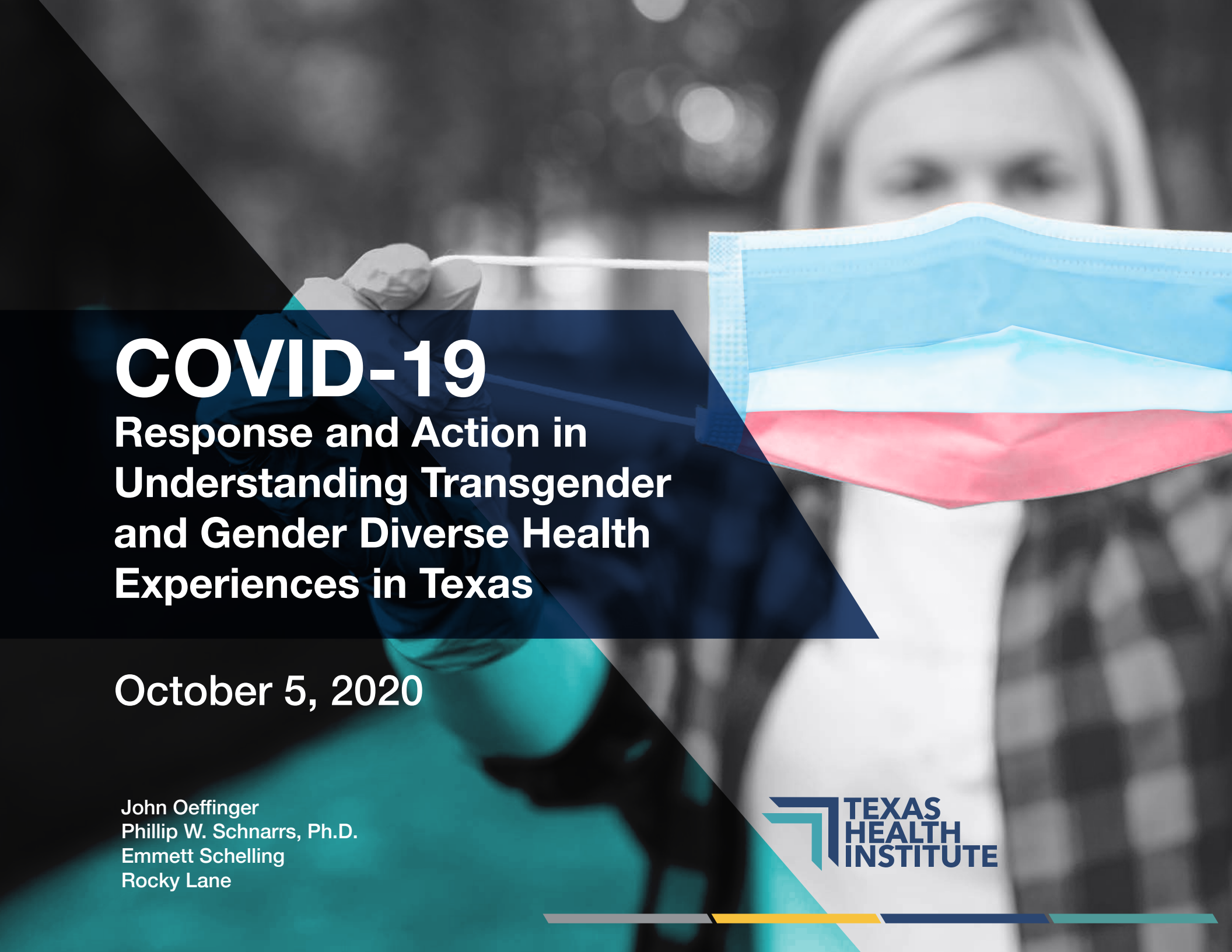

COVID-19

Response and Action in Understanding Transgender and Gender Diverse Health Experiences in Texas

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Texas by the numbers[1,2]

Age	Transgender population
13 to 17	13,800
18 to 24	19,600
25 to 64	88,950
65 or older	15,700
All Adults (ages 18+)	124,500

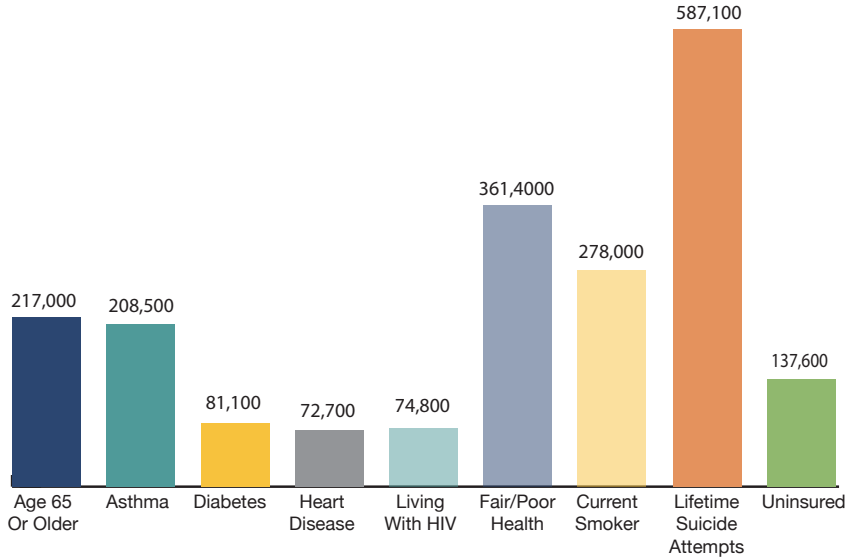
Race or Ethnicity	Transgender population
Hispanic or Latino	54,650
White	46,500
Black or African American	16,800
Other races or ethnicities	6,550

Background

The term “transgender” is used to describe individuals whose gender identity differs significantly from the sex they were assigned at birth, and it includes individuals assigned male at birth who identify as female, individuals assigned female at birth who identify as male, and individuals who describe their gender identity outside of thebinary categories of male and female (e.g., bigender, genderqueer).[3,4]

Transgender individuals experience more violence, discrimination, and victimization compared to cisgender (a term used to refer to one’s gender identity and/or expression aligning with one’s birth sex/gender) individuals.[5,6] Increased risk of stigma-related stressors has also been documented to increase mental health risk factors, such as depression and anxiety, that heighten vulnerability to suicide attempts.[7,8,9] Stigma has serious consequences for health, with transgender and gender diverse (TGGD) people (and especially those of color) experiencing multiple health inequities with limited healthcare access.[10,11]

Figure 1. Estimated number of transgender adults in the U.S. with health-related vulnerabilities to serious COVID-19 illness[12]



The 2019 novel coronavirus, which causes COVID-19, has impacted the health, livelihoods, and social lives of people around the world.[13] The public health response to the COVID-19 pandemic, including shelter-in-place orders and social distancing, may exacerbate existing risk factors for suicide, including among transgender adults.[14] People of color are statistically more likely to:

- Have low-income and "essential" jobs that often result in more direct interactions with people, increasing the likelihood of contracting COVID-19;
- Live in multi-generational or multi-family situations that can make physical distancing difficult;
- Lack health insurance and easy access to health care, which means underlying medical conditions that increase the risk of severe COVID-19 are less likely to be managed well; and
- Lack regular contact with a physician who can help prevent or give timely treatment for COVID-19.[15]

Objective

To reduce the number of suicide attempts and suicide ideation by improving the lives of transgender and gender diverse Texans. This includes increasing access to culturally competent healthcare and reducing stigma, discrimination, harassment, and violence associated with transgender experiences. Reducing violence experienced by transgender women, most importantly black and transgender women of color, needs important attention.

1 in 150 Texas adults are transgender or gender diverse

BIPOC communities
(Black, Indigenous, People of Color)
represent 63% of Texas transgender adults

Impact of COVID-19 on Transgender and Gender Diverse Texans

Texas COVID-19 & You LGBTQ+ and Ally Survey, led by Drs. Phillip Schnarrs and Oralia Loza, took place between May 3, 2020 and July 31, 2020. The summary of findings[16] underscored:

- Gender and racial/ethnic disparities persist at the start of the COVID-19 pandemic.
- Significant gender differences between transgender and gender diverse people and cisgender people were primarily focused on measures for mental health and barriers to healthcare and services.
- Significant ethnic and racial differences between White, Latinx, and other people of color were primarily focused on measures for COVID-19, employment, financial security, and housing.

Socioeconomic Challenges

Texas has historically not addressed the needs or rights of LGBTQ+ communities. This study and data were a first look at LGBTQ+ health at a statewide level in Texas. The COVID-19 pandemic has exacerbated the gap between cisgender and transgender people demonstrating significant differences in food insufficiency and inability to pay rent or mortgage. The 2015 US Transgender Survey found nearly 34% of Texas respondents were living in poverty, compared to 12% in the U.S. population. A major contributor to the high rate of poverty was the 17% unemployment rate in Texas—three times higher than the 5% unemployment rate in the U.S. population at the time of the survey. Twelve percent of the national survey had visited or used services at a public assistance or government benefits office in the past year, such as for receiving Supplemental Nutrition Assistance Program (SNAP or food stamps) or Women, Infants, and Children (WIC) benefits.[17] In looking at rent or mortgage, the 2015 national survey found only 16% of respondents owned their homes, in contrast to 63% in the U.S. population. Thirty percent have experienced homelessness at some point in their lives. Eight percent experienced homelessness in the past year because of being transgender.

Figure 2. Socioeconomic Challenges by Cisgender and Transgender [18]

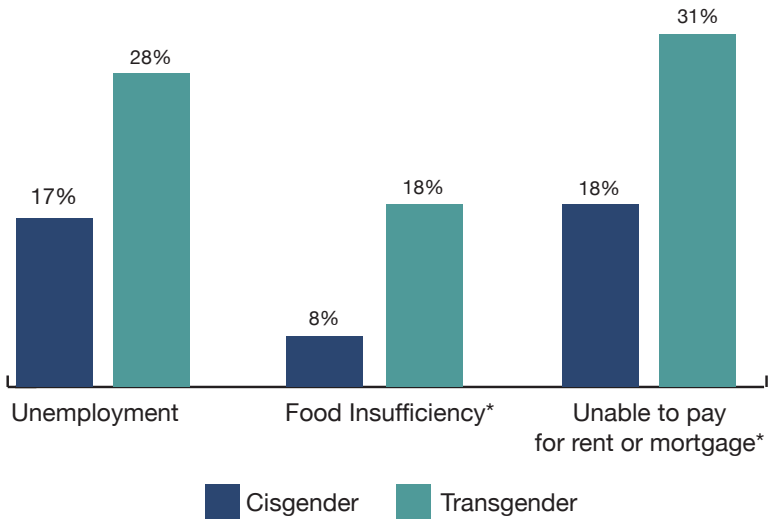
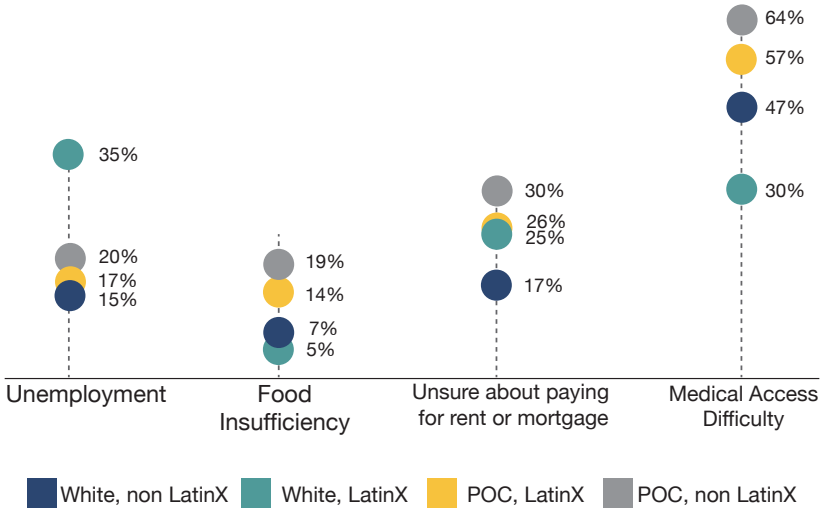


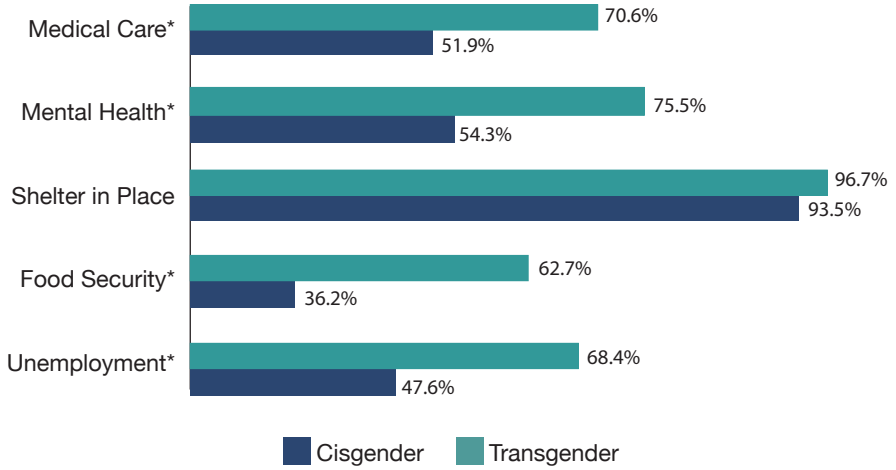
Figure 3. Socioeconomic and Access Challenges by Race and Ethnicity [19]



Access to Care and Insurance Rates

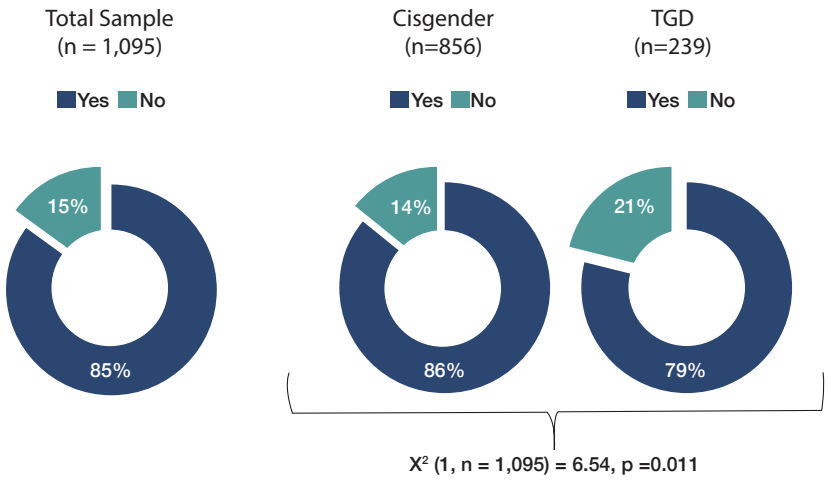
The 2015 national survey found 22% of Texas respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 38% did not see a doctor when needed because they could not afford it. In many cases, people of color never even make it to the physician's office. That's because Texas has the highest population of uninsured in the U.S. – 5 million out of a population of 29 million in 2019. And people of color in general have higher rates of insurance than whites (27% of the Hispanic population is uninsured, 16% of Blacks, 18% of American Indians/Alaska Natives, 16% of Asians/Pacific Islanders, 12% of whites, 12% other, according to the Urban Institute).[20] Texans say health care is the toughest living expense for them to afford, according to a 2019 poll by the Episcopal Health Foundation. Fifty-five percent of Texans say it's difficult for them to pay for health care, including 27% who say it's "very difficult."[21]

Figure 4. Difficulty with Access to Social Services and Health Care during COVID-19 Pandemic [22]



Note: Respondents reporting at least a little difficulty or more.
***denotes data is significantly different between cisgender and transgender - p<0.001**

Figure 5. Do you currently have health insurance or are you covered by any health plan? [23]



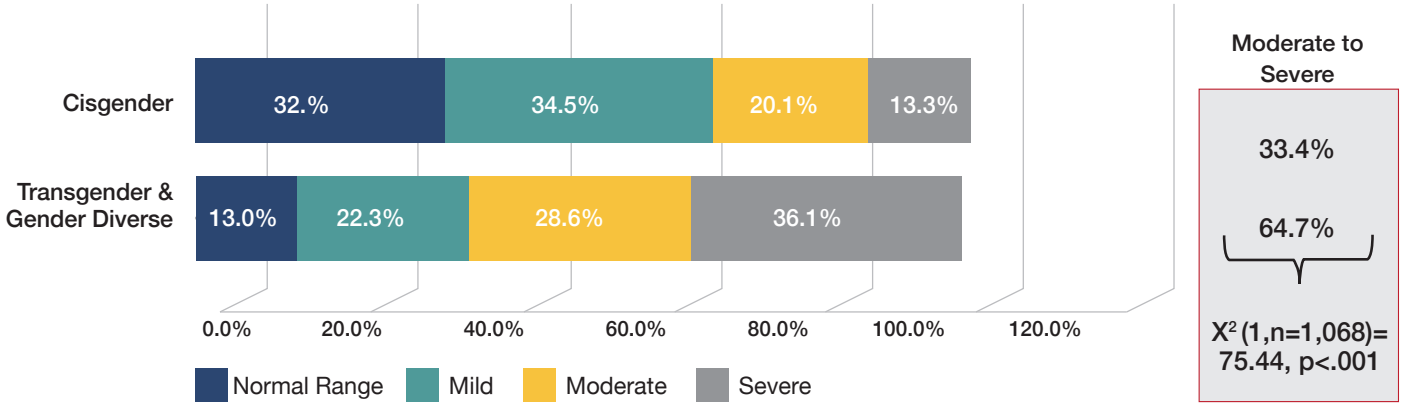
Fourteen percent of the national respondents were uninsured, compared to 11% of adults in the U.S. population. The most common source of health insurance reported by respondents was an employer-sponsored insurance plan (either through the respondent's employer or someone else's employer 53%. Fourteen percent of respondents had individual insurance plans that they or someone else purchased directly from an insurance company, through healthcare.gov, or from a health insurance marketplace, and 13% were insured through Medicaid.[24]

Mental Health

Anxiety and depression are the two most prevalent illnesses among patients, and in the general population. Because these two mood disorders are frequently co-morbid, they can have especially problematic outcomes. The nature of these mood disorders can make filling out long questionnaires difficult if patients are suffering from fatigue or loss of concentration.[26] Nationally, 39% of respondents reported currently experiencing serious psychological distress, a rate nearly eight times higher than in the U.S. population of 5%.[27]

Living alone may increase isolation and certain risks. In particular, older individuals and those with health conditions that put them at risk are recommended to stay home as much as possible.[28] Those who live alone and may be disconnected from family and other networks may need special assistance related to health care and daily living.[29] The Williams Institute estimated 294,800 transgender adults live alone in 2015.[30]

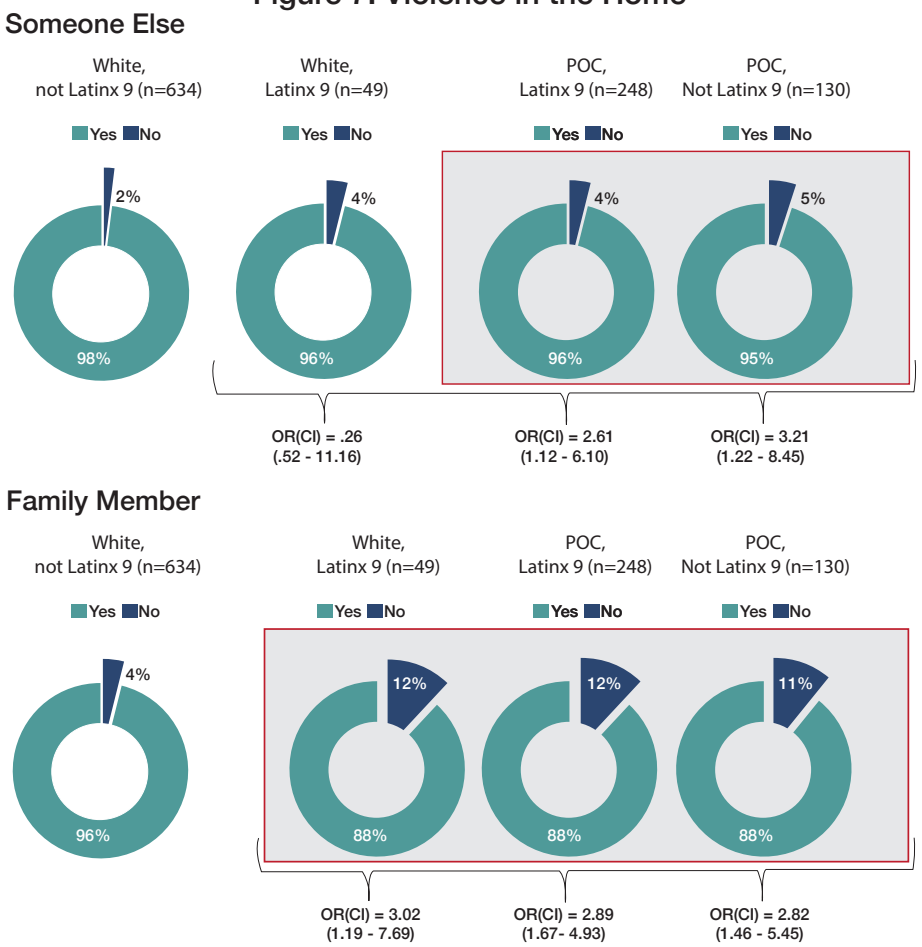
Figure 6. Anxiety and depression as measured[25] by the PHQ-4



Violence in the Home

It is important to note that home may not be a safe place for many individuals, particularly transgender individuals. Many transgender people experience conflict or rejection from their families due to their gender identity. For instance, 801,100 transgender people would say that their relationship with their parents is strained or conflicted.[31]

Figure 7. Violence in the Home[32]



Additionally, based on data from the 2015 USTS, we estimate that 755,900 transgender adults have experienced intimate partner violence in their lifetimes.[33] Official orders to mitigate the spread of coronavirus, like "stay-at- home" orders, may place transgender people in situations where they must shelter with family members who do not accept their gender identity and may place transgender people at added risk for intimate partner violence.[34]

Recommendations

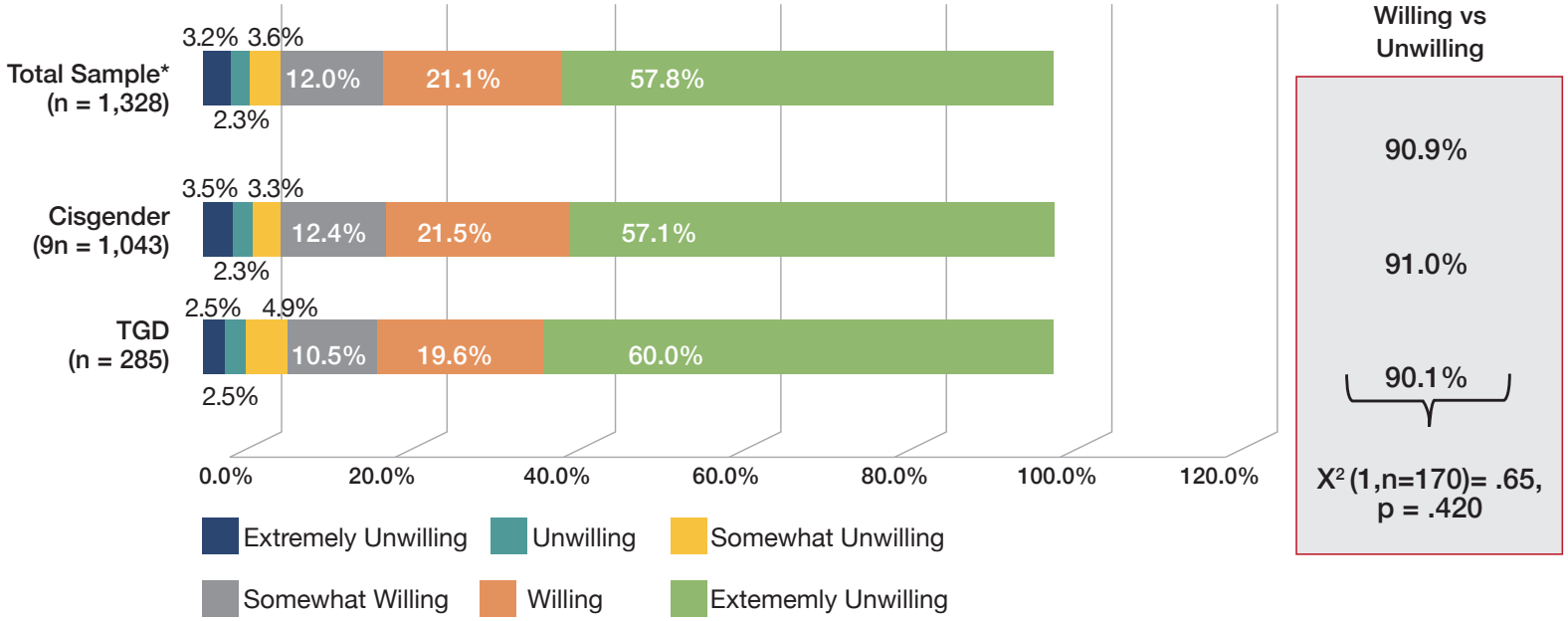
The staggering racial inequities in COVID-19 are not new, nor an accident. They are a reflection and result of a long history of systemic racism, neglect and disinvestment in some communities over others across the state and nation. As COVID-19 has exposed, the consequences of such neglect extend far beyond historically disenfranchised populations to the physical and economic health and well-being of all communities.[35] To that end, we offer several recommendations grouped in three themes: community engagement; transgender and gender diverse inclusion; and, data and transparency.

Community Engagement

Create culturally adapted programs for COVID-19 vaccinations
When a COVID-19 vaccine is ready for widespread use, the question of who will get it first will present a major equity stress test.[36] An equity perspective requires the most vulnerable people are among the vaccine first to get the vaccine. Health care workers and nursing home residents must also be at the front of the queue. This can be accomplished by using our existing local public health infrastructure to develop equitable prioritization. Grassroots community-based organizations that have trusted relationships must be engaged to broker this community strategy. We can create workplace vaccination centers for essential workers as well as pop-up locations in the hardest hit zip codes and neighborhoods where vulnerable families live.[37]

Recommendation: Connect local health departments in Texas willing to create vaccination plans with trusted TGGD grassroots community-based organizations.

Figure 8. Willingness to get a COVID-19 vaccine[38]



*prefer not to answer removed

Increase research in Suicide Prevention/Intervention

In Texas, there were 3,488 deaths by suicide in 2016, with 1-1/2 times more suicides than homicides. The highest rates in Texas are for seniors and the middle ages. Suicide is the 2nd leading cause of death in Texas among older teens, college age youth and young adults and the 3rd leading cause of death among young teens, ages 10-14. However, suicide is considered to be among one of the most preventable of public health tragedies.[39]

The Texas State Plan for Suicide Prevention provides recommendations across the lifespan, including Strategic Directions, Objectives and Strategies specific to the state. The key underlying framework of the original State Plan and this update is that suicide prevention is intended to be community-based and provides the structure needed to coordinate and collaborate across public and private resources. Specifically, Objective 9.3: Promotes the safe disclosure of suicidal thoughts and behaviors by all patients. Texas Health and Human Services Commission and the Texas Suicide Prevention Council support the education of providers about safe and effective guidelines for conducting suicide risk assessments including the Columbia Suicide Severity Rating Scale - C-SSRS.[40] The C-SSRS[41] is employed at all of the state local mental health authorities.

Recommendation: encourage primary care and private providers to deploy the C-SSRS through continuing education and training programs and collaborative outreach with primary care organizations.

Invest in evidence-informed scalable pilots and demonstrations
Understanding the relationship between stigma and suicide attempts within transgender populations is particularly relevant given that in the United States, the lifetime prevalence of suicide attempts among this group is estimated to be as high as 41.0%,[42] compared to less than 9.0% in the general US population[43] and approximately 10–20.0% among lesbian, gay, and bisexual (LGB) adults.[44] It is important to note that these estimates are based on data from convenience samples of transgender individuals, given the lack of population-based data on transgender populations in the US. These disparities highlight the urgent need to better understand attempts and the factors that heighten transgender adults' vulnerabilities to attempted suicide.[45] Preliminary evidence to suggest that societal-level changes (e.g., state-level policy reform) may influence the prevalence of suicide attempts in transgender individuals.[46]

Recommendation: identify and encourage mental health and local community organizations pursue evidence-informed scalable pilot projects and demonstrations to better understand the relationship between stigma and suicide attempts.

These disparities highlight the urgent need to better understand attempts and factors that heighten transgender adults' vulnerabilities to attempted suicide.

Further, relatively limited transgender and gender diverse clinical research exists in Texas. The Patient-Centered Outcomes Research Institute (PCORI) funded Trans*FORWARD*: A Statewide Transgender-Powered Research Collaborative in Texas to establish regional research hubs across Texas. TGGD people, clinicians, and researchers are developing patient-centered outcomes research and comparative effectiveness research projects.

Recommendation: identify community-based, regional funding organizations, and healthcare organizations to collaborate with the eight regional hubs to implement pilot projects. Pilot project data can be used to scale federal funding projects improving TGGD health outcomes.

Transgender and gender diverse inclusion

Emphasizing Patient-Centered Medical Home and Primary Care
The medical home encompasses five functions and attributes: Comprehensive Care, Patient-Centered, Coordinated Care, Accessible Services, Quality and Safety.[47] Risk and vulnerability encompass many dimensions of the transition from adolescence to adulthood. Transition from pediatric, parent-supervised health care to more independent, patient-centered adult health care is no exception. The tenets and algorithm of the original 2011 clinical report, "Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home," are unchanged.[48] Transgender adolescents are a marginalized and at risk population; compared to cisgender (non-transgender) peers, they are more likely to experience bullying, victimization, and depression. Given the evidence that gender dysphoria and psychological functioning improve following social and medical gender affirmation, it is imperative that medical providers identify transgender adolescents and connect them to appropriate services.[49] Initial results from this ongoing qualitative study of a rarely interviewed population demonstrate that transgender youth, even when reporting positive experiences with their primary care provider as participants in our study did, have several recommendations to improve care in their medical home to better meet their needs.[50]

Recommendation: identify influencers such as People's Community Clinic (Austin) and other FQHCs employing a transgender medical home model as demonstration and awareness education sites. Identify collaborating organizations to expand into adult primary care organizations using TGGD processes and framework.

Develop Community Health Workers transgender and gender diverse continuing education programs

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[51]

Recommendation: identify willing continuing education developers to develop new TGGD courses. Example topics might include:

- Creating and implementing a COVID-19 Vaccine Plan with significant attention working with BIPOC (Black, Indigenous, People of Color) communities.
- Delivering culturally competent transgender healthcare. Respectfully collecting Sexual Orientation and Gender Identity (SOGI) information.
  Training front line and back office staff in respectful interactions with TGGD people.
- Designing patient information collection forms and electronic health record systems to include chosen names, pronouns, gender identity, working with TGGD people who are not "out."

This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery

Data and Transparency

Continuing BRFSS SOGI opt-in Module 21 participation

In 2013, the CDC developed a question module for the Behavioral Risk Factor Surveillance System (BRFSS) to collect data on Sexual Orientation and Gender Identity (SO/GI). The CDC began giving states the option to add this module to their BRFSS questionnaires in 2014 and is currently one of the 25 optional modules that are decided on by

individual states each year. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. The SGM-related questions are included in an optional SOGI module of the survey.[52] Texas added Optional Module 21: Sexual Orientation and Gender Identity in the 2015 through 2019 questionnaires.[53]

Recommendation: Encourage the Department of State Health Services to continue adding Module 21 in future questionnaires.

Ensure transgender and gender diverse people are added as key stakeholders in Ryan White funding decisions

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV. The RWHAP funds grants to states, cities/counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.[54] Of the over half a million individuals who received HIV care from HRSA's Ryan White HIV/AIDS Program (RWHAP), 1.9% were transgender.[55] The low percentage of transgender people receiving Ryan White funds is an example the population is not represented as a key stakeholder in the communities awarded funding.

Recommendation: encourage intentional efforts at the local level to increase TGGD participation and funding. Local health departments and healthcare systems who receive the bulk of the funding should seek out and connect with TGGD grassroots organizations, especially BIPOC TGGD organizations.

Acknowledgement

THI is grateful to Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (EA #10671) for funding the patient-centered engagement part of our work. We are most appreciative of the transgender and gender diverse people in our project, our clinicians and researchers who provide culturally competent transgender healthcare and actively participate with us. Our group has provided invaluable insights through our discussions, regional summits, and Project ECHO sessions. The combined efforts substantially contributed to the development of this brief.

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About THI

Texas Health Institute (THI) is a non-profit, non-partisan public health institute with a mission to advance the health of all. Since 1964, THI has served as a trusted, leading voice on public health and healthcare issues in Texas and the nation. THI's expertise, strategies, and nimble approach makes them an integral and essential partner in driving systems change efforts. THI works across and within sectors to lead collaborative efforts and facilitate connections to foster systems that provide the opportunity for everyone to lead a healthy life.

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Endnotes

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[30] This estimate relies on data from the 2015 U.S. Transgender Survey, which was

conducted by the National Center for Transgender Equality. Analysis completed by the authors. (To find out more about the U.S. Transgender Survey, visit http://www.ustranssurvey.org/reports.)

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