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GENDER AFFIRMATION SURGERY & AFTERCARE: WHAT PROVIDERS NEED TO KNOW

Sangyoon Jason Shin, DO

6/15/2022

CLINICAL EDUCATION INITIATIVE
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE

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[video transcript]

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Dr. Sanyoon Jason Shin. Jason Shin is an attending physician of the Department of Medicine at Mount Sinai Beth Israel Medical Center. He is an associate professor in the Department of Medicine at the Icahn School of Medicine at Mount Sinai. Currently, he serves as the medical director of ambulatory care for the Mount Sinai downtown which includes unions where the Blavatnik family Chelsea Medical Center and the New York I and air informatory of Mount Sinai and Burma right at Mount Sinai since 2016, Dr. Shin has also served as medical director of preoperative services and preoperative quality slash safety for the Mount Sinai at Sinai downtown campus including New York Eye and Ear Infirmary of Mount Sinai. He has led efforts to standardize and improve the preoperative screening process for surgical patients, yielding decreases in operation room case delays cancellation rates within 24 hours and rates of adverse events. Additionally, he has created Mount Sinai Health Systems only universal point of pre admission testing or Pat, a program that has increased convenience, efficiency and satisfaction for our pre surgical patients. In 2015, he as he was the lead hospitalist for the surgical code management service, collaborating with multiple surgical specialties to provide post operative medical management. He currently serves as medical director of the inpatient services for mountain Sinai center for trench medicine, and transgender medicine and surgery, or CTMS, where he helped to develop a novel interdisciplinary approach to care for transgender surgical patients. These efforts led to commendations during the Joint Commission on Accreditation of Healthcare Organizations surveys, as well as some of the high highest Press Ganey scores in the region. Prior to joining the Mount Sinai Health System, Dr. Shin served as Assistant Professor in the Department of Medicine at SUNY Downstate Medical Center, and an academic hospitalist for the Northwell Health System. He completed his internal medicine training at the Philadelphia College of Osteopathic Medicine Conservatorium and earned his Bachelor of Arts from Tufts University. That was a mouthful. So thank you so much, Dr. Shin for being here today, helping create this course for us at CEI. And I will let you take it from here.

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No, thank you for that really long and welcoming introduction. So hello, everyone. I'm very honored to be here, especially in the month of June. Thank you to the CIA and the team for inviting me. I am is a very special place at Sinai. And I'm very excited that, you know, we're able to really do this together today to just go over, you know, some of the some of the things that I've learned over the years, this is going to be a very collaborative informational session that I hope if you have questions, please do ask and I look forward to spending the next hour with you. So the title of the talk today will be gender formation, gender, affirmation, surgery and aftercare, what the providers need to know. And again, I have no disclosures to share at this point. Some of the learning objectives will be we will discuss how to best prepare patients for the GHS gender affirming surgeries review the different types of surgeries that are available currently, at our campus at Mount Sinai, we will then identify common gender affirming post surgical issues and how we offshoot them, and then I will do my best to try to explain the importance of the psychosocial aspects of how we recover our patients. And I think I hope some of this will be useful in your own setting. So for the brief actual overview, we will go through an

introduction of what we do. And essentially I'm going to take you through a timeline of how the patients navigate our health system from the conception of surgery through the optimal, you know, medical optimization that occurs three months prior to the or through the two week period, and then immediately post up what we do. And then we'll go through the specifics of how we medically manage our patients. And really the importance of other aspects that are included in the patient's recovery, such as the social support and the psychosocial considerations, how our nursing leads are really crucial to the recovery process, what we measure in terms of, you know, how we track the levels of success for the post discharge course, and you know, and I would love to talk about the next steps with all of you. So why don't we get started So to introduce, you know, our background and how this came about, you know, for our transgender patients in our community, you know, it is a known, published fact that, you know, our patients are at increased risk for experiencing discrimination, and having misunderstanding during, you know, their provision of health care. So this really leads to a decreased access to high quality care specifically for our trans patients. So having that mindset, you know, we at Sinai really wanted to develop a patient centered, multidisciplinary integrated care model, where we can really follow the patient, you know, in a in the best way from the point of contemplation of surgery, all the way through to a point of full recovery. So our existing approach really builds on it recovery model that, you know, is already out there called eras, I'm sure some of you are already aware. So taking some of the evidence based approach from colorectal and other surgeries, you know, surgery services that we've succeeded in, we wanted to capitalize on five key opportunities. So we wanted to foster a collaborative decision making process. How do we best put forward a preoperative lifestyle modification for our patients? How do we standardize the current existing perioperative care? And really, how do we achieve the full post operative recovery in the best way, and use the data to drive further quality improvement. And really, we you know, we really believe that rethinking the clinical pathway in a multimodal interdisciplinary fashion was the best way to go forward in terms of approaching our transgender surgical patients, we wanted to improve quality and reduced resource utilization.

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So just to give you a visual, you know, overview of how we approach our patients. So starting three months prior, you know, we do have various disciplines of infectious disease management, hormone management, psychosocial along with other assessment that, you know, we complete in order for our transformations to move through the affirming process. And then really, from the two week period, prior, we move into a very active stratification with our anesthesia colleagues, in terms of the cardiac risk stratification, what are the non cardiac issues to consider, you know, continuing to promote the smoking cessation, the infection prevention measures that are in place, and then the surgery actually occurs? And then how do we follow our patients in the post operative setting immediately? So what are the considerations from the surgical standpoint? What is What are the common medical issues that we run into? What are the social and nursing, you know, components that we really had to really learn, you know, through the various cases in order for us to come up with the best model. And you know, I'm safe, and proud to say that, you know, our partnership with our nursing and social work colleagues have really been crucial for achieving success. So let's start with the three months prior, how we greet our patients and how we optimize them. And I hope some of this will be helpful to our medical colleagues out there. So really, we start out with various components of

the infectious disease screening and management, hormone management, psychosocial assessment, how we document our visits in terms of getting the right documents through to get the approval, you know, we do have some considerations of the BMI in terms of the surgeons, you know, preferences and requirements, how we move through the reproductive counseling. And, you know, also how do we financially navigate these cases for the patient's, you know, best outcome and obtaining informed consent? So, for the infectious disease management, you know, where do we start? You know, do we screen everyone for STIs? You know, based on, you know, what a particular group that the patient may belong to? Obviously, the answer is no. And I think that is really one of the key things that we've had to really educate and really influenced the culture of practice among the providers that are out there, you know, we want our patients to be treated the same, we want the risk assessments to be based on the current anatomy and the sexual behaviors that the patients present with and you know, obviously, you know, our patients can be at the, you know, category of high risks, you know, based on having multiple partners and having practices of unsafe sex and if that is, you know, turned out if that turns out to be true during the, you know, the Health Information taking process, then we will recommend to do further testing, you know, with serologic screening processes with HIV, hep B and C and syphilis and others, but again, you know, we don't hydroactive for the recommendations or the technique, you know, for trans patients that would be, you know, different from our non trans patients. For the, you know, the prevalence of HIV and how we manage our patients, we tried to have the viral load to be undetectable, sometimes that is not possible. So I think up to 200 copies per ml, you know, I think the literature does point that up to 10,000, based on the surgeons comfort and preference is okay to proceed, I think, in our particular setting, our surgeons do have a pretty low threshold, because when we get into the procedures such as you know, facial feminization, or some of the other procedures, where, you know, there is a high risk of sort of, you know, insult that could potentially happen to the surgeons, so we do want to be mindful, you know, we do look at obviously, you know, with the neutrophils, and to see the port count to be adequate for our patients to proceed. And again, you know, the patients are advised to continue the, you know, the retroviral therapy throughout, and the compliance is obviously, you know, stressed and assessed during the history taking process. And we do work pretty closely with our infectious disease colleagues, to make sure that the patient is, you know, at an optimal point. You know, anecdotally, we did have a few cases where the patients have changed medications, or there was some sporadic use of the therapy where, you know, the viral load was, you know, moving up and the patient's status had to be, you know, monitored a little bit longer. But again, you know, it doesn't happen too often, which, luckily, for us, were able to proceed Hepatitis C, again, you know, we want to try to have the patient to be in remission prior to surgery. And we, you know, coordinate this very closely with our hepatologist through direct referral process.

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Hormonal management, again, I think, starting early to understand what mode of the therapy that the patient has been on. And understanding the duration of the therapy is really important in terms of how we titrate and have the patients to continue the hormonal therapy. And it's interesting, you know, about five years ago, I think the general consensus, especially in particular with the estrogen use, was to really stop prior to any major surgery. And through the data that we collected at Sinai, you know, about 900. And I think it was about 50 patients, we

actually found that, you know, holding was in what not, not only was it contributing to, we had no really incidents of adverse events. But we actually found that, you know, there are current evidence and anecdotal episodes that did suggest that the patient's, you know, actually did not do very well in terms of the mental health standpoint. So there were increase in suicidal ideation. And I think the prolonged period of not being on the hormones did deteriorate some of our patients status, so we actually continue our estrogen therapy, unless there's a history of thrombophilic condition that is present. But you know, we found this to be not a high risk procedure, and I'll share the paper that we published in the Journal of endocrine. And this really, I think, did set a new tone, in terms of how we approach our patients. And if you look at the estrogen data that really exists out there, a lot of it is based on the post menopausal woman, which really is a bit different than how we should approach our translations. So I think if you have patients who are on estrogen, I would ask to continue. And I think looking at the mode and the duration of the therapy is probably the most important thing to do. And if the patients have been on the therapy for a long time, then it's probably, you know, a very safe practice to continue and follow through the normal, you know, prophylactic measures in the post operative setting. So that's, you know, what we have to say about the estrogen therapy, in terms of the testosterone measures, you know, we do look at the viscosity. So if the H and H, you know, does tend to be a bit higher than the cut off of the 15 slash 50. You know, we will hold generally in about two to four week period, depending on how the injections are given, and try to collaborate with the discussion with the patient. Any questions so far? Okay. Just looking alright. So, this is the paper that I described, where, you know, we really wanted to understand for ourselves why the general practice was developed prior to our involvement of, you know, stopping hormones. And, you know, I think really questioning you know, how we want to approach our patients and having a research that is specific fit for a transmission to move the needle is very important. And, you know, we found through our data collection that you know, no, you know, venous thromboembolism, the incidence, there was no increase among our patients and remaining on estrogen was safe for our patients. So you know, we're very happy to continue to hormone in our patients and have a safe outcome also at the end. Progesterone, you know, it's interesting. So we actually don't give progesterone in the setting of concurrent treatment with estrogen, there is data, suggesting that there are higher risks of cardiovascular disease and breast CA, in terms of a prolonged use. So these the synergistic sort of approach that, you know, is out there, we routinely don't do that. So, you know, if the patient's on it, you know, I would have some discussions around the progesterone. But again, I think estrogen is really the, you know, the major hormones to continue and to look at, in terms of spironolactone, you know, there's no evidence of increased risk monitoring the potassium levels, but again, I think, because it is a diuretic, to reduce the risk of intra operative hypotension, you know, we do hold on the day of surgery. And again, it's given for the moderate, anti androgenic effect, in conjunction with estrogen. So this we do see often from our endocrine colleagues, but again, spironolactone, we will hold on the day of surgery.

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What are some of the psycho social needs that we do need to address, so we have a pretty robust process in terms of screening our patients to make sure that the level of satisfaction stays in the post operative setting? Right, there's no regret. And you know, it's a very arduous, prolonged process. So when you, you know, read about it in the news of, you know, farming

care, I mean, if you look at the, the months of the recovery, right, the time off from work that's required is about three months for our patients, you know, and, you know, having a caretaker, having the right lodging, you know, having to transportation, that's all setup. So I just want to show that it's a huge commitment from our patients to do this. And having the right psychosocial assessment and support is crucial. And I think this also stresses the importance of, you know, why our patients do this, right. You know, this is not something trivial to our patients, it's a major commitment and how we take our patients, you know, we need to take our patients in a really a serious manner, and to navigate this process with them. So in terms of the housing and the support, you know, our social work team will start to log a list of our patients and start to do a screening outreach. And the psychiatry assessment is done for the emotional risk and the concern for a potential at the compensation. And really, I think understanding to understanding to be trauma informed about the patient's past history is important at this point. And again, we will reassess at the time of the medical evaluation. And, you know, I have daily conversations with my mental health and social work colleagues, just to make sure that, you know, things are stable to proceed. The medical necessity letter, I'm sure many of you have come in contact, or you know, have had questions about this, right. So currently, with the states sort of navigation, it's built around a gender dysphoria code, which is a psychiatric code, and hopefully, I hope something that would change I think over time, but I think in terms of the documentation, right, we do need to have a language that indicates that there is persistent dysphoria, despite ongoing hormonal conservative treatment, and establishing a medical necessity to have the proper coverage that would come with the surgery. Or our campus at Sinai, we do have BMI cut off at the surgeons discretion and preference. So for the male to female, vaginal plasti, as well as the phalloplasty cases with the FTM cases were a little more flexible, but I would say in particular with the vaginal tissues on BMI of less than 33 is required for the hysterectomy and orchiectomy. You know, for the obvious reasons, you know, the BMI requirement isn't much different than some of the other procedures that we do. So less than 40 is required. And, you know, while the evidence is scant, you know, BMI can be an independent risk factor for some of the conditions. So, you know, we do try to take that into consideration. But if the metabolic equivalent or the exercise capacity is high, I think then some of those things can Okay, um, and you know, we do early referrals for nutrition and medical weight loss, which is, you know, an easy access for us at Sinai. Some of the reproductive options and consultations, we do try to do this early, we do have a very robust department within Sinai for our trans patients to consider options. And you know, whether it's a cryo preservation of the sperm prior to the surgery or in early stages of the HRT, you know, we do want to try to encourage and the counts, you know, may not return to the pretreatment level after the discontinuation. So this is something to consider, I think, for our patients. And really, I think for our, you know, trans male patients, right, I think harvesting and preserving some of the Oba prior to the hysterectomy and the rectum ease. Pregnancy remains possible after the initiation than the discontinuation of the testosterone. However, it may not return to full fertility. So we want to make sure that we discuss these options early with a specialist. You know, interestingly,

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you know, there are current studies going on in terms of looking at the aneuploidy of the harvested ova in terms of our trans patients who have had prolonged exposures to testosterone. And if you look at the current evidence of patients who have had PCOS, for instance, the, the

the quality and sort of the aneuploidy of the ovaries tend to be low in terms of so the aneuploidy seems to be low, were making the quality high for the harvesting. So again, I think, you know, is this something that would carry over to our trans patients who have had a prolonged exposure to testosterone, perhaps so this is something that we're exploring and, you know, we find to be a an encouraging sort of a quote unquote, side effect of being on a prolonged hormone therapy. So um, you know, something to consider that I think, that we can do. I have a question, many patients asked for letters for surgery on the initial primary care appointment, it is hard to attest to persistence for based on one visit, I have only not written a letter once, I'm not sure why it still needs to be done. Yeah, I think with the the care, the persistent piece is important. And the prolonged use of hormones is, you know, something that we do, you know, get asked about. So I would say that is an important piece that you know, we would consider. Okay, so let's move on. Financial navigation, obviously, is an important piece, we do want to try to cover as many of our patients as possible, navigating their insurance, you know, can be sometimes very stressful. So we have a team dedicated to really making sure that the proper documentation, the testing, and the language is evidence. So you know, we want the patients to feel comfortable. And through the informed consent, right, I think we want to have the patient's empowered to, you know, not only provide the consent, but understand what you know, is at risk in terms of moving ahead with this procedure. Right, as you know, it is not reversible. So, you know, we want to make sure that this piece is well taken care of. So, that is at the three month mark. So now, we have the surgery booked, you know, the letters are approved, the initial clearances are given. So now, how do we medically optimize and approach patients at a two week mark? So really, this is the point where there is an active discussion with our anesthesia colleagues, you know, we looked at some of the the high risks, you know, that may be involved in terms of the cardiac conditions and non cardiac conditions. So I'll you know, walk through the Sinai approach in terms of how we optimize our patients. And we'll look at the importance of smoking cessation and also the infection prevention measures that we've put in at Mount Sinai. So really, I mean, many of you have done this, but you know, the whole point of doing a decent preoperative medical evaluation is really to identify, assess and optimize any clinical risks that may be present. So we can, you know, offer solutions that may influence short and long term outcomes. This really goes beyond in my opinion, you know, medically clearing a patient, we want to be as comprehensive systemic and specific as possible. So not only reviewing the patient's known medical issues and identifying the risk factors, but really suggesting with specific parameters, how do we optimize patients in the perioperative period, you know, is what we do that I think is very crucial. So you know, instead of writing you know, control blood pressure, right, we can give some types graded range of blood pressure when to start, you know, the when to restart the blood pressure medication and the post operative setting. And again, I think with some of the older, you know, trans patients that we have had, we want to be tried to, we want to try to understand all the aspects of known risk factors before we proceed with the cases. So how do we perform our risk stratification at Mount Sinai? So really, you know, initially, it comes down to booking the case, understanding that the right as a category is given or assigned to the patient. So you know, as a one tends to be a very normal healthy patient, right as a to being a patient with a mild systemic disease. And as a three, generally is when we start to, you know, look at some of the conditions more specifically. So, you know, is there a systemic disease that's severe? Are there substantial functional limitations, right? What type of anesthesia do we use? What are the sorts of the kidney conditions that we would look at.

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So these are the most common cardiac risks tools that we use, I'm sure many of you are already aware of some of these risk factors. So we have the revised cardiac risk index, the mica, or the Gupta risk index, that's more specific to the cardiac risks, the ACS Nesquik calculators, you know, that are quite broad, but is the most sensitive, and obviously, the vascular one we don't really use for the gender affirming care. But, you know, the reason I put these existing models up is I wanted to show that, you know, particular models do have a binary way of logging the patients in terms of the risks, and certain ones don't. So we actually try to use the risk screening tools that don't have a binary gender specificity, right, because I think, as we develop the model of care around or trans patients, you know, we want to have a simple system that is not discriminating, you know, in particular, with our non binary population. So, you know, if you have patients that are geared more towards an inpatient service, I think on rcri is a good one. Right? You know, it tends to stratify in a very simple way into the low intermediate and the high risk categories. You know, the mica tends to be the most sensitive in terms of some of the elective and the sort of cosmetic work that's offered to the patients. So again, using the independent predictors, you know, and you can find all these calculators in terms of getting the perioperative risk, and the mace events and or in terms of the major or cardiac events to occur. And again, I think, if you want to have the most specific, sort of the sensitive tool, you know, it would be the NIST Squibb which can calculate not just cardiac, but nine other significant outcomes. So this is the tree that, you know, we generally walk through in terms of having our patients to be, you know, safely assess from a cardiac standpoint. So when the patients are scheduled with surgery, you know, the first thing we really looked at is, you know, is it an emergent surgery? Or is it a non emergent surgery? I mean, for many of our patients, you know, it's, it's urgent. So, you know, we do want to try to proceed as quickly as we can. Interesting to note that during COVID, you know, we did, you know, really, you know, we really tried hard to not stop, I think, you know, some of the cases to the delayed in a really prolonged fashion, because we really did believe that, you know, this is of a medical necessity and over urgent nature that we wanted to proceed with, you know, having our patients to be operated on. And, you know, we're quite proud of that. And I think our patients are too. So understanding the risks and the urgency and the beginning. And then we move into, you know, is it a low risk surgery versus a high risk surgery? And, you know, really the most important piece is, you know, what is the functional capacity of the patient? Right, so, can the patient walk, you know, one flight of stairs? Can the patient walk, you know, four blocks, you know, in the city, you know, that was suggested to me of a metabolic equivalent that's greater or equal to four, and then you would know that, okay, do I need any further testing to assess? And generally, if it's a if the answer is yes, then you would proceed? If there is a poor functional status, then, you know, you can consider at that point, you know, do we, you know, want to consider a further pharmacologic stress testing again, but I think it's important for us to know that depending on the EKGs, and diagnostic testing that we put out there, if we do follow the path of revascularisation, you know, it would delay the case for, you know, pretty much of an extended you know, extended amount of time So, you know, we do want to be judicious about who to which types of patients we send to cardiology. So again, so this is a very simple way of thinking about the perioperative process. One of the measures, sorry, let me just look at the questions,

how do you navigate the dichotomous segregation pre and post surgical housing? I will answer this at the end. So I will come back to Okay.

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Um, one of the things we look at, you know, that, you know, we incorporate it outside of the cardiac screening, and I think this is something that's very quick. And if our ambulatory colleagues around the state can really do this with us, I think it would really add tremendous value is to really screen the sleep apnea early on through the stopband questionnaire. And, you know, the questionnaire is pretty simple, as you can see, right, in terms of the symptoms that are present, what is the BMI of the patient, right? Is there a high blood pressure that is marked by the patient, what's the age and of the neck circumference. And, you know, it's interesting that in the post surgery, surgical setting, during recovery, we have found in time and time again, that patients who have scored high actually did have episodes of, you know, retention, and opioid related, you know, respiratory failure. So, I think, you know, for us to do this early on, and to try to intervene by having, you know, the right, you know, rightfully, you know, die diagnosed and, you know, fitted CPAP machine, or the BiPAP, that will be available, I think is really crucial for us. So this is something that we've incorporated into our clinics to make sure that we can screen out some of the high risk patients, the stopband scoring of five or greater, would be of concern. And that's something that you would mark, and the stop band of between three and four, but with a co2 value, or the bicarb, that is greater than 27. So 28 or higher, would equate the stop pain scores to turn into six. So that would indicate that the patient would be at an elevated risk for the sleep apnea. So you know, we do want to suggest that to our patients, we do go through pretty robust screening of the risk for the VT prophylaxis. So we want to make sure that, you know, in terms of the scoring, you know, most of our patients would fall into the moderate category, given the nature of the surgery and hormonal prescription. So, you know, obviously, having the mechanical as well as a chemical prophylaxis is suggested, but we do want to, you know, be mindful of some of the higher points and extended criteria that would, you know, sometimes come across, sometimes that we come across. So, you know, it's important for us to do this on every patient, and to really understand that, you know, that, you know, at some points if we need to give the post discharge prophylaxis that we would do so. So, again, the majority of our patients, you know, we want to be mindful to provide adequate coverage, I think, for those patients who are at high risk, we want to make sure that, you know, we go through the prophylaxis, and give the extended therapy as needed. Again, if there's a history of the hormonal therapy, then, you know, we would think about changing the route of the hormonal therapy, and, you know, considered to give an extended treatment in the discharge setting some of the common tests that we order, right in the pre surgical setting, again, we don't order all these tests, it's based on the discretion of the provider. And I think, you know, some of the testing, you know, is as needed, given the patient's presentation. Smoking cessation, you know, is one of the most important ones that we screen, in particular for the primary tissue related transfers, so, vaginal plasti and phalloplasty is we really tried to stress that, you know, because smoking is related to the detrimental effects of the vasoconstriction and the relative ischemia. You know, we do take this pretty, you know, seriously and strongly in our patients. So, you know, when the nicotine and cotinine levels are above the cutoff, we will have an active discussion with the surgeons.

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Infection Prevention, you know, we implemented a daily preoperative chlorhexidine wipe three days prior leading up to the or this has actually led to a much more decreased the incidence of SSI and surgical site infection. So again, I think, you know, something of an idea that came from the OBGYN world, you know, we use now for our, our trans patients, and, you know, I think this has been a great step that's been added to our process. So now now I will walk through with you the the post operative considerations and recovery. So these are the types of procedures that are offered at Sinai and the recovery of the hospital stay that's related. So for the vaginal pasties of the primary from the discharge to the post update three, we do try to, you know, have our patients within the 90 minutes vicinity revisions, generally, we try to discharge within 24 hours and on post op day one, again, depending on the deepening and related procedures, we will tag the Visiting Nurse service to support the patient's facial feminization can be anywhere from outpatient to a one night recovery. transmasculine surgeries are much more prolonged and challenging in terms of the recovery. So we do have skilled facilities, you know, these are done in stages. So we want to make sure that the recovery planning is done well in advance. And the top surgeries, you know, are of a lower risk in terms of the procedures that are offered. We use a Winback therapy that we've taken from the orthopedic practice, and this has really led to an increased speed of granulation and decreasing complications. So we're very happy with this mode of recovery that we offer to our patients. And again, for the chemical prophylaxis, right, you know, we tried to have a vast majority of our patients to be in the moderate category to have mechanical as well as the chemical prophylaxis. But you know, understanding that some may fall into go home with some of the Lovenox coverage for about one to two weeks to you know, depending on the mobility, that, you know, presenting, really get moving, you know, we want our patients to walk as soon as post op day one, you know, twice a day, you know, to the bedside, and coming back, pulmonary toilet, you know, bowel function returning, you know, these are all the steps that we do try to standardize and to, you know, to give to our patients, and it's been a very helpful way for our patients to recover, you know, with our team that, you know, is supporting the patients. So, what are some of the other components that we look at, you know, adapting the enhanced recovery process? So, you know, looking at the pain control, you know, right, I think with the current, you know, opioid, you know, situation, right, how can we have an established system, you know, around meds that are non opioid based pulmonary toilet and hygiene is very important for us vital signs on a two, four hour basis with the escalation of the vital signs that are deranged, VT prophylaxis, along with an infection control that's very specific to our patients. And, you know, and discharged, obviously, on the Seven Day Course. Gi and nutrition, you know, we have a nutritionist that's also rounding with us, I'll get to that in a bit. But we have a pretty robust interdisciplinary approach in terms of how we recover patients from a nutritional standpoint, in terms of the Foley right, I think post op, day seven and bottom surgery patients, you know, it will come out, and the activity, you know, it's a pretty rapid process, you know, on post op day one without sitting up, right, we do want them to start moving. And, you know, we want the patients to move as quick as we can.

38:32
So, in summary, you know, I think, on the surgical part, and we're gonna go through the recovery after this, the interdisciplinary approach, but you know, we continue the hormone therapy, the negative blood pressure has been a different process that we've adopted from

other existing evidence based literature that's been successful to us, and really, you know, implementing the tried and true methods of the era's protocol, and the teamwork has been contributing to our current success. So in terms of the approach that we do for our patients, I just want to share with our providers that are out there that really just as it is with other, you know, health care related issues, having an interdisciplinary interdisciplinary approach really solved many of our existing, you know, concerns that we had for trans patients. So from the medicine standpoint, right, some of these things are very common in the post operative setting, right, so looking at the volume status, looking at DVT prophylaxis, but I think really what made the difference for us was instituting an interdisciplinary approach for all of our patients from the post op day one through the discharge. It really allowed us to address active issues quickly and promote the discussions to happen. So what we do is daily, we round on all our patients and I actually did this right before I came here in starting in 2018, with an interdisciplinary team of clinic co-chair with a surgical, you know, with the surgeon or the PA spiritual care, psychiatry, nutrition, social work and, you know, our various team members from nursing, we round on every patient. So we go through what are the specific needs, what occurred overnight, and we try to offset all these active issues as they come up. So, you know, having the staff that have gone through the transgender sensitivity training that are already trauma informed, right, I think this has really been a game changer for us. And, you know, having our team to do this on a daily basis, this is obviously pre COVID. But I think having our team to really show that we care in a group, sort of an interdisciplinary fashion, really allowed our patients to feel safe, and to recover in a very meaningful way. So, you know, our social work, I mean, you know, team members are really one of the most important sectors that we have, you know, looking at the psychosocial considerations, you know, doing the robust pre admission planning, and having the right and correct transportation and post operative discharge, you know, as something as simple as transportation, you know, it really can derail the whole sort of the recovery and the impression. So, you know, we want to try to make sure that we do that appropriately. So, you know, we really strive for care, that's trauma informed, right? Why are the patients you know, afraid to travel during the day, it's because they may have had more incidents than, you know, I may have had during the day, and the nighttime is more comfortable for them to, you know, show up to the appointment and do other important things, right, I think we want to be as affirming as possible, you know, we want to align what the patient's needs and expectations are, we want to empower them, right, we want to explain things in a plain language, and also take our existing barriers into the account. So, you know, this all really starts with the pre admission planning from our social workers, where they really try to recognize what are the cultural and, you know, diverse sort of, you know, needs that our patients may have, and really imparting a sense of empowerment to the patients and the caregivers, that this is the process that you're going to go through, these are the needs that you will have, and these are the things that we would ask you to prepare before you land on the day of surgery. And I think being flexible in terms of the care planning, right, so changing the apartment, changing the caregiver, you know, having a the right type of cushion to sit on. And if they don't come in with one, you know, we're happy to supply one. But again, I think having the collaboration and the discussion early on has been very important to us. So this sort of gives you a visual overview of how we land on the satisfying and you know, the satisfactory transition of our patients. So having the right transport through the homecare through the servitude facility through the caregiver, you know, having the medulla or the wound back company to, you know, be with us every step of the way, and giving

us an option on number, having the outpatient team, right, having the right checkup on our patients, and also transitioning between the inpatient and the outpatient setting is really important. And I think that's why today's lecture is really, I'm so happy to share this with you. Because, you know, it's a work that we all do together in order to get to a safe outcome. Our nursing, I mean, I really, this is a very obvious point. But, you know, without our nurses, none of this would happen. So really having the cultural sensitivity of the preferred name and pronouns, using, you know, the right techniques in terms of how to off shoot any of the, you know, the wound back issues, or the pain related issues, really educating the patient comes down to all of our nursing staff, right, I think, how to care for the Foley how to troubleshoot how to, you know, take care of yourself when you get home. I mean, my nurses are so educated and experts at the recovery process that, you know, I sometimes ask them, you know, when I forget about some of the specifics, and they are just experts, and masters at this point of the recovery and education piece, so I'm so proud of them. And, you know, they work very closely with our visiting nurse services. So, you know, the patients go home, and we have, you know, many of these escalating issues, right, you know, where does the tube go again, you know, I'm feeling fatigued, you know, my, I'm not eating so well, my bowels are irregular, I'm in pain. You know, you, you know, when do I, you know, restart my hormones, right. So I think really partnering with our visiting nurse service, or the CHA that's out there has been crucial for us. And I think finding more services around the state that will partner and educate with us, I think, has been really key to our success of having patients from outside of New York City. So the homecare really, you know, we want to have qualified licensed professionals who are trained It's friendly and trained. And really, you know, I think having them to partner with us has been a really great addition to our group.

45:10

So, you know, we've done all this, right? I'm sharing all this stuff with you. But, you know, is this really helpful? Does this really work? So we tried to measure our success based on the pre and the post implementation by looking at the Press Ganey score. And looking at the percentile ranking, which I know some of you know, that is, you know, harder to move in terms of the improvement. But really, I think instituting this evidence based transferring the trauma informed, interdisciplinary approach to our recovery process, it really improved on all fronts. So the communication with nurses communication with doctors, the hospital environment, the discharge information, the care transition, but most importantly, the willingness to recommend, you know, really shot to a level that we were so proud of. And, you know, I'm happy to say that, currently, we have a level of puts out percentile ranking, that is some of the highest in the country. So I think, you know, it's such a difficult thing to do in New York City, but to do it with our trans patients, it really sends a strong message, I think, to our administrators and to, you know, our leaders that, you know, you know, we can take our most marginalized, needy population, and, you know, implement a process that can be modeled after for all the other patients. So, you know, this is something that we're very proud of. And, again, the approach that I've just described to, you know, we did recently published in transgender health in order to show that, you know, the interdisciplinary healthcare really approach can significantly improve their sense of satisfaction over transgender and non binary patients. So yeah, I mean, you know, we have a lot to improve on still, but, you know, I would like to, you know, have more further studies that are based on our patient population to better risk stratify. So I think, like I

showed you, you know, using their current evidence, but really to drive that up based on that, and then tailoring to our needs, I think, is really the key to success. And we've been trying to be more robust about how to do our follow ups in the three months setting. So I think partnering with many of you out there, right, the primary care providers that, you know, we want to touch base with, right, what are the necessary health care screenings. And I think, you know, for many of our patients, because they are non mobile or limited mobility, you know, limited mobility is, is present in the beginning of the recovery. So having a journal therapy with our social work team, has been important to us. So, you know, I think I really appreciate your attention and time. But I think the the key for us really, is to understand that, you know, we have many ways to go. But it's a very complicated and dynamic process. But really taking the contemplation from the very beginning, and threading a, you know, sort of the story or the, you know, the the thread of I think what we can do, right for the patients based on the existing evidence, and partnering with all of you out there, I think, will be the key to our success. So I think at this point, maybe I will look at some of the questions, Tara, is that okay?

Tara 48:32
Yeah, that's no problem. You'd like to first book in the q&a. Yeah, answer those?

48:40
Sure. So one of the questions I have a is, let's see, is there a process in place to communicate with the primary care doctors postoperatively? Yeah, I mean, you know, I originally started out my career as a hospitalist. And I think it's so important to not only send the post operative note right away, so we actually have a process where the post op reports get released, you know, immediately. So as the patients come in, we sign a waiver. And as soon as the documents are available, we send the notes to the primary doctors, but I think on beyond that, you know, if we have, you know, adverse events or some questions, you know, I've certainly engage the team to reach out, you know, while the patients in the hospital so I think that's something that we do. So yeah, I think that's really an important thing to do. And I think the second question was, What recommendations would you offer to STI clinic employees who may have to engage a client to determine their sexual history and may need to ask about body parts used when having sex and the client identifies as transgender female or male? That's actually a very good question. So I think in particular with our trans patients, I think having a very specific name for the body parts is generally a bit dicey. Because there are many ways that the patients identify with, you know, their, you know, genital organs, right, for instance. So I would say something like, you know, your your bottom or something I think that's a bit more vague is really the best way to introduce yourself if you're not if you don't have that sort of relationship with the patient in the beginning. So I think, you know, sort of shying away from sort of the specific term, but I think sort of asking in a very general sense of, you know, you know, when you have sex, right, with your, you know, front or the back, right, I, you know, I think that that's sort of the way that we approach our patients. And, you know, I think using, you know, words, you know, such as I think, you know, you know, that are more specific, you know, I will leave that up to the providers, but that's sort of the training that, you know, we give to our staff, and how do you navigate to dichotomous segregation pre and post surgical housing in the hospital? I? That's a great question. I think, you know, we have different campuses that house these programs, and, you know, we actually meet on a weekly basis to go over any active issues on the pre to the post surgical needs. So again, I

think having that interdisciplinary closely communicated approach is the first place to start and hopefully, if you can be on the same campus, I think that's even better. And let's see one other question. What do you usually check for Hepatitis B Serologies. I've seen hep B antigen and antibody customer surface antigen is negative wasn't sure why that is being checked routinely? Yeah, you know, Hepatitis B, I mean, you know, it's not as much of a risk to the providers, it's more really for the patients. Right. So I think looking at the liver numbers, understanding the hep B panel in terms of the, you know, the surface to the core to the infectivity, I mean, if you want to check, I think the level, that's fine, but I think in terms of the hep B Serologies, as long as you can just work out that, you know, the level is controlled, and, you know, and it's not an active situation, you know, I think, you know, you and the hepatologists would most likely, you know, optimize to proceed. And that's what we've seen. So

Tara 52:31
we have another question in the chat box a little further up, fall, read it out loud. Within the LGBTQIA plus community, the idea of passing as a chosen gender is important to some persons in the transgender community. There are some older persons that may not have access to hormone therapy or surgery and not appear as feminine as their counterparts, what options are offered to them? And what mitigating factors are concerning.

53:00
Yeah, I mean, listen, I think surgery is not for everybody. You know, I think the there is a variety of treatments that are not based on hormones and surgery procedures. So I think looking at, you know, some of the, the psychosocial supports, right, I think really, you know, for our older patients, you know, it comes down to having the proper psychosocial diagnoses and sort of the support system that's built around that, that really starts the conversations. So I think having the right mental health support team, surrounding our patients is the first step to go. And then obviously, having the base also screening, right, from a primary care standpoint, just because our patients are trans. Right, they still need the, you know, the colonoscopy ease and all the screenings that come with our patients. So I would, you know, sort of approach it that way.

Tara 53:57
And we have another question from the same. Attendee, Michelle. What the hormones a transgender female use allow her to experience menopausal symptoms. One of my clients who identifies as a transgender female told me, sorry, told me the above, and I validated her experience. What is the recommendation when this topic comes up again?

54:20
Yeah, I think it's all about titration. So, right, the patient's already on the hormones, if there are concurrent symptoms on top of it, you know, I would certainly encourage you to get, you know, some colleague expert advice on it, but it's going to come down to the mode of delivery and the dosing. Right. So, you know, I think you're doing exactly what you should, which is, you know, to affirm and verify, but again, but I think there's always room for improvement in terms of titration. So yeah, I think that's a totally a fair treatment plan and a question, and thank you.

Tara 54:57

Great, and thanks, everyone for your questions. Last slide. questions on this topic? Definitely. And we have one more in the q&a. How often do you discourage patients from surgery during the pre op assessment and or recommend delay with counseling.

55:10
So, this does happen quite often. And you know, and I am actually not the one that comes in to do this, because generally when I get involved, the patients have already had much of the processes clear. But I think a lot of this comes down to the or, again, the psychosocial support system that we have within Sinai. So when the screening is done in the beginning, and we have, you know, a support system, or the sort of the, you know, the the mental health piece that may need, you know, a little more help, then, you know, we do have a plan of action that we document, and we always tell our patients that this is not a denial, it's just, you know, we need some more time to optimize your condition, you know, to get to the endpoint. So again, I think that would be my advice, which is not to say no, but to say, we're going to delay with the final result that you know, we will come back to, you know, reevaluate, and hopefully proceed. So yeah.

Tara 56:17
Great. I'd like to say a special thank you to Dr. Shin for presenting today. Excellent.

[End Transcript]