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Original article

Improving Access to and Utilization of Adolescent Preventive Health Care: The Perspectives of Adolescents and Parents

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Abstract

Purpose: To examine the perspectives of publicly insured adolescents and their parents on ways to encourage adolescent utilization of preventive health services.

Methods: We conducted eight focus groups with 77 adolescents enrolled in a large Medicaid managed care plan in Los Angeles County, California, and two focus groups with 21 of their parents. Discussions were recorded, transcribed, and analyzed using the constant comparative method of qualitative analysis.

Results: Adolescents and parents reported that the most effective way to encourage preventive care utilization among teens was to directly address provider-level barriers related to the timeliness, privacy, confidentiality, comprehensiveness, and continuity of their preventive care. They reported that incentives (e.g., cash, movie tickets, gift cards) might also be an effective way to increase preventive care utilization. To improve adolescent receipt of surveillance and guidance on sensitive health-related topics, most adolescents suggested that the best way to encourage clinician–adolescent discussion was to increase private face-to-face discussions with a clinician with whom they had a continuous and confidential relationship. Adolescents reported that the use of text messaging, e-mail, and Internet for providing information and counseling on various sensitive health-related topics would also encourage adolescent utilization of preventive health services. Parents, however, more often preferred that their teen receive these services through in-office discussions and clinician-provided brochures.

Conclusions: State agencies, health plans, clinics, and individual providers may consider focusing their efforts to improve adolescents' utilization of preventive services on basic structural and quality of care issues related to the clinician–patient relationship, access to services, and confidentiality.

Keywords: Adolescent health services; Preventive health services; Ambulatory care; utilization

National medical organizations recommend routine preventive care for all adolescents [1,2]. Although the recommended frequency of visits may vary across guidelines, from annually to every 3 years, they all reflect the importance of addressing important health behaviors that are often established during adolescence [3]. Adolescent preventive care provides an opportunity for adolescents to receive information, counseling, and guidance regarding critical health-related behaviors that represent many of the major causes of adolescent morbidity and mortality. Decisions about these behaviors may not only influence health during adolescence, but may also have long-term effects on their health as adults. However, a substantial proportion

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of U.S. adolescents does not routinely utilize preventive care [4–7]; utilization may be especially low among African American youth, Latino youth, and youth living in poverty [4–7]. Even when adolescents do attend preventive visits, studies suggest that most of them do not receive many recommended preventive health services, including counseling and guidance on risky health behaviors [8–10].

Adolescents' perspectives on barriers to preventive care visits have been well studied [8,11–16], and several studies have proposed and examined particular strategies to improve preventive care utilization [17–20]. To develop practical strategies for increasing preventive care utilization among economically vulnerable adolescents, we need a rich and broad understanding of what adolescents and their parents think would work.

We sought to examine the perspectives of low-income adolescents on how healthcare organizations and providers can increase preventive care utilization, and to supplement these data on adolescents with the perspectives of their parents.

Methods

Eligibility and recruitment

Two study recruiters attempted to call 1,164 randomly selected households with adolescent Managed Care Medicaid enrollees in a commercial health plan (enrolled continuously for at least 12 months) living within a 15-mile radius of the plan's community resource center (the focus group site). Eligible adolescents (age, 13–17 years) had parental consent to participate and were selected to provide the desired mix of enrollee age, gender, and primary household language (English or Spanish by parent report). Among households contacted, 394 had a disconnected telephone number and 296 could not be reached after $\geq$ 2 attempts. Recruiters successfully contacted 474 households; 209 adolescents declined to participate, and 62 agreed to participate but had schedule conflicts. The remaining 203 were scheduled on a first-come basis until each of the 8 focus groups had at least 10 scheduled participants. Parents of teens who had already participated in a focus group were invited to participate until 24 parents were scheduled for two focus groups.

Teen groups were stratified by gender, age [13–15,16–17 years], and household primary language; parent groups were stratified by household primary language only. We used this stratification to allow teens with varying levels of preventive care utilization to discuss sensitive topics in groups with same-sex peers and to identify specific issues for teens from Spanish primary language households. All teen focus groups were conducted in English (all adolescents spoke English fluently); one parent focus group was conducted in Spanish.

Study procedures

We conducted a review of published data on adolescent preventive health services, and then developed a focus group discussion guide (see Table 1 for general questions; the full discussion guide is available upon request). It included questions to elicit discussion on three major topics: (1) views on and experiences with preventive visits; (2) ways in which health plans, clinics, and clinicians can help to increase adolescent access to and utilization of preventive visits; and (3) strategies that health plans, clinics, and clinicians can use to encourage teens to discuss important health-related topics during preventive visits. Each topic focused specifically on preventive visits. In the beginning of each group, the facilitator described the preventive visit in detail and mentioned that she would be discussing preventive visits only. Participants discussed multiple examples to help them understand the difference between sick and preventive visits; we reinforced their understanding of preventive visits by asking those with a preventive visit to describe it. The focus group discussion guide included general questions used in every group to elicit participants' views, without first offering specific examples. It also included a number of optional ''probes'' or questions to generate discussion in cases when no ideas were brought up, and to obtain parents' views on adolescent-generated ideas. The RAND Human Subjects Protection Committee approved the study.

The focus groups were held in December 2007 and January 2008; each group included 6–12 participants, lasted approximately 2 hours, and was conducted by an experienced, bilingual focus group moderator. Participants completed a brief demographic survey and received a cash honorarium.

Analysis

Sessions were audiotaped, transcribed, translated if in Spanish, and imported into a qualitative data management software program. Two experienced qualitative coders and 2 authors (T.C. and P.C.) read the first two transcripts and created codes for key points within the text. Through an iterative process, these codes were developed into a codebook using standard procedures [21]. The coders then independently coded each transcript consecutively, and discussed discrepancies and modified the codebook (with T.C.). To measure consistency between coders, we calculated a Cohen's kappa [22] using a randomly selected sample (33%) of quotes (independently coded) from each of the major themes. Kappa scores were 82%–92%, suggesting excellent consistency [23].

Next, the research team performed thematic analysis of the 1,067 unique quotations that dealt with the three major topics. The analysis was based in grounded theory and performed using the constant comparative method of qualitative analysis [21,24]. The team identified the most salient themes; these were the concepts and ideas that emerged from the quotes within each topic. Next, we examined each theme, its frequency and distribution, and patterns within and between the groups. Because we aimed for thematic representation, we present not only consensus, but also key dissenting