WELCOME!
Upper Manhattan Regional Group
February 23rd, 2018
William F. Ryan Community Health Center
Opening Remarks

Dan Belanger | NYSDOH - AI
AIDS Institute, Ending the Epidemic Call to Action: 2018

- Facilitate Rapid Access to HIV Treatment with Patient Consent
- Establish Goals Regarding Viral Suppression Rates and Monitor Progress
- Take Steps to Eliminate the Long-Standing Problem of Stigma
Introductions & Meeting Overview

Jonathan Gómez | NYSDOH – AI
Before leaving today’s meeting - please complete the QI project update form for your agency – summarizing progress toward achieving the 2017 cascade goals set by your team.
Agenda

Morning (10:30am – 1:00pm)

• Welcome – Opening Remarks

• 2017 Organizational HIV Treatment Cascades

• Reducing Stigma in HIV Care

• Working Lunch – QI Project Update Sheets and 2017 Cascade Plans

Afternoon (1:00pm – 4:00pm)

• Transgender Healthcare: Addressing Barriers to Care for Transgender People

• Wrap-up: Announcements, Next Steps & Evaluations
During the meeting, connect with others and discuss potential new strategies to reduce HIV and cross-sectional stigma at your agencies.

We will ask you to share at least one new idea or partnership before the meeting ends.
2017 Organizational HIV Treatment Cascades

Anna Bezruki | NYSDOH – AI
Organizational HIV Treatment Cascades

Quality of Care Program
AIDS Institute
February 2018
Presentation Agenda

- Overview
- Requirements and Measurements
- Reporting Methodology
- Analysis and Improvement Plan
- What’s Next?
- Q&A
Organizational HIV Treatment Cascades

- Component of the annual Quality of Care Program Review
- Created to bring attention to gaps along the continuum of care for PLWH
- Implemented in 2017 by the Office of the Medical Director in the NYSDOH AIDS Institute as part of the strategy to End the Epidemic by 2020
  - Providers can visualize the quality of care being provided to PLWH at their own organization
Results of 2017 Cascades

- In 2017, 97 organizations submitted cascades
  - Gaps in care identified at every step of the cascade
  - Magnitude of gaps varied greatly among organizations
    - Organizations reported between 0 and 4,288 open patients
Cascade Requirements Overview

- Cascades
  - Newly diagnosed/new-to-care (if applicable)
  - Previously diagnosed
    - Open
    - Active
- Drill-down of previously diagnosed caseload (in cascade or table format)
- Methodology Section
- Improvement Plan
NEWLY DIAGNOSED/
NEW-TO-CARE CASCADE
Newly Diagnosed/New-to-care Cascade

- **Purpose:** This cascade enables organizations to see the outcomes for a particularly vulnerable group of patients – those diagnosed within the measurement year (2017) and those new to care at an organization.

- **Terminology:**
  - Newly Diagnosed/New-to-care Caseload: All patients diagnosed in 2017 and all patients who are new to an organization’s HIV program in 2017, regardless of the year in which they were diagnosed.
Newly Diagnosed/New-to-care Cascade: Summary

**Newly Diagnosed/New-to-care Caseload**
- All newly diagnosed patients and all patients who are new to an organization’s HIV program, regardless of the year in which they were diagnosed.

**Linked to Care**
- Percentage of people diagnosed with HIV at the organization in 2017 linked to care within 3 days.

**Prescribed ART**
- Percentage of newly diagnosed and new-to-care patients who were prescribed ART in 2017. May exclude patients newly diagnosed at the organization who were linked externally.

**Received Viral Load Test**
- Percentage of newly diagnosed and new-to-care patients with a recorded viral load test in 2017. May exclude patients newly diagnosed at the organization who were linked externally.

**Virally Suppressed**
- Percentage of newly diagnosed and new-to-care patients with viral load <200 copies/mL at last test of 2017. May exclude patients newly diagnosed at the organization who were linked externally.
PREVIOUSLY DIAGNOSED CASCADES
Terminology Overview

Previously diagnosed patients
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients

Deceased by end of 2017

Incarcerated at end of 2017

Confirmed in HIV care elsewhere at end of 2017

Active patients
All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients.

Non-Active Patients
All open patients who received services from the organization in 2017, but did not receive HIV primary care services.
Previously Diagnosed Cascades

- Two cascades for previously diagnosed patients
  - One for all open patients (active + non-active)
  - One for active patients (broken down by HIV care site, if multiple care sites)

- NOTE: Exclude all active patients who are new-to-care from the previously diagnosed cascade. That is, the previously diagnosed and newly diagnosed/new-to-care cascades are mutually exclusive
## Open Caseload Cascade: Summary

<table>
<thead>
<tr>
<th>Open Caseload</th>
<th>Active Caseload</th>
<th>Prescribed ART</th>
<th>Received Viral Load Test</th>
<th>Virally Suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>All previously diagnosed patients who received services from an organization within 2017, except those who were deceased by the end of the year, incarcerated at the end of the year, or were confirmed to be in care elsewhere by the end of the year</td>
<td>Percentage of open patients who received HIV primary care services within 2017</td>
<td>Percentage of open patients who were prescribed ART in 2017</td>
<td>Percentage of open patients with a recorded viral load test in 2017</td>
<td>Percentage of open patients with viral load &lt;200 copies/mL at last test of 2017</td>
</tr>
</tbody>
</table>
Example: Open Caseload Cascade

**HIV Treatment Cascade, Previously Diagnosed Open Patient, 2017**

- **Open** – # of PLWH, diagnosed before measurement year, with any visit in 2017, except those confirmed to be in care elsewhere, deceased, or incarcerated
- **Active** – percentage of open patients with HIV visit in 2017
- **Prescribed ART** – percentage of open patients with ART prescription in 2017
- **Received Viral Load Test** – percentage of open patients with documented viral load test in 2017
- **Virally Suppressed** – percentage of open patients with viral load <200 copies/mL at last viral load test in 2017

**Data Source** – Infinity EMR
Active Caseload Cascade: Summary

Active Caseload
- All open patients who received HIV primary care services within the organization in 2017, except those new-to-care in 2017.

Prescribed ART
- Percentage of active patients who were prescribed ART during 2017.

Received Viral Load Test
- Percentage of active patients with a documented viral load test in 2017.

Virally Suppressed
- Percentage of active patients with a viral load <200 copies/mL at last test of 2017.
Example: Active Caseload Cascade

**HIV Treatment Cascade, Previously Diagnosed Active Patients, 2017**

- **ACTIVE:** # of open patients who received HIV primary care services at the organization in 2017
- **PRESCRIBED ART:** Percentage of active patients who were prescribed ART in 2017
- **RECEIVED VIRAL LOAD TEST:** Percentage of active patients with a documented viral load test in 2017
- **VIRALLY SUPPRESSED:** Percentage of active patients who had <200 copies/mL at last viral load test of 2017
DRILL DOWN NON-ACTIVE CASELOAD BY SERVICE DELIVERY POINT
Previously diagnosed patients
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients

Deceased by end of 2017

Incarcerated at end of 2017

Confirmed in HIV care elsewhere at end of 2017

Active patients
All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients

Non-Active Patients
All open patients who received services from the organization in 2017, but did not receive HIV primary care services
Identify Service Delivery Points for Non-active Caseload

- **Purpose:** To better target (re)engagement interventions to PLWH who may be out of care

- **Required components:** Report service delivery points for non-active patients, and how many non-active patients were seen at each
  - Looking at all previously diagnosed patients who did NOT receive HIV primary care services from the organization
Example: Identify Service Delivery Points for Non-active Patients

<table>
<thead>
<tr>
<th>Service delivery point</th>
<th>Number of non-active patients who received services during CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>88</td>
</tr>
<tr>
<td>Dental clinics</td>
<td>15</td>
</tr>
<tr>
<td>Emergency Departments</td>
<td>150</td>
</tr>
<tr>
<td>Inpatient units</td>
<td>123</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>8</td>
</tr>
<tr>
<td>Substance use services</td>
<td>64</td>
</tr>
<tr>
<td>Supportive housing services</td>
<td>35</td>
</tr>
</tbody>
</table>
DRILL DOWN ACTIVE CASELOAD BY KEY CHARACTERISTICS
Previously diagnosed patients
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

Open patients

Deceased by end of 2017

Incarcerated at end of 2017

Confirmed in HIV care elsewhere at end of 2017

Active patients
All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients

Non-Active Patients
All open patients who received services from the organization in 2017, but did not receive HIV primary care services
Drill Down by Key Characteristics

- **Purpose:** To identify disparities in care among key populations, allowing for targeted improvement work

- **Required Components:** Drill down (disaggregate) the *active* caseload by each of the following key characteristics
  - Age
  - Gender
  - Race/ethnicity
  - Risk Category
  - Housing status
  - Calculate for active caseload, prescription of ART, receipt of a viral load test, and viral suppression
  - Cascade or table format

- **Recommended:** Do the same for the *open* caseload, for one or more of the key characteristics

- **Recommended:** Drill down for multiple categories at once – e.g., by race/ethnicity and housing status
# Definitions: Drill Down by Key Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Categories (adapted from CDC, NYS Bureau of HIV/AIDS Epidemiology, and HUD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0-12; 13-19; 20-24; 25-29; 30-39; 40-49; 50-59; 60+; Unknown</td>
</tr>
<tr>
<td>Gender</td>
<td>Male; Female; Transgender; Unknown</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Non-Hispanic White; Non-Hispanic Black; Hispanic; Asian/Pacific Islander; Native American; Multi-Race; Unknown</td>
</tr>
<tr>
<td>Risk Category</td>
<td>Men who have Sex with Men (MSM); Intravenous Drug Users (IDU); MSM/IDU; Heterosexual; Pediatric risk; Unknown/other</td>
</tr>
<tr>
<td>Housing Status</td>
<td>Stable permanent housing; Temporary housing; Unstable housing; Unknown</td>
</tr>
</tbody>
</table>

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[1] Organizations with transgender patients are encouraged to further disaggregate their transgender patient caseloads by male-to-female (MtF) and female-to-male (FtM).

[2] Defined as short-term arrangement with family or friends, transitional housing or temporary institutional placement including substance abuse treatment facilities and psychiatric hospitals.

Example: Drill Down of Active Caseload

HIV Treatment Cascade, Previously Diagnosed
Active Patients, Breakdown by Housing Status, 2017

Active: # of patients diagnosed with HIV before 2017, who received HIV primary care services in 2017, by housing status
Prescribed ART: percentage of active patients receiving ART prescription in 2017
Received Viral Load Test: percentage of active patients with a documented VL test in 2017
Virally suppressed: percentage of active patients who had VL <200 copies/mL in last VL test of 2017
METHODOLOGY &
ANALYSIS AND IMPROVEMENT PLAN
Methodology Section

- **Purpose**: To allow internal and external stakeholders to understand how the cascade was constructed
- Responses to all specific questions in the guidance, at a *minimum*
  - For each data point, describe the data source(s) used to collect it
    - Which data source(s)
    - Why the data sources were selected
    - What the limitations of the data sources were
  - Who was involved in extracting, analyzing, and presenting cascade data?
Analysis and Improvement Plan

- Report progress on 2017 cascade improvement plan
- Analyze all gaps in care in 2017 data; compare to 2016 data
- Develop specific, time-bound, measurable goals for each gap identified in 2017 and steps/activities planned to achieve goals
- List staff responsible for implementing each step of the improvement plan
- Explain how consumers were involved in development of improvement plan and improvement activities
- Plan for dissemination of the cascades to stakeholders
Next Steps

- Submissions deadline May 31st
  - Send as an email attachment to qocreviews@health.ny.gov and CC your QI coach
- Webinars will be offered from release of guidance until the deadline.
- Contact your QI coach **before** submission for technical assistance and to make sure you are on track for approval.
What happens after submission?

- Confirmation of receipt from the AIDS Institute within 2 business days
- Reviewed by QOC staff and approved by senior medical staff
  - Assessment based on adherence to the criteria in guidance document
  - Importance of Analysis and Improvement Plan
  - Feedback will be provided
  - Do **not** wait to implement improvement plan until approval
- Beginning this month, organizations will be expected to provide updates to their QI coach, including:
  - Progress on cascade construction
  - Quarterly reports on QI activities to address gaps and disparities in cascade and measured outcomes
Summary

- As we enter the second year of the initiative, emphasizing the importance of:
  - Recognizing the opportunity to engage PLWH who receive services from an organization in ongoing HIV care
  - Rapid linkage to care for newly diagnosed patients
  - Drilling down the active caseload to identify disparities in care among subpopulations
- Organizational HIV Treatment Cascades – and the improvement plans generated in the process – have an important role to play in Ending the Epidemic in NYS by 2020
Questions?
Reducing Stigma in HIV Care

Kelly Hancock | NYSDOH – AI
HIV-Related Stigma Reduction: Upper Manhattan
Our Goals:

- Provide a brief overview of the findings of the stigma survey
- As a group - develop greater awareness of the factors promoting and restraining change in stigma
- Share and think more critically about interventions being implemented in the region to change stigma & discrimination
- Increase motivation for action on this statewide initiative
Negative Health Impacts of Stigma for PLWH

Moment-to-moment within-person associations between acts of discrimination and internalized stigma in people living with HIV: An experience sampling study.

Experienced HIV-Related Stigma in Healthcare and Community Settings: Mediated Associations With Psychosocial and Health Outcomes

Kay Emma Sophia MSW, Rice, Whitney S, DrPH, Crockett, Kaylee B, PhD, Atkins, Ghislaine C, MA; Betsy, D, Scott PhD, Turan, Bilent PhD
Measuring and Addressing Stigma in Healthcare Settings

Three Components:
1. Administer the stigma survey to staff members
2. Solicit feedback from consumers
3. Create a stigma reduction action plan based off of results
In general, survey respondents:

- Have not received training on HIV-related stigma and discrimination and key population-related stigma and discrimination
- Did not have knowledge of policy against discrimination of key populations
- Agreed that infection occurs due to irresponsible behavior, and PLWH have had many sexual partners
- Observed people talking badly about:
  - Women
  - People of color
  - **People with a mental health diagnosis**
  - TG/GNC individuals
- Have lack of training:
  - Women’s health
  - People who identify as gay or bisexual (STI screening)
  - TG/GNC individuals
  - **People with a mental health diagnosis**
  - People who use drugs
Why is Stigma Hard to Change?
Exercise
Why is Stigma Hard to Change?

Goals by the end of the exercise
Participants will be able to identify....
- Various factors promoting and restraining change in stigma
- Possible interventions to change stigma and discrimination
Exercise

Why is Stigma Hard to Change?

Thinking about the question…

1. Brainstorm Alone → Write single ideas/answers on a sticky note
   - For around 3-5 minutes
2. Discuss ideas with your group
3. Organize the ideas into key themes
Why is Stigma Hard to Change?

Think about the question for the following populations:

- Young YMSM of color
- TGNC Individuals

1. Brainstorm Alone → Write single ideas/answers on a sticky note (at least 1 idea for each population)
   - For around 3-5 minutes
2. Discuss ideas with your group
3. Organize the ideas into groups for each key population
Stigma Reduction Action Plan
Themes from Upper Manhattan

- Increasing staff education
  - LGBT health (STI screening), mental health, HIV-related stigma, SOGI

- Welcoming, inclusive environment for key populations
  - U=U, women, TGNC individuals

- Updating policies on stigma and discrimination

- Having consumers participate in the HIV Quality Committee/assist in environmental changes

- Consumer empowerment – campaigns and events
Discussion of Interventions Occurring at Agencies

- Which of the key themes from the exercise does the intervention aim to target?
- Anticipated or experienced challenges?
- Next steps?
Thoughts about reducing stigma in Upper Manhattan?

Thoughts about reducing stigma in the key populations?

What are we “missing” in terms of reducing stigma?
Working Lunch: Team Planning

- Complete QI Project Update Sheets
- Discuss 2017 Cascade Plans
Transgender Health
Addressing Barriers to Care for Transgender People
HELLO!
My name is

Name
Pronouns (if you feel comfortable)
Job Title
Modules at a Glance

Introduction
Module 1: Definitions & Concepts
Module 2: Values, Attitudes & Beliefs
Module 3: Barriers & Strategies
Wrap Up
Ground Rules

What do you need in order to speak freely?

- It’s ok to pass
- Listen actively
- Respect the right to have an opinion
- Speak from your own experiences (I statements)
- No personal attacks
- Uphold confidentiality
- Others?
Questions

- Have you knowingly worked with trans people before?
- What kinds of challenges have you met or are you concerned about?
Module 1

GENDER & SEXUALITY TERMINOLOGY & CONCEPTS

Diversity of Transgender Experience
What do trans clients want?
Biological Sex

A combination of physical characteristics
- Reproductive organs
- Chromosomes
- Hormone levels
- Secondary sex characteristics

Intersex:
- A variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t fit typical definitions of female or male.
- DSD: Disorders of Sex Development
Sex Assigned at Birth

Biological sex category assigned at birth

- **AFAB**: Assigned Female at Birth
- **AMAB**: Assigned Male at Birth

Replaces:

- “Biologically male or female”
- “Born male or female”
- “Used to be male or female”, etc.
- “Female-bodied” or “Male-bodied”
I was assigned male at birth, is the way I like to put it, because I think we're born who we are and the gender thing is something someone imposes on you. And so I was assigned male at birth, but I always felt like I was a girl.

— Laverne Cox —
Sexual Orientation

An individual’s emotional, romantic, psychological and/or sexual attraction to other people.

- Transgender, like cisgender, people may have any sexual orientation.
- Gender identity and expression is distinct from a person’s sexual orientation.
Sexual Behavior

The manner in which humans experience and express their sexuality.
Who you have sex with and what activities you engage in.

- Sexual orientation influences but does not limit who someone partners with.
Gender Identity

One's innermost concept of self as male or female or both or neither—how individuals perceive themselves and what they call themselves.

One's gender identity can be the same or different than the sex assigned at birth.
Transgender
(Trans or Trans*)

A person whose gender identity does not fully match their sex assigned at birth.

An umbrella term to refer to the full range and diversity of identities within transgender communities.
Words to Typically Avoid

- Transgenders
- A Transgender (noun)
- Transgendering
- Transgendered
- Tranny/Trannie
- Transvestite
- Transexual/Transsexual
- Crossdresser
- Pre-Op
- Post-Op
- Hermaphrodite
- She-male
- He-She
- It

Unless someone identifies themselves with that label and suggests it’s appropriate for you to use it.
Cisgender

A person whose gender identity matches their sex assigned at birth.

AKA: Non-transgender
Trans woman

A person whose gender identity is female, but who was assigned male at birth. Also:

- Trans feminine
- Woman of Transgender Experience
- Feminine-of-Center

Losing popularity: Male-to-Female (MTF)

Unless someone identifies themselves with that label
Trans man

A person whose gender identity is male, but who was assigned female at birth. Also:

- Trans masculine
- Man of Transgender Experience
- Masculine-of-Center

Losing popularity: Female-to-Male (FTM)

Unless someone identifies themselves with that label.
Gender Expression

The ways in which we each manifest masculinity or femininity.

- Each of us expresses our gender in different ways—style our hair, clothing, or even the way we stand.
- Gender expression varies across cultures.
Gender Non-conforming (GNC)

A person whose gender expression is perceived as being inconsistent with cultural norms expected for that gender.

Note: Not all trans people are GNC, and not all GNC people identify as trans.

To be inclusive, you might hear TGNC (Transgender & Gender Non-Conforming)
Non-Binary

A continuum of gender identities and expressions that fall outside the gender binary. Individuals’ gender identities may be neither male nor female, or both.

Some non-binary people identify as:

- Genderfluid, Genderqueer, Bigender, Pangender, Agender, Neutrois, Androgyne, Gender Expansive, Demigirl, Demiguy
### Traditional Gender Model

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masculine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attracted to Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex only with women</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Gender Spectrum

The gender spectrum ranges from 100% Male to 100% Female, encompassing a wide range of gender identities and expressions.
What is the first thing people think of or ask?

“Have you had **THE** surgery?”

“The preoccupation with surgery objectifies trans people.
I’m more than my body. I’m so much more”

LAVERN COX
Transition Realities

- People are multi-faceted & desire to be seen as whole people, not reduced to their transition.
- Surgery ≠ Realness
- Transition is different for everyone.
- Not everyone chooses to transition medically.
Transition

Any of the processes a TGNC person may go through to affirm a gender identity different than that assigned at birth

- Social
- Legal
- Spiritual
- Personal
- Medical
<table>
<thead>
<tr>
<th>Medical term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Top surgery</strong></td>
<td></td>
</tr>
<tr>
<td>Reduction mammaplasty</td>
<td>Removing some breast tissue to make the chest smaller</td>
</tr>
<tr>
<td>Chest reconstruction</td>
<td>Removing breast tissue and excess skin, and altering the nipple and dark area around it (areola)</td>
</tr>
<tr>
<td><strong>Lower surgery</strong></td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Removing the uterus</td>
</tr>
<tr>
<td>Salpingo-oophorectomy</td>
<td>Removing the fallopian tubes and ovaries</td>
</tr>
<tr>
<td>Colpectomy, or vaginectomy</td>
<td>Removing the vagina</td>
</tr>
<tr>
<td>Colpopceleis</td>
<td>Closing the vagina</td>
</tr>
<tr>
<td>Metaidioioplasty (sometimes spelled “metaidioplasty” or “metoidioplasty”)</td>
<td>Making the clitoris appear larger, to form a small penis</td>
</tr>
<tr>
<td>Phalloplasty</td>
<td>Making a penis using tissue from another part of the body</td>
</tr>
<tr>
<td>Urethroplasty</td>
<td>Lengthening the tube that carries urine from the bladder, to exit through the new penis</td>
</tr>
<tr>
<td>Scrotoplasty</td>
<td>Creating a scrotum (“balls”)</td>
</tr>
<tr>
<td><strong>Other possible surgeries</strong></td>
<td></td>
</tr>
<tr>
<td>Liposuction</td>
<td>Removing fat from the hips, thighs, and buttocks</td>
</tr>
<tr>
<td>Implants</td>
<td>Inserting material into the calf, jaw, chin, or chest to make these areas look more muscular</td>
</tr>
<tr>
<td>Options for MTF Sex Reassignment Surgery</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Medical term</strong></td>
<td><strong>Explanation</strong></td>
</tr>
<tr>
<td>Breast surgery</td>
<td>Inserting implants to make the breasts larger</td>
</tr>
<tr>
<td>Augmentation</td>
<td>(&quot;breast augmentation&quot;)</td>
</tr>
<tr>
<td>mammaplasty</td>
<td></td>
</tr>
<tr>
<td>Face/neck surgery</td>
<td>Surgical changes to the nose, forehead, chin,</td>
</tr>
<tr>
<td>Facial feminization</td>
<td>jaws, cheeks, lips, ears, or eyes</td>
</tr>
<tr>
<td>surgery (FFS)</td>
<td></td>
</tr>
<tr>
<td>Thyroid cartilage reduction,</td>
<td>Shaving down the Adam's apple (&quot;tracheal shave&quot;)</td>
</tr>
<tr>
<td>or &quot;chondrolaryngoplasty&quot;</td>
<td></td>
</tr>
<tr>
<td>Genital surgery</td>
<td>Removing the testicles</td>
</tr>
<tr>
<td>Orchietomy</td>
<td></td>
</tr>
<tr>
<td>Penectomy</td>
<td>Removing the penis</td>
</tr>
<tr>
<td>Vaginoplasty</td>
<td>Creating a vagina</td>
</tr>
<tr>
<td>Labiaplasty</td>
<td>Creation of labia (the &quot;lips&quot; around the vagina)</td>
</tr>
<tr>
<td>Clitoroplasty</td>
<td>Creation of a clitoris</td>
</tr>
<tr>
<td>Other possible surgeries</td>
<td>Removing fat (and possibly excess skin) from the</td>
</tr>
<tr>
<td>Abdominoplasty or abdominal lipoplasty</td>
<td>stomach</td>
</tr>
<tr>
<td>Implants</td>
<td>Inserting material into the hips or buttocks to</td>
</tr>
<tr>
<td></td>
<td>make these areas look more rounded</td>
</tr>
<tr>
<td>Scalp surgery</td>
<td>Various surgical methods to treat &quot;male&quot;-pattern</td>
</tr>
<tr>
<td></td>
<td>baldness (e.g., hair transplants, removing strips</td>
</tr>
<tr>
<td></td>
<td>of bald skin)</td>
</tr>
<tr>
<td>Voice surgery</td>
<td>Surgery on the vocal cords or surrounding cartilage</td>
</tr>
<tr>
<td></td>
<td>to raise voice pitch</td>
</tr>
</tbody>
</table>
6 months before Phallo/Vaginoplasty

- Electrolysis or laser
  - Start 3-6 months before
  - Not within 2 weeks of surgery
- Weight loss may be necessary

3 months before metoidioplasty

- Topical 10% DHT cream 3x daily
- Pumping
  - Amazon.com ($58)
  - www.bostonbump.com ($60)
  - 10-15 minutes

Before Top Surgery

- Stop taking medications (stimulants e.g. Adderall) 2 weeks before surgery
- Stop smoking 2 weeks prior
- Get plenty of exercise, eat clean & drink water
- Weight loss may be necessary
- Stop drinking alcohol 1 week prior

Before Breast Augmentation

- Stop all blood thinner medications & supplements 2 weeks prior
- Stop smoking at least 2 weeks prior
- Stop drinking alcohol 1 week prior
NYS Medicaid Prerequisites for
Gender Confirming Surgery

☐ Ability to give informed consent: patient must comprehend the nature, purpose, and effect of the procedure being requested
☐ Surgery referral process explained in language patient can understand

☐ Patient has had access to continuous hormone therapy
  ☐ 12 months for genital surgery
  ☐ 24 months without significant growth for breast augmentation
  ☐ Has received hormone therapy appropriate to patient’s gender goals
  ☐ Hormone contraindication

☐ Patient has been living for 12 months in gender role congruent with gender identity
☐ Major medical conditions are reasonably controlled

☐ Two referral letters, minimum
  ☐ One mental health letter by a New York State licensed psychiatrist, psychologist, licensed clinical social worker (LCSW), or psychiatric nurse practitioner who has an ongoing relationship with the patient.
  ☐ The second MH letter be written by a New York State licensed psychiatrist, psychologist, psychiatric nurse practitioner physician, or licensed clinical social worker (LCSW), working within their scope of practice.

☐ Has a persistent and well-documented case of gender dysphoria;
  ☐ Has received hormone therapy appropriate to the individual’s gender goals for a minimum of 12 months - unless hormone therapy is medically contraindicated or the individual is otherwise unable to take hormones or individual is not seeking genital surgery
  ☐ Has lived for 12 months in a gender role congruent with the individual’s gender identity, and has received mental health counseling, as deemed medically necessary, during that time;
  ☐ Has no other significant medical or mental health conditions that would contraindicate gender reassignment surgery, or if so, that those conditions are reasonably well-controlled prior to surgery;
  ☐ Has the capacity to make a fully informed decision and to consent to treatment (has signed a sterilization consent form if applicable)
MEDICAL CONCERNS

- A plan for follow up visits and communication with your surgeon
- Ensure you are working with a PCP that can help you with post care
- Drain removal, if necessary
- A plan for complications. What can your PCP do? What does your insurance pay for?
- A plan for dilation, if necessary?
- A plan for revisions. What does your insurance pay for?
Do you have a mental health counselor? Do you have a plan to speak to them if you cannot travel to them?
Do you have clean, safe housing to heal in?
Do you have friends/family that can visit/help you?
Do you have a plan for meal prep/using the bathroom/showering etc. The VNA may be able to help
Stock up on non-perishable groceries. Prepare meals and freeze them.
Do all of your laundry ahead of time so you come home to a clean bed. Clean loose fitting clothing should also be ready.
Do any house cleaning before your surgery as it may be a while before you can do this.
If applicable change your ID after your surgery. Some surgery require surgery before gender markers can be changed.
FINANCIAL CONCERNS

- Do you have a plan for funds lost due to missing work?

- Have you talked to someone in your HR Department (if relevant) about short term/long term disability options?

- Have you made a plan for additional costs? Medical supplies needed, food delivery, care giver costs?

- Collect all of the medical supplies your surgeon has directed you to have on hand.
A lot can happen between the date of your consultation and the date of your surgery.

**Last minute denials:**

- Did you get all of your letters submitted? Are they outdated? Have you seen all of the necessary providers?

- **Prior Authorization (pre-certification) rules**
  - Some insurance companies have rules about the dates of letters, e.g. latter must be dated w/in 60 days of the request of the prior authorization

- **CPT Codes** – make sure the surgeon submits the right codes to avoid delays. They should match the ones in your insurance policy

- Insurance companies are **SLOW**! Sometimes you won’t find out if you’ve been officially approved or denied until mere days before (or the day of) surgery. If you made plans to take time off from work, for someone to watch your kids, try to make a contingency plan if things fall through.
Insurance Snafus

**Medical necessity denials:**
- Length of time engaged with a MH provider
- Length of time on hormones
- Length of time in “desired gender role”
- Sometimes they won’t be specific about the reason for the denial, and they will label the reason for the denial as a lack of medical necessity

Some insurance companies require that people change their gender marker back to the sex assigned at birth to access care.

If there is a denial, sometimes insurance plans will not provide the denial documentation to patients or their advocates in sufficient time, or at all, so that patients can know their rights or are able to pursue their time-sensitive appeals.
Module 2

VALUES
ATTITUDES & BELIEFS
MICRO-AGGRESSIONS & PRIVILEGE
Gender Self-Reflection: Individual Activity

Please complete the activity handout.

You will not be required to share your answers with the group.
Microaggressions & Privilege

Goal

- Understand the impact of subtle prejudice and discrimination that clients may experience commonly, or even daily, outside our clinics or agencies.
“Brief and commonplace daily, verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups” (Nadal, 2008, p. 23)

Intention ≠ Impact
YOU LOOK JUST LIKE A REAL WOMAN
TRANSMEN AREN’T REALLY WOMEN
I WOULD DATE A TRANS PERSON
TRANS PEOPLE ARE USUALLY UNDATEABLE
SO I DESERVE A PRIZE
I LOVE TRANS PEOPLE!
I FETISHIZE TRANS PEOPLE
Sample Microaggressions

1. I never would’ve known you’re trans.
2. As soon as I saw you, I knew that you’re trans.
3. You’ll have to remind me to use the right pronoun because this is hard for me.
4. I think you’re in the wrong bathroom.
5. I’ll always think of you as a [sex assigned at birth].
6. Tell me about your body, transition story, etc.
7. When are you having the surgery?
8. You’re so brave.
9. Have you seen that article about Caitlyn Jenner?
10. Using the wrong name, pronouns, etc.
Cisgender Privilege

A set of unearned advantages that people who identify as the gender matching the sex they were assigned at birth accrue solely due to having a cisgender identity.

- Not having to think about the challenges that TGNC people have to face daily.
- Not having to answer deeply personal questions about one’s body.
Cisgender Privilege examples

- If I get pulled over or have to present my driver’s license, I don’t have to worry about the consequences if the officer notices the “F” or “M” on the ID. If I’m traveling abroad, I don’t have to worry about being detained because my appearance doesn’t “match” the gender on my passport.
- When I go to the gym or a public pool, I can use the showers.
- If I end up in the emergency room, I do not have to worry that my gender will keep me from receiving appropriate treatment nor will all of my medical issues be seen as a product of my gender.
- I am not required to undergo extensive psychological evaluation in order to receive basic medical care.
Module 3

BARRIERS TO CARE AND HOW TO WORK THROUGH THEM
Intersectionality

Having multiple oppressed identities (race, ethnicity, class, gender, sexual orientation, age, language, ability, etc.) affects physical and mental health, well-being, and health-seeking behaviors.
Intersectional Oppression Examples

- **Race/Ethnicity**: How will being targeted by the police as a trans person of color affect my safety?
- **Class**: How will I pay for transition-related costs (freezing sperm, egg harvesting, puberty blockers)?
- **Ability**: Will my provider doubt my identity because of my bipolar disorder diagnosis?
- **Sex**: Will I make less money after I transition?
Intersectional Oppression Examples

- **Orientation**: Will I be subject to anti-gay bias?
- **Religion**: Will I have to choose between gender affirmation and attending services at my religious institution?
- **Citizenship**: Does my country of origin allow me to change my identity documents?
- **Age**: Will people believe me because I'm a child?
- **Age**: Will I be able to find an affirming long-term care facility?
Higher Risk But Less HIV Screening

- TGNC persons avoid medical care
  - 28% delayed care when ill
  - 33% delayed preventive care
  - Low rates of HIV screening (46% never tested)

- Trans women 50 times more likely to be HIV+
  - 45-65% HIV+ Trans women unaware of HIV status

Of those who expressed a transgender identity or gender non-conformity while in school, grades K-12

- 75% experienced harassment
- 35% were physically assaulted
- 12% experienced sexual violence
Respondents lived in extreme poverty. The transgender people sampled were nearly 4 times more likely to have a household income of less than $10,000 a year compared to the general population.

26% had been jobless because of discrimination,

41% had attempted suicide, compared to 1.6% of the general population, with higher rates for those who lost a job due to bias (55%), were harassed/bullied in school (51%), had low household income, or who were the victim of physical (61%) or sexual assault (64%).
19% had been homeless at some point,

Almost 20% of respondents reported being refused medical care, with even higher numbers among people of color.

50% had to teach their medical providers about transgender care.

When sick or injured, 28% postponed medical care due to discrimination and 48% postponed due to inability to afford it.

National Transgender Discrimination Survey

- 98% exposure rate to potentially traumatic events
- 91% of the sample had experienced multiple lifetime traumatic events
- 42% believed the event to be related to their transgender status
- Clinically significant depressive symptoms were noted in 64% of the trauma-exposed sample

Shipherd et al 2011
Lambda Legal study on TGNC health care experience vs. LGB people

Staff Training

- Cultural competency training for all staff
  - Gender-affirming model (pronouns, language, etc.)
- Train appropriate providers on:
  - Writing letters for surgery
  - Importance of provider-client partnership
  - Trauma-informed models of care
  - Hormone protocols, physicals
  - Taking a history
Staffing

- Hire TGNC staff and involve in decisions
- Health Insurance Outreach & Enrollment staff
- Help with insurance & billing issues
- Dedicated Transgender Care Coordinator
  - Name changes, IDs
  - Housing
  - Education
- Utilize Navigators & Peer Models
Inclusive Registration/EHR
Provide Gender-Neutral Bathrooms

Signs available here: www.mydoorsign.com/all-gender-restroom-signs
Use Inclusive Language

LADIES AND GENTLEMEN: HONORED GUESTS, DISTINGUISHED GUESTS

BREAK THE BINARY

GIRLFRIEND/BOYFRIEND: PARTNER, DATE, DATEFRIEND, DATEMATE, BABEFRIEND, BABE, HEART, PERSON, SIGNIFICANT OTHER

BREAK THE BINARY

BOYS/GUYS/GIRLS/LADIES: Y’ALL, FOLKS, PEOPLE, GUESTS

BREAK THE BINARY

GIRL/BOY/MAN/WOMAN: PERSON, HUMAN

BREAK THE BINARY
Visible Signage
Targeted Health Promotion Materials

Trans Masculine Sexual Health Collaborative at Fenway Health
Targeted Prevention Materials

Take Pride, TAKE CARE
Tips for Transgender Women’s Health

Be HIV Sure
One night can change your HIV status
Be safe, be sure, and get tested frequently

For free testing
Call 311, text “TESTNYC” to 877877 or search “HIV” on nyc.gov

HIV prevention just got easier
PreP is a once a day pill that can keep you HIV negative

Call 800-541-2437, 800-233-7432 (TTY).
Prep for sex.org

Health tips
for Trans Men and People of Trans-Masculine Experience
Questions?
Wrap Up: Announcements, Next Steps and Evaluation

Daniel Tietz | NYSDOH – AI
Jonathan Gómez | NYSDOH – AI
Important Dates

2018 Upper Manhattan Full Group Meeting Dates:
• Friday, May 25\textsuperscript{th}
• Friday, August 31\textsuperscript{st}
• Friday, November 30\textsuperscript{th}

Stay Tuned:
• Guidance for 2017 Organizational HIV Tx Cascades
• Training Consumers in Quality (rescheduled, possibly mid-May)
For QI/QM Questions or Assistance Contact

Jonathan Gómez
212-417-4757
jonathan.gomez@health.ny.gov

Susan Weigl
sweigl@yahoo.com
Thanks!!

William R. Ryan Community Health Network
Joseph Lunievicz (ACRIA at GMHC) and D’hana Perry (Callen-Lorde CHC)
Upper Manhattan Steering Committee
AIDS Institute Coaches
& All Participants @ Today’s meeting