

Transitioning from childhood to adolescence to adulthood

You can view this presentation at: youtu.be/QcsKBwmuVsE

[0:00:05] **Dr. Melissa Hutchinson:** Well, thank you all for having us here. And I want to thank Dr. Wilson because that was an awesome talk, and it was really helpful setting up this presentation which is about transitioning from childhood and adolescence to adulthood. So, my name is Melissa Hutchinson, I'm a pediatric neurologist at Nationwide Children's. I work with Dr. Wilson in our clinic, I think we have an awesome clinic as well and I'm so thankful to have the mental health supports that we have for our children. I have no disclosures to report. So today I want to talk about what is transition, and how to plan for this transition and then what are some unique needs for our children with neuroinflammatory diseases around transitioning from a pediatric neurology office to an adult neurology setting.

[0:00:53] So, the first question is, what is transition? Right? And I think it's a big word and it can mean a lot of different things and a lot of different contexts. But for me, I think about transition in this context as a journey. It really is a journey. It is not a graduation, it is not a handoff, it is not a transfer of care, although all of those elements are certainly important in this. It is not a one-time event, it does not happen one day, it is a years-long journey, and it takes some planning, and it takes some preparation. It's a process and during that process we want to make sure that we're providing age and developmentally-appropriate support and education to plan for a future and you know, certainly, I don't have to tell all of you that that can look different for everyone and I think it's really helpful to put it into context that it is a different world, pediatric neurology, it's a family-centered world and the adult neurology care is often individual-centered and looks quite different than the pediatric world.

[0:01:59] And so I think it's really important to highlight that and to acknowledge that upfront so that we can really do a good job of empowering our young people to be prepared for that next stage. So why do we need to plan for this transition? Well, these are just some reasons, but certainly, you can all come up with even more reasons, but for me, it feels as though oftentimes your pediatric neurologist, does serve as your medical home in a sense. They're oftentimes more aware of what's going on in different aspects of your medical life and kind of coordinating that care. So, planning for transition requires planning to transition a lot of different pieces of the puzzle. We have to make sure that we are allowing time for planning a transition to build preparation and build confidence in order to make a successful transition to adult care.

[0:02:53] We want to make sure that we are navigating the management of other comorbidities and other clinics, not just neurology, but maybe urology and physical medicine and rehabilitation and ophthalmology, we want to make sure that we have enough time to plan so that we can provide social and psychological supports. And we heard a lot about the reasons for that in the previous talk and we want to make sure that those supports can carry over. We want to understand and identify that there are going to be different touch points for questions or for emergencies during the transition from pediatric care to adult care. And we want to make sure people know who to call and when to call them. We want to prevent gaps in care and certainly, we want to be able to talk about and take time to understand the legal and financial implications of transitioning care.

[0:03:43] So it certainly takes a lot of planning and there are guidelines. Actually, this is a consensus statement for the neurologists' role and preparing to transition to adult care. And so, this was a bunch of pediatric and adult neurologists that got together, and this is not specific to neuroinflammatory diseases but to any neurologic disease. And they came up with eight different principles of being able to transition successfully from pediatric care to adult care. And so, I tried to, you know, put the abbreviated version of some of these principles on the slide because I want to highlight the fact that it is certainly a journey. Right? And so, one of their guidelines and the consensus statement was that we actually start talking about this transition at age 12, that's pretty early. And at age 12, it's completely appropriate to assess self-management skills.

[0:04:39] We start discussing the expectation that you will transition to an adult care provider at age 13. And then we start discussing the expected legal competency by age 14. So, these are things that we build on over time and we start early and work up to. The recommendation and the consensus statement are that we should have yearly topics sessions and that we should certainly not talk about all of these things in one day because that's super overwhelming. But we should take our time to talk about different aspects of the exact medical condition, medications and side effects, signs, and symptoms to be concerned about who to call when you're concerned, there are some diseases with genetic counseling and reproductive implications. Or certainly, if you're on medications with reproductive implications, there are lots of conversations around puberty and sexuality changes.

[0:05:32] There are lots of conversations around risk behavior such as driving and alcohol use and certainly the emotional and psychological concerns that we heard about in the previous session as well. So, the yearly sessions are building on each and every one of these topics so that we can really have a good transition plan. Part of the goal of the transition plan is to be able to actually identify that adult provider that you're going to be transitioning to and directly communicate with that person in writing, hopefully. At the very least. And ideally verbally, to make sure that that transition plan actually is communicated appropriately to the next neurologist. The consensus statement kind of goes on to discuss the nitty-gritty aspects of what a good transition plan looks like. And so, by the age of 14, you should start developing this transition plan with the patients and clinic.

[0:06:32] And so, the left box explains in these bullet points here, kind of detail some of the various components of who would be involved in developing this transition plan. So, this is not again a one-day-in-clinic type of thing. This is an ongoing conversation with the patient themselves with the different caregivers, with the different health providers and like I said, this is not just the neurologist, this is all of the sub-specialists involved, school personnel, vocational professionals, community services, legal services, and lots of different topics need to be addressed in these conversations. Not only the healthcare, right, but financial concerns, legal concerns, education concerns, employment, housing, community services, this is certainly a journey and it's an all-encompassing opportunity to really set our young people up for success.

[0:07:26] I don't necessarily mean for you to memorize this whole slide, but I put it in here for reference later, because the right box does detail a summary of all of the healthcare issues to think about organizing a plan around. So, one of the goals is to be able to have -- to pre-empt the questions that are going to come up during the transition and some of these bullet points might prompt you to think about different areas that you might not have previously thought about. And so, you know, I think that one of the things that I have learned is that this plan is going to look unique for each patient and each family. But overall, we should really be having a goal to have each of these categories assessed. So, there are several different resources for transitioning and the got transition website I put up here is a federally funded national resource center.

[0:08:25] Again, not really focused on neuroimmunology diseases but overall is a resource for transitioning pediatric patients to adult care medicine. And it has I put a screenshot here because it has a lot of different resources for the youth and the young adults themselves for parents and caregivers and then resources for different research opportunities as well. And I think it's a really rich resource to be able to look and see what other people are thinking about and what other people are doing in terms of reading themselves for transition and their families for transition. I put the QR code here to the left that links you directly to these transition readiness assessments. And so, there's a transition readiness assessment for the youth and then a transition readiness assessment for the parents and caregivers and similarly to what Dr. Wilson was talking about in her previous slide that, you know, we want to assess the patient where they are and in their transition journey if they're ready for transition.

[0:09:27] And we also want to assess the parent and caregiver where they are and if they're ready to support their youth and their patient for transition and these results might look a little different from each of these assessments. And I think that's really important. I think that's something to jump-start the conversation about. So, I highly recommend these resources for assessing readiness for transition and again prompting to think about what areas of transition of care do you and your family need to be thinking about. But another opportunity or another resource, and this is actually what we use in our clinic for Assessment of Readiness for Transition is called the TRAQ it's the Transition Readiness Assessment Questionnaire. And you might be getting the sense that our patients are given a lot of questionnaires in our clinic which they are, but they are gladly filling them out and participating because we use these in our discussions with the families that very day.

[0:10:27] And so, the transition readiness assessment questionnaire is a quick and validated tool that again is not disease specific but it's certainly a great way to assess in a formal way how this patient and child and family are doing in the terms of being ready to transition to adult. So, this TRAQ questionnaire is broken up into five different domains the first being, and I know it's small on the screen, but managing your medications and then the 1, 2, 3, 4, and 5 columns go, you know from, "No, I don't know how to do that," all the way up to, "Yes, I always do this when needed to." So, there are four questions about managing medications, there are a group of questions about appointment keeping, how to make and keep your appointments. Four questions on tracking healthcare issues, a set of questions on talking with your providers, and then managing your daily activities.

[0:11:25] So, it's a quick 20-question questionnaire that you can assess over time how patients and youth are acquiring the skills needed in order to make a successful transition to adulthood. So, we actually administer this track questionnaire yearly to our patients to make sure that we're moving them along when we start our transition process to gain the set of skills that they really need throughout this journey. So, if you read the literature about transitioning from pediatric medical care to adult medical care, there is a lot of literature around the epilepsy population. So, there's there have been some studies in the patients with epilepsy and neuromuscular disease. There's not a ton in the neuroimmunology sector. However, we kind of utilized the

data from the other subspecialties and realize that one of the best things to do to improve outcomes and to have successful transitions is to actually formalize the journey.

[0:12:32] So embedding your transition process into clinic to make sure that you have a step stone -- step stones along the way in order to make sure that we're giving our patients the tools and resources that they need and checking for understanding of those tools and resources is to really formalize this into what we are using a five-step process. So, I'm going to give a ton of credit to Dr. Wilson and then also Dr. Goldstein, who is part of our team, for helping to really paint a picture of our transition program. So, we have phases one through five and our target audience for Phase one is the 12 to 13-year-olds, but we recognize that patients are diagnosed at all different ages, patients are diagnosed in their teenage years and although, you know, they might be over the age of 12 or 13 when they come into our transition -- when they come into our clinic, we do want to start back at Phase one for every single patient. So, we kind of took off the ages and we labeled them as phases so that we make sure that we kind of start at the beginning with everyone.

[0:13:40] So, our goal is to go through some transition teaching during each of our clinic sessions and hit some really key points in each phase of transition. So, I'll just, you know, obviously it's up here for you to read but I'll give you an example for Phase one. We really start with what is transition and why does this matter and why am I talking to you about this even though you're, you know, years from being an adult. We really try to make sure that the patient can explain their diagnosis and really support them to make sure they understand. They don't have to explain their diagnosis to anyone. But if they were to explain their diagnosis to their peers or their school, how would they do that? What words would they actually use? And we have worksheets, and our child psychologist sits with patients and works through that with them and says like what words would you use? Like what sentences would you say?

[0:14:36] And then our pharmacist, Jim Herbst goes through a worksheet on medications and makes sure that our patients know their medications and know why they're taking their medications and that's Phase one. And as you can see Phase two builds on that, it talks about what is, you know, carrying an insurance card and what is an emergency, and who would the patient call for an emergency. They talk about their family medical history and why that's important to explain to future providers. Phase three talks about making a decision as an adult and how to make an appointment and how to refill medications, really practical and useful tools that our kids need as they grow up to become adults. Phase four kind of continues to build on that in terms of discussing goals for adult care and making sure they have a medical summary, making sure that they have the referrals that they need to the other subspecialties, and really with a goal of having a first appointment with their adult provider.

[0:15:38] Phase five is very much still part of the transition process which is actually seeing that adult provider. And so, it's really important for us to stress to our families that transition doesn't end when you're done with the pediatric neurologist. It really requires making and keeping and going to that last appointment with that first appointment with your adult neurology provider and completely transferring your care over. So as, you know, as I was describing earlier, it really has to be a team. The transition team is made up of the health care providers in the neurology clinic, your family, your school, and certainly, the individual and you know just as every team looks a little bit different and every transition process looks a little bit different. It really has become quite clear to me in our clinic that each transition is quite unique, and we certainly need to meet families where they are and modify their transition plan over time.

[0:16:44] So certainly, harkening back again to the previous discussion about how an IEP or a 504 plan can be an individualized plan for learning and supports while in school. I think we need to have the same mindset of a transition plan. I think one size is not going to fit all and I think each family structure, each diagnosis, each

set of medical needs, each set of mental health needs is also unique for each patient. And we need to be willing to have a structure for a journey and have tools and goals in place but willing to be flexible with that structure and tools and goals so that we can really have a successful transition for each of our families. So, the other piece of this puzzle is certainly -- much of what I've shown you was not unique to pediatric patients with neuroinflammatory diseases.

[0:17:34] So, what are some of the unique needs of our patient population? And what do we need to be thinking about? I think there are a lot of unique needs and I think you all know the unique needs even better than I do. But some different areas that certainly I'd like to highlight are legal implications in terms of making decisions, logistical implications in terms of actually making and keeping appointments, and medication referral -- medication refills. Certainly, there are physical mental, and emotional needs of our patients. And one thing that's really important to keep in mind is that we are moving our patients, our children through this process during a very vulnerable time in their lives. So, the normal adolescent brain development is happening during the same years in which we are trying to instill within them the skill set and empower them to take control of their health care during an emotional time, a time where decision-making is sometimes challenging, and puberty and hormones make that even more challenging.

[0:18:51] And so, I think it's reasonable for us to recognize that and to realize that we need to support our patients and our family members in this very vulnerable time for them. There is an increased independence during this time and an increased desire to feel normal and so decision-making is impacted by that. We heard in our previous discussion that our population has an increased risk of psychiatric comorbidities and anxiety, and depression are certainly meaningful to take into account during this transition period. And we also heard that we have a higher incidence of cognitive side effects overall from our disease processes that we treat, but also from the medications that we use to treat these disease processes such as steroids, for example, we know that our patients are not going to be able to avoid medical appointments, sometimes infusions, sometimes feeling sick, sometimes time away from their daily activities.

[0:19:53] And so that is something that you know to help think through and think about as a challenge for working with our patients about how to successfully transition away from the pediatric care model to the adult care model. We know that our patients have multiple subspecialties to care for. It's not just transitioning the pediatric neurologist, it is also transitioning the mental health providers and the -- like I said, ophthalmologist, urologist PM, and our doctors. And we know that we need to think about what the resources are in the adult world that might not come as readily available as in the pediatric world. And so sometimes it's a need to transition to like a different community supports and especially in the areas of psychosocial and interdisciplinary supports. We've found that to be a little bit more challenging. And so oftentimes the pediatric nurse is housed in an academic medical center and there are other academic sub-specialists, certainly, in the adult world, there are also adult sub-specialists, but less so, in the psychosocial and mental health realm, we've heard a lot of different challenges.

[0:21:02] And this weekend I've talked to several different people about their challenges, in finding those subspecialty supports. I think another resource to think about for our patients with inflammatory diseases are resources for continuing school or entering the workforce and how to set themselves up for success and advocating for themselves and getting their needs met in those arenas. So, the entire goal of transitioning and planning a transition is to empower our young people right. And so, we definitely need to be transparent about the differences in the adult care culture. We need to identify a child's unique needs. We need to transition primary care providers before subspecialty providers. We need to make sure that we have an idea about this graduated independence of our young people and have a transition plan document. And so, this slide is meant to be a bit of a best practices slide in terms of what the literature supports for having a successful transition.

[0:22:11] One thing that I want to talk about is this graduated independence. And the reason why I want to talk about that a little bit more using this image is, you know, one thing that I kind of came across again and again when I was reading people's transition stories in terms of how they successfully move from the pediatric world into the adult world is the desire to be able to take that responsibility and to be able to grow with it and have the freedom and the support to make decisions, which sometimes means make mistakes and you know, our adolescents -- any adolescent is craving that independence and craving that opportunity to learn and to grow and to try and I think it's really important that we support them in making their own decisions and being there for them as they make their own decisions but being a safety net behind them as well. And so that's kind of what our goal is in our transition program is to allow patients to have and build on the tools that they will need to be successful while giving them the opportunity to try.

[0:23:26] So I think in summary what I want to leave you with is that this certainly is a journey. It's something that's going to take time, years even in order to be prepared. And I want to empower you all to make a list of your team members who is going to help you on this journey in terms of the professionals in the clinic, but also your family and friends, and school professionals as well. It's important to start early and it's important to individualize the experience to formalize a transition plan and to empower our young people to be able to transition to adulthood appropriately so with that I'll put up the same slide that Dr. Wilson put up in terms of our neuroimmune team and thank all of them for helping to create our transition program. One of our big goals is to build a bridge to the other adult programs in our community. And so, we are at Nationwide Children's in Columbus, Ohio. And we have Ohio State University's neuro-inflammatory clinic.

[0:24:28] And so, I will say that we have a very wonderful advantage of having a neuro immunologist that sees both pediatric patients and adult patients. And so, in our transition plan for our clinic, our goal is to have that neuroimmunologist have the patient's last pediatric visit with them at nationwide Children's hospital and then have that neuroimmunologist have their first adult visit at Ohio State with that particular patient. And so that is our warm handoff model. That is what our goal is kind of at the end of this journey of transition, but that might not be a resource that's available to everyone. However, I definitely would encourage everyone to be able to identify that adult provider early on and encourage their pediatric neurologist to do some type of warm handoff to the adult world as well. So, I'm happy to take any questions and I know Dr. Wilson and I are both available to take questions. Yes.

[00:25:40] **Audience Member:** So, you know, part of this graduated independence is when a child is young and has a neuroimmune disease. The parent goes to school and tells the teacher, "This is what my child has." When they get to the teenage years, they've got to learn how to talk about their own, what is their diagnosis. How do you tell people who are peers and teachers? Is that a big part of what you advocate for with teachers?

[00:26:08] **Dr. Melissa Hutchinson:** Yeah, absolutely. I'm going to go back to our transition journey slide and so this is -- these are our different phases of transition and certainly, I didn't put up all of our specific worksheets that are in our packet but our packet for phase one includes a worksheet that the patient themselves fills out in terms of "what is my diagnosis" and it has a blank, and this means "blank," and so they have to be able to explain it. And then the questions three and four are about how would you explain this to your peers and how would you explain this to your school. And that's kind of where we start and like I said, that's the 12 and 13-year-olds that are -- where we're starting with. And I think one really important point treating pediatric patients is so interesting because there does become a point where you need to turn to the kiddo and talk to them instead of their parents, right?

[0:27:11] And I find that sometimes even earlier than 12 to 13 years is a good time to start doing that. These kiddos hear these words for years, they hear these diagnoses for years. They just kind of grew up with it because that's what it was, those that are diagnosed early on, but at some point, you kind of got to take a

step back and say, "Do you know what we're talking about?" "Do you know why we're talking about this?" And I think it's important to do that at a developmentally and age-appropriate level and then build on that over time. One thing and I think I'll just call you out, Hannah, right now, but one thing that you had said yesterday was -- I think you had said something like, you know, they explained it to my parents, maybe I should have asked more questions and I think that's really important that I actually think I wrote that down and said, "Yeah, I think I do that, I think I explained things to parents," and even with my teenagers and I think we, specifically myself, need to make sure that I'm talking to the patient at an age-appropriate and developmentally appropriate level. Whether or not they were diagnosed early on in childhood or as teenagers. Yeah.

[00:28:33] **Audience Member:** We've got a lot of people that, you know, there are dangers. It's kind of like anything. They sort of want to fit in, so they don't want to be open about medication they're on, their limitations. Do you find that it's really difficult at that time for people, maybe around 16 and up, trying to let them know that maybe this is something that's important. You can't live your lives, like entertainment, especially how kids get when they go to college and things like that. Maybe not taking good care of themselves. They might downplay it and things like that. How is that really handled or is that something you find?

[00:29:32] **Dr. Melissa Hutchinson:** I think we do find that; I think one of the goals in formalizing our transition process is to build that toolbox to be able to, you know, have a formal way of having patients record, you know, what are signs and symptoms that I might experience. What are things that I have to call and tell somebody about what do I do in case of those symptoms in an emergency or in case I develop symptoms? And so, I think formalizing that education and having patients build their toolbox early on, the goal is to make sure that teenagers, adolescents, young adults have the understanding of what could happen or what might happen and what to do -- and how to recognize that and then what to do about that. And so, the goal would be to empower them, to take control of you know, their decision-making. But I think that also kind of harkens back to the picture of the growing plants that I had, which is sometimes it's necessary. And I think that's, you know, one of the things that's very much craved by our adolescent and young adult population is that independence to make decisions and you know, to be able to have a support in a safety net in case the decisions don't go as planned to be able to lean on.

[00:31:08] **Dr. Camille Wilson:** Yeah, absolutely. I was just going to add on to what Dr. Hutchinson said to your question too, I think there's a very developmentally appropriate stage of like, "I don't want to be different, I don't want to stand out, or I don't want to have to miss school because of those infusion, or I don't want that." And I think that's where the psychosocial supports become so important to, so it's not just when you're first diagnosed that you might want to talk with a professional about, "What does this mean? What do I do? What I'm afraid of." But even like, there can be little grief along the way too, of like this is different, I get it and being able to work through that and talk through that I think can be very valuable. And I think that's where ongoing psycho-social support can be so powerful. So, whether it's having a community, like a conference like this where you can be with peers, you can be with people at different life stages and see, "Oh, okay, they made it through, it changed," and I think that's what makes community so powerful within this process, but then also maybe having some of those more formal supports to help when those tough moments come when, because medication adherence is a big concern, like in the late adolescence, early adult years.

[00:32:23] **Audience Member:** I just wanted to make a note. I know I have a question with it, just part of something that we've been through in my own family with my son. When he was younger, he was less than 12, when he was going through a really difficult time with his diagnosis, facing major surgery. And he was incredibly scared then, but he did have the social worker that he talked to, and they actually went through and created a PowerPoint because he was really having a hard time with the questions he was getting from other kids. "Well, why do you use a wheelchair here but you're not using a wheelchair now? Why were you gone for two weeks, and you don't have to make up all of your homework?" So, it really wasn't easy to go through and

to explain not only about his diagnosis, about what they're seeing, but who he is, that he was still up here. He was still a child. It was still important to him to play his video games and for my son, here was a very big step in him taking and owning his own disability and being able to move forward. And looking back now, I can see that as one of those first steps in that transition here because then he owned it and he was able to ask those questions of his physicians about his diagnosis, and the different aspects that needed to be sure he was keeping on top of. It wasn't just mom that had to. So, I just wanted to bring that up. That possibility was an excellent thing. He presented it to his classroom. It was his third or fourth grade classroom at the time, and then he asked me to come in and when there were certain questions that came up, he said, "For that one, you need to ask my mom. She's right there." So, it's just something that I think is a really good idea for kids who aren't sure but will have to face that.

[00:34:33] **Dr. Melissa Hutchinson:** I love that, that's a really awesome idea, an awesome example and I think it really highlights the fact that this is our formalized process that we want to make sure that we have in place in our clinic, but each patient and each family is so unique and the needs are so unique and certainly, again, I'm very thankful to have our mental health providers in our clinic because I can totally see how our patients are benefited by working with them on a weekly or monthly basis in terms of working with them on their anxiety and going to school or working with them on, you know, their communication with their peers and that doesn't have to wait until 12 to start, right? That doesn't have to wait at all, and that's something that we assess for and work on throughout all the years that patients are with us in our clinic.

[00:35:28] **Audience Member:** I'm going to ask you a question. How do you approach it? Because it feels like, especially for parents who have done this for a while, and as one who has done it for a while, it can be really difficult to let the child manage those pieces, to ask all those questions, especially for if you're with a provider for a long time and they are accustomed to talking to you. Do you have any words of wisdom for the parents to be able to say, "Okay, it's all right to step back?" As you mentioned, there are going to be mistakes.

[00:36:14] **Dr. Melissa Hutchinson:** I mean I think that's perfect; I think you talked yourself through now but I'm going to answer the question then I'm going to ask Dr. Wilson to answer the question as well. And so, we have this first conversation about what is transition with the family with the patient and the caregivers and sometimes we have that conversation two or three times, you know, to set everybody's expectations from the beginning and to really set the expectation of this is the process that will happen, let's make it the best that it can be and let's, you know, make sure that we have the tools in each of our tool boxes. And so, I think that being very transparent with the parent in terms of here are the phases that we want to help, you know, bring the child through, parents have been so happy with this handout. They have been really just -- I think a sense of relief almost, in a sense of, you know, thank you for thinking through all of the things that my kiddo is going to need, and I think as this transition kind of happens, it's noticeable that we're talking to the patient and noticeable what -- how the patient is answering the questions.

[0:37:27] We also have some handouts and some literature directed for the parent in terms of like what is this transition? And I can certainly share those with you and what are the goals and why are they here? Why do we have transition? But I think that one of the other powerful things that we're doing is we're stapling the documents and giving them to the patient and so that they can continue that conversation at home, they can continue to expand on different ways the patient answered the different questions and different topics that came up through the discussion because certainly, we can't have that full conversation within the context of clinic that day. And although it's a multiphase and multi-year process, much of the conversations will certainly happen at home, right? I don't know if there's anything you want to add to that.

[00:38:12] **Dr. Camille Wilson:** Yeah, and I think that's such an excellent question because as parents and as caregivers you're that primary voice, you're communicating. And so, I think finding a way to shift that

dynamic where then you're allowing your loved one to have that bigger voice, you know, and talking about what they're thinking, they're feeling what their questions are. And so, I think they got transition resource that Dr. Hutchinson showed before, it has that parent and caregiver section, it has some really thoughtful, even just concrete tips of ways that you can help prepare your young one to be more independent. So, it might be before you go to your neurologist appointment, maybe sit down with your child a couple of days before and come up with questions that maybe your child wants to ask the doctor, right? And so then encourage them to be doing that, and so then it's giving them that ability -- that time to practice, you know, the skills and it might go great, it might be kind of hard and that's ok, that's part of that learning process, and I think that's why we try to map it out at such a young age to give that opportunity to practice like, "Okay, this time, maybe just ask one question," the next time they might want to ask about something else or another domain and as they build that confidence, they can be more independent and then you can take that step back, but while they're with you and under your care it's, you know, kind of shifting that dynamic so that you feel comfortable and your loved one feels comfortable too, because I think that it's a two-sided thing, it's not just helping the child be comfortable about helping the parents and the caregivers say, okay, my kids got this. Yeah.

[00:39:45] **Audience Member:** Thank you very much.