

# Increasing Access in Recuperative Care: Foundations of Health Equity Practices for Supporting LGBTQIA+ Clients

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2024

CALIFORNIA  
**Recuperative Care**  
SYMPOSIUM

SEPTEMBER 12-13 ★ SACRAMENTO

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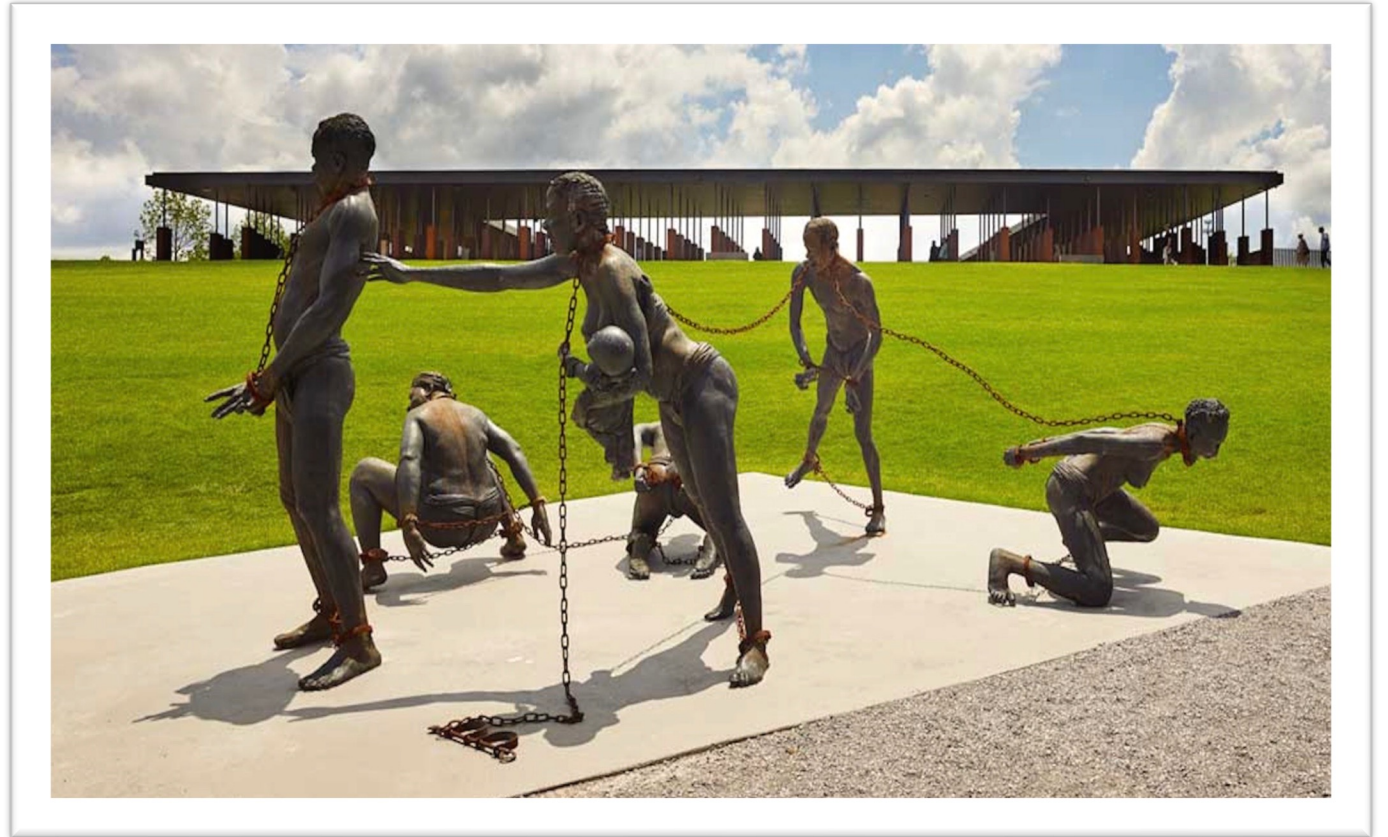
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# Land & Labor Acknowledgement



Go to [native-land.ca](http://native-land.ca) to find out who are the original stewards of the lands you occupy

# What Does Health Equity Mean?

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- Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being. (World Health Organization)
- Health equity means that everyone has a fair and just opportunity to be as healthy as possible at every stage of the human life cycle. This requires removing obstacles to health such as racism, discrimination, poverty, incarceration, and elder abuse and abandonment while promoting easy and local access to safe housing, clean drinking water, good jobs, quality educational systems, fresh foods, and the natural environment. Health care is a fundamental human right. Achieving the highest level of health, wellness & well-being for all people is our goal and north star. (PCA R & E Subcommittee)

# Health Equity are Actions that Requires:

A board approach both internally & externally, this is not one size fits all work.

Being committed to systemic access, well-being & HEALTH CARE AS A HUMAN RIGHT! And access should not be limited due to someone else's personal belief.

**EQUITY**

Development to be done in partnership with those who are experiencing said inequities.

Us to look at equity for our staff as well as our patients.

# Health Equity are Actions that Requires:

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We look at our intent while acknowledging & addressing our impact & the historically legacy that has led to the challenges we encounter daily as staff & with patients.

We develop our programs & services with knowledge that what we do in the clinic only accounts for 20% of a person's well-being.

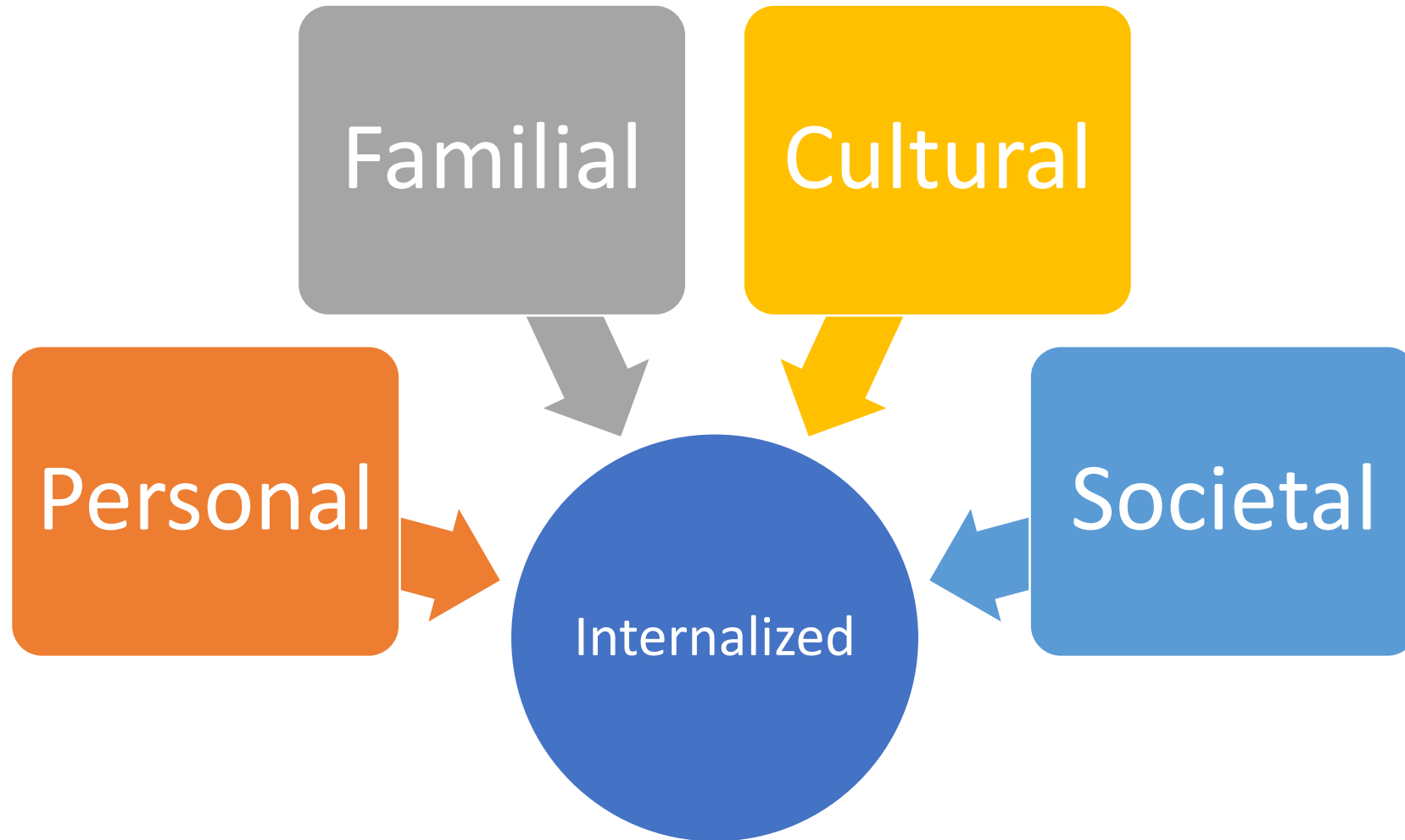
## EQUITY

Addressing roots caused of inequities, otherwise we are simply applying a band-aid to a festering wound

We intentionally partner with patients & communities to build collaborations to resource external programming which accounts for the other 80% of a person's well-being.

# The Narratives We Carry....

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Interpersonal Racism & Bias

Internalized Racism & Bias

Institutional Racism & Bias

Structural Racism & Bias

Medical System & Science  
Legal System & Military  
Education System  
Arts, Literature & History  
Social & Mass Media  
Politics & Religion  
Land Rights & Housing

Systemic Racism & Bias



# Health Equity are Actions & Practices

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## Intentionally Addressing Bias

- What bias do I hold for the patient populations we are called to serve?
- What stereotypes do I impose onto these patient populations?
- Do I hold bias against best practice for the patient populations we serve?

## Authentic & Transparent Self Reflection

- What narratives are being centered in our policies & practices
- When it comes to patient's needs where is there dissonance or gaps?
- How are you engaging staff of all levels & patient's to be active members of the care team.



# Health Equity are Actions & Practices

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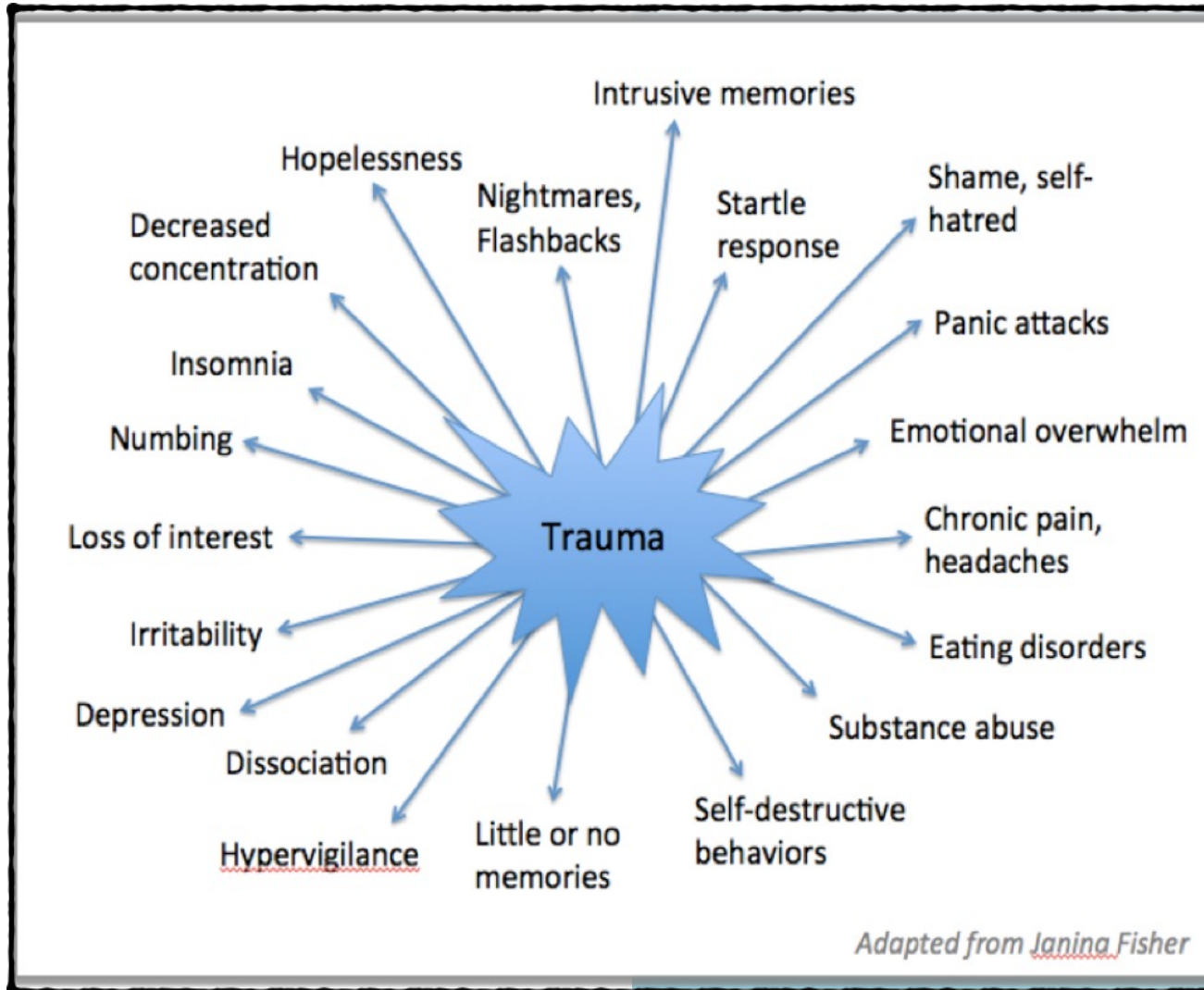
## Trauma Responsive Care

- How are we incorporating the fact that trauma influences how both staff & patient's show up, engage & respond
- How are we adapting the care provide to incorporate the patient needs based on their lived experiences & social drivers of health.
- How are we demonstrating to patients are sites are mentally, emotionally & physically safe space.

## Utilize Intersectionality in Program & Service Development

- **Intersectionality** is the overlapping or intersecting social identities and related systems of oppression, domination, or multiple forms of discrimination (such as racism, sexism, ableism, homophobia, etc.).
- Our identities don't exist in a silo
- How are we asking patients to choose which marginalized identity to prioritize when seeking service

# Manifestations of Trauma



PTSD	Complex PTSD
one or few traumas	chronic inescapable traumas
flashbacks	flashbacks
exaggerated startle reflex	no filter, easily overwhelmed
avoidance of things that trigger or evoke or suggest trauma memory	social isolation avoidance of relationships
nightmares about trauma	night terrors and chronic insomnia
some dissociation, may include Dissociative Identity Disorder	includes fragmented sense of self and Dissociative Identity Disorder
hypervigilance	hypervigilance, some ideas of reference, preoccupation with abuser
anxiety and depression	severe alterations in affect regulation

# Complex Trauma Informed Reframe

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As a result of complex trauma individuals may experience:

**Affect Dysregulation:** problems recognizing, shifting, communicating, and tolerating strong feelings and emotions

**Attentional Dysregulation:** difficulty directing attention and sustaining concentration on present-focused, goal-directed activities and tasks

**Negative Self-Image:** chronic struggles with low self-esteem, distorted body-image, lack of self-worth, self-blame, and self-loathing

**Impulsivity:** difficulty controlling strong urges to engage in risky and potentially harmful or self-destructive actions and behaviors

**Behavioral Dysregulation:** aggression, self-harm, agitation, repetitive rocking, sleep disturbances



# Health Equity are Actions & Practices

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## Survey: LGBTQ+ trust in healthcare

Listening to what our LGBTQ+ respondents have to say tells us there's work to be done:

- 66% of people who identify as LGBTQ+ have had their trust damaged by negative healthcare experiences (69% of people who identify as transgender or non-binary)
- 22-point trust gap between people who identify as both LGBTQ+ and disabled, compared to those who are from neither group
- 25-point trust gap between people who are both LGBTQ+ and from ethnic minority backgrounds, compared to those who are not
- Respondents who self-identified as transgender, non-binary, and 'other' said the two greatest factors behind their negative experiences were their gender (49% compared with 25% for our total sample) and sexual orientation (41% compared with 21%)

# General overview: equitable access in MR

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- Function of conference
- What does it mean for a program to be accessible?
- How does recuperative care tie into greater equity work

# What is Gender-Affirming Care?

## Gender Affirming Care

### Gender Care for the Primary Care Pediatrician

**Child Developmental Framework:**  
Gender identity formation is part of normal child development. Pediatricians should ask all kids at developmental nodal points about their gender as part of anticipatory guidance & screening.

**Using Affirming Language:**  
Start by asking any patient how they identify. Their terms, identifications, & descriptions should guide the language providers use. Use of chosen name in more contexts (ie home) is protective against depression.

### Modalities of Gender Affirmation

- Legal**  
Can include updating
  - Birth certificate
  - Social Security Card
  - Medical record
  - Driver's license/state or city ID
- Social**  
Can include changing
  - Pronouns
  - Name
  - Clothing/style
  - Gender expression
- Medical**  
Commonly used:
  - GnRH agonists
  - Estradiol
  - Testosterone
  - Finasteride
  - Spironolactone
  - Birth control
- Surgical**  
Can include
  - Chest/breast reconstruction, augmentation, removal
  - Hysterectomy, orchiectomy
  - Vaginoplasty, Phalloplasty
  - Facial feminization

Remember: all different kinds of affirmation are completely up to the patient, & providers should support patients in making the changes they want to without making any assumptions. Gender affirmation should be **Patient-Centered Consent-Based Care**.

**Take home points**

- Gender care is primary care!
- Trauma informed care is essential.
- Kids who are safe & loved at home do well.

**References:**

1. Raymond-Kolker R, Forcier M, Chiu C, Berk J. "Gender Affirming Care: Gender Care for the Primary Care Pediatrician." The Cribscribers Pediatric Podcast. <https://www.thecribscribers.com/> April 2021.

# Health and Housing Disparities

THE REPORT OF THE  
**2015** U.S.  
**TRANSGENDER**  
**SURVEY**

**30%**

of respondents to the 2015 U.S. Transgender Survey have experienced homelessness in their lives.

Gender minorities are more likely to experience unsheltered homelessness.

*Seven out of ten (70%) respondents who stayed at a shelter in the past year faced some form of mistreatment, such as being forced out, harassed, or attacked because of being transgender.*

Unsheltered rate by gender, 2018

Cisgender Adults

**48%** unsheltered


Transgender Adults

**56%** unsheltered

Gender Non-Binary Adults


**82%** unsheltered

NAEH analysis of U.S. Department of Housing and Urban Development 2018 Point-in-Time Count data

A large, semi-transparent rainbow flag is positioned in the background, waving. A dark blue horizontal bar runs across the middle of the image, partially overlapping the flag. In the top left corner, there is a dark blue rounded square containing white text.

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INSTITUTE  
*for*  
MEDICAL  
RESPITE  
CARE

## Gender-Affirming Medical Respite: Challenges and Promising Practices

A dark green rounded square logo with white text.

NATIONAL  
HEALTH CARE  
*for the*  
HOMELESS  
COUNCIL

The National Institute for Medical Respite Care is a special initiative of the National Health Care for the Homeless Council.



# Challenges

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Trans and gender-diverse clients face a higher risk of targeted harassment and violence from other MRC program clients.

Staff comfort and competency to provide gender-affirming services varies.

There are barriers to pre/post operative GAC surgical stays in part due to MRC programs high utilization and need to prioritize based on acuity

# Promising Practices

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1. Integrate trans-competency trainings into staff onboarding and continuing education.
2. Establish referral pathways with community organizations and 2sLGBTQIA+ health centers.
3. Prioritize client choice and autonomy when considering room assignments in gendered residential spaces.
4. Identify a staff champion to advance gender-affirming efforts and secure leadership buy-in.
5. Establish collective agreements for all staff and clients that includes anti-gender-discrimination policies.
6. Prioritize community over isolation: establish trans- and gender-diverse support groups and community events.

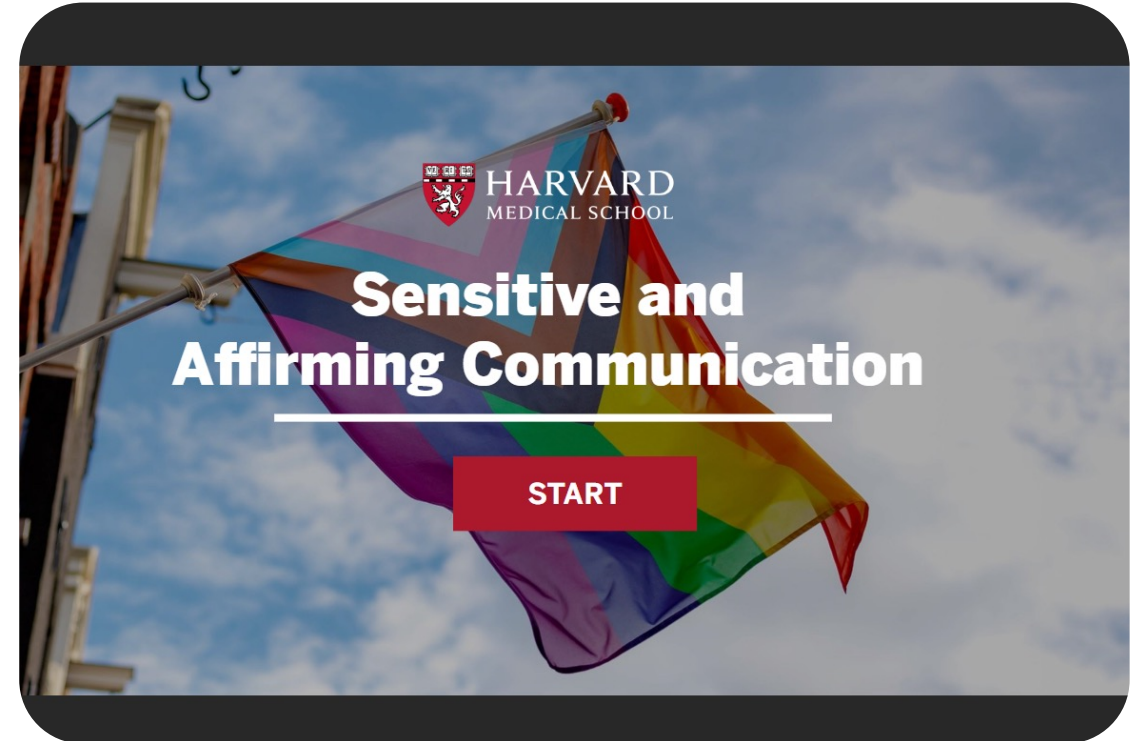
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Have questions? Email us!

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Kelli Klein: [kklein@nhchc.org](mailto:kklein@nhchc.org)



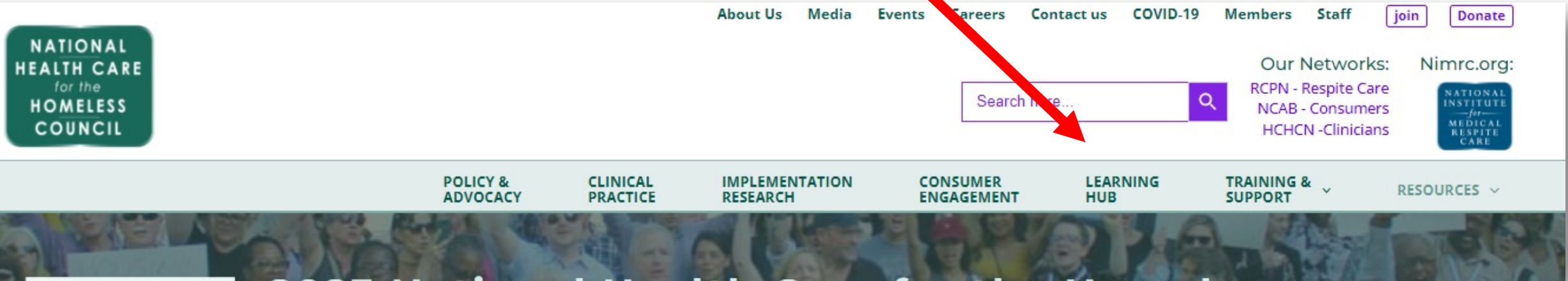
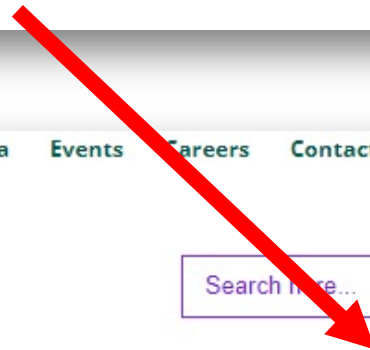
# Promising Practices



HRSA Funded

## Foundations of LGBTQIA+ Health Care and Homelessness: Terminology, Concepts, and Best Practices

This 90-minute webinar will provide participants with an introduction to foundational terminology and concepts related to LGBTQIA+ identity and experience of homelessness with a focus on LGBTQIA+ health care. Participants will learn about healthcare disparities and applicable clinical practices that participants can integrate into their own contexts.



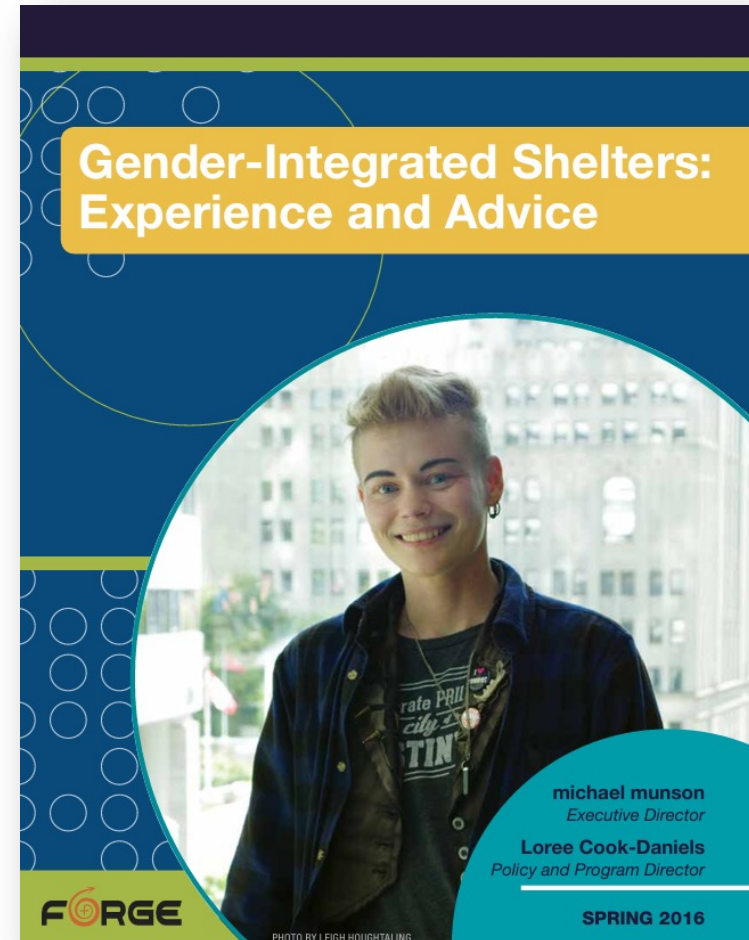
# Promising Practices

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# Promising Practices

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# San Francisco Medical Respite

Neal Sheran, MD

Medical Director

Medical Respite & Sobering Center

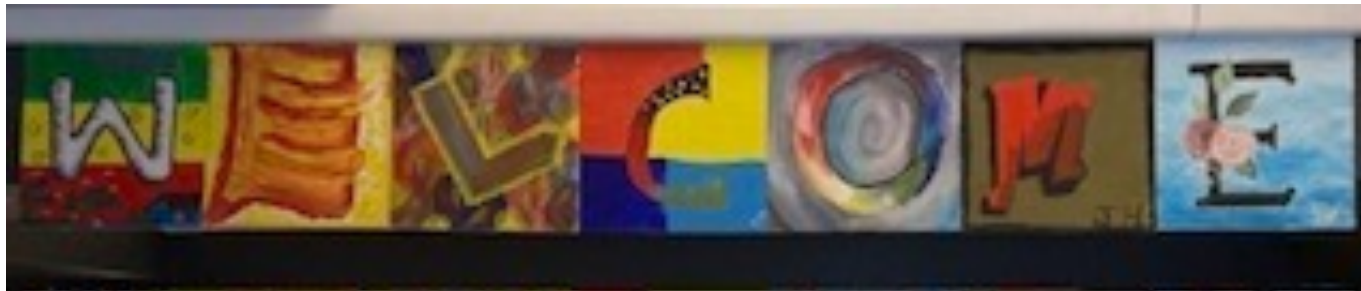
San Francisco Department of Public Health

Carli Fullerton, RN, BSN

Nurse Manager

Medical Respite & Sobering Center

San Francisco Department of Public Health



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# San Francisco Medical Respite

- SFDPH program in partnership with Community Forward SF (CBO)
- Opened in 2007 at 45 beds, expanded to 75 beds in 2018 –  
congregate sleeping arrangements (dorms and some 2-3 bedrooms on  
3<sup>rd</sup> floor).
- Provides Post-acute recuperative care for People Experiencing  
Homelessness who are too sick or frail to be on the streets or in the  
shelters of San Francisco



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# San Francisco Medical Respite

- Clients Referred through SF Hospitals and through Community
- Average Length of stay is 2-6 months



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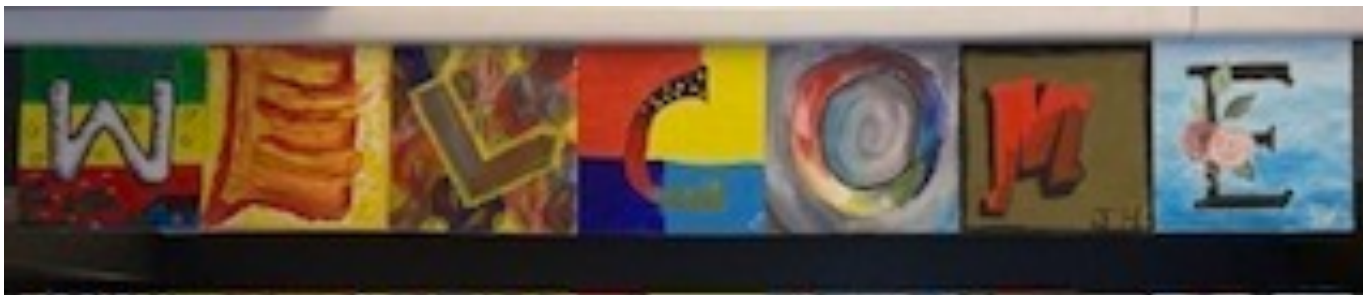


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# Gender Affirming Care: Physical Space

- Floors are gendered:
  - 4 male dorms on first floor
  - 7 rooms for females on third floor
- It is largely a non-congregate facility
  - Benefits are overdose prevention, more support for people on insulin or with a seizure disorder to call for help
  - Challenges in privacy



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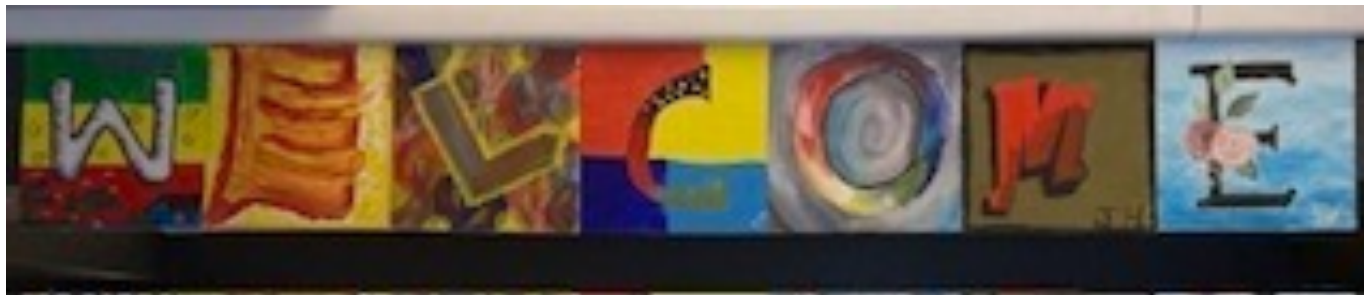


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# Gender Affirming Care: Physical Space

- Trans and gender diverse clients are given choice of what floor they feel most comfortable on but are not isolated from the population
- We have one private room that is generally reserved for post operative recovery of gender affirming surgeries



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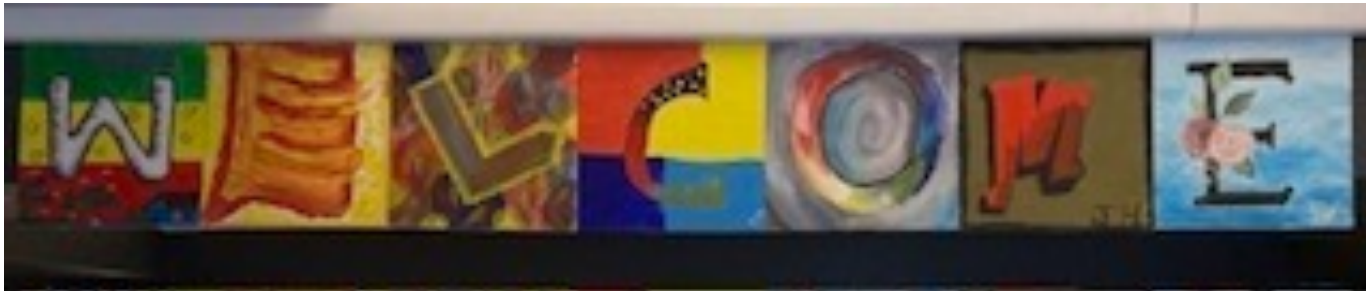


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# Gender Affirming Care: Training & Culture

- Regular staff training on gender affirming care
- Working with CBO shelter staff and medical staff
- Attention to proper pronouns including on the signout
- Education about Intersection of poverty and homelessness with gender affirmation
- Two staff meetings a week (opportunity to explore staff bias and improve trauma informed care)



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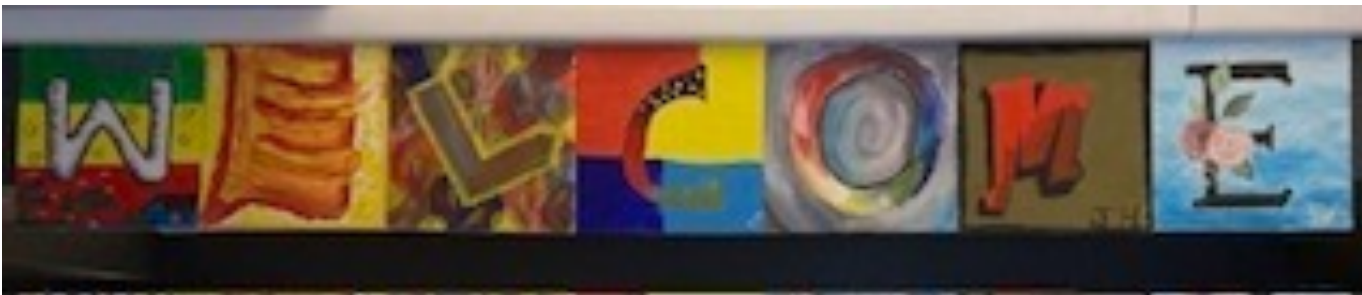
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# Gender Affirming Care: Services

- Discharge planning with awareness of shelters/navigation centers and services that serve trans and gender diverse clients
- Help with ID and other benefits
- Provide medical gender affirming care and refer to clinics that can provide long term care on discharge



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# Gender Affirming Care: Services

- Post operative recovery for gender affirming surgeries
- Collaboration with gender health services (tours to providers serving trans and gender diverse clients)



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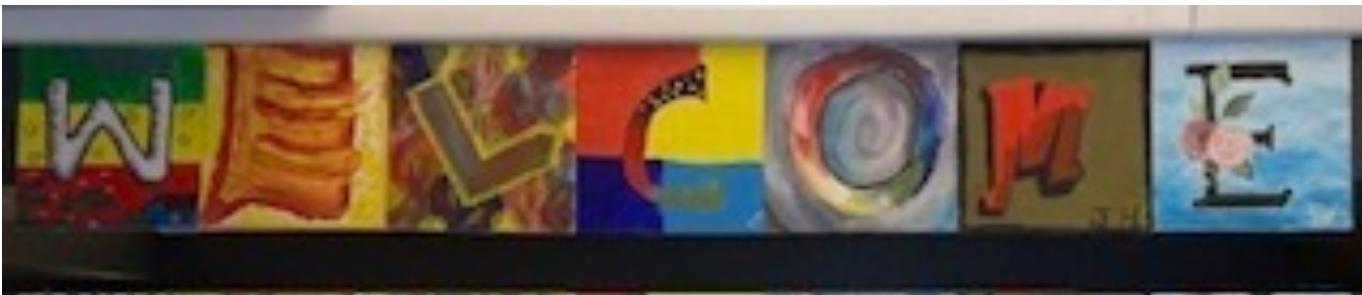


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# Gender Affirming Care: Conflicts

- General standards for common client agreement
- Addressing bias: Staff education
- Trauma informed care: Client education

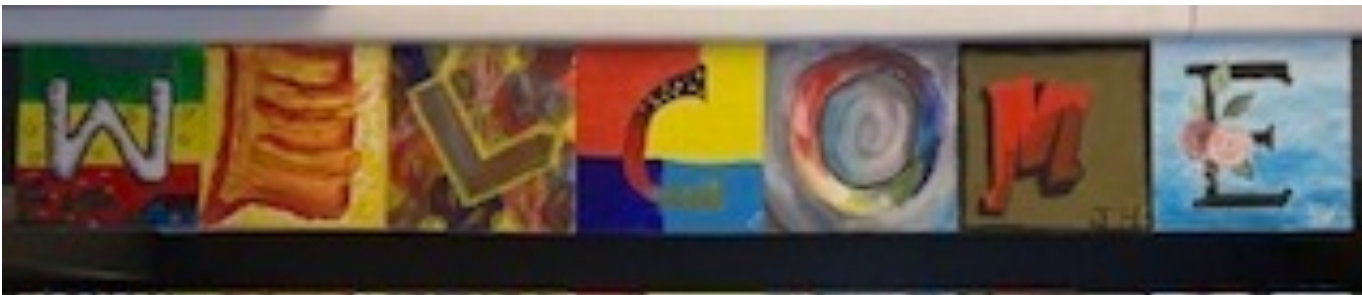


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# Case Study

Alice is a 22-year-old trans woman with type 1 diabetes and methamphetamine use disorder. She was referred to medical respite from the hospital after recovering from diabetic ketoacidosis. She has struggled to get to the DMV to secure an ID and has had trouble securing CAAP benefits. Her blood sugars vary from high to low and she has challenges in eating meals regularly. She has been unable to purchase make-up or the hair piece she likes due to lack of funds. Alice stays on the third floor. A staff refers to Alice with he/him pronouns. Alice becomes upset and non-redirectable. She begins to use threatening language. what do you do?



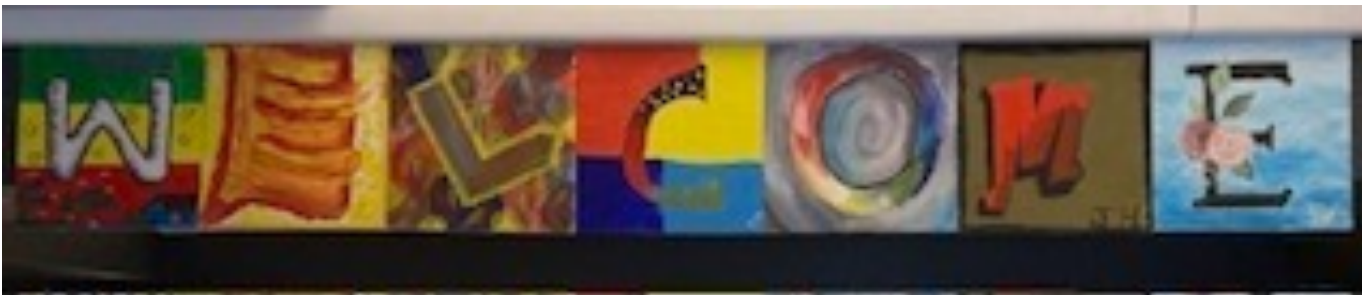
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# Case Study

"You hear raised voices on the third floor. Alice and her roommate are exchanging words. You hear her roommate say as she is wheeling away "I shouldn't have to live with this."

How do you intervene and what more information do you want to know?"



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# Gender Affirming Care in Medical Respite Learning Collaborative

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- Gender-Inclusive Congregate Care Fundamentals: Sept. 18th, 1:00-2:30pm CT
- Policies, Procedures, and Documentation: Oct. 16th, 1:00-2:30pm CT
- Workforce Development: Nov. 20th, 1:00-2:30pm CT
- Community Partnerships and Referrals: Dec. 18th, 1:00-2:30pm CT

*Join us!*



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**Questions?**

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