bolstered in order to fulfill the needs of adolescents in a safe and effective manner. Overall, study results are encouraging and inform policy efforts to support SBHCs as a critical part of the safety net for adolescents.

Sources of Support: This study was conducted as part of the primary author’s doctoral dissertation work.

HEALTH SERVICES

THE ROLE OF SCHOOL-BASED HEALTH CENTERS IN INCREASING UNIVERSAL AND TARGETED DELIVERY OF PRIMARY AND PREVENTIVE CARE AMONG ADOLESCENTS
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Purpose: School-based health centers (SBHC) can provide comprehensive primary and preventive care for adolescents, ensuring equitable utilization of care and the promise of targeted services for high-risk groups such as youth involved in risk behaviors or youth with chronic health conditions. Although research has described patterns of health service utilization at SBHCs, little is known about how the receipt of services differs among adolescent users. Utilization of primary and preventive care, and perceptions of care received, are correlates of access that are especially important factors among underserved populations more likely to be disconnected from traditional care settings. The purpose of this study was to use a nationally-representative dataset to investigate differences in utilization and perceptions of SBHC care among adolescents.

Methods: This study included responses from a sample of 414 adolescents who participated in the Healthy Schools, Healthy Communities User Survey. Three outcome measures represented utilization of care at SBHCs: (1) had a well-care visit, (2) received a primary care service, and (3) received a preventive service. Four outcome measures represented perceptions of care: (1) would recommend SBHC, (2) SBHC staff communicated effectively, (3) SBHC staff were respectful, and (4) SBHC staff gave time to ask questions. Multivariate logistic regression models were used to examine the effects of sociodemographic and health status (e.g., risk behaviors or chronic health conditions) characteristics on outcome measures.

Results: There were few notable and significant differences in either utilization of primary and preventive care or perceptions of care, based on sociodemographic characteristics, risk behaviors, or chronic health conditions.

Conclusions: SBHCs do appear to be successful at eliminating differences in utilization of care based on gender, race/ethnicity, and insurance status. However, null findings suggest that they fall short in delivering truly comprehensive and efficient care to high-risk adolescents and others who might benefit the most, and may not be capitalizing on opportunities to offer targeted screening or counseling. Encouraging results around positive perceptions of care suggest that adolescents would be amenable to consistent utilization of primary care, counseling, or education services offered at SBHCs. In order to foster continuous care and positive health outcomes among adolescents, SBHC administrators should regularly evaluate their scope of services and support quality improvement efforts. Furthermore, policymakers must support optimal delivery of needed services through sustained funding and reimbursement for the delivery of primary and preventive care.

Sources of Support: This study was conducted as part of the primary author’s doctoral dissertation work.

ARE YOUNG ADULTS USING THE EMERGENCY ROOM FOR NON-URGENT REASONS?
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Purpose: Young adults, between the ages of 18-25, utilize overall health care utilization less frequently than children, adolescents and older adults. When they do access care, they tend to seek ER care more frequently than other age groups. This study examines the immediacy of young adults’ ER visits, differences in immediacy between age groups, and for young adults, the diagnoses associated with these visits.

Methods: Using 2009-2010 National Ambulatory Health Care Surveys (NHAMCS), we examined the proportion of young adults’ ER visits that were triaged as immediate/emergent, urgent, semi-urgent and non-urgent. WE used: 1) bivariate models to compare the proportion of non-urgent ER visit rates among young adults, children and older adults; 2) multivariate logistic regression models to examine young adults’ non-urgent ER visit rates by expected source of payment (private insurance, public insurance and self-paid), adjusted for race/ethnicity and sex; and 3) descriptive analyses to examine the top 10 primary diagnoses using the Agency of Health Research and Quality (AHRQ) Clinical Classification Software (CCS) for young adults’ non-urgent ER visits.

Results: Out of 9,254 ER visits utilized by young adults, 8.4% were triaged as immediate/emergent, 43.1% as urgent, 39.1% as semi-urgent, and 9.3% as non-urgent. Young adults’ non-urgent ER visit rate was significantly higher than adults over age 25 (3.9%-7.7%, p < .001) and similar to children and adolescents (9.5-10.7%, p = .13). There were no differences in the proportion of young adults’ non-urgent ER visits by sex and race/ethnicity. Rates for those with expected payment source of private insurance (6.3%) were significantly lower than those with expected sources of public insurance (10.2%, p < .001) and self-paid (10.4%, p < .01). The top 10 primary CCS diagnoses for non-urgent ER visits by young adults were 1) “other aftercare” (12.1%); 2) sprains and strains (11.1%); 3) superficial injury (6.2%) 4) other non-traumatic joint disorder (5.3%); 5) abdominal pain (5.3%); 6) viral infection (5.2%); 7) teeth and jaw disorder (4.5%); 8) eye infection/inflammation (3.7%); 9) open wounds of head, neck and trunk (2.5%); and 10) anxiety disorders (2.5%). These 10 diagnoses comprised of 58% of all primary diagnoses for non-urgent ER visits among young adults.

Conclusions: Young adults have relatively high rates of non-urgent ER visits when compared to the US adult population. Significant disparities exist in non-urgent ER visit rates by expected source of payment/insurance, with those who had private insurance having the lowest non-urgent ER visit rate. The majority of the top 10 primary diagnoses of non-urgent ER visits among young adults appear to be diagnoses that can be addressed at office-based visits. More studies are needed to examine whether these non-urgent ER visits can be replaced by office-based (urgent care or primary care visits).

Sources of Support: The Maternal and Child Health Bureau, Leadership Education in Adolescent Health Training Grant
Methods: eludicite the causes of high TME in order to identify opportuni
tive was to characterize TME for average cost adolescents and
reducing total medical expense (TME) for a patient population.
New accountable care payment models are focusing on
Purpose: To better understand the time and concomitant financial
burden on private pediatric practices caring for adolescents.
Methods: Kids Health First Pediatric Alliance is a private pediatric
primary care independent practice association (IPA) with approxi-
matelty 260 physicians, nurse practitioners, and physician assis-
tants, located in some 50 sites in the Metro Atlanta area. It cares for
more than 500,000 pediatric and adolescent patients. Over the
year from spring 2012 though winter 2013, we collected pro-
spective data at office visits on 8711 children and adolescents be-
tween 4 and 16 years old who presented for office visits. Each
clinician surveyed the first ten eligible study patients during each
of four seasonal quarters. Analytic Methods: Chi-squared tests
were used to compare time each visit required, age of child, and
existence of psychosocial problems. Frequencies between tables do
not add up because of missing data.
Results: Out of a total of 8711 recorded visits, 2347 visits were for
patients age 12 to 16 years – 1197 of those visits were sick visits;
1125 were well visits. We queried the amount of time each visit
required. 956 of the 2347 adolescent visits took 16+ minutes to
complete (41.3%), compared to 1876 of the 6364 4–11 year old visits
(29.8%) (p < 0.0001, Chi-Square df = 1). Patients identified by the
examining clinician as having new, ongoing, and/or recurrent
psychosocial problems were 478 of 2310 adolescent patients
(20.7%) compared to 861 of 6301 (13.7%) in the 4-11 group (p <
0.0001 Chi-Square, df = 1). The number of visits lasting 16+ min-
utes by adolescents with psychosocial problems was 283 of 472
(60.0%) compared to 470 of 854 (55.0%) for children with psycho-
social issues. (p = 0.0832, Chi-Square df = 1).
Conclusions: There are extended time requirements to care for
adolescent patients compared with a younger patient cohort.
Although there is also a trend toward extended time requirements
for adolescent patients with psychosocial problems over younger
patients with psychosocial problems, the difference is not statis-
tically significant. These data need to be presented to those who
fund pediatric care. An understanding of the extended time needed
to care for children and adolescents with psychosocial issues needs
to be shared with pediatric training program directors developing
workforce plans.
Sources of Support: Self-funded by Kids Health First Pediatric
Alliance.

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YOUTH IN CUSTODIAL FACILITIES: A VULNERABLE POPULATION IN NEED OF SERVICES
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Purpose: Studies show that a large proportion of youths admitted in
custodial facilities have several health problems, usually not
taken care of. Despite the fact that many organizations such as the