

Characteristics Associated with Confidential Consultation for Adolescents in Primary Care

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Objective To examine how provider report of confidential consultation in the electronic health record is associated with adolescent characteristics, health risk factors, and provider training.

Study design This prospective cohort study was conducted as part of a larger study implementing computerized clinical decision support in 2 urban primary care clinics. Adolescents used tablets to complete screening questions for specified risk factors in the waiting room. Adolescent-reported risk factors included sexual activity, substance use, and depressive symptoms. Providers were prompted on encounter forms to address identified risk factors and indicate whether confidential consultation was provided. Provider types included adolescent medicine board certified pediatrics and general pediatrics. Differences in proportions of adolescents reporting risk factors by provider type were assessed using χ^2 tests. Associations between adolescent characteristics, risk factors, and provider-reported confidential consultation were examined using logistic regression analyses.

Results The sample included 1233 English and Spanish-speaking adolescents 12-20 years of age (52% female; 60% black; 50% early adolescent). Patients seen by adolescent medicine board certified providers reported sexual activity, depressive symptoms, and substance use significantly more often than those seen by general pediatric providers. Among patients seen by board certified adolescent medicine providers, confidential consultation was provided to 90%. For those seen by general pediatric providers, confidential consultation was provided to 53%. Results of multiple logistic regression demonstrated that female sex, later adolescence, and clinic location were significantly associated with confidential consultation.

Conclusions Provider training is needed to reinforce the importance of confidential consultation for all adolescents. (*J Pediatr* 2018;■■■:■■■-■■■).

See editorial, p ●●● and related article, p ●●●

Confidential consultation is an essential component of adolescent primary care. Whereas confidential care encompasses an array of confidentiality factors during and after the clinical visit, confidential consultation describes the practice of providers engaging in one-on-one discussions with adolescent patients in clinic without the presence of a parent.¹ Confidential consultation provides adolescents with an opportunity to more comfortably and candidly discuss a variety of sensitive topics with providers.² If adolescents perceive that providers will not maintain confidentiality, they may be deterred from seeking care for more sensitive health concerns, which may adversely impact health outcomes.³ For these reasons, a number of professional organizations, including the Society for Adolescent Health and Medicine² and the American Academy of Pediatrics,⁴ have recommended confidential consultation for adolescents during primary care visits to help promote the highest quality of care and best possible health outcomes.

Studies have previously confirmed that adolescents are more likely to seek care, disclose information about sensitive health risk factors, and return for future care if confidentiality is assured.³ It has also been shown that adolescents who are provided with an opportunity for confidential consultation during their primary care visit are more likely to discuss sensitive topics including substance use, mental health, sexual health, and problems at school with their providers than those who are not.¹ Although a number of studies have shown that adolescents,³ parents,¹ and

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CHICA Child Health Improvement through Computer Automation
PSF Prescreener form
PWS Provider worksheet

providers,^{5,6} all believe confidential care is important, many adolescents are still not provided with an opportunity for confidential consultation in primary care.^{1,5,7}

Increasing the number of adolescents who receive confidential consultation in primary care requires a better understanding of the factors that adversely impact the provision of confidential consultation in this setting. Previous studies have shown that parental attitudes,^{5,6} a lack of provider time,^{3,6} ambiguous confidentiality laws,^{3,6,8} and lack of knowledge about those laws all play a role.⁹⁻¹¹ We sought to examine how recorded provision of confidential consultation in the medical record for a large population of adolescents is associated with (1) demographic characteristics of the adolescent, (2) adolescent self-reports of sensitive risk factors including sexual activity, substance use, and depressive symptoms; and (3) provider training.

Methods

Data for this study were gathered as part of a larger clinical trial focused on the implementation of a computerized clinical decision support system in 2 urban primary care settings within the Eskenazi Health Federally Qualified Health Center system between October 1, 2014 and September 30, 2015.

The clinical decision support system being examined, the Child Health Improvement through Computer Automation (CHICA) system, was designed to integrate information from a patient's electronic medical record with screening data collected in the waiting room and best practice recommendations to generate customized physician decision support.

The adolescent CHICA system automatically generates an individualized tablet-based prescreener form (PSF) upon registration using data from the patient's electronic health record that includes age, developmental stage, current and previous medical conditions, and known risk factors for morbidity. Adolescent patients are then asked to complete a 20-item patient questionnaire on the PSF form that asks questions about their physical and behavioral health including topics such as depression, sexual behaviors, and substance use.

Based upon patient responses to the PSF questions, a tailored provider worksheet (PWS) is printed and given to the provider for consultation during the clinical encounter. This form includes 6 provider prompts, 1 prompt regarding the provision of confidential consultation (**Figure**; available at www.jpeds.com) and 5 additional prompts describing specific health needs identified by patients on the PSF questionnaire. If more than 5 additional needs are identified, CHICA prioritizes which prompts appear using specific patient data combined with national clinical guidelines.^{12,13} Following each prompt are corresponding checkbox responses that allow providers to document data, procedures, prescriptions, referrals, and other actions that take place during the encounter. The completed PWS form is then scanned and uploaded into CHICA by clinical staff after the patient encounter. CHICA analyzes provider responses using optimal mark and character recognition to detect which action items were taken by the provider and then records those actions in a database. Together, the PSF

and PWS provide screening and correlative options for provider follow-up. More detailed technical information about CHICA including rule processing, development of Arden rules, data storage, and implementation can be found in previous publications.¹³⁻¹⁶

A total of 1233 English- and Spanish-speaking youth between the ages of 12 and 20 years at first adolescent primary care visit during the study period were included in the sample. Demographic variables included age (categorized as early adolescence [<15 years of age], middle adolescence [15-17 years of age], and late adolescence/young adult [18-21 years of age]), sex, race/ethnicity, insurance type, clinic, and language preference. Other exposure variables included provider type (adolescent medicine board certified or general pediatric provider), sexual activity (self-reported intercourse or forced sex), substance use (self-reported use of alcohol, tobacco, or marijuana; or self-reported high), and depressive symptoms (self-reported sadness, anhedonia, or thoughts of suicide). Descriptive statistics (frequencies and percentages) were calculated for these variables.

Visits with adolescent board certified providers differed from visits with general pediatric providers not only in terms of training, but also in terms of staffing and visit time. Nursing professionals who work with adolescent medicine board certified physicians have received additional training in adolescent-specific health issues such as confidentiality, mental health, reproductive health, and substance use. From a clinical flow standpoint, visits with adolescent medicine board certified providers in the Eskenazi system are longer than visits with general pediatric providers (20 vs 15 minutes). Nursing professionals working with adolescent medicine board certified physicians also perform between-visit case management and triage with patients, resulting in additional opportunities for rapport-building, screening, and counseling on adolescent health issues. For patients seen by general pediatric providers, only a subset of phone calls are routed to nursing support staff. These structural differences facilitate screening, identification, referral, and case management for adolescent-specific health issues.

The statistical significance of differences in proportions of adolescents reporting sexual activity, substance use, and depressive symptoms seen by each provider type were assessed using the χ^2 test. For all subsequent analyses, the outcome variable was provider-reported provision of confidential consultation. Responses indicating that a visit was fully confidential or partially confidential were grouped as "confidential," and responses indicating that a visit was not confidential for any one of 3 reasons (not wanted, not possible, or not appropriate, as determined by the provider) were grouped as "not confidential." Among adolescents who were seen by general pediatric providers ($N = 1001$), both simple and multivariable logistic regression analyses were performed to examine associations between the 3 categories of health risk factors and the outcome variable for visits at which the confidential consultation question was answered. ORs and 95% CIs were calculated. P values of less than .05 were considered statistically significant. All analyses were done using SAS v 9.4. (SAS Institute, Cary, North Carolina)

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