Issues related to Transgender (TG) health disparities are an emergent topic in healthcare. As nurses, we are the most trusted profession, and we represent vulnerable populations through advocacy. Furthermore, nurses are the voice of those marginalized and stigmatized by the inequalities of an

Guest Editor

Dianitza V. Runser, MSN, RN

Dianitza is a native from the Republic of Panama who relocated to the United States 26 years ago. She is a graduate of Delaware State University where she obtained her baccalaureate degree in nursing science. Dianitza graduated in 2009 from Wesley College with her Master of Science in Nursing degree. She is currently attending Chatham University for her Post-Master Certification as a Nurse Educator. At the same time, Dianitza is completing a Post-Masters Certification for the Gerontology Clinical Nurse Specialist at Wesley College. Presently, she works at Wesley College as a full time instructor of nursing. Dianitza is a former employee from Bayhealth Medical Center where she worked in different units including medical surgical, intensive care, intermediate care, endoscopy, and dialysis. She also worked at Polytech High School as a nurse assistant clinical supervisor and liaison. Dianitza is a member of the National Association of Hispanic Nurses (NHAN) and the president elect of the Delaware Hispanic Nurses Association. She is an active member of the Hispanic parish at the Holy Cross, Catholic Church where she volunteers in various activities. Dianitza is a member of Sigma Theta Tau and currently holds the vice president position for the Tau Beta Chapter at Wesley College. For three consecutive years, Dianitza has traveled to Guatemala where she co-teaches a study abroad course for undergraduate nursing students that focuses on ethnography, culture, and health. Dianitza is also a member of the Lecture and Cultural Arts committee at Wesley College. Dianitza can be reached at Dianitza.Runser@Wesley.edu.

Executive Director’s Column

Sarah J. Carmody, MBA

It’s 2018 and I am excited for what’s in store for new DNA member Board of Directors members who took office in the fall. The new DNA President-Elect is Gary Alderson, Chris Otto is Secretary, Jon Leeking is Treasurer, and Terry Towne and Felisha Alderson are members of the Nominating Committee. Thank you to all who offered their expertise and time to run for office!

In the coming months, DNA will be implementing the decisions from the BOD Retreat that was held in January. The Board will focus on our policy agenda, organizational structure, and membership engagement. If you have any comments or suggestions, my email is always open. Please contact me at sarah@denurses.org

As of this writing, the DNA Spring Conference is scheduled for April in Dover with a location to be determined. The focus of this conference is safety with topics that include bioterrorism and active shooter safety. Please check the DNA website for additional details.

Voting for Delaware Today Top Nurses closes February 5th. This program provides opportunity for all nurses regardless of practice to be recognized for their contribution to the nursing profession and patient care. The 2018 celebration of Top Nurses will be held at the Bella Vita at Cavalier’s Country Club on May 12, 2018. I hope that you will join DNA and Delaware Today magazine for this celebratory event! Information on tickets and sponsorship can be found on the DNA website.

Thank you for all you do!

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Did you know that the DNA Reporter goes to all registered nurses in Delaware for free?

Arthur L. Davis Publishing does a great job of contacting advertisers, who support the publication of our newsletter. Without Arthur L. Davis Publishing and advertising support, DNA would not be able to provide the newsletter to all the nurses in Delaware.

Did you know that, did you know receiving the DNA Reporter does not automatically provide membership to the Delaware Nurses Association?

DNA needs you! The Delaware Nurses Association works for the nursing profession as a whole in Delaware. Without the financial and volunteer support of our members, our work would not be possible. Even if you cannot give your time, your membership dollars work for you and your profession both at the state and national levels. The DNA works hard to bring the voice of nursing to Legislative Hall, advocate for the profession on regulatory committees, protect the nursing practice act, and promote educational programs that support your required continuing education nursing.

At the national level, the American Nurses Association lobbies, advocates and educates about the nursing profession to national legislators/regulators, supports continuing education and provides a unified nationwide network for the voice of nurses. I would like to thank the contributing authors for standing up and providing extensive, informative articles on current issues affecting TG people, a topic often overlooked, and to Denise Morris and Patys Stark for sharing their original groundbreaking research in reference to a conceptual model when caring for Transgender people.

In the first article, I will discuss issues regarding the overall lack of knowledge on communicating and improving clinical practice for TG people. The second article written by Denise Morris, EdD, MSN, RN in collaboration with Patys (Pat) Stark, HSN, RN, CHPN will explore and introduce a conceptual framework deemed necessary for nurses to provide delivery of care without assumptions. The third article written by Margaret McElligott, MSN, RN presents the increase rate of suicide amongst TGs due to discrimination matters and lack of acceptance in society. The fourth article written by Brian Wharton, MSN, BSN, RN will be a discussion regarding homelessness among transgender youth and the consequences that influence the development of risky behaviors encountered by this vulnerable population. The final article written by Shari Tenner, MSN, RN will explain issues that create barriers for cancer screenings among Transgender people; consequently, presenting specific cancer screenings to provide better preventive care to TGs.

References

Vision: Delaware Nurses Association is the leading voice, authority, and advocate for the nursing professional in the state of Delaware.

Mission: Delaware Nurses Association provides leadership for the nursing profession and promotes quality health care for consumers through education, advocacy, and influencing health care policy in the state of Delaware.

Goals: Delaware Nurses Association will:
- Promote and lead the nursing profession on issues and trends that affect professional practice
- Promote and support excellence for nurses in practice, education, and research
- Promote professional development and respond to the changing needs of nurses in Delaware
- Maintain and strengthen nursing’s role in client advocacy for consumer safety and quality healthcare

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President’s Message

Belated but Happy New Year. I hope all of your dreams are filled this year and you are able to keep those resolutions. I have no willpower so never make resolutions as I know I will not keep them. My goal is to become more active in providing engagement opportunities for our members. I am so glad to congratulate the new Board of Directors for 2018 – DNA President-Elect Gary Alderson, Secretary Chris Otto, Treasurer Jon Leeking, and Nominating Committee members Terry Towne and Felisha Alderson. It is going to be a fun and exciting year. We had a retreat in January to look at what our goals and plans are for the upcoming months. We hope to add more for our members and encourage involvement. We as a group are being asked to be more involved in Community Issues and will need volunteers to assist with this as we move forward.

New Board of Directors Members

Left to right: Felisha Alderson/Nominating Committee, Chris Otto/Secretary, Gary Alderson/President-Elect, and Jon Leeking/Treasurer

The Delaware Nurse Peer Support Group helps nurses stay engaged in the recovery process and reduce the likelihood of relapse. Peer support can minimize feelings of isolation, provide a sense of hope, and create a safe space to share experiences with other nurses in recovery. These closed meetings are limited to nurses that have experienced problems related to alcohol or substance use. The meetings support the goal of abstinence from addictive substances and achievement of a meaningful recovery.

To the advanced practice providers, the State Of Delaware has created a new Delaware Prescription Monitoring Program (PMP) software. Your existing Delaware PMP account has automatically been transferred into the new software system. You can access the Delaware PMP by:

- Going to: https://delaware.pmpaware.net/login
- Clicking The ‘Reset Password’ button on the homepage.
- Entering your email address on the ‘Reset Password’ page and clicking ‘Request Password’. Instructions will then be emailed to you for resetting your password.
- Note: If the email does not appear in your inbox, please check your spam folder.
- Once you have reset your password, you will be logged into the system.
- If prompted, update your demographic information.
- To request patient reports, please review the How to Make a Request Guide. Additional instructions for use of the new Delaware PMP can be found after logging in by clicking the Training section in the top menu.

Note that the old website, https://deredm-ph. hhdm.com/, is no longer available. If you have any questions or concerns, please contact support directly at 855-263-6401. Technical assistance is available Monday - Friday: 8:00 am - 5:00 pm ET.

For policy questions, you may contact the Delaware State Administrator at (302) 744-4518.

Be Safe and Have a Great Year.

Leslie Verucci

Delaware Nurse Peer Support Group

The Delaware Nurse Peer Support Group helps nurses stay engaged in the recovery process and reduce the likelihood of relapse. Peer support can minimize feelings of isolation, provide a sense of hope, and create a safe space to share experiences with other nurses in recovery.

If you have an interest in being involved with your state organization, please contact the office for more information.

I am also asking you to think about the nurses you work with and some of the amazing things they do everyday for our patients and the community in which they work. Delaware Today Voting closes February 5th so consider nominating one of your colleagues. The awards ceremony will be held on May 17th at the Cavalier Country Club Bella Vita Room. We always have a great turn out and watching the winners’ faces when their names are announced is a gratifying experience for all. Delaware Today does such a great job in recognizing and celebrating the nursing profession.

I want to thank the editors of this edition for the great information they have provided us in the care of the transgender community. Being culturally competent can create a challenging time with patients, but learning all we can will make the visit and the care we provide safer and more holistic.

To the advanced practice providers, the State Of Delaware has created a new Delaware Prescription Monitoring Program (PMP) software. Your existing Delaware PMP account has automatically been transferred into the new software system.

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Delaware Health and Social Services Director of Delaware Mental Health

Nurse Support Group

DANP-APRN-BC

February, March, April 2018

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Several months ago, I attended a Transgender (TG) support group with the assumption that all TG people look and dress according to the gender with which they identify. I came to the meeting prepared to share a health promotion activity that I considered would be beneficial to the group. I realized that evening, how unfamiliar I was to contribute, and how unfair I was to even attempt disseminating “my plan.” After that experience, I have embarked on the journey to become an advocate for the TG population in Delaware. I have realized how few available resources exist to support the healthcare needs of the TG population. The aim of this article is to raise awareness about the narrow knowledge on the clinical management and cultural insight of this vulnerable population from a nursing perspective. Barriers to provide cultural sensitive and competent care for TGs is due to the lack of a broader knowledge on Transgender people (Lim & Brown, 2014). Another area in nursing needing attention to better care for TGs is the development of clinical guidelines specific for nurses (Zunner & Grace, 2012). Nurses also need to stand-up and participate in research that ameliorates communication practices, preventive services, and the effect of treatments for TGs (Levitt, 2015). Learning and keeping an open mind about the unique needs of TGs will strengthen advocacy and improve nursing practices for this population.

Transgender health is an emerging concern among healthcare professionals; however, the worries about the lack of knowledge regarding transgender care poses challenges to healthcare providers (Poteat, German, & Kerrigan, 2015). Ameliorating better communication practices begins by learning specific terminology to help nurses address the TG patient (German, & Kerrigan, 2013). Ameliorating better communication practices begins by learning specific terminology to help nurses address the TG patient (German, & Kerrigan, 2013). In order to establish a trusting relationship, nurses must acquire competence in various issues that can affect the overall health of TG people. A holistic approach including biological, socioeconomic, spiritual, and mental health is improving comprehensive care to TGs. Of the estimated 700,000 (0.3%) identified TGs in the United States, many do not have health insurance nor preventive care (Wichinski, 2015). Other TG persons would rather not seek medical care due to derogative statements and stigma by healthcare providers (Mesics, 2011). As previously mentioned, the physical characteristics of TG individuals differ from one another (Wichinski, 2015). Some TG persons take hormones, and others do not have surgery. On the contrary, some TG persons may have surgery with or without hormone therapy (Wichinski, 2015). Furthermore, some TG people may lack family support when disclosing their identified gender; consequently, they are faced with homelessness, lack of insurance, low-paying jobs, or unemployment (Cornelius & Whitaker-Brown, 2016). Jobless TG persons needing hormones recur to street suppliers; in addition, some TG people become drug and alcohol drug suppliers themselves, thus being exposed to HIV, crime, and violence (Cornelius & Whitaker-Brown, 2016). The unfortunate reality is that young TGs who become homeless due to social rejection usually take negative behaviors such as drug addiction or becoming sex workers (Torres et al., 2015). Transgender youth face challenges for obtaining mental health services; as a result, they deal with mental distress, depression, social isolation, and suicidal behavior (Torres et al., 2015). The complex care for TG persons needs standardization by designing policies and guidelines specific to the nursing profession; thus, updating the evidence of TG knowledge needs attention (Zunner & Grace, 2012). The World Professional Association for Transgender Health [WPATH] (2012) designed standards of care specific for TGs which guides primary care providers on developing better practices when caring for TG people. A gap in the literature, however, exists for the lack of specific nursing guidelines geared toward proficiently caring for TG people. A comprehensive knowledge of all that involves caring for TG people will strengthen the provider-patient relationship; thereby, building a trusting, caring environment (Poteat et al., 2013). Nurses should be aware of TG medications prescribed to TG people, and the short-term and long-term effects of therapy the TG person may face (Bostock-Cox, 2014).

In conclusion, to provide culturally, sensitive care to TGs, nurses and other healthcare professionals should start by learning about issues affecting TG health and improve knowledge on the terminology, for better patient-nurse communication (Wichinski, 2015). Another venue is to improve positive attitudes among newer nurses about TG healthcare by the integrating TG culture and health in the nursing curriculum (Armbru Alegria, 2012). Further, familiarizing oneself with available resources to learn more about caring for TGs, and the comprehensive care needed by this vulnerable population, including treatments, hormone replacement, and surgery. Thus, improving a trusting nurse-patient relationship for better outcomes of Transgender people.

References


Transgender individuals have been a part of world cultures historically, yet the support for the healthcare of such populations has only received attention in recent decades. The World Professional Association for Transgender Health (WPATH) published Standards of Care (7th edition) in 2012, which focused on the medical and psychological approaches that foster the highest quality of care for this vulnerable population. While these standards support an understanding of surgical, hormonal, cosmetic, and psychological care, it does not identify nursing care and nursing related etiologies for transgenderism. Further, an extensive review of the literature offers few evidence based articles related to nursing care or nursing implication for transgender individuals. According to Berreth, the dearth of literature regarding nursing care for the transgender person puts this population at risk for a plethora of problems associated with unformed nursing care. For nursing to properly address the needs of this special population, it is incumbent upon nurses to conduct patient-centered research that is based upon the life experiences of the transgender that is grounded in a conceptual framework specific for nursing care and nursing education.

Denise S. Morris, Ed.D, MSN, RN
Patsy Starke, BSN, RN, CHPN

Denise received her Doctorate in Education from Wilmington University, her Masters in Nursing from Wesley College, and her primary nursing diploma from Beebe School of Nursing. She is currently teaching graduate nursing courses at Wesley College. A strong advocate for inquiry based education and active participatory learning, Denise involves students in research and evidence based practice in a variety of community and small group settings focused upon health promotion and wellness. Her professional interest focuses on vulnerable population health, the spirituality of caring in nursing, complementary and alternative healing, and promoting a culture of curiosity in nursing education. Dr. Morris has pending publications in the Journal of Holistic Nursing and The Clinical Nurse Specialist. In addition, she serves as a member of the Graduate Committee for Wesley College, and is a member of the American Nurses Association, the Delaware Nurses Association, the World Professional Association for Transgender Health (WPATH), the National Association for Clinical Nurse Specialists, and the American Holistic Nurses Association. Denise was recently honored with Excellence in Teaching Award for her contributions to nursing and health professions education. Denise can be reached at denise.morris@wesley.edu

Patsy was born in 1959 as William Patrick Starke. She is a 1996 graduate from the University of Delaware with a Baccalaureate of Science in Nursing and a minor degree in Biological Sciences. Patsy's focus in nursing has always been in the field of Community Health where she began her career providing migrant health care for Delaware's migrant population. She worked in the area of health promotion for Delaware Division of Public Health, and was instrumental in forging a partnership with the March of Dimes Folic Acid Coalition to develop strategies to promote folic acid, as a necessary vitamin in pre-conception health to aid in preventing neural tube defects in the early stages of fetal development. Along with the Folic Acid Coalition, a mascot named Folic Acid Man was created and Patsy became Folic Acid Man to attend community functions; thus, reaching Delawareans to promote the benefits of Folic Acid. Patsy received the Dr. Katherine Esterly Award for lifetime contribution to Perinatal Development in Delaware from the March of Dimes. Patsy has worked in the field of Hospice for the last 15 years, and is a Certified Hospice and Palliative Care Nurse (CHPN). Patsy began her Transition to her true self, as a Transgender Woman, in April of 2016, and she refers to that as her second birthday after a lifetime of struggles with her gender identity. Patsy now dedicates her life and nursing career to: End of Life Care, LGBT healthcare, mainly Transgender Health Care, and advocacy for LGBT equality issues. She is a proud member of WPATH, GLMA, SAGE, and HNPA. She is a prolific writer in poetry and short stories on Medium.com where she publishes her works.
Depression and Suicidality in the Transgender Community

Margaret O. McElligott, MSN, RN

Margaret earned her Baccalaureate (BSN) from The Catholic University of America, her Master of Science in Nursing (MSN) from Wesley College, and Certification in Simulation from Drexel University at age 19. Margaret has worked in many nursing specialties in various medical centers on the east and west coasts, and in the mid-west over her extensive career to include Hematology-Oncology at Christiana Care, Bone Marrow Transplant & Coronary ICU at George Washington University in Washington D.C., ICU Float Pool & Cardio-Vascular Lab at United Hospital in St. Paul Minnesota, Level II Trauma/ED at St. Mary Medical Center in Langhorne, PA, and Medical ICU at Bayhealth Medical Center in Dover, DE. She is currently a member of the Wesley College faculty as an instructor of nursing and the simulation coordinator. Margaret plans, coordinates and facilitates simulation for every clinical course with sophomore through senior nursing students. Margaret also serves as co-teacher for the Palliative Care & Field Study in Guatemala courses. This year she began teaching an Ethics in Healthcare course to Wesley College students. Margaret serves as the faculty adviser to the Delaware Student Nurses Association as well as Faculty Coordinator for the Tau Beta Chapter of Sigma Theta Tau. Margaret can be reached by email at Margie.mcelligott@wesley.edu or at her office at (302) 736-2737.

Transgender individuals are part of a minority population which until recently was not familiar to the majority of society. Transgenderism is defined by the American Psychological Association (APA) as an umbrella term for persons whose gender identity, typically associated with the sex to which they are assigned at birth, is different from the majority of society. Transgenderism is defined by the American Psychological Association (APA) as an umbrella term for persons whose gender identity, typically associated with the sex to which they are assigned at birth, is different from the sex to which people are typically associated. Transgenderism is defined by the American Psychological Association (APA) as an umbrella term for persons whose gender identity, typically associated with the sex to which they are assigned at birth, is different from the sex to which people are typically associated. Transgenderism is defined by the American Psychological Association (APA) as an umbrella term for persons whose gender identity, typically associated with the sex to which they are assigned at birth, is different from the sex to which people are typically associated. Transgenderism is defined by the American Psychological Association (APA) as an umbrella term for persons whose gender identity, typically associated with the sex to which they are assigned at birth, is different from the sex to which people are typically associated.

The National Transgender Discrimination Survey (NTDS) (2016) noted that 41% of all transgender respondents reported having attempted suicide. This number compares to 1.6% of the general population in the United States who report having attempted suicide. Most trans, androgynous, and non-binary participants noted that the predictors of mental health issues for LGBT individuals are experiencing discrimination, harassment, and victimization, which LGBT youths experience disproportionately compared to heterosexuals and cisgender youth. For example, a study with a community-based sample of LGBT youth by Hatzenbuehler and colleagues (2011) found that LGBT youth who interacted with a physician or healthcare provider who refused to treat them, because of their transgender or gender non-conforming status, had attempted suicide. These participants also reported avoiding and or postponing acute care for illnesses; as well as for preventative care because of disrespectful or discriminatory treatment by medical personnel. Medical personnel who lack training or unwillingness to treat all patients with respect and dignity. The ethical principles of justice, autonomy, beneficence, and non-maleficence are foundational in medical ethics. Medical professionals have an ethical obligation to treat all patients with respect and dignity. The ethical principles of justice, autonomy, beneficence, and non-maleficence are foundational in medical ethics. Medical professionals have an ethical obligation to treat all patients with respect and dignity.

Psychological distress (including symptoms of somatization and anxiety), depression, substance use, suicide attempts and PTSD. (p. 527)

Su et al. (2010) conducted a study that assessed an epidemiological profile of two significant public health issues for LGBT individuals in the United States for the impact of transgender identity and the elevated odds of reported discrimination, depression and suicidality. The findings showed that transgender respondents reported depression symptoms compared to 33.4% of non-transgender participants. The reported history of a suicide attempt was significantly higher in the transgender population over the non-transgender respondents, at 37.7% vs. 15.9%, respectively. Several variables were found to be significant predictors associated with depression symptoms. The study indicated that the lack of social support, identity acceptance with age and life experience. The older, more self-acceptance is challenging as this is such a significant public health issue must be addressed to improve the quality of life for members of the transgender community.

The Transgender Mortality Study (MTS) (2016) and the National Transgender Discrimination Survey (NTDS) (2010) conducted a study that assessed an epidemiological profile of two significant public health issues for LGBT individuals. The Transgender Mortality Study (MTS) (2016) and the National Transgender Discrimination Survey (NTDS) (2010) conducted a study that assessed an epidemiological profile of two significant public health issues for LGBT individuals. The Transgender Mortality Study (MTS) (2016) and the National Transgender Discrimination Survey (NTDS) (2010) conducted a study that assessed an epidemiological profile of two significant public health issues for LGBT individuals. The Transgender Mortality Study (MTS) (2016) and the National Transgender Discrimination Survey (NTDS) (2010) conducted a study that assessed an epidemiological profile of two significant public health issues for LGBT individuals.

For the Canadian study, both age groups of transgender men and non-binary males reported significantly higher rates of self-harm than their cisgender peers or the transgender females (Veale et al., 2014). A positive finding from the study indicated an improvement in the prevalence of self-harm in the older age groups of transgender participants of both sexes. The older age group of transgender males also reflected a decline in suicide ideation and attempts. These findings may be attributed to improved self-acceptance with age and life experience. The older, more self-acceptance is challenging as this is such a significant public health issue must be addressed to improve the quality of life for members of the transgender community.

According to Haas, Rodgers, and Herman (2014) the National Transgender Discrimination Survey (NTDS) of 2008, identified negative experiences for transgender individuals who sought healthcare as a contributing factor to suicidality. Some 60% of respondents who sought medical care indicated that the medical provider who refused to treat them, because of their transgender or gender non-conforming status, had attempted suicide. These participants also reported avoiding and or postponing acute care for illnesses; as well as for preventative care because of disrespectful or discriminatory treatment by medical personnel. Medical personnel who lack training or unwillingness to treat all patients with respect and dignity. The ethical principles of justice, autonomy, beneficence, and non-maleficence are foundational in medical ethics. Medical professionals have an ethical obligation to treat all patients with respect and dignity.

It is difficult to quantify an exact number of transgender individuals in the United States for numerous reasons. For example, the U.S. Census Bureau does not collect data on gender identity. The only federal government agencies that have not collected data on transgender individuals for this information. However, a 2017 study by Meerwijk and Servitius published in the American Journal of Public Health addressed this matter. Their study analyzed twelve population-based surveys from 2007 to 2015. Their findings suggested that approximately one out of 1,000 individuals identified as transgender. This represents 0.39% of the population or just under one million people. The authors noted that this figure is likely an underestimate because of the sensitivity of the questions, the broad context of transgenderism and other related factors.

For some transgender individuals, accessing sensitive information can be a personal and relatively uncommon identity. Much research has been conducted on the psychological burden for many transgender individuals. Among this population, the rates of depression and suicide attempts and completions are considerable. This significant public health issue must be addressed with initiatives to improve the quality of life for members of the transgender community.

The Transgender Mortality Study (MTS) (2016) and the National Transgender Discrimination Survey (NTDS) (2016) noted that 41% of all transgender respondents reported having attempted suicide. This number compares to 1.6% of the general population in the United States who report having attempted suicide. Most trans, androgynous, and non-binary participants noted that the predictors of mental health issues for LGBT individuals are experiencing discrimination, harassment, and victimization, which LGBT youths experience disproportionately compared to heterosexuals and cisgender youth. For example, a study with a community-based sample of LGBT youth by Hatzenbuehler and colleagues (2011) found that LGBT youth who interacted with a physician or healthcare provider who refused to treat them, because of their transgender or gender non-conforming status, had attempted suicide. These participants also reported avoiding and or postponing acute care for illnesses; as well as for preventative care because of disrespectful or discriminatory treatment by medical personnel. Medical personnel who lack training or unwillingness to treat all patients with respect and dignity. The ethical principles of justice, autonomy, beneficence, and non-maleficence are foundational in medical ethics. Medical professionals have an ethical obligation to treat all patients with respect and dignity.
Homeless LGBTQ Youth: Transgender Homelessness are an Emerging Population

Brian Wharton, MSN, RN, CPEN

Brian earned his BSN and MSN from Wilmington University. He is a Certified Pediatric Emergency Nurse and is the current chairman of the Pediatric Resource Team at Christiana Care Level 1 Trauma Center in Newark, Delaware. Brian is an adjunct clinical instructor at Delaware Technical Community College. He is a member of the American Nurses Association, Emergency Nurses Association, and is a part of the American College of Emergency Physicians. Brian has an extensive background in working with children/adolescents and is a certified CPR, BLS, ACLS, and PALS provider in children and adults. He is also a pediatric trauma provider with the Delaware Trauma System. Brian is a member of the Delaware Emergency Nurses Association (DENA) and is the current chairman of PCN. He is also a member of ENA, and has an extensive background in working with children/adolescents and is a certified CPR, BLS, ACLS, and PALS provider in children and adults. He is also a pediatric trauma provider with the Delaware Trauma System.

Imagine how amazing it would be to live in a world where no one was homeless! Unfortunately, homeless LGBTQ youth in the United States is highly prevalent affecting millions of Americans. The youth population serves as a large percentage of the overall homeless population. According to Ferguson and Maccio (2015), “More” area where the homeless youth, most aged 15 to 17 years old, are reported to be homeless in the United States, and 40% of these homeless youth are estimated to identify as lesbian, gay, bisexual, transgender, and queer/questioning” (p. 659). Once homeless, LGBTQ youth are an extremely vulnerable and vulnerable population that have to face the problems of being homeless compiled by the obstacles that are induced by their sexuality and identity. Nurses are on the frontline of healthcare; thus, having the greatest potential to positively impact the care and health of LGBTQ homeless.

Literature asserted that mental/physical abuse, sexual abuse, aging out of foster care, runaway, neglect, shame, guilt, depression, and rejection by peers and family are some issues that lead to homelessness in LGBTQ (Ferguson & Maccio, 2015). LGBTQ youth are more likely to be sexually abused, physically assaulted, discriminated against, and acquire a substance abuse issue than their heterosexual counterparts (Ferguson & Maccio, 2015). Homeless shelters are becoming more accepting of the LGBTQ homeless population and are taking proactive approaches in meeting this populations’ needs (Henry, Rosenthal, Shiri, Watt & Associates, 2016). Homeless youth may or may not have access to appropriate healthcare depending on if they seek shelter or are in a non-sheltered environment such as living in a car, under bridges, or in another public space where the homeless population can gather. This becomes a major public health and nursing issue when attempting to assist these youth; therefore, policy makers, advocates, and researchers need to address how to meet the needs of the homeless LGBTQ youth (Ferguson & Maccio, 2015).

Delaware has a low homeless population where unaccompanied youth accounted for only 51 of the total 1,670 homeless that were reported in 2016 (Ferguson, 2015). However, numbers are on the rise; thus, there is great potential for an escalation in this specific population due to the close proximity of our major cities. Two large cities and an increase in the LGBTQ youth population can gather. This becomes a major public health and nursing issue when attempting to assist these youth; therefore, policy makers, advocates, and researchers need to address how to meet the needs of the homeless LGBTQ youth (Ferguson & Maccio, 2015).

The LGBTQ homeless are an underserved population that are vulnerable and require informed healthcare providers. There are great strides being made to serve this population and to meet their needs. As a nurse, it is imperative to remain aware of the obstacles that face LGBTQ homeless and to be empathetic, accessible, and compassionate as nurses do, will ensure that this population has an ally and will receive the support they deserve.

References


Maccio, C. (2015). “More” area where the homeless youth, most aged 15 to 17 years old, are reported to be homeless in the United States, and 40% of these homeless youth are estimated to identify as lesbian, gay, bisexual, transgender, and queer/questioning” (p. 659). Once homeless, LGBTQ youth are an extremely vulnerable and vulnerable population that have to face the problems of being homeless compiled by the obstacles that are induced by their sexuality and identity. Nurses are on the frontline of healthcare; thus, having the greatest potential to positively impact the care and health of LGBTQ homeless.

The LGBTQ homeless population is growing, and there are distinctive risks associated with being transgender and homeless. A provider caring for transgender patients should acknowledge necessary medical assessments associated around the “transition” process, post-operative wound inspections, and medications needed to maintain health (Alegría, 2011).

The LGBTQ homeless are an underserved population that are vulnerable and require informed healthcare providers. There are great strides being made to serve this population and to meet their needs. As a nurse, it is imperative to remain aware of the obstacles that face LGBTQ homeless and to be empathetic, accessible, and compassionate as nurses do, will ensure that this population has an ally and will receive the support they deserve.

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Internationally there is an estimated 25 million people who consider their sexual identity as that of transgender (TG) (Lowry & Vega, 2016). This incidence has been further categorized as 1:1190 TG females (those who are biologically males but who identify as female) and 1:30,400 TG males (those who are biologically female but who identify as male). These statistics are obtained from the literature and are deemed low, as the collection of the data is difficult to obtain and is often incomplete (Dutton, Koenig, & Kristopher, 2008). It is understood the TG population (like the non TG population) will age, and those over the age of 50 will require age appropriate health care screening for cancer and prevention. Help is needed to navigate through the maze of healthcare providers to ensure the appropriate testing in a gender-accommodating manner.

While there is a scarcity of research on transgender health care, it is clear, equitable care is far from the norm. Barriers to healthcare for the TG population include but are not limited to: Gender identity discrimination, negative experiences and experiences of care solely on the healthcare system. A working partnership must be firmly established between the community and the healthcare community so both communities are better served.

The goal is to have the TG client feel free to identify with the sexual orientation and gender role of their choice while obtaining care for the biological gender-specific body. To maintain health, the healthcare system must strive to accommodate the TG population by becoming less sex segregating and more sex integrating as gender and sexual identity do not necessarily remain fixed over the life span. More research is needed to identify needs of the TG population so integration into the healthcare system can meet the objectives of the IHI but more importantly to provide health promotion and disease prevention for this vulnerable population.

Table 1. Suggested Screening (Lindsey, 2014; Edmiston et al., 2016).

<table>
<thead>
<tr>
<th>Screening</th>
<th>Female to Male</th>
<th>Male to Female</th>
</tr>
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<tbody>
<tr>
<td>Breast/Chest Wall</td>
<td>Yes, especially if intact breast tissue. Following breast removal, ultrasound or MRI if traditional mammography is not feasible.</td>
<td>Yes. Risk factors for breast cancer include: breast progestrone therapy hormone therapy for 5 years or longer, family history of breast cancer, BRCA + testing, BMI of &gt;35% or breast implants (Tongson et al., 2017).</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>Yes, especially if intact genitalia, as well as a visual exam of the vaginal tissue for lesions.</td>
<td>No. Pap smear necessary only however a visual exam of surgically created vaginal tissue for lesions.</td>
</tr>
<tr>
<td>Prostate/ PSA Screening</td>
<td>N/A</td>
<td>Yes. Digital rectal exam is necessary. PSA becomes unreliable due to androgen blocking hormone treatment.</td>
</tr>
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References


February, March, April 2018

Care without Assumption: A Conceptual Framework for Transgender Nursing Care continued from page 5

Negative Outcomes
As holistic practitioners, nurses are positioned to explore these life experiences and to create a conceptual framework (McCabe, 1988). The absence of a framework to guide nursing in the provision of care that is without assumption can easily lead to unintended prejudices and discriminatory behaviors (McDowell, 2016). Examples of such unintended consequences are referring to the patient by non-preferred pronouns, room assignment by gender, gender insensitive assessment tools, HIPAA violations, assessment of high risk behaviors and potential negative outcomes such as suicide. A lack of curricular preparation in gender-affirming care creates additional barriers resulting in health inequities and adverse outcomes. According to Reisner et al. (2015), a community sample of transgender patients indicated a 24% incidence of discrimination which resulted in the postponement or delay in needed care. In addition, these patients screened positive for depression and other negative psychosocial symptoms. Grant et al. (2011) indicated key barriers to seeking healthcare included stigmatization, discrimination, and fear of being refused care because of their gender status, and even verbal harassment and physical attack.

Lack of Knowledge
One key functional barrier to transgender care is the lack of provider knowledge about assumption. The current nursing curricula inadequately defines and addresses appropriate transgender care and may contribute to false thinking that may lead to heterosexism and homophobia (Zuzelo, 2014). In addition, the transgender patient is forced to educate the nurse on the limited knowledge currently available for his or her care. Transgender people are already marginalized, feeling oppressed, grappling with social and healthcare disparities, and in need of medical attention, and now they must stop and educate the person they expect to help them (Biederman, 2016). This lack of knowledge will clearly affect the confidence level of the patient and prevent seeking care or withholding key information that supports informed decision making. Nurses can do better. Nurses want to know.

A Guiding Framework
Using a combination of the critical (Weaver and Olson, 2006) and interactional paradigms (Gillis & Jackson, 2002) we created a model entitled “Care without Assumption” (see Figure 1). This model is grounded in key assumptions that nursing practice must move toward the elimination of social struggle and oppression in society, while fostering the examination of the phenomena through the eyes of the people experiencing it. The model aims to shift the paradigm for nursing to that of a gender transcendent world view. Nursing ontology is inately caring, therefore, to be a nurse, one is called to develop the full potential of caring expressed ethically and without bias. Like many nursing models the components include the nurses affect upon the patient domain, the systems domain, and the domain of nursing practice. It includes, however, suggested drivers that support inclusive gender neutral educational preparation, relationship building, self-assessment, process management, and a culture of ongoing research that will establish evidence based protocols and dispel the myth associated with transition. By using the framework, the nurse can move the domains and drivers along a continuum from Assumption to Non-assumption.

The use of such a framework will provide the foundational position for nursing practice and nursing education that might mitigate discriminatory actions and foster normalization of sexual diversity. Additionally, the Care without Assumption framework offers support for the creation of core competencies for transgender care, gender sensitive assessment tools, and a protocol of universal standards of interaction and testing is necessary. As with all models, additional research and testing is necessary.

References

Figure 1. Care without Assumption Model. Nursing model conceptualizing a gender transcendent nursing world view.
HIPAA regulations allow health professionals to share health information with a patient’s loved ones in emergency or dangerous situations—but misunderstandings to the contrary persist and create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation, such as an opioid overdose. This document explains how health care providers have broad ability to share health information with patients’ family members during certain crisis situations without violating HIPAA privacy regulations.

HIPAA allows health care professionals to disclose some health information without a patient’s permission under certain circumstances, including:

- Sharing health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient and the information shared is directly related to the family or friend’s involvement in the patient’s health care or payment of care. For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.
- Informing persons in a position to prevent or lessen a serious and imminent threat to a patient’s health or safety. For example, a nurse whose patient has overdosed on opioids is presumed to have complied with HIPAA if the nurse informs family, friends, or caregivers of the overdose and related information with the patient’s best interest, and how much and what type of health information is appropriate to share with the patient’s family or close personal friends, while the patient is incapacitated so long as the information shared is related to the person’s involvement with the patient’s health care or payment for such care. If a patient’s capacity returns and the patient objects to future information sharing, the provider may still share information to prevent or lessen a serious and imminent threat to health or safety as described above.

HIPAA recognizes a patient’s personal representatives according to state law:
- Generally, HIPAA provides a patient’s personal representative the right to request and obtain any information about the patient that the patient could obtain, including a complete medical record.

Personal representatives are persons who have health care decision making authority for the patient under state law. This authority may be established through the parental relationship between the parent or guardian of an un-emancipated minor, or through a written directive, health care power of attorney, appointment of a guardian, a determination of incompetency, or other recognition consistent with state laws to act on behalf of the individual in making health care related decisions.

For more information visit: https://www.hhs.gov/hipaa/

1 “HIPAA” refers to the Health Insurance Portability and Accountability Act of 1996 and, for purposes of this guidance, the HIPAA privacy and security regulations.

2 This guidance does not discuss the requirements of other federal or state laws that apply to individuals’ health information, including the federal regulations that provide more stringent protections for the confidentiality of substance use disorder patient records maintained in connection with certain federally assisted substance use disorder treatment programs (42 CFR Part 2 implementing 42 U.S.C. §290dd–2). HIPAA does not interfere with other laws or medical ethics rules that are more protective of patient privacy.

3 See 45 CFR §§ 164.510(b)(1)(ii) and 164.510(b)(3).

4 See 45 CFR § 164.512(j)(1).

5 HIPAA requires health care providers to disclose information to preventheaderlessness of a serious and imminent threat to health or safety.

6 See 45 CFR § 164.510(b)(2).

7 See 45 CFR § 164.512(j)(1)(i).

8 See 45 CFR § 164.510(b)(3).

9 See 45 CFR § 164.512(b)(2).

10 See 45 CFR § 164.512(b)(2).

11 See 45 CFR § 164.510(b)(1).

12 See generally HHS Office for Civil Rights Guidance on Personal Representatives: Providing a chart which explains who must be recognized as a personal representative and the legal exceptions applicable to unemancipated individuals and abuse, neglect and endangerment situations.

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From the bedside to the boardroom: Are you ready to serve?

By Connie Mullinix, PhD, MBA, MPH, RN; AnnMarie Lee Walton, PhD, MPH, RN, OCN, CHES; and Diana Ruiz, DNP, RN, APHN, CCTM, CWOCN, NE-BC

Reprinted from American Nurse Today

Use the skills you have—and learn new ones—to advance health care and your career

You're educated and prepared to lead in safety and quality. You're at the bedside caring for patients and working to improve care. However, decisions about the allocation of resources for caring are made at the board level, and there's a dearth of nurses in board positions. Why?

A nurse's insights

The late重度 Connie Curran told the story of a nurse on a hospital board asking significant questions when financial cuts were needed. The proposed solution was to close the hospital pharmacy services in remote parts of the facility during off-shifts. The nurse board member asked, "Who would go to the central pharmacy when patients needed medications in the middle of the night?" The answer: "The nurses." Her next question: "Who will do the nursing care while the nurse is transporting the medicines?" By the end of the conversation, the board realized that the proposed budget solution would actually increase costs.

Because of her intimate knowledge of bedside care delivery and her understanding of the relevant systems, this nurse board member prevented her hospital from making a costly mistake. Clearly, the nursing voice is critical at the board level to help hospitals make effective, financially viable and sustainable healthcare decisions.

What's stopping you?

So why don't nurses serve on hospital boards? Do policymakers not appreciate the value nurses can bring, or are nurses not stepping forward to join? If they're not stepping forward, is it because nursing culture is built on this history of nurses not stepping forward to join? If they're not stepping forward, is it because they were hard workers, stayed in the back of the room and had the skills needed for board service? In The Atlantic, authors Kay and Shipman state, "Evidence shows that women are less self-assured than men—and that to succeed, confidence matters as much as competence." Most nurses are women, so Kay and Shipman's conclusions could easily apply to nurses who don't seek board positions.

However, findings of a recent study of board effectiveness show that there is a greater number of women on a board results in better, more well-rounded decisions. One investment firm tracks the number of women on companies' boards and offers to invest funds in those that have more women and thus greater returns on investments. According to Joy and colleagues, "The correlation between gender diversity on boards and corporate performance can also be found across most industries—from consumer discretionary to information technology."

The nursing voice is critical at the board level to help hospitals make effective, financially viable and sustainable healthcare decisions.

Connie Mullinix is an associate professor in the department of nursing at the University of North Carolina—Pembroke. AnnMarie Lee Walton is a post-doctoral fellow at the University of North Carolina Chapel Hill, School of Nursing. Diana Ruiz is the director of population & community health in the Medical Center of the Americas in McAllen, Texas.

Selected references


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Etiquette

Pagana KD. The Nurses' Etiquette Advantage. 2nd ed. Indianapolis: Sigma Theta Tau International; 2015.

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