UVM Project ECHO: Gender Affirming Care

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Didactic presentation is recorded. Registered participants will receive the link.

The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM

Project ECHO
University of Vermont

Session Agenda

- Welcome Participants and Presenters
- Objectives
- Didactic Presentation (20-30 min)
  - Q&A
- Case presentation(s)
  - Clarifying questions
  - Discussion
  - Recommendations
- Closing Announcements
  - Submission of new cases
  - Completion of evaluations

ECHO Model: All Teach, All Learn

Cohort-based learning on ZOOM

- Have your camera on as much as possible, especially when joining the meeting and during discussions
- Questions and comments are welcome – use the “raise hand” feature or put them in the chat
- This is not a webinar! Participation is key

Case-based learning

- 1-2 participant cases each session using provided template
- Contact Kathy Mariani to present a case

ECHO: Cohort-based learning

- Shared participant directory for additional networking
- Get to know others in the group
  - “Rename” your video
  - Write your name and organization into the chat
- Faculty presenters available for follow up questions

ECHO: Case-based learning

- Participants bring real world scenarios from their work
- Opportunity to receive input from peers and faculty
- Cases sometimes match the topic, but not necessary
- What makes a good case:
  - A complex situation where you would appreciate hearing new ideas

    Question for the group may be: After trying many of the first-line strategies without success, what other things could be tried?
  - A common situation that could be discussed from various perspectives

    The questions you pose could help you and others rethink assumptions or learn new strategies.

Series Objectives

Learning objectives for this ECHO series include the ability to:

- Describe healthcare barriers and challenges commonly faced by transgender individuals, from adolescence to older adulthood
- Identify language changes and strategies that clinics can use to provide supportive, inclusive, and nondiscriminatory care
- Discuss clinical guidelines for prescribing hormonal therapy and managing side effects for patients who are transgender and/or nonbinary

CMIE Disclosures

- University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.5 ***AMA Category 1 credit***™.
- UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to **1 Nursing Contact Hour**.
- Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to: **1.5 MOC points** in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program; It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM or ABP MOC credit.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

CMIE Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Mental Health and Trans/Gender Diverse Care

A Evan Eyler, MD, MPH
Professor of Psychiatry
Robert Larner MD College of Medicine at the University of Vermont

Objectives

- Be able to list and briefly describe at least 3 mental health concerns commonly seen in primary care practice with patients who are transgender or gender diverse (TGD).

- Be able to list at least 3 interventions that can help to reduce suicide risk among TGD persons.

Diversity in Clinical Practice

- This brief presentation will use case examples to foster discussion of TGD mental health care in primary care.
- AND -- Every patient is an individual. These cases are illustrative only and do not capture the diversity of the TGD populations, including intersectionality effects on mental health and the variety of cultural frameworks in which gender expression manifests.
- For example: Xiaoshi et al: Quality of life of transgender women from China and associated factors: A cross-sectional study. *J Sex Med* (2016) 13:977-987. https://pubmed.ncbi.nlm.nih.gov/27117528/

A Few Points - 1

- Gender difference is not evidence of psychiatric illness, nor is it protective from physical or mental illness. TGD persons often have the same mental health concerns as their cis-gender peers.
- TGD people have often experienced gender-based discrimination or abuse and may have sequelae of these experiences in adulthood, both vulnerability and **resilience**.
- First response to suicide risk presentations, and evaluation of mood disorders, are important aspects of the primary care of TGD and cis-gender persons.

A Few Points - 2

- Coming out, starting medical treatment for gender affirmation, and other turning points are often times of heightened vulnerability.
- Social connectedness and support are important deterrents to suicide, especially for youth and older adults.
- Emotional lability sometimes warrants a check of serum hormone levels, though many mood disorders are minimally influenced by estrogen or testosterone (E/T) status.
  - [Use of estrogen and testosterone for treatment of gender dysphoria is still considered off-label.]

Common Clinical Concerns

- Gender evolution/transition/coming out: whether, when, sometimes how
- Transition/adaptation concerns as they arise
- Depression, anxiety, substance use disorders, trauma survivorship and sequelae
- More serious psychiatric illness, including increasing suicide risk or co-occurring illnesses
- Facilitation and coordination of gender affirming care, referrals and documentation
- Advocacy

Gender evolution/transition/coming out

Cases 1&2: Coming Out to Oneself

- **Self-discovery of trans/GD identity may be a gradual process, a matter of fact ("I've always known") or a sudden revelation that may not be welcome.**
- Bryan is a 25 year-old student who calls the clinic at the end of the day, quite distressed. He blurts out to his PA that Christmas is coming, he can't stand the idea of getting anymore "guy gifts" and he doesn't really want to die but can't keep going this way.
- Billy is a 19 year-old retail worker who is seeking transmasculine hormonal care. The realization that he is trans came suddenly and forcefully, similar to "her" coming out as a lesbian 6 years previously.

Case 3: Gradual self-discovery/coming out

- Morgan is a 34 year-old office worker who has been seeking breast reduction surgery. This has been a long process. In the course of her on-line research and talking with her therapist, she concludes that a non-binary identity accurately describes who she is and that she really wants her chest to be flat.

Case 4: Coming Out in the Family

- Frank is a 52 year-old small business owner who presents for follow up regarding HTN/HLD. He abruptly mentions that his son has called to say that he will not be re-enlisting in the Marines and will begin taking estrogen, as part of gender transition, after the current enlistment is up. Frank asks, What is this about? He was always so masculine! Why can't he just be gay?

- **Families are often a key source of support for TGD persons, and families often need support.**

Transition/Adaptation Concerns

Case 5: Transition Concerns, Beyond E&T

- Anne (birth name Andrew) is a 46 year-old married physics professor at a small university who transitioned gender last year. She presents for follow up re: hormonal care.
- What question does she have for her family physician today?

- **Changes in gender expression often bring new gendered experiences, new opportunities and new experiences of discrimination.**

Depression and Other Aspects of Primary Care Psychiatry

Case 6: Depression is a complex illness

- Chris is a 32 year-old IT worker who started testosterone use 2 years ago. Expected development of masculine physical development has occurred and lab values are appropriate. He is concerned that the dose or formulation of testosterone need adjusting because his libido has not increased all that much since starting testosterone and he is still depressed.
- **Patients and families often need education about what hormonal medications do and don't do, including with regard to mood symptoms.**

Depression: A Few Important Questions

- Duration of symptoms, trajectory, treatments tried?
- Recent or past evidence of mood elevation?
- Recent or past psychotic symptoms?
- What is the contribution of substance use?
- What is the contribution or trauma, and/or longstanding emotional dysregulation? (“mood swings”)
- Medication/hormone effects? (Over-rated?)
  - https://www.aafp.org/pubs/afp/issues/2018/1015/p508.html

Important Past History

- **Previous suicide attempts or near attempts**
- *How close to suicide have you come, ever?*
- Past mental health care and response(s)
  - Hospitalizations
  - ED use
  - Substance use disorder treatment or sense that treatment should have been sought
  - Psychotherapy or program participation
  - Medications

Family and Social Histories

- Family history of depression, bipolar, substance use disorders, suicide
- History re: gender identity/expression
- Trauma history: general questions; don't press for details. Safety now.
- Social support, partner(s), education, occupation, means of support
- Is religion or philosophy important?
- What is the most important part of your life? What keeps you going?
- Firearm ownership/access
- Substance use
- ****Typical day. Behavioral Activation Therapy may be needed as a first step.** https://aims.uw.edu/evidence-based-behavioral-interventions-primary-care

Case 7: Treatment Resistant Depression

- Wendy is a 42 year-old manufacturing worker who presents for follow up re: depression and anxiety.
- She has had several medication trials and isn't getting better.
- No recent change in estrogen/spironolactone or changes to her medical history.
- She is on leave from work and has stopped seeing her therapist.

Case 8: Treatment Resistant Depression

- Phil is a 21 year-old student who has been treated for depression through the student health service but has not been getting better, despite robust trials of two first-line anti-depressant medications and meeting regularly with a therapist.
- Treatment with testosterone has been optimized. Around the time of spring mid-terms, he feels much better for a short period of time, and gets a lot done.

Cases 9&10: Hormone Checks

- Rachel is a 43 year-old computer analyst who recently started treatment with estrogen. She finds herself crying frequently, sentimentally, and with little reason.
- Bart is a 25 year-old home security worker who punches a stranger who was “hassling” him, shortly after starting testosterone Rx.

- Both had been treated for depression, with partial success.
- What is the E/T level? How important is that?

Complex Cases and Suicide Risk

Case 11: Trans Care/Palliative Care

- Frieda is a 77 year-old transwoman who transitioned 42 years ago. Her family rejected her at that time. She is now facing a terminal illness with little social support.
- Her home has been her “castle of safety” and she may soon need to leave it. Palliative care has been discussed.
- She is worried about practical aspects of dependent care (F/M unit, ERT, Foley catheter use); becoming unable to advocate for herself – and possibly dying alone and being “buried as a man.”

Case 12: Stuck and Despairing

- Stephanie is a 58 year-old business exec, living publicly as Steve. She has always felt that she was a woman inside, but “did the manly-man thing,” including a masculine profession, conservativism, marriage, children.
- She is quite depressed and alcohol use is escalating. She feels that she can not transition and can’t stand continuing to live as a man.

Case 13: Safety First

- Rick is a 21 year-old university student, staying at his parents home for the winter holidays.
- He asks for antidepressant medication and an increase in testosterone dose. Exploration reveals that he is profoundly depressed and has strong thoughts of suicide.
- He notes that he is starting to feel like people are whispering about him, though he thinks this is unlikely.
- He started treatment with testosterone during the last semester and just came out to his parents.

TGD Suicide (USTS, 2015; ustranssurvey.org)

- n = 27, 715
- 40% had attempted suicide at least once (vs 4.6% US population).
- 7% had attempted suicide in past year (vs 0.6%).
- 71% of those who had attempted suicide did so > once; 46% > 2 attempts; 21% > 4 attempts.
- 82% had seriously considered suicide.
  - Lower education, disabled
  - Victimized, low family support, homeless, having done sex work

- **Data has been collected for the 2022 update – stay tuned**

TGD Suicide (USTS, 2015; ustranssurvey.org)

- M (45%) > F (40%) > NB (39%).
- Very similar pattern re: racial identity (vs 2011); POC higher, but lowest rate still very high (37%).
- Younger than cis peers (older adults already lost?)
- Age at first attempt [new question]:
  - < 14 yo: 34%; **14-17 yo: 39%**
  - 18-24 yo: 20%; > 24 yo: 8%
- Age at most recent attempt [new question]:
  - < 13 yo: 6%; 14-17 yo: 26%
  - **18-24 yo: 41%;** > 24 yo: 27%

Trans US Military Veterans

- Trans adults serve in the US military at 2-3X the rate of general adult population (when permitted).
- Trans vets are more likely to die by suicide.
  - Twice the rate of cis-veteran peers
  - 5.85 times the rate of the general US population
  - More work needed re: intersectionality.
  - Racial identity, SOGI, etc: 24.1% live in rural areas.
- Risk may be reduced by connections to the veteran community, other means of reducing minority stress.

- Tucker RP. Suicide in transgender veterans: prevalence, prevention, and implications for current policy. *Perspec Psychol Sci*, 2019. 14(3) 452-468. https://journals-sagepub-com.ezproxy.uvm.edu/doi/full/10.1177/1745691618812680
- https://www.defense.gov/News/Releases/Release/Article/2557220/dod-announces-policy-updates-for-transgender-military-service/

Safety First

- Ask the question: How strong are any thoughts of suicide you may be having? Intent, plan(s)?
  - Can use an instrument but don't rely on it.
  - Don't rely on suicide contracts.
- Collateral information
- Deterrents: Why not? What keeps you going?
- Access to means, especially handguns
- Presence of psychotic symptoms, especially command hallucinations; severe anxiety
- Substance use
- Past attempts or near attempts
- Family history or recent exposure to suicide
- Safety first: Crisis eval? Emergency dept?
- https://psychiatryonline.org/doi/epdf/10.1176/appi.books.9780890426760 [See p. 18 for more info]

Intervention and Advocacy

Reducing Suicide Risk: “Intervenable Factors”

- Respondent-driven sampling survey, n = 380
- Ontario trans people, age 16+
- In past year:
  - 35.1% had seriously considered suicide
  - 11.2% had attempted suicide
- Fairly large effect sizes were observed re: a number of “intervenable factors.”

- Bauer GR et al. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. BMC Public Health (2015) 15:525. https://pubmed.ncbi.nlm.nih.gov/26032733/

Reducing Suicide Risk: “Intervenable Factors”

- Large relative and absolute reductions in suicide risk:
- Social support
- Reduced transphobia
- Having any personal documents changed to appropriate sex designation
- Completing a medical transition via HRT/surg (when needed)
- Reduction in ideation:
  - Parental support for the gender identity
  - Lower self-reported transphobia

Potential Supports and Interventions

- Public policy/laws re: bullying and discrimination
- Social: Bathroom access, promoting stable housing
- School: GSA's, prevention of bullying, fair policies
- Family: Support for family, support for TGD person
- Physician:
  - Facilitate entry into GAC and MH care as needed
  - Identify gender-based/anti-trans violence >> services
  - Foster social inclusion
  - General suicide prevention and wellness.
    - https://www.psychiatrist.com/pcc/depression/suicide/suicide-among-transgender-and-gender-nonconforming-people/

Trans and gender diverse people matter.

We can make a difference.

Additional Resources

- WPATH Standards of Care, v. 8: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
- The Endocrine Society Clinical Practice Guideline: https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence

Thoughts and Questions?

Case Presentation

DO <u>NOT</u> INCLUDE:

Names, Address, DOB, Phone/Fax #, Email address, Social Security #, Medical Record #

Consider the level of detail necessary. Go with less when possible.

The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.

Case Presentation

Bringing Knowledge to Action through interactive, case-based discussions

Participant presents the case and poses the question(s) for the group

↓

Clarifying questions about the case from group to case presenter

↓

Ideas, suggestions, recommendations from participants

↓

Ideas, suggestions, recommendations from ECHO faculty team

↓

Full group discussion

↓

Summary and wrap-up by facilitator

Case

2023 PROGRAM SCHEDULE

SESSIONS ARE ON WEDNESDAYS FROM 12:00 PM-1:30 PM		
DATES	**SESSION**	**DIDACTIC TOPICS (IN ADDITION TO CASE REVIEW)**
January 11	TeleECHO Session #1	Gender Affirming Care and Mental Health (Evan Eyler, MD)
February 8	TeleECHO Session #2	Creating Inclusive and Gender Affirming Clinic Spaces (Anja Jokela, MD and Kell Arbor)
March 8	TeleECHO Session #3	Masculinizing Affirmation: Medical, Surgical and Social (Eric Klett, MD)
April 12	TeleECHO Session #4	Gender Affirming Care Across the Lifespan (Kathy Mariani, MD)
May 10	TeleECHO Session #5	Feminizing Affirmation: Medical, Surgical and Social (Rachel Inker, MD)
June 14	TeleECHO Session #6	Gender Affirming Care for the Adolescent (Erica Gibson, MD)

Closing Announcements

- Confirm case presenter(s) for next session
- Slides are posted at www.vtahec.org
- Recording of didactic portion will be sent by email to the full cohort
  - For the use of registered participants only
- Please complete evaluation survey after each session
- CE information and QR Code will be sent once evaluation is received
- Please contact us with any questions, concerns, or suggestions:
  - Katherine.Mariani@uvmhealth.org
  - Patti.Smith-Urie@uvm.edu