RESEARCH POSTER SYMPOSIA II: GENDER AND SEXUAL HEALTH

13.

CONFIDENTIALITY AND CARING FOR ADOLESCENT PATIENTS IN THE AGE OF THE 21ST CENTURY CURES ACT

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Purpose: Adolescents' confidence that their health information will be confidential is essential to an open, trusting patient-provider relationship. Some elements of adolescent confidentiality are protected by state and/or federal laws. However, the recent final ruling on implementation of the federal 21st Century Cures Act, which was designed to improve patients' access to their electronic health records (EHR), lacks sufficient safeguards to protect adolescent confidentiality. As a result of the Cures Act, parents with proxy access to their child's medical chart can now more easily obtain confidential information that the patient has the right to protect. At many institutions, EHR notes are now automatically shared with patients and proxies, unless providers take specific steps to discuss the adolescent's confidentiality preferences and implement them by "unsharing" notes. Adolescents whose confidentiality is breached face significant risks. Especially if they already mistrust the medical system, a breach can sabotage their rapport with their provider. Adolescent medicine providers are attuned to these risks, but implementing safeguards to help other providers protect adolescent confidentiality is challenging, despite the guarantees provided by the law. To promote needed system-level EHR changes, we aimed to explore feasible, consistent, and generalizable EHR strategies to improve protection of adolescent confidentiality.
Methods: Our study population included all adolescents presenting to our clinic for new patient visits (n=607 unique patients) between 7-1-20 and 6-30-21. Within this group, we analyzed each electronic chart note using manual review, looking for documentation about confidentiality. We also examined whether the provider documented the patient's note-sharing preferences and checked the patient's proxy status in MyChart, our online patient portal. Several interventions were tested to increase the frequency with which we discussed confidentiality with patients. In PDSA cycle 1, we introduced a new smartphrase (a consistent phrase pulled automatically into the EHR templates), that reminded us to discuss confidentiality and proxy access. In cycle 2, we obtained feedback regarding the smartphrase from Adolescent Medicine fellows and faculty and made modifications based on their input. Cycle 3 provided each provider with individualized performance reports on their use of the smartphrase and whether they checked MyChart proxy status. These actions were interpreted as markers that the provider had a conversation with the patient about confidentiality and their proxy preferences.
Results: Before the QI study, virtually no confidentiality conversations were recorded in the medical record. We set a goal that after the interventions, 25% of new patient visits would include a confidentiality conversation, and we substantially exceeded this goal. After three PDSA cycles, the frequency of documented confidentiality conversations increased to 51% in patients <18 years old and to 61% in patients >18 years old. Documentation of note sharing preference increased to 47% in all patients. Provider checks of MyChart proxy status went from <1% to 32%.
Conclusions: Our three QI interventions successfully increased the frequency of confidentiality conversations with adolescent patients. Barriers that likely decreased the number of confidentiality conversations were time constraints on visits and physician concerns about parental objections to losing proxy access.
Sources of Support: N/A.

14.

CHANGES IN ADOLESCENTS AND YOUNG ADULT (AYA) SOLO AND PARTNERED SEXUAL BEHAVIOR DURING COVID-19: A LATENT CLASS ANALYSIS OF AYA FROM 30 COUNTRIES

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Purpose: COVID-19 profoundly altered the ways adolescents and young adults (AYA) organize their sexual experiences. We used latent class analysis (LCA) to examine patterns in self-reported change in solo and partnered behaviors in a sample of AYA from 30 countries.
Methods: Data for the current study were drawn from International Sexual Health And REproductive Health Survey (I-SHARE-1), a multicountry, cross-sectional, online study conducted to assess the impact of the pandemic on adult sexual health across the globe. Participants were recruited through local, regional, and national networks (e.g. listservs of professional organizations and international health organizations, social media, etc.) of each country's research team. AYA participants (N=7527; 18-26 years; 32.3% of total-sample; 60.1% female, 86.1% cisgender, 77.1% heterosexual) were retained. LCA was used to identify and classify patterns (i.e., classes) of changes (increased, stayed the same, or decreased) in seven solo and partnered sexual behaviors (cuddling/kidding/hugging a main partner, sex with a main partner, solo masturbation, sex with a casual partner, sexting, viewing pornography, and cybersex). Random intercept mixed effects multinomial regression (gllamm; Stata 17.0; all $p<.05$) adjusted for country-level clustering was used understand how demographic (age, gender identity, sexual identity, employment status during COVID-19, mental health, distancing or isolation during COVID-19) and country-level predictors (income group, Oxford Stringency Index [national response to COVID-19], Palma Ratio [country-income inequality) and Gender Inequality Index (country-gender) were associated with changes in sexual behaviors.
Results: LCA results suggested a six-class solution: increased solo masturbation and porn + all others stable (11.8%), increased cuddles/hugging and sex with main partner + all others no-change (10.5%), increased cuddles/hugging and sex with main partner + increased solo masturbation and porn use + all others stable (18.8%), all decreased (13.1%), decreased cuddles/hugging and sex with main partner + all others no-change (19.5%) and all no-change (24.3%). Older age (RRR=0.86-0.94), being female (OR=0.39-0.67) and higher mental health scores (RRR=0.68-0.81) were associated with a lower likelihood of increased masturbation/porn, increased bonding/sex with main partner + increased masturbation/porn and a decrease in all behaviors relative to no behavior change. Being a sexual minority (OR=1.40-1.70), ever being in isolation for COVID-19 (RRR=1.21-1.45), having stable employment (RRR=1.25-1.32), being in a country with more stringent lockdown (RRR=1.02-1.07) or with a greater wealth inequality (RRR=1.17-1.55) were positively associated with increased masturbation/porn, increased bonding/sex with main

partner + increased masturbation/porn, and a decrease in all behaviors relative to no behavior change. Greater distancing (RRR=1.16) was significantly associated with increased bonding/sex with main partner vs. all behaviors stable.
Conclusions: The initial wave of COVID-19 impacted AYA solo sexual behaviors, partnered bonding behaviors, in-person sexual behaviors and virtual sexual behaviors. Evidence of individual differences in these classes should inform SRH preparation efforts for future public health emergencies.
Sources of Support: None.

15.

THE FALLACY OF "SYSTEMS LITERACY"; HOW STRUCTURAL VIOLENCE IN SERVICE PROVISION AFFECTS THE HEALTH OF TRANSGENDER YOUTH EXPERIENCING HOMELESSNESS

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Purpose: Clear health and mortality disparities exist both in transgender populations and for youth experiencing homelessness (YEH). Furthermore, transgender youth are overrepresented within populations of YEH. However, no peer-reviewed research has yet explored the structural factors that underlie health disparities experienced by transgender YEH. We conducted a qualitative study to better understand the mechanisms by which structural factors cause health disparities in a population of transgender YEH in the San Francisco Bay Area.
Methods: Semi-structured, in-depth interviews were conducted with (1) youth ages 19-24, recruited through flyers at service provision sites and via snowball sampling, and (2) key stakeholders. Topics explored included physical and mental health, identity, causes of homelessness, survival strategies, HIV risk, violence, stigma, and service access. Interviews were audio-recorded, transcribed, and double-coded. We conducted a grounded theory analysis of our data.
Results: We completed 27 in-depth semi-structured interviews with transgender YEH (n=20) and key informants (n=7). Youth participants included 6 trans women, 3 trans men, and 11 youth who identified as genderqueer, nonbinary, agender or multiple genders. Youth's median age was 22 years, and two-thirds were people of color or mixed. Youth described within-group differences in health and social service systems success and outcomes, tying these differences to a structurally-produced set of skills, attitudes, knowledge, and other traits that allow them to successfully access systems – a concept we are naming "systems literacy." Systems literacy affected systems access, which ultimately impacted trans YEH health, and was itself shaped by structural factors including bias and stigma, criminalization, formal education, childhood economic class, and social ties. Youth also offered systems access-focused recommendations for health and social service provision organizations.
Conclusions: Trans YEH face significant health disparities, mediated by social and structural determinants of health, including structurally-produced systems literacy. In coining the term systems literacy, we frame systems literacy as a structural determinant of health and a form of structural violence. In addition, we aim to draw attention to the bias inherent in systems that require subjects' systems literacy as a prerequisite for systems success and health. Incorporating feedback from trans YEH, we point to modifiable targets for intervention in health and social service provision, toward decreasing systemic violence, decreasing risk exposure, and improving health for trans YEH and diverse marginalized populations.
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16.

THE LINKS BETWEEN DISCRIMINATION, VIOLENCE AND HEALTH OUTCOMES FOR GENDER MINORITY BIPOC YOUTH IN CANADA

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Purpose: Research on stigma, discrimination and violence towards transgender and non-binary (TNB) youth has proliferated in the recent years. With this research, inclusive and anti-bullying school policies have been developed and successfully implemented by some school districts, and additional research has demonstrated improvements in health outcomes of these youth. However, what is lacking in most of the research is how intersectionality plays a role in experiences of discrimination and violence and how these experiences in turn affect the health outcomes for youth who are not only TNB, but also Black, Indigenous, and/or people of color (BIPOC).
Methods: The 2019 Canadian Trans and Non-binary Youth Health Survey was an online survey conducted in English and French. Participants were 14-25 years old, and involved 1,518 youth from all provinces and territories across Canada. Out of the entire sample, 390 of youth were BIPOC. Among this subgroup of BIPOC youth, we conducted logistic regression analyses to explore the relationship between discrimination, such as discrimination based on race or physical appearance, and violence, such as verbal harassment, physical threats, or injuries, with self-rated physical health, self-rated mental health, self-harm, suicidality, and foregone medical and mental health care.
Results: Compared to peers, TNB BIPOC youth who reported experiencing racism had significantly higher odds of rating their physical health as poor or fair (OR: 1.5, 95% CI: 1.1-2.2), foregone physical health care (OR: 1.6, 95% CI: 1.1-2.3), suicide ideation (OR: 1.7, 95% CI: 1.1-2.8), and suicide attempt(s) (OR: 2.6, 95% CI: 1.7-4.0) in the past year. Youth who reported physically being threatened or injured had significantly higher odds of rating their physical health as poor or fair (OR: 2.1, 95% CI: 1.7-2.7), their mental health as poor or fair (OR: 2.1, 95% CI: 1.1-4.4), forgone physical health services (OR: 3.0, 95% CI: 2.3-3.8), forgone mental health services (OR: 2.5, 95% CI: 1.8-3.3), self-harm (OR: 3.6, 95% CI: 2.7-4.8), suicide ideation (OR: 3.1, 95% CI: 2.3-4.2), and suicide attempt(s) (OR: 4.3, 95% CI: 3.2-5.8).
Conclusions: Experiences of discrimination and violence had significant negative relationships to physical health, mental health and access to health care services for TNB BIPOC youth in Canada. This further emphasizes that inclusive laws and anti-bullying policies need to be co-created with TNB BIPOC community members in order to decrease the experiences of discrimination and violence for trans and non-binary BIPOC youth. This is especially important given the health impacts these negative experiences appear to have on TNB BIPOC youth during critical and sensitive periods of their development.
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