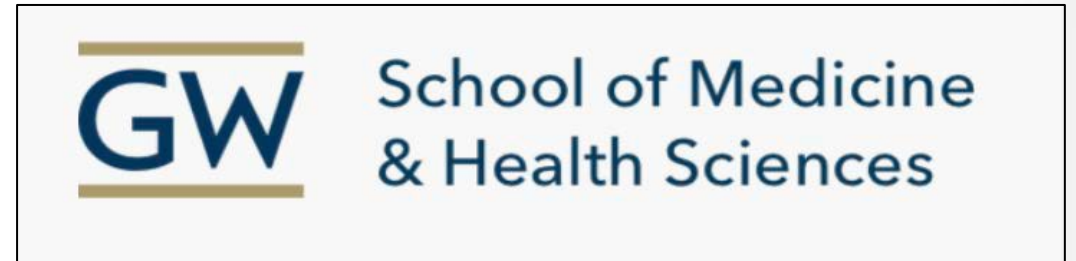


DC | HEALTH

Gender Affirming Care 101

Providing Hormone Therapy

Collaborators





More resources available at:

<https://dchealth.dc.gov/dcrx>

Course Overview

- Gender Affirming Care (GAC)
- Hormone therapy
- Medical bias
- Clinical prescribing guidelines

Presenters

- Dane Ray, MA
 - Counselor, Educator
 - Owner/Operator of D & A Consulting Services
 - Core trainer, The Trainer for Transgender Training Institute
- Bianca Palmisano, RN, MSN
 - Clinical Nurse Coordinator, Mary's Center
 - Owner, Intimate Health Consulting
- David Cornell, MBA, DNP, FNP, AAHIVS
 - Director of HIV Services and Family Nurse Practitioner, Mary's Center

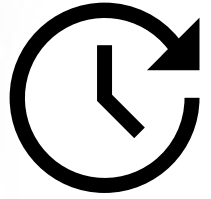
Advisors

- **Shige Sakurai, MA, MBA**
 - Administrator, LGBT Equity Center at University of Maryland
 - Executive education faculty, University of Southern California's Race and Equity Center
- **Penny Jacobs, CRNP**
 - Family Nurse Practitioner, University of Maryland Health Center
- **Oliver Grundman, PhD, MEd, MS**
 - Director of Online Graduate Education Programs in Pharmaceutical Chemistry & Clinical Toxicology, University of Florida

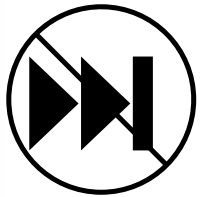
Conflicts of Interest

- None of the speakers or advisors have a conflict of interests to declare.

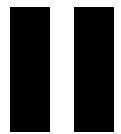
Important Information



The video will progress at its own pace.



Do not attempt to speed up the video.



The video can be paused and resumed later.

Dane Ray, MA



- Mental Health Counselor
- Healthcare Professional
- Diversity & Inclusion Educator
- Travel Enthusiast

Bianca Palmisano, RN, MSN



- Registered nurse and LGBT health consultant
- White, queer, nonbinary
- Multiply disabled
- Stably housed, socioeconomically advantaged
- Social justice advocate

David Cornell,

MBA, DNP, FNP, AAHIVS



- DNP – University of Iowa, Family Medicine Program, 2015
- Post-DNP Residency Program, Duke University School of Nursing, HIV Specialty, 2016 (significant emphasis on sexual health, also gender identity)
- American Academy of HIV Medicine Specialist, 2016-2022.

Learning Objectives

- 1. Review important terminology for working with transgender and/or nonbinary patients and how to incorporate language changes into your medical practice**
2. Discuss underlying discrimination and medical biases related to the provision of care for patients who are transgender and/or nonbinary.
3. Discuss clinical guidelines for hormonal therapy for patients who are transgender and/or nonbinary
4. Practice having conversations around hormone therapy with transgender and/or nonbinary patients
5. Identify best practices that clinics can use to provide nondiscriminatory care, including the training of support staff

Sex & Gender

Sex

- chromosomes
- hormones
- gonads/ genitals
- medical designation:
(fe)male/intersex

Gender

- self-perception
- cultural construct
- identity/expression/performance
- social: (wo)man/man/non-binary

“Sex refers to the biological differences between males and females. Gender refers to the continuum of complex psychosocial self-perceptions, attitudes, and expectations people have about members of both sexes. Even the terms male and female, man and woman are not interchangeable. What it means to be male or female originates from physical characteristics derived from sex chromosomes and genes that lead to certain gonads, internal and external genitalia, and physiological hormones. Being a man or a woman holds broader meaning, with cultural concepts of masculinity and femininity coming into play.”

Social Terms

Transvestite

T*** slur**

**Transgender(s)/
ed**

“ IT”

**Parent/Husband/
Wife**

Sir/Ma'am

Crossdresser

Drag King/ Drag Queen

Transgender person

Patient/ Client

Legal Guardian/ Caregiver

**Loved One/ Spouse/ Significant
Other/ partner/ medical proxy (if
applicable)**

They/You/ the client

Medical Terms

FTM/ MTF

Real Sex

Sex Change

Pre/Post Op

Reassignment

Hermaphrodite

Transgender person / transman/ woman

Transgender or non-binary (person/client)

Biological Sex- (female, intersex, male)

Sex Assigned or Designated at Birth

Gender Affirming Procedures (name change, surgery, hormone replacement therapy/HRT)

Intersex person

Outdated or Inappropriate Terms

Real Name

Lifestyle

Homo/sexual

**Biological
(fe)male**

Preference

Legal Name

Gender Identity

Gender Expression

**Orientations: Asexual, Bisexual, Gay, Lesbian,
Pansexual Queer**

**Assigned or designated: Female/ Intersex /Male at
birth**

Sexual Orientation/ Relationship Status

Knowledge Check #1

What is the distinction between sex and gender ?

- A: Sex is a binary of “male or “female” while gender is a binary of “boy” or “girl”
- B: Sex is what a medical professional may designate at birth, gender is the personal essence of being
- C: Sex is anatomy, gender is social
- D: Sex is constituted of biological, hormonal, and chromosomal traits while gender is a broader construct
- E: B & D

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- E: B & D

ABC's of correcting mistakes

Apologize & **A**cknowledge

Be attentive and responsive, no victim blaming

Correct and adjust, consider the *correction as a gift*



Considerations for Application

- Administrative
- Socioeconomic
- Cultural

Knowledge Check #2

What is an appropriate way to correct misgendering/ outing a trans or non-binary person?

- A. Wait for the client to tell you where it went wrong
- B. Tell your supervisor so that you can try and avoid backlash
- C. You should apologize and be attentive to the needs of the client while correcting yourself
- D. Find out why the client feels that way so that you can learn more about their issues
- E. All of these are examples of how you should correct mistreatment of a client

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What is an appropriate way to correct misgendering/ outing a trans or non-binary person?

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“Born This Way” Simplistic Narratives

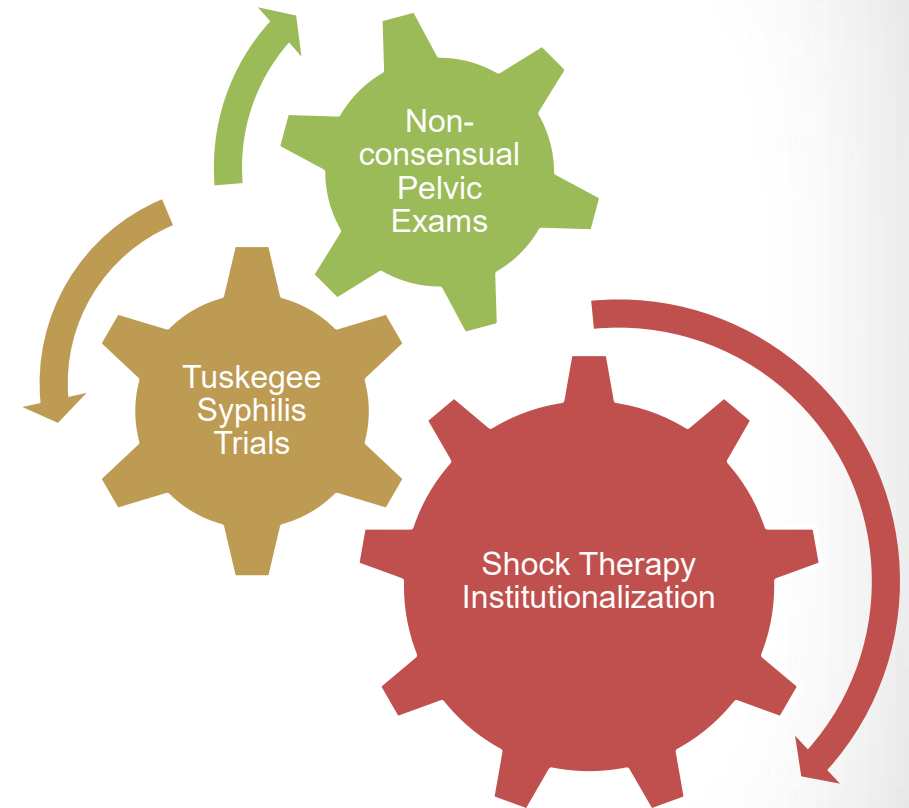
Binary approaches to transition

- All or nothing
- “Born in the wrong body”
- No room to be fluid



Health and Healthcare

- Gender pathologizing/repair
- *Trans Broken Arm Syndrome*
- Medical paternalism
- Education burdening (1)



(1) Butler, R. et. Al (2019). Social anxiety among transgender and gender nonconforming individuals: The role of gender-affirming medical interventions. *Journal of Abnormal Psychology*, 128(1), 25–31.

Knowledge Check #3

What is Trans Broken Arm Syndrome?

- A. Transgender women break their arms more often because of osteoporosis from oestrogen therapy
- B. Medical personnel refusing to treat a patient because they are trans
- C. Providers assume an unrelated medical problem is related to being trans
- D. Transgender patients are assumed to be hypochondriacs
- E. None of the above

Knowledge Check #3

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What This Looks Like In Practice



“Is this homeless patient stable enough to start hormone therapy?”



“You need to be on hormones for at least 6 months before you get top surgery”



“Your depression would probably be a lot less intense if you weren’t trying to transition”

Recontextualizing Stereotypes

Does your family know?

Have you had “the surgery”?

So that means you sleep with _____?

I’m really not a specialist in this kind of thing.

Are you sure you want this? You can’t take it back.

When did you decided to be trans?

Recontextualizing Stereotypes

Do you have
emotional
support?

What does
transition mean
to you?

Can you tell me
about your
relationships?

I'm still learning,
please hold me
accountable.

What
questions do
you have?

What has your
transition been
like so far?

Knowledge Check #4

What is an example of medical paternalism in gender affirming care?

- A. Withholding a referral for orchiectomy because a patient expresses thoughts of self harm
- B. Asking a patient what family or social support they have for their transition
- C. Requiring a psych consult before prescribing hormone therapy
- D. Answers A and C
- E. All of these are examples of medical paternalism

Knowledge Check #4

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GAC Resources for Providers*

American Academy of Family Practice:

<https://www.aafp.org/afp/2018/1201/p645.html>

American Academy of Pediatrics:

<https://pediatrics.aappublications.org/content/142/4/e20182162>

U.C. San Francisco Transgender Care Guidelines:

<https://transcare.ucsf.edu/guidelines>

World Professional Association for Transgender Healthcare (WPATH) Standards of Care:

https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf?_t=1605186324

***NOT an endorsement of any individual resource listed**

Knowledge Check #5

Prescribing hormones for GAC is recommended only after consulting: (select all that apply)

- A: Endocrinology
- B: Gynecology
- C: Psychology/Psychiatry
- D: The patient
- E: All of the above

Knowledge Check #5

Prescribing hormones for GAC is recommended only after consulting: (select all that apply)

- A: Endocrinology
- B: Gynecology
- C: Psychology/Psychiatry
- D: The patient
- E: All of the above

Making the Diagnosis

- Patient-identified, patient-driven, provider-supported
- Informed consent model vs. referral model
- Different from HTN, diabetes, cholesterol, kidney disease, etc. where we treat to a lab value or a symptom
- Never requires endocrinology, gynecology, or psychiatry/psychology.
 - Only to support concurrent diagnoses
- “Gatekeeping.” Also not required for OCP



Knowledge Check #6

Patients seeking GAC can be immediately classified under which diagnosis type(s): (select all that apply)

- A. Sexual Disorder
- B. Identity Disorder
- C. Behavioral Disorder
- D. All of the above
- E. None of the above

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- B. Identity Disorder
- C. Behavioral Disorder
- D. All of the above
- E. None of the above

GAC Diagnoses

- **No one-size-fits-all diagnosis.**
- **Medical mistrust and stigma are REAL!**



Most acceptable diagnoses:

- F64.9/gender dysphoria
- F64.0/gender dysphoria in an adult patient
- F64.2/gender dysphoria in a pediatric patient
- F64.0/Transgender MTF/FTM

Diagnoses to avoid:

- “Hermaphrodite” anything.
- “Endocrine disorder in MTF/FTM transgender person”
- “Hormonal imbalance in transgender patient”
- “Gender identity disorder” of any kind.
- “High-Risk _____ Sexual Behavior”

Dysphoria vs. Nonconformity

Gender dysphoria: “discomfort or distress caused by the discrepancy between a person’s gender identity and that person’s sex assigned at birth”⁽¹⁾

Gender nonconformity: “extent to which a person’s gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex”⁽¹⁾

NOT interchangeable, often separate but may overlap.

(1) WPATH Standards of Care, 2016

Knowledge Check #7

Appropriate goals of GAC should include each of the following components: (select all that apply):

- A. Legal name/gender identifier changes
- B. Surgery/surgeries
- C. Hormone or gender-affirming medication use
- D. Behavioral/Mental Health care for social/family support
- E. The patient's identified goals
- F. All of the above
- G. None of the above

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- G. None of the above

The Patient's (Hi)story



- **Conversation > Interrogation**

How do you identify? When/how did you first identify?

Related past medical, surgical, or mental health care?

Social support? Family, friends, school, work, significant other(s)?

What are your goals in this transition? Timelines, processes, hurdles and opportunities, desires and fears? Thoughts on medications, legal processes, surgeries, social transitions, etc.? Reproductive health?

- Set rational goals for steps together in advance.
- Identify boundaries for safety and offer patient-centered explanations as needed.
- The MOST crucial part of the process: **Be patient and listen.**

Feminizing Hormone Therapies

Medication choices

- Estrogen – estradiol (2-8mg PO QD/SL, 20mg IM QW, 100-400mcg topical)
- Antiandrogens – spironolactone (50-200mg PO QD), finasteride 1-5mg PO QD
- Progesterone – medroxyprogesterone, Prometrium (5-10mg PO qHS)

How to decide?

- Recommend, then let the patient choose!

Considerations

- Cost, convenience
- Social situations
- Smoking
- Street/friend purchasing/borrowing
- Self-injections

Feminizing Hormone Labs

- Labs – CBC, CMP, Lipids, Estradiol, Serum Testosterone, Albumin, Sex Hormone Binding Globulin, Prolactin
- Target estradiol level = “mid-cycle range for cis women”, generally 100-200pg/mL
- Target testosterone level = <55ng/dL (<25ng/dL)
- Consider timing of testing for injectable estrogen:
 - Ideal is 2-4 days post-injection, be mindful of peak/trough.
- May anticipate iatrogenic anemia, changes in lipids.

Feminizing Considerations

- Concurrent tobacco and estradiol use
 - Blood clots/DVT/PE – risk 2.5-4x higher than 1/10,000 community risk
- Decrease or loss of erectile function
- Decreased or low libido (73-88% reported)
- Age > 50? Menopause?
- Prolactinoma/Pituitary Adenoma and galactorrhea
- Migraine onset with feminizing hormone use

Common Feminizing Surgeries

- “Top” surgeries:
 - Breast augmentation/mammoplasty
 - Facial feminization, tracheal shave, vocal cord feminization
- “Bottom” surgeries:
 - Orchiectomy, vaginoplasty (tucking?)
- Body contouring, hair removal, BBL/other lifts, etc.
- NONE required for any transition.
- Consider payment hurdles, timeframes, and stigma

Masculinizing Hormone Therapies

Medication choices

- Testosterone – 20-100mg/week IM/SQ, may double for q2W dosing
- Testosterone – 2mg-30mg topical, applied daily to weekly
- Cypionate vs Enanthate – generally interchangeable, both oil-based

How to decide?

- Fewer options, so let the patient choose!

Considerations

- Cost, convenience
- Social situations
- Smoking
- Street/friend purchasing/borrowing
- Self-injections

Masculinizing Hormone Labs

- Labs – CBC, CMP, Lipids, Estradiol, Serum Testosterone, Albumin, Sex Hormone Binding Globulin
- Target estradiol level = <50pg/mL, but varies w/ cycle
- Target serum testosterone level = Goal is “normal physiologic range” (~300 to ~1100ng/dL)
- Consider timing for injectable:
 - Ideal is 2-4 days post-injection, be mindful of peak/trough.
- May anticipate iatrogenic increases in H&H, RBC, lipids.

Masculinizing Considerations

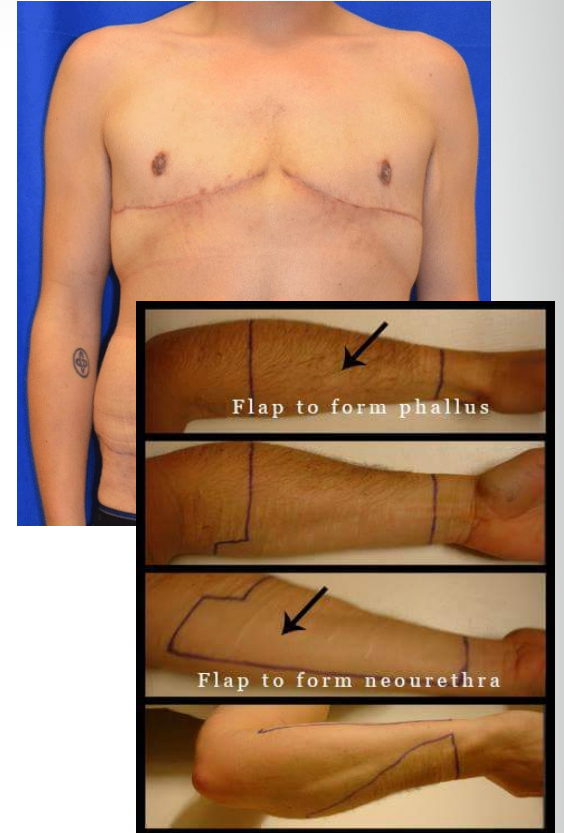
- Polycythemia/erythrocytosis
- Hair growth, also hair loss
- Migraine onset with changes in estrogen levels
- Age > 50? Menopause?
- Metabolic syndromes: obesity, HLD, DM2, PCOS, CVD
- Amenorrhea, pregnancy considerations

*“I never thought I’d
grow a hair there!”*

-Rose Nylund

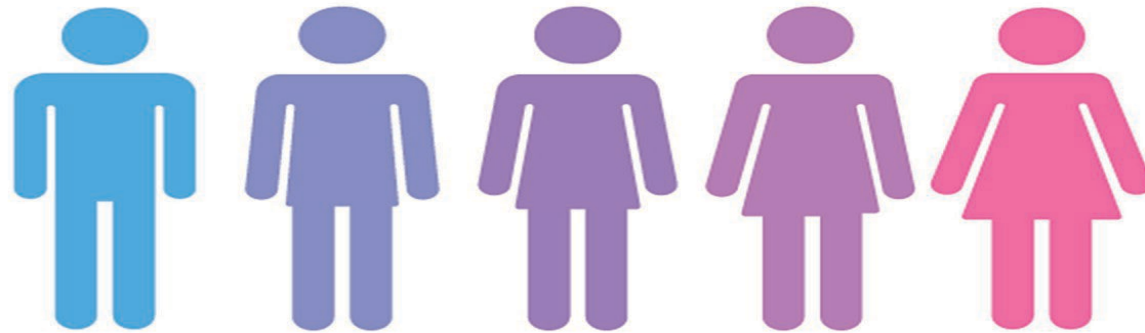
Common Masculinizing Surgeries

- “Top” surgeries:
 - Breast reduction/removal/chest reconstruction (binding)?
 - Facial masculinization
- “Bottom” surgeries:
 - Phalloplasty, scrotoplasty, metoidioplasty
 - Hysterectomy, oophorectomy, orchiectomy, vaginectomy
- Surgical scars may involve stigma.
- NONE required for any transition.
- Consider payment hurdles, timeframes, and stigma



GNB Approach

- Entirely decided by the patient w/ provider support
- Transitions may involve purely psychosocial changes, may involve physical changes
- Consider all options and provide individualized approach



Preventive Care

- ANATOMY, ANATOMY, ANATOMY
- “As a rule, if an individual has a particular body part or organ and otherwise meets criteria for screening based on risk factors or symptoms, screening should occur regardless...”
- Risk screenings based on age and family history
 - Consider current anatomy and pre-operative anatomy
 - Consider identified risk factors (social, sexual, etc.)
 - Again, gender identity ≠ sexual orientation

Knowledge Check #8

Transitions should proceed according to (select all that apply):

- A. Provider Judgment
- B. Medical Guidelines
- C. Patient readiness and request
- D. Lab/test results
- E. Physical/body changes
- F. All of the above
- G. None of the above

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Transitions should proceed according to (select all that apply):

- A. Provider Judgment
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- C. Patient readiness and request
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- G. None of the above

Scenario

- 23y/o Elizabeth Smith presents to establish care and would like to discuss GAC and HRT today
 - Pronouns = she/her
 - “I guess I first identified in early middle school but really didn’t understand it until around 17y/o”
 - Unsure about other surgeries but wants breast surgery and to change her name/identifiers ASAP
 - Lives with mom and one sister. Sister is aware of identity, mom not aware outright. A couple online friends and coworkers at her job in the mall know, are very supportive. Father not around, extended family is distant but sees them maybe once/year.
 - Has been sharing/buying IM estradiol x4 months from a friend she met online.
 - No h/o BH care, has not previously discussed GAC with a medical provider.
- What other questions do you have?
- What recommendations might you make for Elizabeth?

GAC Competencies

- “Hormone therapy is best undertaken in the context of a complete approach to healthcare that includes comprehensive primary care and a coordinated approach to psychosocial concerns.”
- Can be managed by a variety of providers – MDs, NPs, PAs, specialists, primary care providers
- Care coordination is crucial given fragmentation of the U.S. healthcare system and common social disparities in underserved communities.
- Few formal training programs exist – seek opportunities to learn! Mentoring!
 - <https://www.wpath.org/gei/certification>

Non-discriminatory Practices

- SOGI in EMR or paper records. Train ALL staff on importance and universal collection. Same for pronoun “hurdles.”
- Don’t hypersexualize people. Ever. Gender historically = certain body parts we instantly associate with promiscuity when discussed.
- Avoid assumptions (and staring). Breasts ≠ female. Facial hair ≠ male. Gender identity ≠ sexual orientation.
- Provide safe/inclusive bathroom and private spaces
- Empower patients to identify and/or address concerns.
- Encourage universal humility and openness from the front desk to the billing office.
- Actively listen for opportunities and apologize for errors in real time.

Takeaways

- Identity is a strong(er?) driving force and motivator, but also the deepest and most personal quality with risk for trauma
- No firm guidelines for care. Incredibly variable options for care plans
- Seek collaboration to provide comprehensive care
- Every situation is different, every need is different. Meet patients where they are and listen to them first and foremost

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Best Practices: Trauma

- Use patient's vocabulary
- Explain a procedure beforehand in detail
- Ask for permission at each step
- Negotiate comfort levels w/ nudity, physical examination

I know there will be a lot of different people checking on you today.

Is there anything you would like the staff to know that I can note in your chart?

I want to look for any scarring, discharge, or other issues with the tissue of your genitals.

May I use my fingers to move the skin around?

What Do Trans People Want?

*“When I think about the clinic environments that I’ve practiced in, the thing that clearly establishes them [as LGBT-friendly] is the **physicality of the space** and what’s there.*

So – are there rainbow flags, are there HRC stickers? ...It doesn’t have to be much... just something that is a little splash someplace and they will find it.”¹

What Do Trans People Want?

“...Patients described situations in which other patients and clinical staff stared and laughed at their appearance, especially early in their transition, or they were asked questions that forced them to out themselves as transgender in front of other patients or staff who did not need to know about it.”¹

Best Practices: Language

Hello my name is Dr. Jones.
My pronouns are she/her.
It's nice to meet you. What
name would you like me to
use for you today?

- No hallways conversations
- Front desk staff
- Pharmacy prescriptions
- Telephone protocol
- Introductions every time

Gender-Neutral Default

Say THIS	Not THAT
Partner	Husband, Wife, Girlfriend, Boyfriend
They	He or She
Sibling, Child, Relative	Daughter, Son, Aunt, Uncle, etc.
Parent or Caregiver	Mom or Dad
Blood relative, Direct descendants	Maternal grandmother, paternal grandfather, etc.

Gender-Neutral Default

Say THIS	Not THAT
Gestational parent/birthing partner/laboring partner	Mom
Nursing	Breastfeeding
Biological parent/Sperm donor/Egg donor	“Real” mother or “Real” father
Parenting/Parental	Maternity/Paternity

Structural Changes

- Intake paperwork
- Waiting rooms (is it pink?)
- Facilities (signage, restrooms, gowns)
- Diverse brochures
- Longer appointment times
- Telemedicine
- Non-discrimination statement
- Online presence
- Pronoun pins

IF YOU'RE IN A PUBLIC BATHROOM AND YOU THINK A STRANGER'S GENDER DOES NOT MATCH THE SIGN ON THE DOOR, FOLLOW THESE STEPS:

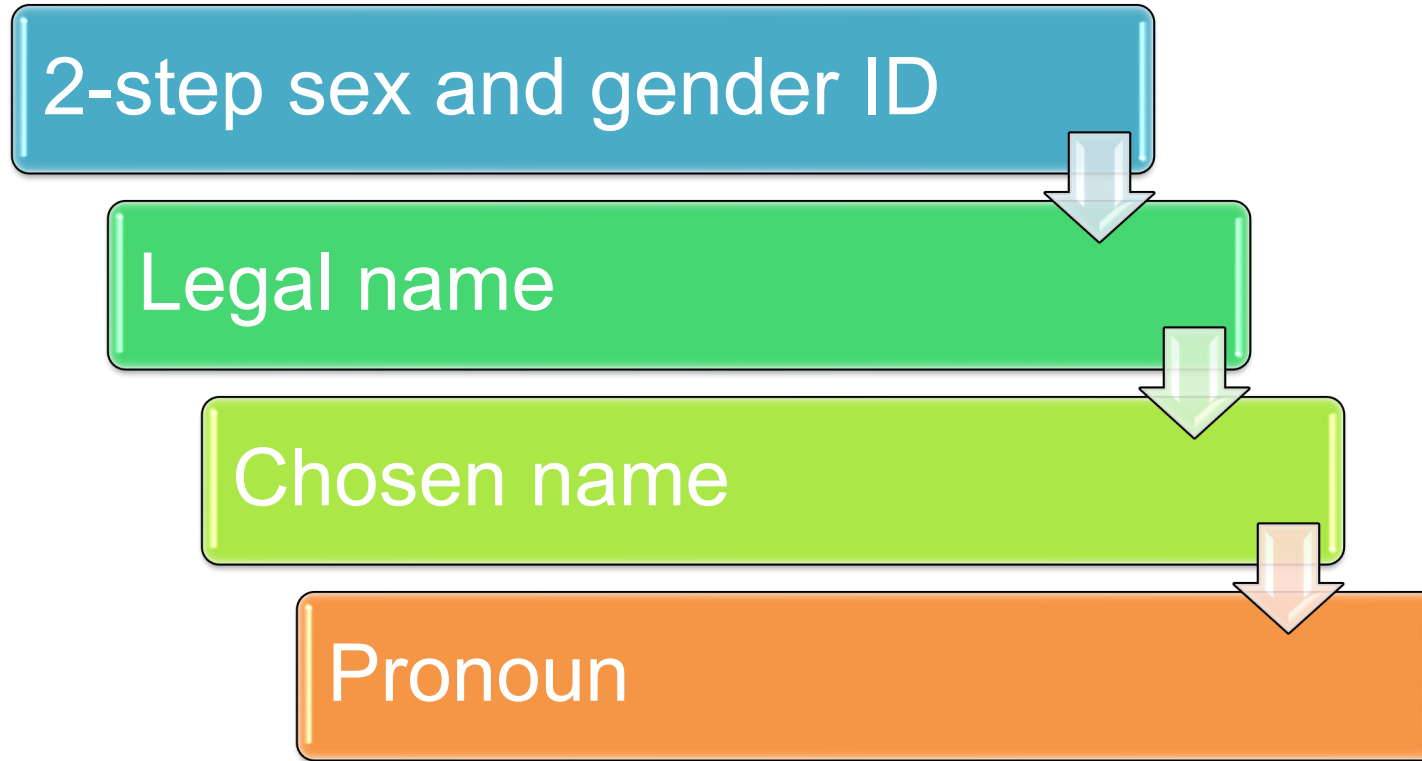
1. DON'T WORRY ABOUT IT, THEY KNOW BETTER THAN YOU.



University of Bristol
LGBT+ Society

#transawarebristol

EHR/Charting



Knowledge Check #9

What is an example of a structural change a clinic could make to better provider gender affirming care?

A: Gender neutral bathrooms

B: Introducing yourself and your pronouns to new patients

C: Including diverse pictures of transgender people in your waiting room posters

D: Placing a non-discrimination statement on your website

E: Answers A, C, and D

Knowledge Check #9

What is an example of a structural change a clinic could make to better provider gender affirming care?

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Thank You

Citations and Resources

American Association of Medical Colleges. Clinical Vignette Series. [Aamc.org/what-we-do/diversity-inclusion/lgbt-health-resources/clinical-vignettes](https://www.aamc.org/what-we-do/diversity-inclusion/lgbt-health-resources/clinical-vignettes)

American Psychological Association. Bias Free Language: Gender. Retrieved 28 December 2020, from <https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/gender>

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, 70 (9), 832-864. doi: 10.1037/a0039906

DC Trans Coalition (2015). Access Denied: DC Trans Needs Assessment Report. [Dctranscoalition.files.wordpress.com/2015/11/dctc-access-denied-final.pdf](https://dctranscoalition.files.wordpress.com/2015/11/dctc-access-denied-final.pdf)

Essential Access Health. (n.d.) Providing Inclusive Care for LGBTQ Patients: A Resource Guide for Clinical Settings. [Essentialaccess.org/sites/default/Providing-Inclusive-Care-for-LGBTQ-Patients.pdf](https://essentialaccess.org/sites/default/Providing-Inclusive-Care-for-LGBTQ-Patients.pdf)

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