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TRANSGENDER-AFFIRMING PRIMARY CARE

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[video transcript]

0:09

Dr. Jeffrey Birnbaum is our presenter today for Transgender Affirming Primary Care. Dr. Birnbaum is an Associate Professor of Pediatrics and Public Health at SUNY Downstate Medical Center and currently serves as the Principal Investigator and Executive Director of the Health and Education Alternatives for Teens or HEAT program. Through his leadership at HEAT, Dr. Birnbaum continues to bring SUNY Downstate acclaim to local, state, national and international levels. HEAT is the only program of its kind in Brooklyn to offer comprehensive medical and mental health care, supportive services, and access to clinical research for HIV positive and at risk youth ages 13 to 24. At HEAT, he has provided medical care to hundreds of HIV positive youth ages 13 to 24 since 1992. And Dr. Birnbaum is an Adolescent Medicine Specialist and Board Certified Pediatrician who has devoted most of his professional career to working with HIV positive youth. He has built the HEAT program into a system of care that provides age and developmentally appropriate culturally competent care for heterosexual, lesbian, gay, bisexual, and transgender youth who are living with or at risk for HIV/AIDS. Today, he operates as a one stop, full service clinic offering a full range of medical and mental health and supportive services that are tailored to meet the special needs of young people. Thank you so much for joining us today, Dr. Birnbaum. And now I will turn it over to you.

1:35

Thank you, Mark and thank you Tara, for that was a great introduction for the topic. So I'm going to come back to many of the things that you said. Let me jump ahead. I have no disclosures to declare! Our learning objectives, you can read them here. Really, we're going to be talking about transgender affirming care, how to talk to patients, and some of the health screenings that we need to provide to patients.

2:06

So you know, as Tara made the affirmation about transgender affirming care, we need to acknowledge the challenges that transgender individuals and transgender non-conforming individuals experience when they walk into a medical care facility. I would use the example of transgender women when they walk in and often get called 'Mister' or by a male name on their insurance card, or the humiliations that a transgender male may suffer when he may be having dysfunctional uterine bleeding and walks into an emergency room. A bleeding uterus is a bleeding uterus, regardless of a person's identity and it needs to get treated as such. But people are often treated very poorly or told that they can't be treated at all, or have a doctor scratching their head and say 'I don't know what to do here.' And so we have huge health disparities as a result of those and hopefully today's lecture will help dispel some of those issues that you may have and make you better informed about these topics.

3:22

Just to talk a little bit about about myself, how did I end up getting into this? I've been doing HIV care largely since the beginning of the epidemic, the last 28 years at the HEAT program. And I walked into transgender care knowing absolutely nothing about it. I had never met a transgender person before. And the first day that I had a transgender patient walk in and say, 'I'm transgender and HIV positive, can I get my hormones from you?' I said, 'well, I'd rather be able to learn how to provide all the care in one location to this young person if it means learning something new I've never done before, I will learn it.' And that brings us to today where I'm teaching you folks about it.

4:15

So one of the major issues, and this is an area where things are rapidly changing, that medical schools historically have provided relatively poor training in LGBT health in general, but transgender health is usually pretty, you know, zero. And so you can see some of these percentages of some of these academic faculty practices and what five hours across four years of medical school. This was from 2011, things have improved since then. I know at Downstate, here, we have several transgender specific lectures separate from LGBT health. So, and quite often, it's content from this lecture I'm giving you today. There's a couple of things.

5:18

There's a lot of slides on terminology, I have some arrows pointing to terms that I think are important for folks to remember. And if I go through quickly, it's because I got a lot of slides and want to make sure I get through all of them and have time for questions and answers. Some terms that you should definitely be familiar with are cisgender, that's a person whose gender identity aligns with the gender label given to them at birth and is consistent with their anatomy. Female to male is somebody who is a transgender individual born female who identifies as male, so the term FTM or female to male should give you a clue as to which direction we're going with a person's transition.

6:02

Gender, this is essentially these are psychological, behavioral, and cultural characteristics associated with maleness and femaleness. And there's usually a gender identity as what a person internalizes as who they are as a human being. Gender affirming, those are behaviors or interventions that help affirm that gender identity that the person has in life. So for many transgender men, growing a beard is a very gender affirming action that they can take. Dressing is another gender affirming, dressing in your chosen gender, or consistent with your identity is another gender affirming activity. Gender discordance is when there's a mismatch between what you were born with and how you identify, that simple.

6:57

Gender expression, again, these are mannerisms, family, personal traits, clothing choices, that's how you express yourself outwardly. Separate from gender identity which is inward, how you identify yourself to yourself. There are some sexual terms there as well, heterosexual, homosexual, which really don't apply to gender identity. People often conflate the issues of gender identity and sexual identity. There is some relation, but they're definitely not the same thing and we'll give some examples of that momentarily.

7:35

Male to female, that's someone born with male anatomy who identifies as female and is a transgender person who may or may not seek gender affirming treatments, but still identifies as female. Sex, that is what you are born with, that's your biology, whether you have x, y, or xx chromosomes. I'm not going to get into intersex today, but that's definitely a related field. But this is what you're born with and what nature has assigned you.

8:09

Transgender, those are people who have gender identities that don't align with the gender labels they were assigned at birth. Transitioning is the process by which people literally transition from what they were born with to a new identity, both changing their outward expression and the way they present to the world, as well as getting medical and surgical interventions. As well as changing their name and legal documents, such as birth certificate, driver's license, passport, social security card, insurance card very important. And transsexual person is somebody who's really gone through some level of treatment, may not just be identifying as transgender but is actually a transgender person who's actually started to take hormones or has had a surgical procedure done. And transphobia is what transgender individuals experience every day when they go out in the street and get name calling and are subjected to acts of violence and things like that, or just being treated poorly in a hospital emergency room for example.

9:21

So where's this term transgender come from? There's a long sordid history with the field of psychiatry. And you could see that the term transgender first came into vogue in the 1980s in the DSM-III, where somebody's identity was first labeled as a diagnosis. We used to use the term gender identity disorder. Now we use another term called gender dysphoria, I'm going to come back to that, but those are diagnoses. And if you think of it from the transgender person's perspective, they're kind of offensive, like who you are shouldn't be a diagnosis. So the term transgender is more of a value free term that doesn't imply some sort of diagnosis. Although for billing purposes in clinical care, we do have to consider what diagnoses might best apply to a transgender individual.

10:30

So are gender identity disorders mental disorders? Well, in the DSM-V which came out in 2013, we had this previously used term gender identity disorder that was dropped from the DSM-IV. Again, we were using a term that describes someone's identity as being pathological. Now, there are certain diagnoses where their identity might be pathological, but this is not one of them. But people with gender issues and transgender individuals do experience something called gender dysphoria, where they feel an intense discomfort with the body they were born with. You hear terms among transgender men, for instance, talking about chest dysphoria, the fact that they were born with female chromosomes and grew breasts. Having a sense of discomfort and psychological distress from having a body that they don't feel comfortable with. So, people will come in for medical care, for hormonal treatment, and you have to use a diagnosis. Even today, when I was giving individual shots in clinic, I may be using as my primary ICD 10 code, gender dysphoria F64 point whatever, depending on the person's age, for billing purposes. Even if the person is feeling comfortable, that's the diagnosis that we use for medical treatment.

12:12

So I raised the point that sexual orientation and gender identity are not the same. Although there is a relationship and people trip over their own language when talking about these things. Because somebody who from my perspective, who is a transgender female, somebody who presents to the world as female and is on hormonal treatment, and so on, who has sex exclusively with and is attracted only to men, I would consider that person heterosexual. So that's their sexual orientation. As a gender identity, they are transgender, it doesn't matter that they may or may not still have a penis, it's that they consider themselves female and live in that identity and they are attracted to and have sex exclusively with males, as an example.

13:07

So it is important to just consider the differences between their gender identity, their sexual identity. And then when you get into sexual orientation and identity, they're not all the same thing, you can have sexual behaviors that don't align with your sexual identity. You could consider yourself, I see this all the time among young transgender women who are early on in their transition, people have been telling them and they've been telling themselves that they're gay, because they were born with a penis and they have sex only with men. But once they start identifying as female, if you use this sort of nomenclature you have to think about it, their orientation and their behavior is with the opposite sex. So these are just things that you need to wrap your head around, that they're not necessarily the same thing and it gets a little bit muddier. And you really have to consider the gender identity of the person when you're trying to figure out their sexual identity, or the best thing to do is ask someone 'how do you identify?' It's better for them to tell you how they identify than for you to make assumptions based on their behavior, their sexual behavior.

14:34

So again, this is a gingerbread man cutout just looking at sexual orientation. Who they're attracted to, gender identity is who they tell themselves they are, and sex is what's their anatomy, and then gender expression is how do they present themselves to the world.

14:54

So in terms of medical care, it is very easy to make mistakes. The most important question I would ask someone when I'm meeting them for the first time, a transgender patient, is 'tell me your name and tell me how you want me to identify you. What pronoun do you use?' Don't make assumptions that if someone is transgender, transgender female may not want to be called she, she may want to be called they. Something that's a little bit more neutral, and that's just more comfortable for them.The name that they have on their insurance that shows up in your electronic medical record may not match the name that they tell you or the name that you're calling them by. So it's important to have adaptations to electronic medical records that allow you to put in somewhere that the person is transgender and that they go by another name. And for billing purposes, you have to use the name on their insurance. Just because that name is on their insurance doesn't mean you have to call them by that name. They may not have changed their name legally, so they cannot change the name on their insurance. And so in such a world where we have to deal with these things, you're prone to make mistakes. It's okay to make mistakes if you're honest with the patient and say, 'I'm sorry, I just misgendered you.' And apologies go a long way when you're being honest about that.

16:33

So taking a history from a transgender patient, asking them at what age did they identify, male, female, gender queer, two spirited that's a Native American term where people feel they're both male and female in the same body regardless of what body they have. But that's the origin of that term. At what age did you begin your transition? If you have, did you take hormones? Where did they get the hormones? These days, hormones are much more easily available, especially for folks on Medicaid. When I first started doing this, it wasn't so easily available and people would buy hormones from friends, they'd get them off the internet. Inject all sorts of things into their bodies that they didn't know what they were injecting half the time. Or were their hormones prescribed by a physician? Are they taking herbal supplements? And apparently soy is quite high in estrogen, so sometimes there are synthetic versions of soy that are out there. And silicone and hydrogel, people will inject themselves to have their breasts be bigger and firmer. You want to know if they're doing that on their own, those are really bad things to do that are not safe for a variety of reasons. And then although with adults, you may do things a little differently, in the case of an adolescent I think it's important to do a thorough mental health history. Not so that you would be a gatekeeper towards starting hormones, so that if somebody has bipolar disorder or post traumatic stress disorder, or whatever it is you can treat those issues in parallel with the transgender treatment. So getting a thorough mental health history is important.

18:36

Minors in New York State, some of you may or may not be HIV providers, may or may not be aware of things that you can provide to a minor without parental knowledge and without parental consent in New York State. Things like HIV testing, HIV treatment, PrEP, birth control pills, getting an abortion, all these things in New York State require just the minors consent. They just have to show a capacity to understand what they are asking you for. 'I want birth control pills because I'm sexually active and don't use condoms, and I'm afraid I'll get pregnant.' Well, that's a capacity to understand. So when it comes to hormones for minors, the short version of the story is it does require parental consent. It seems to me unfair, I think a lot of minors that I take care of could be consenting on their own, but that's the law as it stands right now. You need to get parental consent. If you cannot get parental consent, either the young person has to wait until they're 18, which is kind of after they've had a lot of secondary sexual characteristic changes which they would not desire, worsening their dysphoria. Or they need to sometimes end up in the foster care system, that their identity is not being respected and they may be getting emotionally abused, if not physically abused. And youth in the foster care system typically require parental consent as well, but in situations where parental consent cannot be obtained, there are mechanisms by which you can get an administrative override and start a 16 year old on treatment. So if there are questions about that, we can always come back to that later.

20:41

So you could see we have this youth screening questionnaire where we have both the birth name and the legal name. I thought that was important to show, and what does their ID show? That's what that ID check is about. These questions, what's their biological sex? How do they identify? What's their sexual orientation versus what is their partner's gender? May not necessarily be a match with their sexual orientation, but it's important to ask all of these questions. And then again, asking these questions about past or current hormone use and how they got them. So these are just examples from forms that that we've had put into our EMR.

21:28

And what age they first felt the opposite gender? And when they first started expressing themselves? And these questions about where they feel safe, where they don't feel safe, what are the relationships with your family, and so on. These are questions that we developed over time from just experience and talking to other providers who work with adolescents and young adults. And these seem to be some core questions that, at least in younger folks, are kind of mandatory for for engaging someone in transgender treatment.

22:03

I'm sorry for the change in format. These are other basic questions. What are some of the psychosocial factors involved in their lives? Where do they live? Are they homeless? Do they live with their family? Do they have support who they talk to when they're stressed? What substances do they use? And the bottom question, I'm not sure if you can read it, but it's about are they involved in needle sharing? When I talk about getting hormones off the street or silicone injections, folks often will be needle sharing there and that's important for obvious infection concerns with HIV, hepatitis B, and C.

22:48

Mental health screen, these are some basic questions that we ask about physical, sexual abuse, domestic violence, rape, sexual assault. Were they ever in a psychiatric hospital? Have they ever been on medication? Oh, sorry about that. No idea how I just did that. Let me get back to my question. Trying to read the question on the bottom, which may be cut off from your screen.

23:27

Okay, great, great. Have they ever been in therapy? I don't think therapy is mandatory for transgender individuals, but for young people who may have other different psychiatric comorbidities involved through having abusive families and that sort of thing, I think it's important that therapy be available to them while they're going through a transition because it is a big change.

24:04

Okay, if you have case managers in your clinic, these are things that I think are important to understand as a physician providing medical care to transgender individuals, there's a lot more to this than just providing hormones and doing blood tests. Obviously, those are important, but you need to understand the context of the population that you're serving. So understanding these issues with getting IDs and name changes, that they suffered discrimination. A lot of my patients are involved in sex work, I'll show you a little bit of data, just in order to be able to survive. And so there's a psychosocial context that you have to consider for a lot of transgender individuals. Definitely not all, but in my clinic a disproportionate number of them where we have to consider these issues.

25:00

So I'm going to skip this just because just to say that it's taken 20 years to develop a transgender program, that makes sense. And it's a lot of hit and miss or trial and error, and how we came up with a program, and how we got appropriate funding to provide the services that we provide. You have to start from the ground and build up.

25:27

We use treatment guidelines that are written by the World Professional Association for Transgender Health. Our own protocol adapts the WPATH guidelines. And we also use the Endocrine Society guidelines. And working with community based organizations that serve transgender youth, we make referrals for job training, housing, foster care, schools, things like that. Back and forth, developing relationships with those CBOs helps you better access the population you're seeking to serve. And again, all these issues of homelessness, sex work, untreated mental illness, are epidemics unto themselves. So using this term "syndemic theory" is embedded in our care model where by which you need to treat all of these issues all at once and not just be providing hormones. So these are some of the guidelines, again, I refer to the W path guidelines on the left. And then in the middle was the first transgender treatment guidelines published in 2009, I believe, by the endocrine society. So there are real doctors doing this real specialist not just me making this stuff up serving my underserved population. And I put that one on there, because it's got a much nicer cover than the one on the right, which is the updated version of the endocrine society guidelines, which they updated in 2017. And that's the current standard of hormonal treatment, where to find these. So just to look at some of the data, I keep talking about the psychosocial context, looking at some of these issues that my case management staff has to deal with. And for that matter, I have to deal with as well, I'm just looking at, over the course of the first 15 years that I was doing transgender care, you can see just these incredible percentages, high percentages, including HIV, of the the young people we had in care. And so in order to provide people with stable hormonal treatment and have good outcomes, with their, with their transgender care, you have to address these issues. Otherwise, it's a non starter. It's higher high rates of suicidality, at some point in their past history of street hormone use, and at that point in time, or up until 2017, we had a lot of youth who were using silicone, we don't see so much of that as we used to. Oh, largely because hormones are more readily available as as as breast augmentation surgery. This is more recent data from a little over a year ago, looking at some of the patient demographics, my population has diversified. I used to serve large numbers of females and then transgender guy started coming, it's roughly a 5050 split.

26:32

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27:17

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well. Just looking at over the course of the first 15 years that I was doing transgender care, you can see just these incredible percentages, high percentages including HIV, of the the young people we had in care. And so in order to provide people with stable hormonal treatment and have good outcomes, with their transgender care, you have to address these issues. Otherwise, it's a non starter. There's high rates of suicidality at some point in their past. History of street hormone use, and at that point in time or up until 2017, we had a lot of youth who were using silicone. We don't see so much of that as we used to. Largely because hormones are more readily available as is breast augmentation surgery.

28:30

This is more recent data from a little over a year ago looking at some of the patient demographics, my population has diversified. I used to serve large numbers of transgender females and then transgender guys started coming, it's roughly a 50/50 split.You can see, in particular on the right, the circle graph on the bottom, I have a disproportionately high number of young people who are in the foster care system.

29:01

Looking at their mental health histories, you could see the top right, looking at some of the self reported and documented in their histories of mental health diagnoses that they report to us and we need to address. Young people on the left, looking at about a quarter of them have been on psych meds and have family histories of mental illness, and large percent with suicidal ideation. Looking at the bottom, significant numbers of sexual abuse and substance use being reported. And I don't know if you can read the labels at the bottom, but just to see how high these percentages are is just kind of striking and need to be addressed in the context of medical care.

30:06

Looking at those having done past sex work, you can see 17% of my population reports having had past or current sex work. So that's something that requires a lot of prevention, counseling, and giving them alternatives to doing sex work. Talking to them about job skills and job readiness, engaged in work that's a little safer than doing sex work, and so on. You could see that 41% of my population was prescribed PrEP. And that's important, especially since you can see all the way over on the right, 10% of the population that I currently have in care or had in June 2019 was HIV positive. And you can see all the incidence rates of syphilis, gonorrhea, chlamydia, and so on. So doing ongoing screening. In my clinic, we provide sexual health screening with STD screening every three months, and some people more frequently if they come in and have some symptoms, or know that they've been exposed. So these are just important parts of routine transgender care that need to be considered.

31:33

In terms of physical exams, I try not to do exams unless I absolutely have to. Yes, you should listen to the heart, you should listen to the lungs. But for simple things like the bullet at the bottom, directed STI testing, give them a swab and let them do an anal swab on themselves. Give them a urine cup, let them pee in a cup. You could test for gonorrhea and chlamydia. Probably the most common time we will do a physical exam if somebody has an anal lesion, anal warts we see frequently, or if somebody has a syphilitic manifestation of disease quite often on the anus, then it's important to take a look. With the transgender guys, doing cervical pap screening is important, especially if they've used their vagina for sexual purposes, the higher risk of cervical cancer and abnormal pap smears should still be done, with the understanding that having a doctor look at their exposed genitalia can be a humiliating experience. So giving all that due sensitivity before doing the exam and finding out if they've ever had one before. And don't just say 'we're doing one today,' say 'I'd like to talk to you about the importance of having this exam done. If not today at some point in the future, and we can talk about it, and this is why it's important.'

33:13

Basic goals of hormonal therapy are really simple. This is not rocket science. Medical providers are often intimidated by the idea of giving hormones such as these, but if you've ever prescribed birth control pills, or Depo provera to prevent pregnancy, or any other form of hormonal contraception, trust me you've exposed patients to a lot more risk than you're acknowledging to yourself. And that this is probably a little bit better, because you're probably going to do a lot more safety screening and monitoring of labs than you would with somebody who might be taking oral contraception as an example. But for the basic goals, male to female, reduce masculinizing effects of their endogenous testosterone as early as possible. The earlier you can start in puberty, the better. Quite often, their puberty is finished and you're working against nature. But testosterone has ongoing effects in terms of body hair and musculature and things like that, so you want to reduce the masculinizing effects of that testosterone and do maximum feminization in the shortest period of time. Female to male, just the reverse, you want to reduce feminizing effects of their estrogen, their native estrogen, and maximize their masculinization in the shortest period of time. And obviously for both you want to avoid undesirable side effects.

34:52

Feminizing effects of estrogens are breast growth, redistribution of body fat to a female pattern. Right before coming here to clinic, I was talking to a transgender young man who's been on testosterone for about six months. And I told him, he was starting to look very, very masculine, and I called him dude just to emphasize that. But I did notice as I was saying it that some of his body fat around his hips and his butt are probably still more in a female pattern than a male pattern, but I think it's important to acknowledge someone's change. It can be very affirming for them to hear that from their doctor. So yeah, most of the changes with these hormones are reversible. Although breast enlargement will not

completely reverse after discontinuation of estrogen treatment, if somebody falls out of care or they have a lapse in insurance, the breasts won't go away but they will start to sag.

36:04

Masculinizing effects of testosterone. Probably the most common thing that we see that the patients just love is when they start growing facial hair, especially on teenage boys, when they start getting their pencil thin mustache. It's really a great thing to watch. And cessation of menses, one of the things that causes a huge amount of dysphoria for transgender men is menstruation. So once you start them on testosterone and their hormonal profile reverses from what it had been before, they will stop menstruating. And they'll also notice upper body strength and muscle mass and so on.

36:53

So, in 2015, just talking about gender reassignment surgery, it's becoming an increasing thing that patients that I take care of are able to get referrals for surgery since 2015 when New York State Medicaid began to cover medically necessary cross-sex hormone therapy and gender reassignment surgery. There is a process by which people need to go through in terms of getting certain letters, they need a letter from a medical provider, such as myself or yourselves. They need a mental health letter testifying to the fact that they have gender dysphoria, and this medically necessary surgery is indicated at this time. There are a couple of places, I won't name all of them. But Mount Sinai, NYU, and Montefiore are places where most of my patients go to get their surgical procedures. 15 year olds who say I want breast augmentation yesterday should at least be on hormones for a year, but usually the surgeons won't do surgery on any body unless they've been on hormones for at least a year and are at least the age of 18. I am leaving out an important point before people start on treatment, having discussions with them about fertility, if they wish to have biological children. I refer to it here in the surgery discussion, but it's something that somebody should be aware of prior to going on hormones as well. And so people might consider sperm banking and egg banking prior to starting on hormones.

38:49

This is all about the letters that people require. And I'm going to jump ahead. So what about HIV, I mentioned that I am an HIV specialist. Let's talk a little bit about HIV in the transgender population. And then we'll have, I believe we might be finished at that point, but we'll have time for Q&A. So HIV is definitely on its way down in New York City. You can see in particular among among men, that's cisgendered men, between 2014 and 2018. You can see the decreases most markedly in men, but also in cisgendered women.

39:28

But transgender people, the numbers are kind of low but constant across the age span. And we're going to talk about those low numbers as we go forward here. You can see that across these years that it's primarily transgender women, those are male to female individuals, people born male who identify as women who are getting infected with HIV. You can also see on the left, that we have a younger population who are getting infected with HIV. You'll hear talks about HIV for seniors and people over age 50, but it is in young people who are getting infected in the transgender female population. So you can see a disproportionate shift to the left with the age distribution.

40:34

Compared to the population as a whole, on the right, you can see in the 20 to 29 years of age group, that there's a higher proportion of those testing positive in the transgender group compared to the non transgender group. So again, compared to people who are not transgender, you're less likely to be older than if you are transgender. And I hope that point gets across with the graph here.

41:15

As well, what we're seeing in transgender women who are becoming infected with HIV, as we see with cisgendered men and cisgendered women, we see a disproportionate burden of HIV infection among both Black or Latina transgender women. So also cultural factors to consider in dealing with individuals who are transgender and HIV positive, it's important to be aware of that.

41:50

You can see where folks are being diagnosed, where they live, who are transgender and HIV, certain parts of Brooklyn, Queens, the Bronx looks fairly well covered. Higher so prevalence of HIV and transgender women.

42:11

And I'm going to come back to this issue of multiple epidemics at once. This is across New York City, I gave you my own statistics on these things, but across New York City as a whole among newly diagnosed transgender women, the proportions of those reporting history of substance use, incarceration, sex work, homelessness, and sexual abuse.

42:40

And a final point about HIV. So I have two red arrows. The graph on the left is all individuals in New York City who are HIV positive and what we call HIV care continuum, going from being identified as HIV

positive to becoming virally suppressed. So you can see among all individuals in New York City, we have roughly a 77% viral suppression rate. On the right, we see transgender women, you can see that the rate is somewhat lower, 70% are virally suppressed and that's probably because of difficulties remaining in care. People may not know their HIV status, and so on. But largely, I think it has a lot to do with maintenance in care and having transgender friendly and transgender competent care where they can get their HIV care all in one location.

43:50

It's just important if you're providing care to HIV positive transgender individuals, there's just a lot of information that you need to know. And from my perspective, being able to colocate all of that multidisciplinary care in one place is the way to go.

44:09

Stigma. Let me jump to the next slide. So there's probably an enhanced level of stigma among, I'm not going to read this whole slide, but we did a study in my clinic from 2012 to 2017. And we asked the participants all sorts of questions across many domains, but they would just skip answering the questions about HIV. They would answer all sorts of questions about domestic violence, substance use, street violence, being treated poorly by providers, they would answer all those questions. But when it came time to answering questions about HIV, I think that they just did not want to answer and they would skip the questions. I think that a take home message is that the level of stigma in transgender women around HIV is probably much greater than many other populations. So you need to be sensitized to that. And that's it.

45:21

Mark, I don't know if we need to promote this slide, but you see the CEI line? You guys clearly know that phone number since we have this lecture today sponsored by CEI, should I say anything else about it?

45:39

No, that was great. People can reach out to this number if they have questions related to HIV, PEP, or PrEP, and we will link you to our medical director if you have any of those questions.

45:49

And I apologize for running through a lot of slides quickly, but I wanted to save time for for questions. So we can open this up for questions. And I guess, Mark, you would be reading them?

46:06

Yes, yes. So if anyone has any questions, feel free, you can unmute yourself and ask the question verbally. Or if you would like to put it in the chat box, you can do that as well.

46:17

We had a request from our New York City clinic staff. If there is any pamphlets or materials like the CEI one that we could share with our team, we would be very much interested in that.

46:30

Sure yeah, I can absolutely pass those along to Wendy and she can make sure that they get distributed to everyone.

46:35

Thank you so much.

46:37

You're very welcome. So we do have a question here in the chat box. What is the frequency of performing rectal pap tests?

46:49

Yeah, that's a great question. I would if somebody is having receptive anal sex, I would recommend doing it once a year. I kind of use that standard of once a year largely because I see a lot of HIV patients, and so once a year is probably a reasonable standard. And while you're doing that, make sure to give HPV vaccine to your patients as well. Even if they've received vaccine, it's still important to perform anal pap smears. We tend to have the provider perform the pap smear. In one case, we have given the patient to swab and we got a decent result. If we're teaching them to do gonorrhea, chlamydia swabs, and self swab, it's reasonable to think that you might be able to do a self swab for a pap smear as well.

47:52

Do you perform the rectal pap with the same collection material?

47:56

I just use the cyto brush, not the spatula. And we use the same technique we use in men who have sex with men with performing the anal pap. I find compared to cervical paps, we get a lot of results back that say specimen inadequate. So if you get a result like that, don't be discouraged. It happens. It happens in my clinic, probably somewhere in the vicinity of half the time and you may have to repeat the test.

48:36

How do you recommend we work around the binary gender options in healthcare tools, for instance in lab requisition forms, hearing tests, etc?

48:46

Yeah, what I've had to do is, for instance, we have in our hospital registration system which is completely binary. And the insurance, you know how they're registered has to match their insurance for billing purposes. So we're able to add a notes field, an 'also known as' field to put in the name that they should be called by and add an area where it just is able to state that they're a transgender individual. That's really important because when someone walks in the door, to be able to see their name on the computer screen acknowledging who they are as a human being may guarantee that they'll come back again. And so we can address some of those health disparities. Once we get into note templates, what we've had to do in in my clinic, and these note templates aren't used universally throughout the hospital, we developed our own note templates specific for transgender individuals. I showed some questions from the transgender screening tool. And I realize that working with IT departments with making changes to EMRs can be a very timely process, so my advice would be get started early and you can make some simple changes right away. But in places where in my own hospital where you know, the banner across the top will have the wrong name and it's really disconcerting for the patient who sees it, when they see the other things that we have built into the EMR in terms of note templates specific to transgender care, they're very pleased with it. And it helps avoid mistakes in the future.

50:47

Thank you and Dr. Birnbaum, I had written down a quote that you shared. So if and when we do make a mistake, as clinicians, or do find something that labels an individual other than they choose to be identified. Something like 'I apologize, I misgendered you' or 'our system is binary and we are working to upgrade that.' Like to acknowledge in a way that you did make an error or that you do recognize that this is limited. Is that good advice?

51:25

Yes and I think it's also important, you know, I guess I'm talking to a largely a group of medical providers today, it's important to talk to your security, have trainings for your security guards and your registration clerks and phlebotomists, and so on. We had some bad incidents with our phlebotomy department, where they insist on yelling out the name of the person, what's on their insurance because they say that they're legally required to do and patients won't have their labs drawn down there anymore. So it adds work on at my end, where I'm drawing all the blood in the clinic.

52:10

So making sure the message is really spread to anybody that's involved in patient care.

52:15

Yes,

52:16

Thank you. We're doing our part by starting today. And we really, really appreciate your time and this very insightful lecture. Thank you so much.

52:26

Well, thank you for inviting me.

52:28

We also at CEI, we have pronoun buttons that we have available now that organizations can order. So I would definitely recommend those and then all of the providers can wear those, I think one thing that we're finding in general is that the more that we normalize declaring our pronouns, it helps to just make it a more safe space for for folks of all creeds.

52:53

Thank you. And Mark, we do have an ongoing conversation with EHE's human resource team to see if we can can get their support in in this type of initiative and we would be very interested in ordering some pronoun buttons. So we will follow up about that. Thank you.

53:10

Oh, we have one last minute question. What is Ze? I saw that on one of the slides. Ze is just another preferred pronoun that some people choose to go by as like a gender neutral pronoun.

53:21

Yeah, I would say it's easy to make mistakes with pronouns because he and she, you're so used to he and she and it's easy. I find personally, full disclosure here to refer to a transgender female as she from day one, as opposed to calling someone Ze or they. Sometimes, you just have to get used to pronouns and just really respect what the person's asking you to identify them as.

53:54

Great, well, thank you so much again, Dr. Birnbaum for presenting today.

[End]