SEARCHING FOR THE “IDEAL” ADOLESCENT HEALTHCARE VISIT

Charles J. Wibbelsman, MD*

*Chief, The Teenage Clinic, Kaiser Permanente, San Francisco, California.

Address correspondence to: Charles J. Wibbelsman, MD, The Teenage Clinic, Kaiser Permanente, 2200 O’Farrell St, San Francisco, CA 94115-3394. E-mail: charles.wibbelsman@kp.org.

ABSTRACT

Adolescent patients develop at differing rates, and healthcare services for these patients must consider these differences in order to be most effective. Engagement in risky behavior is a hallmark of the adolescent years, and adolescents will generally not discuss such behaviors unless confidentiality can be ensured. Traditional fee-for-service healthcare has tended to alienate the adolescent patient, necessitating that they look for healthcare from outside sources. The group model health maintenance organization (HMO) provides advantages in relation to adolescent medicine. These advantages include a prepaid health plan that facilitates quality confidential care at a one-stop, comprehensive clinic. Two adolescent patient cases in a group model HMO with an emphasis on confidentiality are presented. The first demonstrates how a group model HMO can protect confidentiality when referrals must be made, and the second distinguishes privacy (protecting the patient’s dignity) from confidentiality (protecting the patient’s information).

CONFIDENTIALITY

Most causes of morbidity and mortality in the adolescent population are directly related to risky behaviors that begin during adolescence. The primary causes of mortality during the adolescent years (ages 10 years to 19 years) are injuries, homicide, and suicide; these factors distinguish mortality of this age group from that of all other age groups in the United States. Screening and early detection of risky behaviors are therefore an essential part of the adolescent healthcare visit. Concerns about privacy dictate whether most adolescents are willing to discuss risky or sensitive behaviors. Assurance of confidentiality facilitates diagnosis and treatment of the adolescent patient, as adolescents are more willing to communicate and seek healthcare from physicians who assure confidentiality.

Explaining the protections and limits of confidentiality to adolescents can be difficult for a variety of reasons, including the complexity of and variations in the interpretation of guidelines. In addition, billing and medical record procedures might limit guarantees of confidentiality delivered by the physician. The message of confidentiality must be conveyed in a trustworthy manner that allows the adolescent to understand the guidelines and concepts governing confidentiality.

WHERE ARE ADOLESCENTS GETTING HEALTHCARE AND ADVICE?

A variety of settings provide adolescents with healthcare and medical advice: the traditional family physician fee-for-service office, adolescent clinics in academic settings, county health departments, managed care settings, school counselor offices, and the Internet. Adolescents tend to seek medical care in settings that ensure confidentiality, thus making the patient most comfortable discussing sensitive issues, such as sexual behavior or substance abuse. In the ideal situation, the adolescent would seek healthcare from within the system that provides his or her medical insurance; however, when confidentiality is compromised, perhaps due to differences in state consent laws or administrative restrictions, adolescents might seek medical help from outside the healthcare provided by their insurer.

The adolescent population is inherently at risk for many significant public health concerns; yet, this population faces many barriers to receiving health services. For example, adolescents are more likely than any other age group to be uninsured or underinsured. Additionally, many adolescents with insurance are not able to or willing to use their parents’ policies due to concerns regarding confidentiality or lack of awareness regarding covered services and how to file claims. In an attempt to improve access to healthcare for adolescents, the Society for Adolescent Medicine has proposed that healthcare systems be evaluated for their effect on adolescents based on availability, visibility, quality, confidentiality, affordability, flexibility, and coordination.

WHO PROVIDES HEALTHCARE TO ADOLESCENTS?

Different types of primary care and adolescent medicine physicians provide healthcare to adolescents. Results of a survey conducted in a health maintenance organization (HMO) and published over a decade ago suggest that the majority of internists and pediatricians felt only fair to poor in competence on a variety of adolescent conditions. These results contradicted the belief that pediatricians are appropriately trained to provide adolescent healthcare. Aside from adolescent medicine specialists, family practitioners treat the

<table>
<thead>
<tr>
<th>Specialty (%)</th>
<th>Internal Medicine (n = 163)</th>
<th>Family Practice (n = 126)</th>
<th>Pediatrics (n = 135)</th>
<th>Obstetrics/Gynecology (n = 79)</th>
<th>Adolescent Medicine (n = 12)</th>
<th>Total (n = 575)</th>
<th>P value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for use</td>
<td>Consultation 67 (66)</td>
<td>74 (68)</td>
<td>42 (48)</td>
<td>42 (48)</td>
<td>68 (68)</td>
<td>68 (68)</td>
<td>.164</td>
</tr>
<tr>
<td></td>
<td>Primary care 35 (33)</td>
<td>44 (48)</td>
<td>42 (48)</td>
<td>42 (48)</td>
<td>34 (34)</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education 55 (52)</td>
<td>52 (68)</td>
<td>33 (33)</td>
<td>60 (60)</td>
<td>&lt;.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not used 8 (8)</td>
<td>17 (17)</td>
<td>5 (5)</td>
<td>8 (8)</td>
<td>&lt;.001</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The greatest number of adolescent patients and rate themselves as most knowledgeable and competent in areas of adolescent healthcare. Most clinicians who care for adolescents understand the importance of providing services designed specifically with the developmental needs of the adolescent in mind. The concept of a teen health center that could provide resources for consultation, education, and, to a limited extent, primary care of adolescents has been reported to be well accepted by primary care physicians (Table 1).9

A more recent survey conducted in a California group model HMO queried pediatricians regarding their preventive services to adolescent patients during routine nonacute-care visits.10 Physicians who saw adolescents as patients were also included in the survey and were asked to provide information regarding screening of these patients in 24 recommended areas. In general, the pediatricians reported higher screening rates in areas of immunization, blood pressure, and school performance; however, screening for use of smokeless tobacco, sexual orientation, sexual and physical abuse, and alcohol use while riding a bike or swimming occurred less often (Table 2).10 Additionally, compared with physicians who saw older adolescents, pediatricians who saw younger adolescents (aged 12 years to 13 years) were less likely to screen for sexual intercourse, alcohol, tobacco and other drug use, access to handguns, consistency of seatbelt use, and risk of suicide. This finding is exceptionally unfortunate, because risky behavior in adolescents can occur in these younger patients, and adolescent patients who are educated about the dangers of such behavior before the behaviors begin are less likely to undertake hazardous activities. Also, if trust is established early in the relationship between the young adolescent and the physician, the adolescent will be more likely to discuss sensitive issues with the physician in the future.

Because many primary care physicians feel unprepared to screen adolescent patients about risky behaviors, investigators have been directing efforts toward determining how to best educate these physicians about adolescent issues. A study within Kaiser Permanente in Northern California recently demonstrated how pediatricians can increase their skills in interviewing adolescents and identifying at-risk patients.11 This skills-based training, which included didactic, discussion, demonstration role plays, and interactive role plays, provided effective intervention skills that allowed for an increase in the screening of adolescent patients in 5 key risky behavior areas (Table 3).11

### Table 2. Percentage of Pediatricians Providing Screening and Education to Adolescent Patients

<table>
<thead>
<tr>
<th>Areas of Screening</th>
<th>Adolescent Patients Screened</th>
<th>Physicians Reporting Providing Service to All Adolescent Patients</th>
<th>Mean (SD), %</th>
<th>Mean %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization status</td>
<td>92 (20)</td>
<td>76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>92 (21)</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating disorders</td>
<td>41 (37)</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>78 (33)</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>68 (34)</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>17 (29)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>15 (26)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close friends sexually active</td>
<td>26 (33)</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use</td>
<td>70 (36)</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use while driving</td>
<td>47 (41)</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol use while riding a bike or swimming</td>
<td>11 (24)</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close friends' use of alcohol</td>
<td>40 (39)</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cigarette use</td>
<td>77 (33)</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smokeless tobacco use</td>
<td>19 (31)</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family members' use of tobacco</td>
<td>55 (39)</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close friends' use of tobacco</td>
<td>41 (40)</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illicit drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Illicit substance use</td>
<td>70 (35)</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>14 (26)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to handguns</td>
<td>30 (37)</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistency of seatbelt use</td>
<td>59 (42)</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistency of helmet use</td>
<td>57 (38)</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health and school performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>46 (36)</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>35 (37)</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School performance</td>
<td>85 (25)</td>
<td>8</td>
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</table>

MANAGED CARE (HMO) MODEL FOR ADOLESCENT HEALTHCARE

In the fee-for-service setting, adolescents seeking healthcare are faced with some advantages, such as a family physician who knows the family and the adolescent, and some disadvantages, such as bills for services sent to the parents, making confidentiality hard to provide. The replacement of traditional fee-for-service healthcare delivery systems by managed care has been a gradual process, starting over 3 decades ago, and different types of managed care exist today. The 3 original managed care plans were managed fee-for-service, preferred provider organizations, and HMOs. Currently, prepaid managed care is the dominant method of healthcare financing and service delivery.

There are 6 common types of HMOs, which differ by their makeup of physicians (contractors or employees) and fees (negotiated prices within the network or higher deductibles outside of the network). Many group/staff model HMOs have provided structured and confidential care to adolescents for more than 30 years. One example of the group model HMO is Kaiser Permanente, which provides one-stop, easy access, comprehensive, confidential care, including preventive medicine, inpatient care, and outpatient care. In this type of healthcare delivery (a group model HMO), a group of physicians contracts each year with a health plan, and patients (the health plan members) are seen by those physicians exclusively. This system may allow for referrals to specialists within the plan, thus further protecting confidentiality.

The Teenage Clinic at Kaiser Permanente in San Francisco was started in 1955 by Dr Sol Cohen, a pediatrician with the Permanente Medical Group in San Francisco. Today, Kaiser Permanente has more than 15 Teenage Clinics in 4 geographic regions across the United States with more than 4000 adolescent visits annually. This prepaid system allows adolescents to seek confidential care for the most sensitive issues without worrying about medical bills being sent to the home. The Teen and Young Adult Health Centers of Kaiser Permanente provide the following services for adolescent health: routine medical care, services related to sexuality and reproduction, violent behavior, and emotional and mental health (Figure).
Education and counseling are important attributes to this teen health center. Allied health services providers, such as nutritionists, sports medicine specialists, and substance abuse counselors, are integral members of the healthcare team. Quality of care, patient satisfaction, and utilization/costs are evaluated in the center, and the effect on morbidity and mortality is being evaluated. Cost-effective care in this model was demonstrated in 2002. That year, Kaiser Permanente in both Northern and Southern California waived the copayment for emergency contraception and injectable contraceptives, because cost analysis demonstrated that the cost to the healthcare delivery system of unintended pregnancies far outweighed the loss of income from such copayments.

**Patient Cases**

**Case 1**

**History**

An 18-year-old male comes into the clinic for a routine baseball physical examination. The patient is an only child, attends a reputable preparatory school, has good grades, has a supportive family, and is athletic.

**Evaluation**

A careful one-on-one confidential history and examination are performed. The physician includes as a key component to this visit disclosure of the confidentiality agreement by explaining it in a language the adolescent can understand. The explanation includes a statement by the physician that if anything the adolescent discloses could result in harm to himself or another person, then the contract of confidentiality cannot bind. Also, the patient is queried for screening purposes and then educated regarding risky behaviors.

**Outcome**

When asked if his friends drink and if they have ever asked him to drink, the patient reveals that he drinks heavily with his friends after the games on Fridays and reports binge drinking on occasion. The patient feels this drinking is “no big deal; all of my friends are with me, and we would not do anything stupid.” The physician counsels the patient about the risks of drinking and queries him about driving or swimming after episodes of drinking. The patient indicates that he generally does not drive himself home after these parties.

**Discussion**

Due to the high incidence of heavy drinking, even binge drinking, this patient needs referral to a chemical dependency and recovery program and possibly to a counselor in substance abuse. Within a group model HMO, the programs needed are readily available, and no referral to an outside practice is necessary, thus keeping expenses low and confidentiality high. Teens that abuse alcohol are at greater risk for abusing other substances and at greater risk for morbidity/mortality. This and future discussions with the adolescent therefore include screening for other substance abuse. Because the practitioner finds no signs of imminent harm to the adolescent patient, the practitioner keeps the findings of this healthcare visit confidential.

**Case 2**

**History**

A 14-year-old female presents for a routine annual visit and needs a school form completed. The patient is the youngest child in her family, has 4 siblings, and has acceptable grades. Both of her parents work outside the home.

**Evaluation**

A careful one-on-one confidential history and noninvasive examination at this well-care visit are performed.

**Outcome**

The evaluation reveals that the patient has been sexually active for the past 2 years, has a history of 3 sexual partners, has had no STD screening in the past, and does not use contraception other than occasional condom use. The physician also determines that this patient has a poor body image and has engaged in occasional episodes of bulimia.

**Discussion**

A discussion of confidentiality takes place between the provider and the adolescent patient, and an important distinction between privacy and confidentiality is made. In the healthcare setting, privacy for the patient has to do with respecting the patient’s dignity by performing the physical examination and discussions without the parent or legal guardian being present; confidentiality is an agreement between the patient and physician that information...
discussed during or after the patient visit will not be
shared with other parties without the explicit per-
m ission of the patient unless harm could come to
the patient or another person.

This young sexually active girl is at risk for con-
tacting or spreading STDs and is screened for Chlamydia trachomatis infection. The provider
educates the patient and provides urine-based non-
invasive screening for this common STD. Pelvic
examinations can be stressful for young patients, and the US Preventive Services Task Force recently
issued new cervical cancer screening guidelines that
recommend a Pap smear to be performed within 3
years of a woman's sexual debut. Although the
pediatrician has identified the patient as sexually
active, the Pap smear does not have to be performed
at this particular visit. Rather, screening for chlamy-
dia and gonorrhea with a noninvasive urine test is
performed at this visit. The adolescent can resched-
ule a return visit on her own, at a later time, for a
pelvic examination and Pap smear. It is also impor-
tant to obtain a confidential phone number from
such a patient at this return visit if you should need
to reach her with test results. Often a cell-phone
number, beeper, "safe" phone number, or even a pri-
 vate call to her at school can ensure this confiden-
tial communication.

This patient is also at risk for pregnancy, so she is
counseled regarding contraception and is offered
oral contraceptives at this visit. The adolescent is
couraged to make a confidential follow-up
appointment; at that follow-up appointment, when
the gynecologic examination takes place, arrange-
ments for conveying test results in a manner that will
not disrupt the confidentiality agreement should be
discussed. Also at this follow-up appointment, the
physician can discuss the prescribed contraceptive
method with the patient, answer any questions she
has, and assess compliance.

The patient is referred to psychiatry because of her
tendency toward bulimia. Eating disorders in adoles-
cent patients should be taken seriously, with immedi-
ate intervention, due to the high potential for
irreversible effects associated with such disorders.

O pportunities for Future Improvement
 Families and adolescents need improved education
regarding the availability of a given health plans ser-
 vices specifically designed to meet an adolescent’s
needs. This education might help parents decide
which healthcare plan to select for their family and
should educate the adolescent about available health
service options. All healthcare visits with adolescents,
especially well-care visits, are prime opportunities for
the physician to screen and educate the patient regard-
 ing risky behaviors. Improvements in adolescent
healthcare can also be gained by skills-based training
of physicians who feel uncomfortable screening for
risky behaviors involving sexuality and drug use in the
adolescent patient.

Concl usion
 Provision of quality, confidential, and compre-
hensive healthcare to adolescents is of paramount
importance. Many adolescents undertake risky
behaviors that might result in morbidity and mort-
ality. Habits of adolescents, including those involv-
ing healthy and unhealthy decisions, commonly
continue into adulthood; therefore, early interven-
tion and education of adolescents might have long-
term beneficial effects. The group model HMO is a
prepaid health plan that serves as an example of an
ideal model of top quality primary and comprehen-
sive care for the adolescent. Prepaid group model
services allow adolescents to obtain confidential
care for healthcare issues, including even the most
sensitive issues, without potential risks to confiden-
tiality by means such as medical bills being sent to
the home.

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