social security number also had no MA.

Conclusions: Medicaid is the most common source of health care financing for youth in detention centers in Maryland. However, these youth are at risk of losing MA benefits due to federal legislation that prohibits use of federal funding for “inmates of a public institution.” Youth in the juvenile justice system face more health disparities than their peers making access to dental, mental, and somatic health care of critical importance. Policy changes are needed to ensure youth receive health care and health insurance coverage while in detention centers and have health insurance upon release into the community.

Sources of Support: None.

69.

THE FUTURE ADOLESCENT MEDICINE WORKFORCE: A SURVEY OF CURRENT ADOLESCENT MEDICINE FELLOWS

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Purpose: While the number of American Board of Pediatrics certified subspecialty fellows has nearly doubled over the last decade, the number of adolescent medicine (AM) fellows in training has not changed. To ensure a future workforce of board-certified AM specialists, the reasons why physicians choose to specialize in AM must be understood. This study had two purposes: (1) to develop a profile of AM fellows including demographics, training experiences, timing and types of exposures to AM, career expectations, and opinions about AM as a field, and (2) to identify common experiences that influenced physicians to seek AM subspecialty training.

Methods: In the spring of 2008, we conducted an electronic survey of all AM fellows in ACGME accredited fellowship programs and those committed to begin training in July 2008. Links to the survey were sent to fellowship program directors who were asked to forward it to current and incoming fellows. The survey included questions regarding demographics, training experiences, career expectations, and attitudes and beliefs about AM. Open-ended questions allowed fellows to describe experiences and influential forces that directed them to training in AM. Data were analyzed for means, medians,