

Caring for the LGBTQ Adolescent Moving Evidence into Practice

Christopher W. Blackwell, Ph.D.,
APRN, ANP-BC, AGACNP-BC, CNE, FAANP, FAAN
Associate Professor & Program Director
AGACNP Programs, College of Nursing
University of Central Florida

Disclosures

Dr. Blackwell has no disclosures to report



Objectives

- Identify at least one unique health disparity that affects lesbian, gay, bisexual, transgender, and queer (LGBTQ) adolescents;
- Recognize three components of the health history that are unique to LGBTQ adolescents;
- Provide at least one strategy to eliminate health disparities in LGBTQ adolescents;
- Identify the pharmacologic agents used in HIV PrEP and PEP prophylactic regimens and outline their associated prescribing principles in adolescents;
- Articulate the role nurse practitioners can play in community outreach with LGBTQ adolescents and prioritize suggested future research directives in LGBTQ adolescent health.



Introduction

Current LBTQ Adolescent Health Disparities: Prevalence and Incidence Data

- NPs lack knowledge on LGBTQ care and are even less familiar with the implications associated with providing care to LGBTQ adolescents.
- Newer (2018) CDC guidelines allow prescribing of pre-exposure HIV prophylaxis (PrEP) to adolescents as well.
- Yet most NPs are unaware of the proper regimen for adolescents, who remain at high risk for infection.
- NPs need solid understanding of LGBTQ adolescent health, prevention research, and their clinical and public health role in treating LGBTQ adolescents.



Introduction

Current LBTQ Adolescent Health Disparities: Prevalence and Incidence Data

- Few national studies include LGBTQ youth
- Trend could be changing as national data systems are collecting sexual orientation data:
 - Behavioral Risk Factor Surveillance Survey (BRFSS)
 - National Health and Nutrition and Examination Survey (NHANES)
 - National Survey of Family Growth (NSFG)
 - Youth Risk Behavior Survey (YRBS)
 - National Crime Victimization Survey (NCVS)
 - American Community Survey (ACS)
 - National Health Interview Survey (NHIS)– 2013
 - National Survey of Drug Use and Health (NSDUH)– 2015



Introduction

Current LGBTQ Adolescent Health Disparities: Prevalence and Incidence Data

- About 3.5% of Americans identify themselves as LGB while .3% identify as transgender
- LGBT youth are at a higher risk for:
 - Substance use
 - Sexually transmitted diseases (STDs)
 - Cancers
 - Cardiovascular diseases
 - Obesity
 - Bullying, isolation, rejection, anxiety, depression, and suicide



Introduction

Identifying Risk for the LGBTQ Adolescent: The Role of the Nurse Practitioner

- Provision 1 of the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015a) asserts:
“The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1).
- The interpretive statements that accompany this provision affirm that “the need for and right to health care is universal, transcending all individual differences” (p. 1) and that “nurses consider the needs and respect the values of each person in every professional relationship and setting” (p. 1).
- Nurses are expected to lead in the development, dissemination, and implementation of changes in public and health policies that support protection against discrimination due to sexual orientation, gender identity, and/or expression.



Introduction

Identifying Risk for the LGBTQ Adolescent: The Role of the Nurse Practitioner

- Provision 1 of the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015a) asserts:

“The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1).
- The relationship that nurses create with their patients should be one of trust and compassion.
- Nurses should first identify and then set aside any bias or prejudice in the provision of nursing care.
- Interpretive Statement 1.2 instructs nurses to consider “factors such as culture, value systems, religious or spiritual beliefs, lifestyle, social support system, sexual orientation, or gender expression, and primary language when planning individual [patient], family and population-centered care” (ANA, 2015a, p. 1).
- However, these factors must not be used to discriminate or prohibit access to compassionate and high- quality care.



Introduction

Identifying Risk for the LGBTQ Adolescent: The Role of the Nurse Practitioner

- Provision 1 of the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015a) asserts:
- The nurse-patient relationship is at the core of health care.
- Nurses practice with compassion and respect for the human rights of all individuals regardless of sexual orientation, gender identity, and/or expression.
- As expressed in Nursing: Scope and Standards of Practice (ANA, 2015b), nurses are expected to provide culturally congruent, competent, safe, and ethical care to all patients across all settings.



Introduction

Identifying Risk for the LGBTQ Adolescent: The Role of the Nurse Practitioner

- Culturally congruent practice is the application of evidence-informed nursing that is in agreement with the cultural values, beliefs, worldview, and practices of patients and other stakeholders (ANA, 2015b).
- To demonstrate cultural congruence and safe practice, nurses must advocate for patient centered treatment, equal access, equal services, and equal resources for all populations that may be adversely affected by bias or prejudice.
- Nurses have an ethical duty to honor and respect the identities, beliefs, values, and decisions of all patients (ANA, 2015a).
- Check out the ANA Position Statement:
 - <https://www.nursingworld.org/~49866e/globalassets/practiceandpolicy/ethics/nursing-advocacy-for-lgbtq-populations.pdf>



The LGBTQ Adolescent Clinical Care Encounter

- Hadland and Colleagues (2016) ID the following principles underlying LGBTQ Youth-Friendly Services:
 - Availability: The presence of health care providers with knowledge, competence and experience working with young people and with people with current or possibly developing LGBTQ identities, feelings, and/or behavior
 - Accessibility: The relative ease with which LGBTQ youth can obtain care from an available provider
 - Clinical services are located near where LGBTQ youth live, study, work or otherwise spend time
 - Technology (*e.g.*, online patient portals, email, telemedicine) is increasingly used to improve access for youth
 - Clinical services are easily obtained, with expanded hours during evenings and weekends, same-day urgent bookings, drop-in visits, allowances for late appointments



The LGBTQ Adolescent Clinical Care Encounter

- Hadland and Colleagues (2016) ID the following principles underlying LGBTQ Youth-Friendly Services:
 - Acceptability: The extent to which clinical services are culturally competent and developmentally appropriate for LGBTQ youth, and to which confidentiality is assured and protected
 - The clinic has a policy affirming its inclusive services for LGBTQ, and the clinical environment has signs, stickers, and other statements showing it is LGBT- friendly
 - Health brochures and other reading materials are tailored to the needs of LGBTQ youth
 - Confidentiality is assured and protected in every patient encounter and health care providers spend time one-on-one with patients to elicit sensitive information



The LGBTQ Adolescent Clinical Care Encounter

- Hadland and Colleagues (2016) ID the following principles underlying LGBTQ Youth-Friendly Services:
 - Equity: The degree to which clinical care is friendly to *all* LGBTQ youth, regardless of race, ethnicity, language, ability to pay, housing status, and insurance status, among other factors. The clinic has a policy affirming its inclusive services for LGBTQ, and the clinical environment has signs, stickers, and other statements showing it is LGBT- friendly
 - High quality care is provided to all youth, regardless of whether they are lesbian, gay, bisexual or transgender
 - Culturally competent care is provided to LGBTQ youth of color and services are available for non-native English-speaking patients
 - Services are provided free-of-charge for uninsured LGBTQ youth



The LGBTQ Adolescent Clinical Care Encounter

- Legal Considerations for Practice with LGBTQ Minors
 - Varies from state to state
 - Florida example:
 - Parental consent required in most circumstances, with the exception of:
 - *STDs* — Any minor may consent to examination for and treatment of sexually transmissible diseases. The law even provides that the occurrence of the consultation, examination, and treatment cannot be divulged in any direct or indirect manner, including sending a bill to the parent. As a result, providers should have a system in place so that insurance providers are not billed for STD treatment, which is often difficult because co-payments are often requested prior to medical care being provided, and minors may not realize that, if their parents' insurance pays for the care, their parents will automatically receive an explanation of benefits for the treatment.



The LGBTQ Adolescent Clinical Care Encounter

- Legal Considerations for Practice with LGBTQ Minors
 - Varies from state to state
 - Florida example:
 - Parental consent required in most circumstances, with the exception of:
 - *Maternal Health and Contraceptive Information and Services* — Minors may receive, without parental consent, maternal health and contraceptive information and services of a nonsurgical nature only if the minors are married, have become parents, are pregnant or, in the opinion of the provider, would suffer probable health hazards if such services were not provided.
 - The term “health hazard” is undefined in the law. One could argue, based on the recent findings of the American Academy of Pediatrics (“AAP”), that any developing minor’s pregnancy itself is a “health hazard.”



The LGBTQ Adolescent Clinical Care Encounter

- Legal Considerations for Practice with LGBTQ Minors
 - Varies from state to state
 - Florida example:
 - Parental consent required in most circumstances, with the exception of:
 - *Abortion* — A provider is subject to discipline under the Medical Practices Act if he or she performs an abortion on a girl age 17 or younger without giving the girl's parent or legal guardian notice, in person or by telephone, of the planned abortion 48 hours in advance of performing the procedure.



The LGBTQ Adolescent Clinical Care Encounter

- Legal Considerations for Practice with LGBTQ Minors
 - Varies from state to state
 - Florida example:
 - Parental consent required in most circumstances, with the exception of:
 - *Substance Abuse Treatment* — Providers may provide substance abuse services to a minor without the patient's parent's consent. Thus, a lawyer advising a minor about substance abuse treatment could tell the minor that under Florida law, he or she can receive treatment for substance abuse without the consent of his or her parent. The law also prohibits the release of information about such treatment without the minor's consent. Even when a parent consents to treatment, medical information about the substance abuse treatment cannot be released without the parent's and the minor's consent



The LGBTQ Adolescent Clinical Care Encounter

- Legal Considerations for Practice with LGBTQ Minors
 - Varies from state to state
 - Florida example:
 - Parental consent required in most circumstances, with the exception of:
 - *Outpatient Emotional Crisis Services* — A child 13 years old or older can receive, without parental consent, mental health diagnostic and evaluative services or individual psychotherapy, group therapy, counseling, or other forms of verbal therapy from a licensed mental health professional.



The LGBTQ Adolescent Clinical Care Encounter

- Obtaining an LGBTQ Appropriate Health History
 - Hafeez and Colleagues (2017) Report:
 - Young LGBT individuals find it difficult to report their sexual identity to their clinicians.
 - Some clinicians are not well educated in addressing the concerns of members of this community.
 - A study conducted in Washington DC showed that 68% of sexual minority youth reported about not discussing their sexual orientation, and 90% reported reservations about reporting them to their clinicians.
 - Another study used purposive sampling to recruit nine women between the ages of 18 and 24 years who identified themselves as belonging to a sexual minority student group at a university in the Southwestern United States.
 - Their audio interviews showed that the disclosure of sexual orientation and provider's attitude were important influencing factors that negatively affected their experiences about health care delivery



The LGBTQ Adolescent Clinical Care Encounter

- Obtaining an LGBTQ Appropriate Health History
 - Not a problem to ask parent to leave, but his/ her choice for minors
 - During social Hx, vital to be non-judgmental:
 - “I want you to know that I am here to provide you with the best treatment I can. I am not here to judge. Anything you tell me is private and will help me help you make good health decisions.”
 - “Do you identify as a male, female, transgender, transfluid, or something else?”
 - “How would you prefer I refer to your gender today? He, She? Something else?”
 - “Do you have sexual relationships with men, women, or both?”
 - “What kind of activities do you engage in when having sex?”
 - “Tell me about your use of condoms and other types of protection?”
 - ”How often do you use drugs or alcohol? What kind? How much?”
 - “Have you ever used steroids or other hormones? How did you get them?”
 - “Tell me about the last time you felt bad about yourself or felt down? Have you ever felt like hurting yourself?”



Major LGBTQ Health Concerns

- Depression and Suicidality:
 - Hafeez and Colleagues (2017) Report:
 - Data from the National Longitudinal Study of Adolescent Health revealed that sexual minority youth are prone to be isolated and disconnected from social networks
 - This estrangement can increase the risk of depressive symptoms among sexual minority males
 - Bisexual males and females were also more likely to express depressive symptomology than heterosexual individuals



Major LGBTQ Health Concerns

- STDs
 - Hafeez and Colleagues (2017) Report:
 - LGBT youth are more likely to engage in high-risk sexual behaviors leading to an increased incidence of STDs. The rates of gonorrhea, chlamydia, and HIV are twice as higher in sexually minority youth, as in heterosexual men
 - According to the Dane County Youth Assessment Surveys (2008-2009), multiple factors accounted for unsafe sexual behaviors in LGBT youth including earlier age of sexual encounter, increased number of known and anonymous sexual partners, lack of education on safe sex practices, ineffective use of condoms, and testing and perception of STDs acquisition



Major LGBTQ Health Concerns



- Peer victimization and family rejection
 - Hafeez and Colleagues (2017) Report:
 - Peer victimization is one of the leading causes of high-risk sexual behaviors in middle and high school students
 - LGBT youth are frequently bullied at schools.
 - They frequently get into fights, engage in truancy, and struggle with emotional distress and conduct problems.
 - Early victimization and emotional distress explained about 50% of disparities between LGBT and heterosexual youth in emotional distress in both boys and girls (each $p < 0.015$)



Major LGBTQ Health Concerns

- Peer victimization and family rejection
 - Hafeez and Colleagues (2017) Report:
 - Another important issue is family rejection which was frequently observed in families with LGBT youth.
 - To further explore the impact of family acceptance or rejection, a study enrolled 245 LGBT Latino and non-Latino white young adults from the LGBT locale, whose sexual orientation was known to at least one parent.
 - This study showed that family acceptance was more dependent on the family dynamics than the young person's sexual orientation or gender identity.
 - Parents belonging to Latino community, low socioeconomic status, religious affiliation, and immigrants were less accepting.
 - In addition, family acceptance was associated with the positive self-esteem and good general health.
 - It was protective against negative health outcomes such as depression, recreational substance use, and suicidal behaviors



Prophylactic Prevention of HIV Infection: Post-Exposure

- Although large-scale studies about PEP are lacking, PEP is clinically effective (80%) and recommended (Landovitz & Currier, 2009) when:
 - The source is known to be HIV+
 - The source is of unknown serostatus (test source in occupational exposure)
 - The source has an increased likelihood of being HIV+:
 - MSM, MSM/W, commercial sex workers, history of incarceration, residence in a county with a seroprevalence rate $\geq 1\%$
 - The behavior has an increased ($\geq 1\%$) likelihood of transmitting HIV:
 - Receptive Anal Intercourse = 1%-30% chance of infection
 - Insertive Anal Intercourse = .1-10% chance of infection
 - Receptive Vaginal Intercourse = .1-10% chance of infection
 - Insertive Vaginal Intercourse = .1-1% chance of infection
 - Oral Intercourse: Few documented cases
 - Needle Sharing: .67% per needle-sharing event
- Ideally, begin PEP within 36 hours but no more than 72 hours after exposure



Prophylactic Prevention of HIV Infection: Post-Exposure

Source: <http://cdc.gov/hivpolicies/law.risk.html>

Table 1. Estimated per-act risk for acquiring human immunodeficiency virus (HIV) from an infected source, by exposure act^a

Exposure type	Rate for HIV acquisition per 10,000 exposures
Parenteral	
Blood transfusion	9,250
Needle sharing during injection drug use	63
Percutaneous (needlestick)	23
Sexual	
Receptive anal intercourse	138
Receptive penile-vaginal intercourse	8
Insertive anal intercourse	11
Insertive penile-vaginal intercourse	4
Receptive oral intercourse	Low
Insertive oral intercourse	Low
Other^b	
Biting	Negligible
Spitting	Negligible
Throwing body fluids (including semen or saliva)	Negligible
Sharing sex toys	Negligible

Source: <http://www.cdc.gov/hiv/policies/law/risk.html>

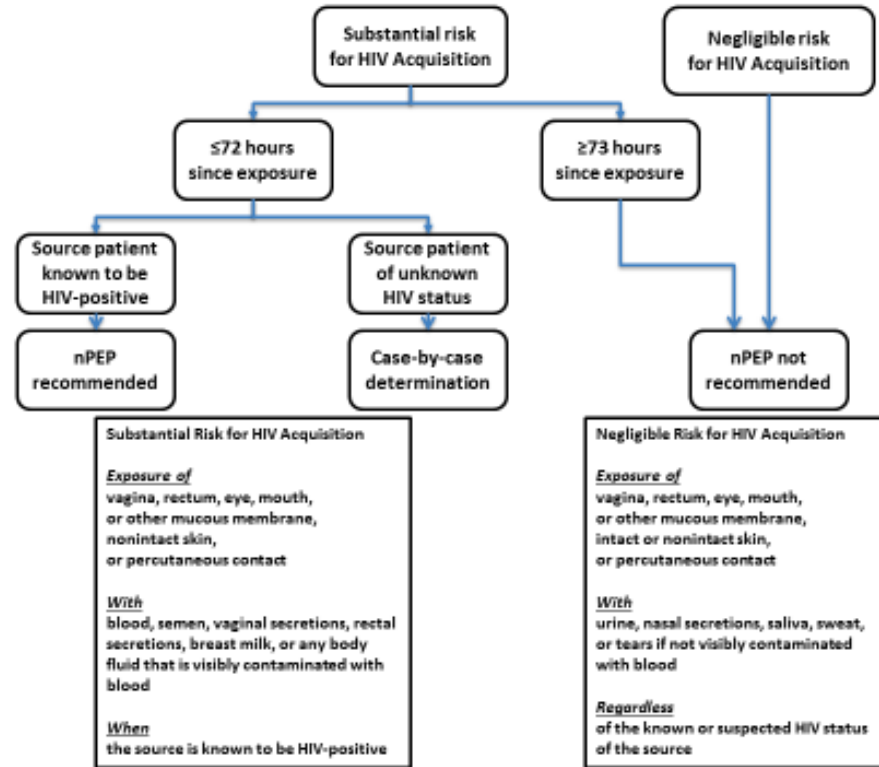
^a Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and preexposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.

^b HIV transmission through these exposure routes is technically possible but unlikely and not well documented.



Prophylactic Prevention of HIV Infection: Post-Exposure

Source: <http://cdc.gov/hivpolicies/law.risk.html>



Prophylactic Prevention of HIV Infection: Post-Exposure

Source: <http://cdc.gov/hivpolicy.risk.law.html>

Table 5. Preferred and alternative antiretroviral medication 28-day regimens for nPEP^{a,b}

Age group	Preferred/ alternative	Medication
Adults and adolescents aged ≥ 13 years, including pregnant women, with normal renal function (creatinine clearance ≥ 60 mL/min)	Preferred	A 3-drug regimen consisting of tenofovir DF 300 mg and fixed dose combination emtricitabine 200 mg (Truvada ^c) once daily with raltegravir 400 mg twice daily or dolutegravir 50 mg once daily
	Alternative	A 3-drug regimen consisting of tenofovir DF 300 mg and fixed dose combination emtricitabine 200 mg (Truvada) once daily with darunavir 800 mg (as 2, 400-mg tablets) once daily and ritonavir ^b 100 mg once daily
Adults and adolescents aged ≥ 13 years with renal dysfunction (creatinine clearance ≤ 59 mL/min)	Preferred	A 3-drug regimen consisting of zidovudine and lamivudine, with both doses adjusted to degree of renal function with raltegravir 400 mg twice daily or dolutegravir 50 mg once daily
	Alternative	A 3-drug regimen consisting of zidovudine and lamivudine, with both doses adjusted to degree of renal function with darunavir 800 mg (as 2, 400-mg tablets) once daily and ritonavir ^b 100 mg once daily



Prophylactic Prevention of HIV Infection: Post-Exposure

Source: <http://cdc.gov/hivpolicy/law.html>

Table 2. Recommended schedule of laboratory evaluations of source and exposed persons for providing nPEP with preferred regimens

Test	Source	Exposed persons			
	Baseline	Baseline	4–6 weeks after exposure	3 months after exposure	6 months after exposure
	For all persons considered for or prescribed nPEP for any exposure				
HIV Ag/Ab testing ^a (or antibody testing if Ag/Ab test unavailable)	✓	✓	✓	✓	✓ ^b
Hepatitis B serology, including: hepatitis B surface antigen hepatitis B surface antibody hepatitis B core antibody	✓	✓	—	—	✓ ^c
Hepatitis C antibody test	✓	✓	—	—	✓ ^d
	For all persons considered for or prescribed nPEP for sexual exposure				
Syphilis serology ^e	✓	✓	✓	—	✓
Gonorrhea ^f	✓	✓	✓ ^g	—	—
Chlamydia ^f	✓	✓	✓ ^g	—	—
Pregnancy ^h	—	✓	✓	—	—
	For persons prescribed tenofovir DF+ emtricitabine + raltegravir or tenofovir DF+ emtricitabine + dolutegravir				
Serum creatinine (for calculating estimated creatinine clearance ⁱ)	✓	✓	✓	—	—
Alanine transaminase, aspartate aminotransferase	✓	✓	✓	—	—
	For all persons with HIV infection confirmed at any visit				
HIV viral load	✓	—	—	✓ ^j	—
HIV genotypic resistance	✓	—	—	✓ ^j	—

Abbreviations: Ag/Ab, antigen/antibody combination test; HIV, human immunodeficiency virus; nPEP, nonoccupational postexposure prophylaxis; tenofovir DF, tenofovir disoproxil fumarate.

^a Any positive or indeterminate HIV antibody test should undergo confirmatory testing of HIV infection status.

^b Only if hepatitis C infection was acquired during the original exposure; delayed HIV seroconversion has been seen in persons who simultaneously acquire HIV and hepatitis C infection.

^c If exposed person susceptible to hepatitis B at baseline.

^d If exposed person susceptible to hepatitis C at baseline.

^e If determined to be infected with syphilis and treated, should undergo serologic syphilis testing 6 months after treatment.

^f Testing for chlamydia and gonorrhea should be performed using nucleic acid amplification tests. For patients diagnosed with a chlamydia or gonorrhea infection, retesting 3 months after treatment is recommended.

- For men reporting insertive vaginal, anal, or oral sex, a urine specimen should be tested for chlamydia and gonorrhea.
- For women reporting receptive vaginal sex, a vaginal (preferred) or endocervical swab or urine specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive anal sex, a rectal swab specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive oral sex, an oropharyngeal swab should be tested for gonorrhea. (<http://www.cdc.gov/std/tg2015/tg-2015-print.pdf>)

^g If not provided presumptive treatment at baseline, or if symptomatic at follow-up visit.

^h If woman of reproductive age, not using effective contraception, and with vaginal exposure to semen.

ⁱ eCrCl = estimated creatinine clearance calculated by the Cockcroft-Gault formula; eCrClCG = [(140 – age) x ideal body weight] + (serum creatinine x 72) (x 0.85 for females).

^j At first visit where determined to have HIV infection.



Pre-Exposure Prophylaxis

- PrEP therapy is indicated for patients considered high risk for sexually acquired HIV
- Examples of such individuals might include a non-HIV-infected partner of an HIV infected individual



Pre-Exposure Prophylaxis

- Prior to Starting Tx:
 - Document Negative HIV AB Test
 - Confirm Creatinine Clearance > 60 mL/m
 - Screen for Hep B
 - Screen for STDs



Pre-Exposure Prophylaxis

- The PrEP dosage is one tablet (emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg)
- The drug is taken orally with or without food and should be prescribed with a frequency of once daily
- In addition to the medication, which should be prescribed in no more than a 90-day supply, the patient should be educated about risk reduction strategies, particularly consistent use of condoms during every sexual encounter



Pre-Exposure Prophylaxis

- Tx Monitoring:
 - Document negative HIV screening every 2-3 months
 - Review adherence and provide safer sex counseling at each visit
 - Screen for STDs every 6 months, even in those asymptomatic
 - Assess creatinine clearance after 3 months of starting Tx, then every 6 months



Pre-Exposure Prophylaxis

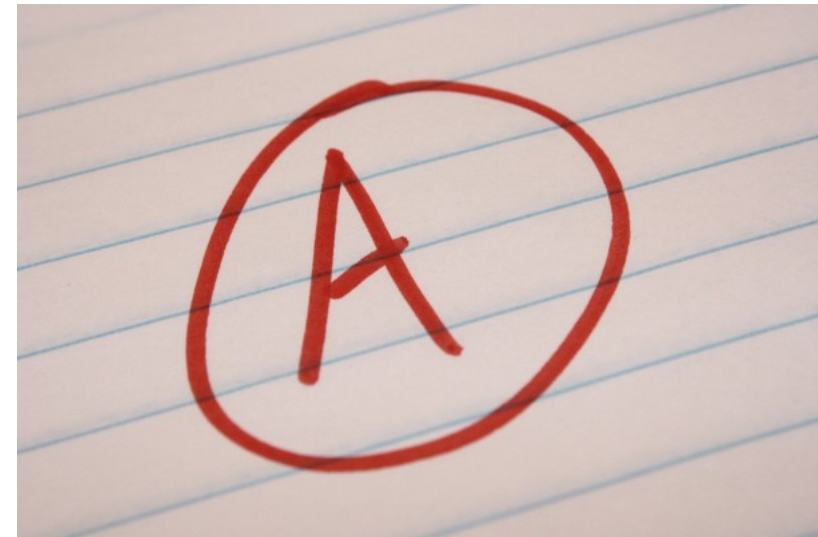
- The financing of antiretrovirals for PrEP is emerging as an important healthcare policy issue
- The daily cost of PrEP can be up to \$13,000 per year
- Additional monitoring and screening costs per person have been estimated to be \$1,300 per year.
- Most private insurance companies cover PrEP
- LOTS of programs to assist with copays and getting patients on PrEP:

<https://www.truvada.com/how-to-get-truvada-for-prep/truvada-cost>



Pre-Exposure Prophylaxis

- The Patient Protection and Affordable Care Act requires insurers to cover preventive services with an A or B rating from the United States Preventive Services Task Force (USPSTF)
- June 2019 USPSTF A Rating for PrEP!



Pre-Exposure Prophylaxis

- PrEP therapy with the use of FTC/TDF is an approved approach to preventing HIV in individuals at high risk for sexually acquired infection
- The once-daily regimen has been shown as significantly effective at preventing HIV in both men and women including heterosexual and bisexual persons



Pre-Exposure Prophylaxis

- Evaluating patient appropriateness for PrEP, performing pretreatment evaluations prior to initiation of treatment, and close monitoring of therapy are all responsibilities NPs will assume as this treatment becomes more widespread in the U.S. healthcare system.
- Cost of the therapy is also a major blockade to its implementation, and this will continue to be a prevalent issue in the foreseeable future, but there is help to pay for PrEP.



Moving Forward

- Community and Public Health Outreach
- Prevention Education in the Clinical Setting
- Future Research and the Responsibility of the Nurse Practitioner



References

Please see the supplemental handout, which includes a bibliography and additional resources for more information.

Go to <https://guides.ucf.edu/CONLibBibliographies> to access the online bibliography!



Bibliography Compiled by:
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Christopher W. Blackwell, Ph.D.,
APRN, ANP-BC, AGACNP-BC, CNE, FAANP, FAAN
Associate Professor & Program Director
AGACNP Programs, College of Nursing
University of Central Florida