Differences in Receipt of Time Alone with Healthcare Providers Among US Youth Ages 12–17

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Background: Time to meet privately with a health care provider can support optimal adolescent health, but numerous barriers exist to implementing this practice routinely.

Methods: We examined parent reports on their children aged 12 to 17 from a nationally generalizable sample to quantify the presence of time alone with health care providers at the state and national level, as well as socio-contextual correlates using logistic regression analysis.

Results: We estimated that only 1 in 2 adolescents had a confidential discussion at their last medical visit. Certain child, family, and health care factors were associated with lower likelihood for having had confidential discussions. Specifically, adolescents who were Asian; did not have mental, emotional, or behavioral problems; were uninsured; or lived in households with parents who were immigrants, less educated, or did not speak English had significantly lower odds for having had time alone compared with referent groups.

Discussion: Clinical and structural efforts to rectify these gaps may assist a broader share of youth in benefiting from private health care discussions with providers. (J Am Board Fam Med 2024;37:309–315.)

Keywords: Access to Health Care, Adolescent, Adolescent Health, Confidentiality, Health Services Accessibility, Logistic Regression, National Survey of Children's Health, Primary Health Care

Background

The opportunity to privately meet with one's health care provider is a cornerstone of effective adolescent medicine.^{1–3} Adolescence is a phase of numerous biological and psychosocial changes, characterized by burgeoning autonomy, increased medical decision making and self-management, and in some cases greater risk behaviors.^{4–5} Confidential discussions without caregivers present provide an opportunity to explore and counsel adolescents on a range of key topics, including family and social relationships, gender and sexuality, sexual risk and protective behaviors, substance use, mental health, and puberty.^{5–7} Adolescents who are afforded such private visits

experience more positive perceptions toward providers, and are more willing to discuss sensitive topics and return for services.⁸⁻⁹

Despite its importance and inclusion in authoritative pediatric guidelines, numerous barriers may impede health care providers' ability to engage in private time alone with adolescents. For example, health care providers are variably experienced with engaging adolescents on sensitive health topics such as sexual activity in a developmentally appropriate manner.^{2,8,10} Limited time available for visits may also result in providers foregoing or deferring confidential time.^{2,7} Structurally, heterogeneity in laws, policies, and professional guidelines concerning minor consent or confidentiality can further hinder providers' ability to carry out the practice.^{2,11}

Previous national studies have identified certain factors that correlate with receipt of confidential visits among young people. Grilo and colleagues identified that adolescents' age, race/ethnicity, risk behaviors, and household income was associated with lifetime prevalence of experiencing private time with their primary care provider, as well as the

This article was externally peer reviewed.

Submitted 7 June 2023; revised 10 November 2023; accepted 13 November 2023.

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Conflict of interest: The author has no conflicts of interest to report.

Funding: The author received no funding for this work.

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provider's gender and years of experience.¹¹ Edman et al. observed that younger, female, and Hispanic teenagers were less likely to receive confidential visits.¹² These studies provide a foundation for understanding confidential care access in the US, but additional research capturing family (eg, primary household language) and health care (eg, insurance status) dimensions of youth's lives is needed to better distinguish which families are not yet receiving this vital aspect of care.

Methods

Sample

We examined data on children ages 12 to 17 (n = 20,014) participating in the 2018 to 2019 National Survey of Children's Health (NSCH), who possessed valid data on confidential discussions with providers. The NSCH is a web and mail-based survey completed by parents or caregivers of a randomly selected child aged 0 to 17 in the household, described in-depth elsewhere.^{13–14}

Measures

Time Alone with Health Care Provider

Our primary dependent variable was assessed by an item asking the adolescents' parent, "at his or her LAST medical care visit, did this child have a chance to speak with a doctor or other health care provider privately, without [parent] or another caregiver in the room?" Respondents reporting "yes" were classified as having had private, confidential time alone with a health care provider.

Socio-Contextual Factors

Caregivers reported on various factors of the index child across the social ecology. For the current study, we focused on select child, family, and health care characteristics. Child factors included child sex, race/ethnicity (Asian, Black, Hispanic/Latinx, Other, White), special health care needs status, and whether they had mental, emotional, or behavioral (MEB) problems (see Table 1).¹³ Of note, we included the socio-cultural construct of race/ethnicity to understand potential differences in receiving confidential visits patterned by structural determinants of health.

Family factors included parental nativity, highest level of parental education, household primary language, and household income (based on federal poverty level [FPL] categories). Parental nativity was defined based on whether at least 1 caregiver was born outside of the US versus no parent born outside the US Household language was dichotomized based on whether the primary family language was English or not.¹³

Health care factors included medical home, insurance status (insured or not insured), and insurance adequacy. Whether adolescents belonged to a medical home was determined based on whether participants affirmatively endorsed receiving each of the following: a personal doctor or nurse, a usual source for sick care, and receiving "family-centered" care. Adolescents who needed referrals or care coordination also had to deny problems with these components.¹³ Adolescents' insurance was deemed adequate if caregivers reported that the young person currently had coverage, the coverage was sufficient to meet their needs, and permitted them to see needed providers. Caregivers also needed to report that they did not pay for out-ofpocket expenses or the costs they did pay were "usually" or "always" reasonable.¹³

Data Analysis

We estimated the prevalence and 95% confidence intervals (CIs) of time alone with health care providers at the state, regional (based on Health Resources and Services Administration (HRSA) administrative divisions), and national level. Next, we calculated nationwide odds ratios (ORs) and 95% CIs for likelihood of confidential health care discussions in relation to child, family, and health care correlates. Data were analyzed using complex sample weights to permit estimates generalizable to all US Noninstitutionalized 12- to 17-year-olds. The University of Minnesota institutional review board deemed the study not human subjects research.

Results

The overall prevalence of having had time alone with a health care provider at youth's last medical visit was 53.5% (95% CI: 52.0, 55.1). State-specific variation ranged from 32.8% (Utah) to 76.5% (Vermont). At the regional level we observed that HRSA region VI, generally encompassing the south central region of the US, had the lowest prevalence (45.4%) whereas HRSA region I, approximating the northeast states, had the highest (71.8%; Appendices 1–2). In general, there were differences in prevalence of confidential time alone across

	Time Alone at Last Health Care Visit% (95% CI)	Odds Ratio (95% CI)
Overall	53.5 (52.0–55.1)	_
Child		
Sex		
Female	53.9 (51.7-56.1)	Ref
Male	53.2 (51.1–55.3)	0.97 (0.82-1.16)
Race/ethnicity		
Hispanic/Latinx	50.3 (45.7–54.9)	0.84 (0.70-1.00)
White NH	54.7 (53.2–56.1)	Ref
Black NH	55.7 (51.1-60.2)	1.04 (0.87-1.24)
Asian NH*	49.6 (43.2–56.0)	0.82 (0.68–0.97)
Other NH	54.2 (49.0–59.4)	0.98 (0.82–1.17)
Special health care needs		
Yes	56.3 (53.6-59.0)	Ref
No	52.4 (50.5–54.2)	0.85 (0.72-1.02)
Mental, emotional, or behavioral problems ^a		
Yes	58.8 (56.2–61.3)	Ref
No*	51.4 (49.5–53.3)	0.74 (0.62–0.88)
Family		
Parental nativity		
Parent(s) born in U.S.	54.6 (53.0–56.2)	Ref
>1 parent born outside U.S.*	48.7 (44.7–52.7)	0.79 (0.66-0.94)
Parental highest education		
Less than high school	45.1 (36.8–53.7)	0.63 (0.53-0.75)
High school or equivalent	48.3 (44.3–52.4)	0.72 (0.60–0.86)
Some college or technical school	54.1 (51.3–56.9)	0.91 (0.76–1.08)
College degree or higher	56.5 (54.7–58.3)	Ref
Household language		
English	55.0 (53.5-56.4)	Ref
Not English*	42.2 (35.8–48.8)	0.60 (0.50-0.71)
Household income		
<100% FPL (lowest)*	47.5 (42.8–52.3)	0.68 (0.57-0.81)
100 to 199% FPL	54.9 (51.0–58.8)	0.91 (0.77-1.09)
200 to 399% FPL*	51.6 (49.0–54.3)	0.80 (0.67–0.96)
>400% FPL (highest)	57.1 (55.0–59.2)	Ref
Health Care		
Medical home		
Yes	54.4 (52.5–56.4)	Ref
No	52.7 (50.4–55.0)	0.94 (0.78-1.11)
Health insurance status		
Insured	54.1 (52.6–55.7)	Ref
Not insured*	41.6 (34.2–49.4)	0.60 (0.51-0.72)
Health insurance adequacy		
Adequate	55.0 (53.1–56.9)	Ref
Not adequate	50.8 (48.2–53.4)	0.85 (0.71-1.01)

Table 1. Prevalence and Odds Ratios of Time Alone with Health Care Provider at Last Visit Among Adolescents Ages 12–17—United States, 2018–2019

Notes. *Significantly different effect estimate from logistic regression (P < .05). ^aRespondents were classified as having a mental, emotional, or behavioral problem if they responded yes to at least 1 of 10 conditions: Tourette syndrome, anxiety, depression, behavioral or conduct problem, developmental delay, intellectual disability, speech or other language disorder, learning disability, Autism Spectrum Disorder or Attention Deficit/Hyperactivity Disorder.

Abbreviations: NH, non-Hispanic; FPL, federal poverty level; CI, confidence interval.

socio-ecological levels, and these differences were further borne out in regression analyses (Table 1).

Among child-level factors, we observed that odds for time alone were not significantly different by sex or special health care need status. For race/ ethnicity, Hispanic/Latinx and Asian youth had lower rates of confidential health care discussions than the population average, whereas White, Black, and Other youth had higher rates. Odds for time alone were significantly lower for Asian youth compared with White youth (OR: 0.82, 95% CI: 0.68– 0.97); all other ethnic groups were not found to be significantly different from White youth despite absolute differences. In addition, there were significantly lower odds for time alone for children without MEB problems compared with those with MEB problems.

At the family level, we observed 21% lowered odds for time alone among students in households with ≥ 1 immigrant parent. Similarly, odds were 40% lower for households where English was not the primary language (OR: 0.60, 95% CI: 0.50– 0.71). Although time alone rates generally increased with parent education, odds were not significantly lower for children of parents with lower education compared with those parents who completed college or more. Time alone also varied by family income, and there were significantly lower odds for families with household incomes <100% FPL and 200 to 399% FPL compared with those in the highest income group (>400% FPL).

Finally, access to health care resources including a medical home, health insurance, and insurance deemed as adequate generally evidenced higher rates of receiving private time alone. However, among these 3 factors we observed significantly lower odds for time alone only for youth without insurance compared with those with insurance (OR: 0.60, 95% CI: 0.51, 0.72).

Discussion

In this nationwide analysis, we estimated that only roughly half of adolescents had private time alone with a health care provider at their last visit. Further, across multiple measures, adolescents in less socially advantaged households (ie, lower income, lower parent education, non-English speaking, immigrant parents, and uninsured) had significantly lower likelihood for having had such confidential visits. Geographically, there tended to be lower rates of time alone among youth in the south central and southeastern regions of the country. Findings underscore that despite broadly increased uptake of this practice, health care providers and systems have further progress to make.

Our findings can be situated against prior data on who gets confidential health care discussions. Edman and colleagues' analysis of the same agegroup in another data source documented lower rates of confidential discussions for female and Hispanic adolescents.¹² In contrast, we did not observe statistically significant differences between female versus male vouth or Hispanic/Latinx versus White vouth. Another finding is that Asian adolescents in our study were less likely than White counterparts to have received confidential care, consistent with prior results showing Asian, Native Hawaiian, and Pacific Islander youth reported greater barriers to sexual and reproductive health services¹⁵ and encounter barriers to discussing sensitive topics due to cultural factors like perceived stigma.¹⁶ Finally, we found that adolescents without MEB disorders had lower likelihood for confidential visits compared with those with these conditions; although this may reflect providers' greater recognition of the need for private time in light of MEB conditions,³ according the practice only for youth with pre-existing diagnoses may result in missed opportunities to identify emergent needs.

Practice Implications

The findings outline considerations for providers and the organizations in which they practice. First, providers should be mindful of offering time alone to all adolescent patients, regardless of baseline medical or psychosocial risk, to ensure adequate access for all youth. Strategies to engage and educate parents on the value of confidential care can also be helpful.^{9,17} At a systems level, providers need institutional support to implement this practice effectively and equitably in routine clinical care. Intentional blocking of additional time for adolescent visits may be an option, as would clinical workflow innovations such as electronic health record flags, or "opt-out" protocols for rooming adolescent patients alone by default. Focusing educational or clinical interventions into settings that serve large proportions of low-income, uninsured, or non-English language preference patient families (eg, federally qualified health centers) could help narrow the disparities we document here. Further, the marked variation we found across geographic

regions highlights the potential for best practice sharing across jurisdictions and health systems. Also, our finding that youth without insurance were less likely to access private time alone implicates the importance of state and federal policies to expand insurance coverage for children.

This report has limitations. Our cross-sectional analysis allowed us to examine differences in receipt of confidential care but precludes causal interpretations. The NSCH is also parent-reported, which could have introduced social desirability and recall biases, and has limitations inherent to the survey instrument, such as a paucity of a nonbinary sex category. Further, parent survey respondents may not always be the same individuals who accompanied youth to health care visits (eg, siblings), and the validity of this measure is not yet known. Inclusion of youth's and clinician's perspectives into future studies could help address these limitations and further contextualize our findings.

Ultimately, this study adds new data on adolescents' receipt of confidential care in the US. The findings cast light on the unrealized opportunity to offer private visits with all adolescents, especially those who come from less socially advantaged backgrounds.

The author thanks Donte Fields for analytic feedback and manuscript review.

To see this article online, please go to: http://jabfm.org/content/ 37/2/309.full.

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Appendix

State	Time Alone at Last Healthcare Visit%
Alabama	39.2
Alaska	66.3
Arizona	38.5
Arkansas	37.9
California	53.5
Colorado	65.1
Connecticut	67.5
Delaware	58.1
District of Columbia	64.9
Florida	41.1
Georgia	53.0
Hawaii	61.4
Idaho	47.6
Illinois	57.5
Indiana	47.6
Iowa	56.8
Kansas	55.6
Kentucky	51.4
Louisiana	37.2
Maine	67.4
Maryland	59.5
Massachusetts	74.9
Michigan	55.7
Minnesota	62.4
Mississippi	40.0
Missouri	49.2
Montana	55.9
Nebraska	63.0
Nevada	42.4
New Hampshire	72.0
New Jersev	56.5
New Mexico	48.6
New York	65.1
North Carolina	57.7
North Dakota	62.7
Ohio	53.1
Oklahoma	44.0
Oregon	69.2
Pennsylvania	58.2
Rhode Island	68.5
South Carolina	46.5
South Dakota	51.0
Tennessee	50.2
Texas	47.4
Utah	32.8

Appendix Table 1. Prevalence of Time Alone with Health Care Provider at Last Visit Among Adolescents Ages 12– 17, by state—United States, 2018–2019

Continued

Appendix Table 1. Continued

State	Time Alone at Last Healthcare Visit%
Vermont	76.5
Virginia	47.7
Washington	61.1
West Virginia	60.8
Wisconsin	57.5
Wyoming	53.8

Appendix Table 2. Prevalence of Time Alone With Health Care Provider At Last Visit Among Adolescents Ages 12– 17, by Health Resources and Services Administration Region—United States, 2018–2019

Health Resources and Services Administration Region	Time Alone at Last Healthcare Visit	
I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)	71.8 (68.4–74.9)	
II (New York, New Jersey, U.S. Virgin Islands, Puerto Rico)	62.4 (57.0–67.6)	
III (Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia)	55.6 (52.1–59.1)	
IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)	47.9 (45.0–50.8)	
V (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)	55.4 (52.3–58.4)	
VI (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)	45.4 (40.1–50.8)	
VII (Iowa, Missouri, Nebraska, Kansas)	54.4 (51.1–57.8)	
VIII (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)	53.1 (49.3–56.9)	
IX (Arizona, California, Hawaii, Nevada, Pacific Islands [American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau])	51.1 (45.2–56.9)	
X (Alaska, Idaho, Oregon, Washington)	61.5 (57.1–65.8)	