



APIWC/SFDPH: TRANSACCESS

API WELLNESS CENTER AND THE SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH:
TRANSACCESS

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This intervention is dedicated to the clients of the TransAccess Clinic,
and to all those who fight for equality, health, and justice for trans and
gender non-conforming peoples everywhere.

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PREFACE

This intervention chapter distills the experiences and lessons learned from the TransAccess clinic, a federally-funded demonstration project intended to improve engagement and retention in care for transgender women of color living with HIV. It seeks to provide readers with the tools to implement a gender-affirming and holistic HIV primary care program for transgender women of color, while maintaining a safe and caring environment. Throughout, we will address what we consider to be the central tenets and themes of the TransAccess philosophy and the core responsibilities of the clinic and case management staff.

We will close with lessons that our team has learned and how we have adapted the intervention to incorporate these lessons as we continue to grow our program. This manual continues a tradition of sharing knowledge within the medical community, while incorporating insights from behavioral health, addiction medicine, social justice movements, and the wisdom shared with us by our client and staff community.

INTRODUCTION

TransAccess is a demonstration project initiative to design, implement and evaluate innovative interventions to improve timely entry, engagement, and retention in quality HIV care for transgender women of color (TWOC) living with HIV. The primary focus of this initiative is to identify, successfully engage, and retain in care transgender women of color living with HIV—particularly women who are

not engaged in medical care, or those who are poorly engaged in care. Strikingly (but not surprisingly), our clients who are the least engaged in care, are also those who are the most profoundly affected by concurrent stressors including unstable housing, poverty, substance use, mental health problems, and recurrent gender-based traumas.

While over the course of the TransAccess project we have served a patient population of staggering medical acuity and psychosocial complexity—**22 percent of TransAccess clients are in the top 5 percent of medical utilizers in the San Francisco public health system**—it is nonetheless possible to achieve a high rate of virologic suppression in this hard-to-reach and extremely vulnerable population. A monthly assessment of TransAccess program outcomes finds that on average, 60-70 percent of TransAccess clients have an undetectable HIV viral load (<200 copies/mL). In our experience, what it takes to achieve these results are two essential organizing principles – or roughly speaking, the “what” and the “how” of a successful program:

1. What: A program model that integrates:

- a.** trans-affirming medical care: medical care that integrates and prioritizes client’s gender identity, experiences, and the clinical interventions necessary to affirm gender
- b.** intensive psychosocial and behavioral health support
- c.** community empowerment/affirmation

All 3 components are vital to a successful program model.

2. How: An approach to care that is:

- a.** trauma-informed: using the standard trauma-informed model with our clients and understanding of the prevalence of trauma in a client community like TransAccess
- b.** radically accepting (of client norms, priorities, and values).

EVIDENCE OF NEED

LOCAL EPIDEMIOLOGY

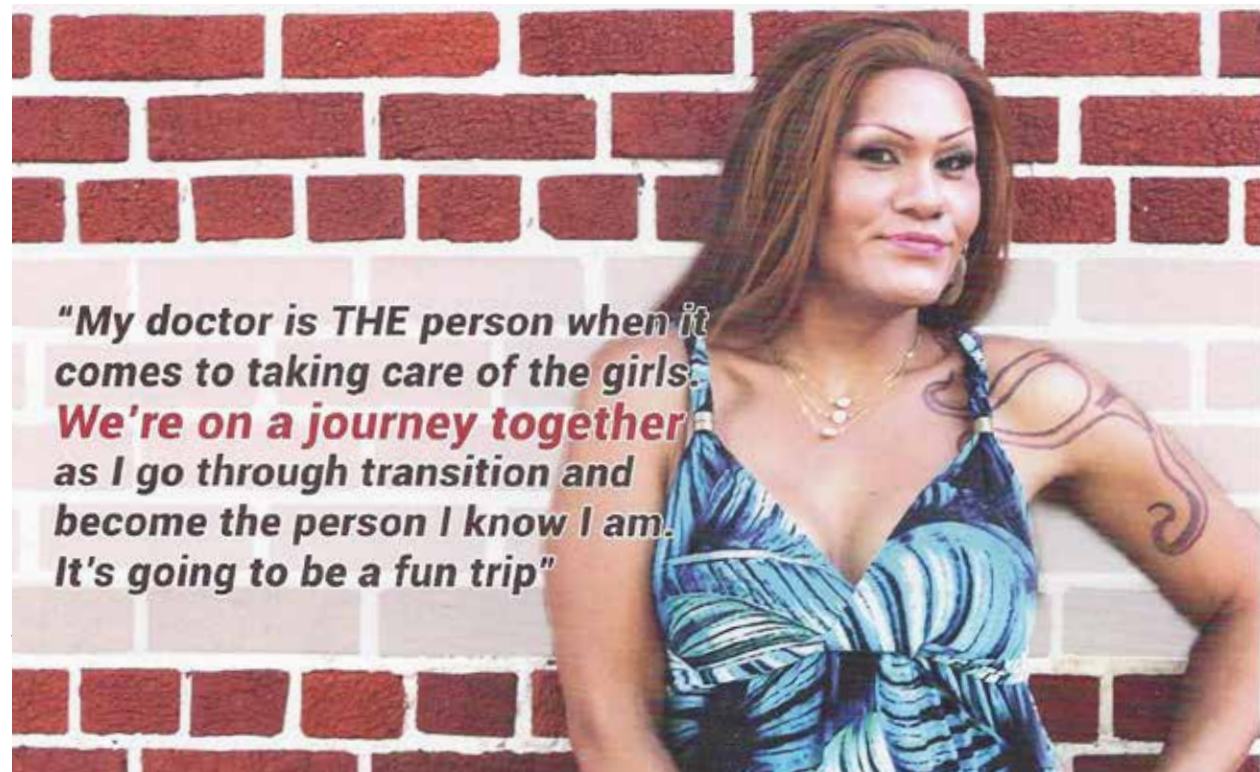
Because public health data on transgender individuals living with HIV is inconsistent (many transwomen are still classified as men-who-have-sex-with-men, or “MSM”), we gathered evidence of need at the time of our SPNS application from urban needs assessments and risk behavioral studies. Disproportionately high rates of HIV prevalence among transgender women, and especially among transgender women of color, have been documented in studies throughout the United States.

At the time the Asian & Pacific Islander Wellness Center and the San Francisco Department of Public Health

applied for a SPNS grant, a body of literature had amassed regarding transgender women and HIV specifically in the San Francisco Bay Area. Studies of HIV prevalence in San Francisco yielded self-reported HIV positivity rates ranging from 22 percent to as high as 60 percent among transgender women of color, along with positivity rates based on HIV testing of between 33 percent and 63 percent among African American transgender women (Ramirez-Valles 2010). Throughout the duration of the TransAccess intervention, transwomen of color, particularly those who identify as Black/African-American, have been a demographic disproportionately at risk for HIV infection, nationally and locally.

After the TransAccess clinic opened in 2013, data continued to support a need to support transwomen living with HIV. In 2013, a meta-analysis (Baral et al. 2013) showed that the estimated HIV prevalence among transgender women was 22 percent in the United States and four other high-income countries. While it is uncertain exactly how many transgender people live in San Francisco, recent studies report an estimate of 0.6 percent of adults in the United States, who identify as transgender (Flores et al. 2016). Although California has a higher concentration of transgender and gender non-conforming residents than national numbers, at .76 percent (Flores et al. 2016), transgender people are still disproportionately

Transwomen of color are at the intersection of marginalized communities and are more likely to have experienced a multiplicity of stigma in healthcare and the community, at large.



affected by HIV, compared to their cisgender counterparts. As recently as 2014, the San Francisco HIV Epidemiology Annual Report found that transwomen—or “transfemales” as the report states—make up 2 percent of the 15,979 living cases of persons with HIV (SFDPH 2014).

Moreover, transgender folks experience significant difficulties when attempting to access all types of health care, and due to fears of discrimination, provider insensitivity, hostility and lack of knowledge about transgender health, many avoid care altogether (Sanchez et al. 2009). Transwomen of color are at the intersection of marginalized communities and are more likely to have experienced a multiplicity of stigma in healthcare and the community, at large. TransAccess, therefore, set out to address the many barriers faced by San Francisco’s transgender women of color who are living with HIV, starting with the clinical environment and working from there to advocate for transwomen of color, locally and nationally.

PROGRAM DESCRIPTION

ORGANIZATIONAL BACKGROUND

In 2012 TransAccess forged a unique public/private partnership model: the medical services of Tom Waddell Health Center, a public community health clinic that specializes in transgender medical care, were integrated into TRANS:THRIVE, a highly respected and trusted community-based transgender support program at Asian & Pacific Islander Wellness Center. This partnership has operated with the explicit goal of enhancing utilization of and retention in HIV medical care by underserved transgender women of color. The program created a unique neighborhood-based transgender medical home and a weekly clinic specifically designed to address the complex needs of this critically impacted population. API Wellness Center/TransAccess is centrally located in San Francisco’s Tenderloin district – which holds most of San Francisco’s homeless/marginally housed populations and is home to many low-income trans and gender non-conforming peoples. The TransAccess team has provided HIV primary care and psychiatric services to transgender women of color on Wednesday and Thursday afternoons since the clinic opened in 2013. TransAccess is committed to creating a safe, welcoming, and respectful environment for transgender women of color.

The Tom Waddell Health Center is one of 12 public FQHC clinics that make up San Francisco’s Community Oriented Primary Care Program. Since 1994, Tom Waddell Health Center has operated Transgender Tuesdays, a nationally respected primary medical home providing services specifically tailored to the needs of low-income transgender individuals. With over 400 active patients, the Transgender Tuesdays clinic offers care through a highly skilled, multi-disciplinary medical team, which has many decades of combined expertise in serving and supporting transgender women of color. The program utilizes a harm reduction model and a trauma-informed care approach tailored to the social, economic, and political realities of our clients. Services provided by the medical team include comprehensive HIV medical care, transgender care including medically supervised hormone therapy and other gender-affirming treatments, medical social work, and psychiatry.

Asian & Pacific Islander Wellness Center (API Wellness), Tom Waddell's partner agency, is a non-profit, multi-service community-based agency established in 1987 to address the AIDS crisis. API Wellness operates the HIV Care Program, which provides case management, mental health counseling, and substance use counseling for persons living with HIV. Additionally, API Wellness is home to the Wellness Clinic, the city's newest FQHC, which provides primary medical and psychiatric services to low-income and uninsured individuals. API Wellness's TRANS:THRIVE, the agency's flagship program for transgender clients, serves 600 unique clients annually, making it the largest program of its kind in the nation. TRANS:THRIVE offers a wrap-around transgender-specific drop-in center, which operates five days per week and offers social programs, leadership development, support groups, psycho-educational workshops, psychotherapy, and case management. This program provides the backdrop and support network for the TransAccess clinic.

PROGRAM BASICS

What

The program combines on-site primary care (MD and RNs with joint HIV and transgender health expertise, plus behavioral health services including medical social work and psychiatry) staffed by the Tom Waddell Health Center, with enriched wrap-around services provided by the API Wellness (including 5 days/week, on-demand case management and peer navigation; drop-in community support services, and weekly group sessions offered for community members to discuss risk reduction, coping skills, and shared successes). All staff within TransAccess utilize a harm reduction model.

TransAccess provides care to all eligible clients and recognizes that the model needs to adapt to the needs of the community; therefore, clients may enter into one of two variations of the model:

- **Full intervention:** at any given time about 75 percent of our client base is receiving the full intervention, meaning that they receive primary care (clinician and nursing), as well as psychosocial auxiliary services, such as behavioral health, psychiatry, case management, peer navigation, and drop-in services.
- **Support services only:** for those clients who are satisfied with their current primary care services, this variation provides the the full scope psychosocial auxiliary services, including behavioral health, psychiatry, case management, peer navigation, and drop-in services. The remaining roughly 25 percent of our clients opt into support services only.

Where

The TransAccess program is a neighborhood-based medical home that operates out of API Wellness with the collaboration of Tom Waddell staff, in the historically underserved Tenderloin District of San Francisco.

When

Every Thursday from 1-6 pm, API Wellness hosts the TransAccess Clinic, which specifically provides HIV primary care, trans-affirming medical care, and all support services to transgender women of color in a setting that is safe, welcoming, and respectful of transgender populations and their needs. The first hour is dedicated to a support group that is run for and by transwomen of color. While this group was not part of the original framework for TransAccess, it emerged organically to provide a sense of community on clinic days.

Halfway through the TransAccess project, the team identified the need for increased mental health support and added a half-day of access to the Tom Waddell mental health team. **Every Wednesday from 1-6pm, the LCSW and psychiatrist provide appointment-based and drop-in services to clients**, so as to increase their access to mental health services, counseling, and psychiatry

CORE VALUES

We started TransAccess in 2012 with a general vision of the kind of care that HIV+ transgender women of color deserve, informed by the experiences of seasoned HIV care and transgender health providers. In the 5 years of our clinic's operation, our daily work with our clients have taught all of us – clients and providers alike – what it takes to meaningfully and sustainably provide care and support for this highly-impacted, yet vibrant and resilient, population.

Through many conversations with our clients, focus groups, team retreats, and reflections from every TransAccess team member across multiple disciplines, we have distilled some of our best lessons learned into a set of core values that serve as guiding principles for every aspect of our work.

Many care models exist for the provision of HIV services to underserved populations. In our experience working with HIV+ transgender women of color, our clients consistently tell us that **it is our approach to care—more than the model itself—that drives our high rate of engagement and retention.**

The following values embed best practices for HIV care and treatment while imbuing each with the TransAccess philosophy:

- **Trans-affirming care:** we create a psychologically and physically safe environment that enhances trans-visibility and the voices of clients in the clinic community
- **Self-actualizing services:** we ground our provision of services in the rights, values, and preferences of the client
- **Mindful medicine:** our medical care and clinical interventions are grounded in a psycho-social and holistic understanding of the client
- **Care coordination and continuity:** we coordinate any and all types of services and assistance to meet the client's identified needs, so that care is continuous from linkage to adherence

- **Harm reduction:** we use a non-judgmental, non-coercive, and de-stigmatizing approach in order to assist clients in minimizing risk in their environments
- **Community-centered:** we maintain that belonging (to a family, a tribe, a movement, or indeed, a community) is a central aspect of an individual's health and wellbeing—all the more so for individuals who have historically not belonged, been actively excluded and/or othered. This is why we consider “a sense of community” to be a health outcome, on par with traditional physical health outcomes, such as blood pressure or viral load. Promoting and nurturing an individual's journey toward belonging and inclusiveness is a healthcare responsibility.
- **Radical healthcare:** we maintain a commitment to ending transphobia and poor health outcomes in trans and gender non-conforming peoples by contributing to the body of trans-health research, exploring and integrating the boundary between medicine and social justice, disrupting conventional models of care and embracing alternate models and approaches that provide a level of care and support that is commensurate to and sufficient for the disproportionately intense medical and psychosocial needs of our clients. We have integrated a social justice lens by inviting staff and clients to participate in local and regional activism, testimonies, and movement-building.

CASE CONFERENCE & CARE PLAN

When interviewed about their roles and the unique philosophy of our intervention, staff consistently reported that our hour-long weekly case conference was an absolutely essential part of our program. Each Thursday, before clinic opens to clients, all team members gather for an hour to discuss client updates, changes to care plan, evaluation needs, and goals for the week. With such high-acuity clients, across medical and psychosocial domains, it is crucial to allow your program staff to coordinate client treatment plans and for all team members to provide input. Having a clear, but flexible, plan invites clients to weigh in on their treatment, ensuring their agency in determining their healthcare.

The care plan or treatment plan, as mentioned throughout the manual, reflects the shared objectives agreed upon by the client and the team. This plan includes goals for HIV primary care, transgender care, gender-affirming procedures and surgeries; living environment; benefits attainment; and all objectives within the psychosocial domain. The development of the care plan is an interactive process that encourages the client to actively participate in the decision-making process related to her/their care, support, and treatment. The purpose of the care plan is to:

- document and organize/plan for comprehensive support services and to promote continuity of care at a level that is desirable to the client;
- demonstrate a relationship between actions and the wants, needs, strengths, and limitations of the client as documented in the client assessment;
- ensure that the care plan is a realistic reflection of what the client and the case manager can accomplish together for the benefit of the client;
- provide an ongoing, living agreement for the client and the team.

THEORETICAL BASIS

ACHIEVING AND MEASURING OUTCOMES

As a means of achieving the overall goal of improved health outcomes for transwomen of color living with HIV in the San Francisco Bay Area, TransAccess has implemented a number of measurable outcome objectives. The Logic Model (see VIII. Appendix Section 1) outlines those inputs and activities that contribute to tangible outputs, products of the program, and ultimately metrics for evaluating the project's outcomes.

The logic model inputs, activities and outputs of TransAccess result in measurable outcomes, designed to provide a means of assessing how well TransAccess utilizes resources to achieve its goal. Given the aims of this SPNS intervention, TransAccess prioritized high retention rates in care when developing the intervention. While our partners at Tom Waddell Urban Health Center had successfully paved the way for linking TWOC to care, TransAccess aimed to improve retention and continuity of care. With that said, we did not establish a target retention rate until one year into the recruitment of clients, once we were able to review client trends and coordinate realistic objectives with other demonstration sites in the Bay Area.

In 2014, HRSA released the RSR Report, which disaggregates RWHAP data into particular populations; this helped our project get a better sense of how RWHAP recipients nationwide were doing in terms of retaining high-acuity populations. At first glance, retention rates from transwomen living with HIV seem reasonably high. For instance most age groups range from 75-100 percent retention, with young transwomen (age 20-24), having the lowest retention rate at 69 percent (RSR 2014). Yet, once you filter by race and housing status, the rates shrink. Transwomen experiencing unstable housing—our target demographic—average a retention rate of just 66 percent; in this category, Black/African-American transwomen, who are unstably housed, have the lowest retention rate at 61 percent (RSR 2014). For context, the average retention rate for accessing primary care for the general population of folks living with HIV that same year was 80.4 percent (RSR 2014). Our desired outcome was then projected at retaining 75 percent of clients across the entire TransAccess client cohort.

Outcome objectives for prescribing ART were decided internally. We were committed to providing our clients with access to ART; however, for our population, many clients were not realistically ready to start ART, due to environmental, medical, and psychosocial factors. We, therefore, set our outcome at 90 percent for ART prescription. Rates for viral suppression, defined as <200 copies/mL in most recent viral load test, show similar outcome gaps for transwomen. Similarly, transwomen with unstable housing average a suppression rate of 53 percent, compared to a viral suppression rate of more than 81 percent for the general population (RSR 2014). Black/African-American transwomen, who are unstably housed, have the lowest viral suppression rate at 50.7 percent (RSR 2014). Our desired outcome was then projected at achieving viral suppression among 60 percent of clients, for those receiving the full intervention—meaning, they access our primary care provider onsite.

PROGRAM OPERATIONS

STAFFING TRANSACCESS

The TransAccess program is made possible by an integrated and dedicated team. The team is comprised of many key players, from both APIWC and the Tom Waddell Health Center:

Title	Full-time Effort (FTE)
Peer Navigator	1-2 at 1.0 FTE
Senior Case Manager	1 at 1.0 FTE
Medical Doctor (Internal Medicine or Family Medicine with HIV/Transgender experience)	1 at .20 FTE
Medical Doctor (Psychiatry)	1 at .1 FTE
Registered Nurse	1-2 at .15 FTE
Medical Assistant	1 at .1 FTE
Licensed Clinical Social Worker	1 at .2 FTE
Researcher-Evaluator	1 at .5 FTE
Program Director/Manager	1 at .5 FTE

While the above breakdown represents the ideal staffing model for TransAccess and like programs, other models should account for staffing fluctuation. Over the course of the five year intervention, TransAccess saw significant fluctuation, particularly in staffing the role of peer navigator. For this reason, adequate and ongoing training is integral to the success of staff, especially for peer navigators, who are at risk of burn out and attrition.

Peer Navigator Training

- Health Insurance Portability and Accountability Act (HIPAA) and how to safeguard client's personal health information (PHI)
- HIV 101: the basic principles of HIV care and treatment
- Direct mentorship senior by senior case manager to support and facilitate the implementation of client's treatment plan

- Supervision: Weekly supervision with senior case manager, with a focus on minimizing the harmful effects of vicarious trauma and ensuring ongoing self-care
- Additional support and mentorship from the LCSW/behavioral health clinician
- Professional development goals and opportunities discussed quarterly with Program manager/director

The Clinic Flowchart (see IX. Appendix Section 2) breaks the TransAccess program down into the roles each staff person plays and which key program components their position oversees. The first step—Referral and Linkage—is anecdotally attributed to word-of-mouth recruitment during the nursing and/or primary care intake. Most often, clients are referred to Trans Access by another client, or word-of-mouth.

PEER NAVIGATION

“This job keeps us evolving. It’s not just that you are learning, professionally, from the staff and the clients, but you evolve in your personal life: medically, spiritually, holistically.”

–SG, Peer Navigator

“I see now why this program works: the combined passion—and compassion—of everyone on the team means it can’t not work.”

–TDLC, Peer Navigator

The Peer Navigators on the team provide hands-on support to the client in order to actualize the care plans made by the team as new clients enter the program. A secondary role of peer navigators is to provide general support for clients, which often comes down to listening, to help our clients manage the erosive effect of daily life stressors, micro and macro aggression due to societal racism, transphobia, and HIV stigma. Our peers are both trans-women of color and cite their similar experiences to clients as a key reason that can provide effective on-the-ground support. Unlike the medical and mental health staff, clients can access peer navigators five days a week, on a drop-in basis. The key responsibilities of this position include:

- supporting each client to actualize her care/treatment plan
 - care/treatment plan established at time of client entry
 - plans are then modified, as needed, during weekly case conference
- providing care navigation to all clients
 - assisting clients with keeping and getting to appointments, esp. primary care visits and referrals to specialists
 - supporting clients at other agencies and government organizations (e.g., accompanying clients to Social Security for enroll for benefits, signing up for insurance at MediCal office, etc.)

- conducting outreach
 - including home visits for clients who have fallen out of care, or require additional outreach and support (e.g. emotional support and encouragement) to access medical care
- maintaining daily communication with client
 - text message
 - social media
 - phone calls
 - in-person meetings
- providing community, support, and affirmation for any aspect of day-to-day life, such as: coping with stress, societal transphobia, micro and macro aggression, housing insecurity, and so on
- charting all interactions with clients in Ryan White database and in Intervention Exposure Data form
- increasing health and navigation literacy
 - goals regarding systems navigation are integrated into care/treatment plan
 - peer navigators first escort clients to appointments and model systems navigation

CASE MANAGEMENT

“You have to get in the nooks and crannies of our community to find the people who will support our clients.”

—SS, Senior Case Manager

The Case Manager on the team provides consistent support to the client in order to actualize the objectives made by the team and client. Like our peer navigators, the case manager has an open door policy, meaning the clients can access her on a drop-in basis. The key responsibilities of this position include:

- providing medical case management to all clients
- setting care/treatment plan with team for all clients, in conjunction with client and full care team
- supervising peer navigators in implementation and actualization of care plan
- maintaining open communication with clients
 - text message
 - phone calls
 - in-person meetings
- coordinating and tracking appointments for:
 - housing
 - » emergency housing/ shelter
 - » transition programs

- » treatment/detox
- » permanent residence
- specialty medical care, not provided onsite
- health insurance
 - » interface with MediCal, Medicare, etc.
- benefits programs
 - » food assistance programs
 - » emergency AIDS funding programs
- completing all referrals to housing and other community support programs
- coordinating our Digital Storytelling workshops, wherein clients participate in a workshop that trains them to tell a part of their story with the aid of images, music, and narrative techniques
- charting all interactions with clients in Ryan White database and in Intervention Exposure Data form
- retaining high risk/high acuity clients in HIV primary care

SOCIAL WORK & PSYCHIATRY

Social Work/Behavioral Health Clinician

“The system has not served transgender women, particularly women of color, well. A huge part of our work is advocacy: help change the system so that it may better serve our clients and help our clients succeed in programs.”

–JM, Social Worker

The Social Worker on the team plays a crucial role in this intervention, by serving as a behavioral health clinician and point-person for all mental and behavioral health program as well as liaising between the San Francisco Department of Public Health systems and the onsite TransAccess initiative. The key responsibilities of this position include:

- Conducting psychosocial and mental health assessments to identify clients’ behavioral health needs
- Determining and making optimal referrals to psychiatry, psychotherapy, and/or other mental and behavioral health programs
- Triageing and managing urgent psychosocial needs, including “5150 Assessments” for clients, to determine if they are at imminent risk of harm to self or others
- Assessing clients with substance use disorders, and providing appropriate referrals based on client preferences, motivation, readiness, and other factors
- Coordinating complex care plans, esp. interface between primary care and referral services/programs, such as psychiatry, psychotherapy, substance use treatment programs, intensive case management programs,

and gender-related services such as mental health assessments for gender-affirming surgeries etc.

- Providing emergency mental health support and counseling
- Coordinating mental health treatment planning between peer navigators, case manager, and medical staff
- Training staff on the affects of mental health issues on other aspects of client and treatment planning

Psychiatry

In a structural factors snapshot conducted in 2015, we confirmed what the team already knew: a significant proportion of our client population (36.6 percent), at the time of program entry, were experiencing severe mental illness, defined explicitly as bipolar disorder and/or psychosis. The majority of our clients, however, have experienced more common mental health challenges, such as major depression, anxiety disorders, and PTSD. Halfway through the program, in response to the high rate of SMI and the detrimental impact of untreated mental illness on HIV health outcomes, the team incorporated a Mental Health Clinic to the TransAccess program. The mental health clinic includes a half-day on Wednesdays, where our LCSW and Psychiatrist work onsite at API Wellness in conjunction with on-site case managers and other psychosocial support staff. The psychiatry clinic is available to clients by appointment or by drop-in. The Psychiatrist has played a huge role in supporting our team to better serve the TransAccess clients and reducing the barriers to receiving mental health services. Key responsibilities include:

- Providing accurate diagnosis of underlying mental health disorders
- Mental health treatment including pharmacotherapy and limited psychotherapy
- Diagnosis, referral, and treatment of substance use disorders

CLINICAL TEAM

Primary Care

The primary care provider offers competent and up-to-date HIV care, transgender health care, as well as general primary care toward the overall health and greater wellness of the client. The primary responsibilities of the medical doctor includes:

- **HIV care:** diagnosing HIV; monitor disease progression; provide and oversee HIV antiretroviral therapy and opportunistic infection prophylaxis; address adherence challenges.
- **Transgender health care:** providing care to transgender and gender non-conforming client populations, with special emphasis on assessing appropriateness and readiness for gender transition treatments and therapies; initiating, monitoring and supporting all gender-related treatments throughout a client's lifetime, including cross-sex hormone therapy and gender-affirming surgeries and procedures, such as mammoplasty, orchiectomy and vaginoplasty); and, working collaboratively with multidisciplinary approach to address gender dysphoria, trauma associated with gender identity and pervasive societal transphobia, and empowerment of gender identity.

- **Primary care:** providing primary care services including management of all general medical conditions not covered above, such as hypertension, diabetes, and other medical problems; provision of age-appropriate health screenings and preventative care; recognizing mental health and substance use challenges and provision of appropriate and timely referrals for treatment and/or support; and, working collaboratively with medical social work, case management, and other medical/mental health providers to coordinate client's overall treatment plan.

Nursing

The two nurses on the team provide competent and up-to-date nursing care and support for HIV, transgender health, and general primary care. Their key responsibilities include:

- **HIV care:** Work with PCP to support all aspects of HIV care, including HIV medication adherence support; dispensing HIV medications; medication reconciliation; client education regarding HIV, sexual health, etc.
- **Transgender care:** providing gender-affirming nursing care, including provision of hormone therapy, client education with respect to gender affirming surgeries and procedures; assist PCP with monitoring gender transition treatments and goals; providing general emotional support for clients affected by gender dysphoria, or traumas related to societal transphobia.
- **Primary care:** Provision nursing care in general primary care context, including clinic triage, lab draws, immunizations, STI treatments, dispensing medications, medication reconciliation, delivering clinic-based treatments.

INTERVENTION OUTCOMES

SUSTAINABILITY

As the program comes to its final year in the SPNS project, the team looks toward analysis, dissemination, and sustainability. As mentioned throughout, our clients have come to rely on the services of TransAccess and, many of them, are in the process of stabilizing their environment, HIV primary care, and are in the middle of gender-affirming surgeries. One of our outcomes, then, has been the focus of sustaining the program and engaging in conversations with the San Francisco Department of Public Health, Tom Waddell Urban Health Center, and other programming at API Wellness to ensure the continuity of HIV primary care, transgender care, and support services specifically for transwomen of color.

ANNUAL INTERVENTION COST

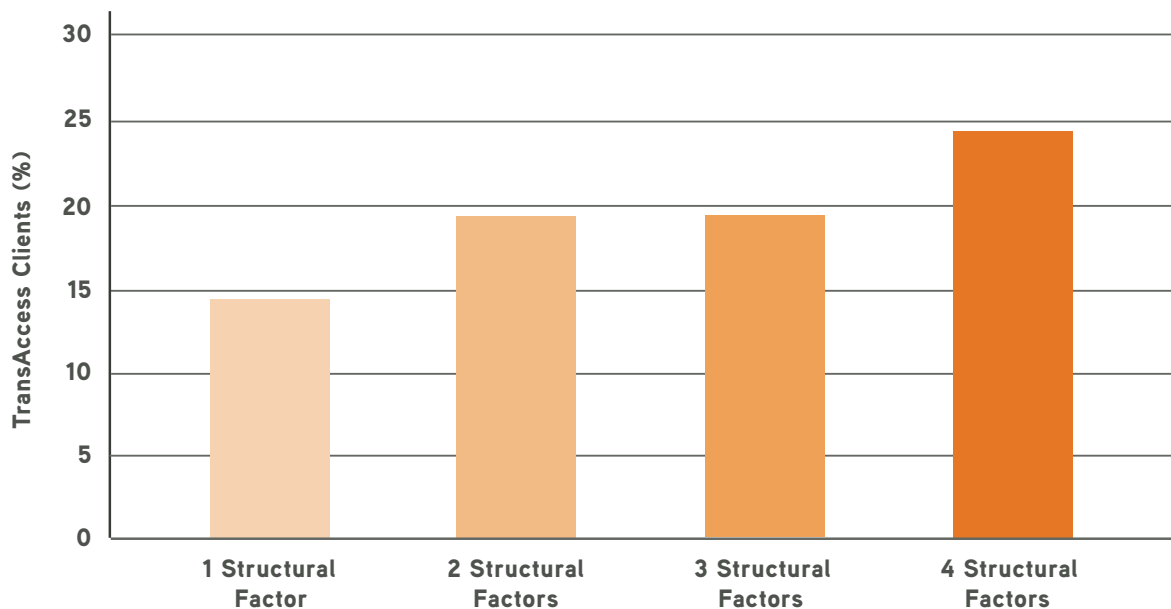
The approximate annual cost of the intervention was \$191,851 including direct and in-kind costs.

BASELINE OUTCOMES

Utilizing our logic model and the early goals of the program, we have been able to assess how well we have achieved our objectives for enrollment, outreach, and reducing barriers for TWOC living with HIV.

1. **ENROLLMENT:** We enrolled 61 clients of our eligible clients by August 2016, the close of the enrollment period for the multisite study. While this number was lower than we had expected, we were able to focus on the retention of those enrolled and improve the number of clients presenting for the follow-up surveys.
2. **CLIENTS SERVED:** The program has served 80 transwomen of color living with HIV in the Bay Area over the course of the intervention:
 - a. 65 clients receiving the full intervention of services (primary care and auxiliary psychosocial services)
 - b. 15 women accessing just support services (auxiliary psychosocial services, only)
3. **ACUITY:** Our caseload was affected by the incredibly high medical and psychosocial acuity of the clients we served:
 - a. 22 percent of our clients are in the top 1-5 percent of high utilizers in SF (CCMS 2017)
 - high utilizers are defined as those with highest utilization of clinic, emergency department, psychiatric services, and inpatient hospital utilization
 - b. According to intake data, approximately one-third of TransAccess clients were diagnosed with advanced AIDS at the time of program entry
 - c. At baseline, 78 percent of TransAccess clients experience 1 or more structural factors. In this analysis, structural factors included: homelessness, active sex work, substance use, and severe mental illness (see figure below).

Figure 1: Structural Factors Affecting Care Outcomes



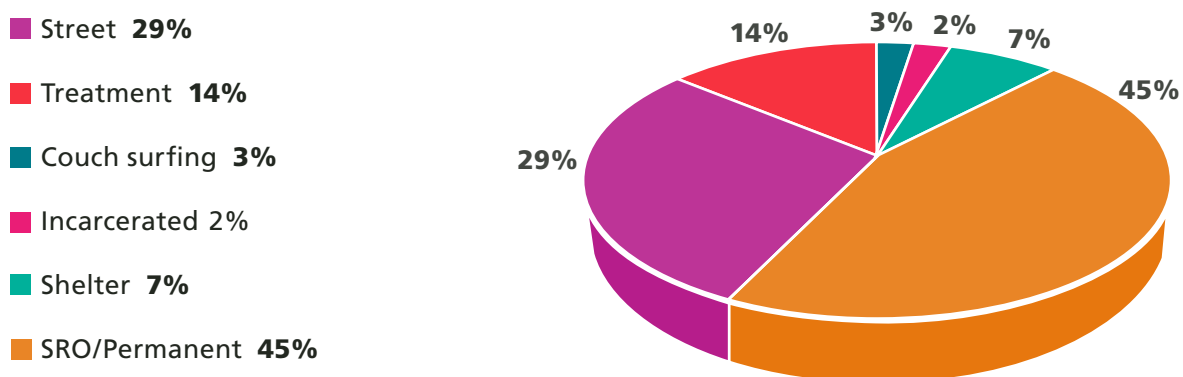
PROGRAM OUTCOMES FOR ACTIVE CLIENTS

Utilizing our logic model and the objectives we had for program outcomes, we have been able to assess how we met our goals with respect to retention, viral suppression, and improving the health and lives of TWOC living with HIV.

1. **RETENTION IN CARE:** prioritizing both retention in support programming and HIV primary care, we rely on our intervention exposure data—the number of encounters with peer navigators, our social worker, and our case manager—as well as, the number of medical visits within a six-month period. For active engagement in our program and due to the high acuity of our clients, we expect and see a much higher rate of visits than typical definitions for retention in HIV care.
2. **VIRAL SUPPRESSION:** Throughout the course of the intervention, we would conduct viral suppression (<200 copies/mL) snapshots to see how many of our clients had experienced suppression during their last set of labs.
 - a. On average, 68 percent of active clients were virally suppressed, during the monthly snapshot of active clients, which surpassed our goal of 60 percent viral suppression for active clients
3. **HOUSING:** While most clients were unstably housed during time of enrollment, and although the San Francisco housing crisis is having deleterious effects on our already high risk populations, the TransAccess program was able to secure some form of temporary or permanent housing for many of our clients through emergency shelters, SROs, permanent residences, and treatment programs.

65 percent of our clients were literally homeless at baseline. Of those that were housed, most were unstably housed or had experience literal homelessness recently. This graphic below represents a 2016 snapshot of the housing status of active (not lost-to-follow-up) clients, 3 years into the TransAccess intervention. This graphic highlights successes in housing clients in single room occupancies (SROs), permanent housing, and treatment programs; while also highlighting system housing issues in terms of availability and sustainability for our clients, as evidenced by the percentage of clients who remain homeless:

Figure 2: 2016 Housing Status of Active Clients Post-Intervention



LESSONS LEARNED

As stated earlier in this manuscript, among our most important lessons learned are two essential organizing principles of a successful program. Simply put, these are the “what” and the “how” of a building a successful program. We believe that there are three essential pillars that hold up successful program for HIV+ transgender women of color. Here, we provide the “what” of TransAccess—the tangible components or skeleton of our program, as well as the “how”—the heart and soul of the program.

1. Community, empowerment of trans-identities, and belonging

As presented in our values statement, we maintain that belonging (to a family, a tribe, a movement, or indeed, the larger LGBTQI community) is a central aspect of a person’s health and wellbeing. The reason that we intentionally named “community and belonging” as the first pillar of a successful program is because our clients have shown us that it is staggeringly difficult for anyone, more so those with a history of trauma and marginalization, to achieve and sustain their medical and behavioral health goals without familial or community support.

What we’ve learned regarding community building and empowerment can be divided into two categories: structural interventions and interpersonal approaches.

Structural interventions, utilized by TransAccess:

- **Digital Storytelling Workshop:** as a requested addendum to the original TransAccess model, three rounds of storytelling workshops were added for the TransAccess cohort. Each round, 4-6 clients participated in a structure workshop where they learned how to tell their own story, frame it, and create a digital representation of their narrative. These informal workshops gave clients time and space away from the clinic environment to listen to and be heard by their peers.
- Location of primary care services within a community-based organization known for serving the trans and gender non-conforming communities
- Creation of a protected half-day clinic for transgender/gender non-conforming clients only
- A support network naturally and organically grew from clients coming to TransAccess for care. This is especially evident in the waiting room, where clients waiting to be seen socialize with one another, share information and resources, and provide mutual support.
- A support group facilitated by transwomen of color that runs concurrent with the TransAccess clinic. The group provides a safe space to build a sense of shared sisterhood.
- Supporting programs and initiatives that amplify client visibility and social justice, supporting TransAccess clients to help testify at City Hall for the life-saving impact of trans-inclusive HIV services, including more images of transgender clients in our clinic space, etc.
- Support and promote client participation in civic and LGBTQI movement activities, including organizing clients to participate in the Transgender Day of Remembrance, TransMarch, San Francisco LGBTQ Pride celebration, etc.

- An inherent asset in clinics developing partnerships with community-based organizations is being able to draw from and grow the neighborhood engagement and community trust. TransAccess and TransThrive staff have a long history of organizing clients to participate in community and civic activities that promote LGBTQ pride, equality, inclusiveness and community.
- TransAccess peer navigators promote APIWC-sponsored events, such as SF Pride and Trans Day of Remembrance, encouraging TransAccess clients to join or even volunteer. The case manager and clinical team see this community engagement as part of the care plan and, similarly, encourage clients to attend these events.

Interpersonal approaches, utilized by TransAccess:

- All TransAccess program staff share a strong belief that our work is not limited to the provision of healthcare services alone, but that together with our clients, we are all part of a larger movement toward social justice and equality. Part of effecting change beyond TransAccess is achieving empowerment within, making sure clients lay claim to their voice and their power to help effect change for the better.
- Much has been written about the concept of “medical homes”, which generally means a clinic that provides multidisciplinary services, including medical care and psychosocial services. However, most conventional models place the emphasis on the “medical” component. At TransAccess, one success we are especially proud of is the creation of a program that prioritizes the word “home”.
- Many of our clients arrive at our program feeling rejected, ostracized, or alone. Many have become estranged from their biological families, or feel betrayed or let down by their own community, friends, or intimate partners. TransAccess aims to be a place to recover from that: a place where clients feel safe and free to be exactly who they are.
- Some tips for instilling this sense of home and belonging include:
 - Radical acceptance: Accepting our clients exactly as they are, in all their varied expressions of gender, and whatever their values and priorities may be (even if health isn’t at the top of a client’s priorities).
 - Non-judgmental acceptance of a client’s choices, even around issues such as sex work, substance use, not taking meds, etc.
 - Showing vulnerability and one’s own humanity: For example, when our primary care provider meets a client for the first time, he often introduces himself by sharing why this work is so meaningful to him. For example, *“When I first started working with trans clients at our clinic, I saw the lengths that people would go, and the sacrifices people make, simply for the chance to become your most authentic self. The need to be who you are, regardless of the consequences, I get that. I respect that.”*
 - Human touch: warmth, laughter, food, and hand-written cards from team as the main mode of outreach for clients who have dropped off from care (“We miss you; hope to see you back in clinic soon”).

2. Intensive psychosocial and behavioral health support

Early on in TransAccess’s evolution, it became clear that psychosocial stressors and disparities, untreated mental health problems, poor coping mechanisms such as substance use, intense and recurrent traumas, and the chaos of surviving daily life as a transgender woman of color are the primary factors that drive poor outcomes in our clients. Data supporting these observations have been presented in earlier sections regarding structural factors (such as homelessness, substance use, severe mental illness and sex work) in our client population. In order to meet the extraordinarily high level of psychosocial needs of our clients, TransAccess evolved and in its second year of operation, expanded the program’s psychosocial and behavioral health staffing. Our model now includes peer navigators for day-to-day care navigation and general emotional support; senior case managers to coordinate higher level referrals and benefits (such as insurance, governmental benefits, housing, etc); medical social work/behavioral health clinician to assess, triage, and refer clients to mental health and substance use treatments, as well as coordinate complex care plans; and a psychiatrist for the management of severe mental illness, with a particular emphasis on methamphetamine-associated psychosis. Please refer to Section V for specifics on each team’s roles and responsibilities.

One additional insight comes from an analysis of intervention exposure amongst TransAccess clients, which reveals just how intensively our clients utilize and require psychosocial services such as peer navigation, case management, and medical social work. One of our behavioral health team members shared an illustrative comparison, stating: “...It feels like we are working in an intensive case management program, with primary care and psychiatry on site.” The operative word here is “intensive” – which reflects both the acuity of the urgent psychosocial and mental health challenges our clients face, as well as the experience of staff members providing that support.

Our recommendation to any emerging clinic or program is to dedicate sufficient staffing and resources toward psychosocial and behavioral health staff, and to ensure that the staff-to-client ratio reflect the intensity of our clients’ needs.

3. Co-location of HIV and trans-affirming primary care

Perhaps the single most important lesson learned regarding medical care provision for HIV+ transwomen of color, is the importance of having HIV care and transgender care co-located in the same provider or clinic.

Because gender dysphoria and gender-based trauma informs so much of our clients’ lives, the opportunity to meet a client’s gender-related needs (such as cross-sex hormone therapy) represents an incredible opportunity for client engagement and retention. For many clients, gender dysphoria and transition-related needs take precedence over concerns about HIV treatment. Many opportunities now exist for HIV providers to gain knowledge, confidence, and experience in transgender care issues. In our experience, having a provider who is versed in both HIV and transgender care issues has been a major draw for our clients. ■

REFERENCES

- American Psychological Association. (2009). Report of the APA Task Force on Gender Identity and Gender Variance.* Washington, DC. <<http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf>>.
- Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz TE, Beyrer C. (2013). Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infect Dis.* March; 13(3):214-22.
- Centers for Disease Control and Prevention. (2011). HIV Infection among Transgender People. <www.cdc.gov/hiv/transgender/pdf/transgender.pdf>.
- De Cuypere G, Van Hemelrijck M, Michel A, Carael B, Heylens G, Rubens R, Hoebeke P, Monstrey S. (2007). Prevalence and demography of transsexualism in Belgium. *Eur Psychiatry.* Apr;22(3):137-41.
- Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). *How Many Adults Identify as Transgender in the United States?* Los Angeles, CA: The Williams Institute.
- Health Resources and Services Administration (HRSA). (2015). *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2014.* <<http://hab.hrsa.gov/data/servicesdelivered/2014RWHAPDataReport.pdf>>.
- Kellogg TA, Clements-Nolle K, Dille J, Katz MH and McFarland W. (2001). Incidence of human immunodeficiency virus among male-to-female transgendered persons in San Francisco. *JAIDS,* 28(4):380-384.
- Ramirez-Valles J, Kuhns LM, Campbell RT and Diaz RM. (2010). Social integration and health: Community Involvement, stigmatized identities, and sexual risk in Latino sexual minorities. *Journal of Health and Social Behavior,* 51(1):30-47.
- San Francisco Department of Public Health. (2015). HIV Epidemiology Annual Report 2014. <<https://www.sfdph.org/dph/comupg/oprograms/HIVepiSec/HIVepiSecReports.asp>>.
- San Francisco Department of Public Health. (2017). Coordinated Care Management System Client Report. Public access restricted.
- Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City. *American Journal of Public Health,* 99(4), 713–719. <http://doi.org/10.2105/AJPH.2007.132035>

INTERVENTION APPENDIX

Figure 1: TransAccess Logic Model

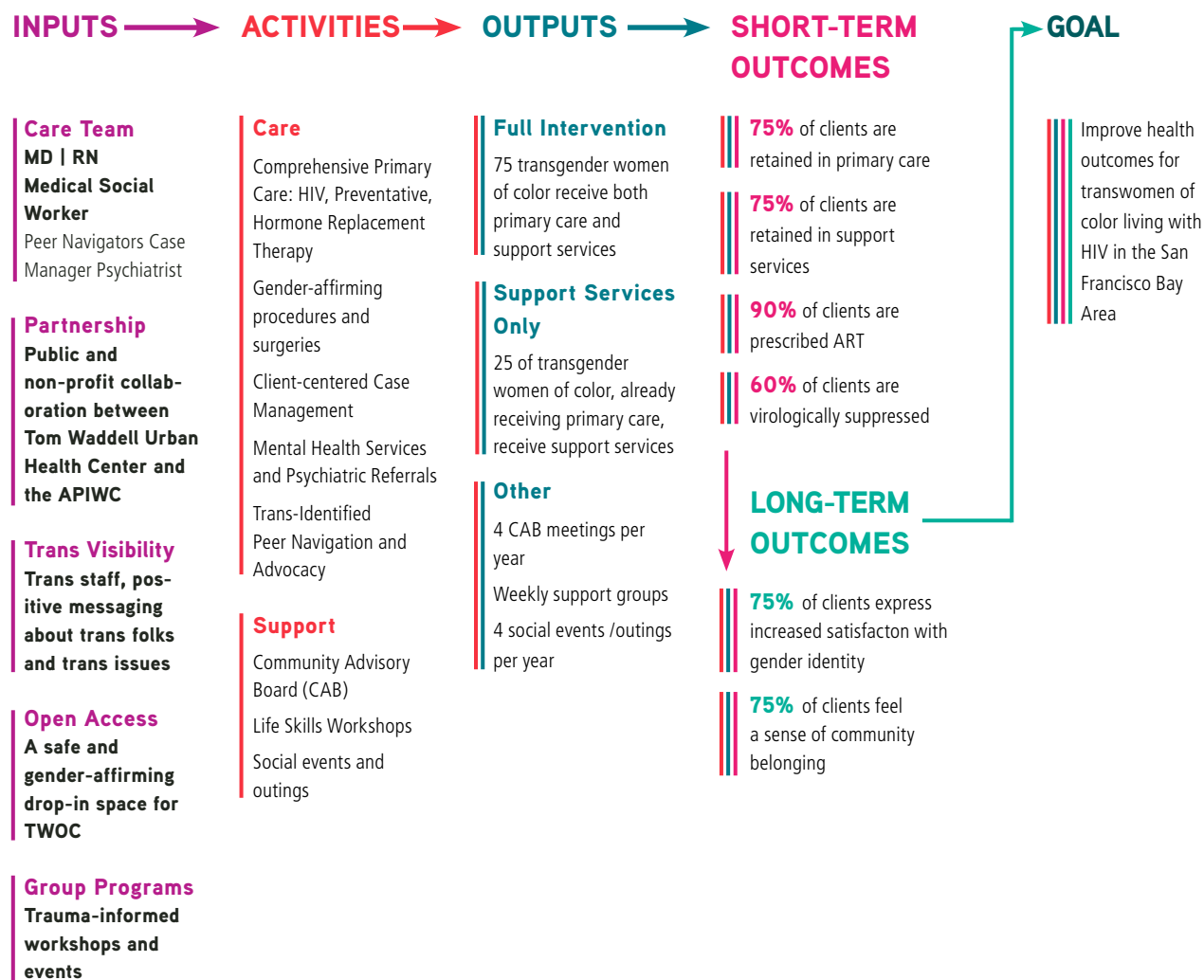


Figure 2: Clinic FlowChart

