Minor Consent and Confidentiality for Sexual Health Services in California Webinar Transcript
10/25/2023

Nicole Nguyen:
Hi everyone. Good afternoon. Thank you so much for joining us today for our webinar titled Minor Consent and Confidentiality for Adolescent Sexual Health Services in California. We hope you are all doing well and staying safe. My name is Nicole Nguyen. I'm the program manager of the Family Planning Access Care and Treatment Program, are also known as the Family Pet Program at the California Prevention and Training Center. The CAPTC under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's events. So, before we get started, I just want to go over some really quick housekeeping slides. For those not familiar, we'll go to webinar. So first please make sure you check your audio and select your desire setting to join you through your computer audio or through your phone. If your internet is a little bit shaky, we highly recommend that you call in through your phone for the best possible sound.

Nicole Nguyen:
And then also please check that you're able to see the Go-To Webinar viewer screen with the slides on the left and the control panel on your right. And then there's this little orange box with a white arrow on it. So, this is how you can hide or show your control panel if you don't want to see it or if you accidentally clicked it. This is how you can make it appear again. And then right under that is the audio tab where you can change your audio preference at any time. And then third, please submit audio, your comments and questions via the questions box. So, today's webinar will take about 90 minutes and we'll have full time at the end for the presenter to answer all your questions. Please send in your questions throughout the webinar and our speaker will address it as many of them as possible.

Nicole Nguyen:
At the very end, the webinar will be recorded and then responses to questions not answered today live by our presenters will be sent out to participants later. Along with the recording and slide deck, there is an evaluation at the end, so please fill it out because your feedback is extremely important to us and it really guides us in developing our future content. And this is also how we can track your participation for CME purposes. And then speaking of CMEs, I want to acknowledge that we're working with University of Nevada Regional School of Medicine to provide CMEs for this event. This webinar qualifies for 1.5 CME credits and is only available to those who watch the webinar live today. Those who watch the recording afterward will not be eligible for the CME credits. Billing to access your CME certificate will be included in the follow-up along with the recording slides and the evaluations.

Nicole Nguyen:
All right, and then also for transparency, we want to state that all presenters, planners, or anyone in position to control the content of this CME activity have indicated that you do not have any financial relationships with any commercial entities related to the content of this activity. Alright, and then also lastly, before I introduce Rebecca, I just wanted to note that while this webinar is sponsored by the Office of Family Planning and the Family PACT Program, the information our speaker will be discussing is more focused on minor consent and confidentiality for adolescent clients accessing sexual and reproductive healthcare in California. And won't dive into any deep questions about Family PACT policies or specific program benefits like billing or coding. If you have questions regarding specific

administrative policies or benefits or wondering if your clients will qualify for the Family PACT services, please send us those question in the question box question.

Nicole Nguyen:

We'll get them answered in the written q and a that will be sent out afterward. So, while we won't be able to answer those questions live today, we will collect them and get the answers out to you at a later time. And so now for the exciting part, I get to introduce our wonderful presenter. We're really excited to have Rebecca Gudeman here today. Rebecca is an attorney and the senior director of health at the National Center for Youth Law. Rebecca has advocated for young people for more than 30 years. She's a leading national expert in multiple areas, including confidentiality and information sharing across child serving system, adolescent health access and healthcare consent. In 2016, Rebecca also launched the reproductive health equity project for foster youth, a really groundbreaking collaborative for public and private agencies that partner with me to promote their healthy sexual development. She also shares her wealth and expertise on teenhealthlaw.org.

Nicole Nguyen:

It's a go-to resource of information that includes resources on confidentiality, minor consent, child abuse reporting and health information, and sharing a variety of states and settings. And then in 2015, Rebecca also received the National Chapter Recognition Award from the Society of Adolescent Health and Medicine. And in 1997, she was named the American Bar Association Young Lawyer Child Advocate of the Year. She holds undergraduate and graduate degrees from Harvard and a law degree from University California at Los Angeles. And so, with that, we're really, really excited. Thank you so much for joining us today, Rebecca, and then that Mike is yours. So, I'll go ahead and share your screen.

Rebecca Gudeman:

Excellent. Thank you so much Nicole. As we do this transfer over of screens, I just want to appreciate you all for sharing a little bit of time with me today and we hope to make it interesting. As Nicole said, I'll start with a presentation, but we hope to have a lot of time at the end for questions and conversation. Please feel free though to add your questions to the chat box as we're moving on. And while I may not answer them in the moment, we will be sure to get to them at the end. Okay. Let me see now I need to just turn on my screen here. Okay. Alright. Nicole, are we seeing the screen, okay?

Nicole Nguyen:

Yes, you're good. I can see your screen.

Rebecca Gudeman:

Okay, great. Thank you so much. We were practicing this, but I just wanted to make sure before I jumped in. All right. Well just as a quick introduction, for those of you who aren't familiar with the National Center for Youth Law, we are a national legal advocacy organization with our home office in Oakland, but we also have offices in DC, Phoenix and in LA. And we use a range of tools from litigation policy, advocacy education, technical assistance research, community partnership, really all with the goal to further opportunities for young people in many different areas including health. And you all in the description for today, you may have seen our learning objectives, but that really serves as our agenda. So, I'm going to start by talking about some of the minor consent laws in our state, talk about confidentiality and then talk about some of the best practices around implementation.

Rebecca Gudeman:

And finally close with some resources and your questions. And I would not be a good lawyer if I didn't add a few caveats because that's what we always do. So, this information does provide information, it's not legal advice and you will probably find me saying in some places that this is something where you really need to go to your legal counsel for specific advice on how it applies in a circumstance. So just be forewarned about that by definition cannot be a comprehensive review of laws, but hopefully we'll give you a broad brush that helps point you to questions and places where you can get additional information should you wish for more. We've made sure that the law is accurate as of October 2023, but of course laws always do change. So, if you are referring back to this at some point, please make sure you're double checking the accuracy of anything that is stated. And I think that's it. The only other thing is a quick note on language. We at the National Center for Youth Law believe all people deserve comprehensive and reproductive and sexual health, education and care. And we recognize that people of many different gender identities and sexual orientations can get pregnant and have needs. And I will strive to use neutral language in this presentation, but there are maybe a few places where I use some genderized terms and where I do it's because that's what we see in the law, in research or in data.

Rebecca Gudeman:

Alright, now let's just do a quick background before we jump into specifics about the law. I am going to be talking about consent and confidentiality. They're very interrelated, but they are different and it's important to keep those differences clear, especially when we're talking about the law because they refer to distinct legal concepts. So, consenting for care means granting permission to a provider to engage in a health test, exam or service. A healthcare provider generally must obtain consent before providing care. So, this is really oversimplified, but I like to think of consent as that opening that door into a healthcare service, it's permission to pass into that exam room. Federal and state laws and court decisions help establish which individuals have the legal authority to provide consent. And there are times when minors can consent for themselves, and we'll be talking about that in just a minute. But then a service is provided and once it is, it's within that sort of confidentiality bubble confidentiality is what happens to the information generated within that bubble and it tells us who's allowed to hear it or see that information and who has permission to make decisions about what happens to that information. So again, the two concepts are interrelated, but they implicate different laws. So, I'm going to talk about them separately and you'll see why it's important to make sure you keep those differences separate.

Rebecca Gudeman:

But let's just start talking generally about why minor consent is important. Minor consent is important because confidential health services are essential in promoting teens. Health. Adolescents are at a unique and vulnerable time of change and development both physically and emotionally, particularly because they're beginning to establish their own identity and autonomy and it's normal and healthy and appropriate to want to develop boundaries and independence. Adolescence is also a turning point. Decisions made by youth during this time will impact their life moving forward in their development. And so clinical providers have the opportunity to deliver evidence-based preventive health services and education that's been demonstrated to promote resiliency, to mitigate harm. And why do we need minor consent? We need it to make sure that door to care, the one we saw on the other slide, and thus time with clinical experts is open for all who need it.

Rebecca Gudeman:
So why is confidentiality important? Because young people worry about it. The first data point in the red box here is from research study published in the Journal of the American Medical Association on adolescents reports of parental knowledge of their use of sexual health services. So, 40% of female adolescents who were sitting in a waiting room in a family planning office, they were asked, would you be here if your parent had to be involved? And 40% said that they would not seek the services if it required parental consent. The second data point is from adolescent responses to the 2013 to 2015 National Survey of family growth from the Centers for Disease Control. And digging a little bit more into that JAMA study I mentioned. So, we had 40% of young people saying no, they would not be seeking out care if their parent had to be involved.

Rebecca Gudeman:
Of those who said that they would not be seeking care, one out of five or 20% said they would use no contraception if they weren't able to seek it out at the family planning clinic on their own. And only 1% said they would stop having sex. So confidential access to sexual health services is important, but what this data also shows us is that the majority of youth do involve their parents in their healthcare decision-making. And so, we really want to support voluntary communication with parents or with adult supporters. Voluntary communication can be helpful in supporting adolescents' health. The difference is mandated communication. Mandated communication and disclosure can be counterproductive unless it's really necessary to protect the health of a young person or the public. And that's why A, we see a consensus among national recommending bodies that strongly supports minor's access to confidential care for sensitive services like sexual health services.

Rebecca Gudeman:
And in short, all of us want to know that our personal health information will be kept private and young people are no different. So, with all that said, it should be no surprise that in all 50 states we have minor consent laws, laws that allow minors to consent to healthcare in certain situations. And many of these laws have been on the books for over 50 years. So, it's really not anything new, but each state's laws look a little different. So, let's look at California's laws now just as a general matter healthcare, as we said before, healthcare providers usually need consent or permission to engage in a healthcare service. And as a general rule, when people are younger than 18 years old, they need a parent or legal guardian to consent for that care. But there are a number of exceptions to this rule. So just as one example, in an emergency when it's impossible to get a parent or guardian to consent in a timely way, a healthcare provider may proceed without consent. And you'll see a couple other broad categories of exceptions up on this list. The final one being minor consent laws. So, let's look at those.

Rebecca Gudeman:
In California we have two different broad categories of minor consent laws, status laws, so basically meaning based on the minor situation in life their status, they are able to consent to general healthcare. And then we also have service laws, meaning that we have carved out some specific healthcare services and said that these are so important. We want to grant minors the authority to consent to the care on their own. So, let's look at our status laws in California. In California, minors may consent to their own medical care if they're married or divorced, if they're in the armed forces, if they've been emancipated by a court or if they're 15 or older living apart from their parents and managing their own financial affairs. Okay, so we're going to do a quick quiz for everyone. This is a hypothetical. So, we have 17 year old Emma, and she's come into a clinic with her one-year-old child. She wants flu shots for both of them and would like to discuss contraception. Given the status exceptions and just the status exceptions that

we saw on the previous slide, would Emma be able to consent to both her flu shot and contraceptives? So, I think if my friends can pop up the poll for us, you all will have a chance to vote on either yes, no, or not enough info.

Nicole Nguyen:

Let me try that. I'm actually having a little bit difficulty. Nic, are you able to launch the poll for me?

Rebecca Gudeman:

I am not sure how to launch a poll. Is someone else able to actually?

Nicole Nguyen:

Oh. There you go. Thank you. And so, we'll give everyone about 60 seconds to answer that I Okay, just one last seconds and then Nic, go ahead and once you're ready, go ahead and close it and share the results.

Rebecca Gudeman:

Okay, thanks. We've got 53% said yes, she could consent to both flu shot and contraceptives. 29% said not enough info and 18% said no. Thank you so much for showing us the poll results. If we could flip back to the slides. So, the answer here is actually C, not enough information. So just as a reminder, Emma can consent to both the flu shot and the contraceptives. So, both general medical care if she's married or divorced in the armed forces emancipated by a court or if she's 15 or older, living apart from parents and managing her own financial affairs. In this case, we don't have enough information. We don't know if she's 17, but we don't know where she's living or if she's managing her own financial affairs. We don't know if she's been emancipated by a court. It's important to note that in California, being a parent or being pregnant is not sufficient to emancipate someone and it does not allow them to consent to their own healthcare in a general way.

Rebecca Gudeman:

That is not true in all states, but that is our state law here in California. All right, so let's say she can't, we've decided she can't consent under a status exception. What are our state's service exceptions? So, here's California service exceptions, and we have included in the links in the handout section, a chart, a minor consent chart that includes more information about each of the minor consent laws in California. So, you'll find more detail there. But you'll see here it includes pregnancy related care, outpatient mental health services, substance use disorder services, intimate partner violence. I just want to uplift that. You'll see in purple some asterisk that those are laws that have a lower age limit. Young people must be 12 or older before they're able to consent to these services. And you'll see the red hashtag. This is to flag that there were some laws passed during this 2023 legislative session that will change the laws that have been flagged the outpatient mental health services and substance use disorder.
We will be updating our materials to reflect those changes when they go into effect in 2024. So, January 1st, 2024. But what I want to do now is dig into the sexual health related minor consent services you see on this chart. Okay, so in California, a minor 12 or older can consent to their own S-T-D-S-T-I related testing, treatment and prevention. And this does include HIV. And you'll see this last bullet here about prevention includes a minor's right to consent to their own, for example, vaccination for HPV or hepatitis B. The law was written in such a way that it can cover new medical developments as we've seen and as we continue to see more advances in preventive technologies.

Rebecca Gudeman:
And here you'll see that minors of any age in California can consent to contraception. And this applies to both prescription like pill patch for example, and non-prescription methods like condoms. It also applies to birth control that requires insertion. Now of course, if a healthcare provider assesses a risk of any kind of coercive sex or believes that their mandated reporting duty is triggered, they will certainly make a report. But it's important to highlight that even where, for example, a mandated child abuse report is necessary, that doesn't prevent the young person from still consenting to and accessing the healthcare that they want and need. And we will talk about mandated reporting a little bit more in just a bit pregnancy related service. California minors of any age may consent to pregnancy related care on their own, and this includes pregnancy testing, prenatal care, postnatal care, and abortion.

Rebecca Gudeman:
Again, like contraception, there's no minimum age defined in law. And this is both protected by statute and under our California state constitution. So, let's do a couple more quizzes. So, if you all can help me pop up this next quiz, I'll start reading it as you're getting it set up. 16-year-old DVO is sexually active. After discussions with him, the provider recommends both HPV vaccination and to begin prep prophylactic HIV medication to reduce Devon's risk of infection. Given the service exceptions in California, may Devon consent to the vaccination and to prep on his own. So, our options are yes, no, yes to one but not the other or not enough info.

Nicole Nguyen:
And the poll has just been launched.

Rebecca Gudeman:
Thank you.

Nicole Nguyen:
And I'll give her once again, another 60 secs to answer. All right, second, I'm going to close and launch the results.

Rebecca Gudeman:
All right, thank you. So, we've got the majority of you said yes, but we do have a smattering in a number of other areas. So, the answer to this one is a Devon may consent to both. Devon is 12 or older, and minors 12 or older may consent to preventive healthcare that prevents sexually transmitted infection or sexually transmitted disease. Prep is a medication designed to lower the risk of HIV aids infection. And HPV is the HPV vaccine is designed to prevent HPV, which is considered a sexually transmitted disease. Okay, let's go to our next poll. Sorry, we have a couple of them in a row for y'all. So, the next poll please. 15-year-old Amalia would like to discuss contraception. She's heard about implants, but once more information given service exceptions in California, would Amalia be able to consent to a contraceptive implant?

Nicole Nguyen:
Well, has been launched for another 60 seconds. Okay, should we close and share your results?

Rebecca Gudeman:
Great, thank you. All right, so now the vast majority of you said yes that she can consent and that is correct. The answer here is a minors of any age can consent to contraceptives, including contraceptives that require implantation. Alright, we have our final poll for you now for a little bit. I promise our final question, 15-year-old Amalia who we just saw. Now she wants a pregnancy test, and she already knows that if the test is positive that she wants an abortion, given the service exceptions in California, would Amalia be able to consent to both the pregnancy test and to an abortion? And our options are yes to both. No to both, yes to the test, but not the abortion. No to the test, but yes to the abortion or not enough info. We're throwing everything at you with this one.

Nicole Nguyen:
And the poll has just been launched. Hey, close the poll and sharing the results.

Rebecca Gudeman:
Okay, so again, the vast majority of you said yes to both with a few saying yes to test, but no to the abortion. The answer here is yes to both minors of any age may consent to pregnancy related care, which includes pregnancy testing and minors of any age in California may consent to abortion. And that is something both protected via state statute and the state constitution. And I just wanted to emphasize that part. The California constitution affirmatively grants this right to minors. So, article one, section one of the California Constitution grants every Californian a fundamental right to privacy that the California Supreme Court back in 1997 determined protects the right to choose for all including minors. And in 2022, the California voters added article one, section 1.1, which you see on this slide, and is considered a right to reproductive freedom to the state constitution.

Rebecca Gudeman:
So, both of these two fundamental rights in the state constitution stand separately from the US Constitution and stand no matter what may have happened at the federal level with Supreme court decisions at the federal level. So, this is a right protected both by statute and by our state constitution here in California. Okay, so now while this webinar is about sexual health services, it's really critical to acknowledge the important role that mental health and wellness plays in anyone's ability to take care of their other health needs, especially when dealing with, for example, pregnancy. Our youth advisory board at the National Center for Youth Law lifted up to us that mental health needs can be a primary barrier to addressing sexual health. So, we wanted to just flag quickly that minors in California also have the right to consent to certain outpatient mental health care on their own when they're 12 or older. And even if you don't provide this service or you don't provide it in your clinic or network, knowing what referral sources are out there for your patients can be really important. So, to sum up, what do all these laws mean for healthcare providers? It means that minors can seek these services mentioned previously on their own. It means that providers do not need parent permission to provide these services. And let's just look at how this might play out. We have one, I think this is, we have two more quizzes and they're coming up right now. And so, let's look at how this plays out in a case scenario. So 14 year old Alisa is in foster care, their foster parent brings them to a clinic and says, I've had too many young people get pregnant while in my care, we want Alisa to get an IUD and offers a document to the clinic that is from the court that says this foster parent has care, custody and control of Alisa. May the health provider proceed based on the foster parent's consent and requests for an IUD. Your options are yes, no, or not enough information.

Nicole Nguyen:
And the poll has just been launched.

Rebecca Gudeman:
Alright, let's see what we've got. We have, let's see, 56% said no, 15% said yes, 29% said not enough info. Alright, so the answer to this is that the healthcare provider cannot proceed. So, the answer is no. The healthcare provider cannot proceed based on the foster parent's consent alone. And there's sort of two parts to this question. So first, when we look at parents and guardians, the right of a minor to consent to contraception or pregnancy related care incorporates a right to refuse care. So, parents cannot substitute their consent unless we have a situation where we're talking about an adult or a minor who is been deemed not competent and has been conserved by a court. Short of that happening, the minor has the right to consent or refuse care, which means a parent's support is great, but it is not legally relevant. Now the second layer here is youth and foster care. Youth and foster care, just like all adolescents, have the same minor consent rights as all adolescents. So, they have the right to consent to or refuse contraception on their own again, as per state statute and the state constitution. So, in this case, a foster parent cannot substitute their consent even if they have the right to consent to healthcare generally. Okay, our next question, 15-year-old Chandra seeking an abortion says that she's come here from out of state. Would Chandra be able to consent to an abortion? Yes. No, not enough information.

Rebecca Gudeman:
All right, let's see what we have. And we have 80% saying yes and 17% saying not enough information, 4%, no. The answer here is yes. And so, this was about abortion, but it could have been about any minor consent service in the state. And really the simple rule is that while you're in California, California laws apply. So even if this is a young person whose state of residence is Nevada or Oregon or New York, when they come to California, California, minor consent laws are what are applicable. So, if they have the right to consent to abortion in California, Chandra has the right to consent here while in our state. Okay, I am now going to shift to talk about confidentiality. If you have any questions about any of the consent material that we just went through or things that I didn't address, please don't hesitate to include it in the questions and we'll try to get to that when we get to the end.

Rebecca Gudeman:
But now let's start in on confidentiality. When we talk about confidentiality, there are rules at both the federal and state level. At the federal level, everyone's heard of HIPAA, the Health Insurance Portability and Accountability Act. And what it really does is set a baseline across the country. But what HIPAA says that if there is any state law that offers more confidentiality protection to a patient, then we should defer to that state law. And California is one of the states that has a significant body of legislation that protects health information and, in several places, sets a higher bar than does HIPAA. And I mentioned that because it's important to know that what we do in California and what we need to abide by in California may not always look like what our colleagues do in other states. So, people may use colloquially the term HIPAA, it's because of HIPAA. But it's important to know that when we're talking in California, really what we mean is it's because of HIPAA and our state law.

Rebecca Gudeman:
It's also important to acknowledge that in addition to these, there may be some specific laws at the federal or state level that apply because of the type of healthcare you're providing or the funding

stream, and those may set their own and sometimes higher confidentiality rules and may be really what you need to defer to. And a prime example are rules, federal regulations that apply for any services funded through the Title 10 family planning program. These may apply in lieu of HIPAA or state law if they are more protective. So, it's really important to speak with your own legal counsel about what laws apply in your setting given the type of services you apply provide and the funding streams. But that said, moving forward, I'm going to talk about HIPAA and the California Medical Confidentiality of Medical Information Act because those are the two rules that apply to most folks in this state.

Rebecca Gudeman:

So, when we look at HIPAA and the California Confidentiality of Medical Information Act, the general rule is that healthcare providers must protect the confidentiality of personal health information. And as a general matter, in order to release that information, the provider needs assigned authorization. And we use the term authorization just to keep it really separate from consent to care because sometimes it may be a different person who's consenting to care than the person who is signing an authorization. Now that said, there are exceptions in confidentiality law that can sometimes allow or require disclosure of information even without that signed authorization. And child abuse reporting is one example, we'll talk about that in a little bit. But first, let's just look at the general rule and that release that signature. When minors received services that they consented to or could have consented to under state or other law, then the minor must sign that authorization form. So, when we're providing minor consent sexual health services and you need a release, the minor patient signs that release. Now one of the big questions is can parents be informed of minor consent sexual health services? And the answer is not without assigned authorization from the minors from the minor patient providers must keep minor consent services confidential from parents unless otherwise instructed by the minor. There are a few minor consent statutes that have different rules, and you can find those in that grid that we have linked in the handouts.

Rebecca Gudeman:

Now, as I said, there are exceptions that allow providers to share information or require them to even without a release. And here's just a few examples, but there are many others. So, it's important to work with your own legal counsel, understand when those other exceptions might arise, and to really be clear on when it's a discretionary exception or when it's mandatory. And when I say discretionary, an example would be caring coordination. Both HIPAA and California law allow healthcare providers to share information with other healthcare providers in order to coordinate care, provide treatment, but it doesn't require providers to do so. And that means you as a practitioner or your clinic may choose to adopt policies and practices that support care coordination across from provider to provider, or you may choose to adopt a policy or practice that says we aren't going to do that without getting our patients signed consent because of the type of services we provide or the relationship we have with our patients. But when it's a mandatory disclosure under state law, then there is no such discretion. And child abuse reporting and mandatory public health reporting are two examples where if once that disclosure obligation is triggered, you must report you have no discretion. So, let's just take a second to look at child abuse reporting. There are some activities that healthcare providers are mandated to report. There's public health mandated reporting, there are other mandated reporting laws. Right now, I'm going to be talking about child abuse reporting under the California Child Abuse and Neglect Reporting Act. In general, mandated reporters must report if they have a reasonable suspicion that a minor has been subject to neglect or abuse as those terms are defined within that child abuse and neglect reporting Act hurting oneself or hurting others is not actually mandated to report under the child abuse

reporting law. But there may be ethical duties that require such reports. And for example, as discussed in the Tarof case, sometimes these are called the tarof reporting duties.

Rebecca Gudeman:

This is not to say that those aren't reportable, but I'm going to be focusing on child abuse reporting within the definition of child abuse in our state law. There are several categories and we've included in the handouts a document that provides a lot more information about each of those categories and their definitions. The document is a little bit out of date. The material is still relevant, but I would encourage you to just check on anything if you're looking to rely on it before, check to see if it needs updating before relying on it. And we don't have time to go through all of categories. So, I want to just look at the definition of what is considered reportable sexual abuse.

Rebecca Gudeman:

California defines reportable sexual abuse by reference to criminal statutes in the penal code, and that is not always super helpful for practitioners who have to try to understand what's reportable. But when we look at all those penal codes, it's possible to break them down and really put them into three broad categories. So, the first is what I'm calling sexual assault. It's really any non-consensual or coerced sexual activity. Anything like incest or molestation, all of that would be non-consensual activity that would be reportable under that broad category of sexual assault. Sexual exploitation includes trafficking, it can include pornographic endeavors. Again, the linked material and the handout provides a lot more specific details about what would be included in each of those categories. And then the third category, there are a small set of situations in which disparate age sexual activity is reportable based on the age of the two people involved alone, separate and apart from whether it's considered consensual or voluntary or trafficking in general, if mandated reporters, a mandated reporter must report if they find out a minor has engaged in any of these listed activities or they have a reasonable suspicion that they have.

Rebecca Gudeman:

Now, I know there's often a lot of questions about that third category, again, you'll find more details in the handout about when different sexual activity may be reportable based on age alone. But on the following slide, I'm going to share a graph that just talks about when sexual intercourse may be reportable based on age alone. So now in this chart you'll see some boxes in orange with an m and m that indicates that based on age alone, the sexual intercourse would be reportable. So, age of patient is 12, age of partner is 14, 15, 16, et cetera. That would be reportable based on age alone. You'll notice there's a number of boxes that are in white and have the letter CJ. CJ stands for clinical judgment. We use that because we want to emphasize that even if this is a situation where sexual intercourse is not reportable based on age alone. So, for example, a 16 year old having sex with another 16 year old is in that box with a CJ. The fact that it's in white doesn't mean you never report it. You still need to consider whether this is coerced activity, whether it involves sexual assault, whether it involved trafficking, and do that kind of analysis. And you would still report if you had concerns that it fell into one of those other categories, it just wouldn't be reportable based on age alone.

Rebecca Gudeman:

So, a couple questions that sometimes come up around abuse reporting. Do I need to report all illegal activities? No, just because something's illegal does not automatically mean a police report or ACPS report should be filed. So, remember, we still are under this broad mantle of confidentiality. There's an exception that requires disclosure that opens up those records when for example, there may be a reasonable suspicion of child abuse, but unless in a legal activity falls within that definition of child

abuse, it wouldn't be reported. An example might be you hear about a young person who shares that they drank alcohol or maybe even use some illicit drugs. Those are certainly illegal for a minor, but it isn't something that would be automatically reportable as child abuse. Do I need to inform parents if I make a report? So again, confidentiality law, this is still under the mantle of confidentiality.

Rebecca Gudeman:
Confidentiality includes an exception that allows you or requires you to share information with child protective Services or law enforcement in order to make a report. But it doesn't mean the information being disclosed is suddenly free of any confidentiality, protection and open to anyone else. So, if parents would generally not have a right to that information, for example, because it was disclosed during delivery of contraceptive services, just because a child abuse report is being made doesn't suddenly mean that you can let parents know. So, it may mean that you need to get the minor's consent before you can disclose to parents that a child abuse report has been made. If someone is from another county or state, do I report locally? So, this comes up all the time. Sometimes you may see a patient who comes from another county or another state or even another country and people ask what reporting laws they should follow.

Rebecca Gudeman:
You follow the laws of California, the state that you're in. So, you follow what the definitions of reportable abuse are in our state. And you report pursuant to the California Child Abuse and Neglect Reporting Act. When it comes to where you make that report, you can make that report to your local CPS, even if that person is not from the state. CP then has the duty to investigate whether there needs to be a cross report made to a third agency that has jurisdiction, but there is not an obligation on you to track down the appropriate jurisdiction for making a report for someone who comes from another place. Okay, so that's the end of confidentiality. Again, if you have any questions, please feel free to put them into the question section of the control panel. But for now, I'm going to move on to practice because oftentimes I do these trainings and I say, here's the law, it's black and white, but I know it's really easy for me to say, here's the law and the really hard thing is on you all, how do we implement this and how do we do this in a way that makes our practice feel more adolescent friendly and supportive of the adults who are supporting young people?

Rebecca Gudeman:
Often adolescents are a small percentage of patients you may be seen, and your program and practice may be shaped by the needs of adult clients. But it's important to acknowledge that adolescents do have unique needs and it can be even more critical to think about those needs and think about the needs of your clients who may be part of current or historically marginalized populations who tend to face additional barriers to care. As I think was mentioned at the top, my office coordinates a collaborative of agencies that work to address the reproductive health needs and disparate outcomes frankly, of youth in foster care. Youth in foster care are far more likely to identify as youth of color, far more likely to identify as LGBTQ, far more likely to be low income and to have experienced trauma. And so, we asked them for their advice about what we need to do to make programs and services more adolescent friendly and about their own experiences.

Rebecca Gudeman:
And so just as an example of some of what we've heard, these are some quotes from some of our youth advisors sharing about some of their experiences in general. They lifted up both systems issue as well as individual practice issues when they've sought sexual health services. So just as an example, a lot of

times my doctor will say, I need to do something but then doesn't offer me any support in figuring out how to get that thing done. We heard that a lot around transportation or sort of coordinating with a pharmacy. There's been many times where I felt my doctor had certain stereotypes about me.

Rebecca Gudeman:
I called for an appointment, but I didn't have a phone number they could call back on. So, I just kind of dropped it and didn't go in for care. Personally, I didn't have a regular clinic. I moved around too many times over 16 different locations just in high school. So, each time I moved, it was a different clinic. The World Health Organization has developed quality standards for how to improve the adolescent friendliness of healthcare service delivery. So, you'll see them here, these broad categories, accessible, acceptable, equitable, appropriate, and effective. Our team worked in our collaborative, worked with these and worked with a team of youth and health providers to develop some tools and assessments and policy and practice recommendations to try to help make sexual and reproductive health services more welcoming. And so that's what I'd like to share a little bit with you. Now, these are not my, I'm a lawyer. These are not my advice. This is advice coming from young people and healthcare providers working together. And I'll just flag, we've collected them in something we're calling the Foster Friendly Healthcare Toolkit. I'll show a link to that at the end. But the content I'm about to share, if you want to look at it in more depth, you can find in the toolkit.

Rebecca Gudeman:
The toolkit really is based in three guiding principles. We took the WHO principles and the youth and provider feedback and distilled them into these three. The first is to engage in shared decision-making with youth. This means that the care should be and culturally humble. It looks like collaborating with youth to incorporate healthy choices and healthy behavior, providing options, supporting autonomy and agency and assuring that young people have the time, space and support to choose what's right for them. And I think this quote is great because while as clinicians you bring so much expertise to the engagement, young people are the experts in their own lives and are really the only ones that can tell you why certain things may work or may not work for them.

Rebecca Gudeman:
The second guiding principle is to respect and accommodate individual needs and preferences. Take the time to get to know youth and their priorities as individuals. And remember that the most important concern to address first is the concern that brings the patient to the room. Even if you as a provider feel compelled to address many other issues. And oops. And we think this quote sort of encapsulates this, people are really looking to create that connection with you, and they will be more open and forthcoming if you are able to approach them in a way that feels like you recognize them as humans is what they've told us.

Rebecca Gudeman:
Our final one is to center the impact of response to and recovery from trauma. A lot of times we hear about trauma-informed care. Sometimes people talk about trauma responsive and healing centered approaches. This is certainly important when you're dealing with groups like youth in foster care who've by almost by definition all been through trauma, but too many of us have been through trauma. So, adopting these practices across your clinic can be really powerful and a lot of this has to do with providing agency and autonomy and also being very confidentiality conscious. So let me use a case example to just sort of highlight how this might happen in practice. So, V is 16 years old, non-binary and currently living in a short-term residential therapeutic placement. This is what we call group homes.

Now their legal name is Victoria, but their chosen name is VV arrives at the health center in a group home van. And when it's time for the appointment v's. Brought to the exam room on their own, what should be the provider's first step? So, I just want you to take a second to think about how your ideas on how you would approach this person. I'm not going to ask folks to sort of volunteer anything, but just think about what you see here.

Rebecca Gudeman:
And if we think about those grounding principles we were just talking about, one of the ones that jumps out for me is respecting and accommodating individual needs and preferences. You will do a lot by recognizing up front when you go in the room that V identifies as non-binary and simple things like asking about pronouns and preferred names. Making sure you use general neutral questions can help send that signal that you are recognizing their individual needs. If we think about the third prong about trauma, this person's coming in from a group home that it's important to recognize that there may be trauma in their lives. And so, some of your first steps may be to want to establish safety and parameters for confidentiality. I'll note that the toolkit I mentioned has tools that go into more depth about all of the things I've just mentioned about how to explain confidentiality, a tool for engaging in a trauma-informed introduction and how to even physically set up rooms in a trauma-informed way.

Rebecca Gudeman:
Just as an example of one of the toolkit tools that we have, this is one of the tools in the toolkit. It's a trauma sensitive approach to a physical exam and it talks about, it gives some sample language here. So, before we get started, I'm going to walk you through what we'll be doing during the exam, how to talk through an exam, and then what to say after the ways to ask questions. And it has hyperlinks to additional materials. There are also tools for how to explain confidentiality and plain language and adapt what you're saying to the audience depending on their age and what they're there for.

Rebecca Gudeman:
If we go back to V, let's say you've done a great job introducing yourself and v's decided your energy is good and that they want to open up and they tell you they've been dating someone and would like to go on birth control. How do you approach this? So again, just think about it for a second and if you think about the principles that we were laying out there around shared decision making, centering the impact in response to trauma and respecting and accommodating individual needs, I'll let you just think about it a little bit. What I will flag is that we have in the toolkit both some tools that might be helpful for this tools on how to do shared decision making approach to contraceptive counseling and even tools on how to do inclusive counseling with folks across the gender spectrum because of course it's not just cisgender heterosexual females that can get pregnant, anyone with a uterus and ovaries can even if they're taking testosterone. And so, there's more details on how to both do counseling across the gender spectrum and to do so in an inclusive way. And also, there's a lot of tools in there that talk about shared decision making and understanding how a young person can be an expert in their own lives.

Rebecca Gudeman:
So, V shares with you that they're worried that their group home supervisor may be confiscating their birth control and they also mentioned that they're not sure they'll be able to come back for another appointment since they have limited access to transportation. So, this case highlights why it's so important to know the rights of young people, whether they're in foster care or in the general community so that you sort of have flags go up if you hear about things that don't sound right. Just as an aside group, homes are not allowed to confiscate contraception. So that would be illegal, but that

doesn't mean it doesn't happen and it's important to take into account when you are coming up and using shared decision making with a contraception plan for somebody like V. So, is there contraception that may be appropriate given the living circumstances and the realities that VIA is living in right now?

Rebecca Gudeman:
Some of the other things you'll find in the toolkit, these are just a couple examples of other tools that you'll see there. So, encourage you to take a look and you'll see a lot more youth quotes and voice there. If you're interested in the toolkit, there's a link here. A lot of the other charts and guides I've mentioned today can be found on our website, teen health law.org. And I would encourage you to go back to that in January because as I said, some laws are updating at that point. So, we'll have updated material online and I think that brings us to questions. So, we welcome questions in the question section of the control panel or if you later on think of things, I don't hesitate to reach out to me. I've put my email on this slide. We will be updating in addition to sort of answering questions here, we'll be updating some materials for our website. So, if there are a lot of frequently asked questions here that resonate, we will try to make sure that we create material to be responsive to your needs. And I think that is it.

Nicole Nguyen:
Thank you so much. That was wonderful. So, Rebecca, I think if you want to, you can start with the q and a. We do have a lot of good questions and I just want to remind everyone I know if you're familiar with our webinar that we usually end at one 30 sharp. So, if you have to leave, don't worry about it. But Rebecca has also kindly agreed to stay on for an extra 15 minutes to answer any questions. Since we get a lot of questions coming in, we have a really robust audience. So, if you need to leave, go ahead and still put in your questions. We'll get them answered and get out to you in a few weeks. So, take it away, Rebecca.

Rebecca Gudeman:
Okay, so I'm just going to start to go through the questions I see here. I see a question, does prevention include consenting to HPV vaccines? And the answer is yes. Minors 12 and older may consent to preventive STI services and that does include consenting to the HPV vaccine. I, okay, let's see. If a teenager presents for a visit in the clinic, is it enough to get consent over the phone from the guardian or do the guardians have to be physically present? Okay, so as we said, as a general rule, a parent or guardian usually needs to consent to healthcare. So, I'm assuming in this case we're not talking about minor consent services. We're talking about let's say a physical exam. There's nothing in black and white law that explicitly requires a parent to be physically in front of you when they consent to services or to sign a written document.

Rebecca Gudeman:
That said, for risk management purposes, your lawyer or your organization may choose to adopt a practice that requires physical presence or requires a signature. And it sort of depends on where you work and the kinds of services that you provide. So, the answer to that question is the law itself may not explicitly require it, but your practice may choose to adopt that in order to make sure that you can assure that this is in fact the parent that's calling. Or if for example, you're trying to get a consent, that will be an ongoing consent in order to just sort of document it for your records.

Rebecca Gudeman:
Let's see. What protections or guidelines are there for providers who use minor reported status? Exceptions like living separate from family and that ends up not being true. Okay, so this is one of those things where it's important to work with your legal counsel on the best approach because the law doesn't explicitly require you to get a notarized document from the young person swearing on their mother's grave or whatever, that they are in fact living apart from their parents, that they're 15 or older. But your counsel and your administrative team may choose to adopt different policies and practices in order to be able to sort of show that you've at least taken a look. So as a practical matter, if someone's been emancipated by a court, they would have a court order, they might have an ID from the DMV that says that they're an emancipated minor. There are different ways to confirm that they in fact fit that criteria. Some people have created their own forms with check boxes that they'll ask a minor to fill out to confirm whether they're living apart and financially independent. But again, that's really something to work with legal counsel on to decide how frequently you see young people that might fit that category and what would be sort of appropriate. That wouldn't ultimately become a barrier to care for young people who legitimately fit into that criterion. Okay.

Rebecca Gudeman:
Is a parenting minor able to consent for care for their own child even if they cannot consent to all care for themselves? Yeah. Thank you for asking that. So, a parent is able to consent to healthcare for their own child even if the parent is a minor. So going back to I think that original quiz question, if we've got a parent coming in with their one-year-old child and asking for flu shots, the minor parent may not be able to consent for their own flu shot, but they would be able to consent for their child flu shot. They would be able to consent to brain surgery for their child, but the parent may not be able to consent for their own brain surgery. They would need their own guardian or parents' consent. It's sort of an interesting sort of dichotomy. We've set up contraception services. What about permanent methods of contraception? Thank you for asking about that. Minors are not able to consent to sterilization. I should have made that clear on this slide. So, minors can consent to long-acting contraception, but they cannot consent to sterilization as a minor.

Rebecca Gudeman:
Contraceptive services are for all minors less than 12 included? Yes. Minors of any age, including minors under age 12, can consent to contraception just as minors of any age may consent to pregnancy related care. And sometimes that throws folks. But really what they've wanted to acknowledge is that everybody goes through puberty at different ages and stages. And if we have a young person who's 10 or 11 who has questions, who thinks they might need contraception, who thinks they might need a pregnancy test, we want to make sure that every door to care is open so that they can come in and see you. Maybe this is about education, sexual health education, maybe this is someone who is in a dangerous relationship, but we want to make sure both that their immediate healthcare needs are met and that we have eyes of trained experts on them to make sure that we know what's going on and that they're taken care of.

Rebecca Gudeman:
Going back to that original case, if the 17-year-old wants only contraception and not the flu shot, then she will be able to receive contraception services. Correct. So, the 17-year-old parents may not have been able to consent to a flu shot, but because we have a service exception that allows minors to consent to contraception, she would be able to get the contraception on her own. She just wasn't able

to get both services in that case scenario. Does consent for contraception also include assurance that info will not be shared with parents or is parents a separate set of laws? Yeah, so as they are separate laws, but as we saw the law in California is that if the minor consented or could have consented to the care, so the minor consented to contraception or could have, they can then the minor controls release of that information and it cannot be shared with parents without getting explicit written consent from the minor patient.

Rebecca Gudeman:
Okay. Let's see. Okay, I see a couple folks flagging where they believe there may have been in practice some violations of these laws. That's not something I can comment on in a general webinar, but to the extent that you have questions or concerns about, that's something to flag to your own legal counsel or maybe reach out separately and I can talk to you about it in more detail offline. Can mental health care include medication? So, minors 12 or older in California who are considered mature enough to participate intelligently in services, may consent to outpatient mental health therapy on their own. This does not include the right to consent to psychotropic medication. So, if a minor needs psychotropic medication, they would still need to get their parent or legal guardian's consent.

Rebecca Gudeman:
Is a foster parent even the legal guardian for a minor? Wouldn't it be their caseworker? That's a great question. In some cases, the person with legal custody with healthcare consent rights may still be their own biological parent. In some cases, it may be the foster parent and it depends on the status of the case. It can be really confusing. We actually have some materials up on teen health law.org that helps explain who's able to consent for general healthcare for kids in the foster care system depending on sort of the stage of their case and the type of care that they need. Is it an emergency situation? Is it minor consent? So, if you work with a lot of youth in foster care, I encourage you to take a look on our website.

Rebecca Gudeman:
Could you pull up the minor consent exceptions based on status slide one more time please? Absolutely. And I also will say that they are included in the handout that's called the minor consent grid on the final page you'll find of the final page of that grid. But let me see if I can both share my screen, and I will go back to the beginning. Sorry for close your eyes for a second as I screen back through these. Okay, I'm getting there. Alright, there's our status exceptions. Alright, there is a question about patients with intellectual disabilities or that are non-communicative and parents making medical decisions and they usually don't have legal documentation as providers. Just follow the parent's lead. Yeah, this is really common. It's really tricky. It can be confusing for the parents because they're so used to making decisions and it may be obvious that their child, even if the child is now 18, 19, 20 years old, doesn't have the capacity to consent to healthcare. But if this is a young person who is, whether they're a young adult or a minor who is really going to need assistance moving forward, then the parent should be encouraged to establish a conservatorship to get legal documentation that gives them the legal authority to continue to make healthcare decisions on behalf of their child. And there are legal service organizations that can help them with that and that have a lot more information available like disability rights that have a lot more information available on sort of what that process might be.

Rebecca Gudeman:
Do we need to look at both the status and service coverage in order for the minor to provide consent? That's a great question. It really depends on the kinds of services that you provide and the kinds of clients that you have coming in. If you have a lot of young people coming in, a lot of minors coming in

for general healthcare, it may behoove you to have some materials that help explain the status exceptions and that allow miners to, like we were saying before, do check boxes to identify whether they meet one of these categories. If what you primarily provide is family planning, it may be less relevant because most of the services you provide may fall under the service exceptions and so it would be less necessary. Oops, where did our service exceptions go?

Rebecca Gudeman:
So, if you really focus on contraception family, STI services, it may be that you pretty much know that you're covered here, but it can be helpful to at least know that there are exceptions in both categories. For IUD consent, do we need to collect consent from both foster care and minor patient? No. So minors, whether they're in foster care, juvenile justice, even immigration, they have the right and they have the exclusive right to decide whether or not to have contraception including IUDs. So, if a minor in foster care once an IUD, their consent alone is sufficient and if they say no, that is sufficient. It can't be overridden by the foster care system or a foster parent.

Rebecca Gudeman:
Let's see if the sexual health related request primary indication is other than contraception such as to mitigate a current medical condition risk, does the minor consent apply? All right, so I think sometimes this comes up when people may be asking for birth control to help with skin conditions is just one example. This is really a question you should bring to your own legal counsel. I know that sometimes young people may claim that they're looking for example to for contraception in order to address a skin condition when in fact their real interest is contraception for contraceptives sake. So, I don't think there's really a black and white answer that I can provide to that, but I do think it's an important question to bring to your own legal counsel to create discussion around what the scope of minor consent might be in those situations.

Rebecca Gudeman:
Okay, I see. Can you explain more about foster parent consent for contraception? I'm not sure what more to say. I can say that we have a lot more information about both rights and obligations of the foster care agency and the rights of youth on a separate website that's called foster repro health.org. And we also have it in our toolkit, which I shared the link to. And if you still have questions or if you serve a lot of youth in foster care and want to talk to us about some of the specifics, I encourage you to reach out via my email address that I shared. I'm going to see if I can get back to the resource link page. So, the toolkit that you see linked here includes more information on delivering services including sort of legal issues delivering services to youth in foster care.

Rebecca Gudeman:
I heard consent laws also change for substance use disorder and treatment. I'm curious what those changes. Indeed. So, the law, a law was passed in 2023 that creates space for young people to consent to certain substance use medications, disorder treatment medications. And that law goes into effect January 1st, and we will be putting updating the chart on teen health law.org at that time to reflect the law. But it was trying to create space for young people to be able to access a small group of young people to be able to access some specific medication as part of substance use disorder treatment.

Rebecca Gudeman:
Does it relate to MAT and consent needed for this? It relates to, and I always say the name wrong by proof. I won't even pretend to say it. So, it does relate to mat, but to a specific medication. Alright. All

right. Question on consent. Consent allows treatment providers to provide services to minors without parent consent. What if a case coordination provider wants to help the minor coordinate their reproductive healthcare? Would the care coordination provider be protected under? I'm not sure I understand. I'm afraid. Jeremy, I'm not sure I fully understand that question that you are asking. I apologize. Please feel free to add more detail or reach out to me privately.

Rebecca Gudeman:
Let's see. We are having a hard time with our EHR and getting appropriate documentation done for sexual health things with patients who are minors. Any insights on that or what our other clinics have done to make sure minor sexual health info is kept separate from general charting? Unfortunately, this has been an issue from the moment we started electronic health records. Part of the challenge is that some of the big companies that sort of do the software for electronic health records, they sell their services nationally. Of course, each state has its own minor consent laws. So, while they recognize that those exist and the confidentiality rules are different across all those states as well, it's not been easy to sort of create space that recognizes exactly the way that we do it in California. I personally find it really frustrating. I know that there are a number of groups nationally looking at this even as we've now gone into the 21st Century Cures Act and really look now we're looking at concerns about electronic health records, not only having information shared with parents but crossing state lines. There are folks looking at that. I think the only thing I can say is that this has been a long-time problem and you aren't alone. Although to the extent that there's anyone on the webinar who has any successes they might want to share, I would encourage you to include that in the chat right now.

Rebecca Gudeman:
Could parents call in to schedule an appointment for their minor through our call center? I appreciate that question because a lot of times we're talking about minor consent laws and really emphasizing that information can't be shared with parents without minor permission. But that doesn't mean we don't want parents involved. We do know that the majority of young people want to include their parent guardian or that supportive adult in their life, and that's wonderful to support them in that. And so, the big question would be just making sure that your client is comfortable with their parent being involved and helping them and that you're able to confirm that carefully and clearly with your client so that they're not feeling pressured to sign a release, for example. Now if a parent is making, sometimes you may not know if it's a parent or someone else making an appointment for a minor. And so that also leads to thinking about when we're in that clinical space, how do we make sure that this is something that the young person actually wants.

Rebecca Gudeman:
Let's see. Are insurance companies required to follow HIPAA policies when it comes to sending the bill to a minor's residence where parents also live? This is an important question. California is one of a few states that has changed some of the rules for insurance. So, in our state, if anyone gets a sensitive service and sensitive service includes any sexual or reproductive health service, insurance companies are supposed to send any communications about that care to the patient, not to the owner of the policy. Now as a practical matter, they may be sending that letter or communication to in the name of a patient but at the home that they share with a parent. So that may not be as protective as we wish, but miners are allowed to reach out to their insurance company and request what's called a confidential communication request and tell the insurance company I want communications about my sensitive healthcare to be sent to an alternative address or an alternative email.

Rebecca Gudeman:
And maybe that's their friend's house, maybe that's their provider's address. But the insurance company is required to accept that request and to start diverting communications to the address that the minor patient shares. There have been some challenges implementing this and getting insurance companies to actually honor this law, but you do have the right to call into your insurance company and confirm that they've got an alternative address on file before you seek a service. So if a young person wants to seek prophylactic HIV medication or wants an abortion or wants a pregnancy test and wants to use their insurance and make sure their parents don't find out, they can try to put these confidential communication requests in place before confirm it's in place and then before they go and seek the service and have information go out. But again, in practice, I think that there have been some breaches, but it is important to know, at least on paper, the law says that there is a way to divert that communication.

Rebecca Gudeman:
Okay. There was a similar question around insurance. 18-year-old is pregnant and partner is 35. Should this be reported? Child abuse reporting is about young people who are not adults about minors, people who are under 17. If this is someone who became pregnant when they were 17, you may want to take a look at the chart and look at the definitions of child abuse and decide whether you think that this is something that would be reportable as someone who was 17 engaging in sexual activity. Was this a coerced relationship? But that I would look to the guide that the more detailed guide that we have in the handouts.

Rebecca Gudeman:
All right. What if an incident was already reported, for example, sexual assault. Do we need to continue reporting if patient continues to disclose when asked the questions? This is an important question to bring back to your own clinic and legal counsel for guidance. The only thing that I can say is that mandated reporting is an individual duty, but it is appropriate and allowed for clinics and agencies to come up with some standardized reporting protocols. So that's why it can be helpful to work with your clinic on how to approach that. And depending on the kinds of service that you provide, it may be that you're in a situation where that would come up a lot. And so, it can be really helpful to talk that through.

Rebecca Gudeman:
Most sexual assault will be reported by the provider. Correct. So again, mandated reporting is an individual duty. So, if you as a provider have a reasonable suspicion of child abuse, that means that your duty to make a report has now been triggered. That said, if you work within a system, the law allows your system to create procedures that centralize reporting. So it may be that you're in a place where they've asked providers to centralize all reports through one staff person. That's okay. It's just on you to make sure that the person who sort of is tasked with that duty actually does make that report. If you think that a report is necessary. Do all these consent and confidentiality laws still operate under FERPA in a school setting? Great question. We have a number of materials that talk about HIPAA and FERPA and the differences in confidentiality rules When you provide services on a school site, consent laws operate the same no matter where you are, whether you're on a school site or in a private or public clinical setting. But confidentiality laws may be different depending on who is employing the healthcare provider, the scope of services being provided, the funding stores, et cetera. So, if you work in a school setting, we encourage you to take a look at the HIPAA FERPA materials we have up on the teen health law website.

Rebecca Gudeman:
Let's see. I see we're sort of up on time. I can stay a few minutes over, but I don't know. I know you wanted to make sure people did evaluations. Is there anything you need to share, Nicole?

Nicole Nguyen:
No, I think that is good. So, if you are able to say as the long as you can, Rebecca is the answers me because you want to, and once it ends then the evaluation will go out and then we'll collect all unanswered questions.

Rebecca Gudeman:
Okay, great. Okay, I can stay a few minutes more comment on reporting. Even if we as providers do not inform parents after report has been made regarding confidential information, we have no control over whether or not law enforcement will divulge information from the report to parents. That's absolutely true and in fact we think it's part of trauma-informed mandated reporting is to help your client understand that, that while you may not be sharing information with their parents, if CPS or law enforcement chooses to go out and investigate, they are not under the same rules and they may well let your parents know. And so, you may want to talk about what does that mean? Is there any danger when parents find out, is there a better way to let parents know? But I appreciate you sharing that comment. I should have said that in the nickel handout, the table addressing when sexual intercourse with a minor must be reported, there's an asterisk at the bottom that states this is about vaginal intercourse.

Rebecca Gudeman:
I was wondering why the table and information doesn't apply to other types of sex. Great question. The answer is that there's slightly different rules depending on the kind of sexual engagement. If it's touching, if it's for example, and the longer handout that we shared includes more details, but we actually will be updated because that has been asked so much. We will be updating that grid to include other types of intercourse, specifically anal intercourse and oh my gosh, I'm blanking. A couple other types of intercourse in order to try to be more comprehensive because that question has come up a lot. So, thank you for that question.

Rebecca Gudeman:
And then someone asked for the toolkit link, so thank you. It's right here. Alright, let's see. I'm going to try to find one more before I need to close out. Why does California put a lower age limit on STI services but not birth control services? So, minors need to be 12 or older to consent to STI services, but minors of any age can consent to contraception services. You ask why? I think that's a question to put to our legislature. I do not know the answer to that. I can make some guesses, but in the end, these laws are written by the folks that we've elected, so we can certainly ask them.

Nicole Nguyen:
Yes, I think that, thank you so much, Rebecca, that was amazing. We have lots of questions that we'll collect, the one that you were unable to answer, and we'll get that out. And again, thank you to the audience after this. This concludes our webinar. So, you'll get an evaluation survey that will comes up in the end. So please fill that out to give us your feedback. And then in about three or four weeks, we will give you the link to a follow-up email with the CME certificate, the recording, the slides, and all the information that Rebecca shared today along with the q and a. So I think with that, I want to thank Rebecca again. This has been amazing. We had so many speakers, so many questions coming in that

we're so excited for. And then so I hope we all enjoy and have a great rest of your week. Thank you so much.

Rebecca Gudeman:

Thank you everyone. Thank you, Nicole. Bye.

Nicole Nguyen:

Take care.