Report on a QI Project Eligible for Part IV MOC

Improving the Delivery of Confidential Care to Adolescent Patients

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

Completing the report. The report documents completion of each phase of the QI project. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste ☑ over the blank box.

For further information and to submit completed applications, contact either:
- Grant Greenberg, MD, UMHS Part IV Program Lead, 763-232-6222, ggreenbe@med.umich.edu
- R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
- Ellen Patrick, UMHS Part IV Program Administrator, 734-936-9771, partivmoc@umich.edu

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 9/21/2015

2. Title of QI project: Improving the delivery of confidential care to adolescent patients.

3. Time frame
   a. Date physicians begin participating (may be in design phase): 9/1/2014
   b. End date: 9/15/2015

4. Key individuals
   a. QI project leader [also responsible for attesting to the participation of physicians in the project]
      Name: Margaret Riley, MD
      Title: Medical Director, Adolescent Health Initiative
      Organizational unit: Family Medicine
      Phone number: 734-998-2163
      Email address: marriley@med.umich.edu
      Mailing address: 2025 Traverwood Dr, Suite A6 Ann Arbor, MI 48105
   a. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/"sponsoring" the project within the specific clinical setting]
      Name: Terrill Bravender, MD
      Title: Division Chief
      Organizational unit: Division of Adolescent Medicine, Department of Pediatrics
      Phone number:
      Email address: tdbrave@med.umich.edu
      Mailing address:

5. Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?
   15 Family Medicine
   23 Pediatrics
   6 Medicine-Pediatrics
   = 44 Total

6. Will the funding and resources for the project come only from internal UMHS sources?
   □ Yes, only internal UMHS sources
   x No, funding and/or resources will come in part from sources outside UMHS, which are: Michigan Department of Health and Human Services Grant

The Multi-Specialty Part IV MOC Program requires that projects engage in change efforts over time, including at least three cycles of data collection with feedback to physicians and review of project results. Some projects may have only three cycles while others, particularly those involving rapid cycle improvement, may have several more cycles. The items below are intended to provide some flexibility in describing project methods. If the items do not allow you to reasonably describe the methods of your specific project, please contact the UMHS Part IV MOC Program office.

B. Plan

7. General goal
a. Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?
Adolescent patients frequently do not receive recommended confidential care resulting in missed opportunities for addressing health concerns specific to this age group. Physicians support confidential care for adolescent patients, but have knowledge gaps around Michigan’s minor consent and parental notification laws. Confidential care may also be difficult to provide in a busy ambulatory care setting with parents present.

b. Physician’s role. What is the physician’s role related to this problem?
The American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the Society for Adolescent Health and Medicine (SAHM) recommend that physicians spend confidential time with adolescent patients, and perform comprehensive risk screening for high risk behaviors. Physicians need to feel confident and be able to (1) initiate time alone with adolescent patients and (2) have confidential discussions about risky behaviors while appropriately navigating relationships with parents and legal issues around confidential care. Physicians additionally need to use a standardized approach for risk screening in adolescent patients, and build workflows into clinic to allow adolescents to complete the risk screening confidentially.

c. Project goal. What general outcome regarding the problem should result from this project? (Specific aims/targets are addressed in #12b.)
Physicians will improve the provision of confidential care to minor adolescents by more frequently spending time alone with adolescents during an annual well child visit, explaining confidentiality laws to the patient, and performing confidential risk screening.

8. Patient population. What patient population does this project address.
Patients ages 12-17 in participating Pediatrics, Family Medicine, and Medicine-Pediatrics practices.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]
   x Effectiveness
   x Equity
   x Patient-Centeredness
   □ Safety
   □ Timeliness

10. What is the experimental design for the project?
   x Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
   □ Pre-post comparisons with control group
   □ Other: _____________________________

11. Baseline measures of performance:
   a. What measures of quality are used? If rate or %, what are the denominator and numerator?
The three main outcome measures were the percent of visits during which a targeted care activity was performed.
   Denominator for all three measures: 20 patient charts of adolescents seen for annual exams (or the total number seen in the past 3 months if less than 20).
   Numerator for each measure: the number of visits for which:
   a. the adolescent patient has confidential time with the physician
   b. confidentiality laws/limits were explained to the adolescent patient
   c. the patient confidentially completed a standardized risk screening assessment

   When performing chart reviews to collect data for primary measures physicians also completed surveys measuring relevant clinic practices and processes that facilitate or impede confidential care for patients. Physicians used the UMHS Adolescent Health Initiative’s Adolescent Centered Environment (ACE) assessment tool to assesses seven measures:
   • Has an adolescent confidentiality policy displayed in the waiting room and/or exam rooms.
   • Provides both visual and auditory privacy for the registration/check-in process.
• I am knowledgeable about confidentiality for minor patients including state laws regarding a minor’s ability to consent for specific services and when parental notification is mandated.
• I discuss the protections and limitations of confidentiality with every adolescent patient.
• I provide time alone with adolescent patients at least yearly to offer a change to speak on confidential subjects.
• When Possible, I bill the adolescent’s insurance for my time using non-confidential cosdes, so than and Explanation of Benefits (DOB) form sent to the parents will not display confidential services received by the adolescent.
• I get a cell number and/or private email address for adolescents to remind them of appointments or get in touch with them about test results.

These items are rated on a 3-point scale: 0 = does not comply, 1 = partially complies, 2 = completely complies.

These ratings helped physicians evaluate root causes of problems and consider changes related to the delivery of the three main measures of confidential care for adolescents.

b. Are the measures nationally endorsed? If not, why were they chosen?
No nationally endorsed measures exist for confidentiality, but confidential care is endorsed by the AAP, AAFP, and SAHM.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?
Medical records and physician self-evaluation forms.

d. What methods were used to collect the data (e.g., abstraction, data analyst)?
Physician completion of medical chart review and self-evaluation tool.

e. For what time period was the sample collected for baseline data?
July 1st, 2014 – September 30th, 2014

12. Specific performance objectives

a. What was the overall performance level(s) at baseline? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

On the last page of this report see the first data column of Tables 1 and 2.

b. Specific aim: What was the target for performance on the measure(s) and the timeframe for achieving the target?
The targets for the three main performance measures are that 95% of adolescent patients seen for well child checks will have physicians (a) spend time alone with, (b) explain minor consent laws, and (c) complete confidential risk screening. Physicians will work to reach these goals from November 1st, 2014 through July 31st, 2015.

No specific targets were set for the measures of clinic practices and processes. Although improvement is expected, these scores primarily guide the assessment of causes and the development of interventions to improve the main performance measures.

c. How were the performance targets determined, e.g., regional or national benchmarks?
The target was set at 95% based on experience in clinic. Occasionally risk screening is not appropriate or possible (i.e. a special needs adolescent unable to independently complete risk screening tool).

13. Data review and identifying underlying (root) causes.
a. Who was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions (“countermeasures”) to address the causes? Briefly describe:
Who was involved? All participating physicians.

- **How?** *(e.g., in a meeting of clinic staff)* In person at provider meetings and/or via e-mail.
- **When?** Between 10/1/2014 and 10/31/2014

b. What were the primary underlying/root causes for the problem(s) that the project can address? *(Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)*

**People:**
- Physicians and staff have knowledge gaps around minor consent and parental notification laws in MI
- Physicians and staff feel uncomfortable asking parents to leave the room for a confidential portion of the visit
- Physicians and staff don’t support the idea/don’t understand the importance of confidential care for adolescents
- Even when physicians and staff support confidential care, they forget to provide it consistently for every adolescent patient.
- Adolescents and parents are not aware of MI minor consent/parental notification laws

**Processes:**
- Standardized adolescent health risk assessment form not utilized
- Medical assistants are not trained to separate adolescents from parents while rooming the patient to facilitate completion of the risk assessment
- Physicians and staff are concerned that it takes too much time to have the patient roomed alone to complete a risk assessment form confidentially and that there are not enough exam rooms to allow for this type of clinic flow

C. Do

14. **Intervention(s).** Describe the interventions implemented as part of the project.

**People:**
- Physicians and staff were provided with an online learning module on MI confidentiality laws, the rationale for confidential time with adolescents, and best practices in the provision of confidential care for minor patients
- Adolescent patients and parents were given handouts at check-in on the confidentiality laws and rationale, and the confidentiality laws were posted in the waiting and/or exam rooms

**Processes:**
- Clinics instated a standardized risk screening tool to be given to all adolescents at well child checks
- Physicians and staff met to work on the development of workflows and scripts to help front desk staff and medical assistants explain confidentiality to families and give the risk screening to adolescents to complete confidentially

**Information Infrastructure:**
- To help physicians remember to provide confidential care consistently, developed WCE EHR templates to include confidentiality prompts/documentation fields
15. Who was involved in carrying out the intervention(s) and what were their roles?
   Physicians designed and facilitated the implementation of EHR template changes.
   Physicians and health center managers encouraged staff to complete the self-study module on confidentiality.
   Health center teams including physicians, managers, nursing, MAs, and providers created scripts for staff to use to explain confidentiality and separate adolescent patients from their parents, and workflows to allow adolescents to complete risk screening confidentially.

16. When was the intervention initiated? (For multiple interventions, initiation date for each.)
   Interventions occurred between December 1st, 2014 and February 28th, 2015.

D. Check

17. Post-intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?
   x Yes   □ No – If no, describe how this data collection

18. Performance following the intervention.
   a. The collection of the sample of performance data following the intervention occurred for the time period:
      3/1/2015 – 3/31/2015
   b. What was post-intervention performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)
      On the last page of this report see the second data column of Tables 1 and 2.
   c. Did the intervention produce the expected improvement toward meeting the project’s specific aim (item 12.b)?
      For the three main outcome measures all sites showed meaningful improvement that ranged from 11 to 38 percentage points above baseline scores. Although performance now ranges from 81% to 88%, continued work was needed to get to the goal of 95% of patients having confidential time spent with their physician, having confidentiality laws explained, and confidentially completing a risk screening questionnaire.
      An expected increase occurred across each of the seven measures of clinic practice and process. The average rating across all seven measures improved from “partially complies” (1.05) to halfway between “partially complies” and “completely complies” (1.55).

E. Adjust – Replan

   a. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of the continuing/new problem(s), and considering possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:
      • Who was involved? All participating physicians
• **How?** *(e.g., in a meeting of clinic staff)* In person at provider meetings and/or via e-mail.
• **When?** April 1st$^{th}$, 2015 – April 30$^{th}$, 2015

b. **What were the primary underlying/root causes for the continuing/new problem(s) that the project can address?** *(Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)*

**People:**
- Physicians and staff continued to have knowledge gaps around minor consent and parental notification laws in MI and feel uncomfortable asking parents to leave the room for a confidential portion of the visit.

**Processes:**
- Medical assistants continued to struggle with confidence in separating adolescents from parents while rooming the patient to facilitate completion of the risk assessment.
- Staff and physicians were resistant to change workflow to allow for confidential completion of risk screening due to persistent concerns about space issues, time issues, and fears that parents would be upset.

**Information Infrastructure:**
- Though WCE EHR templates to include confidentiality prompts/documentation fields were developed, physicians were not consistently using the templates.

**F. Redo**

20. **Second intervention. What additional interventions/changes were implemented?**

**People:**
- Staff Sparks (mini-trainings) created by the Adolescent Health Initiative reviewing confidentiality laws, rationale for confidential time, and best practices were delivered to providers and staff by physician site leads and health center managers during clinic meetings.

**Processes:**
- Physicians, medical assistants, and staff piloted different workflows to allow fine-tuning of processes to allow adolescents to complete risk screening confidentially.
- Staff and providers worked to standardize successful workflows to make sure most patients were able to participate in risk screening.
- Staff and providers role played interactions with parents to gain comfort in separating parents from adolescent patients for risk screening.
- Front desk staff piloted adding risk assessment to check-in folders at the beginning of the day to minimize missed opportunities in screening.

**Information Infrastructure:**
- Physician site leads encouraged participating physicians to use WCE EHR templates that include confidentiality prompts/documentation fields.

21. **The second intervention was initiated when?** *(For multiple interventions, initiation date for each.)*
   May 1st, 2015 – July 31st, 2015

**G. Recheck**

22. **Post-second intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?**
X[ ] Yes   [ ] No – If no, describe how this data collection

23. Performance following the second intervention.

a. The collection of the sample of performance data following the intervention(s) occurred for the time period:
   August 1st, 2015 – August 31st, 2015

b. What was the performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

On the last page of this report see the third data column of Tables 1 and 2.

c. Did the second intervention produce the expected improvement toward meeting the project’s specific aim (item 12.b)?

For the three main outcome measures, the second intervention cycle produced continued improvements in each measure, with scores now 89%-90%. More work is needed to get to the goal of 95% of adolescents receiving the recommended confidential services.

For the ratings of clinic practice and process measures, the ratings increased for six of the measures and remained about the same (1.9) for the highest rated measure. The average rating across all seven measures improved from halfway between “partially complies” and “completely complies” (1.55) to predominantly “completely complies” (1.69). Continued improvement on the clinic practice and process measures is likely to lead to improvements on the outcome measures.

H. Readjust


a. Who was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:
   • Who was involved? All participating physicians.
   • How? (e.g., in a meeting of clinic staff) In person at provider meetings and/or via e-mail.

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)

People:
- Physicians and staff knowledge of the confidentiality laws remained tenuous, particularly for those physicians who don’t see as high a volume of adolescents and didn’t regularly apply or explain the laws

Processes:
- Medical assistants continued to struggle with confidence in separating adolescents from parents while rooming the patient to facilitate completion of the risk assessment
Clinics realized they need a designated area away from the parents for adolescents to complete the risk assessment confidentially (separate clipboards for parents and teens wasn’t enough)

Workflows weren’t always consistently used to include risk screening in the initial check-in/rooming of adolescents, particularly if usual staff were absent and floats were filling in

Information Infrastructure:
- Though WCE EHR templates to include confidentiality prompts/documentation fields were developed, physicians were still not consistently using the templates, residents were identified as a specific group not regularly using the templates
- As more confidential screening was done, clinics realized that workflows and a place in the EHR were needed for directly contacting adolescents for confidential results or follow-up

*If no additional cycles of adjustment are to be documented for the project for Part IV credit, go to item #25.*

*If a few additional cycles of adjustments, data collection, and review are to be documented as part of the project to be documented, document items #20 – #24 for each subsequent cycle. Copy the set of items #20 – #24 and paste them following the last item #24 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #25.*

*If several more cycles are included in the project for Part IV credit, contact the UM Part IV MOC Program to determine how the project can be documented most practically.*

I. Future Plans

25. **How many subsequent PDCA cycles are to occur, but will not be documented as part of the “project” for which Part IV credit is designated?**
   
   No formal additional PDCA cycles are planned for the cohort of physicians who participated in this project. Performance of rates of about 90% nearly achieved the “stretch goal” of 95%. Physicians can continue to use the materials provided during the project to perform independently further local changes and assessments. Project leaders remain available for consultation.

26. **How will the project sustain processes to maintain improvements?**
   
   Many of the improvements were made by “automating” procedures within clinic when adolescent patients are seen for well visits. The changes that are now standardized workflows should be self-sustaining. Physician site leads additionally plan to discuss barriers and successes with confidential care for adolescents at clinic meetings over the course of the next year.

27. **Do other parts of the organization(s) face a similar problem? If so, how will the project be conducted so that improvement processes can be communicated to others for “spread” across applicable areas?**
   
   This project on adolescent confidentiality is being rolled out at additional UMHS sites (including new departments) and outside sites in 2015-2016, which will help with spread.

28. **What lessons (positive or negative) were learned through the improvement effort that can be used to prevent future failures and mishaps or reinforce a positive result??**
   
   Involving multi-disciplinary teams in planning workflows and getting buy-in significantly helped successful implementation of change. Deep rooted concerns with the provision of confidential care was a surprising barrier to initial buy-in, and helping physicians and staff better understand why confidential care is important was key.

J. Physician Involvement

*Note: To receive Part IV MOC a physician must both:*

a. **Be actively involved in the QI effort, including at a minimum:**
   - Work with care team members to plan and implement interventions
• Interpret performance data to assess the impact of the interventions
• Make appropriate course corrections in the improvement project

b. Be active in the project for the minimum duration required by the project

29. Physician’s role. What were the minimum requirements for physicians to be actively involved in this QI effort? (What were physicians to do to meet each of the basic requirements listed below? If this project had additional requirements for participation, also list those requirements and what physicians had to do to meet them.)

a. Interpreting baseline data, considering underlying causes, and planning intervention.
   Physicians had to participate as described in item #13a.

b. Implementing intervention.
   Physicians had to participate as described in items #14, #15, and #16.

c. Interpreting post-intervention data, considering underlying causes, and planning changes.
   Physicians had to participate as described in item #24a.

d. Implementing further intervention/adjustments.
   Physicians had to participate as described in items #20 and #21.

e. Interpreting post-adjustment data, considering underlying causes, and planning changes.
   Physicians had to participate as described in item #24a.

30. How were reflections of individual physicians about the project utilized to improve the overall project?
All participating physicians reflected on the project and specific processes at their individual site. These reflections shaped the workflows, etc that individual sites chose to adopt.

31. How did physician participation in this effort impact medical practice and/or the care provided?
Physicians were ultimately responsible for initiating confidential time with adolescent patients, explaining minor consent laws to them, and ensuring that they completed the risk assessment confidentially. These improvements in physician-delivered confidential care were a clear changes in medical practice that positively affect minor adolescent patients.

32. How did the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?
All participating physicians did their own chart reviews, reflected on root causes of below goal performance, and helped determine operational steps to improve performance. All physicians then did their follow-up chart reviews to assess for improvement, and plan appropriate next steps to continue to strive for the project goal.

K. Sharing Results

33. Are you planning to present this QI project and its results in a:
   X□ Yes □ No Formal report to clinical leaders?
   X□ Yes □ No Presentation (verbal or poster) at a regional or national meeting?
   X□ Yes □ No Manuscript for publication?

L. Project Organizational Role and Structure

34. UMHS QI/Part IV MOC oversight – this project occurs within:
   X□ University of Michigan Health System
   • Overseen by what UMHS Unit/Group?
UMHS Adolescent Health Initiative

• Is the activity part of a larger UMHS institutional or departmental initiative?
  X ☐ No    ☐ Yes – the initiative is:

☐ Veterans Administration Ann Arbor Healthcare System
  • Overseen by what AAVA Unit/Group?
  • Is the activity part of a larger AAVA institutional or departmental initiative?
    ☐ No    ☐ Yes – the initiative is:

X ☐ An organization affiliated with UMHS to improve clinical care
  • The organization is: Physicians at one IHA clinic and the Corner Health Center.

• The type of affiliation with UMHS is:
  X ☐ Accountable Care Organization: Both IHA and Corner Health Center are affiliated with UMHS through participation in the Physician Organization of Michigan ACO

☐ BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (specify which):

☐ Other (specify):
Table 1. Percent of Patients with Recommended Care Performed (primary outcomes)

<table>
<thead>
<tr>
<th>Recommended Care (chart audit)</th>
<th>Baseline Period (7/1-8/30/15)</th>
<th>Post-Intervention Period (3/1-31/15)</th>
<th>Post-Adjustment Period (8/1-31/15)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 706</td>
<td>N = 458-462</td>
<td>N = 619</td>
</tr>
<tr>
<td>Confidential time spent with patient.</td>
<td>77%</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Confidentiality laws/limits explained to patient.</td>
<td>45%</td>
<td>83%</td>
<td>89%</td>
</tr>
<tr>
<td>Standardized risk screening (e.g., RAAPS) confidentially completed by patient.</td>
<td>59%</td>
<td>81%</td>
<td>89%</td>
</tr>
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</table>

Table 2. Mean Scores on Clinic Practices and Processes

<table>
<thead>
<tr>
<th>Clinic Practices and Processes (physician survey)</th>
<th>Baseline Period (7/1-8/30/15)</th>
<th>Post-Intervention Period (3/1-31/15)</th>
<th>Post-Adjustment Period (8/1-31/15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = does not comply</td>
<td>N = 48</td>
<td>N = 44</td>
<td>N = 44</td>
</tr>
<tr>
<td>1 = partially complies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = completely complies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has an adolescent confidentiality policy displayed in the waiting room and/or exam rooms.</td>
<td>0.71</td>
<td>1.59</td>
<td>1.86</td>
</tr>
<tr>
<td>Provides both visual and auditory privacy for the registration/check-in process.</td>
<td>0.69</td>
<td>1.24</td>
<td>1.43</td>
</tr>
<tr>
<td>I am knowledgeable about confidentiality for minor patients including state laws regarding a minor’s ability to consent for specific services and when parental notification is mandated.</td>
<td>1.43</td>
<td>1.78</td>
<td>1.89</td>
</tr>
<tr>
<td>I discuss the protections and limitations of confidentiality with every adolescent patient.</td>
<td>1.05</td>
<td>1.67</td>
<td>1.74</td>
</tr>
<tr>
<td>I provide time alone with adolescent patients at least yearly to offer a change to speak on confidential subjects.</td>
<td>1.54</td>
<td>1.92</td>
<td>1.90</td>
</tr>
<tr>
<td>When Possible, I bill the adolescent's insurance for my time using non-confidential codes, so than and Explanation of Benefits (DOB) form sent to the parents will not display confidential services received by the adolescent.</td>
<td>0.70</td>
<td>1.15</td>
<td>1.39</td>
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<tr>
<td>I get a cell number and/or private email address for adolescents to remind them of appointments or get in touch with them about test results.</td>
<td>1.05</td>
<td>1.47</td>
<td>1.65</td>
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<tr>
<td>Overall mean on the seven items</td>
<td>1.02</td>
<td>1.55</td>
<td>1.69</td>
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