clinical guidance and pearls related to the gender transition process. The curriculum was unveiled at the 7th Annual NYS Sexual Health Conference, and then shared on the CEI YouTube channel where it is presented as 3 episodes, broken into 12 parts, each 5 to 18 minutes long. The YouTube link has been shared on multiple clinician listservs, with an international subscriber base. The link is also available on the employee learning and performance platform used by a major academic medical center. By disseminating through multiple access points, we aim to build awareness and competence to a broader audience. Utilization of YouTube enables our team to assess curriculum usage by tracking numbers of views and learner comments. Beginning in October 2021, the curriculum will also be accessible on the open source CEI website for free Continuing Education (CE) credits, both medical and nursing. As with all curricula on the CEI website, demographic information regarding viewers and evaluation feedback are collected.

Results: Preliminary results reveal that between 6/29/21 and 9/9/21, the videos have been viewed 871 times through the CEI YouTube channel. The consensus feedback received (verbal comments, responses to listserv posts) has been overwhelmingly positive. Access to CE accredited videos will open on Oct 1, 2021. Information regarding number of views, completion of the entire 3 part series, demographics of viewers (profession, age/race/ethnicity practice specialty, practice location) will be reported along with quantitative and qualitative evaluation results.

Conclusions: An accessible, short educational video curriculum has been well-received and easily disseminated via the Internet during an initial marketing rollout. It has the potential to build competence broadly among clinicians to provide an affirming and inclusive healthcare experience for transgender and gender diverse patients. The video format is particularly appropriate during a pandemic, when in-person engagement has been challenging in both patient care and continuing education activities.

Sources of Support: New York State AIDS Institute, Clinical Education Initiative.

46.

WHAT PEDIATRIC PRIMARY CARE PROVIDERS NEED TO SUPPORT GENDER DIVERSE YOUTH: PERSPECTIVES ON CONSULTATIVE SUPPORT FOR GENDER-AFFIRMING CARE

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Purpose: The demand for pediatric gender-affirming care has increased throughout the COVID-19 pandemic, highlighting the need for telehealth-based specialist-to-primary care provider (PCP) consultative support. Accordingly, the purpose of this study was to identify PCPs' perspectives on receiving training and consultation in pediatric gender-affirming care using three telehealth modalities, with the larger goal of informing the development of future consultative support offerings.

Methods: PCPs who had previously reached out to the Seattle Children's Gender Clinic for a gender care consultation were invited to participate in a semi-structured, one-hour Zoom interview. During the interview, three different telehealth modalities (tele-education, electronic consultation, telephonic consultation) were described and participants were asked to share their perspectives on 1) the benefits and drawbacks of each modality, 2) which modality would be most effective in supporting them in providing gender-affirming care in the primary care setting, and 3) factors that would make a consultation platform successful. Interviews were transcribed and analyzed using an inductive thematic analysis framework by two authors using Dedoose qualitative analysis software. All participants provided informed consent and all study procedures were approved by the Seattle Children's Institutional Review Board.

Results: Interviews were completed with 15 PCPs. For the tele-education platform, PCPs most often identified continuing medical education (67%) and the community or network it creates (47%) as benefits and the commitment required (73%) and scheduling difficulties (40%) as drawbacks. For the electronic consultation model, timeliness of response (67%) and convenience (53%) were cited as benefits and electronic medical record system requirements (60%) and difficulty conveying the message electronically (53%) were considered the main drawbacks. For the telephonic consultation, PCPs identified the ability to have a conversation (80%) and the timeliness of response (60%) as the main benefits and phone-tag (87%) and finding time to make the initial call (40%) as the main drawbacks. Regarding the most effective platform, responses were mixed: 27% endorsed the electronic consultation, 27% the tele-education platform, and 20% the telephonic consultation, with the remaining 27% suggesting a hybrid of the three models. Finally, responses regarding what would make a platform successful were much more varied across participants, with the most common responses including being non-judgmental and supportive (33%) and flexible with the ability to pivot to other platforms as needed (27%).

Conclusions: With the increasing demand to provide gender-affirming care in the primary care setting, further training and support is necessary for pediatric PCPs to deliver this time-sensitive care. The results of this study indicate the need for a more flexible suite of gender-focused specialist-to-PCP telehealth-based consultative services to facilitate the provision of pediatric gender-affirming care.

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47.

DEVELOPMENT OF QUALITY ASSURANCE MEASURES OF GENDER-AFFIRMING HIV PREVENTION SERVICES FOR YOUNG TRANSGENDER WOMEN

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Purpose: Human immunodeficiency virus (HIV) prevention services including HIV testing and Pre-Exposure Prophylaxis (PrEP) are a crucial component of healthcare for young transgender women (YTW), who are disproportionately impacted by HIV in the U.S. However, these services and spaces are often not inclusive or gender-affirming. The purpose of this study was to adapt and develop two quality assurance measures of HIV prevention services for use with transfeminine identified youth quality evaluators in order to assess HIV and sexually transmitted infection (STI) services for gender-affirming competencies.

Methods: Focus groups were conducted with provider and research experts in transgender health and HIV care for adolescents (N=14) and transfeminine identified youth experts (N=7) in transgender health to obtain feedback on two measures adapted from the Quick

Investigation of Quality (QIQ) framework. These included: (1) a mystery shopping site assessment tool and (2) a facility audit tool. The mystery shopping site assessment tool was originally developed to assess LGBTQ+ competency in HIV testing and counseling services for young men who have sex with men. The facility audit tool has been used to address quality and access in other populations experiencing similar barriers to care. Nominal group technique was used to prioritize items for inclusion. The five focus groups were recorded and transcribed, and the research team used thematic analysis to identify the most salient themes and incorporate participant feedback into the development of the tools.

Results: Researcher, provider, and youth experts (n=21) expressed overall support of using these tools to evaluate HIV prevention services and made several valuable suggestions to tailor them to the needs of YTW. Research and provider experts made several content-based suggestions, such as adding items to address the behavior of other clients in the waiting room, presence of trans-specific symbols and materials in the facility, ADA and Spanish language-speaking accommodations, and diversity and inclusion training for staff. Youth experts were more likely to offer suggestions that improved the overall clarity, conciseness, and readability of items, such as removing repetitive items and rephrasing confusing questions. Feedback that was not incorporated directly into the tools was included in training materials developed for the youth quality evaluators.

Conclusions: By leveraging input from a diverse group of researcher, provider, and youth experts in transgender health, we adapted and developed two tools that take an intersectional approach to measuring the quality of HIV prevention services for young transgender women. Next steps are to recruit and hire youth quality evaluators to pilot and validate these tools with agencies that provide HIV prevention services in a large urban area.

Sources of Support: Stoneleigh Foundation, Leadership Education in Adolescent Health.

48.

HOSPITALIZATION FOR SUICIDE ATTEMPT AND SELF-HARM AMONG YOUTH DIAGNOSED WITH GENDER DYSPHORIA

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Purpose: Transgender and gender non-conforming (TGNC) youth experience severe discrimination which has been linked to adverse mental health outcomes, including an increased prevalence of suicidality and self-harm. Few epidemiological studies have examined this relationship; thus, we studied the relationship between hospitalization for suicidality, self-harm and gender dysphoria in a large, nationally representative database.

Methods: We used the 2016 Kids' Inpatient Database to identify a subset of TGNC youth < 21 years of age captured by the database (using ICD-10 gender dysphoria-related codes). We identified suicidal ideation or suicide attempt using either explicit "suicidality" codes, or one of 355 distinct self-harm codes. Using descriptive statistics, prevalence of suicidality and self-harm was compared between youth with and without gender dysphoria. A multivariable logistic regression model adjusting for individual, admission and hospital-level variables was constructed looking for association between gender dysphoria and suicidality.

Results: The cohort included 3,115,589 subjects, of whom 1,980 (64 per 100,000 admissions) had gender dysphoria. Analysis of demographic variables revealed the gender dysphoria diagnosis group was comprised of a disproportionately lower proportion of non-white, publicly insured, and low median income young adults compared to the entire cohort. Prevalence of suicidal ideation and suicide attempt in the entire cohort was 2%, compared to 35.3% in young people with gender dysphoria. Using the expanded definition of self-harm and attempted suicide, prevalence increased to 44.1%. After adjusting for individual, admission and hospital-level variables, subjects with gender dysphoria had 7.89 increased odds of attempted suicide or suicidal ideation (95%CI: 7.09-8.79).

Conclusions: Using a large and representative database, we found significantly higher prevalence of suicide attempt and self-harm in hospitalized youth with a gender dysphoria-related diagnosis. For youth hospitalized after suicide attempt or self-harm, gender-affirming care and inclusive language is essential to reduce psychological stress secondary to physician-mediated interpersonal discrimination. Importantly, this study only captured TGNC youth with a formal gender dysphoria diagnosis, and not all youth who identify as TGNC have a diagnosis or disclose their identity; thus, the results should not be generalized to the entire population of TGNC youth. Furthermore, there were fewer non-white, publicly insured, and low median income youth with a gender dysphoria diagnosis compared to the entire cohort, which suggests inequities in accessing gender-affirming care among racial minority and economically disadvantaged youth. The results of this study highlight the need for structural interventions and policies to reduce discrimination and improve access to gender-affirming care in order to prevent these adverse outcomes.

Sources of Support: Stoneleigh Foundation, Leadership Education in Adolescent Health.

49.

EXPLORING PROVIDER'S PERSPECTIVES OF BLACK TRANSGENDER AND GENDER DIVERSE YOUTH'S GENDER AFFIRMATION GOALS AND BARRIERS TO ACCESSING CARE

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Purpose: Black transgender and gender diverse youth (TGDY) often face barriers and inequities in accessing gender affirming medical care, even before factoring in intersectionality and community stigma. Pediatric gender care is often provided in large multi-disciplinary gender clinics, which can present barriers for Black TGDY as they often include long wait times, prioritization of patients seeking gender affirming medications (as opposed to social transition only), and a lack of diversity among gender clinic providers and staff. It is known that having a primary care physician (PCP) is associated with greater trust, better patient-provider communication, and an increased likelihood that patients will receive appropriate care (1). Little is known about the gender affirmation goals among Black TGDY compared to those of other races and ethnicities, and how PCPs can be utilized to improve access to care. The purpose of this study was to understand provider's perspectives of their Black TGDY's gender affirmation goals and barriers to care.