CME Accreditation

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Providence SWEDISH

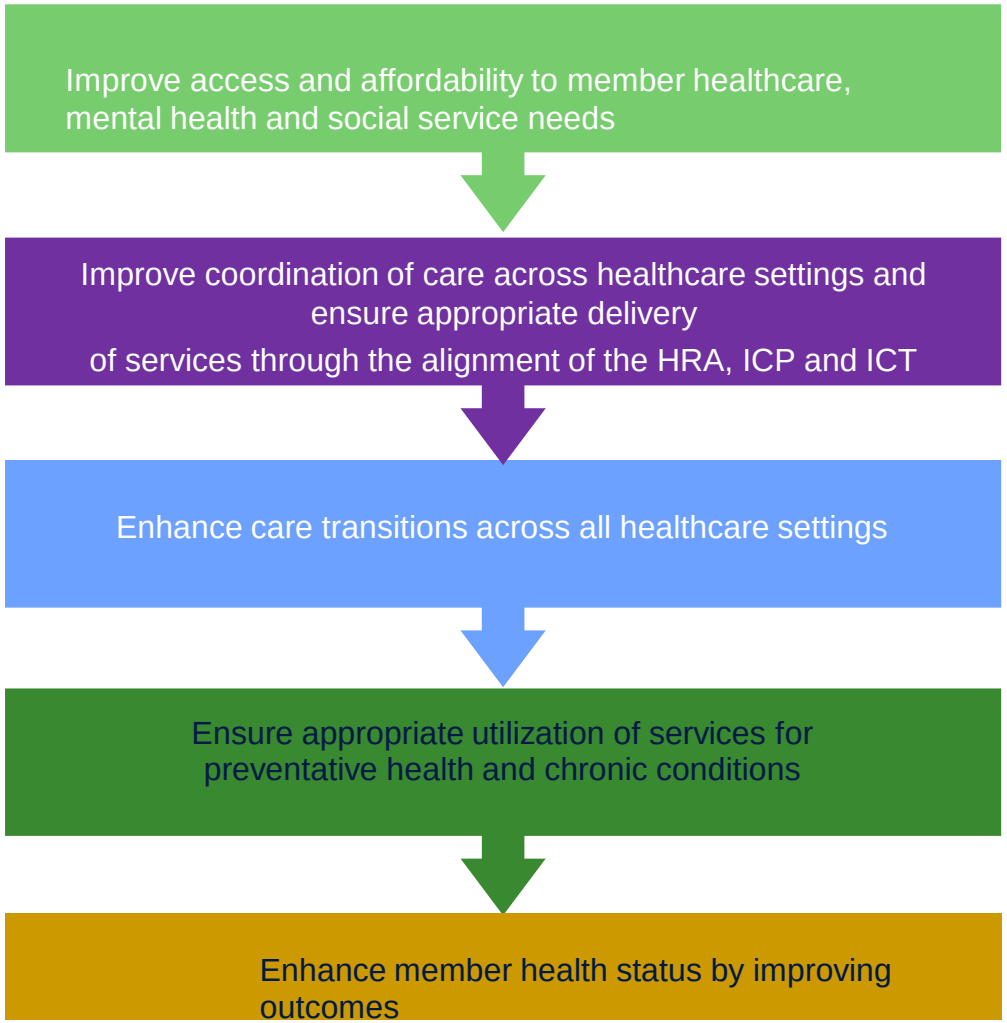
Providence

Annual Special Needs Plan (SNP) Model of Care Training

Ambulatory Care Management

2024

Special Needs Plan: Goals



Special Needs Plan: MOC

- Model of Care (MOC): CMS requires SNP Plans to develop a MOC that describes their approach to caring for their target population. The SNP MOC is a working framework on how the SNP proposes to coordinate the care of the SNP enrollees.
- Required Training: CMS requires all employed and contracted staff, who provide direct and indirect care coordination services to SNP members, to complete initial SNP MOC training and annually thereafter. Delegates this requirement to each medical group to provide initial and annual training for all employed and contracted staff and maintain the documentation of that training.

Types and Eligibility

Medicare Advantage Special Needs Plans (SNPs)

Chronic Special Needs Plan (C-SNP)

- **Eligibility Verification: within 30 days post enrollment**
  - Balance Plan: DM
  - Heart First Plan: CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
  - Strive Plan: DM, CHF, Arrhythmia, CAD, PVD, Chronic Venous Thromboembolic Disorder
  - VillageHealth Plan: ESRD

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP/D-SNP)

- **Eligibility Verification: Monthly**
  - Connections Plan
  - Connections at Home Plan
  - Designed for members who have both Medicare Part A and Part B, Full Medicaid benefits and FIDE SNP

Institutional Special Needs Plan (I-SNP)

- **Eligibility Verification: Annually**
  - Embrace Plan
  - Healthy at Home Plan
  - Meet state criteria for Nursing Facility Level of Care (NFLOC)

D-SNP Focus: Connections & Connections at Home

Connections:

Designed for people who have both Medicare and Medi-Cal

Including Medicare benefits, all Medi-Cal benefits, plus drug coverage and extra benefits like transportation, dental, vision coverage, acupuncture, hearing and more.

Connections at Home:

Designed for people who have both Medicare and Medi-Cal, and meet the State of California criteria for nursing facility level of care and live in their own home or nursing facility

As the only FIDE SNP in California, SCAN provides and administers all the Medicare benefits, all Medi-Cal benefits, drug coverage, including Long Term Services and Supports (LTSS) in designated counties (below).

California - LA, RV, SB, SD

Only FIDE SNP in CA

Connections at Home: LTSS Qualifying Criteria

Criteria:

- Chronic medical conditions that affect member's daily functioning
- Activity of Daily Living (ADL) deficits (requires physical assistance with at least 1 ADL)
- Skilled need- requires intermittent or constant nursing monitoring of health conditions
- Live in the service area (LA, Riverside, San Bernardino & San Diego)
- Members are assessed every year to ensure that they continue to qualify to receive services.

Services include:

- Care coordination
- Personal Care and light homemaking
- Travel Escort for medical appointments
- Home delivered meals
- Incontinence and hygiene supplies
- Bathroom DME
- Nutritional supplements (Rx required, not as sole source of nutrition)

For More Information:

- If you have a member who may qualify for LTSS, please contact us via Member Services: 800-559-3500, or our LTSS Call Center: 800-887-8695.

D-SNP New Requirements

Alzheimer's Disease and Related Dementias (ADRD) Training

Dementia care training is an integral part of the Interdisciplinary Care Team (ICT) component to ensure an understanding of Alzheimer's Disease and Related Dementias (ADRD) including symptoms and progression, behaviors and communication problems caused by and/or related to ADRD, caregiver stress and management, and community resources available for those affected by ADRD.

New SNP Requirement

The 4 Elements of Model of Care

Overall Special Needs Plan Population Type

-Chronic SNP **(C-SNP)**
-Fully Integrated Dual Eligible SNP **(FIDE-SNP)**
-Institutional SNP **(I-SNP)**

MOC 1: Description of SNP Population

Subpopulation – most vulnerable

MOC 3: Provider Network

- Specialized Expertise
- Use of Clinical Practice Guidelines and Care Transition Protocols
- MOC Training for Provider Network
- Staff/Providers deliver care to SNP members must complete annual MOC training

Population → Care Coordination → Provider Network → Quality Measurement and Performance

MOC 2: Care Coordination

-Health Risk Assessment **(HRA)**
-Face to Face Encounter
-Individual Care Plan **(ICP)**
-Interdisciplinary Care Team **(ICT)**
-Care Transition Protocols **(CT/TOC)**

MOC 4: Quality Measurement and Performance

- Quality Performance Improvement Plan
- Measurable Goals and Health Outcomes
- Measuring Patient Experience of Care
- Ongoing Performance Improvement Evaluation
- Dissemination of SNP Quality Performance
- Quality Measure Monitoring
- SNP model of care program evaluation process
- Quality Improvement Plan

Face to Face Encounters

Face to Face Encounter - New Requirements

Within the first 12 months of enrollment, as feasible and with the member's consent, the organization conducts face-to-face encounters to deliver health care, care management or care coordination services.

A face-for-face encounter must be either in person or through a visual, real-time, interactive telehealth encounter.	The encounter must be between the member and representative from any of the following: • A member of the ICT • Organization's case management and coordination staff. • A healthcare provider contracted with the health plan.

New SNP Requirement

Health Risk Assessment (HRA) Triggers

- "Poor" self-rated health
- 8 or more medications
- Moderate to Severe Depression (PHQ-2)
- Difficulty with ADLs – (Bathing, Eating & Toileting)
- 3 + Falls in the last year
- 3+ SNF admissions in the last year
- 3 + ER visits in the last year
- Report difficulty managing health condition
- 3 + hospital admissions in the last year
- Requests a Case Manager/RN

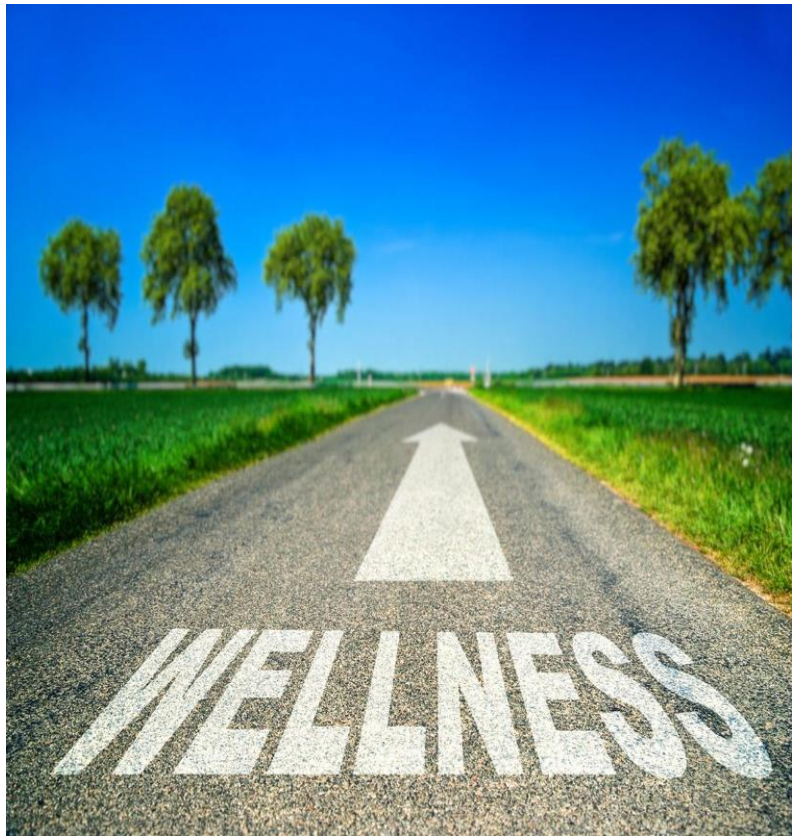
Member Benefits

Health Risk Assessment (HRA)-Health Plan performs an initial HRA

Transportation–the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP and region

In addition, SNP plans may have benefits for **Dental, Vision, Podiatry, Gym Membership, Hearing Aides or lower costs for items such as Diabetic Monitoring supplies, Cardiac Rehabilitation. CSNP Focus – Balance includes $0 insulin benefit, including coverage through the gap. T**hese benefits vary by region and type of SNP.

Individualized Care Plan (ICP)



- Must be completed within 30 days of notification by Health Plan of a new SNP patient per CMS/Health Plan requirement
- Developed based on the patient's assessment and identified problems
- Includes patient's self-management plans and goals
- Includes barriers and progress towards goals
- Shared with patient/caregiver, PCP, and any settings where the patient has a transition of care: Hospital, Skilled Nursing Facility
- Updated with changes to health such as new diagnosis, hospitalization, or at least annually and communicated to ICT and patient

When to Update the Care Plan:

- Clinical review identifies a change of health status not reflected on the SCAN care plan
- During member outreach/assessment, a new concern is identified
- As a result of Interdisciplinary Team review
- A change of health status that occurs at any point during the member journey (e.g. admit/discharge from a facility)

Send the revised care plan to the member and PCP

Interdisciplinary Care Team (ICT)

- All SNP members require interdisciplinary care
- **Interdisciplinary care can be formal or informal**
- **Our *formal* ICT team meets weekly** and consists of Medical Director, Social Worker and SNP Care Management nurse
  - Patients/caregivers are invited to ICT during the initial assessment and care plan sign-off. They have the right to opt in or out of participation.
  - The PCP is invited to join the weekly ICTs
- ***Informal*** ICT can occur in person, over the phone or electronically between any two members of the patient's care team

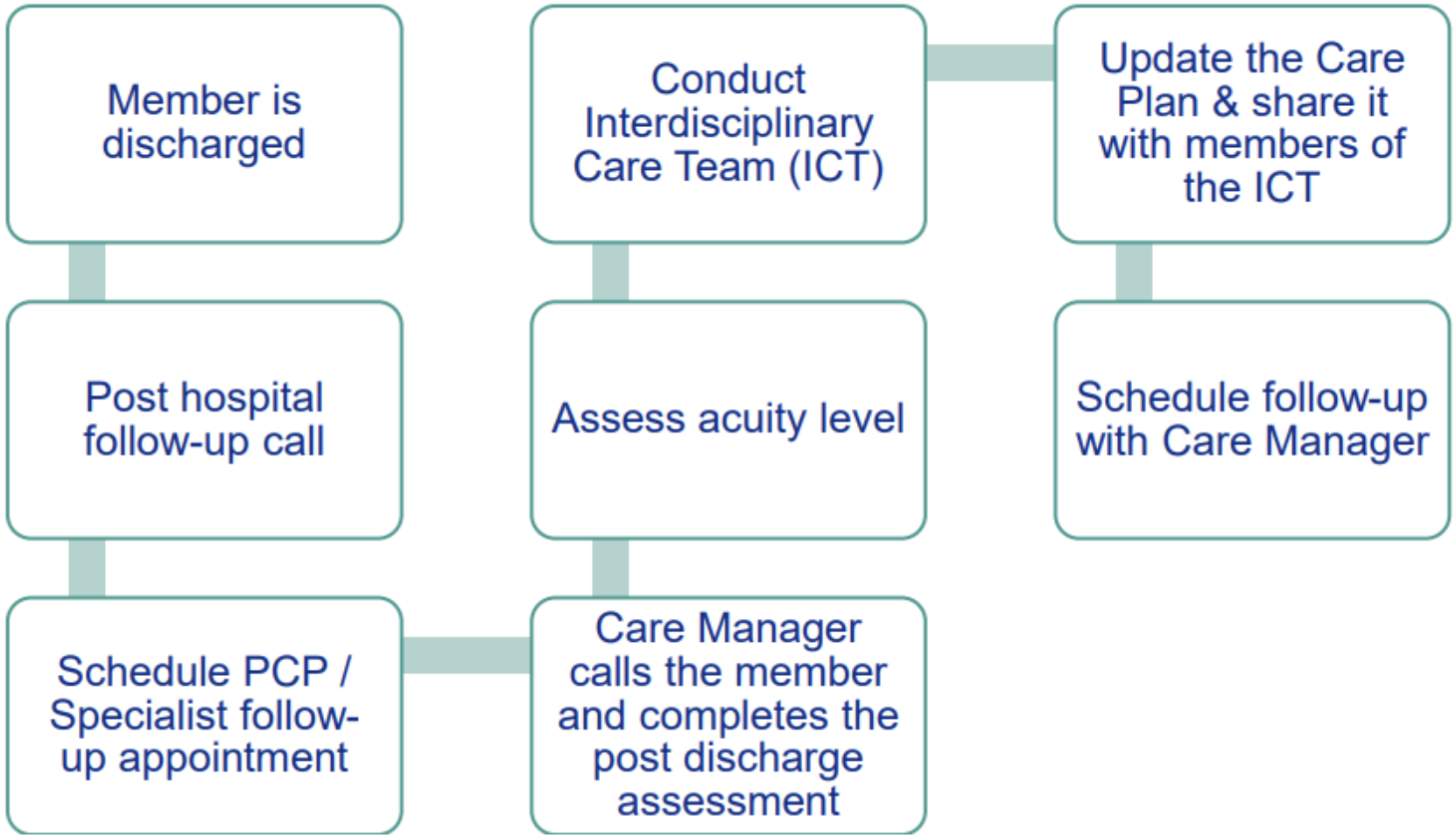
Transition of care (TOC)

- Patients are at risk of adverse outcomes when there is a transition between settings
- Patients experiencing an inpatient transition are identified
- The patient's care plan is shared between care settings upon admission
- PCP is notified of patient's discharge

Discharge follow up call is made to patient; Care Manager to review the following:

- ❑ Discharge instructions and verify understanding
- ❑ Medications and ensure new prescriptions have been filled and picked up
- ❑ Follow-up appointments in place
- ❑ Home Health start date and confirm they have been in touch with the patient (if applicable)
- ❑ Durable medical equipment has been delivered (if applicable)
- ❑ Additional education around diagnosis, symptoms, when to call the doctor
- ❑ Nurse Advice Line and Urgent Care Center information provided
- ❑ Questions the patient/family/caregiver may have

Coordinating Care Transitions



Care Transitions (CT) Documentation

Care Transitions documentation must include:

- "Patient outreach was completed/attempted within 5 business days of discharge from one setting to another".
- Notification to PCP within five business days of discharge
- Ensure follow-up services and appointments are scheduled within 5 business days of transition
- The team ensures there is an identified provider directing the member's care and any other providers who need to be aware of the transition are notified.
- Care plan transferred between settings before, during, after transition of care
- Member coaching occurred
- Members of the ICT and members/caregivers have access to the plan of care

Advance Directive

Advance Directive is an ongoing conversation that:

- Involves *shared decision making* to clarify and document an individual's wishes, preferences, and goals regarding future medical care.
- This comprehensive process is critically important to ensuring patients receive the medical care they want in the event they lose the capacity to make their own decisions.
- PCPs are required to educate and should encourage each Member to complete an advance directive and document in the Member's medical record
- Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)).

Resources: PREPARE (prepareforyourcare.org)

Quality Measurement and Performance

Measurable Goals and Health Outcomes

SCAN identifies specific health outcome measures (examples below) and initiates activities and operational processes to improve and enhance member experience.

Improve access to Annual Flu Vaccine.	Improve access to SNP Care Management.	Improve Care for Older Adults – Medication Review.	Controlling Blood Pressure.	Medication Reconciliation Post-Discharge.	Statin Therapy for Patients with Cardiovascular Disease.	Getting Appointments and Care Quickly.	Hospitalization for Potentially Preventable Complications (HPC).

Role of SNP Care Manager

- ❑Reviews Health Risk Assessment (HRA) from Health Plan
- ❑Performs an assessment of medical, psychosocial, cognitive and functional status
- ❑Develops a comprehensive individualized care plan with member input
- ❑Identifies barriers to goals and strategies to address
- ❑Discusses member care at Interdisciplinary Care Team (ICT) meetings
- ❑Facilitates transitions of care calls after an ED visit or acute hospitalization
- ❑Provides personalized education for optimal wellness
- ❑Encourages preventive care such as flu vaccines and mammograms
- ❑Reviews and educates on medication regimen
- ❑Promotes appropriate utilization of benefits
- ❑Assists member to access community resources
- ❑Assesses cultural and linguistic needs and preference

Your Role as the Physician

- ✓ Review comprehensive and individualized care plans created for each patient
- ✓ Encourage your patients to engage with their assigned SNP Care Managers and take advantage of the benefits.
- ✓ Participate in ICT meetings for your patient if necessitated
- ✓ Collaborate with patient care during Transitions to reduce gaps in care and readmission risk
- ✓ Provide medical documentation necessary to the SNP Care Manager for the assessment and care planning process

MOC training attestation documentation

*Friendly reminder to complete Microsoft Forms, "Provider Education/Attestation" as evidence that you completed this training.

Thank you for your time!

Providence

Disability Awareness

2024

Objectives

- Explain the prevalence and types of disabilities within Providence’s population
- Identify and explain the legal requirements related to access for person with disabilities
- Define the basic rights of persons with disabilities
- Identify the physical accessibility components at a provider's office that are assessed and reported.
- Define your responsibilities in interacting with members, visitors, patients & their companions with disabilities.
- Use appropriate terminology and proper etiquette when interacting with people with disabilities
- Identify available resources and community resources.

Definitions: Impairment vs disability

Functional Limitations

- Difficulty completing basic or complex activities because of a physical, mental, or emotional restriction.
- May be due to behavioral and/or chronic health conditions.

Functional Capabilities

- Strengths of a person with a disability to perform certain activities, with or without accommodations.

Impairment

- Alteration of a person's health status as assessed by medical means
- Typically identified with an organ or body part
- Ranges from mild (pinky amputation) to severe (tertraplegia)
- Does not include impact on person's ability to function in society

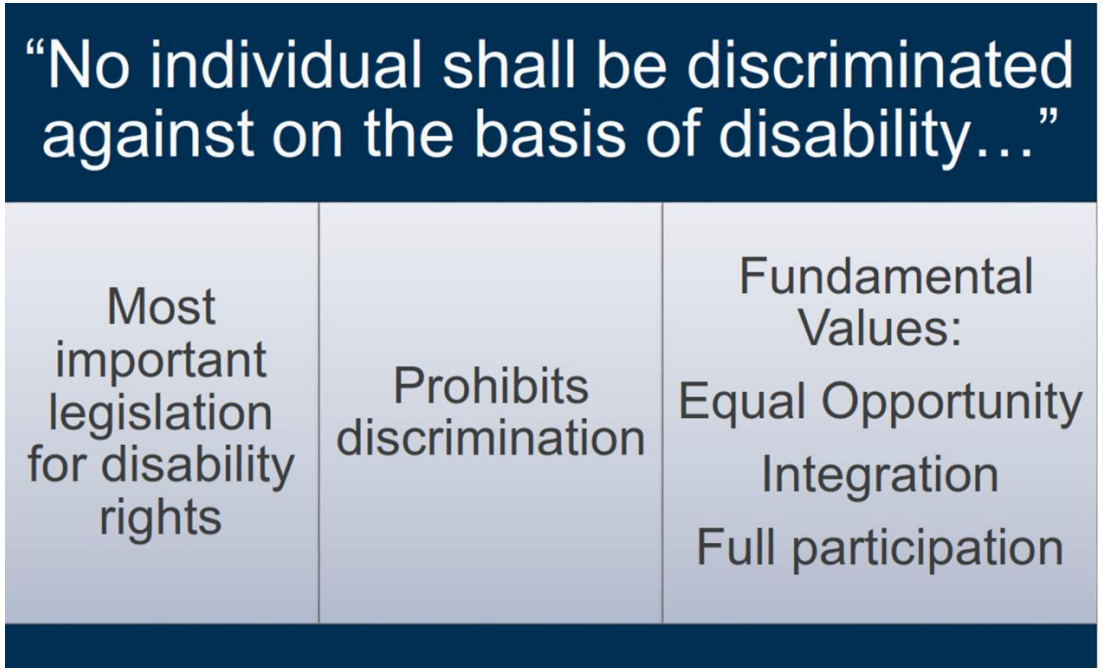
Disability

- A physical or mental impairment that substantially limits one or more of the major life activities (mobility, cognitive, vision, speech, or hearing)
- Birth (congenital) to acquired over lifetime
- Visible or hidden

Americans with disabilities act

The ADA requires:

- Medical care providers make their services available in an accessible manner.
- Policies, procedures and guidelines be in place regarding non-discrimination based on disability.
- Providence is committed to providing equal access for members and their companions with disabilities.



The Rehabilitation act of 1973

Section 504- Prohibits discrimination due to disabilities in programs that receive federal funding

"No qualified individual with a disability …shall be excluded from, denied the benefits of, or be subjected to discrimination under" any program activity.

Program accessibility

Effective communication

Accessible construction and alterations

Section 508- Requires electronic and information technology to be accessible to people with disabilities including employees and members of the public

Visual and audio outputs, optical aids

Accessibility- related software: Jaws (job access with speech)

The Olmstead decision

- Olmstead, or Olmstead v. LC, is the name of the most important civil rights decision for people with disabilities in our country's history. This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following three-part test is met:

- The person's treatment professionals determine that community supports are appropriate;

- The person does not object to living in the community; and

- The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

Most integrated setting

Integrated setting

- Refers to a setting that, “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible”
- Term means services and benefits to persons with disabilities should not be separate or different from a person without disabilities unless the separate programs are necessary to ensure that benefits services are equally effective

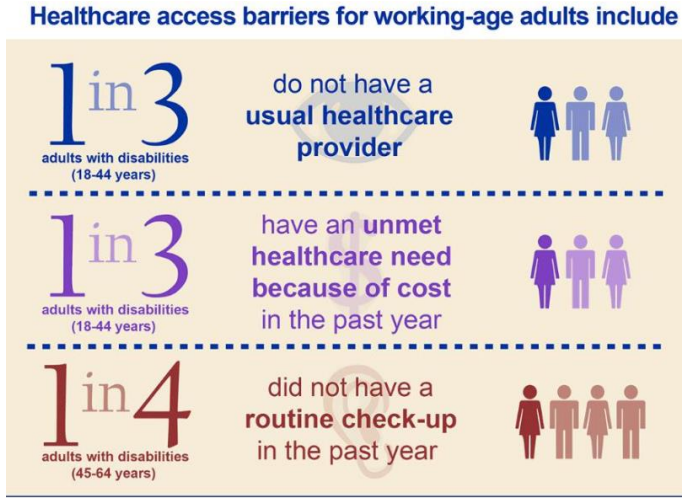
Least restrictive

- Least restrictive environment is terminology for educations settings
- All other settings use the term “integrated setting”
- A “least restrictive environment/setting possible” means members are treated in an environment and manner that respects individual worth, dignity, privacy and enhances their personal autonomy.

Disabilities and healthcare access

- Persons with disabilities and functional limitations may encounter environmental barriers to care.
- Most difficult barriers to overcome are attitudes.
- Focus on individual's ability rather than on disability.

Physical Access	Communication Access	Program Access
Ability to get: • To • Into • Through • Onto	**Ability to::** • Understand what is being asked • Use the information given • Result in effective communication	**Participate in:** • Health education • Prevention & treatment • Community-based programs



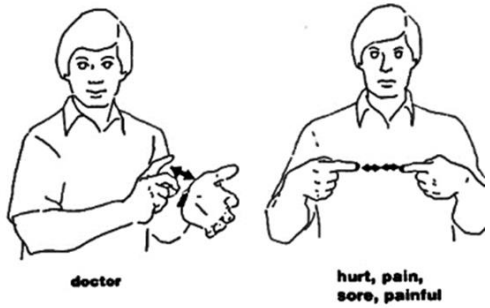
Accessibility requirements for providers

- **<u>Intended to meet the needs of any patient to improve program access and health outcomes</u>**

- Department of Health Care Services (DHCS) requirement MMCD PL 12-006 requires California plans " to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve high volume of seniors and persons with disabilities."
- Required for all Medi-Cal contracted providers

Physical access

Effective communication



Reasons for accommodations

Functional limitations may create a need for accommodations such as:

- Physical accessibility.
- Changes to provider office policies.
- Accessible exam or medical equipment.
- Effective communication.
- Member and health education materials in alternate formats.
- Physical disabilities may be more obvious, but unseen mobility issues are more common.
- For example, a member may experience an issue with physical ability to move around or walk a distance due to hip or knee problems, breathing issues, weakness, etc.

Never assume to know the member's disability

Types of physical accommodations

- Put yourself in the position of a person who is sight impaired, uses a wheelchair or is hard of hearing. Then think about what you would need to access information or simply enter an office
- Can you think of additional common types of physical accommodations? There are many barriers to access that are often overlooked by people who don’t need them.
- These are everyday things we use, including: elevator, doors, doorways, hallways, restrooms, parking lots, telephones, forms and documents

Speech Disabilities

Members with speech disabilities may use:

- Their own voice
- Letter board
- Pen and paper
- Augmentative and alternative communication devices
- Speech generating devices (SGDs) “talk” when certain letters, words, pictures, or symbols are selected
- Speech-to-speech relay services (STS)
- A call that uses a specially-trained communications assistant

Speech disabilities can be:

- Developmental
- Result of illness or injury
- No speech
- Difficult to understand

Communication tips

If you have trouble communicating:	
Ask the member how he or she wants to communicate	Speak slowly, clearly and patiently, and give time to respond

Don't:
Assume — which also includes not assuming someone from another culture understands American Sign Language.
Rush or ask the member to hurry.

Use People-First Language			
Person with a disability	Person who is deaf	Person who uses a wheelchair	Person with an intellectual disability

Avoid Negative Language:
Handicapped person, blind person, wheelchair-bound or mentally retarded

- When talking about a disability or with a person with disabilities, focus on the person, not the disability, avoid negative language and use people-first language

Communication tips

Members with mental health and/or substance abuse conditions may need consideration:

Know how to get help in the event of a crisis, remain calm and offer support

Keep stress levels to a minimum

Change words you use

Ask what environment they are most comfortable in

DON'T:

- Finish their sentences or cut them off
- Mimic or mock their speech
- Assume you know what they are saying
- Be patronizing

Resources and Authorities

- Contact the member's assigned health plan for interpreting services
- Centers for Disease Control and Prevention, Disability and Heath www.cdc.gov/disabilities
- Deaf and disabled telecommunications program (DDTP)1-800-806-1191 http://ddtp.cpuc.ca.gov
- California telephone access program https://www.youtube.com/watch?v=9j3lwGUvS0c
- California relay services (CRS) http://ddtp.cpuc.ca.gov/default1.aspx?id=1482
- Title 29, The United States Code, Section 794 (section 504 of The Rehabilitation Act of 1973)
- Americans with Disabilities Act of 1990
- DHCS Facility Site Review (FSR), Physical Accessibility Review Survey (Attachment C- "29 elements")
- Department of Health Care Services (DHCS)

Providence

Cultural Competency and Patient Engagement

2024

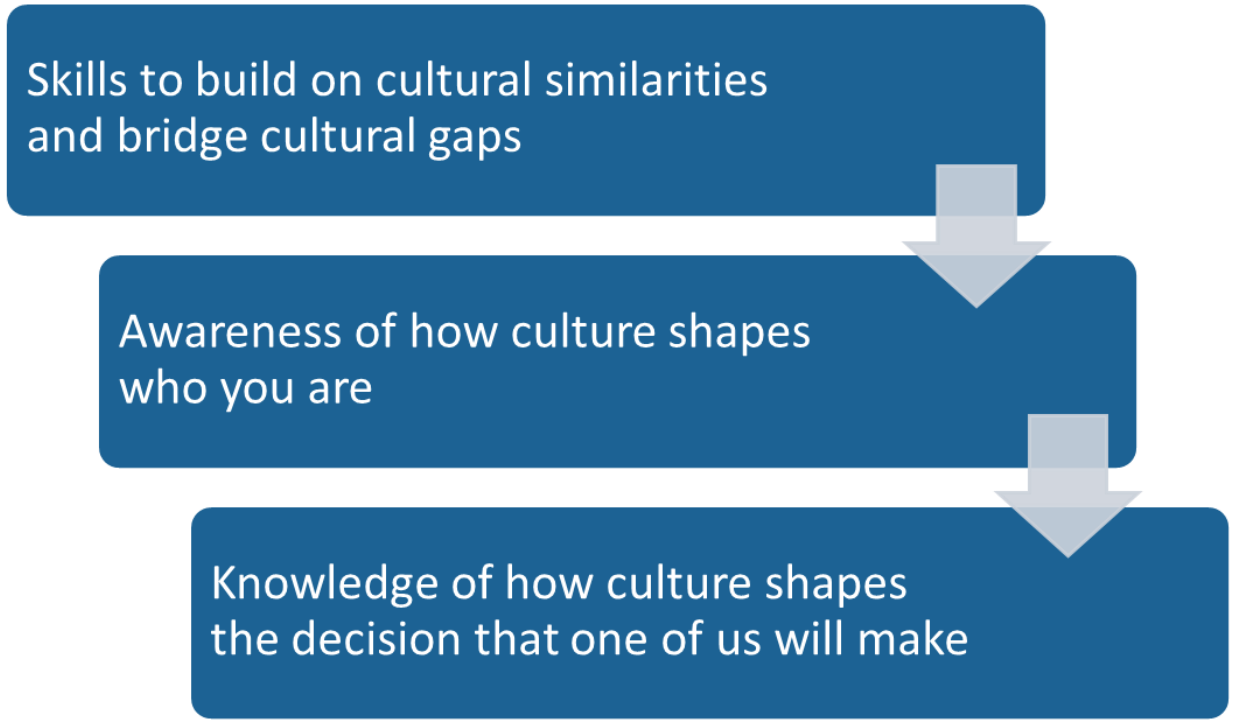
What is Culture?

- Culture refers to integrated patterns of human behavior that includes language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.
- We use it to create standards for how we act and behave socially.

- [1]Source from http://minorityhealth.hhs.gov and The Cross Cultural Health Care Program

Building Cultural engagement

Culture is not only learned but it is shared, adaptive, and is constantly changing.



Individual Culture

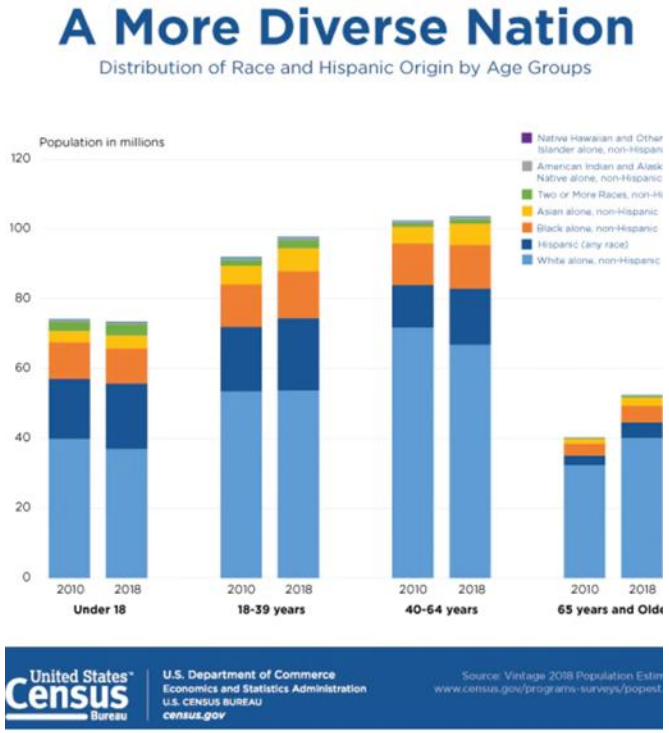
- Our view of illness and what causes it.
- Our attitudes toward doctors, dentists, and other health care providers.
- When we decide to seek our health care provider.
- Our attitudes about seniors and persons with disabilities.
- The role of caregivers in our society.
- Culture is a unique representation of the variation that exists within our society.

The Health Care encounter

- Because everyone brings their cultural background with them.
- There are many cultures at work in each health care visit.
- Our personal culture includes what we find meaningful- beliefs, values, perceptions, assumptions and explanatory framework about reality.
- These are present in every communication.

Did you know?

- 1 in 6 people living in the US are Hispanic (almost 57 million)
- By 2035, this could be nearly 1 in 4. (CDC, 2015)
- 20% of people living in the U.S. speak a language other than English at home (CIS, 2014).
- Latino population in the U.S. has grown by 43% between 2000 and 2010 (Census, 2011)
- 17% of the foreign-born population in the U.S. are classified as newly arrived (arriving in 2005 or later). (Census, 2011)



Barriers vs. Benefits

Barriers to communication	Benefits of clear communication
•Speech patterns, accents or different languages may be used (Linguistic)	• Safety & Adherence
•Many people are getting health care coverage for the first time (Limited Experience)	• Physician & Patient
•Cultural Barriers	• Satisfaction
•Each person brings their own cultural background and frame of reference to the conversation (Cultural)	• Office Process
•Health system have specialized vocabulary and jargon (systemic Barriers)	• Saves Time & Money

Clear communication

Possible patient thoughts…

- I tell you I forgot my glasses because I am ashamed to admit I don't read very well.
- I don't know what to ask and I am hesitant to ask you.
- When I leave your office, I often don't know what I should do next.
- I'm very good at concealing my limited reading skills.

Here's what your team can do…

- Use a variety of instruction methods.
- Encourage open-ended questions
- Use Teach Back Method or "Show Me" method.
- Use symbols, color on large print direction or instructional signs.
- Create a shame free environment by helping with materials.

Clear communication cont.

Possible patient thoughts…

- I put medication into my ear instead of my mouth to treat an ear infection because the instructions said, "For Oral Use Only".
- I am confused about risk and information given in numbers like % or ratios. How do I decide what I should do?

Here's what your team can do…

- Explain how to use the medications that are being prescribed.
- Use specific, clear & plain language on prescriptions.
- Use plain language to describe risks and benefits, avoid using just numbers.

Clear communication cont.

Possible patient thoughts…

- I am more comfortable waiting to make a health care decision until I can talk with my family.
- I am sometimes more comfortable with a doctor of my same gender.
- Its important for me to have a relationship with my doctor.

Here's what your team can do…

- Confirm decision-making preferences
- Office staff should confirm preferences during scheduling

Clear communication: Limited English proficiency

Possible patient thoughts…

- My English is pretty good but at times I need an Interpreter.
- Some days it's harder for me to speak English.
- When I don’t seem to understand, talking louder in English intimidates me.
- If I look surprised, confused or upset I may have misinterpreted your nonverbal cues.

Things the provider team can do :

• Office staff should confirm language preferences during scheduling.
• Consider offering an Interpreter for every visit.
• Consider the volume and speed of the patient’s speech
• Mirror body language, position and eye contact.
• Ask the patient if they're unsure.

Language assistance services

Language assistance is available at no cost

- Interpreter support available.
- Sign language Interpreters.
- Speech to text interpretation for hearing loss in patients who do not sign.
- Member informing materials in alternative formats (i.e., large print, audio, and Braille).

Contact the health plan for assistance with language services

Use professionally trained Interpreters

Hold a brief introductory discussion with the Interpreter and …

- Introduce yourself and give a brief nature of the call/visit.
- Reassure the patient about your confidentiality practices.
- Be prepared to pace your discussion with the patient to allow time for interpretation and avoid interrupting during interpretation.

Alternate formats are required

- Under Title II of the Americans with Disabilities Act and Section504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.

- Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.

- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language Interpreters, Tactile Interpreters, captioning and assisted listening devices.

Providence

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Caring Well for LGBTQIA+ Patients at Providence

Creating a welcoming environment for trans+ patients

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Objectives

- Understand how caring well for trans+ patients aligns with Providence's mission
- Get comfortable with terminology and definitions, affirmative language skills
- Build empathy for our patients
- For the purposes of this training, trans+ is an umbrella term that encompasses transgender, gender diverse, and intersex patients. Note: not all intersex people identify as transgender.

Providence | Providence Mission and Values – Our Professional Responsibilities and Commitments

Mission: As expressions of God's healing love, we are steadfast in serving all, especially those who are poor and vulnerable.

Values: Compassion I Dignity I Justice I Excellence I Integrity

Vision: Health for a Better World

Promise: Know me, care for me, ease my way

Caring well for LGBTQIA+ people is in direct alignment with our mission, values, and promise.

It is our professional responsibility to care well for our LGBTQIA+ patients at Providence.

Providence recognizes Caregiver personal values are diverse;
at the Providence workplace it is expected that professional care align with Mission, Values, and Promise.

https://www.providence.org/about/our-mission

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LGBTQIA+ History and Background

- LGBTQIA+ people have always been part of society – transgender people were acknowledged, accepted, and celebrated in ancient societies.
- Persecution, harassment and abuse of transgender people is more prevalent in recent history (1900s-present day)
- Transgender people are now starting to be more widely accepted again, but still face tremendous amounts of persecution, violence, and stigma – especially transgender femmes and people of color.
- Approximately 20 million adults identify as lesbian, gay, bisexual or transgender people (2020).
- LGBTQIA+ people are in every town, every city, every zip code. California and Texas have the largest number of LGBTQIA+ adult residents (2020).

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Health Disparities and Inequities of the LGBTQIA+ Community

- LGBTQ+ youth are **more than four times as likely** to attempt suicide than their peers[1]
- Transgender and nonbinary youth were **2 to 2.5 times** as likely to experience depressive symptoms, seriously consider suicide, and attempt suicide compared to their cisgender LGBQ peers[3]
- Transgender and nonbinary youth who reported gender identity acceptance from adults and peers had significantly lower odds of attempting suicide in the past year[4]
- Transgender people are also more likely to attempt suicide as a result of this and other stressors: 4.6% lifetime suicide attempt rate among general population, 42-46% among transgender and gender diverse population.
- LGBTQIA+ patients face significant community and family discrimination, which contributes to these disparities.

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Why is this important in healthcare?

<u>Discrimination of LGBTQIA+ patients:</u>

22% of transgender patients avoided or postponed seeking needed medical care because of disrespect or discrimination from health care staff

41% of LGBTQ people who lived in a nonmetro area said it would be “very difficult” or “not possible” to find the same type of service at a different hospital

29% of transgender patients surveyed said a doctor or other health care provider refused to see them because of their actual or perceived gender identity

Patient Experience: Discrimination in Health Care, Disparities and Inequities

The California Transgender Advisory Council - Transgender, Gender Diverse or Intersex Workgroup (CTGI Workgroup) participants expressed several challenges accessing healthcare, including:

- Lack of competent care
- Absence of safe gender-affirming care
- Providers not recognizing TGI identities
- Patient difficulty changing names and pronouns within medical systems and EHR
- Confusion among providers regarding providing preventive care procedures
- Absence of integrated TGI care
- Lack of TGI-affirming HIV care
- Safety concerns and a scarcity of doctors in rural areas.

Providence Patient and Family Advisory Council (PFAC) patients confirmed these same concerns. PFAC members, like the CTGI Workgroup, also highlighted that patients experience intersectional barriers to care related to race, socioeconomic status, age, disability, body size, and immigration status. These identity factors compound health disparities amongst TGI individuals.

Citations:

- Providence Patient and Family Advisory Council
- TGI Final Report 2024

Patient Experience: Barriers to Care, Disparities and Inequities

The CTGI and Providence's PFAC have also highlighted that trans+ patients experience:

- Difficulty with navigation to begin gender-affirming care.
- The feeling from the community that many doctors just didn't "care" about them.
- There is systemic discrimination and consistent misgendering of people seeking services. There were reports of doctors setting requirements before TGI individuals can receive gender affirming care that are more stringent or inconsistent with the current standards of care (i.e. requiring more letters for surgery than necessary).
- There is a lack of follow-up on referrals made to fellow practitioners.
- Enrollees and insureds are hesitant to seek services due to a history of high 8 denial levels.
- Lack of insurance coverage of needed prescriptions and proper equipment (i.e., hormones and syringes of the correct gauge and length).
- Lack of adequate and competent in-network providers for referrals to care.
- The assumptions of femininity and masculinity are reflected in denials of surgical procedures (i.e., breast augmentation or facial feminization).
- Insurance coverage does not include financial support for recovery from surgical procedures.

Citations:

- Providence Patient and Family Advisory Council
- TGI Final Report 2024

Pronoun Reference Sheet

She	Her	Her	Hers	Herself
He	Him	His	His	Himself
They	Them	Their	Theirs	Themselves

These are some examples – there are many more.

If you don't know someone's pronouns, ask! And remember, mistakes happen – apologize, correct yourself, and move on.

Image Source: University of Alberta, Swedish LGBTQ+ Program

Integrating pronouns into introductions, patient appointments, and work environments can be simple.

For example: “Hi, I’m Juan and my pronouns are he/him. What name do you go by, and what are your pronouns?”
You can also do this in meetings: “Hi everyone. I’m Allie. I’m an MA and I go by she/her.”
Add them to your email signature next to your name: D. Marshall (pronouns they/them/theirs)

When checking someone in, ask someone’s full legal name, pronouns, and what they like to be called (these might be different than what you assume!)

- Example: "Welcome. Can you please tell me your legal name as it shows up on your insurance?" (let patient respond) "Thank you. How do you like to be called, and what are your pronouns?"

It’s also a good idea to verify someone’s name, pronouns by stating what you see written in their chart and asking if those are correct. It gives people an opportunity to check in on name/pronouns and verify.

What if I make a mistake?

•Despite a person's best efforts, mistakenly using the wrong pronouns can happen. If you mistakenly use the wrong pronouns, simply apologize, correct the pronouns, and move on.

•Do not over-apologize – this can be harmful.

•In some situations, if a person feels comfortable and safe doing so, they may correct another person's mistake using the wrong pronouns – the same way you'd correct someone mistakenly using the wrong name.

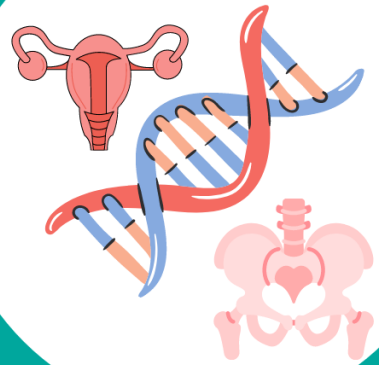
•Example: "In our conversation, I learned that she – I'm sorry, he – had some additional questions for the nurse"

•Example: Person 1: "I walked into his room - " Person 2: "THEIR room" Person 1: "Thank you. I walked into their room and was glad to see they were improving"

Basic LGBTQIA+ Terminology

Gender

Gender Expression



Sex Assigned at Birth

Sexual Orientation

Gender

Gender identity | One’s innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Gender may be related to the pronouns people would like to use as well (e.g., she/her, he/him, they/them, etc.)

Gender Expression

Gender expression | External appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being masculine, feminine, or androgynous. These are informed by social context.

Sex Assigned at Birth

Sex Assigned at Birth | The sex (male or female) assigned to a child at birth, most often based on the physical characteristics of reproductive organs, secondary sexual characteristics, chromosomes, and hormones of the child's external anatomy. Also referred to as birth sex, natal sex, biological sex, or sex. Commonly abbreviated as AFAB (assigned female at birth) or AMAB (assigned male at birth).

Sex assigned at birth is completely independent of gender identity.

Sexual orientation | An inherent or enduring emotional, romantic or sexual attraction to other people. Examples include heterosexual, bisexual, pansexual, gay, lesbian, queer, asexual, etc.

Note: an individual's sexual orientation is independent of their gender identity.

Key Takeaways

- Using medically accurate and appropriate terminology, as well as terminology indicated by the patient, helps facilitate more effective communication with patients
- Using this terminology and people's names and pronouns as they have indicated (even if those names/pronouns have not been indicated in their records or legal documents) can ensure communication is LGBTQIA+ inclusive and creates a welcoming environment, especially for trans+ patients.
- Avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or non-intersex
- Do not use language, whether verbal or nonverbal, that demeans, ridicules, or condemns trans, gender diverse, intersex or other LGBTQIA+ individuals

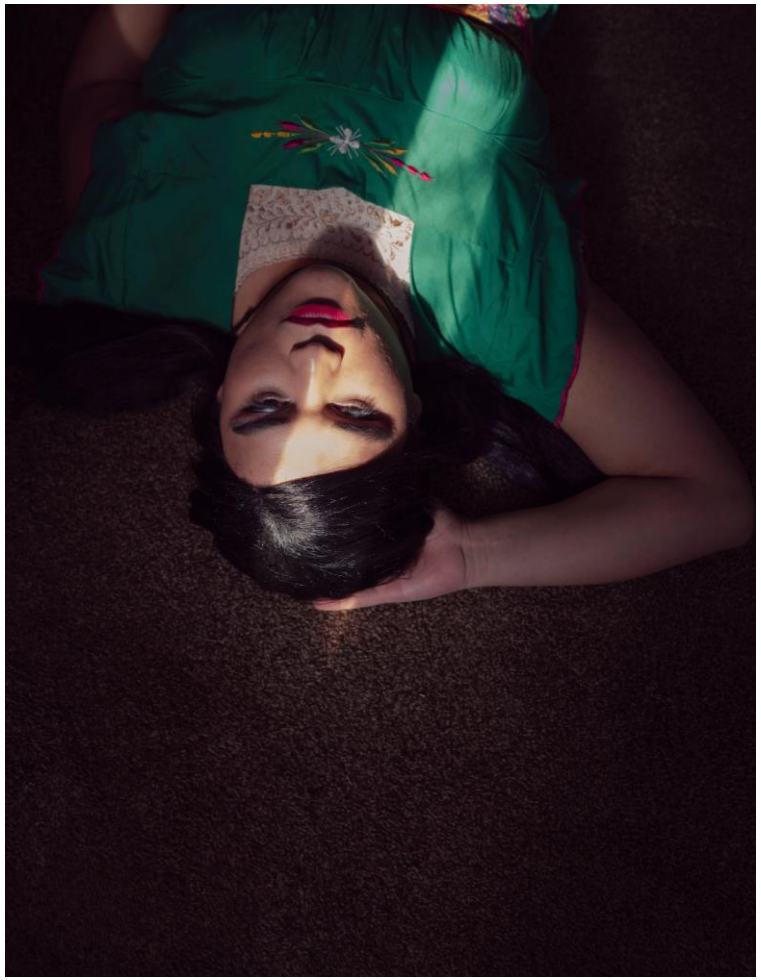
Examples of bias and microaggressions against transgender and gender diverse people (what to avoid!)

Use of transphobic wording, such as incorrect gender pronouns, belittling language, and publicly questioning a person's gender

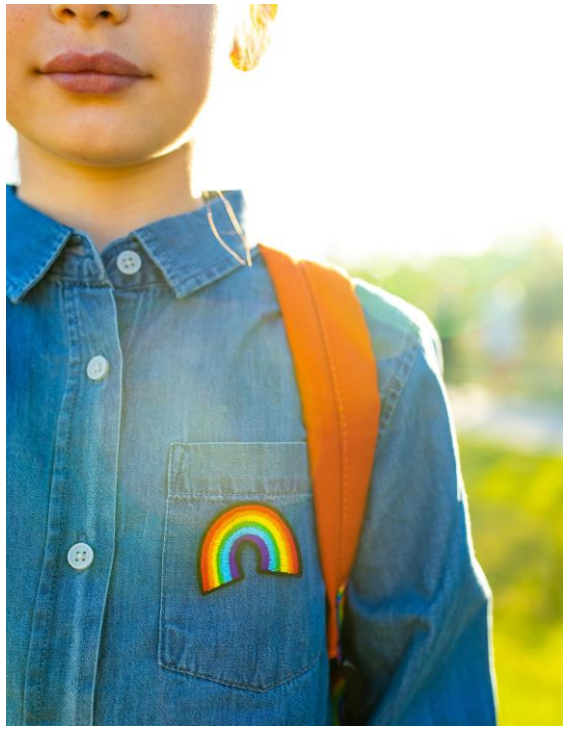
- "But she's not a REAL woman"
- Using different pronouns than what a person has indicated as the pronouns they use for themselves
- "Why can't you just be a butch lesbian?"

Assumptions that all trans people are the same, such as assuming all trans people undergo gender-affirming surgeries.

- "Oh, my uncle is trans – he had surgery last year. When are you having surgery?"
- "When are you going to REALLY transition?"



Examples of bias and microaggressions against transgender and gender diverse people (what to avoid!)



Upholding the gender normative and binary culture that denies a transgender identity.

- "Boys don't wear dresses"
- "You're so pretty for a trans woman!"
- "There are only two genders –I don't get how you can feel like a man and a woman."

Denying the existence of transphobic experiences.

- "I was confused about this stuff too, when I was their age. They'll get over it, it's just a phase."
- "They're only dressing like that to get attention. If they didn't dress like that, then they wouldn't have any problems!"

Examples of bias and microaggressions against transgender and gender diverse people (what to avoid!)

Denial of personal body privacy, such as asking intrusive medical questions or questions about appearance.

- "Have you had bottom surgery?"
- "You're not going to let them take puberty blockers, are you?"
- "If you're really a girl, why don't you shave?"

Not seeing trans people as humans.

- Referring to transgender/gender diverse people as "it" or "thing"

Examples of bias and microaggressions against transgender and gender diverse people (what to avoid!)

Assumptions that trans people have a mental illness.

- The medical system pathologizes transgender people – transgender people are required to have mental health assessments and letters of permissions before receiving many kinds of affirming treatment.
- Cis-gender people are not required to get these same assessments for similar surgical or hormonal interventions.
- This reinforces that transgender people must have a mental illness to seek care, and cis people who seek similar care do not.
- Example: Gender affirming care, specifically surgery often requires letter(s) of approval from a mental health therapist. Breast augmentation or reduction, hormone replacement therapy, hair transplants, elective plastic surgery for cis-gendered people does not.

10 Additional Tips for Improving Care to Trans+ Patients

Providence | Tips for Improving Care for Transgender People

1. Welcome transgender people by getting the word out about your services and displaying transgender-positive cues (signs!) in your office

2. Treat transgender people as THEY would want to be treated (platinum rule!)

3.Remember to always refer to transgender people by their name and pronoun that corresponds with their gender identity

4. If you are unsure about person's gender identity or how they wish to be addressed, ask politely for clarification.

5. Establish an effective policy for addressing discriminatory comments and behavior in your office or organization.

Adapted from: http://transgenderlawcenter.org/wp-content/uploads/2011/12/01.06.2016-tips-healthcare.pdf

Providence | 10 Tips for Improving Services for Transgender People

6. Remember to keep the focus on care rather than indulging in questions out of curiosity

7. Keep in mind that the presence of a transgender person in your treatment room is not always an appropriate "training opportunity" for other health care providers

8. It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care.

9. Never disclose a person's transgender status to anyone who does not explicitly need that information for care.

10. Become knowledgeable about transgender health care issues.

Adapted from: http://transgenderlawcenter.org/wp-content/uploads/2011/12/01.06.2016-tips-healthcare.pdf

Providence | CITATIONS

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- https://www.glaad.org/reference/transgender
- UCSF Transgender Center for Excellence
- Fenway Health

Providence | Additional Resources

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- https://transgenderlawcenter.org/resources/health
- https://www.thehrcfoundation.org/professional-resources/transgender-patient-services-support-resources-for-providers-and-hospital-administrators
- https://www.thetrevorproject.org/resources/category/gender-identity/
- https://www.lavenderrightsproject.org/
- https://thegalap.org/
- https://straightforequality.org/transmaterials
- https://transequality.org/
- https://icath.info/

Providence | Provider Attestation

Please select the link below to attest that the training has been reviewed and completed.

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Questions? Email cme@swedish.org