



This document has been produced to reflect conversations that took place during a community forum, held by the Nova Scotia Rainbow Action Project (NSRAP) on January 25, 2014. The forum was held to address the development and implementation of policies for the coverage of sexual reassignment surgeries (SRS) [also known as gender affirming surgeries (GAS) and/or gender reassignment surgeries (GRS)]. It was our intention to create a space for those who will be affected by these policies and their implementation to have conversations and make recommendations.

We would like to acknowledge and thank prideHealth, South House and Transform Health Care for supporting this event.

Framing Information

Speakers: Kate Shewan and Lisa Buchanan - NSRAP, Tracy Barbrick - Department of Health and Wellness, Jim Oulton and Francoise Susset - CPATH

Note: These notes were transcribed from notes taken by hand during the event. While we have made our best effort to reflect what was said, these notes are subject to recording and transcribing errors. As a result caution should be used in relying on this information and none of the comments attributed to speakers should be treated as direct quotes.

Tracey Barbrick, Dept. of Health and Wellness and Lisa Buchanan, Chair NSRAP, provided an update on the recent meeting with the Hon. Leo Glavine, Minister of Health and Wellness and the current status of the SRS implementation.

NSRAP recently met with the Minister of Health. Present at the meeting were Lisa Buchanan, (Chair NSRAP), Kate Shewan (Vice-chair, NSRAP) and Cybel Rieber (Coordinator, Pride Health).

What was your impressions of the meeting with the minister? (Lisa B.)

Got a good vibe, the Minister appeared to be willing to inform himself and was aware of the key issues. Work around planning for the implementation has been going on quietly in the background at the Department of Health and Wellness ("D.H.W.").

What work has been done? (Tracey B.)

There has been an assessment of existing billing codes, to review what codes already exist and can be used (for example billing codes already exist for hysterectomies). Need docs who are practicing who do procedures often enough to be qualified.

Jurisdictional scans of other provinces have been carried out to determine what is covered and what is not covered in various provinces. Partnerships have been formed with Mental Health N.S. Mental health and addictions identified the trans community as a priority population.

Who is at the table for SRS conversations?

Department of Health and Wellness has been working on this. The commitment in June from the NDP Government was after two years of behind the scenes research in the D.H.W. Patricia Murray, head of mental health and addictions MHNS is involved, particularly around the area of assessments.

What is the timeline?

There is likely to be a two phased approach. The first phase is to identify which procedures will be covered under the provincial medical insurance (MSI) and to put billing codes in place for these procedures. (Billing codes are the codes that allow a doctor to bill the province for services they perform.) D.H.W. needs input from the community regarding what is most important on a limited D.H.W. budget, need priorities when determining what is to be funded. D.H.W. has committed to having this first phase completed by April 1.

D.H.W. wants to work with CPATH and NSRAP to figure out priorities for billing codes, they need to “Manage expectations”. Need to make new billing codes. Start with a piece/ Can't say everything is insured on April 1, need to understand barriers to access (referrals, surgeries., etc.).

The second phase is around system supports in mental health, particularly around the area of assessments. This is a bigger piece which will be worked on over the next year.

How can communities input coverage discussions?

D.H.W. is looking for input on phase one now, input on phase 2 will come later.

Jim Oulton and Francoise Susset from CPATH provided some context around how they have seen Trans healthcare managed in other provinces and the CPATH perspective.

What is CPATH?

CPATH is the Canadian Professional Association for Transgender Health. It is a volunteer based Nonprofit organization, formed in 2007 when Canadian Clinicians come together at WPATH in 2007 and decided to form a Canadian organization. It is across many health disciplines.

Strategic plan 2013-2018. Vision: A Canada without barriers to the health, well-being and self-actualization of trans and gender diverse people. Strategic plan available on the CPATH Website.

CPATH in conjunction with Pride Health carried out 3-4 major trainings in NS, last year, with 6/8 health regions represented.

Priorities for NS?

Rural and urban confident surgeons. Ongoing education. NS decentralized access for assessments for hormone treatments and surgeries.

What do SRS policies look like across Canada?

It is very complex, with different concerns in different provinces. Political process is different in each province. For example in Quebec most things covered.

A summary of what procedures are covered by province (summarized from surveys posted on the CPATH website) appears in appendix 1. Some provinces provide mastectomy with chest contouring, some just cover mastectomy without chest masculinization, which is just silly, it is not the point of the procedure. Mastectomy is not the same as chest contouring surgeries.

Doctors use the World Professional Association for transgender health (“WPATH”) standards of care (“SOC”) when assessing patients for eligibility for hormone therapy and for surgeries. What are the Criteria for SOC 7?

The assessments are not psychotherapy. This is the major difference between SOC 6 and 7. The psychological assessment is a general assessment, maybe 2 to 5 sessions, not super long term. One of biggest barriers is lack of trained professionals. NS has maybe the highest number trained in Canada.

Health departments don't have to worry, the medical profession already have the standards in place for assessments. One of the challenges is that the Health Departments in the provinces are concerned about doctors practicing outside of their area of expertise, however this is not a concern as the doctors code of ethics ensures medical professionals are not allowed to work outside area of expertise.

Provincial Health Departments sometimes feel like there is something very different or special about trans patients, but in reality the processes are in place with the medical professionals for them to manage trans patients in a similar way to how they manage other health issues.

Some of the WPATH criteria for surgery are:

Chest surgery – WPATH wants one letter. Hormones not a requirement for chest surgery,
Bottom surgery – 2 mental health referrals (by someone with a masters in mental health fields ability to DSM diagnosis). No real life test. Live as felt gender for at least one year.
Hormone prescriptions can be done by GP.

Where are people going for surgeries?

There are three surgeons in Canada that do bottom surgeries. Two in Montreal and one in Vancouver. Having troubles getting professionals to do this work and keep doing it. Get trained, have one difficult case and get scared and drop out.

Lots of people from various provinces are sent to Montreal and Toronto. For example, in Manitoba assessments are done in province and patients are sent to Montreal for surgeries.

In some provinces patients can be funded for surgeries outside country. In some cases this can actually be cheaper for the provinces. There are also rapid developments in surgical techniques, often in overseas clinics. Bangkok conference in February should provide additional information.

Question and Answer session:

What are the practical impacts of new billing codes?

Billing codes are the codes that allow a doctor to bill the province for services they perform.

There will be wait times, sequence will be based on the assessment process. District health authorities (“DHA”) will manage the process once you have your letter. Surgeons can bill for procedures as of April 1.

Can someone go in April 2?

If you have your referral letter the DHA will refer you to a surgeon as usual, there will be wait times, and people will go into sequence.

Will there be reimbursements for surgeries carried out before the processes are in place?

Minister is asking for advice. Every recommendation has a price tag. There is a backlog of all kinds of surgeries in NS. Retroactive pay will be discussed – no definitive yes or no. The Province is working in debt. There is no specific money attached to this yet.

What is the timeline for referral for surgery? How will the Back log be dealt with?

The process for referrals is not expected to change on April 1st, (this will be phase 2). The billing codes will be implemented on April 1 but the clunky system will be the same until barriers fixed. There is a major backlog within mental health services of people trying to get referrals. MHAS is starting to figure this process out, there will be meetings on this starting January 30th. The trans population has been identified as a priority for MHAS mental health supports, and dollars have been allocated for this.

Will Nova Scotia connect internationally and take the lead nationally?

(Jim - CPATH)

Important to give as many options as possible if surgeons in NS aren't interested in being trained. Complex surgeries that may not have perfect outcomes, but are still life saving. Lots of surgeons around the world are working to perfect their procedures and doing complex innovative things. CPATH encourages looking abroad, post op complications common vs complex procedures.

(Tracey DHW)

N.S. hasn't examined international options for surgeons yet, there are concerns around quality assurance. There have been some aftercare incidents and adverse events that have had to be dealt with in NS as result of medical tourism.

Will NS seek connections with surgeons outside the province?

Yes, N.S. has already established networks and held discussions regarding linking with surgeons in Montreal, etc.

Will CAMH be used in assessment? Could the existing peer supervisory group be utilized to form a local clinic for assessments?

No decisions have been made on the ongoing process for managing assessments. The DHW is interested in a process that will allow assessments to be carried out here in N.S. (applause)

What about procedures not covered elsewhere in Canada?

NS will not likely be front runner in Canada.

Manitoba is working on getting electrolysis, laser, facial feminization procedures covered. This may be the model to follow. There are some feminizing procedures that aren't covered anywhere in Canada, is there any chance they will be covered here?

Unlikely we are going to be front runner.

What are the rules for qualifying for surgeries for people relocating to Nova Scotia from another province?

This will be based on existing rules already in place for any other medical coverage.

Will relocation require reassessment across provinces?

Consider doing the same they do with other surgeries, few surgeons will do procedures based on other people's assessments, unsure.

If you have an assessment from another province where nothing is covered, can this assessment be used if you move to NS? Don't know, DHW hasn't thought of this yet.

Is there a plan to bring surgeons to NS?

Can't accurately answer before April 1.

Education and training?

Last time – 45 prof, this time ? # days 2 day clinical, 1 day case study. Pride health not mandatory training. NS 2 rounds of clinical training. Francoise organizing more trainings here. Pride health doing trans health trainings in NS but they are in no way mandated for docs. Had 2 trainings, for clinicians here in past several years. Next one in May.

Community Discussions

The first discussion focused on access to resources and professionals. Members of this discussion identified barriers, real or perceived, to accessing a variety of services, amongst those, hormone assessment and prescription. There was particular concern raised around the initial phase of hormone prescription, and a perceived monopoly that one physician has on these assessments. Participants expressed that this creates a bottleneck in the process, often creating extremely long wait times. Throughout the discussion, one main want of most participants was for health care professionals to receive training, education and professional development around these issues, so they can both make educated decisions and know what they have the right to do. Once policies are written, participants believed it was important that there be a concerted effort to disseminate information about these policies to health care professionals, so they have adequate resources to address their patients concerns. Increasing the capacity for assessment throughout Nova Scotia, both in HRM and in rural Nova Scotia, was very important to members of this discussion, many of whom live rurally.

The second discussion focused on the specifics of what could be offered.

Covering chest/top surgery with contouring for men, including all options such as double incision with nipple grafts as well as the periareolar/keyhole technique done with liposuction. As well, covering breast augmentation for women, along with facial feminization surgery, laryngoplasty/chondrolaryngoplasty, and permanent hair removal via electrolysis and laser hair removal. These are all costly procedures, and while not deemed as high a medical priority by

government officials, these procedures can be considered by the patient as more necessary than genital reassignment in allowing them to live a safe and comfortable life without the threat of violence and harassment from appearing transgender instead of cisgender.

Due to the complexities of some of the specific surgeries and the hours involved, it would be of great benefit for surgical teams to be trained as a unit, and not just individual surgeons. This would mean not just having a plastic surgeon perform a complex genital reconstruction surgery, but a team including a urologist and microsurgeon etc. Attendees requested specialists versus a "Jack of all trades" type of surgeon. A suggestion was made to offer incentives for surgical teams and doctors trained in trans health to come to Nova Scotia/to remain in Nova Scotia.

It was noted by one attendee that chest surgery for men is available at The Landing, and at the Bridgewater hospital but it is private only. Further inquires required. May it also be noted that Nova Scotian surgeon Dr. Morris practices within CDHA as well as in private practice and has a history of performing trans related surgeries, however there have been several concerning undocumented reports of transphobia towards some of his trans patients and is therefore not recommended as one of the surgeons to be covered by MSI for such services without first receiving strict trans health and cultural competency training first.

MSI should be flexible as to patients choices in surgeons and techniques. Some surgeons require different tissue donor sites for different surgical techniques and not all techniques are offered by all surgeons. These different donor sites as well as techniques should be personal choices of the patient only as they all have their pros and cons and there is no one technique that is good for everyone. The province should not cover just one certain surgeon or one certain technique as this forces patients to lose the ability to choose the scars on their bodies and the degree of satisfaction with their bodies to allow them to fully overcome their dysphoria. Along with this, the request was made for a holistic approach to trans health care around recovery, travel, and follow up support. This would be best achieved through gender identity clinics where trained surgeons and mental health professionals were employed.

Not all vaginoplasties are the same just like not all metoidioplasties and phalloplasties are not all the same. Some are done in single stages or multiple stages depending on how many surgeries are required to safely achieve the final result whatever that may be as needed by the patient. This includes options of clitoroplasty and labiaplasty for vaginoplasties, and metoidioplasty with or without hysterectomy, vaginectomy, urethral lengthening, scrotoplasty, or testicular implants, or phalloplasty with all of the above for metoidioplasty as well as glansplasty and erectile implants. Each of these are considered separate surgical options to be done in combination as chosen and needed by the patient to achieve a satisfactory quality of life. And even still, hysterectomies alone can be broken down into different types whether it be the removal of all internal reproductive organs, or a the removal or specific organs and/or combination of the removal of the uterus and or cervix and/or ovaries as an example of the overall complexity of decision-making around the trans patients body and needs.

Logistical requests made by attendees were the de-gendering of billing codes - charging people's body parts and not genders, as well as to eliminate the requirements for SRS in order to change the legal gender marker on government identification. As well there was the request to include surgeon's consult fees under MSI if not already covered.

The third discussion focused specifically on the issues that transgender youth face. There was much concern expressed about what services are provided for youth, versus what services youth understand are available. This issue of perception versus reality creates issues such as services not being utilized, and known services being over-capacity. There was a desire for more education for health care providers, service providers and those who work in a support capacity outside of the health care system to address the issue of under staffing and wait times. Additionally, empowering and supporting health care providers who want to become more educated about these issues, and who want to provide these services. Lastly, making a concerted effort to make resources and information available to youth, so the services that already exist can be utilized by those who need them.

The fourth discussion was an imagining of what participants ideal 'trans healthcare system' looks like. Firstly, this system would be set up with the understanding that all trans people are different, and that we can't make assumptions about what people 'need'. Having flexible policies that acknowledge that transition looks different for all people, and not providing a singular transition model, that individuals can design their transitions path, and moving away from the model of two assumed sexes. It is a system that has moved away from pathologizing trans people, and acknowledging that being transgender is not a mental illness, but it is the societal pressures that create issues for the individual. Additionally, having mental health services that do not jump to the conclusion that any issues an individual faces are caused by one's gender identity. Participants identified that coverage for all 'transition' related services (surgeries, hormones, voice therapy, etc.), and also assistance with peripheral costs such as travel, after care, etc. Gendering medical procedures can create a barrier to those who are trying to access these procedures. Another important aspect of this system would be that trans patients are treated with respect, and are not discriminated against. Discrimination can be a huge barrier to accessing even the most basic health care. It was agreed that a health care system that was in constant consultation with the community would be the only way to provide the services that trans Nova Scotians need.

The fifth discussion focused on strategies to ensure optimal communication between community representatives and the Department of Health and Wellness. The members of this discussion identified priorities for those acting as spokespeople. They would ideally be people who have dealt with government previously and have some familiarity with the system and with useful within-government contacts. They need not necessarily be trans-identified but must be well-educated on issues related to trans health care, able to deliver a consistent and clear message informed by community input, and be dedicated to achieving results that do not leave any community members behind. Some key points identified for discussion included communicating the financial savings to the government and social benefits of providing SRS services (in comparison to the financial and social costs of leaving people underserved or unserved), identifying cost-effective models from other provinces (e.g. Quebec) and allowing for the option to access services outside of Nova Scotia to avoid an in-province backlog. Three main sources of information and knowledge to bring to government contacts are community members, CPATH, and physicians and surgeons working in the area of trans health care.

The sixth discussion was focused on health care settings and asked the question "what are the most important things that health care professionals can do to make health care better for trans communities"? Community members talked about experiencing significant anxiety when accessing health care, and identified that it was crucial for health care professionals to engage in self- and peer education (avoiding the all-too-common scenario in which the patient must educate the

professional on how to provide competent care). Specific mistakes that healthcare professionals must avoid include misgendering people (e.g. referring to someone by the wrong pronoun or by their birth name if they have changed it) and asking inappropriate or invasive questions that are irrelevant to the issue at hand. The discussion also identified that competency has to start from the very beginning of medical or care training and curricula in medical and nursing schools (for example) need serious changes to integrate up-to-date knowledge about gender, the Standards of Care, and appropriate practices for providing care to trans communities. Attitudes held by medical professionals are often overly focused on categorizing people by gender and using outdated language to refer to people's bodies and identities, and must be revisited.

Medical professionals play an important role by acting as mediators between patients and governments/regulating bodies. It is particularly important for them to act as advocates for their trans patients within a system that makes it difficult to access information about what services are available and heavily polices trans people's access to the services they need (e.g. requiring multiple eligibility assessments for those who move between provinces, offering no assistance for travel costs within province to access care). When working with patients facing social oppression, doctors and care professionals must be willing to go the extra mile to ensure that all opportunities are available and that they are educated and able to provide non-discriminatory, competent care. Specific concerns that came up in the course of the discussion included a strong aversion to working with CAMH for any aspect of care.

The seventh discussion overlapped significantly with the sixth, again raising concerns about transphobia in health care and identifying recurring problems such as lack of sufficient medical education and trans patients assuming the responsibility to educate their health care providers. The discussion also focused on specific issues facing rural trans communities and how access to competent health care can be especially difficult in rural areas. Participants identified experiencing or knowing about experiences of discrimination in areas such as Kingston/Greenwood, Pictou County, Glace Bay, Fall River, and Upper Musquodoboit and from practitioners in a wide variety of care fields (e.g. dentists, family physicians, ER staff, specialists, and walk-in clinics). The small number of health care professionals available in many rural areas limits people's options and may result in them being forced to access emergency rooms or walk-in clinics for routine care if they cannot find a regular family doctor. Some participants reported having to refuse to work with GPs who were not adequately informed, though one person described having a positive experience due to their doctor and mental health care professionals working together as a team. Participants identified peer mediation and peer support and education between health care professionals as key to increasing capacity for working with trans patients. Recommendations include: increasing incentives to doctors for being well-informed; making education mandatory (beyond a voluntary one-day workshop); increasing education around HIV/AIDS-related care; equal education across the province and for doctors from different cultural backgrounds; equalizing the level of knowledge about trans issues between older, established GPs and younger interns; and ensuring convenient, easy access to resources for health care professionals.

The eight discussion reflected the frustration participants were feeling with the lack of clear progress on these issues up until now, and discussing ways in which to make sure these policies are in place and effective.

Appendix 1

Current SRS coverage, by province. 2012.

Publicly funded procedures							
Summarized from surveys on CPATH website, Provincial updates: 2012, may be out of date)							
Original data can be found at:	http://www.cpath.ca/resources/provincial-resources/						
	Provinces with coverage ⁴						
	BC	AB	SK	MN	ON	PQ	NF
Mastectomy with chest contouring	Yes	Yes	No	No	Yes	Yes	No
Mastectomy without chest contouring	Yes	Yes	Yes ¹	Yes	Yes	Yes	Yes
Hysterectomy	Yes	Yes	Yes	Yes	Yes	Yes	
Oophorectomy (Ovary removal)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Metaoidioplasty	Yes ¹	Yes	Yes	No	Yes	Yes	No
Phalloplasty	Yes ¹	Yes	Yes	No	Yes	Yes	No
Breast augmentation	No	No	No	No	No	No	No
Tracheal shaving	No	No	No	No	No	No	No
Facial feminization	No	No	No	No	No	No	No
Penectomy	Yes			Yes		Yes	Yes
Orchiectomy (Testicle removal)	Yes	Yes	No	Yes	Yes	Yes	Yes
Vaginoplasty	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Electrolysis	No	No	No	No	No	No	No
Hormone readiness assessments in province	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hormone readiness assessment protocol	SOC7	SOC7	SOC7	SOC7	SOC7	Mix/SOC7	SOC7
Surgery assessments in province	Yes	Yes	No	Yes	Yes	Yes	No
Surgery assessment protocols	SOC 6 + ²	SOC7	CAMH	SOC7	CAMH	SOC7 + ³	CAMH?
Notes:							
1. CPATH 2012 response updated from other more recent information							
2. 1 year RLE required for top surgery (which is additional to SOC requirements)							
3. 2nd letter from psychiatrist required for top surgery (which is additional to SOC requirements)							