Health Care Education and Training, Inc.
Consent, Confidentiality and Youth Friendly Services-201310011559-1

Good morning, and welcome to the first of five free webinars on adolescent reproductive health focused on Indiana. I'm Monique Hensley, Program Manager with Healthcare Education and Training, and I'm pleased to welcome you all today. This webinar is sponsored by the New York City STD/HIV Prevention Training Center, the Indiana Chapter of the American Academy of Pediatrics, and Health Education and Training.

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It is with great pleasure that I introduce our two presenters for today's webinar. Dr. Mary Ott is an Associate Professor of Pediatrics at the Indiana University of Medicine and Riley Hospital for Children. She is board certified in Pediatrics and Adolescent Medicine and has a Master's degree in Bioethics. Her work encompasses general adolescent medicine, adolescent pregnancy, and STD prevention, and ethical aspects of adolescent care. She has consulted locally and nationally on policies and guidelines related to adolescent consent, confidentiality and decision making.

Dr. Marcia Shew is a Professor of Clinical Pediatrics at the Indiana University of Medicine and Riley Hospital for Children. She is board certified in Internal and Adolescent Medicine. Her clinical work has been in general adolescent medicine, reproductive healthcare of young women, and diabetic care of adolescents. Her research has been clinically centered around reproductive health issues including HIV epidemiology and HPV vaccine related studies.

Good morning and welcome to Dr. Ott and Dr. Shew.

Hi, this is Mary Ott, and I'll be doing the first part of the webinar. And before I start I wanted to give a really quick shout out to the New York City STD/HIV Prevention Training Center, which is our regional CDC prevention training center, Healthcare Education and Training, and to the Indiana Chapter of the American Academy of Pediatrics.

Our objectives today are first to talk about paradigm shifts in sexual health with adolescents. And I'll talk about consent and confidentiality including identifying confidential health services, how to explain consent and confidentiality to families, and creating an office that supports adolescent consent and confidentiality.

Dr. Shew will take over and talk about youth-friend office services and sort of the art of confidentiality in interviewing and addressing adolescent sexual and reproductive health (inaudible).

And I want to start out by first talking about these paradigm shifts. The first paradigm shift is a shift from thinking about sex as risk to sexual health. The Centers for Disease Control and Prevention has defined sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality. It's not merely the absence of disease, dysfunction or infirmity. Sexual health instead requires a positive, 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.

And I feel like I like this definition because I feel that it speaks to us as pediatricians and people that take care of teenagers, particularly with the emphasis on positive and respectful approaches to sex in relationships.

The other paradigm shift that I'd like to talk about is shifting from a risk to a developmentally-focused paradigm because sexuality is a funny sort of risk factor. While risk behaviors such as smoking or drinking and driving are always bad, we want our young people to become sexually healthy adults. We want them to be able to express love and affection, we want them to have healthy relationships, we want them to experience the physical pleasure, so I think that it makes it more of a development task than a risk *per se*.

And development is tricky because for teens development is a moving target. Talking about reproductive health with an 11-year-old is very different than talking with a 16-year-old, which is very different than talking with a 19-year-old. They have different needs, different interests, there are different sort of risks, and they have different developmental tasks in terms of development.

The other piece of development that's tricky is I try not to label young people as being like a high-risk individual or not a high-risk individual because what we see is that young people move in and out of high-risk groups. There was a big nationally-representative of young boys that started interviewing them at 14 years of age and did three waves over nine years. And they found that 20% of the young people who were not sexually active in wave one were considered high risk in wave two, but high risk is defined as young people who had multiple partners, who didn't use condoms. And then 40% of those young men identified as high risk in wave one and two were considered low risk in wave three. So as young people move in and out of development, they may experiment with high risk sexual behaviors. And as a pediatrician we need to sort of go into every visit thinking about young people as, you know, thinking that they may not be the same as last time, like development is fluid and we need to sort of understand where they're at and what their needs are right then.

As I think about sexual health, I am always taken to a comment made by a young women from Derry. A couple of years ago we did focus groups across the state of Indiana talking to young people about what they thought about health. And this young woman had a comment about sexual health. And she told us, she said, yeah, keep it real. I hate it when people be like, don't have sex, it's not for you. I want someone to tell me sex is okay, but if you do this, make sure you do it this way. I'm for real. Safe sex is good, just wrap it up.

I want to apologize for the slides not moving forward, and Monique, can you just advance the slides for me when I say slide?

Sure.

So the next part I'm going to go into is let's talk a little bit about consent and confidentiality. And I'm going to do this by using a case. So Krista (sp) is a 16-year-old coming in for a well child visit. She and her

mother are seated in an exam room together. The nurse gives you the heads up that Krista would like to speak to you alone about some private issues. Are you allowed to do that?

Slide.

So in Indiana consent and confidentiality are related. In Indiana the age of majority is 18, which means that when you turn 18 you can consent to all of your healthcare and everything must be confidential. For individuals younger than 18 years of age, they cannot consent to general medical care and general medical care is not confidential. Now laws tend to be black-lined, but development is this really sort of fuzzy, gray curve that goes up. And I always like to comment that because a young person turns 18 doesn't mean they still don't need sort of the support of parents in healthcare decision making. And this is where you get into the art of adolescent medicine, which is sort of working with the young person, when appropriate to do, and to involve their parents in their care.

There are exceptions to the Indiana age of majority law. These exceptions include the following. First is an emancipated minor. So becoming emancipated is complicated. It's a court order. Young people have to go before a judge and demonstrate that they are living apart from their parents and maintaining a separate household. That they are not dependent upon their parents, i.e. their parents don't claim them on their income tax, and that they have a separate legal source of income. There aren't a lot of kids who are declared emancipated.

There are minors living apart where young people can have limited access to healthcare and usually this is used in emergency situations.

Married minors are considered adults under Indiana state law and so can consent for healthcare as well as minors who are active duty in the military.

I note that minor parents are not covered under Indiana law. This is different than our neighbors, for instance Illinois, and it sets up funny situations where a young woman might not be able to consent for her own epidural during delivery but could consent for the newborn to be admitted to the hospital.

There are also specific services that young people need and can consent for. Indiana state healthcare consent law covers STDs and substance abuse. Young people can consent to diagnosis and treatment of STDs and they can also consent to substance abuse treatment at a substance abuse treatment facility.

Contraception is not, and pregnancy-related services are not, a part of Indiana state law, but there is federal case laws and statutes that provide support for confidentiality for these services, in particular for contraception there's a series of federal case law that support minor access to contraception. Clinics supported by federal laws such as Title 10 family planning clinics are explicitly required to provide confidential family planning care so that there are other supports for contraception.

One of the most important sources of support for confidentiality for minors is actually HIPPA, and while we typically think of HIPPA as a threat to minor confidentiality because it allows parents access to records as the personal representative of the minor, it turns out that HIPPA has important protections built into it. Parents are not allowed access to minors' records, i.e. minors can have confidentiality, if the minors can consent under state or other laws, so STD-related care in Indiana, contraception care when it's done in a Title 10 family planning clinic, parents aren't allowed access if the care is under the direction of the court.

And finally parents are not allowed access if the parent agrees that the minor may have confidential care, and this clause is really important because this is a way for us to routinely provide confidential services to all teens. If we talk to parents and teens up front at the start of a visit and at the start of our relationship

with them about confidential care and providing confidential care, document that we've spoken with the parent, then we have support to provide our minors with confidential care.

Next slide.

So explaining consent and confidentiality to Krista and her mother gets us to sort of the art of confidentiality and away from the laws related to confidentiality.

Next slide.

My general advice includes the following. The first is to explain it to the parents and the adolescent together. Then they both heard it at the same time, in the same language. And then there can't be any sort of he said, she said, she said this to me, she said this to me. I think it's really important to explain it together at the start of the visit. The other thing that I emphasize is it's not about keeping secrets. We as pediatricians and care providers for teens really want young people and their parents to communicate about difficult topics like sexuality, STDs, and contraception.

The third is that it's important to define exceptions. While research suggests that the fewer exceptions we can give, the more teens are likely to disclose, I feel that we're really ethically obliged to make sure that young people know the circumstances in which we would void confidentiality. Generally what I say is that I consider breaking confidentiality a very serious issue and that I only do it when something life threatening may happen or when I'm required to do it by law. And this includes when a young person is suicidal or homicidal, if they're a potential harm to themselves, or that there's mandatory reporting, so like child abuse or statutory rape. The final thing that I do is that I always break confidentiality – when I break it I discuss it with the young person first and let them know.

For the moms I find that framing of confidentiality is critical. I like to emphasize the positives. In particular what I let them know is that it teaches responsibility for their own care, it increases their buy-in to their own care and makes them more likely to participate in it, and it provides a safety valve, that if for whatever reason the young person is not willing to talk to the parent about confidentiality, they may have another trusted adult that they're able to talk to. I tend not to talk about laws supporting confidentiality. I just don't, as a clinician I don't find that I get very far with it. I start talking about responsibility, adolescent buy-in, and safety valve, and honestly I go back and start repeating myself if the parent still has questions and concerns and sort of explain it in other words and keep reframing responsibility and buy in.

The other thing with parents is it's really important to start training parents early. I like to start at well checks starting somewhere at ten to 12 years of age, and really the confidential interview is very short generally at this age, and if the young person is uncomfortable being examined alone by the clinician, I always make sure that the young person – I give the young person the option to have their parents in for their physical exam.

Next slide.

For the adolescent, I first explain why I'm doing this. And the language I use is up on the slide. I say I'll be asking you some personal questions because some of the decisions that we make can affect our health. For example, for younger kids I'll talk about smoking and health. For older kids I might talk about pregnancy prevention or substance use.

If I have to talk to the parent alone, I generally talk to them before I talk to the adolescent so that I don't have the appearance of breaking confidentiality. And I feel that talking to the teen ahead of time is really important in letting them know why you're doing it so that they can frame it and it feels less intrusive.

The final thing I want to talk about before I turn it over to Dr. Shew are office policies. And I recommend that offices have written information to parents and caregivers of adolescent patients describing your practice's adolescent policies. I tend to ask the parent to step out of the room for part of every single visit, and I make sure that our insurance and billing staff are aware of protocols to protect adolescent confidentiality. It's important for us as providers to understand when teens are sent – when families might be sent an explanation of benefits, for example, it's important for us to be aware, as the Affordable Care Act wants us to give visit summary and allow portal access, it's important for us to understand what threats to confidentiality might come through these pieces that are in some sense outside of the visit and outside of your control.

Okay. I think that what I'm going to do is turn it over to Dr. Shew now, and then we'll do questions at the end. Thanks.

Well, I just want to remind everybody that we'll have time at the end, so please keep those questions coming in as we go further into this talk.

This next slide is a list of characteristics I give to clinics who want to provide youth-friendly services. And the first one is adolescent focus. And when I speak of adolescent focus I mean that they carry a breadth of services that address the healthcare needs of adolescents. But I also talk about the environment in which we provide services. You know, I'd like to see that there's a room that doesn't have Disney characters on the wall, and an exam table that is appropriate for the adolescent's age. I'd like to see reading material in the waiting room and in the exam rooms that are designated for teens. And also, as I discussed earlier, just that the whole mindset of the clinic is willing to address the needs of the teen. I think it's helpful when services are in a disciplinary.

For us, just within the clinic setting, we have designated nurses or medical assistants that are the point person for the adolescent, and they make my life so much easier. They're well aware of what confidential services mean, they're aware of the teens' issues, they're willing to interface with those adolescents.

Interdisciplinary also means having services such as dieticians and psychologists available to you. They don't need to be on site, but we need to know how we can access them and which providers are teen friendly.

The next characteristic is accessible. For us, it's really understanding how kids get to the clinic. Do they need a bus route, and is the bus working? For sometimes it's teaching them how to access Medicaid taxis. And it's also, do they have the insurance? And if they don't have the insurance, or they temporarily lost insurance, or they don't want to use their insurance for confidential services, do you have a backup method to help them? And that is tied to services being affordable. As Mary has just spent some time talking about confidential services, perceived lack of confidentiality, concerns for mandated parent involvement, are deterrents to adolescents seeking those services they need.

Your services need to be flexible. Remember that teens sometimes carry their own agendas, and it's not necessarily what the parents wants or what we want as providers. And we have to be able to address their needs. And like I suggested at the very beginning, we really hope that services are comprehensive.

Why do we set up the clinic? Why do we provide confidential services? Well I think this was addressed by two studies that I've cited on the slide. The first is that with limits on confidentiality we know that adolescents are less willing to divulge sensitive information. We also know from the second study that kids postpone obtaining services they need. I think one of the biggest reasons I like to do it is as we're providing confidential care, and as we are providing teen-friendly services, that this teaches the adolescent how to negotiate his own healthcare needs, not only with you as the provider, but with the

front staff, maybe with the insurance person, so they really become health sufficient in that manner by providing these types of services.

We have discussed some of the behaviors that are better cared for when services are in place for adolescents. But, again, I want to share data from the Youth Risk Behavior Survey that is done in all 50 states by the CDC as part of this Behavior Surveillance. And what you can see in Indiana, our teens are equally engaged in behaviors that can be addressed within primary care or school-based services that address the needs of teens. I first want you to know that for over half of the teens in Indiana report that they've had sex, and a third of those teens have had sex in the last three months. Despite having sex, the use of contraception is less than perfect, as you can see. This reminds me of the fact that sometimes adolescents state to me that they use birth control, and then when I push them their birth control method is the withdrawal method. Well I as a provider know that that's not a perfect contraception, and I definitely know that there's no value in preventing sexually transmitted infections with the withdrawal method.

I think just discussing this last slide really presents a case scenario that clarifies what I mean by teen friendly services. Perhaps you have a young lady that comes into your clinic concerned that she is pregnant. Well first of all, I'm just excited that she's in my clinic repeating the pregnancy test or getting it for the first time, because studies have shown that teens aren't always the best readers of home pregnancy kits.

But, more importantly, if that pregnancy test is positive, then you can provide immediate STI testing for that young lady. You can talk to her about how the parent, or the mother, or the father is going to react. How the father of the baby is going to react. And you can discuss pregnancy options with follow-up plans.

However, I think if that pregnancy test is negative, that gives you the ability to provide emergency contraception if she's had sex within the last five days. You can address STI and HIV testing. You can assess the relationships and her readiness to continue this relationship and her readiness to discuss ongoing contraception so that we don't have another pregnancy scare.

So my last couple of slides address issues that teens might seek you as a provider alone. However, as Dr. Ott has emphasized, we feel parents are really critical. And I think part of our role is to facilitate the adolescent and parent communication about sexual health and mental health and health behaviors. I think knowing the parents' side of the story is equally important because it gives you the total picture of where that adolescent is coming from. And we're going to show you in the next couple of slides how that might be carried out.

I think involving parents are also important because most adolescents trust their parent and will identify them as the trusted adult. And knowing that they're going to be supportive of their health decision is really important to the adolescent.

As a group, I always push clinics to discuss these questions among yourself. How comfortable are you and your staff about talking to adolescents? If not very comfortable, one might need some in-service training. I also push you to ask what are your feelings and beliefs about adolescent sexuality? And are you able, and your staff, able to separate your own values in order to treat patients? Sometimes clinics have had people come in and do value clarification for the staff, and I think this is helpful when you're setting up those adolescent-friendly services. I recognize that a lot of providers are uncomfortable; however, I really push people to be prepared, and that's based on the fact that we know on average most teens wait 12 to 14 months after becoming sexually active to make their first family planning visit.

Number two, we know sometimes teens come for that very first visit for pregnancy testing. And I think what an opportunity we could have had had we been providing these services a year beforehand and preventing those scares that push teens into our offices.

I think this study nicely represents what happens when providers are seeking information from the teen about sensitive topics. This study interviewed over 300 adolescents after they had seen a provider or had been involved in a provider visit. When they self-reported that the provider had discussed sensitive topics about various areas, what you see is that the adolescent felt more comfortable with the provider. They felt that the provider understood their issues, the provider eased their worries, and you can see that it made it easier for the teen to be involved in the decisions and that the youth was more likely to take responsibility for their own treatment.

So let's talk a little bit about the practicalities. When we set up an interview, and we tend to do it in this fashion. First of all we see the parent and teen together. And as Mary discussed, we talk about confidentiality right at the beginning. I also think it's valuable to have the parent in the room to review the general medical history and also to review the family history because in the past usually the teen has not heard it and this is one way for the teen to learn it, so he can recite those same issues when he becomes older and is seeing a doctor or a clinician for the first time on their own.

As we discussed earlier, sometimes the parent concerns aren't exactly what the teen's concerns are, and nothing is more frustrating to have a teen alone address their concerns, send the teen out of the room, then have the parent come back to the office and say, what about this? I think when both of them are together I put out in front of everybody, what are your concerns, and then I ask the teen, is there anything else you would like me to address? Sometimes we get the sense or we're notified that parent wants to talk to the clinician alone, and we are okay with that. We're real up front that we will then have the teen leave the room, we talk to the parent, and when the parent is done – or let me back up. Sometimes when the parents voice concerns that are not articulated in that first interview session, I ask the parent if they are okay if I bring that up with the teen and letting the teen know that the parent has that concern. We then dismiss the parent, bring the teen in alone, we review the confidential history and why we do that. I do the physical exam, and then what I do is alone with the teen I review the findings and we come up with a plan.

And as Mary suggested, if I'm going to break confidential care, I'm going to tell the teen at this point what I'm going to say to their parents and how I'm going to do it and why I'm going to do it. The teen may not be real happy initially, but like all of us, we'd rather be told ahead of time than have it done behind our back. Then I bring the parent back in the room and then we finalize our findings and come up with a plan.

Again, I just want to emphasize, we do this with the overall goal to provide optimal physical, mental, emotional, social growth and development. That's the agenda for all of us.

What are some of the office-based interviewing techniques? First I like to be empathetic and not judgmental. And that's why we discuss value clarification. I want to ensure that I have time alone with the adolescent. And I can't tell you the numerous times that parents will tell me, oh, we have no secrets, we talk about everything. But as soon as I go ahead and dismiss the parent, the teen reiterates, I'm glad you let Mom go. I don't feel always comfortable discussing X, Y and Z.

Again, we really believe and firmly support confidentiality and consent. We like to give adolescents control because they need buy in, they need to learn how to assume their own healthcare. They really look to parents for guidance, but eventually they are going to have to take the majority of the control.

We work in interviewing to uncover any hidden agendas by the parent or the teen, and then we like to merge the teen and parent's goals for the visit.

Again, I really encourage to avoid verbal and nonverbal communication that can be destructive. So I want to try to say, you did what? I want to take surprised facial expressions off, but I really want to not cross my arms and be working on my computer and not engaged with them.

We want adolescent-friendly environments. As I discussed before, it's really important to have designated, targeted people within the clinic for the adolescents. It's surprising to me when we go in and help others set up services how much conversations you can hear outside the hall, so I encourage areas that are better designed for private conversations.

Mary alluded to this, and again I want to reiterate that conversations need to be age appropriate. When I see a younger teen adolescent, they don't even have a girlfriend or a boyfriend at this point, I find it not useful to say, have you had sex, but I find it more useful to say, have you talked to your parent about sex, and do you have any questions?

Again, providing information about confidentiality, fostering informed and independent decision making, and learning and teaching the teen how to negotiate the healthcare team is really important.

When I'm interviewing an adolescent, I use the mnemonic HEADS, and most of you are probably familiar in our audience, but I'd just like to go over this. HEADS a mnemonic that's used to assess the psycho-social morbidities of adolescents and really gets to those sensitive issues.

H is for Home. Who do you live with? Are you living between two homes? I discover kids that are living between multiple homes that I really have to target compliance issues about who's going to help you take the medication and does the other person know you're taking this medication.

Education is important to me, and I remind people that education is tied to having future insurance. But I like to help identify areas, especially in early teens, when they transition from elementary to middle school. I find kids that are borderline learning disabled are the kids that tend to fall apart when they've gone from a single classroom with the same 25 kids to changing classes every 30 minutes with a different teacher. Also I find kids who self-identify and being in the lower quartile of a class are kids that probably are at risk for other behaviors, and so I ask about not just how is school going because every teen tells me that school is just fine. And when I ask them how are their grades, they tell me excellent. I find excellent grades represents anything from straight A's to straight F's. So I look at things, ask them tell me what grade you are, and I look at their age quickly to see if there is some discrepancy. I ask them to tell me if they're getting special help in any classes and what is that special help need. I'm also teaching kids how to advocate for themselves and parents how to advocate for extra help.

A is for Activities. Are they in sports? Do they go home alone and are they unsupervised?

D is for Drugs, and generally we still have a lot of kids that aren't drinking, that aren't smoking, but, again, I'm reminded the smoking question is not only cigarettes, but is it marijuana. If they're using substances I use another mnemonic called CRAFT, which we put into the resource, but it helps identify kids that may be at greater risk for substance using and probably need referral. The CRAFT looks at the driving in the car while intoxicated, using a substance to relax, using it alone, are they forgetting to do something next morning after using, have their family and friends told them they need to quit, or have they been in trouble at school or law because of substance.

Sexuality, as Mary discussed, it's not only are you sexually active, but who are you attracted to? We're always assessing for suicide and depression. We use the PHQ 2 screener a lot verbally. That's asking if they've had little interest or pleasure in doing things over the last two weeks. Kids who report not at all is great, but if they're experiencing it several days versus more than half the days over the last two weeks versus nearly every day is more bothersome. We do the same with have you felt down, depressed or hopeless over the last two weeks. Again, none at all is scored at zero, feeling that way over several days over the last week is scored as one, feeling like that more than half the days is scored at two, and nearly every day is three.

So if I have kids telling me that they're feeling this way more than half of the days over the last two weeks, we have a formal written screener that takes five minutes to fill out and really gives you some assessment of their depression symptoms. And it also enables me to follow their depression, should I put them on medicine or send them to therapy.

Finally, S is for Safety. Do they feel safe at home? Is there violence in the home? Is there anything we can do to intervene.

Another way assessing sexual history taking by the CDC is called the Five Ps. I use this mostly with older adolescents, not necessarily my younger ones, but again, it's asking about partners. Are you attracted to men, women or both? Tell me about those relationships. I ask about pregnancy. Tell me what you're doing to prevent pregnancy? How would you feel if you became pregnant? And I even think ambivalence about pregnancy is something I'm concerned about.

The third P is Protection from STDs. What are you doing to protect yourself? And number four is Practices. You know, have you had sex? How far have you gone? What types of things do you do to be sexual?

And then the last P is do you have a history of a previous STI?

And then we always add one for extra credit called prevention. And that's really addressing vaccination issues, like the HPV vaccine, Hepatitis A, Hepatitis B, and screening for STIs and other sexually transmitted infections and HIV.

Like I said, the HEADS mnemonic, the Five Ps, all really help to address common concerns and morbidities of sexual activity. We know that screening for lesbian, gay, bisexual, transgender youth is important. It's helpful because these kids are at a higher risk for depression and they truly need support. We know that screening also helps address needs for contraception.

Another eating disorder and disorder eating, I haven't talked a lot about, but a good screening question, what have you done over the last three months to change your weight, is always helpful. We've talked a little bit talking about substance abuse, mental health concerns, school failure and truancy issues, and finally violence and abuse.

Like I said, I think by asking we help to intervene and prevent. We want to know about these risk behaviors so that we can address the morbidities of this population and address the issues that are of common concern to this age group.

We know that by asking we can address the sexual and reproductive health services including pregnancy testing, the contraception needs, and the sexually transmitted infection screening.

We won't go into it too much during this webinar, but just a bite. We in Indiana can now do expedited partner treatment, meaning we can address the need of an untreated partner for a sexually transmitted infection.

And then, finally, I just want to address vaccination issue in teen-friendly services.

Maybe I will jump to my last bullet point first. HPV goes in line at preventing sexual and reproductive morbidities in the future. Unfortunately at this point HPV vaccine is not mandated by the schools, and our rates in Indiana are poor, as well as throughout the rest of the United States. Yet we know this is a safe vaccine and it can reduce morbidities. I find, and studies have proven, one of the biggest issues that helps address better vaccination recommendations is sheer recommendation by the provider. That helps escalate those vaccination rates tremendously.

Again, just a reminder that every ten years that an adolescent is going to need a TDAP booster or probably as we get TDAP (inaudible) a TD booster during their adolescent years. It's recommended by the CDC that adolescents get an annual influenza vaccination. Hepatitis A is recommended for the younger age group, but for us that provide teen care at this current time, I'm having to do catch-up vaccinations through age 17. At 18, the age for Hepatitis A becomes more targeted for high-risk groups. But, again, I would advocate that adolescents that are sexually active are at a risk and that they could benefit from this vaccine.

Again, we're giving meningococcal vaccines, the first dose during the early ten years, but remember we want to give that second booster at 16 or older as those teens really enter into that higher risk period when they're in a college dormitory or military vaccinations.

I'm going to end right here, and as we discussed we have provided you with provider resources that go more into depth. Some of those references we mentioned as we were discussing through the talk.

Okay, I'm going to let Monique come in and help us with the question and answer session.

Well, thank you, Dr. Shew, and thank you Dr. Ott. As a reminder, if you have a question, please feel free to send it to us. Type your question into the Chat Box and make sure that the drop down menu is set to All Panelists, and then hit Send.

We do have several questions. The first question that came in, and this is for either of you, is although he minor may consent to diagnosis and treatment, can the parent be told of the results of the test?

Mary, I'll let you –

Yeah, so it depends on what you're testing for. So STDs have the strongest protection for minors. So minors can consent for STD testing, treatment, diagnosis, and parents do not have access to those records. So if you're talking about STDs, that's very clear. Pregnancy has been, I think, also that we need to respect the minor's right to the results of that test unless there was something that were immediately life threatening, like, say, she had an ectopic pregnancy and was bleeding and it was an emergent type of thing. The support for pregnancy testing comes more from family planning, so the federal case law that supports minor reproductive privacy including contraception.

Drug testing is a little bit different. The urine-based drug test is felt to be a part of the minor's medical record unless they're involved in a federally-identified drug treatment program, so we need to be very careful with drug tests. Because minor consent and confidentiality are a patchwork of laws, what we end up is that it depends on the indication for each of these.

I was just going to add to that, the other thing that I do clinically is a lot of our clinics have spaces for cell phone numbers of the teenagers, so if we're doing STI testing, before I bring the patient back in the room, I've always discussed, now how are you going to get your results? Is it okay if we use your cell phone? And that's one way to share the results with the teen and not getting mom involved.

The other way to do that, as we mentioned, is having a designated person with a phone number that the teen can call into and making sure that they know how to access that nurse for their results. And sometimes a little up front work can really save you from having to do a lot of back peddling.

Okay. And another question is, if you are providing oral contraceptives or other birth control options, but the teen does not want to disclose to the parent, do you send them to a Title 10 program or do you encourage a dialogue at the teen's convenience?

I can handle that first and Mary can add on. This happens a lot. And I think there is a couple of issues involved when I'm making that decision. First of all is I do talk to them about methods and what method are they truly interested in. And we always have our adolescents come a little bit more frequently when we do put them on birth control because we know stopping and starting can be a frequent event. And so I ask the adolescent what do they think they can do with this. If I put them on birth control, first of all, it's amazing how many kids say, can I discuss this with your parent, and we can use that they're having bad cramps. That's a little uncomfortable if I'm not disclosing – a lot of kids will tell me, yeah, my parent knows, I just don't want to raise it, if you're willing to talk to them, great. Because I always ask the teenager how are you going to get back to me if we do this, or is there another issue I can identify that you can see me regularly with. If those start to become problems, then, yes, we do refer out to our Title 10 programs. We're all pretty familiar with school-based clinics, and a lot of our school-based clinics within the area do provide contraceptives for our kids, and it, quite truthfully, is easier for kids to see a provider of medical care on school campus than maybe coming back to the clinic.

So we do sometimes refer out, particularly if the teen doesn't feel like they can get back or if the insurance is going to send an estimation of the benefits and the parent's going to realize what's happening. I think those are all the things that you need to talk to the teenager before you make that decision to provide contraception within the office setting.

And this is Mary. To add on, I do think you can provide OCPs and birth control to the young person and have the young person consent to it. The other thing that a lot of offices do is the parent signs sort of a blanket consent – sometimes we are seeing the kid alone and the parents are signing. But I think if you talk with the parent ahead of time, as the primary care provider for the adolescent, that one of the things your office does is offer confidential services and the parent agrees to that, I think you can safely provide these services. There's also federal case law that supports provision of family planning services to minors. But you don't have to send them out. The things that Marcia was talking about are really sort of the art of medicine and practical logistical issues, you know, so issues around insurance, issues around a parent that, you know, like issues around like kids hiding OCPs and hiding birth control from parents, is making sure that if a conversation needs to happen, we can help them make it happen.

Okay. And that in a way piggybacks on one of the questions that we had about how do we ensure confidentiality on a portal or through an explanation of benefits, and I believe you addressed that. But if you would like to add anything.

So explanations of benefits are complicated because a lot of the EMRs automatically dump information like diagnoses codes and treatments onto the explanation of benefits. My advice is to look at your electronic medical record and see what's on it. In one of the clinics that I work in, we have a physician

look at and edit the explanation of benefits on the computer if we need to. We also – you don't have to have everyone get an explanation of benefits, and it may be that, you know, teens are only a small percentage of pediatric patients. It may be that the practice can have like not routinely give visit summaries to teens. Explanations of benefits that come from insurance companies are a little bit more difficult, and you need to know what the teen's insurance is and what will show up on that because that might be a reason to refer them out.

Okay. And we are running short on time. There is a question. Is EPT allowed for Chlamydia or Gonorrhea or for both?

Go ahead, Mary.

It is, yes. It's allowed for both.

Perfect. And the final question is, are there any templates available with information on confidentiality that anyone can share? Dr. Ott or Shew, are you aware of any?

The Adolescent Health Working Group in California has phenomenal materials. The only complexity is that their materials are specific to California laws so would need to be edited before you use them, but they're great templates. And it's adolescenthealthworkinggroup.net or ahwg.net. And I can give that information to Monique, she can have it at HDET.

There was also a question about in an STD, you know, is STD testing – do you need parental consent for STD testing, and you don't need parental consent for STD testing, and it doesn't have to be done in an STD clinic. You can confidentially STD teens in primary care.

Wonderful. Well, thank you both, Dr. Ott and Dr. Shew. We appreciate you taking the time to join us.

As noted at the beginning of the webinar, information has been provided to you to access continuing education credits. If you are interested in receiving continuing education for this live activity, you must complete the online evaluation by November fourth, and if you happen to miss that deadline, we will be archiving these events.

And please join us for upcoming webinars, or you can view at this link for attached archived webinars. The next webinar in our series is Sexually Transmitted Disease Update, and will be held on November fifth. Registration for this event is open. You can find more information at this link.

Again, thank you Dr. Ott and Dr. Shew, and we appreciate your time. Have a great afternoon.