WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Meeting the Healthcare Needs of Transgender People

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ADRIANNA SICARI: This is Adrianna Sicari from the National LGBT Health Education Center, a program of the Fenway Institute in Boston, Massachusetts. We're pleased to have you with us today for the webinar, Meeting the Healthcare Needs of Transgender People. Today's webinar will last 90 minutes. We encourage participants to interact with our presenter throughout the presentation using chat, hand raising, and the polling questions.

Additionally, we'll have time at the end of the session for moderated Q&A. So with that being said, I'm going to turn it over to Steve Luckabaugh, at the HIV TAC.

STEVE LUCKABAUGH: Good morning. My name is Steve Luckabaugh, and I'd like to welcome you to the Meeting the Health Care Needs of Transgender People webinar. This webinar is brought to you by LGBT Health Education Center, in collaboration with the Partnerships for Care, HIV Training, Technical Assistance and Collaboration Center, or HIV TAC. The Partnerships for Care project is a three-year multi-agency projects funded by the Secretary's Minority AIDS Initiative Fund and Affordable Care Act.

The goals of the project are two, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, build sustainable partnerships between health centers and their state health department. And three, improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. Our speaker today will be Julie Thompson. Julie Thompson joined Fenway Health in 2010. She graduated from the physician assistant program at Northeastern University and has a master's in medical sciences from Boston University. Julie is a primary care provider and an integral provider on women's health and trans health medical teams. She specializes in primary care, LGBTQ health, HIV/AIDS, and sexually transmitted infections.

Julie has presented trans health care competency trainings for medical providers and students in a variety of settings. She has participated on panels and in workshops at trans health conferences and professional education forums. Please join me in welcoming Julie Thompson.

JULIE THOMPSON: Hi, everyone. Thank you so much for being here and thank you to the LGBT Ed Center for having me. Really excited to give this talk on meeting the health care needs of transgender people. As we'll talk about as we get going, access to quality health care is a huge

concern in this population. So addressing these issues, talking about some ways to break down these barriers, and improving our collective health knowledge on how to provide competent health care is so important.

So these are the learning objectives for today. We're going go through a lot of topics in just an hour, so I might go through pretty quickly. But hopefully we'll have enough time at the end for some questions we can delve into a couple of these a little bit deeper for whatever you have the most interest in. So the first thing we're going to do is define some key terms and concepts related to transgender people. So really finding a common language on how to talk about concepts of gender and identities. Then we're going to discuss some specific major health disparities facing transgender people.

We'll describe some strategies for creating a transgender affirming environment for our trans patients at our clinics. So with the goal there of not only in welcoming our trans patients into our practices, but really ensuring that our environments are safe and affirming places. And then finally, we're going to review some general principles of primary care for transgender people. So we'll touch a little bit on hormone therapy monitoring. And then even just on some care screening recommendations.

So first off we have a polling question. So you'll be able to answer these questions I believe on the right. So the first question is, have you ever met a person who is openly transgender? So yes, no, or unsure. And you can answer these questions as we go and I'll fold the answers in as we kind of get moving along.

So first starting with key terms and concepts. The first thing I think it's really important to recognize is that sex and gender are completely distinct concepts. So sex is really, to put it bluntly, what's between our legs. So it really refers to the presence of specific anatomy. So we've all been assigned a sex at birth. And typically this is assigned male or female. So we talk about sex, it's really comprised of a person's genetic makeup and its phenotypic expression.

Whereas when we look at gender, gender is really the perception of a person's sex on the part of our society and our cultural norms. So it refers to attitudes, feelings, behaviors that a culture associates with typically this binary a male or female. So when we come to talking about gender identity, this is really our internal sense of ourselves, an internal sense of our gender. And all people have a gender identity. We all do. And typically this develops by the age of three and tends to remain relatively stable over a lifetime.

So our gender expression or our gender roles is really this presentation of our gender identity. And we do that through our behaviors, our mannerisms, speech pattern, dress, hairstyle. And it's important to know that this can also be on a spectrum. I think if we all were to line it up, we'd all have some bit of masculine or feminine on this sort of spectrum. And so when talking about gender variant or gender non-conforming, that's really referring to a people whose gender expression is different from, again, these societal expectations of male or female norms.

So talking transgender specifically, this is really an umbrella term. So we're referring to a person who is born with the genetic traits or sexual traits of one gender but has the internalized identity of another. And it's really important to recognize there's no one way to be trans. There's many diverse identities and expressions. Many transgender individuals, but certainly not all, seek some degree of medical or surgical intervention.

Using the term gender minority. Again, this is another umbrella term that we use to define a person who identifies as transgender or gender non-conforming or anyone whose gender identity or expression differs from the conventional binary. And then giving definitions of transgender woman and transgender man, just because I think that can sometimes get confusing. So when we talk about a transgender woman, we're referring to someone who is assigned male at birth and now lives female, feminine, or as an affirmed woman or somewhere on the transfeminine spectrum. And sometimes this is shortened to MTF for male to females.

And talking about a transgender man, we're referring to someone who is assigned female at birth and lives male, masculine, or as an affirmed man or on the transmasculine spectrum. So FTM or male to female. Sorry, female to male.

And just to bring up other definitions that you've probably heard. Transsexual is really a medical term which has historically referred to a subset of individuals who have undergone some sort of medical or surgical treatment. It's not a term that's very popular these days because it tends to be very clinical and very specific. Gender queer, on the other hand, is actually a newer term with queer really being reclaimed by the younger generation and more of an empowering term. And this really refers to someone who's rejecting this gender binary in blurring the distinction between male and female. And cis-gender refers to someone who's non-transgender, with cis being a chemistry term meaning same.

So we can think of gender identity a couple of ways. And this might inform how we talk about the idea of changing or shifting our identities. So if we think of gender as an anatomic sex or, again, our genitals, we understand this concept of transitioning from one to the other, reassignment from one to the other. However, if we have a different kind of construct of gender as really determined by your brain or our internal self or sense of our identity, then we're able to kind of see this more on a spectrum and really understand this concept of gender affirmation or really affirming someone's gender anywhere along the spectrum and anywhere along this journey and knowing that it also might change.

And I bring up sexual orientation just to say that sexual orientation and gender identity are also very distinct concepts. So sexual orientation is really referring to how a person identify their physical and emotional attraction to other. So this is including desire, attraction, behavior and identity. So all people have a sexual orientation and all people have a gender identity. And again, those are very different.

And transgender people can be any sexual orientation. This data comes from the National Transgender Discrimination Survey. And it really does show that transgender people are any

sexual orientation. And so this is another question as we move on that things that we need to think about as distinct concepts.

So just reviewing the terminology, again we think of gender identity, that's really the internal sense of ourselves. Gender expression is this outward presentation of how we show our gender identity. Sex, again, is referring really to a specific anatomy. And sexual orientation is really who we desire, who we're attracted to. And of course I need to bring the gender unicorn in here because I think this is a more illustrative way to really show how diverse these concepts can be. So really looking at this on a spectrum and seeing how all of us have all of these different gender identities and expressions and attraction that are really variable.

So when we talk about gender dysphoria on the other hand, we're referring to a range of discomfort or distress that's caused by this discrepancy between a person's gender identity and their sex assigned at birth. And really this is a range. And so really the focus of health care is an individualized approach to determining, what is this range? What is this discomfort, rather? And what goals can we put in place to alleviate this distress?

And really the goals of treatment is to improve a quality of life by facilitating this transition to a physical state that more closely represents a sense of themselves. And this can sometimes mean hormones. It can sometimes mean surgery. It just might mean outward dress or appearance or voice. And again, it's a really broad individualized approach. And really the terms transition or affirmation that we've talked about is this process of not only changing or switching or shifting our identities, but the whole process from recognizing, accepting, and expressing these changes from living and being perceived as the gender assigned at birth to living and being perceived as an individual sees and understands themselves.

And again, this goes beyond medical, mental health, and surgical treatment, but also and most really importantly includes a social affirmation and legal changes. So how can someone move through the world and not just, again, with medical and behavioral health care?

So I'm going to put out now the polling questions of how many people have met an openly transgender individual. And it looks like the majority, 80% of the people listening, have. So that's good. So you're probably aware of a lot of these concepts and terms that we've talked about.

So how many people are transgender in the US? The numbers that we have our about 0.1% to 0.5%. So I think we can assume that these numbers are probably underestimated to some degree. And the reason behind that is that we've seen in a lot of surveys that many transgender individuals actually don't discuss their gender identity with their caregivers. And oftentimes that's because they've experienced discrimination and poor treatment in health care centers in the past when they have disclosed this information. Many transgender people maintain their assigned gender roles for fear of the stigmatization.

So we've seen in a couple studies that large portion of trans individuals aren't disclosing this information. So in a Minnesota study, 45% of trans individuals reported that they did not inform their family physicians that they were transgender. In a National Transgender Discrimination Survey, only 21% reported that they were out-- sorry. 21% reported that they were out to none of their providers and only 28% reported that they were out to all of their providers with a range in between.

So it's really imperative that we change our understanding and we change our clinical practices to really decrease the stigmatization and improve our communication in order to improve this quality of health care. So now we're going to take a look at major health disparities for trans individuals. And so again, this is from the National Transgender Discrimination Survey, which is a survey I've mentioned a few times now. This survey was published in 2011 and surveyed just shy of 6500 transgender respondents.

The really cool thing about this study was really the first time that they've looked at not just urban populations. So not just urban trans individuals, but they really did a great job to try sample a population that mimicked the US. So from all 50 states. Looking at rural, suburban, urban, and different socioeconomic classes. And what we've seen is that transgender people are experiencing very, very high rates of stigma and discrimination in all aspects of life and all over the country. So I'll give you a moment to just take a look at some of these numbers. And really then thinking also about the implications of a lot of these issues as well.

And so the WPATH, which is the World Professional Association of Transgender Health, put out their newest versions of the standards of care in 2011. So this is the seventh version. And in this version, WPATH really wanted to address these significant health disparities and recognize that transgender individuals have unique health care needs to promote their overall health and well being. And that those need to extend beyond hormonal treatment and surgical intervention. So really emphasizing here that, as health care professionals, we need to look beyond medical treatment and see their health care as a whole. So really looking also at deeper health care, insurance needs, financial assistance, and other supportive services.

And then taking a look-- taking a closer look at specific issues and morbidity and mortality in this population, we really need to look at long-term health. And much of our long-term health outcomes comes from European cohorts, the largest of which is this Dutch cohort. So there was a review of this Dutch cohort in 2011. And it showed a significant increase in mortality among trans individuals. And specifically a 50% higher mortality rate in our trans female patient.

And that wasn't due to the things I think as primary care providers we're worried about. It wasn't a hormone-related cancers or cardiovascular disease or diabetes, but it was due to high rates of HIV, AIDS, suicide, and drug-related deaths. And really what I think that's pointing to is decreased access to quality health care. And so if we;re looking at-- again, this comes from the National Transgender Discrimination Survey. If we're looking at barriers to primary care, we're seeing our female patients in this survey report 24%-- just shy of 25%-- reported that they were

refuse care where they sought care in their health clinics. And 20% of trans men were refused care.

And if we look over at the graph on the right, we're seeing-- sorry, the dark blue is trans men and the light blue is trans women in the graph on the right. We're seeing that just shy of 50% of trans men have postponed care due to fear of discrimination for preventive care and 42% postponed needed care. So if we take this data from the right where only 50% of our trans men are accessing care and we put that over on the left, where then 20% are being refuse care, that's not a lot of people getting into health care.

So I really want to take a moment and look at these specific issues in mortality a little bit closer. And so if we look at HIV infection, the National Transgender Gender Discrimination Survey is reporting over 4 times the national average of HIV infection over the general population. So that's looking at over 4% of trans females or 15% of self identified sex workers. And that's compared to a rate of 0.6% in the general population.

And then in the urban studies we're seeing even higher numbers, with trans females reporting anywhere between 27% and 28% being HIV infected. Interestingly, our trans men seem to have a lower rate of HIV infection. In fact, very similar to the general population. However, trans men are actually reporting relatively high rates of high risk sexual behavior. So it's very likely these numbers are being under reported. And if we think back a couple of slides to access to care where trans men aren't getting into care, that's pretty likely.

And in the Dutch cohort, death rates due to AIDS is 30 times higher in for trans individuals. So again, I think pointing to nothing more than decreased access to quality health care. And if we look a little bit closer into who is being HIV infected in this population, we're seeing significant increases in health disparities in our trans women of color. So in the National Transgender Discrimination survey, 25% of black trans women and 11% Latino trans women are reporting being HIV infected. And that's compared to 1% white.

And so really that's pointing to not only facing transphobia, but facing racism in our society and in our medical care. So I think we can all agree that these rates associated with high prevalence of HIV infection and high risk sex behaviors are numerous and pretty complex. But the one thing I really wanted to touch on id the extremely high rates of trauma reported in this population. The effects of trauma and violence on HIV risk behaviors is difficult to study, but we have seen in various reports of women and other HIV patient populations that exposure to violence does seem to inform these behaviors and there does seem to be a need to directly address these experiences.

And so in this survey from New York, there was reported a lifetime prevalence of emotional abuse was 78% among trans women and physical abuse occurred in 50% of trans women. And other studies are showing rates as high as 38% to 60% of past experiences of physical violence. 27% to 46% victims of sexual assault. And most of this violence was attributed to gender identity or expression.

So then we move on to talk about depression and suicide. We're seeing really high suicidal ideation rates, as high as 64%. And in some surveys up to 40% of transgender and gender non-conforming individuals have reported having attempted suicide. So again, that's not suicidal ideation. That's 40% have attempted suicide. And suicide death rates in the Dutch cohort were reported to be six times higher than in the general population.

In another urban study in San Francisco in 2009, both trans men and trans women reported well up over 50% of lifetime incidence of depression. So I wanted to remember Leelah Alcorn, who committed suicide just shy of a year ago. So in December of last year. She was a young trans woman who was raised in a very conservative Christian home in Ohio and was unsupported by her parents. She was actually sent to conversion therapy. She committed suicide at 17 years old after a lack of supports and denial of any trans related services by her family. And this is just an excerpt from one of her suicide notes that I think is important for us to read.

And then moving on the substance abuse, in the Dutch cohort drug-related death in trans females were 13 times higher than the general population. And in the National Transgender Discrimination Survey over a quarter of respondents reported misuse of drugs or alcohol, specifically to cope with mistreatment due to gender identity and expression. So putting all of these things together, we're seeing extremely high rates of discrimination and overall lack of supports at home and at work and at other areas of society. We're seeing huge barriers to seeking medical care. So being outright denied services, disrespect, and harassment in our clinics.

And in the times when our patients, despite those odds, do you make it into our clinics, we're also seeing widespread lack of provider knowledge on how to give health care-- our knowing health care needs and how to provide competent health care to our trans people. And so this all together really equals lack of access to quality health care. And we know that that leads to poor health outcomes. And it is important to remember, again, this huge racial bias for our trans people of color, not only in our medical care but in all aspects of society.

So let's talk about ways to decrease some of these barriers to care. So creating a safe, welcoming, and inclusive environment. Really it's important to signal to the trans community that our health care centers are open to treating trans individuals and not only that, but will not tolerate any disrespect or harassment in the clinics. And so sometimes we can-- ways to do that would be putting these ideals in our mission statements, holding trans related events at our clinics, providing trans services. And not just medical services but thinking about how to navigate legal services, how to provide social support. And then doing active community health outreach to community leaders.

And then it's really important to train all staff about transgender identity and terms and concepts. Because oftentimes it's really the first interaction a patient has in our clinic. And that can be with-- it might be with a pharmacy staff, it might be with the facility staff. And so making sure all employees are trained in trans related care.

Some other recommendations would be specifically training all staff to use client's preferred names and pronouns, posting nondiscrimination policies in highly visible areas. So not just for our staff, but for other people who are accessing the clinic and in our waiting rooms, including transgender or intersex and other options on intake forms and asking for preferred gender. Offering unisex bathrooms. And most of all listening to the terms that our patients use to describe themselves and their needs.

And so this is an example of an inclusive intake form. And really, there's two important things that you can get from a form like this. One is we're signaling to our patients that this is information that we want to know. That we're aware of how important this is to our patients and that we also think that it's important. But also collecting this data allows for us to know who is accessing our clinic and allows us to evaluate for any of these health disparities are really determine the needs of the clinic to meet these health disparities.

And actually, last month there is a very important-- a very important decision was made that the US Department of Health and Human Services will now require all the MR systems certified under the Meaningful Use Program to have the capacity to collect sexual orientation and gender identity information from our patients. So this is an extremely important move that will help to decrease the invisibility of our trans individuals in our health care system and hopefully promote a better understanding of health disparities. So when we're able to see these health disparities, we can really focus on specific interventions to reduce them.

So now we have another polling question. So a transgender client comes into your health center presenting for care. You're unsure of what pronoun to use with this client. For example, he or she. Which of the following is the least preferred strategy to use in this situation? So a, politely ask them what pronoun they prefer, b, avoid using pronouns at all, c, use it as a neutral pronoun, or d, use they as a neutral pronouns.

So you can answer these questions. And I'm going to keep going. We'll come back to this in a minute.

So many issues for transgender patients, as I mentioned, occur right at the front desk. Or kind of these frontline encounters. So for example, people are often called by the name on their insurance record, which doesn't match their preferred name or pronoun. So here's just a few suggestions for ways to prevent these issues and improve communication protocols and create protocols for all patients. Because we can't assume that the person standing in front of us is or isn't trans. We don't know by looking or listening. And do really having these protocols for all patients really helps to avoid any errors.

So asking all patients preferred names, preferred pronoun, how to address mail to someone's home. So you have to think about safety issues for a patient who might be out only in our clinic and not at home if they live with their parents or a spouse. How to leave message on voicemails or answering machines. And then what to do when a name on insurance doesn't match the

preferred name or a name in a chart. Oftentimes these interactions occur in a waiting room, and so how do we handle that delicately.

And having clear lines of referrals for questions. So appointing one staff person who is very trans savvy and knowledgeable about the community to really deal with fielding complaints, assisting referrals, or providing guidance is really, really helpful, that you know that you're always referring a patient to someone who is, again, knowledgeable about the community. And then certainly having protocols for ongoing training and retraining. So I think all of our clinics have a relatively high staff turnover. And so making sure that anyone new coming into the clinic is being trained. But then making sure that everyone is also updated as we go along to new terms, concepts, new screening recommendations and guidelines that always pop up.

And so now I'm going to take a look at the polling question. So, right. So we definitely want to avoid using it as a neutral pronoun. So definitely-- again, we can always guess someone's gender based on their name. So they best thing to do, that we can really do, is ask straightforwardly. Really asking our patients what they prefer is the best strategy because our patients can tell us, we can document it. Patients understand from that interaction that we care and that we want to know.

If we're unable to ask, certainly using gender neutral pronouns or not using any pronouns at all is probably the best way to avoid any errors. The use of neutral pronouns is very commonly they, them, or their. It doesn't typically refer to a person and so clearly our trans individuals are people and are very important people. And so we always want to avoid using it.

And making sure that when we ask this information and we get a person's preferred name and a preferred pronoun that we're documenting this in our patient's chart. So that way the next time a patient comes in, they will be no question. I will say, it's always important to ask our patients occasionally as we get to know them if pronouns change because they might. But for the most part, making sure that we document that. Make sure that everyone else in the clinic is aware of how to address the person correctly.

So some way, just some examples of how we can go about asking these questions in a polite way. So if we're unsure about a patient's preferred name or pronoun, an easy way to do that would be, I would like to be respectful. What name and pronoun would you like me to use? Easy question. And a question actually we can ask anyone, any person whether they're trans or not.

If a patient's name doesn't match insurance on the medical record, other ways we can ask would be, could your chart or insurance be under a different name? Or what is the name on your insurance? So really allowing our patients have that ability to answer in whatever way they feel comfortable.

And mistakes happen. If you accidentally use the wrong name or pronoun, certainly addressing it and apologizing is really helpful. And you can do this in a pretty quick way. I'm sorry. I didn't

mean to be disrespectful is certainly what needs to happen. We don't need to harp on it. But definitely addressing the issue and apologizing is very, very important.

And then creating an environment of accountability in our clinics. So really setting the tone for our clinics and not being afraid to politely correct our colleague. It's really up to us, again, to set the tone for everyone in our clinics and not just providers, but frontline staff, pharmacy, everyone who works in the clinic to really ensure that our clinic as a whole is, again, going to be seen as a safe place. I don't know how many of you are from Boston and ride the T, but Mayor Menino had this really great saying. So if you see something, say something. And I think really that goes for our clinics too. And again, just some recommendations of how we can talk to our coworkers about making sure that we're creating an environment of inclusiveness and welcomeness and safety, really.

And then managing our expectations as providers or as medical staff. So we've talked a lot about how our trans patients-- the majority of trans patients, unfortunately, have experienced some amount of discrimination, harassment, in their health center. And so we're most certainly not going to be the first health care person that people that our trans individuals have met. And so it is probably not uncommon for patients to come into our clinic feeling a bit defensive, being on guard, and maybe expecting the same from us.

So we really shouldn't be surprised if we make a mistake and it resulted in an emotional reaction. And it's important for us to be able to diffuse that reaction. Not take it personally. Apologize for anything uncomfortable that may have happened, whether it was intended or not. And really trying to reestablish an environment of safety and trust. And so I just wanted to show this. So the National LGBT Ed Center has some really, really great publications on how to give affirming care in our health centers. And there is some hard copy publications, as well as tons of webinars and trainings online that I would certainly recommend checking out as well.

All right. And then we're going to move on and talk about general principles of primary care. I think the biggest thing is let's not forget the basics. The whole point of primary care, whether it's for trans individuals or anyone we see in the clinic, is really to promote and ensure physical health, social and emotional well being, and making sure that we're addressing all needs, not just hormones and surgeries. Familiarizing ourselves with key terms and diversities of identities and all of the things we've already talked about and being up to date. Again, this sort of idea of training and retraining is really important.

And then listening, again, to how people are describing their own identities, their partners, and their bodies. And use these terms. So we've talked a lot at this point about preferred names and preferred pronouns, but what about body parts? Oftentimes our trans patients may be dysphoric specifically around their genitals. And so asking questions like, how do you refer to your genitals? What terms make you feel more comfortable? And using these can be a really, really key way of, again, establishing this trust and rapport with your patients.

And again, realizing that our patients may had negative experiences in clinics and not taking it personally if our patients are nervous or feeling defensive. And again, really trying to diffuse that. And finally, avoiding asking questions out of curiosity. So only asking what we need to know. And know that that can be kind of a tough thing to understand because we spend so much time talking about how we really need to ask questions and not assume.

But it's really making sure that we're asking these questions in the right context and asking questions that we really need to know. So for example, if someone were to come in with a sore throat, it certainly wouldn't make sense to ask someone if they've had any bottom surgery or probably if they've been on hormone therapy. But it would be appropriate to ask someone what their sexual orientation is and what sex practices they engage in if we're thinking about STDs in the throat. So it's really making sure that we're treating our trans patients, of course, as we would treat all of our patients.

So just as I mentioned, so when taking a history it's the same for all patients. But of course we want to pay specific attention to health disparities. So we talked a lot about those. And specifically we want to ask about high risk sex behavior, substance use, depression and anxiety, asking about social supports, family rejection, safety at work, safety at home. And also asking about the use of cross sex hormones and gender affirmation surgeries.

And again, this is usually when we're doing a physical we need to know this information. It's not uncommon for a patient to be on hormones off the street or on the internet. So it is really important to ask about those questions.

And recognizing that our patients and ourselves may very likely have different priorities. So oftentimes the need to affirm someone's gender identity can supersede what we see as the most important health concerns. And so it's really important for us as health care providers, again, to meet our patients where they're at. Again, if we ignore our patients' top priorities, it's very unlikely that they're going to listen to what our top priorities are and establishing a good rapport is going to be very, very difficult. So having an open mind and listening to what the most important issues are for our patients and in hopes that they will then be able to listen to what our most important goals are and somehow work on a way of putting those together.

So I'm going to run through hormone therapy just briefly just so you can get an idea of what we're talking about when we do talk about hormone therapy. So in terms of assessing for readiness of starting on hormones and appropriateness of hormone therapy, there's been significant advances. And one of these is really taking an individualized approach and getting away from sort of the cookie cutter idea that our patients have to be in surgery for a certain amount of time or if someone identifies as transgender they need to be hormone therapy and this is the amount of hormones they need. And it's really taking into account different combinations of maybe behavioral health or hormone therapy or surgery or both there or really asking our patients specifically what their goals are.

So the WPATH actually really recognized this as well and put in in their newest versions of the standard of care. The previous versions of the standards of care were always perceived to be about the things that trans persons must do to satisfy clinicians. So really, again, like having our patients prove to us that they're transgender. Having this traditional gender narrative.

But really, this version is much more clearly about how every aspect of what clinicians ought to do in order to properly serve their clients. This is truly a radical reversal and one that serves both parties well. So really pointing to the health care providers to have a better understanding of trans needs and goals and working with our patients to make that happen and come together.

There are lots of protocols and standards of care out there for us to follow. So the WPATH, which we've mentioned a few times, the Center of Excellence for Transgender Health at UCSF had some really amazing protocols, The Endocrine Society. And Fenway Health actually just recently published our medical protocols, which you can find online.

WPATH has put out a criteria for starting on hormone therapy. So it's really a four point criteria. So the first thing, a well documented and persistent gender dysphoria for up to about six months. The capacity to make a fully informed decision and to consent to treatment. Being the age of majority in a given country, so 18 in the US. And if any significant medical or mental health concerns are present, they must be reasonably well controlled.

At Fenway we use an informed consent model. And really what that means is up the prescribing provider to effectively communicate these benefits, risks, alternatives to treatments for their patients. And then based on clinical judgment, really determine if there are any contraindications, whether medical or mental health. Does the patient have the capacity to give informed consent? And does the patient have a clear understanding of the information they're consenting to and have realistic expectations of hormone therapy?

And I will say, being on the trans health team here at Fenway, the majority of people who were interested in starting on hormone therapy, this is really, really straightforward. Ad in the quote, unquote, harder cases, we're almost never questioning someone's gender identity. It's really oftentimes these harder question of, what does it means to have a mental health or medical issue that's reasonably well controlled? What is someone's baseline mental health functioning? Does the person have a capacity to give informed consent? Does our patient have a clear understanding of what they're consenting to?

And sometimes these questions can be really difficult. And oftentimes we rely on our multi-disciplinary health team. So we're quite relying on our behavioral health providers to really help us tease out these harder question. So really, this informed consent model doesn't preclude mental health care. And in fact, mental health care can be really, really helpful to go along with this.

So on our initial visits, we really want to review implications of being on hormone therapy and obtaining consent. So we want talk about reproductive right and what it means to be on hormone therapy, the options in terms of freezing egg and sperm. Permanent versus transient changes. Short- and long-term goals and knowing that those might change. Short- and long-term risk. Screenings and actually unknowns that the long-term health outcomes we don't know.

And then certainly social implications. So what does it mean to transition in your relationship and your house and your job? And again, certainly not all patients need behavioral health care, counseling, or support. But definitely therapy and behavioral health support can be really, really helpful in some of these harder issues. What does it mean to give up reproductive rights at 18? Or what does it mean to transition in your relationship? Or what are my long-term goals? And some of that, behavioral health providers can be really integral in helping patients work through those.

So when we talk about masculinizing hormones or hormones for our F to M or trans masculine individuals, we talk about testosterone therapy. So testosterone is a really strong hormone, so often we don't need any estrogen blockers. Testosterone does a really good job in doing that. There are different modes of administration for testosterone, and the most common of which is probably injectable IM, which is typically dosed every one to two weeks.

But there's certainly other options in terms of topical. So patches and gels and even a long-term testosterone in the form of a pellet. There are certainly different reasons why you might want to choose one over the other. I won't go into the specifics of that now, but certainly happy to answer questions at the end if anyone wants to go into the details.

And these are expected masculinizing effects of being on testosterone therapy. I think it's really helpful to show these to our patients so that there's really an understanding of what a wide variety of how-- or wide response, rather, to hormone therapy and how things can take months to years. And also a reminder that this is sort of like puberty again. And puberty doesn't happen in a month. It usually takes years for that to happen. And so reminding our patients about patience can be helpful and reduce some sort of anxiety.

The things I put in red here are actually permanent changes. And the things in black are things that may transition back if someone were to stop testosterone therapy. And other treatments for our trans masculine individuals, you might hear patients on topical estrogen cream for a vaginal atrophy, finasteride for male pattern baldness, and long acting reversible contraception options for birth control, and maybe also cessation of menses if our patient isn't on testosterone yet but are dysphoric around their period, that might be a great option. Or if someone might have persistent bleeding despite being on adequate doses of testosterone.

Feminizing hormone therapy or hormone therapy for someone on the transfeminine spectrum is really looking at estrogen. But as I mentioned, testosterone is a really strong hormone so oftentimes we do need to suppress testosterone in order for estrogen for the effect of estrogen

to be experienced. And so an anti androgen that's very commonly used in the US is spironolactone. Spironolactone is a pill that's usually dosed twice daily.

And just like testosterone, estrogen has different modes of administration. So there's oral, transdermal, and injectable. And so again, there's different reasons why you might choose one or the other. And we could talk more about that, again, at the end if you'd like.

And these are the feminizing effects of not only of being on estrogen therapy, but also the anti androgens and decreasing testosterone. Again, the things in red tend to be permanent changes. This is really important when we think about fertility and being on spironolactone or anti androgens. It's very common to see a decrease in testicular volume and potentially decrease in sperm production. And unfortunately we don't know-- the time is very variable. So talking about, again, fertility and timing can be difficult at times.

And other treatment therapies for trans females, the most common of which is probably electrolysis or laser hair removal. So being on testosterone therapy can decrease the frequency of hair growth, but it doesn't necessarily remove it altogether. So for hair on face or back or chest, many women rely on electrolysis or laser.

We'll talk about some monitoring recommendations of people on hormone therapy. And then we'll talk about some preventive screening recommendations as well. It's really important to take a moment and take an inventory when we're seeing a patient for preventive care. It's really easy to overthink things when it comes to routine screening preventive care for on cross-sex hormone therapy. So taking the time to do an anatomical survey and ask our patient is really, really necessary.

And again, an easy way to do this might be by asking, have you had any body modification surgeries? And then, based on the answer, use the model. If you have it, check it.

So when someone is on estrogen therapy, some of the things you want to think about would be PEs and DVTs. So venous thromboembolisms. Potentially an increased cardiovascular risk. We want to think about cancer risk, weight gain, decreased libido on androgen blockers, change in lipid profiles, blood pressure, glucose. And so I'm going to go into just a couple of these I think most on our minds if we're prescribing hormones.

The first is venous thromboembolism. And again, we don't have much-- we actually don't have hardly any long term data in the US. What we do have are large European cohort studies. And we have pretty good data in terms of short and medium term outcomes. And again, the largest of which is this Dutch cohort, so I'll talk about them a little bit.

So in the Dutch cohort, there were actually increased rates of venous thromboembolisms, up to 2.6%. In the Belgian courts, there were rates even higher at 6.8%. But interesting, almost all of these patients were treated with ethinyl estrodiol. And that's actually not the estrogen we use here in the US. Ethinyl estrodiol is a type of estrogen that we do use in our birth control pills,

but in these protocols, these European protocols, the doses were quite high. So about 50 micrograms. That that looked to be associated with these higher risks of venous thromboembolisms.

The really interesting info from this data is that in the Dutch cohort the rate was 2.6% in the first year, but then actually fell really significantly after that to 0.4%. And so that makes us think, is there some increased risk in initiating hormone therapy or estrogen therapy in this first year and then that falls off after someone's been on and stays on continuously? And I think we all have patients who come into the clinic and are gone for a little bit and come in and want to restart and gone and come, so they're on and off hormone therapy.

And so the thought is, is this person potentially at an increased risk for going on and off hormones versus some who's just been on? And then we look at cardiovascular disease. We see that actually-- again, we see a higher rate of cardiovascular disease in our trans women. And almost all of these cardiovascular events were associated with the things that we know to be at increased risk of being on estrogen therapy. So they were associated with smoking and with higher baseline cholesterol levels, as well as higher rates of diabetes. And again, ethinyl estrodiol was associated with a threefold increase in cardiovascular death in this population.

So really the recommendations here are avoiding prescribing ethinyl estrodiol at any point. And this also means, again, talking to our patients about any hormones they might be taking off the streets or off the internet. Birth control pills are probably the easiest to get from family members. And so if our patients are taking those, making sure that we're addressing these risks and putting our patients on a safer form of estrogen.

Almost all of these cardiovascular events were also occurring in women over the age of 40. So we might want to consider transdermal or low dose oral estrogen in our trans females over the age of 40. And then again, as primary care providers you want to make sure that we're addressing lifestyle and behavior. So healthy diet, smoking cessation, exercise. All these things that we would address in any of our female patients.

In terms of mammograms for our trans female patients, it is recommended to have mammograms over the age of 50 and having been on a feminizing estrogen for five years. And really the idea being that it's the degree and duration of estrogen exposure that's putting patients at higher risk. So a patient who is 51 years old and has been on estrogen for only a year is probably at a much lower risk than a 51-year-old trans woman who has been on estrogen therapy since they were 20. And so that's really the reason behind that.

There has been-- in the European cohort-- there has been no increased risk of breast cancer seen in women on estrogen therapy. Bone density screenings are not routinely indicated prior to an orchiectomy, though it's recommended to consider if a trans female is over the age of 60 and has gone off her estrogen therapy for longer than five years. And in some of the literature, there has been an increased risk of osteoporosis and osteopenia compared to natal men but generally preserved when compared to natal women. And we do think that estrogen is still

protective so we do see decreased levels of bone turnover markers in the setting of estrogen therapy.

And we also think about the prostate. So even our women who have had genital reconstruction surgery almost always have their prostate still intact. And so it's important to remember that that is still there. So again, doing the anatomical survey. And knowing that being on anti androgens will actually falsely decrease PSA levels. So I know it's not routinely indicated to be checking PSA levels anymore, but if you have been following this in someone, if they're on spironolactone or any anti androgen, it's going to be falsely decreased.

We do think there's probably some protective effect of being on feminizing hormone therapy on the prostate, but we really don't know to what degree that's occurring. So it is really important that we're still doing a review of systems and talking about any signs or symptoms of prostate disease in our trans female patients.

And then switching over and talking about recent testosterone therapy, we want to think about the effects testosterone can have on lipid profiles, causing polycythemia or increased concentration of red blood cells. Sexual health changes. So changes in libido, vaginal atrophy, effects on beast and endometrial tissue, weight gain, increase risk of sleep apnea, insulin resistance, infertility.

And so what we have seen in our trans men is actually no increased risk of cardiovascular disease, at least in the short- and long-term followups that we have in these European cohorts. However, we do know that testosterone can cause an increase in blood pressure. We also know that testosterone can cause an increase in LDL and a decrease in HDL. So have this negative impact on lipid profiles.

And in addition to this, our trans men tend to have a higher smoking rate over the general population and also tend to have a higher rate of obesity when compared to their natal female counterparts. So though we're not seeing increased rates of cardiovascular disease, it's important, again, as primary care providers to make sure we're reducing cardiovascular risk.

There was only one heart attack that was noted in the Dutch cohort, and that was someone who was 72 years old and had been on to testosterone therapy for 42 years. So hard to say really if it was the testosterone therapy that caused that.

In terms of diabetes, there is actually a slightly higher prevalence of diabetes type 2, but almost all of these diagnoses were made before starting on testosterone therapy. This is actually true for trans females as well. There's a higher rate of diabetes, but almost all of these were prior to starting on hormone therapy. So more than anything this really reminds us to check endocrine screening prior to initiating hormone therapy to make sure, again, and we're treating all of the issues that are present. Not only are we doing hormone therapy, but we're also managing diabetes and other primary care issues.

We have seen that there is a high incidence of PCOS like changes in the ovaries after exposure to testosterone. They've seen that after doing hysterectomies on trans men who have been on testosterone for even as little as six months. And PCOS can cause insulin sensitivity. So again, we're not-- it doesn't seem that testosterone itself is causing any higher rates of diabetes, but it is important that we're thinking about any risk of diabetes and making sure that we're screening appropriately.

Health screening recommendations for our trans men. So in our trans men who still have a cervix, Pap smears are recommended for natal females. But it's important to think about the effects of testosterone on not only the vaginal walls, but also the cervical epithelium. We've seen that this atrophy can actually mimic dysplasia. So we actually might want to write on our lab forms that patient has been on testosterone so that the pathologist can take that into account.

We've also seen actually extremely high rates of unsatisfactory Paps in our trans men. There was a paper that was put out I think about two years ago from Fenway that showed a tenfold increase in unsatisfactory Paps in our trans men when compared to their natal female counterpart. We don't know why that's happening, but as providers it's good to know to make sure that we're actually getting a good sample when we are doing Pap screenings.

Mammograms for our trans men who have not had chest reconstruction surgery are same as for natal female. If our patients have had chest reconstruction surgery, mammograms aren't indicated, but it's still important to do clinical chest exams in the clinic once a year. And that's really because we can't guarantee that all of the breast tissue was removed.

I put in here risk of endometrial hyperplasia. And really the reason behind that is we know that testosterone in all of us has the ability to aromatase to estrogen. And so someone who's on exogenous testorone-- it may be high leveles-- is there a possibility that that's a aromatasing to estrogen in the uterine tissue. And actually in recent studies in 2009 and 2010, it actually appears that in more cases than not that the endometrial tissue does the opposite and actually appears to atrophy very similar to post-menopausal women.

That being said, again, we don't have this longer term data. And so it's still recommended to certainly ask our patients if they've had any unexplained bleeding or spotting and making sure that we're evaluating by ultrasound or however necessary depending on the patient and their symptoms.

And finally, bone density screening should be considered over the age of 50 and on testosterone therapy for five years. However, it does seem that testosterone is protective in our trans men. And likely that's due to this increase muscle mass and mechanical loading on the bone. And overall it seems that there's a larger cortical bone size. So not necessarily an increase in bone density overall seen in our trans men.

So contraception is really important to talk to our trans masculine patients about. Testosterone often does stop menses, but it doesn't reliably prevent ovulation. And so making sure that our patients know that there are birth control options out there that don't contain estrogen. So oftentimes these LARCs or long-acting reversible contraception options. One, they're sort of invisible, if you will. So a patient doesn't have to carry around a pill pack. And also these forms tend to decrease bleeding or actually bleeding altogether.

So again, for our patients that might have persistent bleeding despite a work up and testosterone therapy or patients who aren't on testosterone therapy yet or have no intention of being on testosterone but are dysphoric around their periods, these forms of birth control can be really helpful.

And then I'm just going to end on some reproductive choices or talking about reproductive choices. As we talked about a little bit, hormones can potentially produce an irreversible loss of fertility. And it's really important to discuss these prior to beginning on hormone therapy. And talk about what are the options in terms of banking sperm and eggs. There's been some really cool changes that have happened in our insurances in terms of more insurance is covering bottom surgery, whether that's hysterectomy, oophorectomy, genital reconstruction, orchiectomies. And it's actually-- so probably more available for people who wouldn't be able to have that before.

So meaning that like our youth maybe has more access to surgery. But what does that mean in terms of timing and in terms of options and in terms of sperm and egg banking? So there's a lot of questions to certainly talk to our patients about. And again, realizing that opinions might change and, again, behavioral health can sometimes be helpful, but ultimately we have to remember to not take a paternalistic approach to this as well in making sure that our patients have full understanding of the implications of being hormone therapy and of all the options that are available.

That's actually it for the talk. Like I said, I did go through that pretty quickly so hopefully there will be a lot of questions and we can really get into things a little bit more. I have this video here that I think I'll allow-- I'll wait until after and welcome you to take a look at it then just so we have time for questions. This is a really cool video by transgender community members discussing their experiences and perspectives in the health care setting. And I think it really kind of talks a lot about all the topics that we hit. So I think it will be nice to hear from actual community members about their experiences.

So I'll stop here and that will be available after we finish the Q&A.

ADRIANNA SICARI: Awesome. Thanks so much, Julie, for the talk. It was really great. And thanks for all of the attendees for being here. So we do have plenty of time now for Q&A. And as a reminder to our attendees, the way that you will ask a question is to type it into the Q&A section and hit send. And when you hit send, make sure you send it to me, the webinar host, as I'll read the question aloud.

So I do have a few already queued up and so we'll start there and then go on. So the first question, Julie, is, is there an increase in the rate of cervical cancer in female to male FTM patients?

JULIE THOMPSON: So in terms of the data that we have, there has been no increased rates of cervical cancer. Oftentimes cervical cancer is caused by HPV. And so it's really based on sort of sexual practices of our patients. And so as far as we know, there doesn't seem to be any increased risk for our trans patients when it comes to cervical cancer.

I will say, though, the one thing that might put our trans patients at risk would be decreased access to care or dysphoria and fear of coming in for screening. So that's certainly something we want to be aware of. Pap smears are probably one of the most invasive and traditionally gender specific exams that do we do in the clinic. So this can be really dysphoric for a lot of our patients. So making sure that we're talking to our patients about the importance of cervical cancer screening can be really, really helpful.

ADRIANNA SICARI: Awesome. Thanks. So the next one says, trans women are at high risk for HIV. Is there any indication that you shouldn't prescribe PrEP to a trans patient who is on hormone therapy? And before you answer this, Julie, would you mind also just explaining what PrEP is in case someone doesn't know that?

JULIE THOMPSON: Yeah, sure. PrEP is pre-exposure prophylaxis. And PrEP is truvada. And truvada is made up of two antiretroviral medications. And PrEP is really indicated for anyone who considers themselves sort of having-- engaging in high risk. And that's obviously a pretty broad term. But it's a medication taken every day in the hope that-- and what was seen the data-- is pretty amazing at decreasing the risk of seroconverting or of getting HIV.

They're actually doing a lot of studies now looking at-- so there has been a lot of studies on PrEP and showing the success of PrEP, specifically in [? MFM. ?] But not actually specifically in trans women. And actually, they're taking a closer look at PrEP in trans women. Some of the data we have so far is actually showing that PrEP in trans women is safe.

The one thing that they have seen is there does seem to be a slight interaction between truvada, so PrEP, and protease inhibitors. Though again, we're not traditionally using any sort of protease inhibitors when we're using PrEP. So there doesn't seem to be any interaction in terms of specifically PrEP that we've seen so far.

And I think that's a great point to bring up. I think PrEP in our trans women is an extremely important thing to be talking to our patients about because we know it is really, really helpful and successful.

ADRIANNA SICARI: Thanks, Julie. And while we wait for more questions to come in, I just want to remind folks that you'll be able to download these slides as soon as the webinar ends. So a page will automatically pop up and you'll be able to download the slides. So you'll be able to

watch this video click and click on a link right in the slide. And additionally be able to have access to all the graphs and charts that [INAUDIBLE] Julie presented.

Don't have any other questions queued right now, but I do want to make sure that we give folks enough time to ask questions if they have any. Again, to ask a question, if you just type the question into the Q&A section-- oh, here we are. So the question is, is it common for hormone therapy to be started in primary care?

JULIE THOMPSON: So I think that's probably clinic dependent. But I would say yes. Certainly at Fenway Health all of our primary care providers are providing hormone therapy. And really, I think it's important actually for primary care providers to be prescribing hormone therapy and doing transgender care.

I think the more we are referring patients to endocrine or specialists, again, the less access that is for our patients who might not have the ability to afford specialists or to get transportation to another clinic. And I didn't go into the details of hormone therapy just because I think that that's another talk, but hormone therapy is pretty easy, and as we see it's fairly safe.

Of course, there are nuances and there's going to be some tough cases, but for the most part we can and should be doing this in primary care. I think if we can do-- if you can treat someone who is diabetic, you can certainly treat someone who is transgender and do hormone therapy. And so, yeah. I think it is really, really important that we all start doing trans care in primary care.

ADRIANNA SICARI: I have a question that we have gotten in the past that I'll try to present clearly now. And then the question is around like registration staff and front desk staff and how to make sure that everybody in the clinic is prepared if something-- prepared in that if something happens, how to address an issue with a trans patient who's misgendered at the desk, at the front desk, or if another issue like that comes up.

JULIE THOMPSON: Yeah. So I think one of the most important ways to kind of make sure that everyone is trained is doing the training when someone's hired. So everyone-- I think at most places, everyone does an orientation. And so making sure that trans health competency is part of orientation for all employees can be really helpful in avoiding these situations.

And so that-- and again, mistakes are made and often not intentional. But having had the training and the experience of knowing how to deal with that when it happens is really important. But specifically, I think, again, just making sure that-- I think recognizing our mistakes and doing so in a way that isn't harping on it, but just understanding the mistakes that we've made and making sure that a patient realizes that it was, in fact, a mistake and how can we make sure that we avoid this in the future can be the best things that we can do.

ADRIANNA SICARI: Great. And another question we have here is-- I don't know if you're going to be familiar with this, Julie. But the question is around pubertal blockade in young people and

whether or not that's something that we do here at Fenway. And if it is, can you speak a little bit to that and how that works with adolescents?

JULIE THOMPSON: Right. So unfortunately right now, we are not. I'm in internal medicine here, so 18 and over. Soon we will start to have pediatrics here and we're hoping that this might become a part of our practice sooner rather than later. But right now we're not.

And so in terms of the details, I can't really speak too, too much to it, though there is really good guidelines, again, through the Center of Excellence for Transgender Health and UCFS and WPATH, actually. And so, yeah. Definitely a good question for when we get up and running here.

ADRIANNA SICARI: Yeah, Absolutely. And so folks know, there is a resource slide at the end of this slide set that you'll have access to with the downloadable slides. It looks like that might be all the questions we have. So with that though, that will officially conclude today's webinar. Thanks so much to Julie Thompson from Fenway for the presentation, which was really excellent and the HIV TAC for partnering with us on this.