

Culturally Competent Care for HIV-Infected Transgender Persons in the Inpatient Hospital Setting: The Role of the Clinical Nurse Leader

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HIV infection rates among transgender persons are estimated to be high. This often invisible group is stigmatized and suffers greatly from discrimination in employment, housing, and health care (Lombardi & Van Servellen, 2000; San Francisco AIDS Foundation, 2009, Sevelius, Reznick, Hart & Schwarcz, 2009). HIV-infected transgender persons may require inpatient care at some point in their lives. Inpatient health care personnel are often not aware of issues related to transgender clients and may provide culturally insensitive care. The clinical nurse leader (CNL) could provide transgender patients an ideally positioned advocate to model, instill, and coordinate consistent and culturally competent care at the bedside and beyond. The CNL, acting as an educator and advocate involved in direct patient care, can be instrumental in shaping the inpatient experience for the transgender patient while working to maximize continuity of care to improve patient outcomes.

HIV Infection in Transgender Persons

HIV-infected persons are considered to be a vulnerable population in the health care system. The risk for discrimination and disparity in care delivery increases when these people are also transgender persons. Identification of HIV-infected transgender persons can be challenging because the data reporting system at the

Centers for Disease Control and Prevention does not include categories for transgender persons. Current reporting practices prevent important epidemiological data concerning HIV infection from being monitored in transgender populations. Instead, transgender HIV cases have been included in data for other populations (e.g., women, women of color, and men who have sex with men; San Francisco AIDS Foundation, 2009). Prevalence estimates for HIV infection in transgender persons exceed estimates in men who have sex with men populations, which is approximately 25% (Herbst et al., 2008). In the United States, prevalence of HIV infection in the male to female (MTF) population is estimated to be 27%, with transgender women of color being more likely to be infected with HIV (Herbst et al., 2008). Studies included in a systematic review by Herbst et al. (2008) estimated HIV prevalence in transgender women of color to be 56.3% by testing and 30.8% by self-report. Very few studies have addressed issues regarding HIV prevalence in female to male transgender persons, which is

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estimated to be 0%-3% and much lower than in MTF transgender persons (Herbst et al., 2008). Additional factors that potentially contribute to HIV risk for both MTFs and female to males include high rates of mental health issues, physical/sexual abuse, social isolation, economic marginalization, incarceration, inadequate health care, and perception of low HIV risk status (Herbst et al., 2008).

HIV-Infected Transgender Patients in the Health Care System

For HIV-infected patients, interaction with the health system is vital for maintaining health, obtaining medications, and monitoring CD4+ T-cell counts and viral loads. In this way, HIV-infected transgender patients are no different than other populations with HIV infection. HIV-infected transgender persons bear the stigma not only of HIV infection but also of additional transgender-related stigma, further marginalizing an already vulnerable population. The health care system is not structured in a way that allows for easy integration of transgender persons. Generally, patients are designated as either male or female, with little or no opportunity to modify this binary gender designation. Social implications of transgender identity are numerous, ranging from relationships to employment to health care. Transgender identity, like homosexuality, can be met with extreme hostility. As a result, some transgender persons prefer not to be readily identified as transgender by the casual observer because of social stigma and personal safety issues.

Attention concerning specific health care for transgender individuals is focused on HIV prevention and primary care for gay, lesbian, bisexual, and transgender (GLBT) communities. Clinics focused on these populations often provide testing, prevention education, and HIV medication management. Specialty clinics with awareness of and sensitivity to transgender issues often cannot overcome mistrust of health care providers or the health care system because clinics are just one part of the larger health care system.

Like other individuals infected with HIV, transgender persons can develop opportunistic diseases, progress to AIDS, and require hospitalization.

Although some hospitals have units devoted to infectious diseases and staff with expertise in HIV care, many nurses and health care staff have limited knowledge or understanding of transgender people. It is important to make a positive impression so as to facilitate care in patients who distrust health care systems. Hospitals are just one link in the health care chain for transgender patients with HIV. The chronic nature of HIV infection makes trust in health care providers even more crucial. Patients' views of health care workers as ignorant and insensitive concerning transgender issues can act as a serious barrier to care, both in acute care and outpatient settings (Burdge, 2007; Schilder et al., 2001).

Patients in the hospital are often at their most vulnerable, and it is especially at this time that health care workers need to be sensitive to issues related to transgender identity. The specific risks and care needs of transgender persons are not addressed in most nursing and medical schools. As a result, many nurses and physicians have no training to inform their practices regarding transgender care. This lack of clinical and cultural competency can lead to misunderstandings, inappropriate care, and undiagnosed health problems (Vanderleest & Galper, 2009). Important patient teaching and prevention messages can be lost as a result of information not being targeted to the individual patient. Numerous times, nursing journals have acknowledged the need for transgender sensitive care for this population, but the message has not reached the mainstream world of acute care nursing (Adams, 2010; Berreth, 2003; Peate, 2008; Shaffer, 2005). Nurses in all environments, regardless of specialty, need to be educated regarding transgender issues to ameliorate longstanding mistrust of health care systems.

The Role of the CNL

Nursing is a constantly changing field with new knowledge and practice expanding as quickly as health care itself. The CNL role was developed by the American Association of Colleges of Nursing (AACN, 2003) and first outlined in the CNL White Paper in 2003. The CNL creates a role for nurses educated in the implementation of evidence-based practice to bring their skills to the bedside. The

CNL is a master's prepared generalist whose role is one of leadership in improving patient outcomes, helping coach new nurses, and improving communication with physicians. According to the updated 2007 White Paper (AACN, 2007) of AACN, fundamental aspects of the CNL role include the following:

- Leadership in the care of the sick, in and across all environments;
- Design and provision of health promotion and risk reduction services for diverse populations;
- Provision of evidence-based practice;
- Population-appropriate health care to individuals, clinical groups/units, and communities;
- Clinical decision-making;
- Design and implementation of plans of care;
- Risk anticipation;
- Participation in identification and collection of care outcomes;
- Accountability for evaluation and improvement of point-of-care outcomes;
- Mass customization of care;
- Client and community advocacy;
- Education and information management;
- Delegation and oversight of care delivery and outcomes;
- Team management and collaboration with other health professional team members;
- Development and leveraging of human, environmental, and material resources;
- Management and use of client-care and information technology; and
- Lateral integration of care for a specified group of patients. (AACN, 2007, pp. 10-11)

Implementation of this role has been shown to effect change to improve designated quality outcomes on a microsystem level (Hix, McKeon, & Walters, 2009).

Influencing Care for HIV-Infected Transgender Patients in the Inpatient Hospital Setting

The CNL is strategically placed to foster trust through the provision of culturally competent, individualized, quality care. They need to be familiar

with underlying issues related to transgender identity, hormones, and social issues, and how they relate to HIV prevention and care. CNLs play a crucial role in providing and coordinating direct patient care, recognizing that they represent nursing and the health care system, as well as being patient advocates. CNLs as generalists may not initially have the expertise to address transgender issues in their units. Best practice guidelines, such as those developed by the [Transgender Health Services Working Group \(2007\)](#), should be consulted and adopted to suit individual hospital and unit needs. Some hospitals and health care systems, such as the [Department of Veterans Affairs VA Boston Healthcare System \(2008\)](#), [Vancouver Coastal Health \(2010\)](#), and the [United Kingdom Department of Health \(2009\)](#), have developed guidelines for staff that outline appropriate treatment of transgender individuals. In addition, CNLs must seek out transgender-specific resources including health guidelines in professional literature, local transgender or GLBT organizations, and other health care professionals who routinely provide care for transgender persons.

Working with unit managers, CNLs can advocate for transgender educators to provide in-service education sessions for staff. All unit staff may require training to truly make the inpatient unit a comfortable and safe place for transgendered persons. Additionally, staff could be encouraged to spend a day at an outpatient GLBT specialty clinic to further understand the context of inpatient HIV care for transgender patients. Depending on geographical location, it is possible to coordinate training courses concerning transgender issues in health care. Information pamphlets could be placed on inpatient units for easy access to reference materials. In this way, CNLs and other staff can learn to provide culturally competent care for hospitalized transgender persons.

As educators, CNLs are also focused on patient education and care customization. Education regarding HIV transmission is very important for HIV-infected transgender persons. HIV-prevention messages customized for transgender persons should reflect the realities of anatomy and behavior while respecting their identities. Transgender persons may use intramuscular needles for injecting cross-gender hormones. Some transwomen, although discouraged

by medical professionals, use needles for injecting industrial silicone to obtain a more feminine appearance without the compromises in sexual functioning associated with hormone therapy. These uses of needles, in addition to injection drug use, should be specified in HIV transmission prevention messages, and needle sharing should be discouraged. Nurses must assess the sexual behaviors of patients so as to adequately convey prevention and transmission information to the patient. This is important because, although discussing sexual behavior may be very personal, a large number of transgender persons are engaged in sex work, survival sex, and unprotected sex acts (Lombardi & Van Servellen, 2000).

In addition to advocating for education, CNLs can ensure sensitive care by acting as agents of continuity. Often, staffing of nurses on inpatient units leads to discontinuity among caregivers, and patients may have many different nurses during a stay of only a few days. As the role was envisioned, CNLs would be on inpatient units 5 days a week, following 12 to 15 patients everyday (Sherman, Edwards, Giovengo, & Hilton, 2009). Part of continuity can be attained by CNLs having contact with nurses and alerting them to the transgender status of the patient and reminding nurses of responsibilities as they relate to culturally competent care. If competent in this area, CNLs can act as a direct resource for nurses regarding care; if not, CNLs can refer nurses to experts regarding transgender care.

As advocates for transgender patients in hospital systems, CNLs can influence organizations to consider policies, facilities, and documentation that present challenges. Hospital- and system-wide transgender affirming policies and practices must be outlined to establish a clear organizational position on the treatment of gender variant persons. This advocacy can be used to address issues including, but not limited to, respectful language, insurance coverage, safe bathroom access, and inclusive documentation forms. It should be clearly communicated that transphobic language and behavior on the unit will not be tolerated. This includes the use of appropriate pronouns reflecting the gender identity of the patient, and not his or her anatomy. Gender identity can be assessed by asking the patient to self-identify appropriate gender pronouns. Respect for gender identity is important to all therapeutic

interactions (Burdge, 2007; Transgender Health Services Working Group, 2007). With very few exceptions, insurance companies do not cover gender reassignment surgery, cross-gender hormone therapy, or examinations such as Papanicolaou (Pap) smears for male patients. Some health professionals seek out creative insurance billing solutions as a way to ensure coverage of medically necessary procedures for transgender people. Documentation of patient care is often standardized at the hospital level. Both paper and electronic documentation forms need to include options for the inclusion of transgender identities and preferred names to accurately document a transgender person's gender. Nurses should voice support for the creation of gender-neutral bathroom facilities to allow transgender persons to use the hospital's bathrooms without fear or harassment (Mottet, & Tanis, & the National Gay and Lesbian Taskforce, 2008). Advocacy for these patients includes allowing the visitation of chosen family, because many transgender persons can become estranged from families of origin and may not have their partnerships/marriages legally recognized (Holman & Goldberg, 2006; Minter, 2010).

As lateral integrators, CNLs can be of service to transgender persons by communicating with the health care team. By being present at the point of care, it is possible for CNLs to coordinate with all team members involved to ensure respect of a patient's gender identity. By coordinating with local GLBT-focused health care providers, CNLs can make efforts to refer patients to outside providers who have experience and good reputations for working with transgender patients. Compiling a list of transgender-friendly providers is also recommended (Mottet et al., 2008). By making appropriate referrals, CNLs may be able to assist in the continuity of care outside the hospital that is vital for keeping HIV-infected patients healthy and out of the hospital setting.

Risk anticipation as a part of the CNL skill set is used to affect outcomes. Risks related to breaches in privacy can have emotional and social consequences for transgender persons. Individuals may live their lives without telling family members, friends, or coworkers about their gender transition. A patient's transgender status is like other medical information and should not be discussed when visitors are

present unless specified by the patient. Some transgender patients may use different terminology for their body parts related to their cross-gender identification and possible feelings of disconnect from their own physicality. Because of gender dysphoria, transgender patients can be uncomfortable when exposing their bodies to care providers. Special consideration should be given to ensuring privacy during routine hospital assessments or events such as bathing, and changing of Foley catheters. Transgender patients should, if at all possible, be provided private rooms and bathrooms to avoid issues related to placing patients with a roommate. In situations where a private room is not possible, transgender persons should be placed by their self-identified gender and not by their assigned birth sex (i.e., transmen should be placed with male roommates and transwomen should be placed with female roommates; [United Kingdom Department of Health, 2008](#)).

CNLs can begin to address health care mistrust in the often overlooked transgender population by advocating for further staff education, modeling culturally competent transgender care, advocating for transgender patients on inpatient units, and coordinating sensitive and appropriate discharge planning. By challenging the binary gender system, these patients defy the way in which everything from health care to bathrooms is structured. CNLs as leaders in the inpatient clinical setting must envision a new way of delivering and structuring health care to comfortably accommodate persons who do not fit neatly into male or female categories. Research on the ability of CNLs to positively influence microsystems is needed as clinical implementation of the role is in its infancy. CNL competencies and the potential for effecting change on a microsystems level make the CNL role ideal for addressing not only competent care for transgender persons but also for other at-risk populations requiring special considerations in cultural competence.

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