Consent to Confidence, Best Practices for Working With Youth During Their Family Planning Visits Webinar Transcripts October 30, 2025

Nicole Nguyen:

Good afternoon. Thank you for joining us today for our webinar title From Consent to Confidence, Best Practices for Working With Youth During Their Family Planning Visits. We hope you are all doing well and staying safe. My name is Nicole Nguyen, program manager of the Family Planning Program at the California Prevention Training Center. The CAPTC under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event. And then before we get started, I'd like to go over some housekeeping slides if this is your first time with us using the GoToWebinar platform. So the top right ribbon on your screen is the control panel. There's a question icons where you can submit questions and comments, a paperclip icons where you can access any handouts that will be attached from today's webinar. The setting icon controls your audio connection preference, and then there's this three dot icon is how you can toggle between full screen mode and access additional settings. And then to check your audio, please click the settings icon. From there, you can select your desired setting to join either through your computer or calling in through your phone. If your internet connection is a little shaky, we highly recommend that you call in through your phone for the best possible sound.

Laura Ellerbe:

I'm not seeing the slides.

Nicole Nguyen:

Oh, I'm sorry. Am I not sharing screens? Sorry about that. Let me, oh here we go. Sorry about that. Is there if I see my screen now? Okay, sorry. So let me go back there. Okay, yes. So yes, this is the little questions icon so you can submit all the questions and comments for our presenters. Today's webinar will take about 90 minutes and we'll include time at the end for the presenter to answer as many of your questions as possible. This webinar will be recorded and we will send out a follow-up email with the recording and the slide deck. There is an evaluation at the end, so please fill it out because your feedback is extremely important to us and really help guide us in developing our future content. And then I want to acknowledge that we are working with the University of Nevada, Reno School of Medicine to provide CMEs for this event. This webinar will qualify for 1.5 CME credits and is only available to those who watch this entire webinar live today. Those who watch the recording unfortunately will not be eligible for the CME credits. And the link to access your CME certificate will be included in the follow-up email along with the recording slides and the evaluation survey.

Nicole Nguyen:

And then for transparency, we also want to disclose that presenters, planners and anyone in position to control the content of the CME activity have indicated neither they nor their spouse or legally recognized domestic partner has any financial relationships with commercial interests related to the content of this activity. I also want to note that although this webinar is sponsored by the Office of

Family Planning and the Family PACT program, the information discussed today will not dive deep into Family PACT policies or any benefits specific to Family PACT clients. If you have questions regarding any administrative policies, benefits or wondering if your client will qualify for Family PACT services, please send in those questions in the question box and we will answer them privately through email after this webinar ends. Okay, so now I'd like to introduce our wonderful presenters. We are really thrilled to have Sarah Nathan join us today.

Nicole Nguyen:

Sarah is a nurse practitioner at the University of California San Francisco Adolescent and Young Adult Medicine Clinic. She's also a faculty member in the UCSF School of Nursing. She has been practicing clinically since 2008, focusing on primary and sexual and reproductive healthcare for adolescents and young adults. And in addition to being a clinician, she also holds a PhD in nursing with a specialization in health policy. Her research interests are pregnancy preferences, contraceptive decision-making and clinical and policy interventions to promote sexual and reproductive autonomy for youth. Thank you so much for joining us today. And Sarah, I'll hand over the mic to you. So let me stop sharing for a second and you should be able to share now.

Nicole Nguyen:

Yes, I see your slide.

Sarah Nathan:

It's going to take just one second. Sorry. So I can see,

Nicole Nguyen:

Sorry, just

Sarah Nathan:

Great. Can you see that? Yes, I can see it.

Sarah Nathan:

Okay, perfect. Okay. Thank you so much for having me. Really appreciate it. I love speaking about adolescents and young adults. I love working with them, so I'm very excited that so many of you are here today to be able to engage in this content. Few objectives for today's talk, I am going to differentiate between consent and confidentiality for minors specifically in clinical settings, apply the concepts of consent and confidentiality to sexual and reproductive health and then identify fundamentals for care in working with this population. And I have no financial relationships to disclose. I like to frame this discussion and talks that I do on sexual health and thinking about sexual health in a broad way. I really love this quote from the WHO meeting of a group of experts and it says, sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality.

Sarah Nathan:

It's not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence. I think this is so important that we frame this in a broad way for young people, especially because this may be the first time they are accessing any kind of healthcare by themselves and it can be a really scary thing for them. And it is part of our job as healthcare providers to be able to help them move through life and be able to access healthcare in a way that is helpful for them. So I'm going to be talking a lot about centering the young person in every clinical visit, and that means asking them what it is that they need, what are their desires, what makes them happy, and also to really help them understand what does a sexual relationship look like that is free of coercion, discrimination and violence because it may not be obvious to them.

Sarah Nathan:

I'd like to start broad and then we're going to get right into some of the barriers because that's probably part of why you're here today because there are many barriers to providing sexual healthcare to youth. So certainly abstinence only sex education is a barrier and that is to compare it to comprehensive sex education, which is what I hope that we are all going to get to after today's talk. And that really means meeting the needs of youth, understanding the range of preferences that youth have and being able to provide them as much information as we can. Mandated parental notification. In many states this is an obligation and that certainly puts up barriers because many youth will choose to not access care if they think that the services will not be confidential. We're really lucky in California, and I'm going to talk more about that, about there are many services that youth can receive without involvement of parents or guardians. There are many biased healthcare professionals. We all do our best. We all are well-meaning and we have biases. And those can come through a lack of confidential services certainly. So this goes back into mandated parental notification, but confidential services or the lack thereof make a difference sometimes of whether or not a youth is going to engage in services or continue to engage in services. And I think a general discomfort in society with youth sexuality by adults, and this does believe it or not, include providers too.

Sarah Nathan:

Let's jump right in to consent and confidentiality. I want to make sure we're all on the same page in terms of what we're talking about when we say consent and confidentiality specifically in clinical settings. So consent is a patient's ability to give informed consent. So for example, you're giving information and then the patient is choosing whether or not they want to have a certain treatment or medical procedure. Confidentiality is what information stays between the healthcare provider and the patient and what information can be shared with others. And federal and state statutes protect against unauthorized release of personal information. I'll begin with consent. So who can consent to care? As a general rule, minors need a caregiver to consent to care the right of the parent or the guardian to consent to healthcare services for a minor is governed by state laws. Here in California we have a majority of 18 years old. So when we're talking about minors, we're talking about those under 18.

Sarah Nathan:

In California, minors can consent to care in specific situations without parental involvement. So those are these people who are under 18. There's two buckets here. One is a status exception. So that means

if the minor is in the armed forces, married or divorced, emancipated officially by a court or living apart from parents and managing their own financial affairs, if they meet any of these, a minor can consent to their own care. There are also service exceptions and that means the type of service that youth is receiving. So for example, pregnancy related services, contraception, STI, testing and treatment, mental health and substance use. So in California for all these types of services, a youth does not need a parent to consent to these services.

Sarah Nathan:

This is a chart that basically outlines what it is that we're talking about. What are the rights of minors in California? So you can see here the first column are the services the youth can consent to. So as I said, contraception, pregnancy, abortion, STI, treatment, sexual assault services, outpatient mental health services and substance use treatment. And in the middle you can see here what age so many of these minors of any age can consent to. And then some of these are 12 and up. So minors 12 and up can consent to any of these services without parental involvement. And this other column here is about can the provider tell a youth's parent or guardian that they have access to these services? Well, for the majority of them, no, you cannot, unless of course the youth says to you, I want you to involve my parent.

Sarah Nathan:

In this contraceptive visit that we're having today, there are some situations in which a provider should attempt to contact the parent or guardian. Now I think this is sort of ambiguous, a little bit gray area and I think it's a little bit of a gray area on purpose because you certainly can use your own judgment If you think as a provider that it would be inappropriate, it would put the youth at risk, then you don't need to attempt to contact a parent. Involvement in the situation does not equal parental access to the minor's records. It just means an attempt to contact the parent to maybe let them know that they have received this kind of service, but it is not that you would be able to then release the entire record of everything that you talked about in that visit for these specific types of services.

Sarah Nathan:

And of note for outpatient mental health services, for example, a minor can consent to these services for outpatient therapy, but if you're prescribing a medication, so a psychotropic medication that you would need parental consent for. So there are some exceptions to these rules as well. I wanted to also provide, this is just a screenshot of the Medi-Cal minor consent services and I have the reference right here so you can go back to it if you need it for your clinic systems. This shows the exact same thing I'm just talking about that all of these services are eligible for minors to receive without parental consent in California, and these are called the Medi-Cal minor consent services. And you can see here also broken down by age, but just a nice reference for who are not maybe used to doing this or maybe need to justify this to administrations just a nice place to go to be able to see how lucky we are actually in California to have all of these services that minors can access without parental consent.

Sarah Nathan:

Going to move now to confidentiality. These are federal and state statutes again that protect against unauthorized release of personal information. So some examples of federal statutes is like HIPAA, health insurance Portability and Accountability Act, parents have a right, they have access to the minor's health

record except when in states, for example, that have minor consent laws, a minor has accessed that type of service that falls under minor consent. So for example, if a minor is accessing contraceptive services in California, that visit should not be available to the parents. So the open health record should not be able to show everything. So that's why it's so important to have protocols in place for your electronic medical record system so that you're able to lock certain visits or make them sensitive so that a parent, if they're asking for all of the records of their child, wouldn't be able to access everything because the minor again has the right to suppress certain visits because they are able to access those services without their parents seeing them. Title 10 really remains in flux. There's been a lot of political back and forth. There was a 2022 ruling that recipients of Title 10 funding, which provide grants for many reproductive and sexual health services are able to require parental consent depending on state laws. So again, in California we have state laws, so this is sort of the interplay between federal and state. We have state laws that protect minors, but in states that don't have minor protection, confidentiality protections for minors from these Title X clinics are really at risk under this current federal administration.

Sarah Nathan:

As a general rule, confidentiality follows consent. So in California a state with minor consent laws, a minor can consent for that type of service. So again, the example of contraceptive services. A provider can't break confidentiality to tell a parent about that particular service. There are of course exceptions. So communications between qualified professionals for coordination of care, any disclosure of child abuse, so that includes sexual abuse, sexual assault, neglect, willful harming or endangering a child or certainly disclosures of danger to self for others. Those are reasons that you are going to have to break confidentiality even if those disclosures happen within the context of a visit that is otherwise under the minor consent laws. There's also another thing that I want to bring up that some diseases are reportable. So in California we have to report to the health department, gonorrhea, syphilis, hepatitis, HIV. So you may want to let people know, young people know if you're not able to contact them and they need treatment or if they're unreachable, then they may be visited or called by a public health worker. And in that could situation, you may not be able to ensure confidentiality, right sort of out of your hand. So I think it's something else to bring up with young people.

Sarah Nathan:

Important, also in this category of when we sometimes have to break confidentiality is that sometimes consensual sex between two minors is actually reportable as child abuse and all of us as mandated reporters would be required to report it. So I like this chart, it's complicated, but I think it's good if you're working with young people to have a copy of this and please feel free to take this and put it up in your office of when you might have to report. You can see here there's the age of the patient. So for example, you have a 12-year-old patient and they tell you they're having sex with a 14-year-old. So you can see here that that's in that orange category, the M which is mandated report, so that would be a report, but if that 12-year-old tells you they're having sex with a 13-year-old, it's not a report, it's in this white zone.

Sarah Nathan:

CJ means clinical judgment. You are of course always able to report as child abuse. If you are concerned that sex in any way is coerced or involuntary, you are also not required to ask the partner's age. I think this is really important because some providers, and this is going to depend on style, but I personally

don't ask the age of partners. It's also really important that before your patient starts talking that they're really clear, and I'm going to go into this more about the exact language I use, that they're really clear about what it is that if they told you you would have to report so that there's no surprises. So there's no sort of breach in trust of the young person because now they're shocked that you're having to do a report.

Sarah Nathan:

Privacy is important for all of us. We all value our privacy. It becomes extremely important for young people. Early in adolescence though youth are both striving for independence and autonomy and this results in periods where they may be reluctant to be open with adults or seek advice from adults and you as a medical provider can provide a lot of education and information and be a sounding board for young people and it's important that they understand sort of the confined of the relationship. So when you would have to break confidentiality, the assurance of confidentiality becomes a really important consideration for many young people when deciding to access or return for health services. So you want to make sure that you understand confidentiality rules and if you move to another state that's not California, that you understand them so that you can explain them to your patient.

Sarah Nathan:

It's also important, as I mentioned before, to look at your workflow in your electronic health record to make sure certain notes can be suppressed and not shared to make sure after visit summaries are able to be edited or don't print them so that you can make sure that you're providing care and not have to break confidentiality or have a parent see something that they shouldn't see because the patient has a right to that information and doesn't have to share. That's why it's so wonderful to have the family packed program and also minor consent Medi-Cal. This is so essential for individuals. For example, with private insurance that might be their parents might receive itemized bills that might show a chlamydia or gonorrhea test for example, but to be able to enroll young people in Family PACT or Medi-Cal send itemized bills, so specifically for these minor consent services, that is such a wonderful thing that we have to be able to ensure confidentiality for our patients.

Sarah Nathan:

So what do I say? What is sort of the language I use when I'm working with young people? I say the things that we talk about today are going to stay between us, but I have to break that and tell somebody and break confidentiality. If you tell me that you are being sexually or physically abused now or in the past, you are at risk of hurting yourself or someone else if you're under 16 and having sex with someone 21 or older if you're under 14 and having sex with 14, someone who is 14 years or older.

Sarah Nathan:

Also important considerations for working with patients who are undocumented. You can imagine that patients are often concerned about disclosures because of their immigration status and so it's very important to explain the process to patients before you make a report. It's also very important as I said, and this is important for everybody to outline it, is that you would have to break confidentiality so people understand before they disclose. It's very important to understand and have a relationship with law enforcement and what's happening in your specific county between federal law enforcement and local entities. So having a relationship with local police department so that you can explain to your

patient if you do have to do a report, what is going to happen and giving patients the opportunity to tell you as much or as little as they want is important for all patients.

Sarah Nathan:

You are going to explain in the situation where you do have to do a mandated report that you have to do it and why and you are going to inform people that they have some control here. You've taken away some control for sure, but you can give back some by saying that patients can tell you as much or as little as they want and that is what you're going to put in your report. This is a sign that we have in our waiting rooms, in the bathrooms, in clinic rooms. It's from adolescent health working group. Feel free to take it and distribute it. It basically just uses the exact language that I said and somebody can be waiting for you in a room and staring at it and so that they can understand what it is that the confines of the relationship. So what will stay confidential and what won't because it's really important to talk about this often. So when I'm seeing patients who are under 18, it's not just the first time I meet them, we want to review confidentiality at a lot of different visits to make sure that people understand when it is that I would have to break confidentiality how that we have an understanding of some of the basic principles of consent and confidentiality and California. I want to move into some of the important things that I think about when I'm working with young people.

Sarah Nathan:

I think the communications and interactions should be tailored to youth developmental stage. Now there is not one developmental stage for every person. Everybody is different. Everybody has different realities, different experiences, and that's going to change how they may present or their needs. Of course, I think this is just guidelines that can just serve as a place to start, especially if you're not used to seeing young people in your practice. I like to think about adolescent developmental stages because then you sort of have some idea about the person that is in front of you and the way maybe you might change your communication tactics. So early adolescence really a lot of emerging identity peers are very important. So asking about what your peers are doing is very appropriate because that can give you some idea maybe about what the youth is engaging in as well. There's a lot of gains in height and weight.

Sarah Nathan:

There's certainly limit testing. It's important to be concrete and again, focus on the youth's concerns. Really put the youth in the center of this visit and find out from them what it is that they want. Middle adolescents, there's more reasoning about emotions and also emphasizing adult connections. Finding out from a young person, maybe it's not a parent or guardian, but maybe it is an aunt or an uncle or a person at school that really is in that young person's life and is giving them advice or they're able to go to for information. Late adolescence, people are often able to really think more abstract reasoning, thinking about transition planning, concerned about partners or future relationships and so you can engage more in a, so how would this impact what it is that you want to be doing in five years and they're really able to engage in more of that future planning.

Sarah Nathan:

Person-Centered counseling is essential in my opinion for all of us and every single visit we do no matter the age of the patient, but especially important as I've talked about with young people because young

people are constantly being told what to do. They're being told by their parents, by their teachers, they're being told by society that they are risk takers, that they are dangerous, that people should not want to work with them, and it gives them an opportunity if you are able to really get from the person in front of you what it is, what are their goals, what are their desires, what is it that they want out of this visit? I do a lot of normalizing, so I think I say, oh, I have a lot of patients that tell me blah, blah, blah because I think that that helps the young person think, wow, I'm not the only one dealing with this. And that can be really important because again, this might be the first time they're accessing healthcare by themselves. This might be the first time they're bringing up this really sensitive vulnerable issue for them.

Sarah Nathan:

Positive steps and successes should be acknowledged again, because so much of a young person's life could be the world telling them that they're doing the wrong thing or they're taking risks or they're using too many substances or not doing well enough in school, and so there's a lot of pressure there. So taking something from what you're hearing the youth tell you and acknowledge it and say out loud, wow, it sounds like you're really working on this and you're making such progress. Every interaction is really an opportunity because it can be really hard for young people to get in front of us, and so make sure that if they do, you're able to offer a range of services and that if you don't know the answer and you're not the right one to be handling it, that you have resources so that you can give them something before they leave Using open-ended questions.

Sarah Nathan:

Again, this is just important for all of us, but don't close down the conversation. Be curious, be open. And again, this referrals, having referrals for emotional behavioral health wellbeing so that the young person, even if they're accessing physical healthcare from you, that you're able to give them resources for whatever else it is that they need. In our clinic, we're really lucky. Social work is available for warm handoffs. They're part of our team and I do think that that is a huge part of adolescent and young adult medicine is that team approach being able to connect young people because their medical issue may be a small part of what it is that they need. They may need housing resources, food resources, et cetera.

Sarah Nathan:

The discussion of the parameters of your relationship again, should be done not just once but in multiple occasions. And not just talking about confidentiality, of course that's a really important one, but also cost. If there's any of, there's copays that young people are not surprised, that's going to help them feel like they can trust you and ask questions and want to come back and see you and engage care. I'm just a huge believer in this last one, believe youth within reason. It doesn't hurt you to just believe someone or look like you believe somebody, even if inside you're like, this is a ridiculous thing that somebody is saying to me believe youth because it gives a message that you are invested and that you are centering this person in their care and you really are taking them seriously. So I encourage you to try this.

Sarah Nathan:

A really important part of being able to provide what I think is comprehensive care to young people is separating them from the adults in their life. So many of us work in clinics where we do primary care,

which is what I do, and so that can include everything that a young person may need. So a youth might be coming to you for example, for a physical exam or for a visit for their asthma, and they may also want to talk to you alone or need to talk to you alone about sensitive issues. So for the physical exams for example, these are longer appointments for us. So this is really easy to do. It's really important to make that a priority in your clinic and think about how you can separate young people. You want to lay out the course of the visit, so you're going to have the youth, their parent together.

Sarah Nathan:

We're going to start all together. Then parent, I'm going to meet with the youth alone. You can sit in the waiting room and then I'm going to bring you back. You are not singling out their child. This is what we do for every single visit. This is our program policy and you're going to acknowledge that we know that your youth is a minor and here in California they have certain rights and that means that we are going to review consent and confidentiality and explain to the parent that there are situations in which you are going to break confidentiality. So that reassure the parent or the guardian that if your child discloses that they would like to harm themselves, then you can and you will discuss it and you are going to break confidentiality. And then finally thanking the parent for being there, really validate that they are here.

Sarah Nathan:

It is challenging as a parent sometimes to feel like you are losing some control. You want to thank that parent for being invested in their child's healthcare or that guardian or whoever is there with that young person. And you also want to say that it is equally important that youth have autonomy. And so you're going to appreciate both in this visit when you have the youth alone for the portion of the visit where maybe you're going to do the exam and you're going to talk to the young person. You can encourage youth to discuss issues of sexual health with their parent. And I do this because we know that it is really valuable to have an adult in your life that you can talk to about things. Of course only if this is appropriate. There's a lot of different individual circumstances that would make this not appropriate.

Sarah Nathan:

You can help explore approaches the youth might take to be able to have this conversation. How do they imagine this conversation would go? You can offer support tools and you can offer to facilitate. I often do this or I say, would it be helpful if when we bring your parent back we all talk about this? Of course you need to get the consent of the minor to say, Hey, we've just decided that you'd like to start a contraceptive method today. Would you like help in talking to your parent about that? And maybe the answer is no, but that's something that you can offer because that facilitation models how they can have these more difficult conversations with the adults in their life.

Sarah Nathan:

Specifically, I also want to touch on sexual and reproductive approaches or approaches to working with people in the area of sexual health because that is a lot of what we do when we working with young people. First off, as I started this whole presentation, let's think about sexual health in a really broad positive way. So sexual exploration with yourself, with others is part of a normal healthy development and we want to make sure that young people understand that adults understand that so that we are not creating an environment of shame of people feeling that they can't share things. Of course, these are all really vulnerable places. These are things that are very difficult to talk about often. And if we approach it

as that this is normal and healthy and a part of development that can really help people to think, maybe not on today's visit, but maybe in a couple of months when I've met you a couple of times, I'm going to feel comfortable talking to you about this, discussing that we all deserve relationships, sexual or not, that are free of coercion and violence.

Sarah Nathan:

And then as I talked about earlier, talking about what that looks like and what that means and refraining from making assumptions. We all are going to make mistakes, but keeping things broad. So when asking about the types of sex, so what are the body parts someone is using or they are interested in using? And so what body parts are touching, what body parts or what body parts are entering, what body parts. And it's not because we're nosy really explaining to people. The reason that I'm asking you these questions is because I want to understand where we should be testing, for example, for STIs where we should be swabbing because where are you at risk to have potentially gotten a sexually transmitted infection or are you having a type of sex that would put you at risk for pregnancy? And so we just want to let people know that we're curious and we are keeping an open mind and we are trying to figure out and help best support them in terms of keeping them healthy.

Sarah Nathan:

Reproductive autonomy is a huge topic. I'm going to briefly touch on it. I think it is really important and I am happy to talk more about it in the questions. It's so important and I think that over the years there's been so many well-meaning clinical interventions and public health initiatives that really have focused on pregnancy prevention for young people. And the way that we prevent pregnancy among young people is we promote contraceptive use and that all youth, we should be working towards getting all youth to be using contraception or to be not getting pregnant. But we know that some youth want to be pregnant, some youth are ambivalent, undecided, or maybe fatalistic about the possibility of becoming pregnant.

Sarah Nathan:

And interventions that promote contraceptive use as the end game, as the only focus really undermine the autonomy for young people and also perpetuate a mistrust in the medical system. So if a young person feels like you as a provider are only going to be preaching about IUDs, then that may make them not want to show up. And so all of this to say that is really important to respect sexual and reproductive autonomy in young people just like we do with adults. But I think that sometimes we forget that extra step of that. We're talking about reproductive autonomy and that is equally important in young people. There are a range of preferences that young people have around the way they want to have sex, who they want to have sex with, whether they want to be pregnant, whether they don't want to be pregnant, how they want to prevent that pregnancy, specifically when assessing a need for contraception because I think this comes up a lot in working with young people. There are a lot of approaches here. I like asking a direct question, just as simple as what are your needs, if any, regarding a contraceptive method.

Sarah Nathan:

There are a lot of tools, there are some scripted tools like one key question, and that's about whether you would like to become pregnant in the next year or the self-identified need for contraception? You

might want to play around with this if you are not as comfortable talking about the subject with teens and you kind of want a script. But I like being direct because I think if you're just asking about pregnancy intention, that's complicated because some people may not know how to answer that question. They may not know if they want to be pregnant, they may want to prevent pregnancy now, but then in a few months they might want to consider pregnancy. So I think some of these one-key questions or one question can be a little limited.

Sarah Nathan:

You can just let the patient dictate if they need and want additional information, which is why I like to kind of go to the direct question first. And again, there's not a right or wrong if you like the key question, if you like other tools, but allowing the patient to really dictate if they need or want additional information. And then also making sure that patients know about non contraceptive benefits of methods. So somebody might not even be having a type of sex that puts them at a risk to become pregnant, but they might benefit from a contraceptive method that for example, would decrease heavy menstrual bleeding. So we shouldn't make assumptions that young people know about this. And if a patient does desire a contraceptive method asking about the priority feature in a method to help guide counseling, some people that priority might be that it is the most effective method possible and it lasts the longest, right?

Sarah Nathan:

Other people, their most priority feature may be that they want to be able to insert it by themselves. They want to be able to put the ring in and out. They want to be able to take a pill every day. They want to make sure they get a period every month, they never want a period again for their whole life. There is a huge range of priorities and there's not a perfect method. And the method someone choose will not be perfect and we can trial and error. So I think that this is a place that you can experiment with people but really allowing them again to tell you what it is that they prioritize in a math lab.

Sarah Nathan:

Alright, I wanted to at the end here, get into some cases. I know we're a really big group, but I think these cases can just allow us to have a little bit of a discussion and you put some of your reactions, some of your thoughts in the chat. And Nicole is going to help me and read them out so we can sort of move this along in a way that we can sort of integrate some of the things that we've been talking about in order to think about the best practices in adolescent and young adult health and how we might approach these patients. There's no wrong answers of course, but Rh, she her is a 16-year-old requesting a pregnancy test. She's been trying to get pregnant, has not used any contraceptive method in a year and would like tests ordered to see if there's something wrong with her. So I think just first reactions to this case, what comes to mind here for you?

Nicole Nguyen:

I'm waiting to see if the comments are coming in.

Sarah Nathan:

Yeah, thank you.

Nicole Nguyen:

And please put them in the questions.

Nicole Nguyen:

Oh, so here's, okay, so why are you trying to get pregnant? To be honest, is her period regular? Why does she want to be pregnant? Does she have regular sex? Is someone pressuring her to become pregnant? What is her motivation to get pregnant? What is she thinking? And let's see, I would tell her it's very common to take a year or more to become pregnant, but let's talk about why you are seeking pregnancy. Are you having any regular periods? Are you tracking your periods? Do you know about ovulation? Can we talk about timing of contraception?

Sarah Nathan:

Great. So I think we all probably have some kind of reaction to this and it's important to understand what your reaction is. And once you do that, I would encourage all of you to exactly be curious, ask questions. What I, tell me a little bit about how you've been trying to get pregnant or how often are you having sex? What makes you think there's something wrong with you? Getting more information and all that and being curious and allowing this patient to have some opportunity to talk about what this would mean to her and where she is in the process of thinking about how this would impact her life of pregnancy. And again, people are just have a lot of different ideas and thoughts around being pregnant and it might be an initial reaction that this person is too young, it's not going to be great if she gets pregnant and we don't know what her story is. So allowing her to give us some of that is helpful. But I love these ideas of all these questions that you can ask her. Okay, JM, they/them 16-year-old is in clinic today with their mother visit to discuss heavy painful periods after discussing the options to decrease menstrual bleeding. Mother is very clear that she doesn't want JM to use hormonal contraceptives. When you speak with JM alone, they disclose they would like to be on a contraceptive method because they're having sex with someone with a penis and do not desire pregnancy. They've heard a lot about the IUD and want to know more. So what do you think here? Where would you start with this case?

Nicole Nguyen:

I'm seeing some comments in who is, who's in a safe adult that you can speak to about safe sex? Talking about confidentiality, I would make arrangements with JM to obtain an IUD at a visit without their mother. See what have you heard about the IUD and what do you like about it? And depending on the age of consent in the state should consider a confidential visit for the patient. Let's start with what you have heard or what, and then tell them more about it. Why does mom have concerns about hormones informing JM about their rights and ability to get an IUD, confidentiality, and if they want to. And then offering benefits and complications of the IUD. What other menstrual symptoms are you having and education about? Various methods of birth control, supporting the decision and providing information and schedule a visit without the parent for placement.

Sarah Nathan:

Yeah. Great. So really important here. This is why it's so important to be able to talk to JM alone in this scenario, right? You might've missed half the thing here, if you only went into the visit and talked about just the heavy painful periods with mom in the room. I think yes, validating mom. Mom, what are your

concerns? What are you concerned about with the hormones? And then talking to jam alone and talking about the IUD and getting all that information, what it is that you're really interested about, the IUD, what makes you really like it? And then yeah, getting that person another appointment. The best time to get an IUD and we try to do this as much as possible in my clinic if it is okay with the young person, is to be able to do the IUD then and there to be able to provide contraceptive methods when the person is asking for them, if that's possible.

Sarah Nathan:

But you want to strategize this with JM, if an IUD appointment can not be done quickly, most likely this would have to be set up as another appointment. And depending on the insurance, if they have private insurance and you'd have to get them on a minor consent Medi-Cal or Family PACT for that next visit. So that might be the case that this has to be another visit. Another thing too is talking to JM, be like, Hey JM, one of the indications for example, a Mirena IUD is decreasing heavy, painful period. So if you want, we can go talk to mom about an IUD as a method for decreasing this as well and that maybe there's a slightly lower hormonal content than the pill, for example. So you don't have to then disclose to mom every single reason why an IUD might be a benefit.

Sarah Nathan:

So you're able to still protect some confidentiality unless JM feels like they do want to disclose. So there's a lot of ways to go, but I really appreciate all of your comments about thinking through the way that this could go. And again, it's really nice in clinics where you can have a system where you can enroll patients in another type of insurance that gives them that confidentiality because for some private insurances, a parent might get an itemized list of, for example, that a birth control pill was prescribed or the IUD procedure was done. So it is really important to be able to offer confidential services to young people.

Sarah Nathan:

This is a pretty common scenario. This last case, so many of you may have seen this in your clinic RF, she her is a 16-year-old. You've seen this patient for primary care in your clinic accompanied by her mother. You've also seen her subsequent visits and prescribed her oral contraceptive pills because just as an aside, many young people will choose to come to your clinic with their parent for some types of visits and then very clearly come for these minor consent service visits by themselves. And that's totally appropriate. Her mother found a pill pack in her backpack. Mother called the clinic upset that the provider had prescribed this medication to her daughter without asking for parental permission. So what do you do in this situation? How would you handle this? And have you done anything wrong?

Nicole Nguyen:

It might be another thought too bad mom. Sorry, not sorry. This is something your daughter can get under the law without permission. Describe patient's, right? And confidentiality. Let's see, what else? Asking for any cultural issues. Oh, cannot acknowledge that patience was ever seen. Educate parents on confidentiality rights that minors have praising her daughter for being responsible.

Sarah Nathan:

Yeah, so these are great. Thank you. Yeah, you haven't done anything wrong because you haven't disclosed this to the parent because under laws in California, this is a service that RF can consent to without parental involvement. And in fact you, the provider would be at fault if you had done so without the permission of this young person when you are prescribing, for example, pills because harder to hide these in a sense you can talk through with a young person. I think it's a really good idea to think through the scenarios. How angry would your parent be if they found these pills or your guardian? How angry would they be if they found these right? Oh, super angry. Okay, wow. Can you keep these in a place where your parent won't see them, like a backpack, might not be the best place?

Sarah Nathan:

And so are there places that you can think about in your life that they could be more hidden? So you can help a young person work through some of these scenarios because you know that this is possible and these are difficult situations. I mean, I think you do want to let the parent know that I understand your concern and my job as a healthcare provider in California is to help also protect the rights of your child. And part of that is respecting the laws of minor consent. So I think this is a challenging thing for parents if they are not aware of minor consent. That's why it's so helpful to be able to go through these things if you can with when young people are coming to your clinic for the first time or at physical exams. It might happen annually when you think that maybe a parent would be there talking about these things and that doesn't mean that it will fix it and that parents still may not get angry. They might forget that you have this conversation, but you can try.

Sarah Nathan:

Great overall clinical policy takeaways. I mean there's so many, but I hope that you have some understanding right now of consent and confidentiality laws here in California. And I encourage you to think about promoting sexual and reproductive autonomy wherever you can. And that's really by engaging in how to provide resources to young people and helping them to get their needs met, get their preferences met. So maybe that's avoiding pregnancy or maybe that's becoming pregnant or maybe that's understanding their contraceptive need or understanding their need around sexual health or different types of treatments or where they're at. And really allowing young people to have some autonomy in this sphere.

Sarah Nathan:

Promoting sexuality is a natural healthy part of development for everyone. Sexual health is not just the absence of disease, we really want to think about it in a positive light. There are a range of preferences around sexual health, identity, the behaviors, the actions, everything. There's a huge range and we may not even understand all the things on that range. And so we can ask our patients too to help us better understand if that's what is needed, centering the patient always in the interaction, allowing them to drive the interaction as much as we can and allowing youth to design programs and clinical services. I think having youth advisory boards in clinics or having opportunities to be able to talk to our young patients about what it is that we could be doing that helps get their needs met better every once in a while. If you have a clinic that sees a lot of young people finding ways to meet their needs better by changing your policies in your clinic or designing the hours differently, I mean in the range of both possible. But I think that that is a great exercise to be able to engage young people. And again, they may not have ever been asked for their opinions here. And so this really sets them up for a lifelong journey in

navigating healthcare. So what a wonderful thing to be able to do in my opinion as a healthcare provider, is to start them off on that healthcare journey in a positive light that takes into account their thoughts and feelings.

Sarah Nathan:

And part of that is expanding contraceptive access. And again, we are very lucky in California, but for those who desire a method and breaking down clinical systems and allowing for potentially same day insertions of methods if that's what is needed and desired by the young person. So here's some references and you'll get these slides. I really look forward to the questions and if we don't get to all of them, you can feel free to email me. But this has been really great, so I look forward to having a discussion with you.

Nicole Nguyen:

So yes, I think there's some questions coming in already. We've assign them to you. So go ahead and go ahead start and then please continue to send the questions in and Sarah will try to get to as many of them as she can.

Sarah Nathan:

Yeah, so a question about chaperone use for sensitive exams, procedures. Should 12 and up be allowed to decline a chaperone with the parents' knowledge? If it's in the context of a type of visit where that needs a procedure, if it is a concern for a sexually transmitted infection and that's what the purpose of the exam would be for, and so the patient should be able to say what they need for that visit.

Sarah Nathan:

What if the parent refuses to step out of the room? This is really challenging and this does happen. And I think just going back to the idea of this is a clinic policy, so we do this with all patients. We are not singling out your child. It is clinic policy for every single minor at this clinic to be able to have time alone with the provider. And so we hope that that would work. And then sometimes you have to escalate this if a parent is really refusing to step out. But I do think that for the most part, if we can explain to parents and talk about minor consent and the laws, then I think that a lot of people will appreciate that.

Sarah Nathan:

I know laws are different state to state, how do you suggest handling an adolescent who wants to keep it confidential from their parent in a state where it is not allowed? So yeah, I guess I'm not exactly sure what thing, but for example, if anything in the sexual health realm, if this is talking about the birth control pills, this is really challenging. That's why we are so lucky in California. I think that the more you can strategize with the patient, if you can be with them alone for a little while of like, okay, we are going to prescribe you birth control pills, that's what you want.

Sarah Nathan:

Would it be okay if we had a conversation with your parent about other reasons to prescribe this medication that are not about sex? So that could be a way to say like, hey, there's all of these non-

contraceptive benefits for example. I mean the contraceptive one is a little bit easier, right? Because there are non-contraceptive benefits. And so can we strategize, can we talk with your parent and we don't have to disclose the sex, but we can talk about this as a health concern you're having because of your heavy periods. And can that be a reason why you're getting it?

Sarah Nathan:

Otherwise it's just really difficult. I mean this is why I'm so concerned about the current situation because that a lot of adolescents are going to have to choose and they are not going to be able to or they're not going to get services because they are fearful about if it's going to be confidential or not. How would you respond if a minor wants their parent to remain with them at all times? Yeah, I think again, it's the minor that gets to decide. I would definitely have a minute with the parent out of the room to ask that question. And then if the minor's like, look, I want my parent to be in the room, then just asking them to making sure that they understand the types of questions maybe that you're going to be asking. I think that maybe that may not be as clear. So I think that that is always something that can come up.

Sarah Nathan:

Is there any specific directive for unaccompanied youth? I'm not sure exactly what an unaccompanied youth is. So if they come to the clinic by themselves or if there's an unaccompanied youth in the country because their parents are in other countries and they're living here, this used to come up a lot in the clinic that I worked at before. If there are who's ever the guardian for that person, they are the ones that are being able to direct care. So even if there's not a formal guardianship, but who's ever taken responsibility for that person who they're living with, then that's the person that would be under the eyes of the law in California.

Sarah Nathan:

Besides developing open communication, how to approach birth control methods with a teen mom who is not interested. So a teenager who is a mother, that's how I'm understanding it, or the mother of a teen. So we can go either way with that, but so if the mother of the teenager is not interested in birth control methods for their child, but their child is certainly here and you can try to figure out a way with the young person to be able to prescribe or be able to provide a method that is be able to be hidden from the parent. But I think for a person who is a teen mother who's not interested in birth control, so maybe a teenager who already has a child, maybe you're thinking about for prevention in the future, again, if somebody is not interested in birth control, they're not interested in birth control. I think being able to provide information, asking the questions about what it is that they're concerned about using, and thinking about what another pregnancy would mean for you in your life, I think. So that is really important to be able to think about that. And from their perspective, how would they deal with that?

Sarah Nathan:

Are there best practices for documenting in the EMR teen versus parent contact information, B heads type assessment that have confidential info better are within a more general well child check? Yeah, it's a great question. You can have. So we use Epic in my clinic, two different notes. So we have a note, the note, whatever the general note that you did today, and then you can open up a second note. And I assume this is the case for other systems that are not Epic, we can lock our a note. So you can have

multiple notes for the visit. So one of them is just the general note, the second note, you can choose to lock it basically. And there's a bunch of different reasons. One of them is because the person is between 12 and 17 and for confidentiality reasons, you're locking it. So then basically it's a suppressed note so that the adult does not have access to it.

Sarah Nathan:

And so that is what you can do. So we chart whatever we want in that note. And you can have templates for sexual reproductive health sensitive service notes and that way you can suppress that information. You want to make sure that your AVS your after-visit summary. Also, you can also, in certain systems, the best practice would be to have it be complete AVS or not complete. You don't want to do a complete one because maybe you've ordered chlamydia/gonorrhea testing because of the conversation you've had with them in that sensitive visit part of the visit. So you want to be able to look at your system. So there's not a best practice. I know every system is so different, but I think that it's worth it, I guess a long answer to say that it's very much worth it to work with the people in your agency that are on the backend in terms of it and are able to troubleshoot and say like, Hey, we want to accomplish this, how would we do it? The overarching concern is that parents should not have access to certain types of information that fall under the minor consent laws in California.

Sarah Nathan:

I was trying to see what you come through. How do you handle consent with an adolescent, with neurodevelopmental, excuse me, disorder or intellectual disability? Great question. Very complicated. And there's such a range for neurodevelopmental disorders and intellectual disability. Certainly if somebody is conserved, then they don't have the same consent abilities and rights. So I think it's understanding the individual patient in front of you, but in many situations you might have to talk with the patient alone first to be able to understand where they are in the spectrum and how much you think that they understand. But certainly people do have a right to having confidentiality.

Sarah Nathan:

You say sometimes you need to escalate this. Can you discuss what that might look like? A parent refusing to leave the room, you might need to get your clinic manager involved. So sometimes as clinicians, we do need to work in the context of larger systems. You have managers, administrative people who are available to say, yes, this is our clinic policy and this is why. So that you are not the only person, not the only lone voice in this, that it is a system effort. Even though RH care can be consented to as a minor. Would it still be recommended to explain mandatory reporting laws to the youth when you have their first visit? Yes. I think, again, it's always really important to be able to explain to the young person that under these certain are the certain services that reproductive health care can be consented to. These are the, and there are mandatory reporting laws, especially around the issue. I think for consensual sex between two young people, they may not think about that as an issue because for them they're having consensual sex, but because you're a mandated reporter, that might change things if they do disclose, for example, the age of their partner. So I think, as I said, using having things in clinic, not just my voice, but also pamphlets, hanging on the walls, systems like that, to be able to have people understand that there are exceptions to the confidentiality, especially around disclosures of abuse, self-harm, et cetera. So that again, it's not a surprise.

Sarah Nathan:

Any advice for when a provider orders blood work for RPR and HIV and parent question the order. Parents usually will see it when we give lab slips to them at blood draw in office or blood draw in office. Yeah, this is the big issue. So this is about clinic policies and workflows and in your EMR, right? So if for example, somebody has private insurance, then often with private insurance there is itemized list of things that were ordered. Or if you are just giving them a lab slip or you're drawing the blood in the office, then it might be easy for a parent if they're with that young person. So that may not be the best workflow. If it is very important for that young person for their parent to not know that they're getting an HIV test for example, or a syphilis test. You can give the patient, for example, Family PACT or Medi-Cal minor consent and then order those labs under that insurance and you have to create another encounter for the visit that day.

Sarah Nathan:

Or you can tell the patient to come back on another day because they'd be able to see you by themselves, or think about how to not give a lab slip or not give an AVS. And these are all depending on where you're working and how it works, if it's just an electronic system that is transmitting the lab orders or if it's actual paper. But I think certainly making sure that you understand what it looks like when you print out an AVS. Sometimes there's policies just like handing an AVS to the family at the end of the visit. Maybe you don't do that. Maybe AVS is not going to be the thing for your clinic. Or you can have certain AVS that are designed to not print out everything. But I think working through these systems and then telling a young person, is this important to be unknown from your parent? Is it super important that your parent does not know that you're getting this kind of blood draw? There's other ways to just say, look, every single person in our clinic gets a test for chlamydia/gonorrhea who's above 15, right? You can also do that and that's possible. So you kind of have to work with your own clinic system.

Sarah Nathan:

This is kind of related to when a provider orders labs screening for STIs, a summary of the visit will show the orders including diagnosis. Usually parent will ask for a copy of the summary, what should we do in that case? So you can just not put that as a, again, you can change the AVS to limit, to not say, to pick and choose what your AVS prints is. I guess what I'm trying to say, you cannot put a diagnosis called STI screening. You could put do for screening or something like that if you wanted to at least have a summary of the diagnoses, but maybe not the tests that were ordered. So I think you have to work within your systems to be able to find a way to be able to do this. Again, creating a separate encounter where and under that encounter is where you order all of the labs for that day that are maybe STI testing.

Sarah Nathan:

So you can be creative and really working with your IT team to be able to tailor what it is that you need, say what it is, the goal, which is to be able to protect the confidentiality of young people. And then really importantly within the visit, once you understand what your system is capable of to really making sure that a young person knows what might happen. And so if I say like, hey, you want birth control pills today, I can prescribe them and you have private insurance, so if I prescribe them, it's possible that this is going to go on your parents' summary of medications for this month, whatever. How big of a deal is that? And then you can kind of work with the young person. And same thing with ordering labs AVS, so

an after visit summary. So that's what I'm referring to when I say the AVS. And so that is just sort of a printout of the summary of the visit. And for many systems, it's just going to automatically take every single one of your visit diagnoses and the tests that you've ordered, but you can be able to tailor that.

Sarah Nathan:

A question here, I'm not sure if I missed it. What about foster children in terms of whoever is the guardian? So if it is a foster parent, that person is the one that can give consent for the duration. So different people in foster care are under different situations, but the person that has been designated to be the is the person that can give consent. Everything still applies though that young people are still able to consent for the specific services. Now separate from foster care as a whole other situation that I briefly mentioned about a court can, you can go through a formal process and become emancipated a youth as a minor. And so somebody may have gone through that process and then again, and there's a further even more gray area. For example, unhoused youth may not be living anywhere near a parent, don't have any contact with a parent in those kind of situations. It's a gray area. We don't want to withhold care. The young people would be able to consent for their own care too, even for situations that are not specifically mandated under the minor consent. These are all great questions. Note, should, our note of documenting a CPS report be made confidential in the patient's chart or should the patient have access knowing should the patient have access to it knowing they request their medical records? I think I'm understanding, but if you're doing a CPS report, you would want it to be, it's not going to be confidential. So you're telling somebody that you're doing it and both for the parent and the young person. And so it wouldn't be confidential because somebody is going to be reaching out. And it depends in your county whether also law enforcement is going to get involved. Just we have a few more minutes and seeing if I've answered everything.

Nicole Nguyen:

Hi, sorry. I think I can help too with some questions.

Sarah Nathan:

Yeah. Sorry, I mistakenly didn't ask them as I started answering them or getting rid of them from the board.

Nicole Nguyen:

One of the questions is what if the patient's mother comes into the clinic with a referral and wants to know what the referral is for and why?

Sarah Nathan:

I may not be exactly understanding a referral to what I mean. So it depends if it's a referral from an outside person to your clinic and you're going to be dealing with sexual reproductive issues, you can't disclose anything until you've talked to the young person to see what it is that they want. So it's like if you're being referred to talk about contraceptive methods because a person is having sex, but then yeah, you would need to make sure with the young person that you understood, that's a perfect situation that you could talk to the healthcare provider that referred to you first. And that's a great thing is that you can always talk to other healthcare providers. That's not breaking confidentiality. So I'm sorry

if I'm not quite understanding the referral part, but if it's a referral, for example, from you to someone else for mental health, you would want to understand, again your medical systems where you would want to be able to suppress that referral so that it wasn't known to the parent. I'm thinking about if you're referring for therapy for a young person, they don't want their parent to know. In that situation though, really you are required to inform the parent that you are making a referral for mental health care. So it really just depends on the type of situation and also the type of insurance they have. So Medi-Cal insurance is really nice because it doesn't give itemized lists of all the things that you're doing in the visit.

Sarah Nathan:

How do you handle it when a parent insists a minor get on birth control and that minor doesn't want it actually happens a lot here. We typically try to come to an agreement with both parties, but it's tricky, especially if the minor is sexually active. That sounds challenging. I don't believe in providing care in that way because something that the minor would have to do, maybe they'd have to take a pill every day, they'd have to put a patch on them. An IUD insertion, like I'm not doing a procedure for example on somebody who doesn't give permission.

Sarah Nathan:

And especially about this birth control. These are services that a minor can consent to on their own. And so therefore, I know this is complicated and it would involve talking to everybody, but I think that we can't force our minor patients to be put on birth control. It's really difficult. And I know this conversation can be really difficult and I just wouldn't feel right forcing somebody to do this if it's not something that they wanted. And that just goes against sort of the principles of autonomy. I know this is really difficult and in the end you can only advise what you're going to advise, but I don't think we should be forcing people into using contraception if they don't want to. Typically, you say that we can come to an agreement and I think that understanding both sides of it and making sure that you have time alone with the young person is going to be really important in these situations and having time with both the parent and the child together because the young person is your patient. And so that's really where the obligation lies.

Nicole Nguyen:

Oh, okay. Another question was at what age are we testing teams for STIs? Is there an age different for males versus females?

Sarah Nathan:

So in terms of the consent for being able to do STI testing is 12 and up. And so I think it just depends on a risk profile in terms of the type of sex that the person is having, who they're having sex with, partners, how many partners, and just the way that somebody is having sex or if they're having sex, the type of sex they're having with who is the way that we think about testing. But certainly anybody 12 and up is eligible to receive STI testing. Yeah, I also just quickly, the CDC STI treatment guidelines go into much further detail, but it's nice. It will often have a little section on adolescents too in considerations, which I think is great. But thank you so much. I really, really appreciate all these questions and thank you.

Nicole Nguyen:

Yes. And then I just want to answer one last question. The question was, do you have any good website or online resources you can give to early adolescents about sexual anatomy and other health topics? So I just want to share that. For the Family PACT program, we have a bunch of new client education material. So that's been redesigned with fifth-grade-level reading in mind. So there's ones all about the pills, all about the patch, the ring, all the different birth control contracept that you can use to share with your clinic. They're both available in English and Spanish. And then Sarah, do you know of any other websites or online resources to give?

Sarah Nathan:

Bedsider.org is a really great one, and they now have a Bedsider Plus for providers. So with a lot of patient-facing information, too. So I put a plugin for that and that's a great resource as well. And then of course, Planned Parenthoods also have a lot of great outward-facing patient information about sexual reproductive health.

Nicole Nguyen:

Wonderful. Yes. So I'm just going to pop that last link in so that we can share that. Well, and then, sorry. There you go. And then for Bedsiders, I have that as well.

Sarah Nathan:

Yeah, bedsider.org, I believe. Yeah,

Nicole Nguyen:

Which is really fun. That has always been, I used to use that when I was a teen in college trying to navigate sexual health, everything. So I'll put that.

Sarah Nathan:

Yeah, there's just a lot around. There's some, I think excitement around being able to provide resources to young people, especially in states where there's more restrictions. So I think that doing what we can to be able to give people these resources is really, really important. There's also another plug, the UCSF Reproductive Health Hotline, and that's just for providers, but I welcome it. That's a really great, that's new, and it's sort of any provider questions about sexual reproductive health is really great as well. Oh, great. Yeah, that's their website. And it's a free resource for any providers, not for patients, but for providers. So you can ask your questions and I think that's a great resource as well.

Nicole Nguyen:

Yeah. So I think that's about it. We're at, and we're right on time. That concludes our webinar. Thank you, Sarah, so much for this wonderful, wonderful presentation. It's been awesome. And so I just want to remind everyone, we will send out all the information, the slides, the evaluation, and your CME link in about four weeks with everything in it. And then there'll be an evaluation that comes up right after this webinar ends. So please fill that out to give us feedback. And then again, I want to thank you, Sarah, for

such a wonderful presentation and I hope you all enjoy it and have a great rest of your week. Thank you so much. And thank you, Sarah. This was awesome. Thank you. It's a pleasure.

Sarah Nathan:

Thank you so much for the opportunity.