DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

Criteria A: A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 month in duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

AND

Criteria B: The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers:

- The condition exists with a disorder of sex development.
- The condition is post-transitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

2017 Endocrine Society Guidelines

- **Trained Mental Health Professionals meeting specific criteria should diagnose GD in adults**
  - Competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes,
  - Ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder),
  - Training in diagnosing psychiatric conditions,
  - Ability to undertake or refer for appropriate treatment,
  - Ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and
  - Practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)
- **Criteria for Gender-Affirming Hormone Therapy for Adults**
  - Persistent, well-documented gender dysphoria/gender incongruence
  - The capacity to make a fully informed decision and to consent for treatment
  - The age of majority in a given country (if younger, follow the criteria for adolescents)
  - Other mental health concerns, if present, must be reasonably well controlled

Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: 2017 Endocrine Society Guidelines

	Transgender Male (F to M)	Initial	Follow up	Transgender Female (M to F)	Initial	Follow up
Bloodwork	Testosterone	Every 3 months until reaches normal physiologic male range	1 – 2 times per year	Testosterone	Every 3 months	1 – 2 times per year
	Hematocrit & Hemoglobin	Every 3 months for first year	1 - 2 time per year	Estrogen	Every 3 months	1 – 2 times per year
	Lipids	Regular intervals		Electrolytes (K)	Every 3 months for first year	Yearly
				Prolactin	Annually during transition	Every 2 years when stable
Physical Exam		Every 3 months for first year	1 - 2 times per year		Every 3 months for first year	1 - 2 times per year
Other	Screening for osteoporosis		Yearly	Routine Cancer screening		Yearly
	Female cancer screening as appropriate		Yearly	Osteoporosis		Begin at age 60
	Cardiovascular Risks		Yearly	Cardiovascular Risks		Yearly

UNCLASSIFIED//FOUO – Not for Distribution Draft Deliberative Document As of 1500 7 November 2017

Medical Utilization for Study Cohort (n=994) (Oct 1, 2015 through Oct 3, 2017)

Includes Direct Care and Purchased Care

		Any Mental Health		Psychotherapy		Hormone Therapy		Surgery		Total FY2016 to Present
		Individuals	Encounters	Individuals	Encounters	Individuals	Scripts	Individuals	Encounters	
Air Force	Active	240	7,367	240	5,155	99	906	2	3	240
	Reserve	5	35	5	44	1	2	0	0	5
	Total	245	7,402	245	5,199	100	908	2	3	245
Army	Active	328	11,163	326	7,543	169	1,899	11	13	331
	Reserve	31	730	32	558	20	433	1	1	33
	Total	359	11,893	358	8,101	189	2,332	12	14	364
Coast Guard	Active	20	461	20	205	14	127	0	0	20
Marine Corps	Active	61	1,485	61	1,188	20	110	6	7	61
	Reserve	2	55	2	35	1	2	0	0	2
	Total	63	1,540	63	1,223	21	112	0	0	63
Navy	Active	292	8,269	283	4,773	138	1,160	9	9	294
	Reserve	4	205	3	128	4	51	1	1	4
	Total	296	8,474	286	4,901	142	1,211	10	10	298
Other	Total	4	239	4	126	3	64	0	0	4
Total	Active	945	28,984	934	18,990	443	4,266	28	32	950
	Reserve	42	1,025	42	765	26	488	2	2	44
	Total	987	30,009	976	19,755	469	4,754	30	34	994

Mental Health visits average about 15 per year

*Data Extracted October 3, 2017 from MHS Data Repository (MDR); Cohort from **July 27, 2017 extract**

2015 U.S. Transgender Survey

Table 7.4: Procedures among respondents with female on their original birth certificate

Type of procedure	Have had it	Want it some day	Not sure if they want this	Do not want this
Chest surgery reduction or reconstruction	21%	52%	17%	10%
Hysterectomy	8%	44%	28%	19%
Metoidioplasty	1%	15%	37%	47%
Phalloplasty	1%	11%	31%	56%
Other procedure not listed	3%	7%	13%	77%

2015 U.S. Transgender Survey

Table 7.5: Procedures among respondents with male on their original birth certificate

Type of procedure	Have had it	Want it some day	Not sure if they want this	Do not want this
Hair removal or electrolysis	41%	49%	5%	5%
Voice therapy (non-surgical)	11%	46%	19%	24%
Vaginoplasty or labiaplasty	10%	45%	23%	22%
Augmentation mammoplasty	8%	36%	31%	24%
Orchiectomy	9%	40%	24%	27%
Facial feminization surgery	6%	39%	30%	25%
Tracheal shave	4%	29%	29%	38%
Silicone injections[28]	2%	9%	27%	61%
Voice surgery	1%	16%	32%	51%
Other procedure not listed	5%	13%	15%	67%

MHS Proposed Medically Necessary Sex Reassignment Surgery (SRS*)

May be considered when all of the following criteria** are met:

- Cross-sex hormones used continuously and responsibly for required/recommended time according to type of surgery = 12 months
- Regular participation in psychotherapy throughout transition period at frequency determined jointly by patient and mental health provider has been completed, if required
- Knowledge of all practical aspects of surgery (e.g., cost, required length of hospitalization, likely complications, post-surgical rehabilitation, SHCP policy including limitations, etc.) has been demonstrated
- Progress in consolidating one's gender identity has been demonstrated
- Progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health has been demonstrated
- Endocrinologist or physician responsible for endocrine treatment and mental health provider must certify that the individual satisfies the eligibility and readiness criteria for SRS.

*The 2017 Endocrine Society guideline use the terms "gender-reassignment surgery," "gender-confirming surgery" and "gender-affirming surgery." For DoD purposes, the term "sex reassignment surgery" is interchangeable with the 2017 Endocrine Society guideline terms.
**Criteria are based on 2017 Endocrine Society Guidelines for treatment of Gender Dysphoria

Gender Dysphoria Care Direct Care vs. Purchased Care and VA

	AVAILABLE TREATMENTS			
	DIRECT CARE	PURCHASED CARE		VA
Behavioral Health Counseling	YES	YES		YES
Hormonal Therapy	YES	YES		YES
Sex Reassignment Surgeries	Allowed*	AD	Non-AD	NO
		YES**	NO	
Genital Reassignment Surgeries	Currently no demonstrated capability in MTFs	YES**	NO	

COMPARISON OF CIVILIAN INSURERS and MHS

SEE ATTACHED HANDOUT

*MTF Capability includes mastectomy, hysterectomy, gonadectomy, breast augmentation and other select non-genital reassignment surgical procedures

** Under SHCP

MHS MEDICALLY NECESSARY SURGICAL CARE*

Proposed MHS criteria for surgical procedures are based on the 2017 Endocrine Society Guidelines for treatment of gender dysphoria

Female-to-Male

PROCEDURE	CRITERIA
Hysterectomy and salpingo-oophorectomy (removal of uterus and ovaries)	1. Meet SRS Guidelines noted on previous slide, required 2. 12 months of hormonal therapy required (unless medically contraindicated) 3. 12 months of full time continuous RLE required
Chest masculinization aka Mastectomy (removal of breast)	
Metoidioplasty (enlargement/ lengthening of clitoris)	
Phalloplasty (construction of "new" phallus from skin or muscle grafts)	
Placement of testicular prostheses	
Scrotoplasty (re-arrangement of labia to create scrotum)	
Urethroplasty (creation of longer urethra from skin to enable standing voiding)	
Vaginectomy (removal of vagina)	

Male-to-Female

PROCEDURE	CRITERIA
Orchiectomy (removal of testicles)	1. Meet SRS Guidelines noted on previous slide, required 2. 12 months of hormonal therapy required (unless medically contraindicated) 3. 12 months of full time continuous RLE required
Penectomy (removal of penis)	
Vaginoplasty (construction of "new" vagina from skin or intestinal tube)	
Clitoroplasty (rearrangement of penile tissues to create "new" clitoris)	
Labiaplasty (rearrangement of scrotum to create "new" labia)	

*This list is based on existing civilian insurance industry standards and will be reviewed periodically to remain current.

Surgery Waivers
Supplemental Health Care Program

- Most non-genital sex reassignment surgeries can be performed in military treatment facilities (MTFs)
- MTFs currently do not have demonstrated capability to perform genital reassignment surgeries
- Payment for surgery for gender transition indications is not allowed through TRICARE by statute. Transition surgeries that cannot be performed at MTFs are only available for active duty Service members through a waiver process under the supplemental health care program.
- Since policy change in July 2016, there have been 18 applications for waivers for surgical consultation
  - 2 SMs who have completed consults have applications for waivers for surgery pending
- To date, no one has had surgery through the SHCP

Recovery Times After Surgery

- Time to return to full duty following gender transition surgeries depends on type of surgery and type of activity required of the SM.
  - With no complications, recovery time for mastectomy, hysterectomy, oophorectomy and orchiectomy would be expected to range from four to eight weeks.
  - SM would be expected to return to their work environment at some point during that time period and may need a gradual return to full activity over several more weeks.
- No genital reassignment surgeries have been performed by MHS so no experience with recovery times and return to full duty.
  - A review of web sites on recovery time for genital reassignment surgery in civilian sector shows recovery times vary from 6 weeks to 3 months.
  - How to extrapolate to return to full duty for a Service member is unknown.

Estimated Recovery Times, by Surgery*

Selected Surgical Procedure	Average Recovery Time (assumes no complications)	Notes
Hysterectomy*/** (laparoscopic approach, recommended)	4 weeks desk job 6-8 weeks unrestricted activity	(data for all indications) Major complication = 9.5% Minor complication = 28%
Hysterectomy* (abdominal approach) with or w/o Oophorectomy	6-8 weeks	(data for all indications) Major complication = 6% Minor complication = 27%
Chest masculinization* (Mastectomy)	2-4 weeks (desk job) 4-6 weeks (physically demanding job)	Low complications
Orchiectomy*	3-4 weeks desk job 6 weeks unrestricted activity	Very low complications
Vaginoplasty**	6 weeks desk jobs (some restrictions) 6-8 weeks resume physical activity 3 months for unrestricted activity	• Recommend stay in area of hospital where procedure performed for up to 2 weeks • Major complications 1.5%-10% • Minor complications ~25%,self limiting
Phalloplasty** (2 stages, 2nd surg 9-12 mos later)	6 weeks desk job 8-12 weeks return to activity 3 months unrestricted	• Recommends stay in area of hospital where procedure performed for up to 3 weeks/complications 10-80%
Metoidioplasty** (2 stages, 2nd stage performed >/=3 mos later)	3 weeks desk job 6 weeks return to activity 8 weeks unrestricted	• Recommends stay in area of hospital where procedure performed for up to 3 weeks • <5% complication rate

*From Mayo Clinic, UCSF Center of Excellence for Transgender Health websites and **Dr. Loren Schechter

Estimated Recovery Time for Vaginoplasty from Two SHCP Waiver Requests

PROCEDURE	CENTER	RECOVERY TIMES				
		Inpatient	Post-op Bedrest	Con leave	Light duty	Non-deployable
Vaginoplasty	Papillon Center New Hope, PA	6 days	3 days	6 weeks	2-3 months	6 months
Vaginoplasty	Johns Hopkins	Not Provided	Not Provided	Not Provided	Not Provided	Not Provided

Estimated Recovery Times Obtained from TG Surgical Centers by Managed Care Support Contractors

PROCEDURE	RECOVERY TIMES		
Vaginoplasty	Return to Work	Light Duties or Reduced Hours	Avoid Strenuous Activities
	4-6 Weeks	Up to 2 months	3 months
Male reassignment Phalloplasty or metoidioplasty	Return to Work	No strenuous Activity (including significant walking)	
	8 weeks	3 Weeks	

Sample Scenarios

1. Most common treatment plan: New Diagnosis, Hormones Only (both MtF and FtM)
   - +/-mental health therapy
   - Initiation of hormone therapy – Every 3 months blood work and physician visits though titration of dose can be paused for deployment
   - No surgery
   - **Up to one year potentially not deployable**
2. FtM Treatment Plan: New Diagnosis, Hormones and Some Surgery
   - +/- mental health therapy
   - Initiation of hormones – Every 3 months blood work and physician visits though titration of dose can be paused for deployment
   - Chest masculinization w or w/o hysterectomy – 4-8 weeks recovery
   - **As much as one year plus 4-8 weeks (13-14 months) potentially not deployable, but treatments may not be over a continuous time period**

Sample Scenarios

3. Scenario #2 FtM Plus Additional Surgery
   - MH therapy, hormones with 12 months of monitoring though titration of dosing can be paused for deployment
   - Chest masculinization/+/- hysterectomy -4-8 weeks recovery
   - +Metoidioplasty– 8 weeks full activity
   - **As much as one year plus 16 weeks (16 months) potentially not deployable, but may not be over a continuous time period**
4. MtF Treatment Plan: New Diagnosis, Hormones, Surgery
   - MH therapy
   - Initiation of hormone therapy – Every 3 months blood work and visits though titration of dose can be paused for deployment
   - Vaginoplasty – 3 months
   - **As much as one year plus 3 months (15 months) potentially non-deployable, but may not be over a continuous time period**

2015 U.S. Transgender Survey

Released December 2016

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

2015 U.S. Transgender Survey

- Survey accessible through a website during summer 2015
- 27,215 respondents*
  - 18% have served (or currently serving) in military
  - 0.5% are current SMs
  - 2% on active duty at time of survey in Reserves or National Guard
  - 15% are Veterans (vs 8% in US population)

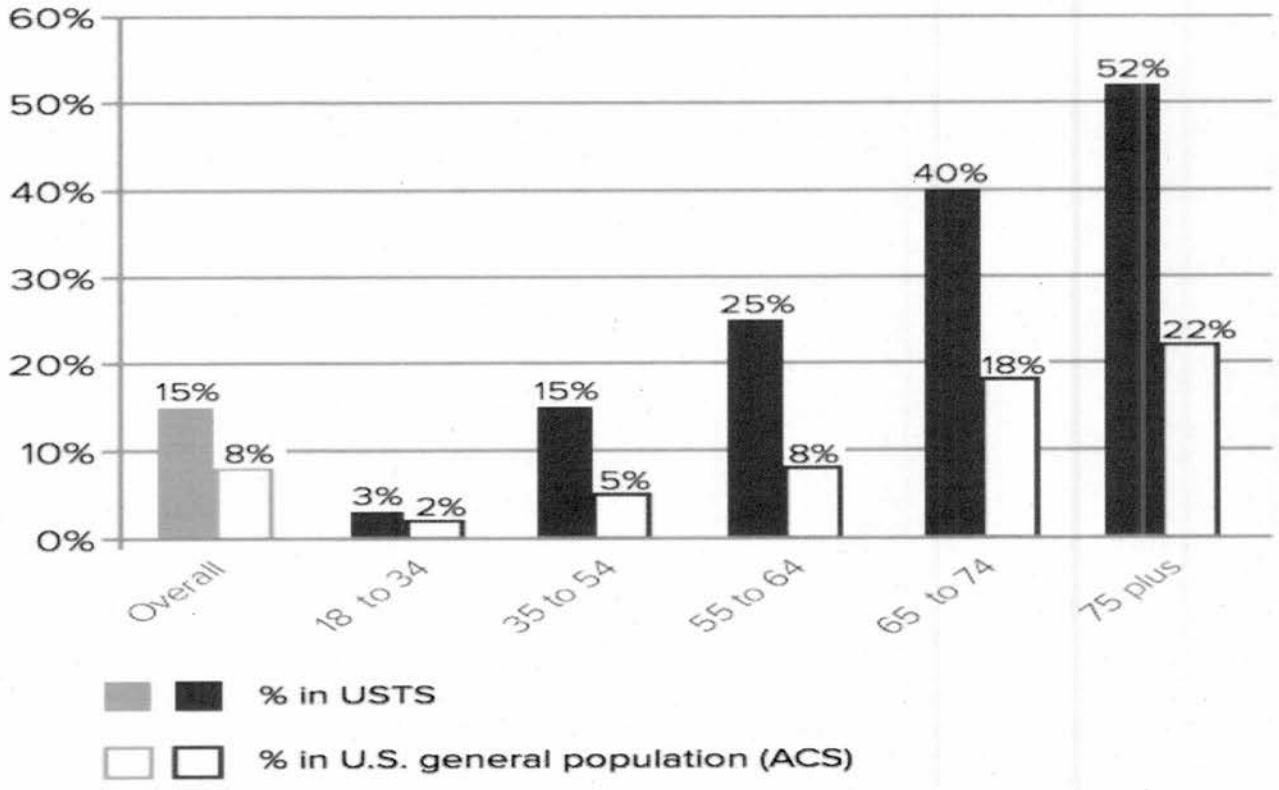
**Estimate of total TG population in US by Williams Institute: (June 2016) 1.4 M adults identify as TG in US; based on CDC's Behavioral Risk Factor Surveillance System (BRFSS) data*

2015 U.S. Transgender Survey

Percent former military within the age group of respondents compared to general population who are former military.

Figure 12.1: Veteran status *

AGE (%)



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2015 U.S. Transgender Survey

Figure 4.4: Age they started to think they were transgender

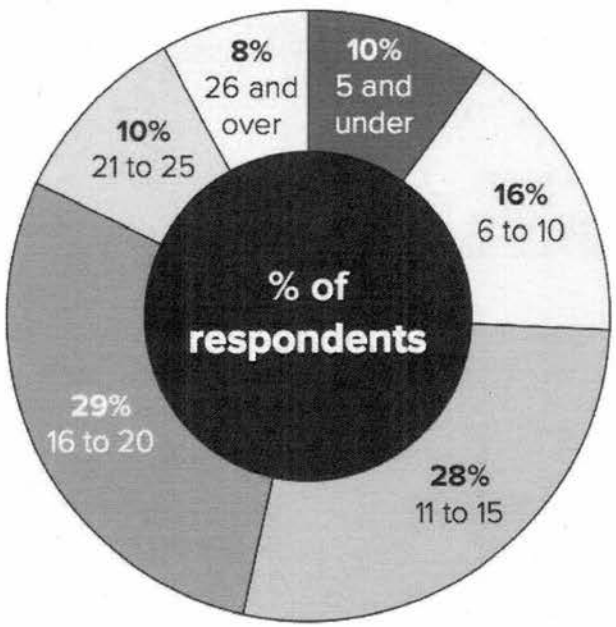
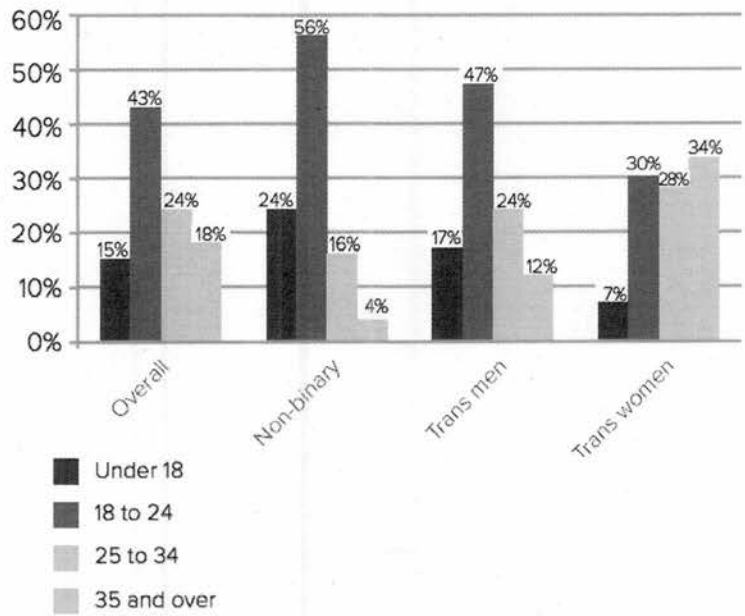


Figure 4.9: Age began transitioning

GENDER IDENTITY (%)



2015 U.S. Transgender Survey

Table 12.3: Type of discharge

Discharge	% of veterans who separated more than 10 years ago
Honorable	79%
General	7%
Medical	6%
Other-than-honorable	3%
Entry level separation	2%
Bad conduct	1%
Retired	1%
Dishonorable	<1%
Not listed above	2%

2015 U.S. Transgender Survey

Table 12.4: Source of hormones

Source of hormones	% of current service members who take hormones
Off-post medical doctor	74%
Off-post pharmacy	57%
On-post pharmacy	15%
Friends, online, or other non-licensed sources	15%
On-post medical doctor	13%

2015 U.S. Transgender Survey

Other Key Findings

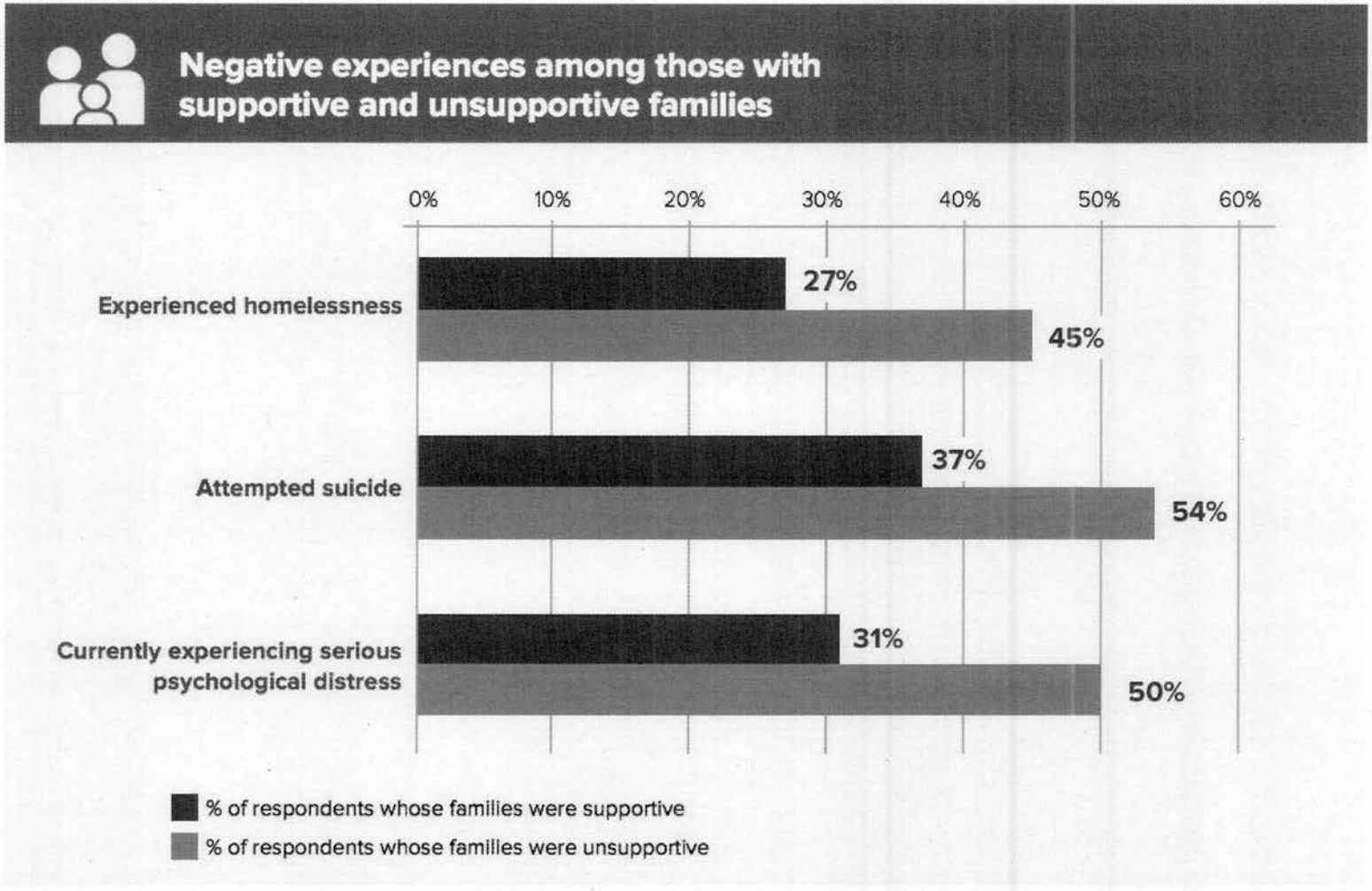
- Of current TG SMs whose leadership or commanding officers knew or thought they were TG, 23% said actions were taken to discharge them.
- 60% of TG SMs who separated from the military within the past 10 years said they might or would return to the military if the ban on TG SMs was lifted.
- 19% of respondents who separated from the Military >10 years ago said they were discharged partly or completely because of their TG status
  - 19% left the military to avoid being mistreated or harassed as a TG person

Back up slides

Hormones for Transition
2017 Endocrine Society Guidelines

	Transgender Female (M to F)	Transgender Male (F to M)
Medications	Anti-androgens (block testosterone) Estrogen Oral Transdermal patch Parental (IM injections)	Testosterone Parenteral (IM or SQ injections) Transdermal patch
Routes	Oral, parenteral or transdermal preparations	Parenteral or transdermal preparations
Comments	More complex than the transgender male regimen (F to M)	Follows the general principle of hormone replacement treatment for male hypogonadism
Selected Results	Breast development is generally maximal at 2 years after initiating hormones. Over a long period of time, the prostate gland and testicles will undergo atrophy.	Results in cessation of menses, increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire

2015 U.S. Transgender Survey



Comparison of Civilian Insurers and MHS

(From slide 11)

	MHS		Aetna		United		Cigna		Health Net		Anthem BC		Conn Medicaid (Aetna)	
	Cover	Not Cov	Cover	Not Cover	Cover	Not Cover	Cover	Not Cover	Cover	Not Cover	Cover	Not Cover	Cover	Not Cover
Hysterectomy and BSO	X		X		X		X		X		X		X	
Mastectomy	X		X		X		X		X		X		X	
Metoidioplasty	X		X		X		X		X		X		X	
Phalloplasty	X		X		X		X		X		X		X	
testicular prostheses	X		X		X			X	X		X		X	
Scrotoplasty	X		X		X			X	X		X		X	
Urethroplasty	X		X		X		X		X		X		X	
Vaginectomy	X		X		X		X		X		X		X	
Vaginoplasty	X		X		X		X		X		X		X	
Clitoroplasty	X		X		X		X		X		X		X	
Labiaplasty	X		X		X		X		X		X		X	
Orchiectomy	X		X		X		X		X		X		X	
Penectomy	X		X		X		X		X		X		X	
Abdominoplasty		X		X		X		X		X		X		X
Breast Augment		X		X	X			X	X*	X*		X		X
Blepharoplasty		X		X		X		X		X		X		X
Electrolysis		X						X		X		X		
Face-lift		X		X		X		X		X		X		X
Facial bone reduction		X		X		X		X		X		X		X
Hair transplant		X		X				X		X				X
Hair removal		X		X		X		X		X		X		X
Liposuction		X		X		X		X		X		X		X
Reduction thyroid chondroplasty		X		X	X			X		X		X		X
Rhinoplasty		X		X		X		X		X		X		X
Voice modificat		X		X		X		X		X		X		X
Lip enhancement				X				X				X		X
Skin resurfacing				X				X						X
Brow lift				X				X				X		X
Chin implants				X				X				X		X
Nose implants				X				X				X		X
Lip reduction				X				X				X		X
Calf implants				X				X				X		X
Collagen injections				X				X				X		X
Others				X										X
Breast reduct						X	X							

***MTF Capability includes mastectomy, hysterectomy, gonadectomy, breast augmentation and other select non-genital reassignment surgical procedures.**

**** Under SHCP**

PANEL OF EXPERTS MEETING AGENDA

Date: November 21, 2017
Time: 1500-1700
Room: 3D1063

Overview:
The Panel of Experts will receive supplemental transgender data from [redacted] and discuss any issues with the proposed transgender policy questionnaire.

Subject	Speaker	Duration
Overview	Mr. Tony Kurta	1500-1505
Presentation of Meeting Minutes	Mr. Tony Kurta	1505-1530
Supplemental Transgender Data	[redacted]	1530-1630
Discussion of Policy Questions	[redacted]	1630-1700

Meeting Homework/Deliverables:
Approve meeting 5 and 6 minutes

Save the following dates for upcoming meetings: Thursday, 30 November, 7 December, and Wednesday, 13 December. All meetings currently scheduled from 1500 – 1700.

Administrative:
Questions or issues please contact, [redacted].

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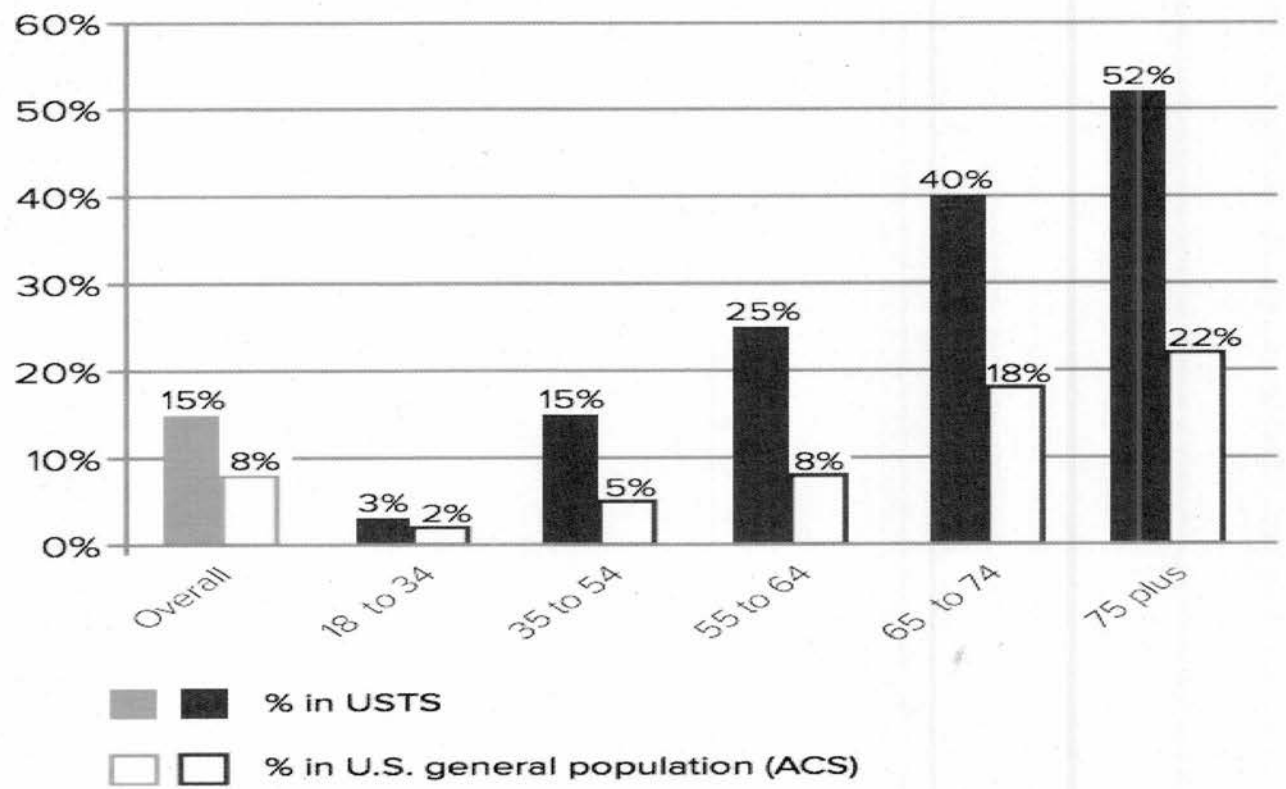

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2015 U.S. Transgender Survey

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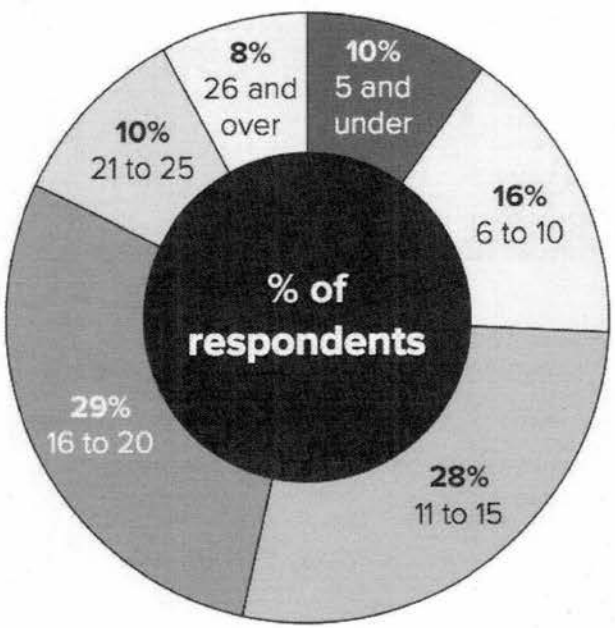

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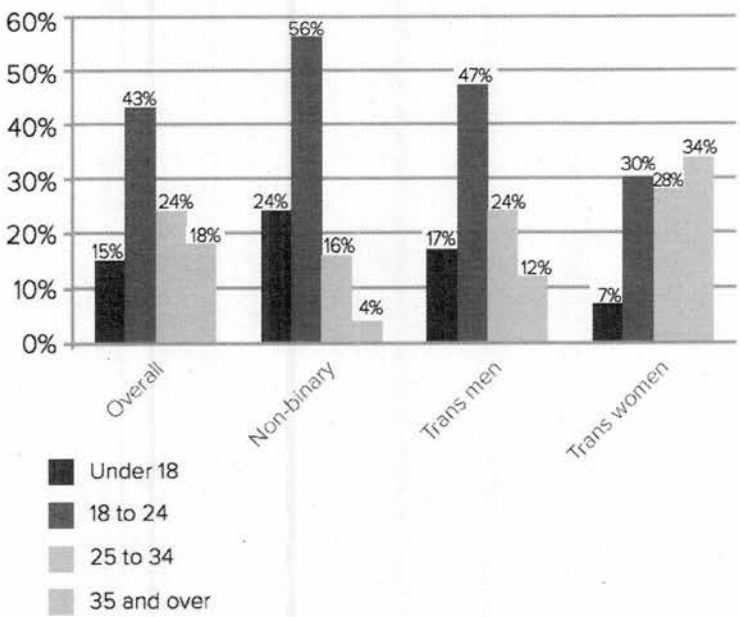

2015 U.S. Transgender Survey

Table 12.3: Type of discharge

Discharge	% of veterans who separated more than 10 years ago
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2015 U.S. Transgender Survey

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2015 U.S. Transgender Survey

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- 19% of respondents who separated from the Military >10 years ago said they were discharged partly or completely because of their TG status
  - 19% left the military to avoid being mistreated or harassed as a TG person

Additional Administrative Data

Medical Utilization Comparisons Methodology

- Determined selected medical utilization for the Study Cohort of 994 TG service members with gender dysphoria for comparison with matched AD SM with and without selected MH diagnoses
  - Limited the group studied to those in an Active Duty or Activated Guard status for the entire period of time from FY16 to July 2017
  - Study Cohort = 691
- Matched 5:1 with all non-TG service members (age and gender match; N = 3455)
- Matched 5:1 with non-TG service members with a mental health diagnosis
  - Major Depressive Disorder
  - Anxiety
  - Adjustment Disorder
  - Matching included sex, age, rank, Service
  - Control Cohort = 3455
- Raw data presented; insufficient time to do statistical analysis

Demographic Distribution of Cohort (N=691) and Control Groups (N=3455)

Characteristics		Cohort		5-1 Control	
		Count	%	Count	%
Sex	Female	349	50.51	1,745	50.51
	Male	342	49.49	1,710	49.49
Age	<25	281	40.67	1,405	40.67
	25-40	388	56.15	1,940	56.15
	40+	22	3.18	110	3.18
Rank	E1-E4	354	51.23	1,770	51.23
	E5+	293	42.4	1,465	42.4
	Officer	44	6.37	220	6.37
Major Depressive Disorder	No MDD	525	75.98	2,625	75.98
	Has MDD	166	24.02	830	24.02
Anxiety	No Anxiety	533	77.13	2,665	77.13
	Has Anxiety	158	22.87	790	22.87
Adjustment Disorder	No Adj Dis	472	68.31	2,360	68.31
	Has Adj Dis	32	31.69	1,095	31.69

UNCLASSIFIED//FOUO – Not for Distribution Draft Deliberative Document

As of 0900 21 November 2017

Demographic Distribution of Cohort and Control Groups

SERVICE		Cohort		5-1 Controls	
		Count	%	Count	%
	Army	226	32.71	1,130	32.71
	Air Force	188	27.21	940	27.21
	Marines	38	5.5	190	5.5
	Navy	216	31.26	1,080	31.26
	Other	23	3.33	115	3.33

Other includes Coast Guard, PHS and NOAA

Results – Study Cohort vs. Age-Gender Matched AD SMs

Average Encounters per Service Member

	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Any Mental Health	28.1	1.5	10.4	0.1	TG > C	TG > C
Psychotherapy	20.7	NA	9.2	NA	TG > C	NA

Total Number of Individuals for SI, Hormones and Procedures

	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Suicidal Ideation	74 (10.7%)	41 (5.9%)	47 (1.4%)	19 (0.5%)	TG > C %	TG > C %
Cross-sex Hormone Therapy	352	NA	4	NA	TG > C	NA
Breast Augmentation	0	0	2	0	C > TG	No diff
Breast Reduction	7	3	1	5	TG > C	C > TG
Facial Feminization/ Masculinization	3	0	8	0	C > TG	No diff
Genital Surgery	3	0	3	1	No diff	No diff
Hysterectomy	NA	16	NA	9	NA	TG > C
Voice Therapy	25	NA	18	NA	TG > C	NA

Results – Study Cohort vs. AD with MH Diagnosis

Average Encounters per Service Member

	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Any Mental Health	28.1	1.5	19.7	1.4	TG > C	No diff
Psychotherapy	20.7	NA	15.4	NA	TG > C	NA

Total Number of Individuals for SI, Hormones and Procedures

	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Suicidal Ideation	74 (10.7%)	41 (5.9%)	215 (6.2%)	108 (3.1%)	TG > C %	TG > C %
Cross-sex Hormone Therapy	352	NA	4	NA	TG > C	NA
Breast Augmentation	0	0	2	0	C > TG	No diff
Breast Reduction	7	3	2	3	TG > C	No diff
Facial Feminization/ Masculinization	3	0	9	0	C > TG	No diff
Genital Surgery	3	0	2	1	No diff	No diff
Hysterectomy	NA	16	NA	17	NA	No diff
Voice Therapy	25	NA	0	NA	TG > C	NA

Separation Data

Cohort members	993*
Cohort members that are continuously AD 10/1/2015-7/1/2017	691
Cohort members who may have separated	302
Cohort members who may have separated in separation file	194
Unknown	108

*1 of the original 994 was not found in DEERS

Reason for Separation

High to Low Comparison

See attached handout

Reasons for Separation

	Study Cohort		Percentages of all Separations for the Same reasons from 10/1/2015 - 7/1/2017 (not matched, taken from entire set of 408,409 SMs separated)	
	Frequency	Percent	Frequency	Percent
Expiration of term of service	74	38.14	197,959	48.47
Temporary disability retirement	19	9.79	10,408	2.55
Permanent disability retirement	12	6.19	10,801	2.64
Unqualified for active duty, other	9	4.64	18,979	4.65
Disability, severance pay	8	4.12	11,480	2.81
Drugs	8	4.12	8,836	2.16
Retirement, 20 to 30 years of service	8	4.12	39,925	9.78
Character or behavior disorder	7	3.61	2,480	0.61
Early release, in the national interest	7	3.61	8,603	2.11
Officer commissioning program	6	3.09	9,691	2.37
Failure to meet weight or body fat standards	5	2.58	6,064	1.48
Military service academy	4	2.06	1,213	0.3
Commission of a serious offense	3	1.55	6,979	1.71
Failure to meet minimum qualifications for retention	3	1.55	2,386	0.58
Other	3	1.55	5,147	1.26
Pattern of minor disciplinary infractions	3	1.55	1,508	0.37
Alcoholism	2	1.03	1,081	0.26
Court-martial	2	1.03	1,216	0.3
Erroneous enlistment or induction	2	1.03	4,105	1.01
Juvenile offender	2	1.03	2,618	0.64
Breach of contract	1	0.52	135	0.03
Condition existing prior to service	1	0.52	475	0.12
Discreditable incidents, civilian or military	1	0.52	3,538	0.87
Entry level performance and conduct (former Trainee Discharge program)	1	0.52	9,176	2.25
Secretarial authority	1	0.52	624	0.15
Unfitness, reason unknown	1	0.52	692	0.17
Unsatisfactory performance (former Expeditious Discharge program)	1	0.52	9,061	2.22
Total	194		375,180	

Cohort Deployment History (All OCONUS)

994
- Cohort of Service members with a primary diagnosis of gender dysphoria – FY2016 to July 2017

393
- Deployed in support of OEF/OIF/OND

114
- Deployed following a primary diagnosis of gender dysphoria

69
- Deployed following a primary diagnosis of gender dysphoria AND after July 1, 2016

Costs and Cost Comparisons

Originally presented on Nov 2

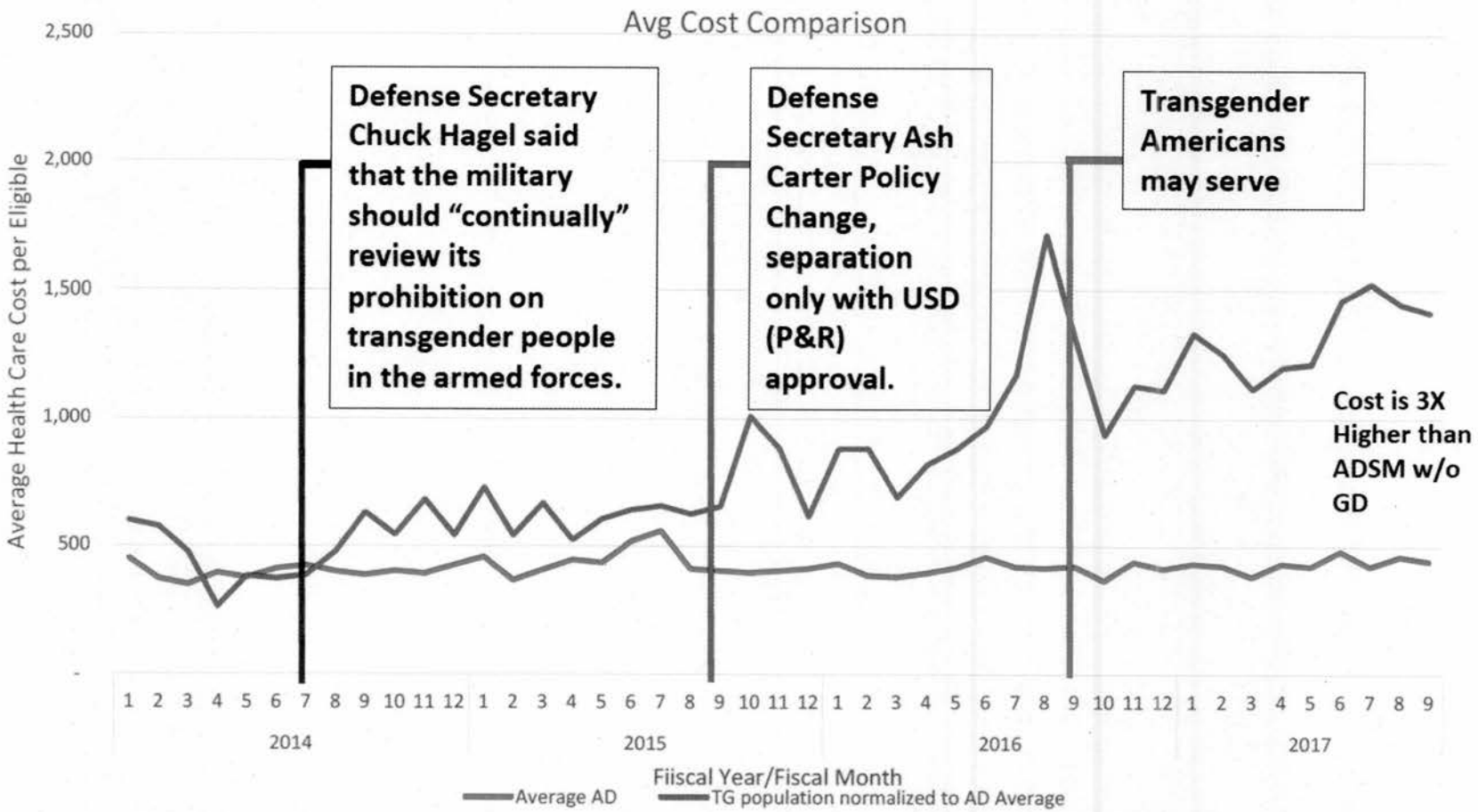
Cost of Services for Gender Dysphoria

(Purchased Care Paid Costs; Direct Care Estimated Costs)

	FY14	FY15	FY16	FY17	TOTAL
Direct Care	$ 82,558	$ 83,563	$ 650,492	$ 2,172,849	$ 2,989,462
Purchased Care	$ 5,421	$ 3,884	$ 10,094	$ 16,509	$ 35,908
Pharmacy	$ 1,264	$ 2,693	$ 3,406	$ 6,130	$ 13,493
TOTAL	$ 89,243	$ 90,140	$ 663,992	$ 2,195,488	$ 3,038,863

Average Health Care Expenditures:

Transgender Active Duty (TRICARE Prime) vs Average Active Duty



Source: M2 (Purchased Care: Inpatient (TED-I); Professional (TED-NI)); (Direct Care: Inpatient (SIDR); Professional (CAPER)); Pharmacy (PDTS); Population (DEERS)

Summary of Findings

- Not all individuals who are transgender have gender dysphoria; civilian experts stated that the field is moving away from a mental health diagnosis to gender incongruence
  - Emerging evidence strongly suggests being transgender has a biological basis, possibly genetic component.
- Gender dysphoria is preventable if people who are TG can transition, is treatable and, according to civilian experts, curable
- We cannot assume all SMs who are transgender presented to the MHS or their commanders after the ban was lifted
  - In the MHS data system, there were 1076 ADSMs to date with dx of GD from FY16- July2017; cannot determine number of TG from this system
  - Numbers of transgender SMs are likely closer to RAND estimates
- Some people who are TG do not choose any medical treatments for transition; for those that choose to transition, the majority choose hormone therapy
- Only a minority choose surgeries. Of the surgeries chosen, most are not genital reassignment surgeries with only 2% FtM having genital surgeries and 19% MtF having genital surgeries.
- **Hormone therapy and deployability:** civilian endocrine expert said that it is safe to pause initiation/titration of dose of hormone treatments and/or stop hormones (may need to wean off) in order to accommodate deployments. Military endocrine expert stated that most of his TG patients are stable by 6 months after initiation of hormone therapy.
- Most common TG surgeries such as chest masculinization, hysterectomy, oopherectomy have similar "con" times as for non-TG persons, averaging 6-8 weeks; can be performed in MTFs
- The more complicated genital surgeries, specifically phalloplasties and metoidioplasties are typically 2 stages with 2-3 months con times; currently need to be performed by civilian providers

Reasons for Separation

	Study Cohort		Percentages of all Separations for the Same reasons from 10/1/2015 - 7/1/2017 (not matched, taken from entire set of 408,409 SMs separated)	
	Frequency	Percent	Frequency	Percent
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Secretarial authority	1	0.52	624	0.15
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Unsatisfactory performance (former Expeditious Discharge program)	1	0.52	9,061	2.22
Total	194		375,180	

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: November 30, 2017
Time: 1500-1900
Room: 3D1063

Overview:
The Panel will review minutes from previous meetings and will begin deliberation on a proposed transgender service policy. The completed proposal is scheduled for presentation to the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff on December 15, 2017.

Subject	Speaker	Duration
Overview	Mr. Tony Kurta	1500-1505
Presentation of Meeting Minutes	Mr. Tony Kurta	1505-1530
Discussion of TG Policy	Mr. Tony Kurta	1530-1900

Meeting Homework/Deliverables:
Approve meeting 5, 6, and 7 minutes

Save the following dates for upcoming meetings: Thursday, 7 December, 1500-1900 and Wednesday, 13 December, 1500-1700. DSD/VCJCS meeting is scheduled for 15 December.

Administrative:
Questions or issues please contact, [redacted].

Guidance

SECDEF guidance: "Consistent with [DoD goals for] military effectiveness and lethality, budgetary constraints, and applicable law, the implementation plan will establish the policy, standards and procedures for transgender individuals serving in the military."

P&R Guidance: Using the SecDef's criterion of consistency with DoD goals for military effectiveness and lethality, while mindful of budgetary constraints and applicable law, the Panel must provide recommended answers to several questions.

1. Will the Panel recommend that the DoD begin accessing transgender individuals?
2. Will the Panel allow for in-service transition in the future? If so, what will be allowed and what will not be?
3. If the Panel recommends that future transitions be disallowed, what does the Panel recommend concerning the currently serving transgender population?

The Transgender Working Group, chaired by the Director, Accession Policy will incorporate the Panel's recommendations into a revision of the current DoDI that sets forth the standards and processes that will apply to transgender Service members. This working group will also develop the implementation plan to support that DoDI revision.

Dignity & Respect "First and foremost, we will continue to treat every Service Member with dignity and respect." - SecDef Interim Guidance, September 14, 2017

Medically necessary care: "Service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. As directed by the Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex." – SecDef Interim Guidance, 14 September 2017.

Accessions policy: "The procedures set forth in DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, dated April 28, 2010 (Change 1), which generally prohibit the accession of transgender individuals into the Military Services, remain in effect because current or history of gender dysphoria or gender transition does not meet medical standards, subject to the normal waiver process." - SecDef Interim Guidance, September 14, 2017.

Retention policy: "An otherwise qualified transgender Service member whose term of service expires while [the] Interim Guidance remains in effect, may, at the Service member's request, be re-enlisted in service under existing procedures." - SecDef Interim Guidance, September 14, 2017.

Definitions

Gender Dysphoria (Diagnostic and Statistical Manual of Mental Disorders version 5 which is the basis for the classification code used for documenting military medical diagnoses): In adolescents and adults, gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Gender Incongruence: not applicable for the purposes of the Panel's deliberations.

Medically necessary: Those health-care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine. (Transgender Work Group)

Medical Treatment Plan: The plan, developed between the patient and health care provider, that outlines the steps anticipated for the patient's transition to the opposite sex. (Transgender Work Group)

Sex Reassignment Surgery or gender affirmation surgery: All surgical procedures related to transition from the birth sex to the preferred gender. (DHA Memorandum of November 13, 2017).

Stable in the preferred gender. No functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Transgender Work Group)

Transgender Service member: A Service member whose gender identity differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment or receive a diagnosis of gender dysphoria. (Transgender Work Group)

Estimates on the size of the Transgender Population in the Military:

Number of GD diagnoses:	994, from June 1 2016 – July 26, 2017; 1,076 as of October 3, 2017
OPA survey estimate:	8,227 – 9,732 on active duty
Rand estimate:	2,150 – 10,790 across all components

Gender Dysphoria treatment regime

Diagnosis requirements: Under current policy, receiving a diagnosis of gender dysphoria requires 6 months of counseling (Panel III minutes) and according to the Diagnostic and Statistical Manual of Mental Disorders version 5, at least two of the following criterion must be met:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Behavioral Health Counseling: The initial step in identifying the severity of an individual's mental health condition(s) that may or may not exist. If a mental health condition exists, the person/Service member is treated or further referred to a psychotherapist depending on the identified condition.

Cross-sex Hormone Therapy: A common medical treatment associated with gender transition and can be started upon receipt of a diagnosis for gender dysphoria. (Draft DoDI 1300.XX, Military Service by Transgender Service members with Gender Dysphoria) "During the first year, the Clinical Guidelines from the Endocrine Society recommends laboratory work every 90 days to monitor hormone levels. (Panel VI slides) Opinions vary on the Service member's deployability during this period – a military endocrinologist stated that TG SMs should be able to deploy after 180 days of beginning the hormone regimen. (Panel II minutes) The civilian endocrinologist stated that hormone initiation can be paused or discontinued safely to accommodate deployments. (Draft Panel V minutes), Commanders report that TG Service members are non-deployable for this entire period (Panel I minutes).

Real Life Experience (RLE): The phase in the gender transition process during which the individual commences living in the gender role consistent with their preferred gender. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities. (Transgender Working Group)

Surgeries: *Note1: The 2015 U.S. Transgender Survey cited by [redacted] showed that 20% of MtF and 2% FtM TG individuals initially wanting* ***genital*** *surgery actually have the surgery.* ***This was originally reported as all surgeries, not specifically genital surgeries.*** *(Panel IV slides) Note2: the following table only depicts currently authorized procedures.*

Compiled data based on presentations from Panel IV and Panel VI

Procedure	Estimated Recovery Time (assumes no complications)	Estimate on how many may desire*	Notes
Hysterectomy (vaginal approach, recommended)	**4 weeks unrestricted (vaginal)**	**128/313**	**(data for all indications) Major complication = 9.5% Minor complication = 28%**
Hysterectomy (abdominal approach) with or w/o Oopherectomy	**6-8 weeks unrestricted**		**(data for all indications) Major complication = 6% Minor complication = 27%**
Chest masculinization (Mastectomy)	**4-6 weeks unrestricted**	**151/313**	**Low complications**
Phalloplasty* Metoidoplasty*	**3 months unrestricted 8 weeks unrestricted**	**151/313**	**Recommends stay in area of hospital where procedure performed for up to 2 weeks**
Orchiectomy	**6 weeks unrestricted**	**75/313**	**Very low complications**
Peniectomy/ Orchiectomy/ neovagina*	**6-8 weeks (back to strenuous work) 3 months for biking/swimming**	**151/313**	• **Recommends stay in area of hospital where procedure performed for up to 2 weeks** • **Major complications rare** • **Minor complications ~25%, most soon after surgery**

*** - Data provided did not differentiate between genders, so all data shown is based on all 313 treatment plans that were examined.**

Current Gender Marker Change Policy

A Service member on active duty, who receives a diagnosis from a military medical provider for which gender transition is medically necessary may, in consultation with the military medical provider and at the appropriate time, request that the commander approve:

- The timing of medical treatment associated with gender transition;
- An ETP associated with gender transition, consistent with Paragraph 3.2.d, and/or
- A change to the Service member's gender marker in DEERS.

(DoDI 1300.28 – *In-Service Transition for Transgender Service Members)*

The Commander will respond promptly to any request for medical care and ETPs associated with gender transition no later than 90 days from the date of the request. The commander approves, in writing, the gender marker change in DEERS.

Current Transgender Service member Data

When presenting data, [redacted] *stated that while a great deal of data would be presented, it may be insufficient to draw actionable conclusions. Instead, it is helpful to show trends. With such a small population to examine, and barely a year of open transgender service, using the data to predict long-term issues would not be advised. With only 15 months of transgender service, very few of the transgender Service members would have progressed sufficiently to surgeries - unless they started their transition prior to the enactment of the policy. (Panel II minutes)*

- Between October 1, 2015 to July 26, 2017, there were 994 AD SMs with a diagnosis of GD - (Panel IV slides)
- Service members with GD accounted for more than 30,000 mental health visits over a 2-year period. (Panel IV slides)
- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)
- Between 67 and 77% of Service members have surgeries included in their treatment plans (Panel IV slides)
- Using limited data, the Army and Air Force reported that their transitioning Service members averaged 167.4 and 159 days of limited duty, respectively. The Navy, by policy, does not allow limited duty profiles for transition. (Panel IV slides)
- According to the 2015 U.S. Transgender survey, only 2% of completed Female-to-Male (FtM) transitions included genital reassignment surgeries. In Male-to-female (MtF) completed transitions, approximately 10% had genital reassignment surgery. The most common transition-related surgeries that can be performed in military treatment facilities are mastectomy (21% of FtM), hysterectomy (8% of FtM) and breast augmentation (8% of MtF). (Panel VI slides)

- The 2015 U.S. Transgender Survey shows that the military seems to have a higher prevalence of transgenderism than the greater American public. (Panel VI slides)

- The DASD-HA study cohort of 691 transgender Service members revealed: (Panel VII slides)
  - The transgender population in the military is mostly under 40 years old (97%) and in the rank of E1-E4 (51%).
  - Higher rates of mental health and psychotherapy encounters per individual (29.6) when compared to the control group that consisted of active duty service members with a mental health diagnosis (21.1)
  - A higher rate of suicidal ideation than the control group that consisted of active duty service members with a mental health diagnosis (10.7 vs 6.2%).
  - 69 Service members deployed following a primary diagnosis of gender dysphoria after July 1, 2016.

Readiness, Lethality, and Military effectiveness

- The vast majority of commanders agreed that from time of diagnosis to the completion of a transition plan, the SM would be non-deployable for 2-2.5 years (up to a year of hormones to achieve stability, then surgeries). (Panel I minutes) Transgender Service members maintained that most complex surgery (gender reassignment surgery) required six weeks of Convalescent Leave followed by an unspecified period of light duty. (Panel II minutes)

- The three genital reconstruction surgeries (vaginoplasty, phalloplasty, metoidioplasty), have as-yet unknown impacts on individual military readiness and that the deployability of individuals who had the surgeries would be an issue. Example: one Service member recently had a vaginoplasty and her medical treatment plan forecasted 10.5 months of non-deployability after the surgery. (Draft Panel VI minutes)

- One military physician stated that the surgical portion of a complete gender reassignment, would generally be scheduled as five or six surgeries over a 15-month period. (Panel III minutes)

- When asked about the percentages of transgender individuals that opted for medical procedures, the civilian medical experts provided the following information, based on their personal experience:

	Male to Female (MtF) transitions	Female-to-Male (FtM) transitions
% that desire medical intervention	50	50
% (of above) that desire surgery	33	33
Desire cross-sex hormones	majority	Majority

Remarks	Majority of surgical procedures are chest augmentation surgery	Majority of surgical procedures are mastectomies

- One commander remarked about how it would be extremely difficult for a TG SM to operate in a SOCOM world with austere living conditions and non-emergency medical support not readily available. He also raised the issue that some military specialties, like air traffic controllers, have their standards set by another agency – in that case the FAA. The FAA does not allow an individual to control air traffic until they have been hormonally stable for 5 years, effectively closing that specialty to TG SMs. (Commanders, Panel I minutes)

- When asked what happens if an individual on cross-sex hormones was unable to take them for a period of time, a military physician stated that the answer depended on the specific situation. In short, side effects of cross-sex hormone withdrawal include increased fatigue, mood swings and decreased libido – and these symptoms are similar to those of a cisgender individual that stopped taking hormone supplements. The longer an individual was on cross-sex hormones when they had to stop, the more intense those symptoms would be. The same panelist remarked that there would likely be a decrease in combat ability for an individual who stopped taking their cross-sex hormones. (Panel III minutes) Transgender Service members who appeared before the panel had a different perspective. One of the Service members has been off of hormones for more than 2 years with little effect and another compared the side effects of skipping a week of hormones to a bad case of pre-menstrual syndrome. One of the Service members sometimes skips hormone injections and this leads to oily skin, and mood swings, both of which are manageable. (Panel III minutes) Civilian medical experts maintained that if a Service member was deployed and lost their cross-sex hormones, the most likely effect would just be an angry Service member. As a matter of routine in civilian care, the use of cross-sex hormones are halted before and after surgeries for a period of time without any issues. (Draft Panel V minutes) However, cross sex hormones can be provided in multiple ways – topical creams, injections or pills – so it is be unlikely that an individual would be unable to take cross-sex hormones anywhere in the world. (Panel III minutes) There are risks associated with cross-sex hormones, but they are small. Birth control pills contain more hormones than cross-sex hormones do. (Panel III minutes)

- Providing adequate mental health support to a deployed transgender Service member could be problematic - there are few deployed psychotherapists that could provide the required treatment for a transgender Service member prior to surgeries – and none in the most austere environments (e.g., Syria, Somalia). Mature theaters (Korea, Afghanistan) would likely be able to support transgender Service members with mental health and medical support. (Draft Panel VI minutes)

- Receiving a diagnosis of gender dysphoria takes approximately 6 months of counseling. (Panel III minutes)

- The civilian endocrinologist stated that it is safe to pause initiation/titration of dose of hormone treatments and/or stop hormones (may need to wean off) in order to accommodate deployments. It will just freeze the progress of the individual's transition. (Draft Panel V minutes)

Budgetary constraints

- Several commanders indicated a budgetary impact as they received no additional monies to pay for the numerous TDY trips throughout CONUS for specialized medical care and had to pay out of O&M Funds. (Panel I minutes)

- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)

Unit cohesion

- One commander spoke of his 'dueling' EO issues; his TG SM (a female with male genitalia), has an approved ETP for full-time real life experience and is authorized to use female shower facilities. This led to an EO complaint by the females assigned to the unit who believed their privacy was invaded by this. That led to an EO complaint by the TG SM claiming that the command was not supporting her rights.

Applicable laws, standards, and guidelines

- Statutorily, TRICARE is forbidden from paying for gender reassignment surgery. All transition-related surgeries must be processed through the Supplemental Health Care Program. In any case, if an individual does not meet required guidelines, the Department can refuse to perform the procedure until the individual meets all criteria contained in the guidelines. (Panel II minutes)

- The Military Health System follows the 2017 Endocrine Society guidelines for the treatment of gender dysphoria. (Panel VI slides) The recovery estimates contained within those guidelines are based on an assumption that the individual will return to their civilian life, which does not directly translate onto the military population and their unique requirements. The DoD will most likely have to develop its own military-specific recovery estimates that would likely be higher than the civilian estimates (Draft Panel VI minutes).

- The prevailing Endocrine Society guidelines are also the reason why an individual is non-deployable for the first 12 months of taking cross-sex hormones. (Panel III minutes). Both the military endocrinologist (Panel III) and the civilian endocrinologist (Panel IV) believed that an individual should be able to deploy after only six months of cross-sex hormones.

Deployability

Department of Defense Instruction (DoDI) 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, February 5, 2010 provides the following information:

Deployment: The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including

intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

Contingency Deployment: A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

DoD Policy states that DoD personnel may deploy if:

> "Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration." (Paragraph 4.3.b)

The DoDI also adds that

> "Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical capabilities of the deployment..." (Paragraph 4.e)

Enclosure 3 to the DoDI is entitled "*Medical conditions usually precluding contingency deployment*" and within it, the enclosure states:

> "Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity." (Paragraph b.1.)
>
> "Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment." (Paragraph b.5.)

The DoDI also charges the Joint Staff and COCOMs to develop their own medical standards for deployment into their area of operations. Using CENTCOM as an example, their medical deployment standards, contained in Modification 13 to *USCENTCOM Individual protection and individual – Unit deployment Policy* (March 23, 2017) states:

> "Deployed Health Service Support infrastructure is designed and prioritized to provide acute and emergency support to the Expeditionary mission. All personnel...travelling to the CENTCOM AOR must be medically, dentally and psychologically fit." (Paragraph 15.C)

Questions and Answers

ADMIN DATA PRESENTED DURING PANEL MEETINGS

[redacted]

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: December 7, 2017
Time: 1500-1900
Room: 3D1063

Overview:
The Panel will review minutes from the previous meeting (5-7) and will continue deliberation on a proposed transgender service policy. The completed proposal is scheduled for presentation to the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff on December 15, 2017.

Subject	Speaker	Duration
Opening Remarks	HON Robert Wilkie	1500-1505
Presentation of Minutes	[redacted]	1505-1530
Supplemental Data	[redacted]	1530-1545
TG Policy Discussion	[redacted]	1545-1830
Policy Validation	[redacted]	1830-1900

Meeting Homework/Deliverables:
Approve meetings 5, 6, 7 minutes.

Save the following dates for upcoming meetings: Wednesday, 13 December, 1500-1700. DSD/VCJCS meeting is scheduled for 15 December.

Administrative:
Questions or issues please contact, [redacted].

The Federal Aviation Administration (FAA) and Gender Dysphoria

Because FAA guidelines for cross-sex hormones were brought up as an issue by a commander that appeared before the Panel, Military Personnel Policy reached out to the FAA to determine the validity of the claim that the use of cross-sex hormones would cause a pilot or air traffic controller to lose their medical certificate. The following information is provided:

- The 2017 "Guide for Aviation Medical Examiners" (extract enclosed) was last published October 25, 2017. The Guide serves as the standard for an individual receiving their Airman Medical Certificate which allows them to control aircraft.
- The standards contained in the Guide apply to air traffic controllers as well as pilots.
- The Guide contains a section on Gender Dysphoria. If a transgender individual completed gender reassignment surgery more than 5 years ago or has been on cross-sex hormones for more than 5 years, the local medical provider can issue a medical certificate. If less than 5 years in either case, the issue must be forwarded to the FAA for adjudication.
- On the form the medical provider must fill out, it states in the notes that "side effects from hormone therapy can be aeromedically significant." According to [redacted]:

  > The actual hormones prescribed depend on whether transitioning from male to female (much more frequent) or female to male (less common, but typically more side effects).
  >
  > From an FAA medical certification perspective, the symptoms/side effect for typical hormone treatment include: deep venous thrombosis, pulmonary embolus, polycythemia, obstructive sleep apnea, cardiovascular disease, high blood pressure, prolactinoma, diabetes, and destabilization of some psychiatric conditions. These side effects do have readiness implications and presumably a service member might not be deployable or not fit for flying duties for part of their transition time due to the serious nature of some of these medications.
  >
  > FAA medical officers specifically ask treating physicians whether or not their patients are experiencing these side effects.
  >
  > Of note, we recently worked a pilot special issuance for a civil airman treated at Bethesda. The endocrinology specialist there was very familiar and comfortable with the transition process.
  >
  > - *Email from [redacted], 1 December 2017*

- During the period November 1 2012 to October 31, 2017, a total of 87 applicants were issued a FAA medical certificate (under special issuance) for gender dysphoria:
  - Class I: 24
  - Class II: 29
  - Class III: 34

    According to the FAA website, first-class is designed for airline transport pilots; second-class for commercial pilots; and third-class for the student, recreational and private pilot

Information current as of 1130, December 4, 2017

2017

GUIDE FOR AVIATION MEDICAL EXAMINERS

Welcome to the Guide for Aviation Medical Examiners. The format of this version of the Guide provides instant access to information regarding regulations, medical history, examination procedures, dispositions, and protocols necessary for completion of the FAA Form 8500-8, Application for Airman Medical Certificate.

To navigate through the Guide PDF by Item number or subject matter, simply click on the "BOOKMARK" tab in the left column to search specific certification decision-making criteria. To expand any "BOOKMARK" files, click on the corresponding + button located in the front of the text. To collapse any of the expanded files, click on the + button again.

The most current version of this guide may be found and downloaded at the following FAA site:
http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide/

LAST PUBLISHED: October 25, 2017

	Gender Dysphoria All Classes Updated 01/27/2016	
CONDITION	**EVALUATION DATA**	**DISPOSITION**
A. Completed gender reassignment surgery **5 or more years ago** OR Treated with hormone therapy **for 5 or more years**	If there is no evidence of a mental health diagnosis and the airman is doing well on current treatment:	**ISSUE** Annotate Block 60
B. Treated with Hormone therapy* for **less than 5 years** OR Gender reassignment surgery **less than 5 years ago** OR History of a **coexisting mental health concern** OR **History of mental health treatment** such as psychotherapy or medications for any condition other than Gender Dysphoria (Information is required if the airman has ever had a mental health diagnosis [including substance use disorder] or has received treatment for a mental health condition at any time. If treatment was short-term counseling for Gender Dysphoria only, note in Block 60.)	Submit the following to the FAA for review: ☐ A completed FAA Gender Dysphoria Mental Health Status Report or an evaluation from the treating physician, using World Professional Association for Transgender Health guidelines (WPATH), which addresses items listed in the Mental Health Status Report. ☐ Updated evaluations AFTER: • Hormone therapy: If on hormones, a current status report describing the length of time on the medication and side effects, if any. • Surgery: If surgery has been performed within the last one year, a status report from the surgeon or current treating physician showing full release, off any sedation or pain medication, and any surgical complications (e.g. DVT/PE/cardiac, etc.).	**DEFER** Submit the information to the FAA for review. **Follow up Issuance** Will be per the airman's authorization letter

Notes:

The AME may ISSUE (no further information is needed), **if the airman**:

- Was evaluated for or diagnosed with Gender Dysphoria and has never undergone treatment (counseling or support group for GD does not require information);
- Has no history of other mental health diagnoses or treatment; and
- Is otherwise qualified

*Side effects from hormone therapy can be aeromedically significant. The airman should be warned not to fly per Title 14 CFR 61.53 if they experience medication side effects.

FAA Gender Dysphoria Mental Health Status Report

(Updated 08/30/2017)

Name _____ Birthdate _____

Applicant ID# _____ PI# _____

The following information must be addressed in the treating provider's evaluation. Evaluation should be performed in accordance with a comprehensive mental health assessment following the World Professional Association for Transgender Health (WPATH) guidelines. Submit either this form* or supporting documentation addressing each item to your AME or to the FAA at:

Federal Aviation Administration
Civil Aerospace Medical Institute, Bldg. 13
Aerospace Medical Certification Division, AAM-300
PO Box 25082
Oklahoma City, OK 73125-9867

1.	I am a board certified psychiatrist or licensed psychologist AND I meet the criteria for a qualified mental health professional" per WPATH (current version) guidelines.	[ ] Yes [ ] No-explain
2.	This airman meets the DSM-5 diagnostic criteria for Gender Dysphoria and the condition is not secondary to, or better accounted for, by other diagnoses.	[ ] Yes [ ] No-explain
3.	PSYCHIATRIC HISTORY:	
	Current mental health diagnosis or coexisting mental health concerns.....	[ ] None [ ] Yes-explain
	Previous mental health diagnosis or coexisting mental health concerns.....	[ ] None [ ] Yes-explain
	ER visit or hospitalization for any psychiatric illness or condition ever.....	[ ] None [ ] Yes-explain
	Any suicide attempt(s) ever.....	[ ] None [ ] Yes-explain
	Substance Use disorder per DSM-5..... (e.g. alcohol, cannabis, stimulants, hallucinogens, opioids)	[ ] None [ ] Yes-explain
4.	PSYCHIATRIC TREATMENT: (List start and end dates on each. For medications, also note name, dose, and side effects, if any.)	
	Current use.....	[ ] None [ ] Yes-explain
	Previous use.....	[ ] None [ ] Yes-explain
	Psychotherapy for any condition other than GD (e.g. depression, anxiety).....	[ ] None [ ] Yes-explain
	Other treatments (e.g. cognitive therapy, talk therapy, electroconvulsive therapy)	[ ] None [ ] Yes-explain
5.	CURRENT STATUS: Airman is doing well. There are no mental health concerns. Psychotherapy (if any) is for gender dysphoria only. No other treatment is needed (do not include support group or support group counseling).	[ ] Yes [ ] No-explain
6.	Any evidence of cognitive dysfunction or is a formal neuropsychological evaluation indicated?	[ ] None [ ] Yes-explain
7.	Do you have ANY concerns regarding this airman?	[ ] None [ ] Yes-explain

_____ _____
Treating Provider Signature Date of Evaluation

_____ _____
Name or Office Stamp Phone Number

***For any response which requires further explanation, submit supporting documentation. In some cases, actual records will be required.**

Time to Return to Full Duty After Transition Surgery in MTFs

- The Services and NCR were requested to provide actual recovery times (times to return to full duty) for gender transition surgeries performed in the MTFs
- Surgeries performed included mastectomies, hysterectomies, orchiectomies and facial feminization
- Recovery times were available for 36 procedures performed in 13 different MTFs
  - 6 Army
  - 4 Navy
  - 1 Air Force
  - 2 NCR

MASTECTOMY

CPT Code 19303-19304

	Primary Procedure Code	# Days to Full Duty	Comments
Army	19303	30	Average # Days = 39 Range 14 – 75
Army	19303	14	
Army	19304	75	
Army	19394	42	
Army	19304	28	
Army	19304	27	
Navy	19303	42	
Navy	19303	42	
Navy	19303	42	
Navy	19303	42	
Navy	19304	42	
Navy	19303	42	
Navy	19303	42	
Navy	19303	42	
Navy	19304	42	
NCR	19304	30	

HYSTERECTOMY

CPT Code OUT9FZZ

	Primary Procedure Code	# Days to Full Duty	Comments
Army	OUT9FZZ	68	Average # Days = 67 Range 30 – 237 (Avg # days w/o AF = 55)
Army	OUT9FZZ	42	
Army	OUT9FZZ	42	
Army	OUT9FZZ	87	
Army	OUT9FZZ	96	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	60	
Navy	OUT9FZZ	45	
Navy	OUT9FZZ	45	
Air Force	OUT9FZZ	237	
NCR	OUT9FZZ	31	
NCR	58262	30	

ORCHIECTOMY

CPT Code 54520

	Primary Procedure Code	# Days to Full Duty	Comments
Army	54520	45	Average # days = 38.3 Range 35-45
Navy	54520	35	
Navy	54520	35	

OTHER PROCEDURES

	Procedure (s)	# Days to Full Duty	Comments
Army	Facial Feminization	42	1 case
Army	Hysterectomy & Mastectomy	89	Procedures performed two months apart

Guidance

SECDEF guidance: "Consistent with [DoD goals for] military effectiveness and lethality, budgetary constraints, and applicable law, the implementation plan will establish the policy, standards and procedures for transgender individuals serving in the military."

P&R Guidance: Using the SecDef's criterion of consistency with DoD goals for military effectiveness and lethality, while mindful of budgetary constraints and applicable law, the Panel must provide recommended answers to several questions.

1. Will the Panel recommend that the DoD begin accessing transgender individuals?
2. Will the Panel allow for in-service transition in the future? If so, what will be allowed and what will not be?
3. If the Panel recommends that future transitions be disallowed, what does the Panel recommend concerning the currently serving transgender population?

The Transgender Working Group, chaired by the Director, Accession Policy will incorporate the Panel's recommendations into a revision of the current DoDI that sets forth the standards and processes that will apply to transgender Service members. This working group will also develop the implementation plan to support that DoDI revision.

Dignity & Respect "First and foremost, we will continue to treat every Service Member with dignity and respect." - SecDef Interim Guidance, September 14, 2017

Medically necessary care: "Service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. As directed by the Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex." – SecDef Interim Guidance, 14 September 2017.

Accessions policy: "The procedures set forth in DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, dated April 28, 2010 (Change 1), which generally prohibit the accession of transgender individuals into the Military Services, remain in effect because current or history of gender dysphoria or gender transition does not meet medical standards, subject to the normal waiver process." - SecDef Interim Guidance, September 14, 2017.

Retention policy: "An otherwise qualified transgender Service member whose term of service expires while [the] Interim Guidance remains in effect, may, at the Service member's request, be re-enlisted in service under existing procedures." - SecDef Interim Guidance, September 14, 2017.

Definitions

Gender Dysphoria (Diagnostic and Statistical Manual of Mental Disorders version 5 which is the basis for the classification code used for documenting military medical diagnoses): In adolescents and adults, gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Gender Incongruence: not applicable for the purposes of the Panel's deliberations.

Medically necessary: Those health-care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine. (Transgender Work Group)

Medical Treatment Plan: The plan, developed between the patient and health care provider, that outlines the steps anticipated for the patient's transition to the opposite sex. (Transgender Work Group)

Sex Reassignment Surgery or gender affirmation surgery: All surgical procedures related to transition from the birth sex to the preferred gender. (DHA Memorandum of November 13, 2017).

Stable in the preferred gender. No functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Transgender Work Group)

Transgender Service member: A Service member whose gender identity differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment or receive a diagnosis of gender dysphoria. (Transgender Work Group)

Estimates on the size of the Transgender Population in the Military:

Number of GD diagnoses:	994, from June 1 2016 – July 26, 2017; 1,076 as of October 3, 2017
OPA survey estimate:	8,227 – 9,732 on active duty
Rand estimate:	2,150 – 10,790 across all components

Gender Dysphoria treatment regime

Diagnosis requirements: Under current policy, receiving a diagnosis of gender dysphoria requires 6 months of counseling (Panel III minutes) and according to the Diagnostic and Statistical Manual of Mental Disorders version 5, at least two of the following criterion must be met:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Behavioral Health Counseling: The initial step in identifying the severity of an individual's mental health condition(s) that may or may not exist. If a mental health condition exists, the person/Service member is treated or further referred to a psychotherapist depending on the identified condition.

Cross-sex Hormone Therapy: A common medical treatment associated with gender transition and can be started upon receipt of a diagnosis for gender dysphoria. (Draft DoDI 1300.XX, Military Service by Transgender Service members with Gender Dysphoria) "During the first year, the Clinical Guidelines from the Endocrine Society recommends laboratory work every 90 days to monitor hormone levels. (Panel VI slides) Opinions vary on the Service member's deployability during this period – a military endocrinologist stated that TG SMs should be able to deploy after 180 days of beginning the hormone regimen. (Panel II minutes) The civilian endocrinologist stated that hormone initiation can be paused or discontinued safely to accommodate deployments. (Draft Panel V minutes), Commanders report that TG Service members are non-deployable for this entire period (Panel I minutes).

Real Life Experience (RLE): The phase in the gender transition process during which the individual commences living in the gender role consistent with their preferred gender. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities. (Transgender Working Group)

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Surgeries: *Note1: The 2015 U.S. Transgender Survey cited by* [redacted] *showed that 20% of MtF and 2% FtM TG individuals initially wanting* ***genital*** *surgery actually have the surgery.* ***This was originally reported as all surgeries, not specifically genital surgeries.*** *(Panel IV slides) Note2: the following table only depicts currently authorized procedures.*

Compiled data based on presentations from Panel IV and Panel VI

Procedure	Estimated Recovery Time (assumes no complications)	Estimate on how many may desire*	Notes
Hysterectomy (~~vaginal~~ laproscopic approach, recommended)	**~~4 weeks~~ 6-8 weeks unrestricted ~~(vaginal)~~**	**128/313**	**(data for all indications) Major complication = 9.5% Minor complication = 28%**
Hysterectomy (abdominal approach) with or w/o Oopherectomy	**6-8 weeks unrestricted**		**(data for all indications) Major complication = 6% Minor complication = 27%**
Chest masculinization (Mastectomy)	**4-6 weeks unrestricted**	**151/313**	**Low complications**
Phalloplasty* ~~Metoidoplasty*~~ (2 stages, 2nd surgery 9-12 mos later)	**3 months unrestricted ~~8 weeks unrestricted~~**	**151/313**	**Recommends stay in area of hospital where procedure performed for up to 2 weeks**
Metoidioplasty (2 stages, 2nd stage performed >/=3 mos later)**	**8 weeks unrestricted**	**151/313**	• **Recommends stay in area of hospital where procedure performed for up to 3 weeks** • **<5% complication rate**
Orchiectomy	**6 weeks unrestricted**	**75/313**	**Very low complications**
Peniectomy/ Orchiectomy/ neovagina*	**6-8 weeks (back to strenuous work) 3 months for biking/swimming**	**151/313**	• **Recommends stay in area of hospital where procedure performed for up to 2 weeks** • **Major complications rare** • **Minor complications ~25%, most soon after surgery**

*** - Data provided did not differentiate between genders, so all data shown is based on all 313 treatment plans that were examined.**

Current Gender Marker Change Policy

A Service member on active duty, who receives a diagnosis from a military medical provider for which gender transition is medically necessary may, in consultation with the military medical provider and at the appropriate time, request that the commander approve:

- The timing of medical treatment associated with gender transition;
- An ETP associated with gender transition, consistent with Paragraph 3.2.d, and/or
- A change to the Service member's gender marker in DEERS.

(DoDI 1300.28 – *In-Service Transition for Transgender Service Members)*

The Commander will respond promptly to any request for medical care and ETPs associated with gender transition no later than 90 days from the date of the request. The commander approves, in writing, the gender marker change in DEERS.

Current Transgender Service member Data

When presenting data, [redacted] *stated that while a great deal of data would be presented, it may be insufficient to draw actionable conclusions. Instead, it is helpful to show trends. With such a small population to examine, and barely a year of open transgender service, using the data to predict long-term issues would not be advised. With only 15 months of transgender service, very few of the transgender Service members would have progressed sufficiently to surgeries - unless they started their transition prior to the enactment of the policy. (Panel II minutes)*

- Between October 1, 2015 to July 26, 2017, there were 994 AD SMs with a diagnosis of GD - (Panel IV slides)
- Service members with GD accounted for more than 30,000 mental health visits over a 2-year period. (Panel IV slides)
- **Individuals with untreated gender dysphoria have roughly a 25 times higher risk of suicide than cisgender individuals, (*Bauer, et al. BMC Public Health, 2015; Maguen and Shipherd, 2010)* but studies indicated that is largely due to an inability to transition or treat gender dysphoria. With treatment, suicidal ideation can significantly decrease. (Panel III minutes). Civilian medical experts agreed with that statistic, when asked. (Panel V minutes).**
- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)
- Between 67 and 77% of Service members have surgeries included in their treatment plans (Panel IV slides)

- Using limited data, the Army and Air Force reported that their transitioning Service members averaged 167.4 and 159 days of limited duty, respectively. The Navy, by policy, does not allow limited duty profiles for transition. (Panel IV slides)

- According to the 2015 U.S. Transgender survey, only 2% of completed Female-to-Male (FtM) transitions included genital reassignment surgeries. In Male-to-female (MtF) completed transitions, approximately 10% had genital reassignment surgery. The most common transition-related surgeries that can be performed in military treatment facilities are mastectomy (21% of FtM), hysterectomy (8% of FtM) and breast augmentation (8% of MtF). (Panel VI slides)

- The 2015 U.S. Transgender Survey shows that the military seems to have a higher prevalence of transgenderism than the greater American public. (Panel VI slides)

- The DASD-HA study cohort of 691 transgender Service members revealed: (Panel VII slides)
- The transgender population in the military is mostly under 40 years old (97%) and in the rank of E1-E4 (51%).
- Higher rates of mental health and psychotherapy encounters per individual (29.6) when compared to the control group that consisted of active duty service members with a mental health diagnosis (21.1)
- A higher rate of suicidal ideation than the control group that consisted of active duty service members with a mental health diagnosis (10.7 vs 6.2%).
- 69 Service members deployed following a primary diagnosis of gender dysphoria after July 1, 2016.

Readiness, Lethality, and Military effectiveness

- The vast majority of commanders agreed that from time of diagnosis to the completion of a transition plan, the SM would be non-deployable for 2-2.5 years (up to a year of hormones to achieve stability, then surgeries). (Panel I minutes) Transgender Service members maintained that most complex surgery (gender reassignment surgery) required six weeks of Convalescent Leave followed by an unspecified period of light duty. (Panel II minutes)

- The three genital reconstruction surgeries (vaginoplasty, phalloplasty, metoidioplasty), have as-yet unknown impacts on individual military readiness and that the deployability of individuals who had the surgeries would be an issue. Example: one Service member recently had a vaginoplasty and her medical treatment plan forecasted 10.5 months of non-deployability after the surgery. (Draft Panel VI minutes)

- One military physician stated that the surgical portion of a complete gender reassignment, would generally be scheduled as five or six surgeries over a 15-month period. (Panel III minutes)

- When asked about the percentages of transgender individuals that opted for medical procedures, the civilian medical experts provided the following information, based on their personal experience:

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	Male to Female (MtF) transitions	Female-to-Male (FtM) transitions
% that desire medical intervention	50	50
% (of above) that desire surgery	33	33
Desire cross-sex hormones	majority	Majority
Remarks	Majority of surgical procedures are chest augmentation surgery	Majority of surgical procedures are mastectomies

- One commander remarked about how it would be extremely difficult for a TG SM to operate in a SOCOM world with austere living conditions and non-emergency medical support not readily available. He also raised the issue that some military specialties, like air traffic controllers, have their standards set by another agency – in that case the FAA. The FAA does not allow an individual to control air traffic until they have been hormonally stable for 5 years, effectively closing that specialty to TG SMs. (Commanders, Panel I minutes)

- When asked what happens if an individual on cross-sex hormones was unable to take them for a period of time, a military physician stated that the answer depended on the specific situation. In short, side effects of cross-sex hormone withdrawal include increased fatigue, mood swings and decreased libido – and these symptoms are similar to those of a cisgender individual that stopped taking hormone supplements. The longer an individual was on cross-sex hormones when they had to stop, the more intense those symptoms would be. The same panelist remarked that there would likely be a decrease in combat ability for an individual who stopped taking their cross-sex hormones. (Panel III minutes) Transgender Service members who appeared before the panel had a different perspective. One of the Service members has been off of hormones for more than 2 years with little effect and another compared the side effects of skipping a week of hormones to a bad case of pre-menstrual syndrome. One of the Service members sometimes skips hormone injections and this leads to oily skin, and mood swings, both of which are manageable. (Panel III minutes) Civilian medical experts maintained that if a Service member was deployed and lost their cross-sex hormones, the most likely effect would just be an angry Service member. As a matter of routine in civilian care, the use of cross-sex hormones are halted before and after surgeries for a period of time without any issues. (Draft Panel V minutes) However, cross sex hormones can be provided in multiple ways – topical creams, injections or pills – so it is be unlikely that an individual would be unable to take cross-sex hormones anywhere in the world. (Panel III minutes) There are risks associated with cross-sex hormones, but they are small. Birth control pills contain more hormones than cross-sex hormones do. (Panel III minutes)

- Providing adequate mental health support to a deployed transgender Service member could be problematic - there are few deployed psychotherapists that could provide the required treatment for a transgender Service member prior to surgeries – and none in the most austere environments (e.g., Syria, Somalia). Mature theaters (Korea, Afghanistan) would likely be able to support transgender Service members with mental health and medical support. (Draft Panel VI minutes)

- Receiving a diagnosis of gender dysphoria takes approximately 6 months of counseling. (Panel III minutes)

- The civilian endocrinologist stated that it is safe to pause initiation/titration of dose of hormone treatments and/or stop hormones (may need to wean off) in order to accommodate deployments. It will just freeze the progress of the individual's transition. (Draft Panel V minutes)

Budgetary constraints

- Several commanders indicated a budgetary impact as they received no additional monies to pay for the numerous TDY trips throughout CONUS for specialized medical care and had to pay out of O&M Funds. (Panel I minutes)

- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)

Unit cohesion

- One commander spoke of his 'dueling' EO issues; his TG SM (a female with male genitalia), has an approved ETP for full-time real life experience and is authorized to use female shower facilities. This led to an EO complaint by the females assigned to the unit who believed their privacy was invaded by this. That led to an EO complaint by the TG SM claiming that the command was not supporting her rights.

Applicable laws, standards, and guidelines

- Statutorily, TRICARE is forbidden from paying for gender reassignment surgery. All transition-related surgeries must be processed through the Supplemental Health Care Program. In any case, if an individual does not meet required guidelines, the Department can refuse to perform the procedure until the individual meets all criteria contained in the guidelines. (Panel II minutes)

- The Military Health System follows the 2017 Endocrine Society guidelines for the treatment of gender dysphoria. (Panel VI slides) The recovery estimates contained within those guidelines are based on an assumption that the individual will return to their civilian life, which does not directly translate onto the military population and their unique requirements. The DoD will most likely have to develop its own military-specific recovery estimates that would likely be higher than the civilian estimates (Draft Panel VI minutes).

- The prevailing Endocrine Society guidelines are also the reason why an individual is non-deployable for the first 12 months of taking cross-sex hormones. (Panel III minutes). Both the military endocrinologist (Panel III) and the civilian endocrinologist (Panel IV) believed that an individual should be able to deploy after only six months of cross-sex hormones.

Deployability

Department of Defense Instruction (DoDI) 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, February 5, 2010 provides the following information:

Deployment: The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

Contingency Deployment: A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

DoD Policy states that DoD personnel may deploy if:

> "Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration." (Paragraph 4.3.b)

The DoDI also adds that

> "Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical capabilities of the deployment..." (Paragraph 4.e)

Enclosure 3 to the DoDI is entitled "*Medical conditions usually precluding contingency deployment*" and within it, the enclosure states:

> "Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity." (Paragraph b.1.)
>
> "Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment." (Paragraph b.5.)

The DoDI also charges the Joint Staff and COCOMs to develop their own medical standards for deployment into their area of operations. Using CENTCOM as an example, their medical deployment standards, contained in Modification 13 to *USCENTCOM Individual protection and individual – Unit deployment Policy* (March 23, 2017) states:

> "Deployed Health Service Support infrastructure is designed and prioritized to provide acute and emergency support to the Expeditionary mission. All personnel...travelling to

the CENTCOM AOR must be medically, dentally and psychologically fit." (Paragraph 15.C)

Questions and Answers

[redacted]

ADMIN DATA PRESENTED DURING PANEL MEETINGS
VERSION 2, UPDATES IN **RED**

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: December 13, 2017
Time: 1500-1730
Room: 3D1063

Overview:
The Panel will review minutes from previous meetings and will receive the brief created for the Deputy Secretary of Defense on 15 December. Any corrections to products going to the 15 December meeting will be updated during the meeting.

Subject	Speaker	Duration
Overview	HON Robert Wilkie	1500-1505
Presentation of Meeting Minutes	[redacted]	1505-1520
Pre-brief of DSD presentation	[redacted]	1520-1700

Meeting Homework/Deliverables:
Approve meeting 6, 8 and 9 minutes; approve DSD Brief

Save the following dates for upcoming meetings: DSD/VCJCS meeting is scheduled for 1530, 15 December.

Administrative:
Questions or issues please contact, [redacted].

Data extracts

Key information used by the Panel to make reccomendations.

PERSONNEL AND READINESS

Transgender Service

- Medical costs for treating Gender Dysphoria (GD) have risen from ~ $660K in FY16 to ~ $2.2M in FY17.
- Since policy implementation, the medical costs for SMs with GD has increased nearly 3 times compared to a non-GD Service member.
- A limited review of administrative data indicates that transgender Service members with gender dysphoria have an 8x higher rate of suicidal ideation than Service members as a whole (12% vs. 1.5%). Transgender SMs with Gender Dysphoria have a 9x higher rate of mental health encounters than Service members as a whole (28.1 vs 2.7). The latest Status of Forces survey shows 14% indicated a suicide ideation at one point in their life for all survey respondents (not limited to TG). The 2015 U.S. TG survey indicated an overall suicide ideation rate of 37% with a supportive family, 54% with an unsupportive family.
- Between 67% and 77% of Service members have surgeries included in their treatment plans; this percentage may be high due to DoD transition policy requiring all medically necessary care to be included in a treatment plan in advance of treatment.
- 34 (non-genital) sex reassignment surgeries have been performed in the direct and purchase care systems. Currently, there are 22 SMs requesting a waiver for genital surgery (evaluations or surgery). One genital surgery has been completed in purchased care.
- Data provided shows that for non-genital surgeries (assuming no complications), the range of recovery is between 2 and 8 weeks. Genital surgeries range between 3 and 6 months before the individual was fully prepared to return to duty.
- Currently available in-service data showed that transitioning Service members in the Army and Air Force averaged 167.4 and 159 days of limited duty, respectively cumulatively for transition over a 1 year period.
- Endocrine Society guidelines for cross-sex hormone therapy recommends 12 months of monitoring of hormone levels, which could result in a period of 12 months of worldwide non-deployability.
- 69 out of 994 Service members deployed following a diagnosis of gender dysphoria since July 1, 2016.

Cost of Services for Gender Dysphoria

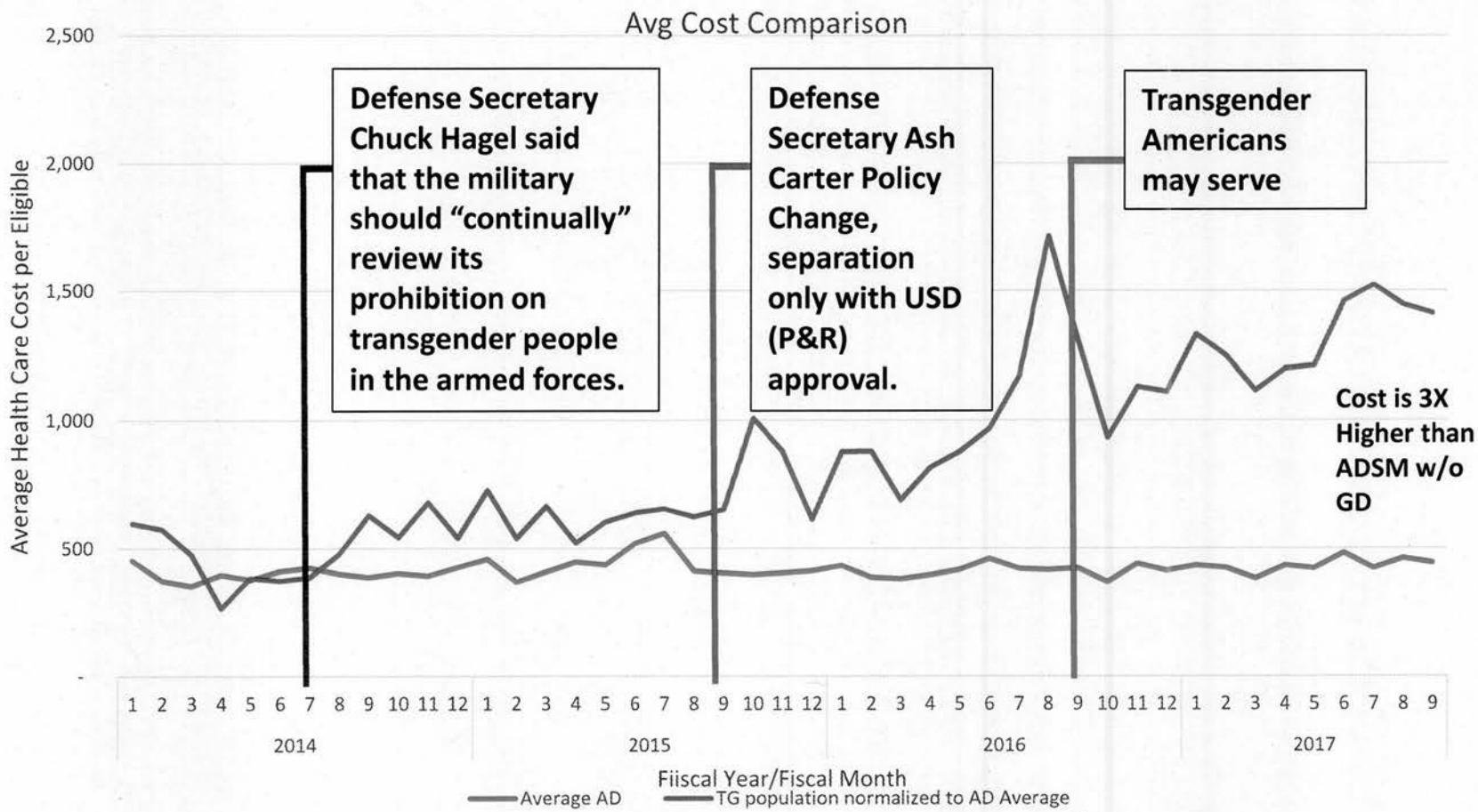
(Purchased Care Paid Costs; Direct Care Estimated Costs)

	FY14	FY15	FY16	FY17	TOTAL
Direct Care	$ 82,558	$ 83,563	$ 650,492	$ 2,172,849	$ 2,989,462
Purchased Care	$ 5,421	$ 3,884	$ 10,094	$ 16,509	$ 35,908
Pharmacy	$ 1,264	$ 2,693	$ 3,406	$ 6,130	$ 13,493
TOTAL	$ 89,243	$ 90,140	$ 663,992	$ 2,195,488	$ 3,038,863

Supports Bullet 1

Average Health Care Expenditures:

Transgender Active Duty (TRICARE Prime) vs Average Active Duty



Supports Bullet 2

Results – Study Cohort vs. Age-Gender Matched AD SMs

Average Encounters per Service Member

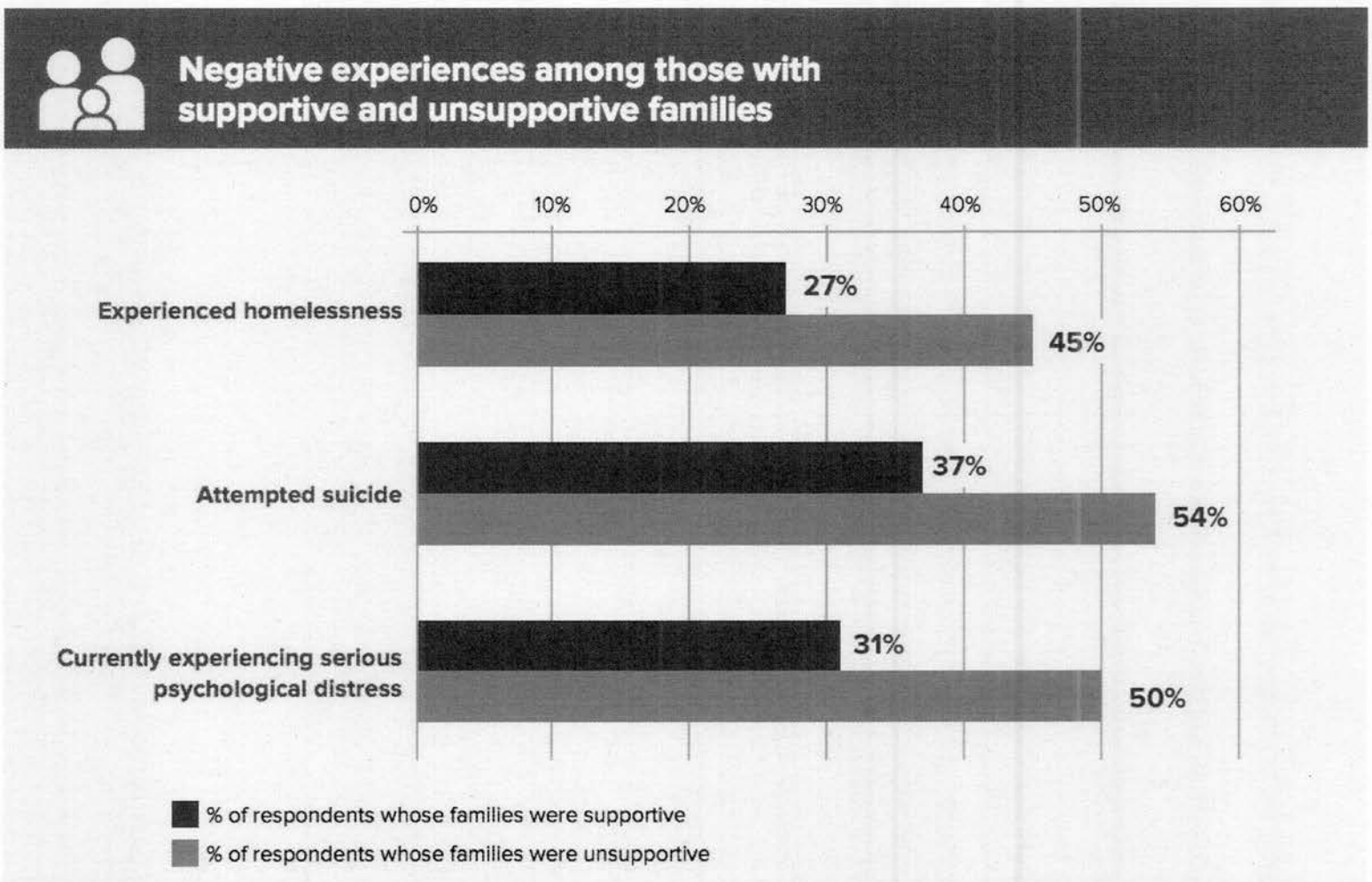
	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Any Mental Health	28.1	1.5	10.4	0.1	TG > C	TG > C
Psychotherapy	20.7	NA	9.2	NA	TG > C	NA

Total Number of Individuals for SI, Hormones and Procedures

	STUDY COHORT		CONTROLS		COMPARISONS	
	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient
Suicidal Ideation	74 (10.7%)	41 (5.9%)	47 (1.4%)	19 (0.5%)	TG > C %	TG > C %
Cross-sex Hormone Therapy	352	NA	4	NA	TG > C	NA
Breast Augmentation	0	0	2	0	C > TG	No diff
Breast Reduction	7	3	1	5	TG > C	C > TG
Facial Feminization/ Masculinization	3	0	8	0	C > TG	No diff
Genital Surgery	3	0	3	1	No diff	No diff
Hysterectomy	NA	16	NA	9	NA	TG > C
Voice Therapy	25	NA	18	NA	TG > C	NA

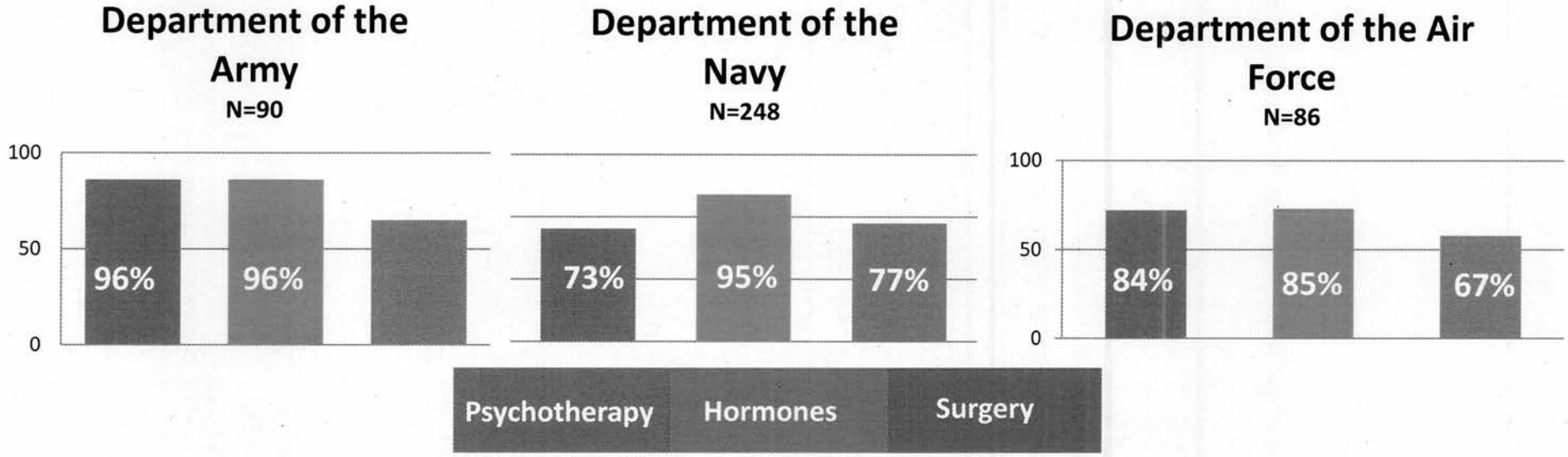
Supports Bullet 3

2015 U.S. Transgender Survey



Supports Bullet 3

Service Data – Approved Treatment Plans*



	ARMY	NAVY	AIR FORCE
Number of Service Members with surgeries as part of treatment plan^	65	190	58
Percent of Treatment Plans with surgery included	72%	77%	67%

**Services only had access to treatment plans submitted to their TG care teams (TGCT/MMDT)*
^A Civilian study shows that 23% of MtF and 2% FtM TG individuals initially wanting surgery actually have surgery.

Supports Bullet 4

Surgeries in Study Cohort, FY2016 to Present

Direct Care and Purchased Care

SERVICE		Resection of Uterus/ Hysterectomy	Mastectomy	Excision Procedures on the Testes	Totals
Air Force	Active Duty	3			3
	Guard/Reserve				
Army	Active Duty	6	5	2	13
	Guard/Reserve		1		1
Marine Corps	Active Duty	1	6		7
	Reserve				
Navy	Active Duty	4	3	2	9
	Guard/Reserve	1			1
Totals		**15**	**15**	**4**	**34**

Supports Bullet 5

Procedure	Estimated Recovery Time (assumes no complications)	Estimate on how many may desire*	Notes
Hysterectomy (laproscopic approach, recommended)	4 weeks desk job 6-8 weeks unrestricted	128/313	(data for all indications) Major complication = 9.5% Minor complication = 28%
Hysterectomy (abdominal approach) with or w/o Oopherectomy	6-8 weeks unrestricted		(data for all indications) Major complication = 6% Minor complication = 27%
Chest masculinization (Mastectomy)	2-4 weeks (desk job) 4-6 weeks (physically demanding job)	151/313	Low complications
Phalloplasty* (can be 2 stages, 2nd surgery 9-12 mos later)	6 weeks desk job 8-12 weeks return to activity 3 months unrestricted	151/313	Recommends stay in area of hospital where procedure performed for up to 2 weeks
Metoidioplasty** (can be done in 2 stages, 2nd stage performed >/=3 mos later)	3 weeks desk job 6 weeks return to activity 8 weeks unrestricted	151/313	• Recommends stay in area of hospital where procedure performed for up to 3 weeks • <5% complication rate
Orchiectomy	3-4 weeks desk job 6 weeks unrestricted activity	75/313	Very low complications
Vaginoplasty	6 weeks desk jobs (some restrictions) 6-8 weeks resume physical activity 3 months for unrestricted activity	151/313	• Recommends stay in area of hospital where procedure performed for up to 2 weeks • Major complications rare • Minor complications ~25%, most soon after surgery

Supports Bullet 6

SERVICE DATA – Profiles/LIMDUs/Restricted Duty

	Department of the Army*	Department of the Navy**		Department of the Air Force***
Number of Service Members with a diagnosis of Gender Dysphoria on Profile/ LIMDU/Restricted Duty	87 (90)	22 (248)		52 (86)
Average Number of Profiles/LIMDUs/Restricted Duty per transitioning SM	3.4	0.1		1.9
Average number of days a transitioning Service Member is in a Profile/LIMDU/Restricted Duty status	167.4	1-90	3	159
		90-180	12	
		180-270	3	
		270-360	2	
		>360	2	
Range of Days on Profile	0 - 537	1 - 360+		1 - 365

UPDATED 2 NOV

Supports Bullet 7

Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: 2017 Endocrine Society Guidelines

		Transgender Male (F to M)			Transgender Female (M to F)		
		Initial	Follow up		Initial	Follow up
Bloodwork	Testosterone	Every 3 months until reaches normal physiologic male range	1 – 2 times per year	Testosterone	Every 3 months	1 – 2 times per year
	Hematocrit & Hemoglobin	Every 3 months for first year	1 - 2 time per year	Estrogen	Every 3 months	1 – 2 times per year
	Lipids	Regular intervals		Electrolytes (K)	Every 3 months for first year	Yearly
				Prolactin	Annually during transition	Every 2 years when stable
Physical Exam		Every 3 months for first year	1 - 2 times per year		Every 3 months for first year	1 - 2 times per year
Other	Screening for osteoporosis		Yearly	Routine Cancer screening		Yearly
	Female cancer screening as appropriate		Yearly	Osteoporosis		Begin at age 60
	Cardiovascular Risks		Yearly	Cardiovascular Risks		Yearly

Supports Bullet 8

Cohort Deployment History (All OCONUS)

994

- Cohort of Service members with a primary diagnosis of gender dysphoria – FY2016 to July 2017

393

- Deployed in support of OEF/OIF/OND

114

- Deployed following a primary diagnosis of gender dysphoria

69

- Deployed following a primary diagnosis of gender dysphoria AND after July 1, 2016

Supports Bullet 9

Health Data on Active Duty Service Members with Gender Dysphoria

Comparison health care data with statistical analysis, deployment, treatment plan, surgical recovery times, separation data and cost data

December 13 2017

Gender Dysphoria (GD) Medical Utilization Comparisons Methodology

- Reviewed select medical utilization (i.e., mental health visits/admissions, hormones, surgical and other procedures) for the Study Group of 994 TG service members with GD
  - Limited the group studied to those in an Active Duty or Activated Guard status for the entire period of time from FY16 to current (July 2017)
- Final GD Study Group = 691
  - Study Period: Oct 2015 to July 2017 (22 months)

Medical Utilization Comparisons Methodology

Created two control groups:

- **"MH+ Control Group"** - Matched 5:1 with non-TG service members by:
  - Major Depressive Disorder (Yes/No)
  - Anxiety (Yes/No)
  - Adjustment Disorder (Yes/No)
  - Matching included gender, age group (<25, 25-40, 40+), rank group, Service
  - MH+ Control Cohort = 3,455
- **"AG Control Group"** - Matched 5:1 with non-TG service members by:
  - Matching included age group (<25, 25-40, 40+) and gender
  - AG Control Cohort = 3,455
- Study Period Oct 2015 – July 2017

Study Group Descriptive Data

		STUDY GROUP Count	STUDY GROUP Percentage
Study Group Size	**N**	**691**	**100%**
Age Group	<25	281	41%
	25-40	388	56%
	40>	22	3%
Gender	Female	349	51%
	Male	342	49%
Sponsor Service	Army	226	33%
	Air Force	188	27%
	Marines	38	5%
	Navy	216	31%
	Other	23	3%
Rank Group	Jr Enlisted	354	51%
	Sn Enlisted	293	42%
	Officer	44	6%

Descriptive Data (continued)

		STUDY COHORT Count	STUDY COHORT Percentage
Study Group Size	**N**	**691**	**100%**
Major Depressive Disorder	No	529	77%
	Yes	162	23%
Adjustment Disorder	No	488	71%
	Yes	203	29%
Anxiety Disorder	No	543	79%
	Yes	148	21%

- The Age-Gender matched 'AG Control Group' - Major Depressive Disorder, Anxiety, and Adjustment were not very prevalent

Regression Analysis

- Multiple regression models were run for both control groups to assess if there is significant difference between the study and control groups regarding psychotherapy and any mental health utilization.
- Dependent Variables of Interest
  - Psychotherapy visits
  - Any mental health visits
- Regressions controlled for combinations of the following independent variables:
  - Age Group
  - Gender
  - Rank (officer vs. enlisted)
  - Service
  - Presence of MH Conditions
    - Major Depressive Disorder, Anxiety or Adjustment

Summary of Results: Psychotherapy Encounters

	STUDY GROUP (n=691)		MH+ CONTROL GROUP (n=3455)		AG CONTROL GROUP (n=3455)	
	Outpatient (Oct 2015-July 2017)		Outpatient (Oct 2015-July 2017)		Outpatient (Oct 2015-July 2017)	
	Avg. Encounters per service member	Total Encounters	Avg. Encounters per service member	Total Encounters	Avg. Encounters per service member	Total Encounters
Psychotherapy	**20.4**	**14,088**	**7.9**	**27,237**	**1.99**	**6,864**

- After controlling for age, sex, rank, service, and presence of any of the three mental health disorders (MDD, Anxiety, Adjustment), there is a **statistically significant** effect in psychotherapy utilization between study group and both control groups.
  - Individuals in the Study Group (GD) on average generate **13 more psychotherapy encounters** over a **22 month period**.
  - The Study Group had 2.5 x the number of psychotherapy visits than the MH control group and 10 x the number of visits than the age and gender matched control group

Summary of Results: Any Mental Health Encounters

	STUDY GROUP (n=691)		MH+ CONTROL GROUP (n=3455)		AG CONTROL GROUP (n=3455)	
	Outpatient (Oct 2015-July 2017)		Outpatient (Oct 2015-July 2017)		Outpatient (Oct 2015-July 2017)	
	Avg. Encounters per service member	Total Encounters	Avg. Encounters per service member	Total Encounters	Avg. Encounters per service member	Total Encounters
Any Mental Health	**28.1**	19,379	**10.7**	36,818	**2.69**	9,297

- After controlling for age, sex, rank, service, and presence of any of the three mental health disorders (MDD, Anxiety, Adjustment), there is a **statistically significant** effect in mental health utilization between study group and both control groups.
  - Individuals in the Study Group (GD) on average generate **18 more mental encounters** over a **22 month period**.
  - The Study Group had 9 x the number of MH visits than the age and gender matched group
  - The Study Group had over 2.5 x as many MH visits as the MH control group

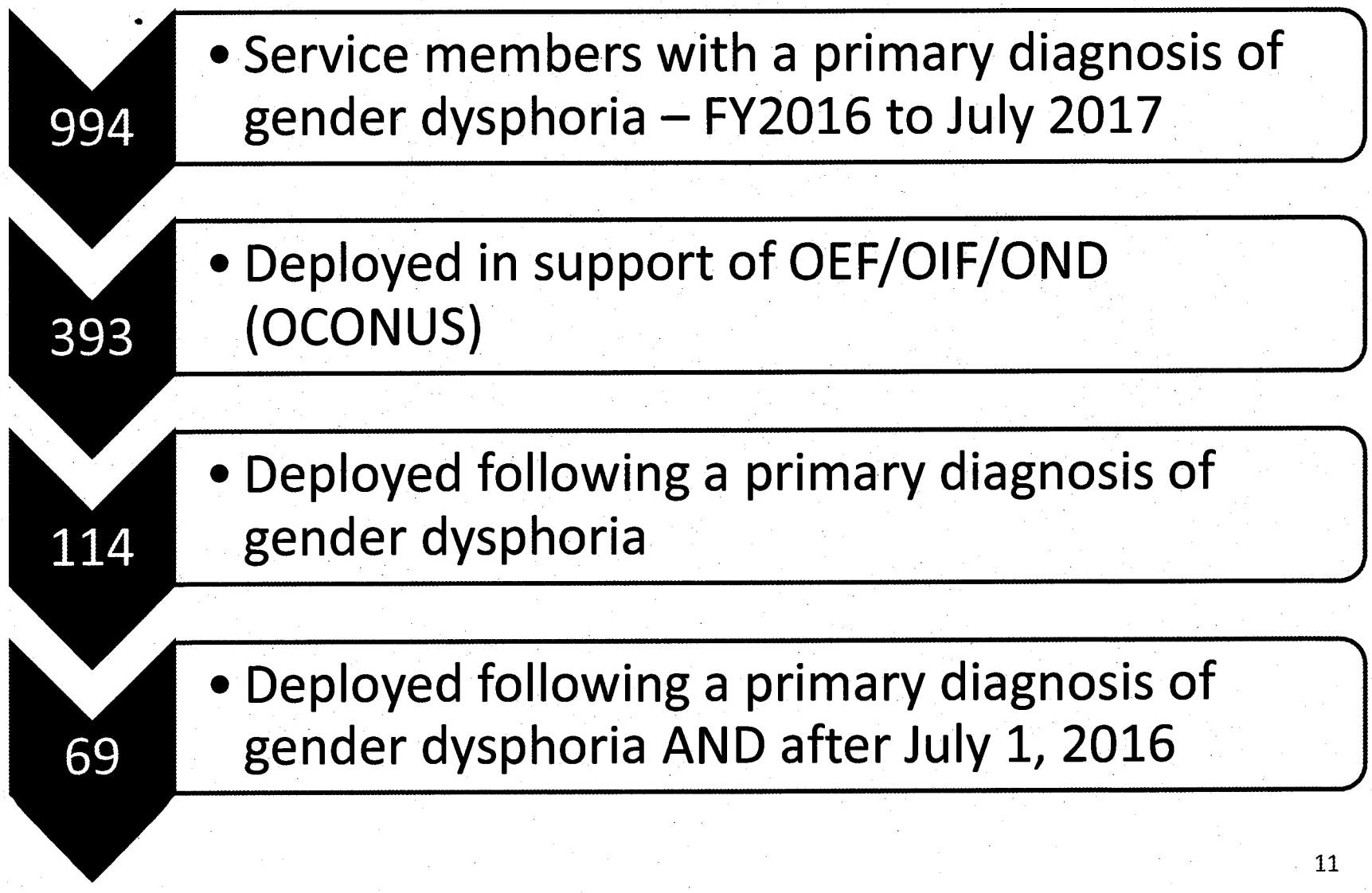
Summary of Results: Suicidal Ideation

	STUDY GROUP (n=691)		MH+ CONTROL GROUP (n=3455)		AG CONTROL GROUP (n=3455)	
	(Inpatient and Outpatient) (Oct 2015-July 2017)		(Inpatient and Outpatient) (Oct 2015-July 2017)		(Inpatient and Outpatient) (Oct 2015-July 2017)	
	Individuals Receiving Treatment	Percentage	Individuals Receiving Treatment	Percentage	Individuals Receiving Treatment	Percentage
Suicidal Ideation	**81**	12%	**235**	7%	**52**	1.5%

- Also ran multiple logistic regressions to calculate the odds ratio of suicidal ideation while controlling for age and gender.
  - Only 12% of our Study Group reported suicidal ideation compared to the 25% reported in one civilian sector study.
  - The Study Group had an 8 x higher rate of suicide ideation than age and gender matched AD SMs over a 22 month period.
    - **Result is statistically significant**
    - Note: The AG Control Group did not have sufficient suicidal ideation prevalence for analysis.

DEPLOYMENT DATA

Study Group Deployment History



Cohort Deployment History

114

- Deployed following a primary diagnosis of gender dysphoria

6

- Were medically evacuated from CENTCON following a primary diagnosis of gender dysphoria
- 4 had a mental health diagnosis identified as the reason for evacuation

69

- Deployed following a primary diagnosis of gender dysphoria AND after July 1, 2016

3

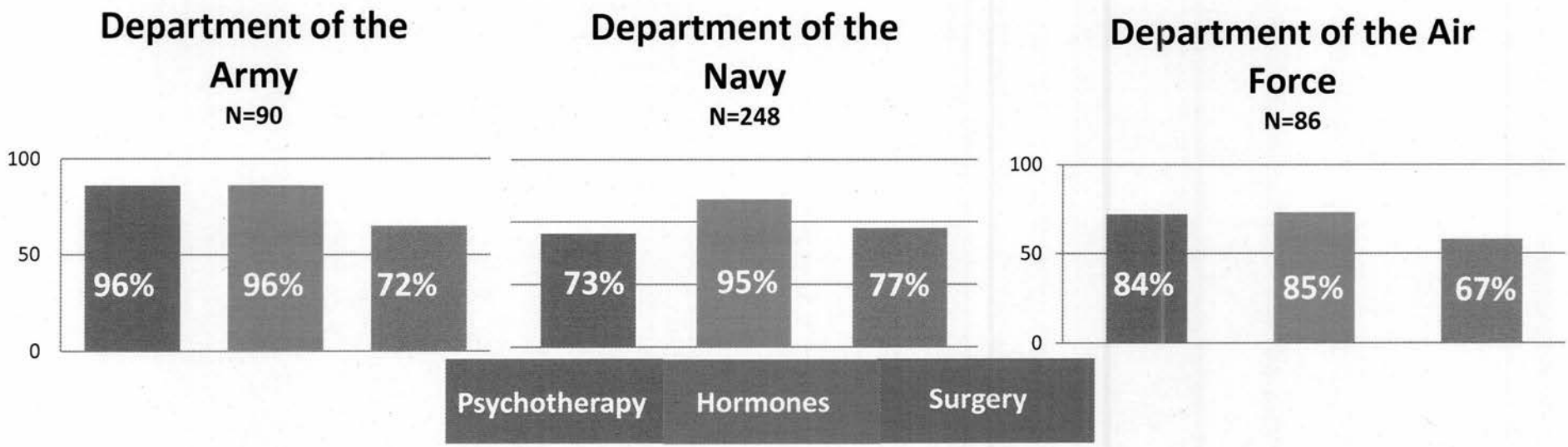
- Were medically evacuated from CENTCOM following a primary diagnosis of gender dysphoria AND after July 1, 2016
- 1 had a mental health diagnosis identified as the reason for evacuation

TREATMENT PLAN DATA

Service Data Request

- Data collection will cover the time period from **September 1, 2016, to August 31, 2017**
- Data request included:
  - Number of SMs with approved treatment plans
  - Number of SMs receiving psychotherapy and cross-sex hormones as part of the treatment plan
  - Number of SMs with sex reassignment surgery as part of the treatment plan
  - Total number of profiles/LIMDUs and days on restricted duty for each transitioning SM
  - Total number of days on profile/LIMDU/restricted duty
- Army, Navy and Air Force coordinated definitions and methodologies of collection for data elements

Service Data – Approved Treatment Plans*



	ARMY	NAVY	AIR FORCE
Number of Service Members with surgeries as part of treatment plan^	65	190	58
Percent of Treatment Plans with surgery included	72%	77%	67%

**Services only had access to treatment plans submitted to their TG care teams (TGCT/MMDT)*
^A Civilian study shows that 23% of MtF and 2% FtM TG individuals initially wanting surgery actually have surgery.

SERVICE DATA – Types of Surgeries Included in Treatment Plans

	ARMY	NAVY	AIR FORCE
Hysterectomy/Oophorectomy	**	97	14
Orchiectomy	**	61	12
Mastectomy/Augmentation	**	113	38
Genital Reassignment	**	118	19
Other	-	-	27

* An individual service member may have more than one surgical procedure in their treatment plan
** Army responded this level of detail is not consistently provided or individualized in proposed medical treatment plans on file.

SERVICE DATA – Profiles/LIMDUs/Restricted Duty

	ARMY*	NAVY**		AIR FORCE***
Number of Service Members with a diagnosis of Gender Dysphoria on Profile/LIMDU/Restricted Duty	87 (90)	22 (248)		52 (86)
Average Number of Profiles/LIMDUs/Restricted Duty per transitioning SM	3.4	0.1		1.9
Average number of days a transitioning Service Member is in a Profile/LIMDU/Restricted Duty status	167.4	1-90	3	159
		90-180	12	
		180-270	3	
		270-360	2	
		>360	2	
Range of Days on Profile	0 - 537	1 - 360+		1 - 365

* **Army** – profiles for SMs with GD; indication for profile not known; could be for transition or for other indications.
** **Navy** - policy dictates no LIMDU for gender transition. All LIMDUs are for non-transition indications. SMs undergoing transition are non-deployable for the first 3 to 6 months of hormone therapy but not put on LIMDU. Navy provided Avg. Number of days on LIMDU in block times.
*** **Air Force** - profiles are for transition.

SURGICAL RECOVERY TIME DATA

Estimated Recovery Times, by Surgery*

Selected Surgical Procedure	Average Recovery Time (assumes no complications)	Notes
Hysterectomy*/** (laparoscopic approach, recommended)	4 weeks desk job 6-8 weeks unrestricted activity	(data for all indications) Major complication = 9.5% Minor complication = 28%
Hysterectomy* (abdominal approach) with or w/o Oophorectomy	6-8 weeks	(data for all indications) Major complication = 6% Minor complication = 27%
Chest masculinization* (Mastectomy)	2-4 weeks (desk job) 4-6 weeks (physically demanding job)	Low complications
Orchiectomy*	3-4 weeks desk job 6 weeks unrestricted activity	Very low complications
Vaginoplasty**	6 weeks desk jobs (some restrictions) 6-8 weeks resume physical activity 3 months for unrestricted activity	• Recommend stay in area of hospital where procedure performed for up to 2 weeks • Major complications 1.5%-10% • Minor complications ~25%,self limiting
Phalloplasty** (2 stages, 2nd surg 9-12 mos later)	6 weeks desk job 8-12 weeks return to activity 3 months unrestricted	• Recommends stay in area of hospital where procedure performed for up to 3 weeks/complications 10-80%
Metoidioplasty** (2 stages, 2nd stage performed >/=3 mos later)	3 weeks desk job 6 weeks return to activity 8 weeks unrestricted	• Recommends stay in area of hospital where procedure performed for up to 3 weeks • <5% complication rate

*From Mayo Clinic, UCSF Center of Excellence for Transgender Health websites and **Dr. Loren Schechter

Estimated Recovery Time for Vaginoplasty from Two SHCP Waiver Requests*,**

PROCEDURE	CENTER	RECOVERY TIMES				
		Inpatient	Post-op Bedrest	Con leave	Light duty	Non-deployable
Vaginoplasty	Papillon Center New Hope, PA	6 days	3 days	6 weeks	2-3 months	6 months
Vaginoplasty	Papillon Center	6 days	3 days	6 weeks	2-3 months	6 months

Times are not cumulative; total non-deployable = 6 months

****Information from the Defense Health Agency***

Surgeries in Study Group, FY2016 to Present
Includes Direct Care and Purchased Care

SERVICE		Resection of Uterus/ Hysterectomy	Mastectomy	Excision Procedures on the Testes	Totals
Air Force	Active Duty	3			3
Army	Active Duty	6	5	2	13
	Guard/Reserve		1		1
Marine Corps	Active Duty	1	6		7
Navy	Active Duty	4	3	2	9
	Guard/Reserve	1			1
Totals		**15**	**15**	**4**	**34**

33 procedures were performed in MTFs, 1 in Purchased Care.
Of the 34 procedures performed, 25 were for an indication of GD

Time to Return to Full Duty After Transition Surgery in MTFs

- The Services and NCR were requested to provide actual recovery times (times to return to full duty) for gender transition surgeries performed in the MTFs
- Surgeries performed included mastectomies, hysterectomies, orchiectomies and facial feminization
- Recovery times were available for 36 procedures performed in 13 different MTFs
  - 6 Army
  - 4 Navy
  - 1 Air Force
  - 2 NCR

MASTECTOMY

CPT Code 19303-19304

	Primary Procedure Code	# Days to Full Duty	Comments
Army	19303	30	
Army	19303	14	
Army	19304	75	
Army	19394	42	
Army	19304	28	
Army	19304	27	
Navy	19303	42	Average # Days = 39 Range 14 - 75
Navy	19303	42	
Navy	19303	42	
Navy	19303	42	
Navy	19304	42	
Navy	19303	42	
Navy	19303	42	
Navy	19303	42	
Navy	19304	42	
NCR	19304	30	

HYSTERECTOMY

CPT Code OUT9FZZ

	Primary Procedure Code	# Days to Full Duty	Comments
Army	OUT9FZZ	68	Average # Days = 67 Range 30 – 237 (Avg # days w/o AF = 55)
Army	OUT9FZZ	42	
Army	OUT9FZZ	42	
Army	OUT9FZZ	87	
Army	OUT9FZZ	96	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	56	
Navy	OUT9FZZ	60	
Navy	OUT9FZZ	45	
Navy	OUT9FZZ	45	
Air Force	OUT9FZZ	237	
NCR	OUT9FZZ	31	
NCR	58262	30	

ORCHIECTOMY

CPT Code 54520

	Primary Procedure Code	# Days to Full Duty	Comments
Army	54520	45	Average # days = 38.3 Range 35-45
Navy	54520	35	
Navy	54520	35	

OTHER PROCEDURES

	Procedure (s)	# Days to Full Duty	Comments
Army	Facial Feminization	42	1 case
Army	Hysterectomy & Mastectomy	89	Procedures performed two months apart

SEPARATION DATA

Separation Data

Cohort members	993*
Cohort members that are continuously AD 10/1/2015-7/1/2017	691
Cohort members who may have separated	302
Cohort members who may have separated in separation file	194
Unknown	108

*1 of the original 994 was not found in DEERS

Reason for Separation

High to Low Comparison

Study Cohort

	Frequency	Percent
Expiration of term of service	74	38.14
Temporary disability retirement	19	9.79
Permanent disability retirement	12	6.19
Unqualified for active duty, other	9	4.64
Disability, severance pay	8	4.12
Retirement, 20 to 30 years of service	8	4.12
Drugs	8	4.12
Early release, in the national interest	7	3.61
Character or behavior disorder	7	3.61
Officer commissioning program	6	3.09
Failure to meet weight or body fat standards	5	2.58
Military service academy	4	2.06
Pattern of minor disciplinary infractions	3	1.55
Commission of a serious offense	3	1.55
Failure to meet minimum qualifications for retention	3	1.55
Other	3	1.55
Alcoholism	2	1.03
Court-martial	2	1.03
Juvenile offender	2	1.03
Erroneous enlistment or induction	2	1.03
Condition existing prior to service	1	0.52
Discreditable incidents, civilian or military	1	0.52
Unfitness, reason unknown	1	0.52
Unsatisfactory performance (former Expeditious Discharge program)	1	0.52
Entry level performance and conduct (former Trainee Discharge program)	1	0.52
Secretarial authority	1	0.52
Breach of contract	1	0.52
Total	194	

Percentages of all Separations for the Same reasons from 10/1/2015 - 7/1/2017

(not matched, taken from entire set of 408,409 SMs separated)

	Frequency	Percent
Expiration of term of service	197,959	48.47
Retirement, 20 to 30 years of service	39,925	9.78
Unqualified for active duty, other	18,979	4.65
Disability, severance pay	11,480	2.81
Permanent disability retirement	10,801	2.64
Temporary disability retirement	10,408	2.55
Officer commissioning program	9,691	2.37
Entry level performance and conduct (former Trainee Discharge program)	9,176	2.25
Unsatisfactory performance (former Expeditious Discharge program)	9,061	2.22
Drugs	8,836	2.16
Early release, in the national interest	8,603	2.11
Commission of a serious offense	6,979	1.71
Failure to meet weight or body fat standards	6,064	1.48
Other	5,147	1.26
Erroneous enlistment or induction	4,105	1.01
Discreditable incidents, civilian or military	3,538	0.87
Juvenile offender	2,618	0.64
Character or behavior disorder	2,480	0.61
Failure to meet minimum qualifications for retention	2,386	0.58
Pattern of minor disciplinary infractions	1,508	0.37
Court-martial	1,216	0.3
Military service academy	1,213	0.3
Alcoholism	1,081	0.26
Unfitness, reason unknown	692	0.17
Secretarial authority	624	0.15
Condition existing prior to service	475	0.12
Breach of contract	135	0.03

Reason for Separation

Alphabetical Comparison

Study Cohort

	Frequency	Percent
Alcoholism	2	1.03
Breach of contract	1	0.52
Character or behavior disorder	7	3.61
Commission of a serious offense	3	1.55
Condition existing prior to service	1	0.52
Court-martial	2	1.03
Disability, severance pay	8	4.12
Discreditable incidents, civilian or military	1	0.52
Drugs	8	4.12
Early release, in the national interest	7	3.61
Entry level performance and conduct (former Trainee Discharge program)	1	0.52
Erroneous enlistment or induction	2	1.03
Expiration of term of service	74	38.14
Failure to meet minimum qualifications for retention	3	1.55
Failure to meet weight or body fat standards	5	2.58
Juvenile offender	2	1.03
Military service academy	4	2.06
Officer commissioning program	6	3.09
Other	3	1.55
Pattern of minor disciplinary infractions	3	1.55
Permanent disability retirement	12	6.19
Retirement, 20 to 30 years of service	8	4.12
Secretarial authority	1	0.52
Temporary disability retirement	19	9.79
Unfitness, reason unknown	1	0.52
Unqualified for active duty, other	9	4.64
Unsatisfactory performance (former Expeditious Discharge program)	1	0.52
Total	194	

Percentages of All Separations for the Same Reasons from 10/1/2015 - 7/1/2017 (not matched, taken from entire set of 408,409 SMs separated)

	Frequency	Percent
Alcoholism	1,081	0.26
AWOL or desertion	284	0.07
Breach of contract	135	0.03
Character or behavior disorder	2,480	0.61
Civil court conviction	267	0.07
Commission of a serious offense	6,979	1.71
Condition existing prior to service	475	0.12
Court-martial	1,216	0.3
Disability, severance pay	11,480	2.81
Discreditable incidents, civilian or military	3,538	0.87
Drugs	8,836	2.16
Early release, in the national interest	8,603	2.11
Entry level performance and conduct (former Trainee Discharge program)	9,176	2.25
Erroneous enlistment or induction	4,105	1.01
Expiration of term of service	197,959	48.47
Failure to meet minimum qualifications for retention	2,386	0.58
Failure to meet weight or body fat standards	6,064	1.48
Juvenile offender	2,618	0.64
Military service academy	1,213	0.3
Officer commissioning program	9,691	2.37
Other	5,147	1.26
Pattern of minor disciplinary infractions	1,508	0.37
Permanent disability retirement	10,801	2.64
Retirement, 20 to 30 years of service	39,925	9.78
Secretarial authority	624	0.15
Temporary disability retirement	10,408	2.55
Unfitness, reason unknown	692	0.17
Unqualified for active duty, other	18,979	4.65
Unsatisfactory performance (former Expeditious Discharge program)	9,061	2.22

COST DATA

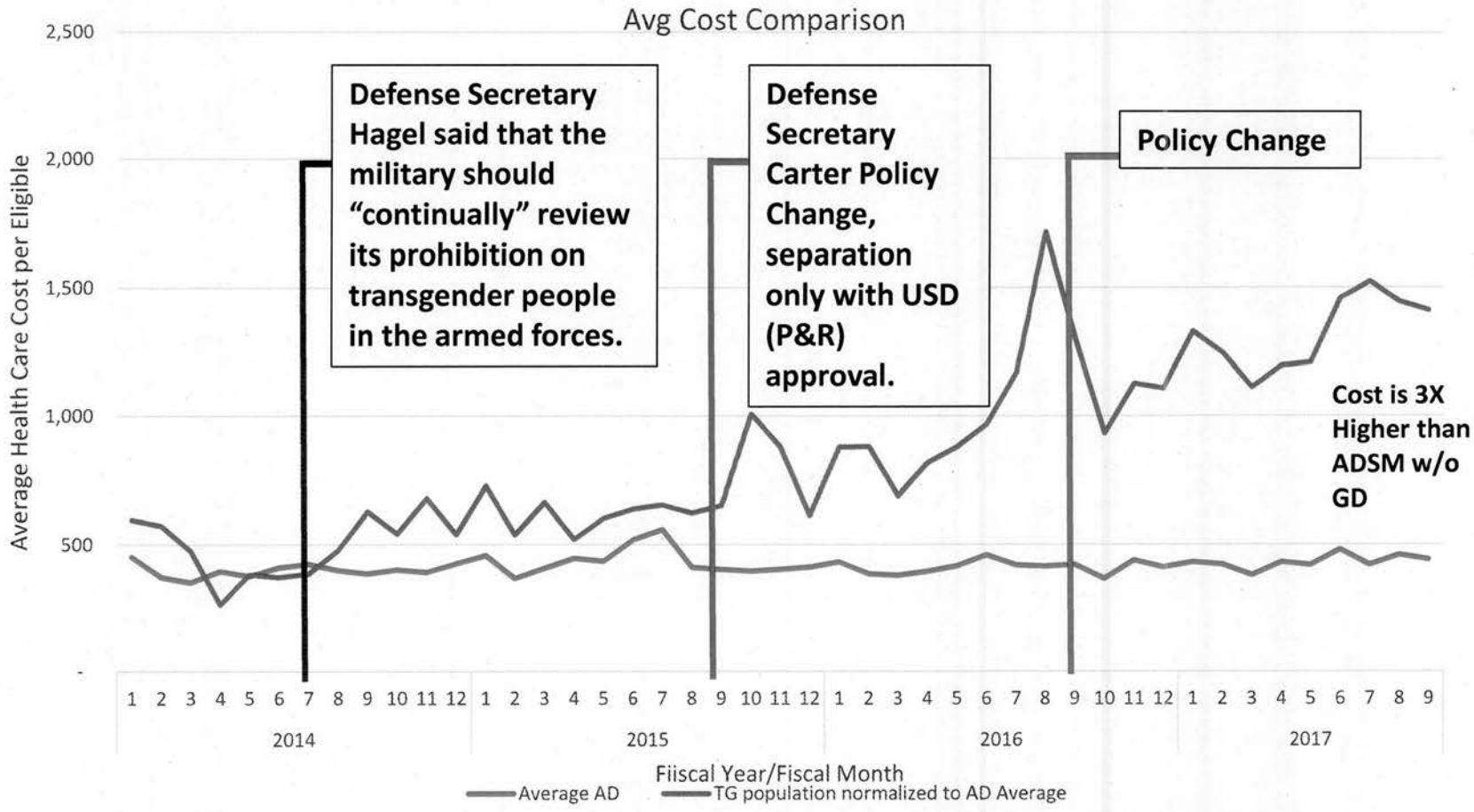
Cost of Services for Gender Dysphoria

(Purchased Care Paid Costs; Direct Care Estimated Costs)

	FY14	FY15	FY16	FY17	TOTAL
Direct Care	$ 82,558	$ 83,563	$ 650,492	$ 2,172,849	$ 2,989,462
Purchased Care	$ 5,421	$ 3,884	$ 10,094	$ 16,509	$ 35,908
Pharmacy	$ 1,264	$ 2,693	$ 3,406	$ 6,130	$ 13,493
TOTAL	$ 89,243	$ 90,140	$ 663,992	$ 2,195,488	$ 3,038,863

Average Health Care Expenditures:

Transgender Active Duty (TRICARE Prime) vs Average Active Duty



Source: M2 (Purchased Care: Inpatient (TED-I); Professional (TED-NI)); (Direct Care: Inpatient (SIDR); Professional (CAPER)); Pharmacy (PDTS); Population (DEERS)

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[redacted]

Guidance

SECDEF guidance: "Consistent with [DoD goals for] military effectiveness and lethality, budgetary constraints, and applicable law, the implementation plan will establish the policy, standards and procedures for transgender individuals serving in the military."

P&R Guidance: Using the SecDef's criterion of consistency with DoD goals for military effectiveness and lethality, while mindful of budgetary constraints and applicable law, the Panel must provide recommended answers to several questions.

1. Will the Panel recommend that the DoD begin accessing transgender individuals?
2. Will the Panel allow for in-service transition in the future? If so, what will be allowed and what will not be?
3. If the Panel recommends that future transitions be disallowed, what does the Panel recommend concerning the currently serving transgender population?

The Transgender Working Group, chaired by the Director, Accession Policy will incorporate the Panel's recommendations into a revision of the current DoDI that sets forth the standards and processes that will apply to transgender Service members. This working group will also develop the implementation plan to support that DoDI revision.

Dignity & Respect "First and foremost, we will continue to treat every Service Member with dignity and respect." - SecDef Interim Guidance, September 14, 2017

Medically necessary care: "Service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. As directed by the Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex." – SecDef Interim Guidance, 14 September 2017.

Accessions policy: "The procedures set forth in DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, dated April 28, 2010 (Change 1), which generally prohibit the accession of transgender individuals into the Military Services, remain in effect because current or history of gender dysphoria or gender transition does not meet medical standards, subject to the normal waiver process." - SecDef Interim Guidance, September 14, 2017.

Retention policy: "An otherwise qualified transgender Service member whose term of service expires while [the] Interim Guidance remains in effect, may, at the Service member's request, be re-enlisted in service under existing procedures." - SecDef Interim Guidance, September 14, 2017.

Definitions

Gender Dysphoria (Diagnostic and Statistical Manual of Mental Disorders version 5 which is the basis for the classification code used for documenting military medical diagnoses): In adolescents and adults, gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Gender Incongruence: not applicable for the purposes of the Panel's deliberations.

Medically necessary: Those health-care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine. (Transgender Work Group)

Medical Treatment Plan: The plan, developed between the patient and health care provider, that outlines the steps anticipated for the patient's transition to the opposite sex. (Transgender Work Group)

Sex Reassignment Surgery or gender affirmation surgery: All surgical procedures related to transition from the birth sex to the preferred gender. (DHA Memorandum of November 13, 2017).

Stable in the preferred gender. No functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Transgender Work Group)

Transgender Service member: A Service member whose gender identity differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment or receive a diagnosis of gender dysphoria. (Transgender Work Group)

Estimates on the size of the Transgender Population in the Military:

Number of GD diagnoses:	994, from June 1 2016 – July 26, 2017; 1,076 as of October 3, 2017
OPA survey estimate:	8,227 – 9,732 on active duty
Rand estimate:	2,150 – 10,790 across all components

Gender Dysphoria treatment regime

Diagnosis requirements: Under current policy, receiving a diagnosis of gender dysphoria requires 6 months of counseling (Panel III minutes) and according to the Diagnostic and Statistical Manual of Mental Disorders version 5, at least two of the following criterion must be met:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender

Behavioral Health Counseling: The initial step in identifying the severity of an individual's mental health condition(s) that may or may not exist. If a mental health condition exists, the person/Service member is treated or further referred to a psychotherapist depending on the identified condition.

Cross-sex Hormone Therapy: A common medical treatment associated with gender transition and can be started upon receipt of a diagnosis for gender dysphoria. (Draft DoDI 1300.XX, *Military Service by Transgender Service members*) "During the first year, the Clinical Guidelines from the Endocrine Society recommends laboratory work every 90 days to monitor hormone levels. (Panel VI slides) Opinions vary on the Service member's deployability during this period – a military endocrinologist stated that TG SMs should be able to deploy after 180 days of beginning the hormone regimen. (Panel II minutes) The civilian endocrinologist stated that hormone initiation can be paused or discontinued safely to accommodate deployments. (Panel V minutes), Commanders report that TG Service members are non-deployable for this entire period (Panel I minutes).

Real Life Experience (RLE): The phase in the gender transition process during which the individual commences living in the gender role consistent with their preferred gender. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities. (Transgender Working Group)

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Surgeries: *Note1: The 2015 U.S. Transgender Survey cited by* [redacted] *showed that 20% of MtF and 2% FtM TG individuals initially wanting* ***genital*** *surgery actually have the surgery.* ***This was originally reported as all surgeries, not specifically genital surgeries.*** *(Panel IV slides) Note2: the following table only depicts currently authorized procedures.*

Compiled data based on presentations from Panel IV and Panel VI

Procedure	Estimated Recovery Time (assumes no complications)	Estimate on how many may desire*	Notes
Hysterectomy (laproscopic approach, recommended)	**4 weeks desk job 6-8 weeks unrestricted**	**128/313**	**(data for all indications) Major complication = 9.5% Minor complication = 28%**
Hysterectomy (abdominal approach) with or w/o Oopherectomy	**6-8 weeks unrestricted**		**(data for all indications) Major complication = 6% Minor complication = 27%**
Chest masculinization (Mastectomy)	**2-4 weeks (desk job) 4-6 weeks ~~unrestricted~~ (physically demanding job)**	**151/313**	**Low complications**
Phalloplasty (can be 2 stages, 2nd surgery 9-12 months later)	**6 weeks desk job 8-12 weeks return to activity 3 months unrestricted**	**151/313**	**Recommends stay in area of hospital where procedure performed for up to 2 weeks**
Metoidioplasty (can be done in 2 stages, 2nd stage performed >/=3 months later)	**3 weeks desk job 6 weeks return to activity 8 weeks unrestricted**	**151/313**	**• Recommends stay in area of hospital where procedure performed for up to 3 weeks • <5% complication rate**
Orchiectomy	**3 weeks desk job 6 weeks return to activity ~~6~~ 8 weeks unrestricted**	**75/313**	**Very low complications**
~~Penectomy/ Orchiectomy/ neovagina*~~ Vaginoplasty	**6 weeks desk jobs (some restrictions) 6-8 weeks resume physical activity 3 months for unrestricted activity ~~6-8 weeks (back to strenuous work)~~ ~~3 months for biking/swimming~~**	**151/313**	**• Recommends stay in area of hospital where procedure performed for up to 2 weeks • Major complications rare • Minor complications ~25%, most soon after surgery**

*** - Data provided did not differentiate between genders, so all data shown is based on all 313 treatment plans that were examined.**

Current Gender Marker Change Policy

A Service member on active duty, who receives a diagnosis from a military medical provider for which gender transition is medically necessary may, in consultation with the military medical provider and at the appropriate time, request that the commander approve:

- The timing of medical treatment associated with gender transition;
- An ETP associated with gender transition, consistent with Paragraph 3.2.d, and/or
- A change to the Service member's gender marker in DEERS.

(DoDI 1300.28 – *In-Service Transition for Transgender Service Members)*

The Commander will respond promptly to any request for medical care and ETPs associated with gender transition no later than 90 days from the date of the request. The commander approves, in writing, the gender marker change in DEERS.

Current Transgender Service member Data

Administrative Note 1: **The information presented to the Panel demonstrated a great deal of variability. As was discussed in various Panel meetings, this can be attributed to two observations: the first is that transgender medical care is an immature field of medicine with the majority of progress coming in the last 20 years with much more to do. The second factor is that transgenderism/gender dysphoria are spectrum issues, so the medical treatment plans would also span the breadth of available care. Two examples are provided:**

- **The wide range of times estimated for nondeployability for transition. Commanders in Panel I were adamant that their experience showed them that their transitioning Service members were non-deployable for up to 2.5 years whereas transgender Service members stated that, if scheduled correctly, their nondeployable periods were minimal. Medical experts provided information that most surgeries (assuming no complications) only required up to 8 weeks of recovery until the individual was fully prepared to return to duty. The limited in-service data presented to the Panel showed that transitioning Service members in the Army and Air Force (that data was available for) averaged 167.4 and 159 days of limited duty, respectively. (Panel IV slides)**

- **Reported suicidal ideation rate for transgender individuals varied from 25 times higher than cisgender individuals to 50 times higher, depending on the source.**

Administrative Note 2: *When presenting data, [redacted] stated that while a great deal of data would be presented, it may be insufficient to draw actionable conclusions. Instead, it is helpful to show trends. With such a small population to examine, and barely a year of open transgender service, using the data to predict long-term issues would not be advised. With only 15 months of transgender service, very few of the transgender Service members would have progressed sufficiently to surgeries - unless they started their transition prior to the enactment of the policy. (Panel II minutes)*

- Between October 1, 2015 to July 26, 2017, there were 994 Active duty Service members with a diagnosis of GD - (Panel IV slides)

- Service members with GD accounted for more than 30,000 mental health visits over a 2-year period. (Panel IV slides)

- Rates of Suicidal ideation:
    - **The 2015 U.S Transgender Survey concluded that a transgender individual with a solid support structure (e.g. family, friends) has a 37x higher rate of suicidal ideations than a cisgender individual. Without that support structure, the rate increase to a 54x higher rate. (2015 U.S. Transgender Survey, Panel VI minutes)**
    - Individuals with untreated gender dysphoria have roughly a 25 times higher risk of suicide than cisgender individuals, (Maguen and Shipherd, 2010) but studies indicated that is largely due to an inability to transition or treat gender dysphoria. With treatment, suicidal ideation can significantly decrease. (Panel III minutes). **Both Military and** Civilian medical experts agreed with that statistic, when asked. (Panel **III,** V minutes).
- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)
- Between 67 and 77% of Service members have surgeries included in their treatment plans (Panel IV slides)
- Using limited data, the Army and Air Force reported that their transitioning Service members averaged 167.4 and 159 days of limited duty, respectively. The Navy, by policy, does not allow limited duty profiles for transition. (Panel IV slides)
- According to the 2015 U.S. Transgender survey, only 2% of completed Female-to-Male (FtM) transitions included genital reassignment surgeries. In Male-to-female (MtF) completed transitions, approximately 10% had genital reassignment surgery. The most common transition-related surgeries that can be performed in military treatment facilities are mastectomy (21% of FtM), hysterectomy (8% of FtM) and breast augmentation (8% of MtF). (Panel VI slides)
- The 2015 U.S. Transgender Survey shows that the military seems to have a higher prevalence of transgenderism than the greater American public. (Panel VI slides)
- The DASD-HA study cohort of 691 transgender Service members revealed: (Panel VII slides)
    - The transgender population in the military is mostly under 40 years old (97%) and in the rank of E1-E4 (51%).
    - Higher rates of mental health and psychotherapy encounters per individual (29.6) when compared to the control group that consisted of active duty service members with a mental health diagnosis (21.1)
    - A higher rate of suicidal ideation than the control group that consisted of active duty service members with a mental health diagnosis (10.7 vs 6.2%).
    - 69 Service members deployed following a primary diagnosis of gender dysphoria after July 1, 2016.

Readiness, Lethality, and Military effectiveness

- The vast majority of commanders agreed that from time of diagnosis to the completion of a transition plan, the SM would be non-deployable for 2-2.5 years (up to a year of hormones to achieve stability, then surgeries). (Panel I minutes) Transgender Service members maintained that most complex surgery (gender reassignment surgery) required six weeks of Convalescent Leave followed by an unspecified period of light duty. (Panel II minutes)

- The three genital reconstruction surgeries (vaginoplasty, phalloplasty, metoidioplasty), have as-yet unknown impacts on individual military readiness and that the deployability of individuals who had the surgeries would be an issue. Example: one Service member recently had a vaginoplasty and her medical treatment plan forecasted ~~10.5~~ **6** months of non-deployability after the surgery. (Draft Panel VI minutes) ***(note: 10.5 months was originally reported but corrected to 6 months during 7 December Panel meeting)***

- One military physician stated that the surgical portion of a complete gender reassignment, would generally be scheduled as five or six surgeries over a 15-month period. (Panel III minutes)

- When asked about the percentages of transgender individuals that opted for medical procedures, the civilian medical experts provided the following information, based on their personal experience:

	Male to Female (MtF) transitions	Female-to-Male (FtM) transitions
% that desire medical intervention	50	50
% (of above) that desire surgery	33	33
Desire cross-sex hormones	majority	Majority
Remarks	Majority of surgical procedures are chest augmentation surgery	Majority of surgical procedures are mastectomies

- One commander remarked about how it would be extremely difficult for a TG SM to operate in a SOCOM world with austere living conditions and non-emergency medical support not readily available. He also raised the issue that some military specialties, like air traffic controllers, have their standards set by another agency – in that case the FAA. The FAA does not allow an individual to control air traffic until they have been hormonally stable for 5 years, effectively closing that specialty to TG SMs. (Panel I minutes)

- When asked what happens if an individual on cross-sex hormones was unable to take them for a period of time, a military physician stated that the answer depended on the specific situation. In short, side effects of cross-sex hormone withdrawal include increased fatigue, mood swings and decreased libido – and these symptoms are similar to those of a cisgender individual that stopped taking hormone supplements. The longer an individual was on cross-sex hormones when they had to stop, the more intense those symptoms would be. The same panelist remarked that there would likely be a decrease in combat

ability for an individual who stopped taking their cross-sex hormones. (Panel III minutes) Transgender Service members who appeared before the panel had a different perspective. One of the Service members has been off of hormones for more than 2 years with little effect and another compared the side effects of skipping a week of hormones to a bad case of pre-menstrual syndrome. One of the Service members sometimes skips hormone injections and this leads to oily skin, and mood swings, both of which are manageable. (Panel III minutes) Civilian medical experts maintained that if a Service member was deployed and lost their cross-sex hormones, the most likely effect would just be an angry Service member. As a matter of routine in civilian care, the use of cross-sex hormones are halted before and after surgeries for a period of time without any issues. (Panel V minutes) However, cross sex hormones can be provided in multiple ways – topical creams, injections or pills – so it is be unlikely that an individual would be unable to take cross-sex hormones anywhere in the world. (Panel III minutes) There are risks associated with cross-sex hormones, but they are small. Birth control pills contain more hormones than cross-sex hormones do. (Panel III minutes)

- Providing adequate mental health support to a deployed transgender Service member could be problematic - there are few deployed psychotherapists that could provide the required treatment for a transgender Service member prior to surgeries – and none in the most austere environments (e.g., Syria, Somalia). Mature theaters (Korea, Afghanistan) would likely be able to support transgender Service members with mental health and medical support. (Draft Panel VI minutes)

- Receiving a diagnosis of gender dysphoria takes approximately 6 months of counseling. (Panel III minutes)

- The civilian endocrinologist stated that it is safe to pause initiation/titration of dose of hormone treatments and/or stop hormones (may need to wean off) in order to accommodate deployments. It will just freeze the progress of the individual's transition. (Panel V minutes)

Budgetary constraints

- Several commanders indicated a budgetary impact as they received no additional monies to pay for the numerous TDY trips throughout CONUS for specialized medical care and had to pay out of O&M Funds. (Panel I minutes)

- Costs for treating GD have steadily risen from ~ $660K in FY16 to ~ $2.2M in FY17. The average GD Service member currently costs DoD nearly 3x more annually in health care expenditures than a non-GD Service member. (Panel IV slides)

Unit cohesion

- One commander spoke of his 'dueling' EO issues; his TG SM (a female with male genitalia), has an approved ETP for full-time real life experience and is authorized to use female shower facilities. This led to an EO complaint by the females assigned to the unit who believed their privacy was invaded by this. That led to an EO complaint by the TG SM claiming that the command was not supporting her rights. **(Panel I minutes)**

Applicable laws, standards, and guidelines

- Statutorily, TRICARE is forbidden from paying for gender reassignment surgery. All transition-related surgeries must be processed through the Supplemental Health Care Program. In any case, if an individual does not meet required guidelines, the Department can refuse to perform the procedure until the individual meets all criteria contained in the guidelines. (Panel II minutes)

- The Military Health System follows the 2017 Endocrine Society guidelines for the treatment of gender dysphoria. (Panel VI slides) The recovery estimates contained within those guidelines are based on an assumption that the individual will return to their civilian life, which does not directly translate onto the military population and their unique requirements. The DoD will most likely have to develop its own military-specific recovery estimates that would likely be higher than the civilian estimates (Draft Panel VI minutes).

- The prevailing Endocrine Society guidelines are also the reason why an individual is non-deployable for the first 12 months of taking cross-sex hormones. (Panel III minutes). Both the military endocrinologist (Panel III) and the civilian endocrinologist (Panel IV) believed that an individual should be able to deploy after only six months of cross-sex hormones.

Deployability

Department of Defense Instruction (DoDI) 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, February 5, 2010 provides the following information:

Deployment: The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

Contingency Deployment: A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

DoD Policy states that DoD personnel may deploy if:

> "Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration." (Paragraph 4.3.b)

The DoDI also adds that

> "Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical capabilities of the deployment..." (Paragraph 4.e)

Enclosure 3 to the DoDI is entitled "*Medical conditions usually precluding contingency deployment*" and within it, the enclosure states:

> "Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity." (Paragraph b.1.)

> "Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment." (Paragraph b.5.)

The DoDI also charges the Joint Staff and COCOMs to develop their own medical standards for deployment into their area of operations. Using CENTCOM as an example, their medical deployment standards, contained in Modification 13 to *USCENTCOM Individual protection and individual – Unit deployment Policy* (March 23, 2017) states:

> "Deployed Health Service Support infrastructure is designed and prioritized to provide acute and emergency support to the Expeditionary mission. All personnel...travelling to the CENTCOM AOR must be medically, dentally and psychologically fit." (Paragraph 15.C)

Questions and Answers

[redacted]

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[redacted]

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: December 22, 2017
Time: 0900-1100
Room: 3D1063

Overview:
Panel of Experts will discuss a proposed policy recommendation submitted by the USMC and discuss additional research questions to complement other submitted questions.

Subject	Speaker	Duration
Opening Remarks	HON Robert Wilkie	0900-0910
Proposed policy discussion	[redacted]	0910-1030
Discussion of additional Research questions	[redacted]	1030-1100

Meeting Homework/Deliverables:

Save the following dates for upcoming meetings: Thursday, 4 January 2018 (T), Thursday 11 January 2018 (T). Both meetings tentatively scheduled from 1500 – 1700.

Administrative:
Questions or issues please contact, [redacted].

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: January 4, 2018
Time: 1500-1700
Room: 3D1063

Overview:
Panel of Experts will discuss proposed policy recommendations.

Subject	Speaker	Duration
Opening Remarks	HON Robert Wilkie	1500-1510
Proposed policy discussion	[redacted]	1510-1700

Meeting Homework/Deliverables:

Save the following dates for upcoming meetings: Thursday, 11 January 2018 from 1500 – 1700.

Administrative:
Questions or issues please contact, [redacted].

TRANSGENDER POLICY PANEL MEETING AGENDA

Date: January 11, 2018
Time: 1500-1700
Room: 3D1063

Overview:
Panel of Experts will discuss proposed policy recommendations and review proposed SECDEF brief.

Subject	Speaker	Duration
Opening Remarks	HON Robert Wilkie	1500-1510
Proposed policy discussion	[redacted]	1510-1700

Meeting Homework/Deliverables:

Save the following dates for upcoming meetings: TBD

Administrative:
Questions or issues please contact, [redacted].

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

ACTION MEMO

JAN 11 2018

TO: SECRETARY OF DEFENSE

THROUGH: DEPUTY SECRETARY OF DEFENSE
VICE CHAIRMAN OF THE JOINT CHIEFS OF STAFF

FROM: Robert Wilkie, Under Secretary of Defense for Personnel and Readiness

SUBJECT: Recommendations by the Transgender Review Panel of Experts

- On September 14, 2017, you directed the establishment of a Panel of Experts to review and recommend changes to Department of Defense policies regarding the service of transgender individuals (Tab A), in accordance with direction from the President on August 25, 2017 (Tab B).
- The Panel, which I chaired, comprised the officials performing the duties of the Under Secretaries of the Military Departments, the Uniformed Services' Vice Chiefs, and Senior Enlisted Advisors.
- You directed the Panel to conduct its review and render recommendations consistent with military readiness, lethality, deployability, budgetary constraints, and applicable law.
- The Panel was informed by testimony from commanders with transgender troops, currently-serving transgender Service members, military physicians, and other health experts.
- The Panel considered available DoD data and information on currently-serving transgender personnel and relevant external research and studies.
- Based on the individual and collective experience leading warfighters and their expertise in military operational and institutional effectiveness, the Panel makes the following recommendations:
    - Transgender individuals should be allowed to enter the military in their biological sex, subject to meeting all applicable accession standards. A diagnosis of gender dysphoria is disqualifying for accessions unless medical documentation establishes stability in his/her biological sex for no less than 36 consecutive months—as determined by a qualified Department of Defense medical provider—at the time of application. [*Gender Dysphoria*: a medical diagnosis involving significant distress or problems functioning resulting from a difference between the gender with which an individual identifies and the individual's biological sex]

- Transgender Service members should be permitted to serve openly, but only in their biological sex and without receiving cross-sex hormone therapy or surgical transition support.
- In order to keep faith with those transgender Service members who receive a diagnosis of gender dysphoria from a qualified military medical provider prior to the implementation of a revised DoD policy in 2018, they should be authorized all medically necessary and appropriate care and treatment, including cross-sex hormone therapy and medically necessary surgery. Such care and treatment should be authorized and provided at government expense even if it is determined to be necessary and appropriate only after the implementation of a revised policy in 2018.
- Transgender Service members should be subject to the same retention standards applicable to all other Service members.

- To ensure consistent application of the policies, procedures, and guidance currently in effect with regard to the accession[1] and in-service transition[2] of transgender individuals, I intend to issue a memorandum clarifying existing guidance regarding privacy concerns that may arise.

RECOMMENDATION: As discussed, based on your review of these recommendations, and other information and input you elect to consider, we will develop a writing by which you would advise the President of your conclusions and recommendations in this matter.

COORDINATION: TAB C

Attachments:
As stated

[1] As required by court order.
[2] As authorized by DoDI 1300.28, *In-Service, Transition for Transgender Service members*, dated July 1, 2016.

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

9/14/17

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
COMMANDANT, U.S. COAST GUARD
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF, NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF COST ASSESSMENT AND PROGRAM EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF OPERATIONAL TEST AND EVALUATION
CHIEF INFORMATION OFFICER OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTOR OF NET ASSESSMENT
DIRECTOR, STRATEGIC CAPABILITIES OFFICE
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Military Service by Transgender Individuals - Interim Guidance

The Department of Defense ("DoD") has received the Presidential Memorandum, *Military Service by Transgender Individuals*, dated August 25, 2017 ("Presidential Memorandum"). DoD will carry out the President's policy and directives in consultation with the Department of Homeland Security ("DHS") with respect to the U.S. Coast Guard. Not later than February 21, 2018, I will present the President with a plan to implement the policy and directives in the Presidential Memorandum. Consistent with military effectiveness and lethality, budgetary constraints, and applicable law, the implementation plan will establish the policy, standards and procedures for transgender individuals serving in the military. The Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff, supported by a panel of experts ("Panel"), shall propose for my consideration recommendations supported by appropriate evidence and information.

To comply with the Presidential Memorandum, ensure the continued combat readiness of the force, and maximize flexibility in the development of the implementation plan, the attached Interim Guidance takes effect immediately and will remain in effect until I promulgate DoD's final policy in this matter. By agreement with the Acting Secretary of Homeland Security, this Interim Guidance also applies to the U.S. Coast Guard.

Attachment:
As stated

James Mattis

cc:
Secretary of Homeland Security

Interim Guidance

First and foremost, we will continue to treat every Service member with dignity and respect.

Accessions: The procedures set forth in Department of Defense Instruction (DoDI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, dated April 28, 2010 (Change 1), which generally prohibit the accession of transgender individuals into the Military Services, remain in effect because current or history of gender dysphoria or gender transition does not meet medical standards, subject to the normal waiver process.

Medical Care and Treatment: Service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. As directed by the Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

In-Service Transition for Transgender Service Members: The policies and procedures set forth in DoDI 1300.28, *In-Service Transition for Transgender Service Members*, dated July 1, 2016, remain in effect until I promulgate DoD's final guidance in this matter.

Separation and Retention of Transgender Service members:

Service members who have completed their gender transition process and whose gender marker has been changed in DEERS will continue to serve in their preferred gender while this Interim Guidance remains in effect.

An otherwise qualified transgender Service member whose term of service expires while this Interim Guidance remains in effect, *may*, at the Service member's request, be re-enlisted in service under existing procedures.

As directed by the Memorandum, no action may be taken to involuntarily separate or discharge an otherwise qualified Service member solely on the basis of a gender dysphoria diagnosis or transgender status. Transgender Service members are subject to the same standards as any other Service member of the same gender; they may be separated or discharged under existing bases and processes, but not on the basis of a gender dysphoria diagnosis or transgender status.

Reestablishment of the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) Central Coordination Cell: The OUSD(P&R) will reestablish the Central Coordination Cell (CCC) to provide expert advice and assistance to the Military Departments and Services and to commanders with regard to this Interim Guidance. The CCC may be reached at https://ra.sp.pentagon.mil/DoDCCC/SitePages/HomePage.aspx.

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

9/14/17

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
COMMANDANT, U.S. COAST GUARD
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DIRECTOR, STRATEGIC CAPABILITIES OFFICE
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Terms of Reference - Implementation of Presidential Memorandum on Military Service by Transgender Individuals

Reference: Military Service by Transgender Individuals – Interim Guidance

I direct the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff to lead the Department of Defense (DoD) in developing an Implementation Plan on military service by transgender individuals, to effect the policy and directives in Presidential Memorandum, *Military Service by Transgender Individuals*, dated August 25, 2017 ("Presidential Memorandum"). The implementation plan will establish the policy, standards and procedures for service by transgender individuals in the military, consistent with military readiness, lethality, deployability, budgetary constraints, and applicable law.

The Deputy Secretary and the Vice Chairman, supported by a panel of experts drawn from DoD and the Department of Homeland Security (DHS) ("Panel"), shall propose for my consideration recommendations supported by appropriate evidence and information, not later than January 15, 2018. The Deputy Secretary and the Vice Chairman will be supported by the Panel, which will be comprised of the Military Department Under Secretaries, Service Vice Chiefs, and Service Senior Enlisted Advisors. The Deputy Secretary and Vice Chairman shall

designate personnel to support the Panel's work to ensure Panel recommendations reflect senior civilian experience, combat experience, and expertise in military operational effectiveness. The Panel and designated support personnel shall bring a comprehensive, holistic, and objective approach to study military service by transgender individuals, focusing on military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law. The Panel will be chaired by the Under Secretary of Defense for Personnel and Readiness and will report to the Deputy Secretary and the Vice Chairman at least every 30 days and address, at a minimum, the following three areas:

Accessions: The Presidential Memorandum directs DoD to maintain the policy currently in effect, which generally prohibits accession of transgender individuals into military service. The Panel will recommend updated accession policy guidelines to reflect currently accepted medical terminology.

Medical Care: The Presidential Memorandum halts the use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, effective March 23, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex. The implementation plan will enumerate the specific surgical procedures associated with sex reassignment treatment that shall be prohibited from DoD or DHS resourcing unless necessary to protect the health of the Service member.

Transgender Members Serving in the Armed Forces: The Presidential Memorandum directs that the Department return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016. The Presidential Memorandum also allows the Secretary to determine how to address transgender individuals currently serving in the Armed Forces. The Panel will set forth, in a single policy document, the standards and procedures applicable to military service by transgender persons, with specific attention to addressing transgender persons currently serving. The Panel will develop a universal retention standard that promotes military readiness, lethality, deployability, and unit cohesion.

To support its efforts, the Panel will conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members. The study will be planned and executed to inform the Implementation Plan. The independent multi-disciplinary review and study will address aspects of medical care and treatment, personnel management, general policies and practices, and other matters, including the effects of the service of transgender persons on military readiness, lethality, deployability, and unit cohesion.

The Panel may obtain advice from outside experts on an individual basis. The recommendations of the Deputy Secretary and the Vice Chairman will be coordinated with senior civilian officials, the Military Departments, and the Joint Staff.

All DoD Components will cooperate fully in, and will support the Deputy Secretary and the Vice Chairman in their efforts, by making personnel and resources available upon request in support of their efforts.

cc:
Secretary of Homeland Security

THE WHITE HOUSE

WASHINGTON

August 25, 2017

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF HOMELAND SECURITY

SUBJECT: Military Service by Transgender Individuals

Section 1. Policy. (a) Until June 2016, the Department of Defense (DoD) and the Department of Homeland Security (DHS) (collectively, the Departments) generally prohibited openly transgender individuals from accession into the United States military and authorized the discharge of such individuals. Shortly before President Obama left office, however, his Administration dismantled the Departments' established framework by permitting transgender individuals to serve openly in the military, authorizing the use of the Departments' resources to fund sex-reassignment surgical procedures, and permitting accession of such individuals after July 1, 2017. The Secretary of Defense and the Secretary of Homeland Security have since extended the deadline to alter the currently effective accession policy to January 1, 2018, while the Departments continue to study the issue.

In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects.

(b) Accordingly, by the authority vested in me as President and as Commander in Chief of the Armed Forces of the United States under the Constitution and the laws of the United States of America, including Article II of the Constitution, I am directing the Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016 until such time as a sufficient basis exists

upon which to conclude that terminating that policy and practice would not have the negative effects discussed above. The Secretary of Defense, after consulting with the Secretary of Homeland Security, may advise me at any time, in writing, that a change to this policy is warranted.

Sec. 2. Directives. The Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, shall:

(a) maintain the currently effective policy regarding accession of transgender individuals into military service beyond January 1, 2018, until such time as the Secretary of Defense, after consulting with the Secretary of Homeland Security, provides a recommendation to the contrary that I find convincing; and

(b) halt all use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

Sec. 3. Effective Dates and Implementation. Section 2(a) of this memorandum shall take effect on January 1, 2018. Sections 1(b) and 2(b) of this memorandum shall take effect on March 23, 2018. By February 21, 2018, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall submit to me a plan for implementing both the general policy set forth in section 1(b) of this memorandum and the specific directives set forth in section 2 of this memorandum. The implementation plan shall adhere to the determinations of the Secretary of Defense, made in consultation with the Secretary of Homeland Security, as to what steps are appropriate and consistent with military effectiveness and lethality, budgetary constraints, and applicable law. As part of the implementation plan, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall determine how to address transgender individuals currently serving in the United States military. Until the Secretary has made that determination, no action may be taken against such individuals under the policy set forth in section 1(b) of this memorandum.

Sec. 4. Severability. If any provision of this memorandum, or the application of any provision of this memorandum, is held to be invalid, the remainder of this

memorandum and other dissimilar applications of the provision shall not be affected.

Sec. 5. General Provisions. (a) Nothing in this memorandum shall be construed to impair or otherwise affect:

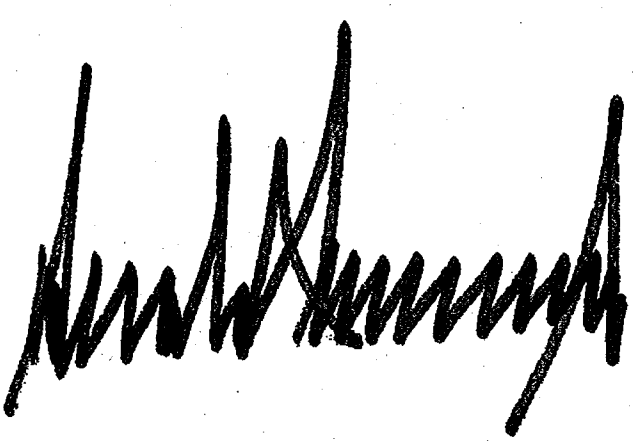
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) The Secretary of Defense is authorized and directed to publish this memorandum in the *Federal Register*.



Hormone Therapy Issues in Transgender Service Members

Cross-sex hormone therapy (CSHT) is a treatment for individuals who are transgender with gender dysphoria (GD), which facilitates their transition from birth gender to desired gender. Though data is limited in cross-sex hormone therapy, the long-term monitoring requirements, adverse outcomes, and deployment opportunities are similar to other common hormone-based therapies. In the case of the female to male CSHT, the transition requires simply the administration of testosterone. In the case of the male to female CSHT, the transition requires blocking the production of testosterone and the administration of estrogens.

For the management of GD, the MHS policy is based on the clinical practice guidelines proposed by the Endocrine Society in their 2017 paper, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*. This document provides guidelines for the diagnosis, mental health, hormonal and surgical treatment for GD. It includes hormone dosing and monitoring recommendations as well as recommended criteria for surgery

HORMONES FOR TRANSITION

	Transgender Female (M to F)	**Transgender Male (F to M)**
Medications	Anti-androgens (block testosterone) Estrogen Oral Transdermal patch Parental (IM injections)	Testosterone Parenteral (IM or SQ injections) Transdermal patch
Routes	Oral, parenteral or transdermal preparations	Parenteral or transdermal preparations
Comments	More complex than the transgender male regimen (F to M)	Follows the general principle of hormone replacement treatment for male hypogonadism
Selected Results	Breast development is generally maximal at 2 years after initiating hormones. Over a long period of time, the prostate gland and testicles will undergo atrophy.	Results in cessation of menses, increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire

MONITORING TESTS

The tests associated with monitoring hormone therapy for GD include:
1. Complete Blood Count (CBC)
2. Electrolytes (Sodium, Potassium, Chloride and Bicarbonate)
3. Liver Function Tests (LFTs) and Lipids (LFTs - Liver transaminases (AST or SGOT and ALT or SGPT), albumin and bilirubin)
4. Estradiol
5. Prolactin
6. Total Testosterone

Hormone Therapy Issues in Transgender Service Members

Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy 2017 Endocrine Society Recommendations							
Transgender Male (F to M)				**Transgender Female (M to F)**			
		Initial	Follow up			Initially	Follow up
Bloodwork	Testosterone	Every 3 months until reaches normal physiologic male range	1 – 2 times per year	**Bloodwork**	Testosterone	Every 3 months	1 – 2 times per year
	Hematocrit & Hemoglobin	Every 3 months for first year	1 - 2 time per year		Estradiol	Every 3 months	1 – 2 times per year
	Lipids	Regular intervals			Electrolytes (K)	Every 3 months for first year	Yearly
					Prolactin	Annually during transition	Every 2 years when stable
Physical Exam		Every 3 months for first year	1 - 2 times per year	**Physical Exam**		Every 3 months for first year	1 - 2 times per year
Other	Screening for osteoporosis		Yearly if indicated	**Other**	Routine Cancer screening		Yearly as indicated
	Female cancer screening as appropriate		Yearly if indicated		Osteoporosis		Begin at age 60
	Cardiovascular Risks		Yearly if indicated		Cardiovascular Risks		Yearly if indicated

For deployability, a change in the type of estrogen or testosterone administration from injections to oral or patch usually requires 2 to 3 months of monitoring to ensure stability.

MHS TESTING LOCATIONS

All of the listed tests can be obtained in all CONUS facilities. Larger MTFs usually have capability to perform these tests in-house. Smaller MTFs can either mail specimens to larger MTFs in the same geographic location or send to them to commercial labs for specimen processing. Anything not done in house is referred to a civilian commercial network with no issue.

OCONUS fixed facilities (Landstuhl, Tripler, Okinawa, Rota, Guam etc.) all have capability to perform CBCs, Electrolytes and LFTs. Larger OCONUS fixed facilities such as Landstuhl and Tripler, have capability to perform Estradiol, Total Testosterone and Prolactin (i.e. hormone levels). Landstuhl and Tripler serve as regional testing centers for smaller OCONUS fixed facilities in AFRICOM/EUCOM, CENTCOM and PACOM. Specimens are flown on a regular basis from smaller MTFs to the regional testing centers.

Deployed/mobilized facilities can provide basic blood work to include CBCs, Electrolytes and LFTs, but not hormone levels. Larger Role 3 facilities in Bagram, Kandahar and Kuwait can successfully ship specimens to Landstuhl within 1-5 days. Forward Role 2 bases and smaller units have difficulty with reliable shipping for hormone levels. It may take up to 16 days for a specimen to make it to the referring clinical site and the ability to keep samples frozen throughout that time period is problematic.

There is capability on some ships to perform CBCs, LFTs, and electrolytes. There is no capability to perform hormone levels. There are multiple shipping, turn-around time, and IT connectivity issues with samples that need to be shipped out, depending on the location of the ship. For ships in port with a MTF in close proximity, specimens can be sent to the MTF for processing. Deployed ships must depend on the mail system for shipping specimens out for processing. Mail services are usually available during replenishment at sea, but there is no guarantee that mail services will be available during every replenishment. And there can be two to three weeks between replenishments. As with Role 2 and smaller deployed facilities, the ability to keep a specimen frozen from the time it is drawn to the time it reaches the referral clinical site is problematic.

SPECIMEN PROCESSING

Typically, a specimen is good for 30 days or longer while frozen and as long as the frozen chain is not broken. Specimens are packed on dry ice for shipping where capability to do so exists. There is limited time before the dry ice evaporates and the sample is lost. The amount of dry ice used for transport usually will typically provide for 3-5 days of transit. In a mobilized/deployed environment, however there is limited to no dry ice availability and units must rely on frozen packs for transport. Frozen packs may be able to keep a specimen frozen for up to 48 hours.

Large Role 3 bases (i.e. Bagram, Kandahar, Kuwait) can successfully ship to Landstuhl within 1-5 days. Role 2 and more forward bases experience difficulty with reliable weekly ground or air transport to the ship out point.

Shipment requirements to Landstuhl are generally as follows:

Estradiol: refrigerated 48 hrs., frozen >48 hrs.
Total Testosterone: refrigerated 24 hrs., frozen >24 hrs.
Prolactin: refrigerated 48 hrs., frozen >24 hrs.

Specimen stability requirements for two civilian commercial labs are shown in the table below.

Commercial Requirements for Specimens – Specimen Stability					
TEST	Specimen	Commercial Labs			
		MAYO		QUEST	
		Refrigerated	Frozen	Refrigerated	Frozen
Testosterone	Serum	14 days	60 days	7 days	21 days
Estradiol	Serum	28 days	28 days	7 days	6 months

RISKS OF STOPPING HORMONES

We are unable to find any data in the scientific literature regarding the risks or effects of Transgender individuals stopping cross-sex hormones, or any references to any concerns specific to this.

Anecdotally, there are a number of instances of transgender men (natal female) who have stopped testosterone in order to produce oocytes for pregnancy with no references to any type of "withdrawal syndrome". Also transgender women (natal male) routinely stop estrogens prior to vaginoplasty and for several weeks post-surgery. Some of these transgender women have reported emotional effects from stopping estrogen, but that is not a universal finding.

There are abundant literature references and internet blogs regarding the consequences of abrupt withdrawal of testosterone in natal males taking testosterone for "Low T", hypogonadism and physical effects (body/strength enhancement). Many of these reports concern men with normal testosterone levels taking high doses of testosterone for the physical effects. Common symptoms reported include anxiety, mild depression, fatigue, headaches, muscle loss and low libido, among others. Most reports state withdrawal symptoms are relatively mild and usually resolve in a matter of weeks to months. The length of time the symptoms persist is highly dependent on the length of time the individual has been taking testosterone and the dose or amount of testosterone taken, with higher doses taken for a long period of time resulting in a longer period of symptoms.

Similarly, there is abundant literature on the effects of loss of estrogen in natal females, the most common reason being menopause.

Hormone Therapy Issues in Transgender Service Members

In their June 17, 2016 publication "*Guidelines for the Primary and Gender Affirming Care of Transgender and Gender Nonbinary People*" authors at the University of California, San Francisco (UCSF) Center of Excellence for Transgender Health discuss the effects of stopping cross-sex hormones in older transgender individuals:

Older transgender women: Since the mean age of menopause in the U.S. is 49, it is reasonable in transgender women who have undergone gonadectomy to consider stopping hormone therapy around age 50. Expected effects of this may be similar to non-transgender women experiencing menopause. Transgender women who retain their gonads but withdraw hormone therapy may experience return of virilization. (Section 9 - Overview of feminizing hormone therapy)

Older transgender men: Older transgender men: No upper age limit exists for testosterone replacement in non-transgender men. As such, there is no age recommendation for the termination of testosterone therapy in transgender men. It is reasonable to consider discontinuing hormone therapy at or around age 50, the age at which non-transgender women undergo menopause. Regardless of the presence of gonads at this age, withdrawal of testosterone will result in reduced muscle mass, body hair and libido. (Section 10- Overview of masculinizing hormone therapy)

NON-TRANSGENDER MEDICAL CONDITIONS REQUIRING REGULAR MONITORING

An MDR data pull was performed to identify ADSMs with two conditions that require regular laboratory monitoring, diabetes and hypothyroidism.

Diabetics on oral hypoglycemic medications require frequent Hemoglobin A1c testing to adjust the dosage, monitor the response to therapy and determine stability on treatment. The American Diabetes Association recommends:
A1C testing should be performed routinely in all patients with diabetes at initial assessment and as part of continuing care. Measurement approximately every 3 months determines whether patients' glycemic targets have been reached and maintained. The frequency of A1C testing should depend on the clinical situation, the treatment regimen, and the clinician's judgment. The use of point-of-care A1C testing may provide an opportunity for more timely treatment changes during encounters between patients and providers. Patients with type 2 diabetes with stable glycemia well within target may do well with A1C testing only twice per year. Unstable or intensively managed patients (e.g., pregnant women with type 1 diabetes) may require testing more frequently than every 3 months (Glycemic Targets: Standards of Medical Care in Diabetes – 2018; Diabetes Care 2018;41(Suppl.1):S55–S64)

Likewise, individuals with hypothyroidism require regular laboratory testing to ensure adequate blood levels of thyroid hormone and stability on their treatment regimen. The American Thyroid Association in collaboration with the American Association of Endocrinologists recommends:

Patients being treated for established hypothyroidism should have serum TSH measurements done at 4-8 weeks after initiating treatment or after a change in dose. Once an adequate

replacement dose has been determined, periodic TSH measurements should be done after 6 months and then at 12-month intervals, or more frequently if the clinical situation dictates otherwise (Clinical Practice Guidelines for Hypothyroidism in Adults: Cosponsored by the American Association of Clinical Endocrinologists and The American Thyroid Association; Ata/Aace Guidelines for Hypothyroidism in Adults, *Endocr Pract.* 2012;18(No. 6))

Service members with Type 2 diabetes and hypothyroidism who are stable on oral treatment regimens for at least one year are deployable. The following table shows the results of the MDR data pull including the number of service members with ICDM-10 codes for one of the two diagnoses, the number on oral medications and the number deployed over the previous 2 year period.

Number of Active Duty and Activated Guard/Reserve with a Primary Diagnosis of Interest - FY2016-17

Condition	# w Diagnosis	# w Diagnosis and on RX	# Deployed 2016-2017 after Dx	# Deployed 2016-2017 after Dx and RX	Testing Frequency
AD with a diagnosis of **diabetes**?	5,945	2,334	528	108	Every 3 months until stable, then every 6 months
AD with a diagnosis of **hypothyroidism**	10,473	6,136	992	620	Measurements done at 4-8 weeks after initiating treatment or after a change in dose; then periodic TSH measurements should be done after 6 months and then at 12-month intervals

Examples of other diagnoses that require periodic blood testing include HIV, malignancy, gout and anemia. Many of these conditions, including diabetes and hypothyroidism, fall under Service categories for assignment limitations and may require COCOM approval for deployment.

There are also non-transgender ADSMs who have ICDM-10 codes for low testosterone and low estrogen conditions who are receiving testosterone and estrogen therapy. Individuals who are stable on their regimens are deployable. The following table shows the results of the MDR data pull including the number of service members with ICDM-10 codes for one of the two diagnoses, the number on oral medications and the number deployed over the previous 2 year period.

Number of Active Duty and Activated Guard/Reserve with a Primary Diagnosis of Interest - FY2016-17

Condition	# w Diagnosis	# w Diagnosis and on Rx	# Deployed 2016-2017 after Dx	# Deployed 2016-2017 after Dx and Rx	Testing Frequency
AD men with a diagnosis of "**Low Testosterone**", "Hypogonadism" and/or "Hypogonadotropic hypogonadism"	9,547	4,176	813	352	Every 3 months until stable, then every 6–12 months
AD women with a diagnosis of **estrogen deficiency** such as menopause, perimenopause, hypoestrogenism due to hypogonadism, castration or primary ovarian failure, polycystic ovarian syndrome or prevention of osteoporosis	2,952	544	180	19	Every 3 months for first year, then annually

SPECIMEN PROCESSING FOR DIABETES AND HYPOTHYROIDISM MONITORING

The same issues discussed above in regards to specimen processing for testosterone and estradiol apply to HgBA1c and TSH testing.

Shipment requirements to Landstuhl are generally as follows:

HGB A1c: refrigerated
TSH, Free T3, Free T4: refrigerated 48 hrs., frozen >48 hrs.

Specimen stability requirements for two civilian commercial labs are shown in the table below.

Commercial Requirements for Specimens – Specimen Stability					
TEST	Specimen	Commercial Labs			
		MAYO		QUEST	
		Refrigerated	Frozen	Refrigerated	Frozen
HgBA1c	Whole blood	7 days	None given	7 days	6 months
TSH	Serum	7 days	30 days	7 days	28 days

OTHER CONSIDERATIONS

Forward deployed service members on hormonal therapy could be evacuated back to larger in-theater MTFs for periodic blood draws to mitigate the challenges with specimen processing. The dollar costs associated with such a medivac as well as the cost to unit readiness and mission accomplishment would need to be determined. Also the risk of movement would need to be factored in.

Case-by-case deployment waivers may be provided by COCOM for a Service member on injectable medications for certain medical conditions when that Service member is in a critical mission essential role and is collocated with a larger medical unit.

Until such time as the MHS has amassed sufficient experience and data to develop guidelines specific to the military setting, MHS policy for the treatment of gender dysphoria is based on the 2017 Endocrine Society guidelines. The Endocrine Society guidelines are recommendations for the care of gender dysphoria in the civilian sector and may not be fully applicable to the military setting. While the Endocrine Society guidelines recommend 12 months of lab work and exams for monitoring initial stabilization, many military endocrinologists are reporting achieving stability in Service members with gender dysphoria in 6 to 9 months.

Prepared by [redacted]