1.

THE YOUNG ADULT PERSPECTIVE ON HEALTH INSURANCE

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Purpose: A critical task for adolescents transitioning to young adulthood is obtaining health insurance, an area of increased focus with passage of the Affordable Care Act. We sought to describe young adult's perspectives on health insurance and HealthCare.gov, including their attitudes toward health insurance, health insurance literacy, and benefit and plan preferences.

Methods: We observed young adults age 19 to 30 years in Philadelphia from January-March 2014 as they shopped for health insurance on Healthcare.gov. The observation period was followed by a semi-structured interview with free listing questions on insurance advantages and disadvantages as well as plan benefit preferences. A follow-up interview was conducted 1-2 months later that addressed participants' plan enrollment decisions, decision satisfaction using the Sainfort decision attitude scale, and intended use of health insurance. Salience scores for free listing responses were calculated. All study sessions were transcribed and analyzed by thematic content using NVivo X software.

Results: Thirty-three highly educated young adults participated in the study with 27 completing the follow-up interview. The most salient health insurance advantages for young adults were access to preventive or primary care (salience score 0.28) and peace of mind (0.27), while the financial strain of paying for health insurance (0.72) was the top disadvantage. Participants were challenged by poor understanding of health insurance terms, especially for concepts like deductible or coinsurance, incorrectly defined by 48% and 78%, respectively. Though participants expressed benefit preferences, which included preventive care (salience score 0.21) and dental coverage (0.18), they had difficulty determining which plans best matched those preferences, partially due to a perceived overwhelming amount of information. Young adults were confused by how tax credits and price discounts were applied and presented that made more comprehensive plans cheaper than less comprehensive alternatives, such as catastrophic insurance. The majority of participants (58%) considered silver tier plans as "middle of the road" options. Ultimately, eight participants enrolled in HealthCare.gov plans: six selected silver plans and three qualified for tax credits, resulting in premiums as low as $0.13 per month. Most participants considered monthly premiums less than $50 (30%) or $100 (36%) affordable. Participants were overall satisfied with their plan choices (mean score 4.2 out of 5), with lower ratings of the usability (3.2) and adequacy (2.8) of the information. The most common intended health insurance use was for routine primary care.

Conclusions: Young adults have an important perspective on health insurance. Their health insurance preferences, such as affordable routine primary care, can inform how to better engage and increase coverage in this population. The challenges that young adults faced when choosing plans on HealthCare.gov indicate areas for improvement in marketplace content and design as well as

opportunities to better prepare and assist young adults in completing this important task for transition to a healthy young adulthood.

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2.

SUICIDE ATTEMPTS IN RELATION TO CHILDHOOD MALTREATMENT AMONG STREET YOUTH: A PROSPECTIVE COHORT STUDY

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Purpose: Street youth have elevated mortality compared to the general youth population and suicide is the most common cause of death, surpassing mortality from both drug overdose and infectious disease. History of childhood abuse and neglect is common among street youth, but it is not known to what extent such trauma predisposes to suicide risk. This study examined suicide attempts in relation to childhood maltreatment in a prospective cohort of street youth.

Methods: From September 2005 to November 2013, longitudinal data were collected as part of the At Risk Youth Study (ARYS), a prospective cohort of street youth in Vancouver, Canada. Inclusion criteria were age 14-26 years and past-month drug use. Participants were recruited through extensive street-based outreach and snowball sampling, and provided informed consent. At baseline and at semiannual follow-up visits, participants completed an interviewer-administered questionnaire with questions on suicide attempts as well as the Childhood Trauma Questionnaire, a tool validated among street youth with 5 subscales for detecting sexual, physical and emotional abuse, and physical and emotional neglect. Urgent referral services were available for acute suicidal risk and disclosure of abuse. Using Cox proportional hazards regression, we examined the association between the 5 types of abuse/neglect and suicide attempt during follow-up, adjusting for potential confounders, including age, gender, recent injection drug use, and recent drug overdose.

Results: Of 629 participants, 68.2% were male, 33.0% were non-white, and 15.9% identified as lesbian/gay/bisexual/transgender, with median age 22 years (interquartile range, 20-24 years). Participants contributed 1841 person-years of total follow-up (median follow-up per participant, 25.9 months). Suicide attempts were reported by 35 (5.3%) participants during follow-up, resulting in a crude incidence density of 19.0 per 1000 person-years. Six participants reported ≥2 suicide attempts (median, 2 attempts; maximum, 4 attempts). Prevalence of moderate to extreme childhood trauma ranged from 16.8% (sexual abuse) to 45.2% (emotional abuse). Cronbach's alpha for each subscale of childhood trauma ranged from 0.77 to 0.95, indicating good internal consistency. In adjusted analyses, moderate to extreme physical abuse significantly predicted suicide attempts (adjusted hazard ratio [AHR], 4.47; 95% confidence interval [CI], 2.12-9.42), as did emotional abuse (AHR, 4.92; 95% CI, 2.11-11.5) and emotional neglect (AHR, 3.08; 95% CI, 1.05-4.89).

Conclusions: Childhood trauma confers a significantly elevated risk for suicidal behavior among street youth. Since suicide is a leading cause of death among street youth, secondary suicide prevention efforts should be targeted towards this marginalized population and be delivered from a trauma-informed perspective.

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3.

CONTRACEPTIVE USE AMONG EMERGING ADULT COLLEGE WOMEN: RESULTS FROM A NATIONAL SURVEY

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Purpose: Emerging adulthood, the developmental period from 18-25 years, is a time when sexual activity is normative and rates of contraceptive use are sub-optimal. Thus, unintended pregnancy disproportionately affects the emerging adult population, with women ages 18-24 having the highest unintended pregnancy rate of all age groups. With most emerging adults being sexually active, contraceptive use is an important health consideration for this population. While a body of research has examined relationships between risk indicators and emerging adult contraceptive use, few studies have identified protective factors that may be associated with consistent contraceptive use. Guided by emerging adult developmental theory and a positive youth development framework, this study explored protective and risk factors associated with consistent contraceptive use among emerging adult female college students, and whether the effects of risk factors were ameliorated in the presence of protective factors.

Methods: Employing data from Wave III of the National Longitudinal Study of Adolescent Health (Add Health), this study evaluated relationships between protective factors, risk indicators and consistent contraceptive use. The study sample included 842 18-25 year old women attending 4-year colleges. Consistent contraceptive use was defined as use of contraception "all of the time" with intercourse in the past 12 months. Protective factors examined included self-esteem (4 items from the Rosenberg Self-Esteem Scale; α=.81), self-confidence ("How confident are you of yourself?"), independence ("How independent are you?"), and life satisfaction ("How satisfied are you with your life as a whole these days?"). Risk indicators included heavy episodic drinking (>5 drinks in a row on at least 2-3 days/month in past 12 months), marijuana use (# times used marijuana in past month), and depressive symptoms (9 items from the CES-D; α=.82). Multivariable logistic regression models were used to evaluate associations between protective factors and consistent contraceptive use and between risk indicators and consistent use. Analysis also examined whether protective factors moderated the effects of risk indicators on consistent contraceptive use.

Results: Self-esteem, confidence, independence, and life satisfaction were all positively and independently ($p<0.05$) related to consistent contraceptive use. Life satisfaction had the strongest positive relationship with consistent contraceptive use in a multivariate model including all protective factors and study covariates (AOR=1.25, p=0.05). In a multivariable model of risk indicators and covariates, both marijuana use (AOR=0.98, p=0.05) and depressive symptoms (AOR=0.91, $p<0.001$) were negatively related to consistent contraceptive use. Protective factors did not moderate the relationships between risk indicators and consistent contraceptive use.
Conclusions: This cross-sectional study, an initial investigation of associations between protective factors, risk indicators and consistent contraceptive use, supports further investigation of these relationships among emerging adult populations. Findings suggest that protective and risk factors work independently to influence consistent contraceptive use among emerging adult female college students. Together with findings from previous studies regarding protective factors, our results support the use of strengths-based interventions during emerging adulthood to promote consistent contraceptive use.
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4.

EAST AFRICAN IMMIGRANT FEMALES AND TRANSITIONS IN IDENTITY DEVELOPMENT: UNDERSTANDING DEVELOPMENTAL PROTECTIVE AND RISK FACTORS IN ADOLESCENCE

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Purpose: Adolescence represents a crucial period for developmental processes including identity formation, role development, interpersonal relationships and the development of health beliefs and behaviors. Immigrant youth are often exposed to new and conflicting norms regarding these aspects of development resulting in unique challenges and opportunities for growth. Identifying and understanding the factors that contribute to the healthy development of immigrant female youth is essential to promoting healthy behaviors. The purpose of this study is to explore how first-generation female Ugandan immigrant youth experience and understand their health and development and how factors such as community, school, family, peer groups and individual characteristics affect their health behaviors and self-development.
Methods: This qualitative study employed grounded theory methods. Multiple interviews with 20 participants and 100 hours of community observation were the primary data collection strategies. Participants were recruited through a community group serving the Ugandan population of greater Los Angeles that is based out of St. Mark's Episcopal Church in Van Nuys, CA. Community leaders initially assisted in recruitment, followed by snowball sampling and included English speaking females aged 12-25 years, who had immigrated to the US at the age of 8 years or later, and self-identified as Ugandan. Dimensional analysis, an approach to the generation of grounded theory was used as a primary analytic strategy. In addition to coding, memo-writing was used as an analytic tool to track the developing conceptualizations and decisions. Emerging areas of salience were then integrated into future interviews for further development and verification. A matrix was used to consider which dimensions and concepts

had the greatest explanatory power.
Results: The dimension with the greatest explanatory power and therefore the central process was that of identity development. This process encompassed participants' ethnic and racial identities, as well as their gender and role identities. Understandings, choices and behaviors shifted throughout adolescence. Participants fluidly defined themselves as belonging to particular racial/ethnic groups, adopted ethnic labels, and defined selves in terms of group membership primarily identifying as African, Ugandan, and black. Participants reflected on their racial and ethnic identity in terms of how it impacted their social status and opportunities, and described various internal and external practices of embodying and/or rejecting different racial/ethnic identities. Factors in various social contexts including community, school, family, and peer group were identified including, but not limited to, family structure, degree of community involvement, racial diversity of school setting, and language proficiency. As both risk factors and developmental assets, these served to impact the transitions in this sample's identity development.
Conclusions: For Ugandan female adolescents, self-development is impacted by the understandings, choices, and tensions surrounding identity, gender, and the challenging dynamics of racial and ethnic stereotypes. This grounded theory study captured not the mean experience of immigrant youth, but starts to describe the range and variation of experiences affecting self-development and the impact of various social contexts. Awareness of and open dialogue of these factors can serve to bolster future promotion and prevention programs with culturally competent, developmentally appropriate, feasible, and effective interventions.
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5.

SELF-RATED HEALTH IN DISPARITIES RESEARCH: CONSTRUCT VALIDITY OF SRH ACROSS RACIAL/ETHNIC GROUPS AND IMMIGRANT GENERATIONS AMONG U.S. ADOLESCENTS AND YOUNG ADULTS

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Purpose: Single-item self-rated health (SRH) measures, in which respondents rate their overall health on a four- or five-point ordinal scale, are often the only health-related questions in large national surveys. SRH is a good proxy for physical and mental health, and it strongly predicts future health and mortality. Studies in adults suggest, however, that the construct of SRH is not equivalent across racial/ethnic groups or immigrant generations and thus may not be valid for health disparities research. No studies have examined whether SRH is an equivalent construct across subgroups for adolescents/young adults. This study uses data from waves 3 (ages 18-24) and 4 (ages 24-32) of the National Longitudinal Study of Adolescent Health (Add Health) to assess the construct validity of a single-item 5-category SRH measure across six racial/ethnic groups (Latino, non-Hispanic White, non-Hispanic Black, Asian, Native American/Alaska Native (AI/AN), and multiracial) and immigrant generations (first, second, and third-plus) among US adolescents/young adults.
Methods: Final sample sizes were 14015 for wave 3 and 14493 for wave 4. We combined health

indicators into dichotomous variables indicating the presence of (1) physical health conditions (chronic conditions, activity limitations, and obesity) and (2) depression (score of 11 or greater on a 9-item CESD). Models treating each physical condition as an independent variable yielded similar results. Control variables included wave 1, 3, and 4 income; age; gender; and national origin. Using linear regression, we examined how well physical health and depression predicted SRH. We used interaction terms (physical or mental health*race/ethnicity or generation) to determine whether physical health and depression are comparably associated with SRH for all subgroups. We then conducted subgroup analyses for Latinos (n=2278) and Asians (n=959) to examine validity of SRH across generations, within race/ethnicity. Finally, to determine whether physical health and depression explain similar amounts of variance in SRH across racial/ethnic and immigrant subgroups, we conducted linear regression stratified by subgroup, using all health variables, and compared R-squared values.

Results: All measures of health were significantly associated with SRH ($p<.001$); SRH decreased with poorer health. There were no significant interaction terms, indicating that physical and mental health conditions equivalently predicted SRH across racial/ethnic and immigrant generation subgroups. For the full sample, number of chronic conditions, activity limitations, obesity, and depression explained 15.1% of the variance in SRH in wave 3 and 19.6% of the variance in SRH in wave 4. Wave 3 R-squared ranged from .087 (for AI/AN) to .22 (for multiracial); wave 4 R-squared ranged from .15 (for Black) to .28 (for multiracial). Ninety-five percent confidence intervals for racial/ethnic groups overlapped. Health predictors explained a smaller proportion of variance for first generation immigrants (5-12% in wave 3; 9-17% in wave 4).

Conclusions: In this nationally representative dataset, SRH demonstrates good construct validity across immigrant generations and racial/ethnic groups. Therefore, SRH can validly be used for health disparities research among adolescent/young adult populations. This study goes beyond previous studies by analyzing SRH validity for subgroups of adolescents and younger adults and by including American Indians/Alaska Natives and multiracial respondents.

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