

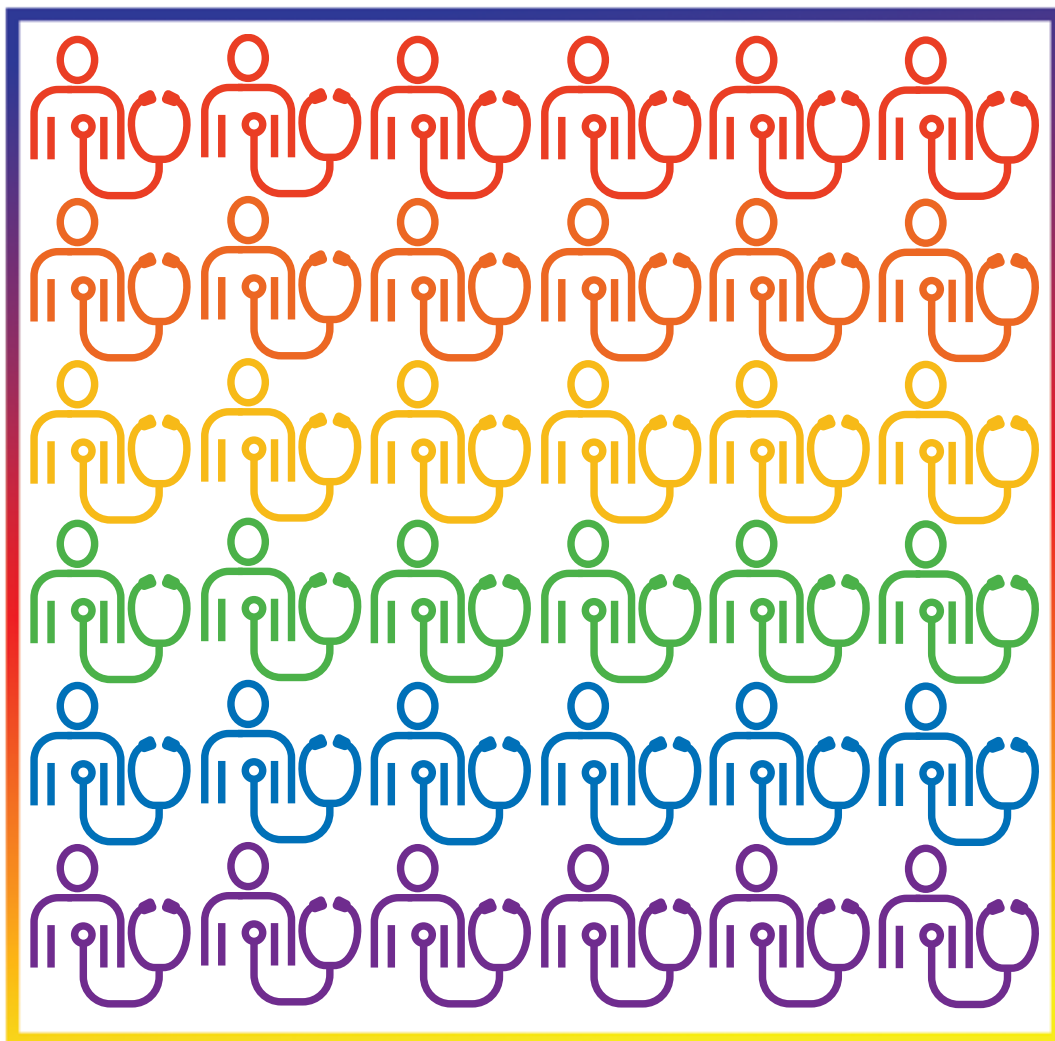
# Family Doctor

A JOURNAL OF THE NEW YORK STATE ACADEMY OF FAMILY PHYSICIANS



**FEATURE ARTICLES:**

- Transgender Patients: Considerations for the Family Physician
- Unique Differences in Screening and Prevention for LGBT Adolescents
- How to Better Meet the Mental Health Needs of Transgender Individuals within a Primary Care Clinic
- Cervical and Anal Cancer Prevention for the LGBTQ Population



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<sup>1</sup>U.S. Department of Agriculture Economic Research Service. Household Food Security in the United States in 2015

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## Articles

<b>Good Family Medicine is Good LGBTQ Care</b> By Mike Hudson, MD .....	18
<b>How to Better Meet the Mental Health Needs of Transgender Individuals within a Primary Care Clinic</b> By Jessica Conner, PsyD; Karen L. Weise, PhD and Nahid Aziz, PsyD .....	21
<b>Non-Medical Body Modification Techniques for Transgender and Gender Non-Conforming Patients: What the Primary Care Provider Needs to Know</b> By Kyan Lynch, MD, MA; Mai-Anh Tran Ngoc, DO; Kelly Farrow, MS, RN, AAHIVS, FNP-BC; Cara Wood, BA and Katherine Greenberg, MD .....	24
<b>LGBTQ+ Inclusive Primary Care: Insights from a Student-Run Clinic</b> By Emma Gerstenzang; Olivia Molineaux; Betsy Szeto; Olivia Nolan; Matt Adan; Cibel Quinteros Baumgart; John McGovern; Teresitta Velez and James Spears, MD .....	29
<b>Unique Differences in Screening and Prevention for LGBT Adolescents</b> By Samuel Sandowski, MD and Mark Maloof, DO .....	32
<b>Transgender Patients: Considerations for the Family Physician</b> By Diane M. Bruessow, PA-C; Lisa M. O'Connor, MD; Elizabeth Eaman, MD and Jason N. Chamikles, DO, JD .....	36
<b>Cervical and Anal Cancer Prevention for the LGBTQ Population</b> By Sarah Hudson, MD and Caroline Donohue, MD .....	42

## Departments

From the Executive Vice President: Vito Grasso .....	6
President's Post: Marc Price, DO .....	8
Advocacy: Reid, McNally & Savage .....	10
Two Views: LGBTQ: The Basics .....	13
View One: Gender Affirmative Terminology By InSung Min, MD, MPH, AAHIVS; Michelle Bejar, MD, MPH, AAHIVS and Leila Hagshenas, MD	
View Two: Inclusive Language Made Easy By Jordana Gilman, BS	

## Index of Advertisers

American Dairy Association .....	3
Bassett Medical Center .....	7
Marley Drug .....	5
MLMIC .....	2
New York eHealth Collaborative .....	Back Cover
Saratoga Hospital .....	47
St. Joseph's Health .....	9

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## From the Executive Vice President

By Vito Grasso, MPA, CAE

**N**ew York is a leader in practice transformation. CPC+, TCPI, Medicaid's DSRIP and numerous private transformation initiatives dot the NY health care landscape. NY has also negotiated a NY specific PCMH model with NCQA. The NY-PCMH model recognizes investment in behavioral health integration, HIT, care coordination, population health and the potential of multi payer support through value based payment.

NY's Advanced Primary Care (APC) project was designed to transform practices over time using increasingly more intensive competency levels. Introduction of a NY-PCMH model as part of PCMH 2017 established alignment between APC and PCMH.

A core benefit of the NY-PCMH initiative is the availability of technical assistance in achieving NY-PCMH recognition from transformation vendors retained by the state using SIM funds. NY contracts with 15 such vendors and can provide technical assistance to practices anywhere in the state. Free technical assistance is available until expiration of the SIM grant at the end of 2020.

### NY-PCMH includes 12 core criteria:

#### Behavioral Health

- Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
- Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression

#### Care Management & Coordination

- Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately

- Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
- Care plan is integrated and accessible across settings of care
- Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
- Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2)
  - A. Target pop. health mgmt. on disparities in care
  - B. Address health literacy of the practice
  - C. Educate staff in cultural competence

#### Health IT

- Has a secure electronic system for two-way communication to provide timely clinical advice
- Provides continuity of medical record information for care and advice when the office is closed
- Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions

#### Value Based Payment

- The practice is engaged in Value-Based Contract Agreement

Practices that participate in NY-PCMH have access to unique support. Practice transformation organizations are deployed throughout NYS at no charge to practices. Enrollment fees are waived for new Recognition and 1<sup>st</sup> Annual Reporting for sustaining practices. Practice transformation technical advisors partner with practices through the entire Recognition Check-In process or First AR process and are required to ensure benchmarked progress for submitting documentation to NCQA.

In order to align with many federal and state initiatives, including MACRA, NCQA has adopted broad definitions of VBP to satisfy the requirement of: “Engage in a VBP contract agreement for either an upside or two-sided risk contract”.

- **Pay-for Performance (P4P) – 1 Credit** - Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/ or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared Savings - 1 Credit** – Payments are FFS, but provider/ practitioners who keep medical costs below established expectations retain a portion (up to 100%) of the savings generated. Providers/ practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the proportion of total savings.
- **Shared Risk - 2 Credits** – Payments are FFS, but providers/ practitioners whose medical costs are above established expectations are liable for a portion (up to 100%) of cost overruns.
- **Two-sided Risk Sharing – 2 Credits** – Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based Payment – 2 Credits** - Payments are not tied to delivery of services, but take the form of a fixed per member, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below that amount. Payments, penalties and awards depend on quality of care.

OQPS and Medicaid convened to review current practice barriers to meeting VBP requirements and have made the following determinations.

- **PCMH 2014 Level 3 & PCMH 2017:** Practices participating in the NYS PCMH model that are unable to meet this standard at the time of their annual renewal (Annual Reporting) date will have the option to attest that they will complete this requirement within one year.
- **Former APC & new practices:** will continue to have the designated 12-15 months to complete the QI 19 requirement.

For more information on NYS PCMH please visit: [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/pcmh/](https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/) or reach out to the SIM team: [SIM@health.ny.gov](mailto:SIM@health.ny.gov)

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## President's Post

By Marc Price, DO

I'm gay friendly. At least that's what a new patient to the practice, Jay, told me the year after I opened my own practice when I asked what had brought him in to my office that day. This took me a little by surprise. Not that I was considered friendly towards anyone in particular, but more that I was considered friendly towards a specific group. I had never thought about it. I wasn't upset, but more curious. Why did he make that bold statement? Who was saying this about me? What exactly did it mean? When I questioned my patient further about his statement, he told me he was given my name from several friends (who also happened to be gay) who told him that I was accepting of all lifestyles and treated everyone with respect. Jay went on to tell me that he had been to see several local doctors and that had not been the case. Once again I was taken aback. This time not due to how he described my attitude, but rather that other physicians he had seen had not treated him the same.

As a physician, we are tasked with caring for our patients. This doesn't just include treating a disease or curing an illness, but rather caring for a patient as a whole. Indeed, even the most current version of the Hippocratic Oath states, "I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug." Additionally, the Osteopathic Oath states, "I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend. . . ." I interpret this to mean that we don't choose who we take care of, but rather we care for those that wish to be cared for by us. In my opinion, which is now shared by both the NYSAFP and the AAFP, healthcare is a basic human right, not a privilege. We should treat all who walk into our offices, clinics, hospitals or any other practice setting with respect and dignity. Regardless of their sexual or religious preferences or choices they have made in their lives, they still deserve medical care in a non-threatening, non-judging, accepting environment,

regardless of whether their physician agrees or shares in their beliefs. The luxury of caring for only like-minded individuals or for only those who share our beliefs and lifestyles is not one the house of medicine can afford. Not to say we need to condone behavior we may disagree with, but that should not hinder the quality and delivery of care we provide.

We have all likely had personal hurdles and difficulties we've experienced in providing care for some of our patients. Many times it's because of some emotion evoked by that patient which makes our objectivity difficult. Sometimes it may be related to a feeling of a connection with a patient which may cause us to give more treatment than is necessary, essentially overtreat, to fulfil a need to do something. Our empathy and emotions get the better of us. When we express these traits, we're considered caring physicians, big-hearted, a good doctor. Yet other times, our own biases and beliefs drag up something not as pleasant. Anger. Hate. A desire not to provide care. When this happens, we're perceived as cold, uncaring, angry, mean, not a good doctor.

I've definitely experienced both ends of the spectrum. I don't think I'm unique in this regard. I will only say to the first, my feeling of connection with patients, that I value these relationships and I do believe that they contribute to me acting as a more caring physician. I also think that by using evidence based medicine and by collaborating and effectively communicating with my patients it helps prevent me from overtreating. As to the later, more negative emotions, I'd like to share a brief memory.

Early in my career I walked into an exam room and was faced with an aging man – one who looked a lot older than he actually was, facing me, sitting on the exam table wearing dirty, torn, tattered jeans and a black t-shirt with faded lettering and the sleeves torn off. There was a heavy stench of body odor and cigarettes and the air felt thick. He had an oxygen cannula in his nostrils connected to a portable tank. On his bare arms were several swastika tattoos. I'm Jewish. One set of my grandparents immigrated here during World War II from Vienna when they fled from the Nazis. Nazis had killed other members of my family.



The swastika is a symbol of the Nazis. Like it or not, without even a spoken word between the two of us, I had a dislike for this man. I sat down. I stared at the chart in front of me. My career started in the heart of the Bronx and then inner city Albany taking care of drug addicts, alcoholics, convicted felons, homeless patients and many others our society deem undesirable. I never shied away from caring for any of them. At that moment I wanted nothing more than to get up and leave the room, to have him be gone and to never see him again. Not even a word had yet been spoken. Instead, I took a deep breath and steeled myself to try to provide good care for this man in front of me. I started my questioning to find out why he was there. I wanted to hate him, but he was respectful and relatively pleasant. I listened to his concerns. He didn't use any racial epithets and he didn't spew hate. I started to focus on his concerns and on him instead of the symbols on his arms that caused so much emotional discomfort. He was a mechanic who was a two-pack a day smoker and had COPD and high blood pressure. Later in the visit, I worked up the courage to ask him about his tattoos. It was a test of sorts. Was he going to spew hate? Was he going to talk about his dislike or distrust of the Jews? He didn't know that I was Jewish. When I asked, he looked a little apologetic and told me that they were from a different time in his life. When he started to become ill with his COPD several years ago, he had been treated by a Jewish pulmonologist who he credited with saving his life. Despite his inability to stop smoking, he had since changed his views about Jews. I also then asked him why he didn't, then, have his inflammatory tattoos removed. His response was simple. That was who he was. It was part of him and who he was. It couldn't be changed and removing the tattoos wouldn't change that either. If anything, it reminded him who he was and who he no longer wanted to be. Then I shared with him that I was Jewish. I treated him that day. As a matter of fact, I treated him for several years until he ultimately succumbed to his advanced COPD. At the time of his death he had become one of those patients to whom I had become endeared.

This is why what Jay, my new patient, told me about his previous primary care experiences caused me concern. When we are in the exam room with our patients, we need not reflect the political differences we hear about in the news, but rather, simply take care of the person in front of us. As physicians we need to be empathetic and understanding, caring and comforting. We need to be interested and concerned. We need to hear them, take their hands in ours and earn their trust. How else can we expect our patients to bare their souls to us and share their lives with us, even for just the expanse of a brief office visit. We can make the difference in someone's life between feeling accepted and loved versus rejected and jaded.

Throughout my years of practice (which are growing longer by the day) I've had many other experiences similar to what I've just told and each time I have to push beyond my own pre-judgements and prejudices. It can be challenging and not every encounter ends in a meaningful way. There are times my initial thoughts and feelings turn out to be correct, for better or worse, and other times they are not, also for better or worse. But caring for patients is the reason why most of us entered this glorious field of medicine. Despite everything that goes on outside of my exam room walls, despite having old social demons return and new ones rise up and despite our own preconceived and prejudiced thoughts, we need to focus on the person in front of us. Everything else needs to fade away. All we can do is enter each patient encounter as a new experience and see where the relationship takes us and remember that everyone deserves a family physician.

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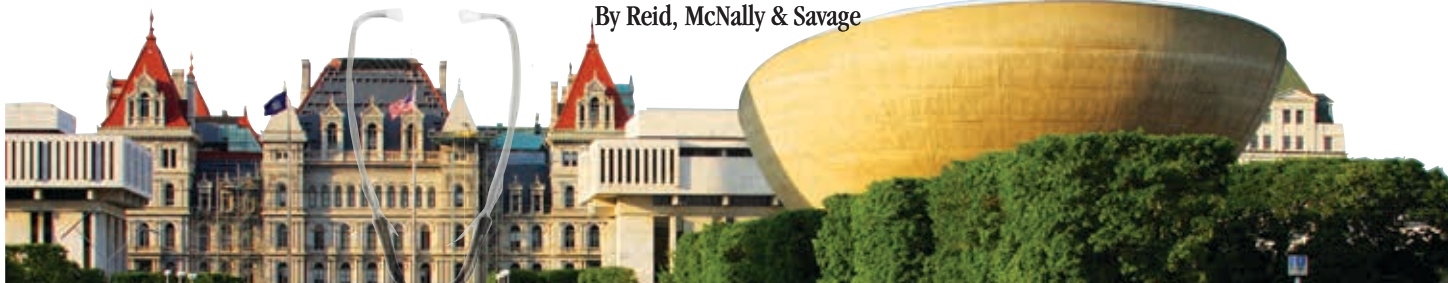
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## Albany Report

By Reid, McNally & Savage



### Elections Update

This November, national and state elections resulted in significant changes in the federal House of Representatives and State Senate.

#### *Andrew Cuomo wins re-election, Democrats sweep statewide offices*

In state-wide elections, Democrats won resoundingly with Andrew Cuomo defeating challenger Marc Molinaro, NYC Public Advocate and Democrat Tish James becoming the first female elected Attorney General following her win over Republican Keith Wofford while Comptroller Tom DiNapoli coasted to reelection. Incumbent United States Senator Kirsten Gillibrand defeated Republican challenger Chele Farley to win her second full term.

#### **Congress**

##### *Democrats pick up three seats in the House*

In three congressional districts, largely in rural areas, Antonio Delgado ousted Representative John J. Faso in the Hudson Valley, Anthony Brindisi led Representative Claudia Tenney in the Mohawk Valley and Nate McMurray narrowly trailed Representative Chris Collins in Buffalo. In NYC, Democrat Max Rose ousted Staten Island Republican Representative Dan Donovan.

Democrats now hold 21 of the 27 congressional districts in New York State and hold a majority now in the House.

### New York State Senate

*State Senate Democrats win majority*

#### **Long Island**

According to unofficial results, as many as four seats on the Island were flipped. Democrat Monica R. Martinez defeated Republican Dean Murray, the local assemblyman, in the 3rd Senate District; James Gaughran beat veteran Republican Carl Marcellino in the 5th Senate District; Democrat Kevin Thomas beat Senate Health Committee Chairman Kemp Hannon in the 6th District; and Democrat Anna Kaplan defeated Republican Elaine Phillips in the 7th District. Democratic Senator John Brooks of Seaford also won a second term in the 8th District against Republican Jeffrey Pravato.

#### **New York City**

To the west, in NYC, Democratic challenger Andrew Gounardes declared victory over Republican Senator Marty Golden (22nd District). Democrats won the day in the City defending all of their seats.

#### **Hudson Valley**

Moving north, Hudson Valley Assemblyman James Skoufis defeated Republican Tom Basile in a contest to replace long-time Republican Senator Bill Larkin in the 39th District near West Point. Republican Senator Sue Serino, of the 41st District, held her seat in a victory over newcomer Karen Smyth. Democratic candidate Jen Metzger, a Rosendale Councilwoman, defeated former Assemblywoman Annie Rabbitt in a contest to replace retiring Republican Senator John Bonacic in the 42nd Senate District. Westchester County-based Democrat Peter Harckman declared victory over incumbent Senator Terrence Murphy.

#### **Capital District – Saratoga**

In the Capital District and surrounding areas, incumbent Republican Senators George Amedore (46th District), Jim Seward (51st District), Jim Tedisco (49th District), and Betty Little (45th District) successfully defended their seats along with Democratic Senator Neil Breslin (44th District). Republican Daphne Jordan defeated Democrat Aaron Gladd in 43rd Senate District seat in the Saratoga region. She will replace retiring Republican Sen. Kathy Marchione.

#### **Central New York**

In Central New York, Republican Bob Antonacci declared victory over Democrat John Mannion to replace retiring Senator John DeFrancisco (50th District) in a very close race. Political newcomer Rachel May, a Syracuse Democrat, defeated Republican Janet Berl Burman in the campaign for the 53rd Senate District. May previously defeated incumbent Democratic Senator Dave Valesky in the September primary.

#### **Rochester – Finger Lakes**

Moving further west to Rochester, all three Republican incumbents successfully defended their seats. In the 55th District, Senator Rich Funke (55th District) defeated challenger Jen Lunsford; in the 54th District Senator Pam Helming (54th District) won over challenger Kenan Baldridge; and Senator Joe Robach (56th District) defeated challenger Jeremy Cooney. To the South of Rochester, Southern Tier Republican Tom O'Mara (58th District) soundly defeated challenger Amanda Kirchgessner.

#### **Western New York**

In the Buffalo region, Republican Senators Cathy Young (57th District), Chris Jacobs (60th District), Mike Ranzenhofer (61st District) and Rob Ortt (62nd District) defended their seats along with Democratic Senator Tim Kennedy (63rd District).

# New York State Assembly

*Speaker Heastie maintains overwhelming majority*

## Long Island

Incumbents largely won the day in Assembly races across the state with a few exceptions, growing the Assembly Democratic Majority unofficially to 107 to 43. Starting on Long Island, the parties swapped two Assembly seats. Republican Michael LiPetri ousted Christine Pellegrino, and Democrat Judy Griffin defeated Brian Curran. Republican candidate Joseph De Stafano defeated Democrat Clyde Parker in a bid to replace Assemblyman Dean Murray. Democrat Taylor Raynor coasted to victory in Hempstead following her victory over longtime Assemblywoman Earlene Hooper in the September primary.

## New York City

In Queens, newcomer Catalina Cruz was elected to the 39th District following her primary victory over Assemblywoman Ari Espinal. In Brooklyn Democrat Mathilde Frontus defeated Republican Steven Saperstein to fill the seat left vacant by Pamela Harris following her resignation, and former mayoral staffer Simcha Eichenstein will replace retired Assemblyman Dov Hikind after an uncontested election. On Staten Island, Democrat Charles Fall coasted to victory to replace Surrogate Judge-elect Matt Titone while Republican Michael Reilly won his race to replace Assemblyman Ron Castorina who lost the Surrogate Judge contest. In the Bronx, Democrat Karines Reyes will replace Luis Sepulveda who became a State Senator following a special election last spring.

## Hudson Valley

In the Hudson Valley, Democrat Nader Sayegh won over challenger Joe Pinion in a bid to replace Shelley Mayer who also became a State Senator following a spring special election. Republicans flipped a seat in the 99th District after Colin Schmitt defeated challenger Matthew Rettig in a bid to replace Senator-elect Jim Skoufis. The race for the state's 104th Assembly District in Newburgh ended with Democrat Jonathan Jacobson capturing the seat, defeating Republican rival Scott Manley in a bid to replace the late Assemblyman Frank Skartados.

## Capital Region – Saratoga – North Country – Mohawk Valley

All incumbents, Democrat and Republican, successfully defended their seats in the Capital region and Saratoga. In the Mohawk Valley, Republican Robert Smullen won over Democrat Keith Rubino to succeed retiring Assemblyman Marc Butler while Democrat Marianne Buttenschon won in her effort to fill the seat vacated by Congressman-elect Anthony Brindisi. In the North Country, incumbent Addie Jenne lost her election to Republican Mark Walczyk in the 116th District.

## Central New York – Finger Lakes - Rochester

In the Finger Lakes, Republican John Salka defeated incumbent Bill Magee to represent the 121st district and Republican Brian Manktelow will replace retiring Assemblyman Bob Oaks. In the Rochester region, Republican Marjorie Byrnes will replace Assemblyman Joe Errigo. Rochester Democrat Jamie Romeo will replace Congressman-elect Joe Morelle following an uncontested election.

## Western New York

In Western New York, Democrat Patrick Burke defeated incumbent Erik Bohlen in a rematch of their April special election to fill the 142nd District left vacant by Mickey Kearns. Democrats took the 146th District in Erie County following a win by Karen McMahon over incumbent Republican Ray Walter.

# 2019 Health Care Priorities Outlined

*Top health care issues likely to elicit Democratic Senate focus*

From marijuana legalization to increased protections for abortion rights, health care is certain to be a major focus of the new Democratic majority in the state Senate as fresh committee chairs and newcomers alike seek to enact liberal policies that Republicans have stymied for years. The defeat of reigning Senate Health Chairman Kemp Hannon to a Democratic challenger also charts a new course for the body as Hannon has served in the chamber for nearly three decades.

## ***Reproductive Health Act***

Gov. Andrew Cuomo has already indicated some policy changes will be placed on a fast track. In particular, the governor said that the Reproductive Health Act, NY S2796— which would shift the state's abortion laws from the penal code to the health statute, as well as make various tweaks to more closely align with federal statute — would be passed within the first 30 days of the new session.

## ***Comprehensive Contraception Coverage Act***

The Comprehensive Contraception Coverage Act, NY S3668 mandates that insurers cover all FDA-approved contraceptive drugs and devices, without co-pays or other cost-sharing mechanisms, and expand access to male and emergency contraceptives. The question is not if the bill will pass in a Democratic Senate but whether it will be on the same day as the RHA or on its own.

## ***GENDA***

For the past decade, the Assembly has fruitlessly passed the Gender Expression Non-Discrimination Act, or GENDA, which would add “gender identity and expression” to civil rights laws that prohibit discrimination based on a person's characteristics. Now, the bill's supporters see a new urgency to pass GENDA because of the Trump administration's proposed gender rule that defines people by their sex at birth.

## ***Marijuana***

A Democratic Senate will also make it easier to pass changes to the state's medical marijuana program, such as a recently introduced measure, NY A11390 for state-run health insurance like Medicaid to cover the drug. Cost has been a major impediment to getting more people to access and use medical marijuana.

The legalization of marijuana for recreational use will likely lead to a lengthy debate. While other states, and now Canada, have legalized the drug, the issue was off the table under the Republican Senate. Assembly Democrats and the Cuomo administration have been working on parallel tracks on the issue, and New Jersey has haggled over a number of details for basically the entire year that Democratic Gov. Phil Murphy has been in office. Among the concerns that will likely need to be hashed out include excise tax rates, a slate of criminal justice reforms sought to address the historical effects of drug law enforcement and how to structure a legal marijuana program. Many lawmakers are interested in setting up ways for minorities and women to operate and own businesses in the industry, and some are wary of allowing big marijuana companies from out of state to step in and dominate the market.

**continued on page 12**

A significant increase of the state's marijuana supply would likely push down the price of medical products, and a number of the 10 authorized medical marijuana operators have lobbied to be first in line for a recreational license.

### ***Expanded Insurance Coverage***

It will also make it easier for lawmakers to pass new insurance coverage mandates, such as an in vitro fertilization effort that failed last year, and Democrats will have a wider berth to crack down on the drug industry and pharmacy benefit managers.

### ***Single Payer***

The possibility of a single-payer health care system in New York was a major campaign talking point for both Democrats and Republicans. The Assembly has routinely passed single-payer legislation, but it was always blocked by the Republican-controlled Senate.

Gov. Cuomo began warming up to the idea during his primary campaign but has not fully embraced what has become a rallying cry for grassroots Democrats and liberal politicians. He has said he believes it is better done on the federal level.

A RAND Corp. study earlier this year found that establishing a single-payer system in New York was financially feasible and could bend the cost curve in the future under a number of assumptions. For instance, the authors had to project the tax rates that would fund its \$139 billion price tag. Taxes would be partially offset by people no longer needing to pay premiums or out-of-pocket costs, under NY A4738.

The State would have to ask for an unprecedented federal waiver to redirect all federal, state and Obamacare-related funds to pay for implementing the legislation, called the New York Health Act. The Trump administration has said it would not grant such a waiver.

New York could theoretically move forward without federal waivers by not touching Medicaid or Medicare funds, but it would significantly alter the funding equation and raise the politically dicey issue of forcing people off their employer-sponsored insurance plans while poor and older residents keep their existing coverage.

The proposal has fractured New York's unions — a divide the bill's sponsors are trying to bridge before it risks derailing the controversial measure. While public-sector unions in New York City have voiced concerns over the bill's potential to curtail their generous health benefits, two leading health care unions are among those continuing to back the legislation. A single-payer system would remove one big-ticket item that the New York State Nurses Association and 1199SEIU would no longer have to collectively bargain for with employers. The issue of health insurance often resonates with rank-and-file members, who interact with patients struggling to pay for their care. The two unions say they support other labor groups pushing for a workaround that would allow them to keep their current benefits.

Sponsors Gottfried and Rivera have said they are amending the bill to address the unions' issues — as well as other changes — and will introduce a new draft next month, when Democrats will have control over the entire state Legislature. The bill has repeatedly passed the Assembly.

### ***Safe Staffing***

The New York State Nurses Association for years has pushed hard for mandatory staffing levels for nurses, which the union says is necessary to ensure safety for workers and will improve patient care. The effort has faced opposition from hospitals wary of the increased labor costs associated with the legislation as well as fellow union 1199SEIU, which has been concerned the mandate would lead employers to cut back on other health care workers that make up a large share of its membership. In Albany, 1199 is known for its political muscle, particularly among downstate Democrats who represent many of its members, and the union-vs.-union dynamic was a partial reason the bill did not pass in the Assembly this year even though it had previously. In June, Cuomo came out in favor of the idea but did not offer specifics on what he believes the proper staffing level should be.

### ***Maternal Mortality***

Lawmakers will also be pressured to address New York's maternal mortality rate, particularly for poor women and those of color. In June Gov. Cuomo established a task force on the issue, with the goal of recommending solutions. Lawmakers, however, failed to come to an agreement on the creation of a maternal mortality review board that would investigate childbirth deaths due to a provision that would allow its work to be used in court proceedings.

### ***Supervised Injection Sites***

On Nov. 8th the governor's office rounded up representatives from the NYS Health Department, New York City Police Department and the advocacy community to read through proposed facility guidelines at a two-hour meeting in New York City, according to Housing Works CEO Charles King, who was present for the meeting. The meeting was confirmed by the governor's office.

The guidelines would establish four supervised injection facilities for opioid users in New York City — and allow Ithaca to move forward on a facility of its own — amid threats of prosecution from the federal Department of Justice. In August, Deputy Attorney General Rod Rosenstein wrote an op-ed in *The New York Times* warning that “cities and counties should expect the Department of Justice to meet the opening of any injection site with swift and aggressive action.”

VIEW ONE

GENDER AFFIRMATIVE TERMINOLOGY

By InSung Min, MD, MPH, AAHIVS; Michelle Bejar, MD, MPH, AAHIVS and Leila Hagshenas, MD

VIEW TWO

INCLUSIVE LANGUAGE MADE EASY

By Jordana Gilman, BS



Compared to their heterosexual peers, LGBT youth experience more risk factors for mental health problems and substance abuse including harassment, victimization and violence.<sup>1</sup> Lesbian, gay, bisexual, transgender/transsexual, and queer / questioning (LGBTQ) adolescents and adults represent a growing and medically underserved population with higher health risks, including elevated rates of depression and suicidality.<sup>2,3</sup> An important contribution to these health disparities is the increased abuse this population experiences. One meta-analysis showed that they experience up to 3 times more abuse during childhood.<sup>4</sup> The LGBTQ community is challenged with some unique barriers to care, including discrimination and disrespect<sup>5</sup>, which can lead to a delay in care or an avoidance of seeking care and interacting with the healthcare system. In a survey done in California of 600 transgender people, 50% of respondents reported needing to teach their providers about their own healthcare.<sup>6</sup> Traditionally, health care has assumed a cis normative structure, where oftentimes, one's sex at birth is presumed. This can make it less welcoming for patients who are trans or those whose gender differs from their gender at birth. This can be observed in the questions providers often ask and how they ask them. There is also a level of transphobia, whether conscious or not, which can stem from one's own discomfort, aversion, or unfamiliarity towards individuals who are gender diverse, ambiguous or questioning. This can come from presumptions that we as providers hold, or from a lack of familiarity with or a lack of vocabulary to help support patient centered encounters. Transphobia can lead to a spectrum of behaviors (conscious or unconscious) that are non-affirming, and possibly discriminatory and at times can be received as traumatic. This is important to recognize as it can be a barrier to creating healthy partnerships with patients.

This paper aims to address some of these disparities by offering primary care providers basic tools to help navigate common terminology which may be encountered. This discussion of terminology is limited as there is great diversity in the LGBTQ population and culture so this review is not completely comprehensive. Another caveat in this discussion is that the terms being presented can often be dynamic for patients and based on personal self-identification, so it is important to be attentive to how patients are comfortable being identified and to check in with these designations over time. Table 1 presents common gender related terminology.

continued on page 14



Providers are increasingly recognizing the need for LGBTQ inclusive language, but often do not know exactly how to go about it. This highlights an opportunity for compassionate, patient-centered care that was historically not part of medical education and therefore goes unpracticed.<sup>1</sup> In a time-constrained environment, providers may neglect to choose wording that is respectful of a patient's gender identity and sexual preferences. Providers who are sensitive to these issues may be concerned that they will "out" a patient to their family, alienate patients based on their beliefs, or place the burden on patients to identify themselves. Searching for appropriate language can feel unnatural, and providers grappling for "politically correct" terminology may hinder the establishment of trust and therapeutic rapport. Use of non-inclusive language may even be taken as discrimination by an LGBTQ patient, which can have longstanding effects on care seeking behavior and health outcomes.<sup>2,3</sup>

In this "toolkit," I offer simple conversational "tweaks" that are inclusive to all patients and avoid perceived risks of embarrassing LGBTQ patients or offending others. These adjustments can do a great deal to create a safe and healing space for all patients.

The following recommendations for providers and health care staff are the result of evidence in the literature as well as personal experience as a lesbian health care provider and transgender health advocate. Each tool has its limitations, but when used as a whole, will make everyday conversations with patients, coworkers, and even friends and family more inclusive.

continued on page 16



**Table 1**  
**Gender related terminology**

<b>Term</b>	<b>What it means</b>
<b>Sex</b>	Male or Female, assigned at birth typically based on one's genitals.
<b>Sexual Orientation</b>	A person's emotional, physical, and sexual attraction to other people and the expression of that attraction.
<b>Transgender</b>	Umbrella term for people whose gender identity and/ or gender expression is different from their assigned sex at birth. This may or may not involve medical (pharmaceutical) or surgical intervention. At times, an individual may no longer identify as transgender once any gender transition is complete.
<b>Trans Woman</b>	(Male-to-Female, MTF) Assigned male at birth, but (now) identifies and lives as a woman.
<b>Trans Man</b>	(Female-to-Male, FTM) Assigned female at birth but (now) identifies and lives as a male.
<b>Transitioning or Gender Transition</b>	A process that some, not all, transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This may or may not include the following interventions: hormone therapy, gender affirming surgery, living full or part-time in the current gender identity, adopting new hairstyles or make-up, binding and other external expressions of gender.
<b>Intersex</b>	1% of children are born with chromosomes, hormones, genitalia and/or other sex characteristics that are not exclusively male or female assigned sex by their doctors and/or families. Intersex refers to a number of conditions in which a person's reproductive / sexual anatomy at birth does not fit the typical definitions of male or female.
<b>Transsexual</b>	Historically has referred to a person who has undergone a medical intervention leading to a gender transition. Replaced by the broader umbrella term "Transgender".
<b>Pansexual</b>	Not limited or inhibited in sexual choice with regard to gender or activity. A person who is sexually inclusive in this way.
<b>Gender Identity</b>	A person's internal sense of gender, which may or may not be the same as the gender assigned at birth. Gender identity is personal and not always obvious. Gender can be affected by culture, it can be dynamic and change over time, and at times, it can be performed.
<b>Gender Expression</b>	The external expression of gender identity. It can be exhibited through a variety of ways, for instance behavior, clothing, hairstyle, body language, voice.
<b>Gender Non-conforming</b>	Someone who does not conform to traditional gender roles when considering the way they identify and express their gender. Traditional roles can vary based on different cultural and societal norms and ideals.
<b>Non-Binary</b>	Any gender identity that does not fit into the gender binary of male and female.
<b>Gender Attribution</b>	The way we find ourselves perceiving someone else's gender (ex: that's a man" or "that's a woman"). The way the world sees someone.
<b>Assigned or Designated Sex at Birth</b>	The sex that typically a medical professional assigned a person at birth. This is often what is designated on someone's birth certificate.
<b>Cis-Gender</b>	Sex assigned at birth is congruent with gender identity.
<b>Cross Dresser</b>	People who wear clothing of a gender that differs from the sex assigned at birth. Drag queen and drag king refer to those who cross dress. This can be for self-expression or entertainment and may or may not exhibit overlap with being transgendered.
<b>Transvestite</b>	A term that is derogatory and is no longer used.
<b>Queer</b>	An umbrella term for those who do not identify as heterosexual, heteronormative, or within the gender-binary. The term also acts as a label setting queer-identifying people apart from discourse, ideologies, and lifestyles that typify mainstream LGBT (lesbian, gay, bisexual, and transsexual) communities as being oppressive or assimilationist. The word queer is still sometimes used as a hateful slur, so although many have reclaimed it from their oppressors, be careful with its use.
<b>Questioning</b>	An active process a person goes through before "coming out." This term is mostly used by young people who are in the process of determining their sexual orientation and/or gender identity.
<b>Gender Fluid</b>	Non-fixed gender identity that can change over time. It is the ability to become one or many of limitless number of genders, for any length of time, at any rate of change.

## view one, continued

It is also important to remember that not all LGBTQ people have the ability to present physically how they feel mentally or spiritually.

**Obtaining a Sexual History:** Asking questions in a way that is not hetero-centric or cis-centric is important in having respectful and honest conversations about sexual and reproductive health.<sup>7</sup> This can be challenging as much training in medicine has primarily entailed language that is more hetero-centric and exclusive of those with non- binary identities. For instance, a commonly used question is “do you have sex with men women or both”. This question does not always help to better understand one’s sexual behaviors.

Some principles to help guides these discussions:

- Explore what sexual activity means to the patient
- Ask about anatomy and behavior instead of a patient’s sexual identity or gender (man, woman, gay or straight) as sexual identity and gender can be dynamic for some patients and do not necessarily reflect sexual behavior. One way to offer STD testing would be to ask patients what “parts” of their body they use during sex. Another way to offer testing would be offer your choice of testing and see what the patient chooses. For instance, “We can treat for gonorrhoea and chlamydia in the throat, urine and anal area. Which test do you not need?”
- Use the words your patients use for their body part as a guide or you can use non-gendered terms like top and bottom as an alternative. Using traditional terminology, misgendering, or using anatomical terminology can at times be very traumatizing for patients, especially in transitioning or transgender patients.

### What can we do to provide gender affirming care in a Primary Care Setting?

- Use **Personal Gender Pronouns (PGPs)**. This is an update from “Preferred Gender Pronouns” which may incorrectly imply that the use of other pronouns is acceptable if not preferred. It is important to remember that even if a person presents physically as “male” for instance, they may prefer to use a more traditionally identified female name. This can become complex as this gender may or may not be consistent with their formal identification. It is critical that we use pronouns that patients prefer in order to foster a safe and supportive environment for patients. Asking about and correctly using someone’s pronoun is one of the most basic ways to show that you respect their gender identity. If you make a mistake in a patient’s PGP, you can apologize and move on. Do not linger and continue to apologize. Make an effort to connect with your patient and use their PGP.

- Ask about **preferred names**, (ask what your patient would like you to call them) which can often be different from a **government name** that a person was given. A government name is stated on a patient’s formal identification documents such as passport, driver’s license, or health insurance card. With transitioning patients, this may or may not be consistent with their preferred name depending on what stage of the process they are in to legally change their government documents to reflect their preference.
- Use neutral pronouns such as they/them/their when a patient’s gender is not yet discerned in a patient encounter. These pronouns may also be the PGP of someone who has a non-binary or nonconforming gender identity.
- Create a welcoming environment for LGBT patients by having gender neutral bathrooms and rainbow signs around the office showing solidarity for LGBTQ populations.
- Make sure patient intake forms ask about preferred name, pronoun, gender identity and sex assigned at birth.
- Providers should acknowledge and assess their own values, attitudes and beliefs regarding trans people and personal difficulties with various gender expressions

Provide training for all patient staff to learn this terminology, and techniques to be sensitive and inquisitive about how patients choose to identify themselves. Misgendering a patient by using the wrong PGP can be traumatizing and could prevent a patient from returning to a provider for necessary care. Also consider how to incorporate PGP’s and preferred names in medical records as part of this training. Keep in mind during the training that everyone comes in with their own attitudes and biases. It is important to assess these attitudes and biases before beginning the training.

### Final Recommendations:

- Providers and health care institutions should strive to foster a safe and supportive environment where clients can explore their identities.
- Use the right terms.
- Encourage office-wide interventions to make your space more LGBT friendly.
- If you aren’t sure about a patient’s gender identity or PGP, ask! Every person’s transition and gender history is different. Don’t assume to know it.

*The authors would like to acknowledge the contributions of the Ali Forney Center in New York City.*

continued on page 17

## Ten Steps to Using More Inclusive Language:

Language Tool	Rationale	Examples
1a. Ask preferred name	An inoffensive question which can merely unmask a preferred nickname or give clues to gender identity.	"Nice to meet you! What would you like me to call you?"
1b. Ask preferred pronouns	Follow-up question after "preferred name" that indicates gender identity other than the birth sex on the medical records chart.	"My preferred pronouns are she/her/hers. What are yours?"
2. Use "echoing language"	Puts patients and families at ease by using the same words that the patient uses to describe gender, relationships, and anatomy.	Patient: "They're my significant other." Provider: "Do you want them to be in the room for our conversation?"
3. Use gender-neutral words	When echoing language is not possible, gender-neutral words avoid making assumptions about a patient's orientation or gender identity.	"Spouses" or "partners" instead of husbands and wives, "significant others" instead of boyfriends and girlfriends, "people" instead of men and women, "children" instead of sons and daughters, "parents" instead of mothers and fathers.
4. Use plural sentence structure	When a pronoun must be used, favor phrasing sentences in the plural so that you avoid gendering entirely.	"Teens who don't want children now may decide otherwise later on" instead of "When he grows up, he may want to start a family."
5. Don't be afraid to say "They"	"They/them/their" have been used as singular pronouns for centuries, and was recently added to the Oxford English Dictionary as a singular pronoun. <sup>4,5</sup> It is often difficult for grammar lovers to think of "they" as singular, but this is a very handy word in conversation. Try thinking of it as a new word entirely and learn this new meaning.	"Someone left you a message. Can you call them back?" "A patient is ready in room 2. Their name is Alex."
6. Speak to patients alone	This is especially important when treating LGBTQ youth. <sup>6</sup> Studies report that only 16-35% of LGBTQ youth are "out" to their PCPs but that many more would like to be. When asked what a physician could do to make talking about their identity more comfortable, 64% of participants responded, "Just ask me." <sup>7,8</sup>	"Do you like boys, girls, or both?" (and if eliciting a sexual history: "do you have sex with penises, vaginas, or both?") "What is your gender identity?" "Do you consider yourself to be straight, gay, lesbian, bisexual, or something else?" "Do you consider yourself to be transgender?"
7. Indicate that you are a safe listener	Demonstrate safety to patients without singling them out and indicate to LGBTQ patients that you will not "out" them to family members. Research conducted by the Gay, Lesbian, and Straight Education Network has shown that two-thirds of students who have seen a Safe Space sticker or poster at school feel comfortable talking with teachers about LGBTQ issues, while less than half of those who have not seen a sticker feel comfortable broaching these subjects. <sup>9</sup>	"Safe space" sticker in exam rooms, rainbow lapel pins on white coat, posters or pictures in the waiting room that reflect a diversity of identities.
8. Be conscious of how you label body parts and processes	Trans men may have gender dysphoria related to their menstruation, breasts, and reproductive anatomy. Trans women may feel similarly about penises. When echoing language isn't possible, you can ask your patient how they would like to refer to their parts.	"I would like to do a routine Pap smear to check for early warning signs of cervical cancer. How would you like me to refer to your parts?" "Do you get a monthly bleed?"
9. Use the right words	There is a lot of terminology to describe LGBTQ identities that may be unfamiliar to providers. This glossary can help <sup>10</sup> <b>sex:</b> natal sex, sex assigned at birth, based on biological "parts" <b>gender:</b> attitudes, feelings, and behaviors that a culture associates with male or female <b>gender identity:</b> a self-sense of gender <b>gender expression:</b> how a person behaves, dresses, and speaks <b>transgender:</b> gender identity different from sex assigned at birth <b>transsexual:</b> most view this as an outdated historical term, someone who has undergone gender affirmation surgery <b>gender dysphoria:</b> strong, persistent distress and discomfort because there is a mismatch between biological sex and gender identity <b>disorders of sex development:</b> ambiguous genitalia at birth, "intersex" <b>transvestite:</b> dressing as the opposite gender, does not inherently reflect gender identity <b>LGBTQIAA+:</b> combinations of these letters are used to refer to the LGBTQ community. They stand for: lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and allied. Sometimes it also includes a "P" for pansexual. The "+" at the end is a catch all! For more on this refer to "Gender Affirming Terminology" in this issue.	
10. Practice, practice, practice	Don't let the fear of making a mistake stop you from trying. If you do make a mistake, just correct yourself and keep going.	"I saw him—sorry, her—when she came to the office last week."

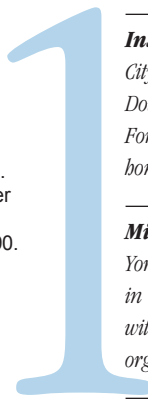
Good luck on your inclusive language journey, and don't give up!

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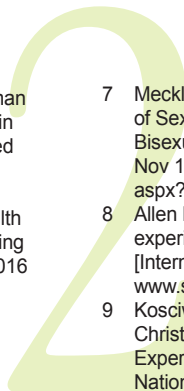
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# Good Family Medicine is Good LGBTQ Care

By Mike Hudson, MD

## Introduction

The LGBTQ population suffers from significant healthcare disparities compared to straight populations, with higher rates of depression, verbal and physical abuse and other concerns.<sup>1</sup> Fortunately, we are well poised in family medicine to help bridge these gaps, and this article discusses strategies for this. Of note, while this article uses LGBTQ as an umbrella term to describe a generally underserved population, each group within this umbrella, and each individual within each group, has unique challenges and strengths, and may or may not agree with the umbrella term nor see it as applying to themselves.

## An Inclusive Environment

As family doctors, we should be inherently non-discriminatory in our care, taking all comers from newborns to the elderly. Creating an inclusive environment is addressed in other articles, with several basics presented here. First, our non-discriminatory care should be codified into a clear policy which explicitly bars discrimination based on (among other things) sexual orientation and gender identity.<sup>2</sup> Our office itself should be welcoming with posters and flyers that include LGBTQ people.<sup>3</sup> There are many high quality and free online sensitivity trainings available, through the federal government's Substance Abuse and Mental Health Services Administration website (<https://www.samhsa.gov/behavioral-health-equity/lgbt/curricula>) and other online resources. Our forms should be culturally sensitive and inclusive, asking for a patient's preferred pronouns and using open language such as "partner" instead of "spouse,"<sup>2</sup> and finally, we should meaningfully engage with the LGBTQ community, partnering with community organizations and supporting their events.<sup>4</sup> The Joint Commission has a comprehensive guide to inclusive environments in *Advancing Effective Communication, Cultural Competence, and Patient-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community: A Field Guide*.

## Adolescents

The adolescent years are often a difficult time for teenagers and their families. LGBTQ youth are no different, and they may also struggle with accepting and integrating their sexual identity, dealing with external and even internal homo/bi/transphobia, and the potential impact of their identity on family relationships. Well adolescent checks for LGBTQ patients maintain the same flow and content as for any adolescent, but population-specific risks and reminders bear special attention.

## Trust and Confidentiality

Confidentiality is a cornerstone to building a trusting and therapeutic relationship with LGBTQ adolescents, as the fear of intentional or accidental disclosure of sexual orientation or gender identity is common. The strategies here echo best practices for all adolescent visits. The visit should begin with the parent in the room, and completed alone with the patient, framed as a routine part of all adolescent visits helping to build the patient's self-responsibility and self-reliance. Remind the patient and the parent of the office's confidentiality policy, and once the parent has left the room reassure the adolescent of this policy. Be sure to ask the adolescent what information is okay to share with the parent, and what should remain confidential. It is not our role to disclose identity or behaviors, nor to make recommendations about who to disclose to or when to disclose. Instead, offer support for the decision making process.<sup>4</sup>

## Sensitive Screening and Education

As with all adolescents, routine screening with validated tools is important. Being culturally sensitive requires taking care to approach questions of sexuality and sexual activity directly and with neutral phrasing such as "tell me about your partner" instead of "tell me about your girlfriend," allowing the patient to use their own language. See Table 1 for specific examples of important, and neutrally phrased, screening questions that fit within common screening frameworks.

Similarly, STI education and information around vaginal, anal and oral sex should be reviewed with all age-appropriate adolescents, regardless of gender, particularly as much sex-education is devoted almost exclusively to heterosexual acts.<sup>4</sup>



**Table 1. Specific Questions for Screening in LGBTQ Youth<sup>4</sup>**

**Safety**

- How are things going at home or at school?
- Do you feel safe when you are at home?
- Do you feel safe in your neighborhood or when you are at school?
- Has anyone ever picked on you? Can you tell me about it? Was it because you are LGBTQ?

**Comfort with Gender and Sexuality**

- Are you attracted to boys, girls or both?
- How do you feel about your attractions?
- What words do you use to describe your sexual identity?
- What gender do you consider yourself to be?
- How do you feel about your gender?

**Sexual History**

- Are you dating?
- Have you had sex with men, women or both?
- When were you first sexually active?
- When you use condoms for anal or vaginal sex, do you use them 5%, 50%, 75% or 100% of the time?

**Mental Health and Substance Abuse**

The internal and external stresses of being an LGBTQ adolescent contribute to significantly higher rates of depression, anxiety, and suicidality.<sup>1</sup> These adolescents face a 2 or 3 times higher risk of suicide attempts, and have higher rates of alcohol, tobacco and other drug use.<sup>1</sup> Increased rates of alcohol consumption often flow from a lack of social outlets that may lead to supportive bars or clubs that normalize substance use. Alcohol and drugs may also be used as self-medication against loneliness and depression.<sup>4</sup> In-person screening is important. So is knowing local resources to refer to for youth-focused support groups and mental health services. This allows for early intervention to help reduce these long-term risks and develop healthy coping strategies.

Part of this assessment should also include asking questions about the patient's comfort with their sexuality and gender, normalizing that these questions are asked of all patients. This affords the opportunity for brief interventions and referrals for those struggling internally with their identity. Finally, be sure to ask specifically about a history of sexual assault, as this information is rarely offered if not asked, and refer to area-specific services for victims. Suggested resources are listed in Table 2.

**“Coming Out”**

As discussed above, disclosing sexual identity to family can be a stressful, emotionally painful process. Research from the Family Acceptance Project clearly demonstrates the unintentional harm that LGBTQ youth suffer from rejecting behaviors of their families.<sup>5</sup> As family doctors we can ask our patients how their families reacted when they came out, and offer support and counseling when needed. Importantly, when enlisted, we can engage the family and leverage our existing relationship to help address the harm that is caused by often well-intentioned actions such as banning LGBTQ friends from the house. We can discuss with the families the long-term harm, such as an 8-fold increased risk of suicide,<sup>5</sup> that highly rejecting behavior creates. We can also suggest an open and honest dialog that allows parents to acknowledge their uncomfortable or angry feelings while also expressing their love for their

child. Lots of support is wonderful, but even a little bit of support goes a very long way for our patients' long-term well-being. Booklets and additional resources are available on the Family Acceptance Project website (<http://familyproject.sfsu.edu/>).

**Bullying and Violence**

One in three youth who identify as lesbian, gay or bisexual report being harassed or bullied at school, and nearly as many report being the victim of cyberbullying.<sup>6</sup> This is nearly twice the rate of bullying of their heterosexual peers.<sup>6</sup> Being cognizant of this risk means taking the time to screen for bullying and for being the victim of abuse. Effective interventions follow the same steps as for any student facing bullying:<sup>6</sup> assure them they are not at fault and don't deserve to be treated that way. Connect them with LGBTQ-welcoming mental health resources, such as those in Table 2. Encourage the patient and their parents to contact the teacher and/or the school principal to discuss their concerns, or we can offer to make these connections on their behalf. If the school does not respond appropriately, the matter can be elevated to the superintendent, the State Department of Education, and the US Department of Education. Additionally, GLSEN ([www.glsen.org](http://www.glsen.org)) is an organization that champions creating safe, affirming schools for all youth which can help proactively engage schools, such as creating Gay-Straight Alliance organizations.

**Adults**

Unfortunately, healthcare disparities for LGBTQ patients persist across the entire lifecycle. Higher rates of depression, suicidality, alcohol and drug abuse and reduced rates of preventive care are as present in adult LGBTQ patients as in adolescents.<sup>1</sup> Family medicine's care for patients at all stages of life improves our ability to address these disparities and efforts to create a welcoming environment for LGBTQ youth are similarly effective for LGBTQ adults. Gaining comfort in talking about the internal stress of gender identity in an MTF teenager directly translates to greater ease in discussing the mental health needs of a middle-aged lesbian woman. Helping guide a family to being more supportive for their gay teenage son builds empathy for a FTM adult rejected by his family in his youth. Stories and experiences treating all age ranges builds compassion and capacity for treating all patients.

Preventive care for LGBTQ adults follows the same core principles of screening and interventions, such as screening for depression and providing regular vaccinations which are covered elsewhere in the edition of Family Doctor.

continued on page 20

**Table 2. General and Mental Health Resources for LGBTQ Youth**

**Parents and Friends of Lesbians and Gays (PFLAG)**

Organization dedicated to advancing equality through support, education and advocacy  
[www.pflag.org](http://www.pflag.org)

**Family Acceptance Project**

Research-based organization working to help families support LGBTQ children  
<http://familyproject.sfsu.edu/>

**The National Runaway Switchboard**

Federal organization with services to assist runaway, homeless and at-risk youth  
[www.1800runaway.org](http://www.1800runaway.org) or 1-800-RUNAWAY

**Trevor Helpline Crisis Intervention for LGBTQ Youth**

24-hour, confidential suicide hotline for LGBTQ youth  
<https://www.thetrevorproject.org/> or (800) 850-8078

**RAINN's National Sexual Assault Telephone Hotline**

Provides counseling for sexual assault survivors and connects them with local resources  
<https://www.rainn.org/about-national-sexual-assault-telephone-hotline> or 800-656-HOPE

**Youth Resource**

A website by and for LGBTQ youth; <http://www.youthresource.com>

## Older Adults

Older gay, lesbian, and transgender people have faced tremendous violence and discrimination in their lifetimes, particularly those born prior to 1946 who did not benefit from the social changes that the Stonewall Riots of 1969 helped to usher in. The first state did not decriminalize consensual, private homosexual sex until 1962--the last to decriminalize it was in 2003.<sup>7</sup> The medical establishment itself is often perceived with caution if not outright fear, which is understandable considering the history of the DSM which considered homosexuality a treatable mental illness until 1973.<sup>7</sup> This makes creating a welcoming and inclusive environment especially critical to addressing their health care needs.

As for all of our patients, we need to be aware of the specific risk factors for elderly LGBTQ health. Cardiovascular disease and cancer risks are elevated in the elderly LGBTQ population as a result of their population's overall higher rates of smoking, hepatitis B and C, and lower rates of cervical cancer screening.<sup>1</sup> Awareness of these higher lifetime risks should guide

our focus on each patient's modifiable risk factors. Efforts to reduce disparities in youth and adult LGBTQ patients will hopefully lead to risks more in line with the general population over the long term.

Elderly caretakers require special comment. 85% of caregivers in the general population provide care for their parents, spouses or relatives.<sup>8</sup> Elderly LGBTQ individuals however, are four times less likely to have children, and are twice as likely to be single.<sup>8</sup> This is coupled with higher rates of estrangement from their biological families.<sup>8</sup> Additionally, elderly LGBTQ are less likely to engage in institutional services understandably fearing discrimination or abuse.<sup>7</sup> This all contributes to a significant risk of isolation and not receiving necessary care and support services, and requires awareness of community services as referral sources.<sup>8</sup> Recognizing that a patient's caretaker may also not fit a traditional role and helping connect them with support services can help prevent isolation and caretaker burnout. SAGE and the National Resource Center on LGBT Aging (<https://www.lgbtagingcenter.org/>) provide a wealth of resources to help connect our patients

with the LGBTQ-welcoming services they may need.

Finally, LGBTQ patients may lack many of the same legal protections that extend naturally to heterosexual married couples. And just as we should address healthcare proxies, wills, and other medical protections with all of our patients, we should be sure to specifically address them with our LGBTQ patients, and help direct them to appropriate resources.<sup>9</sup> The National Center for Lesbian Rights has an excellent document available online at [https://www.lgbtagingcenter.org/resources/pdfs/NCLR\\_LIFELINES.pdf](https://www.lgbtagingcenter.org/resources/pdfs/NCLR_LIFELINES.pdf) that discusses numerous questions around medical, financial, custody and other legal rights and the necessary documents to secure patients' rights.

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# How to Better Meet the Mental Health Needs of Transgender Individuals within a Primary Care Clinic

By Jessica Conner, PsyD; Karen L. Weise, PhD and Nahid Aziz, PsyD

**M**ental health and wellness are highly important for maintaining physical and medical wellness for both transgender and cisgender individuals. Transgender individuals often have unique mental health needs which may be appropriate to address within a primary care setting, particularly considering mental health professionals, at times, have inadvertently contributed to the discrimination this population faces through pathologization and mistreatment.<sup>1</sup>

While, colloquially, gender and sex are often used synonymously, they are distinct constructs.<sup>2</sup> Gender is a role that an individual lives publicly while gender identity is that individual's internal identification. Sex, alternatively, is the biological characteristics an individual is born with and depends on sex chromosomes, gonads, sex hormones, and genitalia. Transgender is an umbrella term which includes anyone who self-identifies as a different gender than that which was assigned at birth. Another important distinction to make is between gender identity and sexual orientation.<sup>2</sup> Gender identity consists of the gender an individual feels themselves to be, independent of any relations to others. Sexual orientation pertains to the individuals to whom that person is sexually or romantically attracted.

## Diagnoses

The transgender adult population in New York State is estimated to be 78,600, or 0.51% of the population, and it is likely that there are transgender individuals in most primary care clinics, even if they have not been thus identified.<sup>3</sup> It is important to note that not all transgender individuals meet criteria for gender dysphoria. The criteria for gender dysphoria are slightly different for children compared with adolescents and adults in the DSM-5.<sup>2</sup> Both include a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six other experiences for children and two for adolescents and adults. The experiences include but are not limited to: a strong desire to be of the other gender or an insistence that one is the other gender and a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender. The incongruence must be associated with clinically significant distress or impairment. Other medical diagnoses sometimes used when providing hormone therapy for this population are ICD-10-CM codes E34.9 Endocrine Disorder Not Otherwise Specified or F64.1 Gender Identity Disorder.

## Context: Sociopolitical & Historical Negative Experiences with Health Professionals

Compared with their cisgender counterparts, transgender individuals have greater healthcare needs related to their increased rates of harassment, assault, sexual violence, sexually transmitted infections including HIV and AIDS, and increased need for hormone providers.<sup>4-6</sup> Despite these increased needs, transgender individuals often face difficulty locating knowledgeable and affordable healthcare providers. Nineteen percent of transgender individuals have been refused health care due to their gender identity, 28% endured harassment in medical settings, and 2% experienced violence in doctor's offices.<sup>7</sup> About 50% had to teach their medical providers about transgender health care.<sup>7</sup> Understandably, many transgender individuals wanted to avoid these experiences and put off seeking medical care when it was needed. Also, fewer transgender individuals compared with cisgender individuals have health insurance.<sup>7</sup>

## Resiliency

Studies have found that, despite many sources of psychological distress, many transgender individuals demonstrate resiliency.<sup>8</sup> Some themes that contribute to resiliency for transgender individuals include the ability to define and have pride in their identity, feeling a strong sense of self-worth, being aware of oppression, being connected with a supportive community of other transgender individuals or family members, having a sense of spirituality, and having hope for their future.<sup>9-12</sup> These various resiliency factors help combat the distress brought on by the minority stress that many transgender individuals face.

## Reasons Transgender Individuals Seek Mental Health Care

To address mental health concerns with transgender individuals, it is helpful to understand that not all transgender individuals have mental health concerns and those who do may have them for gender-unrelated reasons. For the treatment of gender dysphoria, providing support throughout transition, treating mental illnesses secondary to minority stress, and treating mental illnesses unrelated to gender identity, interventions may not look significantly different from interventions with cisgender individuals going through identity struggles, life transitions, or coping with mental illnesses. However, it can be very important to understand the context of the presenting concern and provide affirming, rather than invalidating, care.

continued on page 22

### **Facilitate Transition**

Hormone therapy and gender-affirming surgical interventions are related to increased psychological functioning for transgender individuals.<sup>13-14</sup> Transgender individuals may need 1-2 letters of recommendation from mental health professionals in order to receive these treatments.<sup>15</sup> If letters are required, it may be helpful to refer the patient to a behavioral health consultant or specialty mental health provider who is comfortable writing such letters.

Primary care physicians, nurse practitioners, and physician assistants can decide whether a letter is required to start hormone treatment. Many providers instead adopt an informed consent approach in which, rather than requiring a letter, they make an assessment and diagnosis of gender dysphoria, assess for capacity to provide informed consent, and discuss what can be expected regarding medical and social benefits and risks.<sup>16</sup> When patients have an interest in surgical interventions, it can help to provide basic information about the surgical procedure and make a referral to an experienced surgeon. The informed consent conversation may include exploring psychosocial factors including their support network, their goals for the interventions, how to best navigate employment considerations, ways to cope with dysphoria when they do not receive the desired results immediately, and ways to cope with transphobic individuals, among other concerns.

### **Minority Stress and Related Mental Illness**

Along with typical life stressors, individuals with a minority status face rejection, discrimination, and violence, which is understood to be related to the higher prevalence of mental illness found within these populations.<sup>17</sup> It has been found that 36%-60% of transgender individuals have experienced physical violence, 43%-59% have experienced sexual violence, 27% experienced harassment during the past year, 25% had been homeless, 20% had been denied a job, and 13% reported being fired due to their gender identity

or expression.<sup>4,8,18-19</sup> These experiences are believed to contribute to transgender individuals' increased rates of mental illness including substance abuse, suicidal ideation, and suicide attempts.<sup>20</sup>

### **Gender Dysphoria**

Although an individual's gender identity itself does not cause mental illness, gender dysphoria can be harmful.<sup>15</sup> Approaches for these concerns may include exploring what the patient's gender identity is, working toward self-acceptance and coming out, and finding ways to live authentically.

## **Therapeutic Modalities and Techniques**

Transgender-affirming cognitive behavioral therapy (TA-CBT) is one therapeutic orientation that may work well for primary care providers working with transgender individuals.<sup>21</sup> As with classic CBT, the focus of TA-CBT is on understanding how thoughts, feelings, and behaviors interact, and then identifying and changing maladaptive thoughts and behaviors. By taking a trans-affirmative approach, negative thoughts, often impacted by societal transphobia, are replaced by more positive ones. This change hopefully leads to fewer negative emotions and behaviors such as substance use, isolation, and self-harm. Techniques used in this approach include psychoeducation, challenging negative self-beliefs, modifying cognitive cycles, and helping clients develop a social support network.

## **Practical Tips for Primary Care Providers Working with Transgender Patients**

### **1. Maintain Foundational Knowledge of Gender Identity Including Minority Stress, and Use Appropriate Language**

As reviewed above, it is important for providers to understand the relationship between gender identity, minority stress, and mental illness as well as the fact that negative effects of minority stress can be diminished by social support and trans-affirmative care possibly including psychotherapy, hormone therapy, and surgery.<sup>9, 17</sup> To stay up to date, it may help to take CME credits in cultural diversity topics.

It is also helpful to be familiar with affirming language. "Transgender patient" is typically preferable to "transgendered, transgenders, a transgender, tranny, or transsexual." Other often preferred language include "transition or gender affirmation surgery" rather than "sex change operation, pre-op, and post-op"; "assigned female/male at birth" rather than "biologically female/male or born a woman/man"; the pronouns the patient says they use should be used rather than "it or he/she"; and "legal name, dead name, chosen name, and affirmed name" rather than "real name." In general, the easiest option is to ask your patient (either in person or through careful collection of information through electronic or print health record) what language they use and stay consistent with their language.

### **2. Adopt an Intersectionality Approach**

It is helpful to understand that gender identity intersects with a variety of other cultural identities, leading to a vast array of experiences. Transgender individuals of color, for example, often experience more discrimination, higher rates of HIV/AIDS, more substance use, and are more likely to lack familial support than white transgender individuals.<sup>10, 22</sup> Additionally, some religious transgender individuals may struggle to integrate their gender identity with conflicting religious beliefs.<sup>23</sup>

### **3. Understand the Different Developmental Needs of Children and Adolescents**

Only 12-50% of children maintain cross-gender identification into adulthood.<sup>24-26</sup> Adolescents who identify as transgender, however, are more likely to maintain that identification throughout their lives. For adolescents, it may be helpful to assess readiness for and provide information about puberty suppression and hormone therapy. Fully and partially-reversible interventions such as these can lead to increased psychological functioning.<sup>13</sup>

### **4. Understand the Effects of Gender Identity on Romantic Relationships, Parenting, and Family Formation**

Transgender individuals often face unique challenges in romantic and sexual relationships.<sup>27</sup> Beyond the financial cost

of transitioning that a significant other may help to cover, partners may also face ostracization by friends and family. Additionally, partners may also grapple with their own sexual orientation, trying to incorporate their partner's gender identity. Transgender individuals in successful relationship have found respect, honesty, trust, love, understanding, and open communication to be helpful.<sup>28</sup>

Transgender individuals face both biological and legal complexities when forming a family.<sup>29</sup> Some hormonal and surgical interventions can result in infertility. Other individuals may not feel comfortable being pregnant or impregnating a partner. Providers should discuss with their patient the potential effects the interventions may have on later reproduction and various family building options.<sup>15</sup>

### **5. Stay Up to Date on Research, Changing Laws, Guidelines, and Criteria for Various Interventions**

Research about transgender individuals has been increasing significantly over the past two decades, and it is likely to continue expanding. Simultaneously, laws and guidelines about transgender individuals have been changing; all of which can significantly impact the experiences of transgender individuals. It can be helpful to read relevant guidelines such as the WPATH Standards of Care, UCSF's Center of Excellence for Transgender Health's Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guidelines.<sup>15-16, 30</sup>

### **6. Create an Affirming Office**

It may be more welcoming to display trans-affirmative resources in waiting areas and provide gender neutral bathrooms within the office. It is important to use correct names and pronouns, as well as train support staff and nursing staff in trans-affirming care. One way to make intake forms more affirming involves initially asking about gender identity and then asking about the individual's sex assigned at birth.<sup>31</sup> Information should be collected about the individual's pronouns and legal name, which could be included in additional demographic areas. It can also help to see if the system automatically fills in salutations, legal names, and pronouns on lab orders, prescriptions, and patient instructions and make necessary changes.

### **7. Form Relationships with Other Transgender Affirming Providers**

For individuals requiring letters of recommendation, specialty mental health treatment, and for individuals requiring surgical interventions, it can be important for primary care providers to be connected with other providers including endocrinologists, specialty mental health providers, psychiatrists, and surgeons to consult and make appropriate referrals.<sup>15</sup>

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# Non-Medical Body Modification Techniques for Transgender and Gender Non-Conforming Patients: What the Primary Care Provider Needs to Know

By Kyan Lynch, MD, MA; Mai-Anh Tran Ngoc, DO; Kelly Farrow, MS, RN, AAHIVS, FNP-BC; Cara Wood, BA and Katherine Greenberg, MD

## Background/Intro

Transgender and gender non-conforming (TGNC) individuals have a gender identity that is different from their sex assigned at birth.<sup>1</sup> For many TGNC people, this incongruence leads to discomfort and distress associated with societally gendered body parts, such as breasts, hips, and genitals, known as gender dysphoria.<sup>2,3</sup> Many TGNC individuals who experience gender dysphoria due to body parts seek social, medical, and/or surgical methods to alter their body to better align with their gender identity.<sup>4,5</sup> Some of the most commonly used methods of body modification can be accomplished without medical or surgical intervention and are therefore termed non-medical body modification (NMBM) techniques. These practices reversibly modify a person's body to make their gender expression more consistent with their gender identity, helping to relieve gender dysphoria.

When left untreated, gender dysphoria can negatively affect both mental and physical health outcomes.<sup>6,7,8,9,10</sup> Additionally, TGNC individuals are at high risk of experiencing verbal, physical, and sexual abuse, and more subtle kinds of discrimination when their gender expression does not meet societal expectations.<sup>8</sup> Both gender dysphoria and discrimination threaten quality of life and health outcomes, leading to increased risk of depression, anxiety, suicide, HIV, and other chronic diseases.<sup>11,12,13,14</sup>

NMBMs can help improve a TGNC person's sense of self and overall wellness by alleviating gender dysphoria and decreasing everyday stigma. Using NMBMs can help TGNC individuals conform to cultural norms of femininity and masculinity, increasing their safety in public.<sup>15,16,17</sup> Finally, NMBMs can be used as an interim measure while medical and/or surgical transition are in progress.<sup>18,19,20</sup>

The limited research done on NMBM techniques has largely been conducted by non-governmental organizations that provide advocacy and support for the transgender community. While not produced by a traditional academic publishing channel, this "grey literature" does provide evidence that most methods can be associated with side effects.<sup>21,22,23</sup> However, these side effects must be weighed against the significant potential benefits to patient safety, and physical and mental wellbeing.<sup>18,24,25,26,27</sup> Therefore, primary care providers should be prepared to discuss NMBM methods using a patient-centered, harm-reduction approach.

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NMBM practices are a new area of study, and this paper will reflect our current best knowledge of these methods and their side effects, with examples from real clinical cases. We will review three of the most common NMBM practices in use and conclude with general guidance for clinicians.

## Overview of Common Non-Medical Body Modification Techniques

### *Chest Binding*

Chest binding is a technique which involves the use of a garment or other material to compress breast tissue to reduce the appearance of breasts and to mimic the contours of a post-pubertal male chest. Most commonly used by transgender men and gender non-conforming individuals, cisgender men with gynecomastia may also employ this technique.<sup>18,28</sup>

There are many approaches that a patient may use to chest bind; however, they are not all equal in their efficacy or in their potential to cause physical harm. A 2017 qualitative survey of 1800 adults assigned female at birth (AFAB) with experience binding revealed an array of methods used to chest bind, including: commercial binders, sports bras, shirt layering, elastic or other bandages, athletic/neoprene compression wear, duct tape or plastic wrap, and other homemade devices, including binding with belts, scarves, tight fabric held with pins or tape, back braces, undersized swimsuits, girdles and pantyhose.<sup>18</sup>

This same survey found that over 97% of respondents had experienced at least one negative side effect associated with chest binding. Reported side effects included chest, back, and shoulder pain, generalized symptoms, as well as neurological, gastrointestinal, respiratory, musculoskeletal, and dermatological pathology.<sup>8</sup> A chiropractic narrative review of the literature confirms and emphasizes the musculoskeletal complications, specifically noting possible harmful postural alterations due to binding.<sup>29</sup>

The side effects reported in the study by Peitzmeier et al<sup>18</sup> are consistent with those reported in the grey literature.<sup>21,22,30</sup> However, the recommendations offered on popular blogs are often more reflective of common sense and personal experience rather than evidence. For example, a commonly recommended best practice is to wear commercial binders from reputable companies, rather than other devices. While this is certainly a reasonable suggestion, it is not supported by data offered by Peitzmeier et al., currently the only peer-reviewed study of chest binding health and safety.<sup>18</sup>

There is one point on which investigators and commentators agree: chest binding can be extremely beneficial for patients suffering from chest-related dysphoria. Peitzmeier et al. report a nearly

**Case Study 1:** R is a 15-year-old trans boy who just came out to parents and has started wearing a commercial chest binder at home and school. The binder -- along with a new short haircut, masculine clothing, and using his affirmed name and pronouns -- helps him feel less self-conscious around other people and improves his mood significantly. He wears the binder from about 7am until after school, which is usually around 5pm. One day, while wearing his binder in gym class and running sprints, he started to feel very short of breath, dizzy, and had to sit down on the track quickly when he felt like he was going to pass out.

*Clinician Recommendation:* R received counseling on the respiratory side effects of highly compressive binding. Together, R and his clinician agreed that instead of using his commercial chest binder when exerting himself in gym class or elsewhere, he will switch to a less compressive method: layering two sports bras.

**Case Study 2:** T is a 20-year-old trans man who comes in to discuss starting testosterone therapy. He has been socially transitioned for two years and binding for the last 6 months. He has tried a host of products, including a custom-fitted binder from an online company. He has a history of intermittent migraine/tension headaches, and since he started binding these headaches have become nearly daily and are often very limiting of his daily activities. Trials of various types of binders have not helped, but he does notice that when he leaves his binder off at home his headaches resolve. However, being out in public without a binder leads to significant gender dysphoria and he is eager to find a solution.

*Clinician Recommendation:* In this case, T had already tried many strategies to reduce his risk of getting headaches while binding. Unfortunately, none of these strategies had worked, and his headaches were truly debilitating. Recognizing these factors, T's clinician asked T about his overall goals for transition. When he reported that he was planning to have top surgery in the future, T's clinician worked with him to reduce the time before top surgery. This involved providing documentation and advocating on T's behalf with his insurance company.

universal positive effect on suicidality, anxiety, dysphoria, self-esteem, confidence, and ability to go out safely in public.<sup>18</sup>

Ultimately, best practices for patients who chest bind are those that minimize risk while maximizing the psychosocial benefits associated with the technique. Depending on the patient, this may include reducing the frequency of binding, taking binder “days off”, or switching to a less harmful method, all of which are supported by data from Peitzmeier et al.<sup>18</sup> Alternatively, for some patients, the most effective approach may be a bilateral mastectomy with masculine chest reconstruction, known colloquially as “top surgery”, earlier than planned. Data show that top surgery is important, beneficial, and relatively safe for patients who have chest dysphoria.<sup>26</sup> Indeed, a growing body of literature is demonstrating high satisfaction and very little regret associated with the procedure.<sup>32</sup>

The case studies on page 25 illustrate the need for an individualized, patient-centered, harm-reduction approach to caring for patients who chest bind.

### Genital Tucking

Genital tucking is a practice employed by individuals assigned male at birth (AMAB) who wish to flatten the bulge formed by the penis and scrotum to form a smooth pelvic contour.<sup>19</sup> There are several different ways to tuck; the most commonly used method involves moving the testicles up into the inguinal canals and the penis and scrotum posteriorly before securing them between the buttocks using a garment called a gaff, or an adhesive or tape.<sup>25</sup>

Currently, the authors are not aware of any peer-reviewed articles examining the safety of genital tucking. However, a review of online patient education tools and the grey literature reveals frequently cited

#### Case Study 1:

A 20-year-old transgender woman presents for a routine visit at an ID clinic. She reports that she has employed genital tucking daily for the last 3 years.

The patient is currently feeling well, no pertinent positives on ROS. Examination was WNL today, no s/sx of genital infection or trauma. Reports 6 casual sexual partners in the last 3 months. All STD testing done this week was negative (including rectal, throat, and urine gonorrhea and chlamydia testing).

Urinalysis tests for the last 3 years are unchanged but show persistent microscopic blood present. She reports she has been tucking for the last 3 years but denies any symptoms. UA from today:

Color, UA	Light Yellow
Appearance, UA	Clear
Glucose, UA	NEG
Ketones, UA	NEG
Specific Gravity, UA	1.021
Blood, UA	2+
pH, UA	5.0
Protein, UA	NEG
Nitrate, UA	NEG
Leuk esterase, UA	NEG

**Clinician Recommendation:** This case scenario shows a common and expected variation to UA that can be seen with genital tucking due to minor urethral trauma. In the absence of symptoms or physical findings, this result does not require any harm reduction counseling or intervention to address this result. It is helpful to document that the patient has been assessed for signs and symptoms of infection and trauma—and to perform anticipatory guidance for the patient on symptoms that may require reassessment.

#### Case Study 2:

A 29-year-old transgender woman presents to an ID clinic with scrotal pain. She reports practicing genital tucking intermittently for >10 years, daily for the last 2 years.

The patient has dx of persistent scrotal pain ongoing for the last 2 years (using OTC ibuprofen and Tylenol with some partial improvement). Doppler ultrasounds have been within normal limits. Treated at urgent care for recurrent UTI 2 weeks ago (several in the last 8 months)- symptoms resolved today. HIV positive (dx in 2014), undetectable on medications, no hx of AIDS. STD testing done at urgent care was negative (including rectal, throat, and urine gonorrhea and chlamydia testing), reports 0 sexual partners in the last 6 months. Examination today is unremarkable. Reports she was hesitant to come in today because she doesn't want another provider to tell her to stop tucking. UA from Urgent Care 2 weeks ago:

Color, UA	Yellow
Appearance, UA	Cloudy
Glucose, UA	NEG
Ketones, UA	NEG
Specific Gravity, UA	1.005
Blood, UA	1+
pH, UA	7.0
Protein, UA	30
Nitrate, UA	POS
Leuk esterase, UA	3+

**Clinician Recommendation:** The HPI in this case scenario illustrates an opportunity for the clinician to work collaboratively with the patient to employ harm reduction techniques to decrease pain and infection. If these methods are unsuccessful, this type of scenario is one where a referral to urology to discuss the benefits of orchiectomy or other surgical procedure may help to significantly increase quality of life and decrease complications.

best practices and potential unwanted side effects. Side effects noted in these resources include: skin irritation, rashes, and infections due to tape or adhesives, superficial fungal infections due to heat and moisture, urethral trauma, neuropathic pain, urinary reflux, epididymitis, orchitis, prostatitis, cystitis, and scrotal pain.<sup>25,33</sup> Another concern is dehydration, which can occur when a trans woman purposefully decreases her fluid intake to avoid having to use the bathroom due to fear of abuse or the need to undo her tuck while out of the house. Finally, tucking practices which involve elevating the testes through the inguinal canals may have negative effects on fertility, since the body's temperature is unsuitably high for spermatogenesis.<sup>33,35</sup> Further research is needed to evaluate these concerns.

As is the case with chest binding, best practices for genital tucking focus on minimizing discomfort and maximizing the affirming benefits of the technique. According to a patient education brochure developed at Callen-Lorde, a New York City-based LGBT Health Center, safer tucking methods include: trimming or shaving hair prior to tucking, avoiding duct tape and other adhesives not meant to be used on skin, remembering to use the restroom before tucking, continuing to drink fluids while tucked, and limiting the amount of time spent tucked to four to eight hour periods.<sup>36</sup> Additional best practices offered include ensuring that the penis is completely flaccid prior to tucking, wrapping tissue paper around the penis to reduce skin irritation, selectively choosing seamless, soft undergarments for tucking, and using anti-fungal powder as prophylaxis for fungal infections.<sup>33</sup>

The case examples on page 26 illustrate how tucking may present clinically, and how a clinician may weigh the benefits and risks when determining the best course of action with the patient.<sup>37</sup>

### ***Nutrition and Exercise***

Some TGNC individuals elect to modify their nutritional intake and exercise regimens in order to achieve their desired physique. For example, a subpopulation of transgender men has built online communities dedicated to nutrition, exercise, and bodybuilding, harnessing the power of fitness as a “trans practice”.

However, as with the other NMBM methods discussed in this article, there are risks associated with the use of nutrition and exercise for body modification purposes. Eating disorders and disordered eating practices may play a role for TGNC patients. Regardless of whether they are part of intentional body modification, eating disorders affect transgender people at higher rates than the general population. A 2015 study of nearly 300,000 college students showed that transgender students were almost five times as likely to report an eating disorder as their cisgender peers,<sup>38</sup> and a 2013 survey administered in Massachusetts found that transgender youth were nearly 9 times as likely as cisgender youth to have used diet pills.<sup>39</sup> In a qualitative study of transgender adults by Algars et al., “Participants most frequently described strive for thinness as an attempt to suppress features of one’s biological gender, or accentuate features of one’s desired gender.”<sup>40</sup>

Exercise and nutrition can be valuable tools for patients seeking to modify their bodies to better align with their gender identities. However, as in the cases of chest binding and genital tucking, exercise and nutritional practices can become harmful. Due to the prevalence of eating disorders within this population, providers should incorporate discussions of body image, relationship to food and eating, and eating disorder screening with TGNC patients of all gender identities and body weights.

### **Conclusion**

TGNC individuals are not at inherently greater risk of acquiring physical or mental illness than cisgender peers; however, the stigma and additional stress placed upon TGNC individuals by society has been shown to cause a host of negative health outcomes, including suicidality, anxiety, cancer, stroke, and infections.<sup>41,42,43,44,45</sup> Primary care providers can play a substantial role in reducing this risk by offering gender-affirming care. One aspect of gender-affirming care is discussing NMBM practices with patients.

There are **four key elements** to a successful patient-provider discussion about NMBM practices:

First, the conversation must be grounded in an affirming framework, in which NMBM are correctly seen as critical, sometimes life-saving practices.

Second, providers should be educated about NMBM methods, and feel comfortable discussing them openly with patients. Preferably, a clinician will ask the patient to volunteer language that will help the patient feel comfortable discussing gendered body parts. For example, the previously mentioned Callen-Lorde brochure uses “PB & J” as euphemisms for the testes/scrotum (PB) and penis (J), to avoid using gendered language that may be uncomfortable for trans or gender non-conforming patients.<sup>36</sup>

Third, clinicians need to reasonably determine whether a complaint is related to the NMBM practice in question, or if there may be an unrelated cause. This can be difficult in some circumstances and requires a clinician to understand the NMBM practice and its associated side effects. This element also often requires a thorough history of present illness.

Finally, the fourth element of a successful patient-provider discussion about NMBM practices is a patient-centered, collaborative, harm-reduction approach to treatment. TGNC patients often seek reassurance that a clinician is aware of the benefits of a NMBM technique, and that the clinician won’t dismiss the patient’s concerns, or insist that the patient stop the practice altogether without an alternative. Once these ground rules are established, TGNC patients are much more likely to follow the advice of a clinician who is trying to maximize the benefits of NMBM techniques, while minimizing the negative side effects, as seen in the case examples.

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# LGBTQ+ Inclusive Primary Care: Insights from a Student-Run Clinic

By Emma Gerstenzang; Olivia Molineaux; Betsy Szeto; Olivia Nolan; Matt Adan; Cibel Quinteros Baumgart; John McGovern; Teresitta Velez and James Spears, MD

## Introduction to Q Clinic

Q Clinic is a medical-student run free clinic that was established in 2015 at Columbia University Vagelos College of Physicians and Surgeons in New York City. The clinic provides a wide variety of primary care services to LGBTQ+ identified people, with a particular emphasis on serving those who are un- or underinsured, and is open one evening per week, in the multipurpose space of a local church. Pre-clinical medical students serve as administrators, and are supported by clinical students and faculty attending physicians who provide clinical care. As the majority of Q Clinic patients are between the ages of 18 and 29, many visits are for well visits, sexual health, and mild acute illness, as well as some management of chronic conditions. In this article, we will share our unique experience of LGBTQ+ care and the practices we've developed in serving this patient population, with the hope that family medicine providers who care for a diverse population of patients may be able to adapt some of these practices for their own use.

## Our Best Practices

Many members of the LGBTQ+ community, including a significant number of Q Clinic patients, have had negative prior healthcare experiences related to gender or sexual identity, and may enter healthcare settings expecting or fearing mistreatment. Data suggests that LGBTQ+ individuals report lower rates of satisfaction with their healthcare providers and are more likely to report distrust of their providers. Establishing trust, creating a sense of welcome, and setting clear expectations, as well as an open-minded focus on patients' expressed needs, desires, and preferences, is crucial.



## Clinic Space

Creating a safe and affirming clinical space for LGBTQ+ individuals requires attention to every encounter at the clinic. The first step is to create explicit messages of welcome, and ensure that the environment authentically reflects these messages. At Q Clinic, this begins with the logo, which incorporates the letter "Q" as in "Queer" and the pride flag, and extends to signage throughout the clinic space. Q Clinic is held in a nontraditional location, having partnered with a church in downtown Manhattan that provides services to the LGBTQ+ community. Posters, reading materials, and art on display in the church space utilized by the clinic contributes to an inclusive atmosphere that celebrates all sexual and gender identities.

Another aspect of the physical environment crucial to patient comfort, especially for those who identify as transgender or gender non-conforming (GNC), is the availability of accessible bathrooms. Q Clinic provides a single-occupancy restroom for patient use. Much has been written on this subject in the national debate over restroom use, and in the context of healthcare provision it is all the more relevant. The prevalence of gendered bathrooms and the associated possibility of violence and discrimination may contribute

to both poor health outcomes and loss of patient follow-up.<sup>1</sup> Expressions of tolerance and welcome must be rooted in practical considerations for patient comfort and safety, of which restroom access is one important example.

## Inclusive Demographic Collection

Another important component of identity-affirming patient care is the intake form (Figure 1). At Q Clinic, intake forms include questions regarding gender identity, sex assigned at birth and preferred pronouns. Studies show that this information is important to patients: among a survey of 101 patients who identify as transgender, 90% thought it was important for their PCP to know their gender identity.<sup>2</sup> At Q Clinic, these questions each include check boxes as well as an "other" option with a blank line, to allow patients to self-identify and describe themselves as accurately and honestly as possible. Questions about biological sex or sex assigned at birth are clearly explained on the intake sheet (see Figure 1). Preferred names and pronouns are systematically entered into the EMR so that all involved in the patient's care can reference this information.

## Approach to the Patient Encounter

The beginning of the patient-provider interaction provides another opportunity for collaborative care. Medical language is often gendered, which can be insensitive to many queer identities. For example, the term "Women's Health" may seem exclusive of trans-men or trans-masculine individuals who require routine cervical and breast cancer screening, or other related care. Cognizant of this, medical students at Q Clinic begin patient encounters with phrases such as "As you probably know, some medical language can be very gendered and limited, so if there's language you would prefer us to use when talking about your body or your experiences, you can either let me know that now, or you can model it

continued on page 30

in our conversation.” For example, some patients may prefer to use the term “chest” rather than “breast.” While providers may be well-meaning in their use of clinical terminology, an opening statement that acknowledges the limitations of medical vocabulary can empower patients to establish their preferred terms before opportunities for confusion or discomfort arise.

In all cases, Q Clinic providers strive to avoid assumptions. For example, while some transgender or GNC individuals may seek hormone therapy or gender-affirming surgery, others may not; this is a personal choice, and should not be a matter of scrutiny in any setting. As such, conversations are guided by gathering necessary and pertinent information regarding a patient’s primary complaint, avoiding “curiosity questions.” For example, when a patient arrives with a chief complaint of headache, it is unnecessary to discuss whether or not they have chosen to have gender-affirming surgeries.

### *Taking an Appropriate Sexual History*

During the clinical encounter, Q Clinic providers make an effort to frame particularly sensitive questions in order to create honest, comfortable dialogue that enables the highest quality medical care. In the context of sexual health for LGBTQ+ individuals, patients may have had experienced assumptions about their sexual practices, habits, and risks based on their perceived sexual identity.

At Q Clinic, providers ask permission to discuss sexual history and begin with simple, open-ended questions. For example: “Tell me about your sexual practices.” Or, “What past experiences have you had with testing or treatment for STIs?” When asking sensitive or detailed questions, providers explain the purpose of the question. For example: “We offer 3-site STI testing to everyone who feels they may be at risk. The sites we test depend on where a person has been exposed to bodily fluids, and include the throat, the rectum, and the urethra. Are you interested in having STI testing today?” IF YES: “Which sites do you feel need to be tested, based on your sexual practices?” Inviting a patient to characterize their own risk allows providers to get a complete picture of a patient’s habits, without tying their behaviors to particular gender norms or expectations around sexuality or sexual behavior. It does not replace clinical judgment with regard to the medical necessity of a given test. Finally, it is important for the provider to determine if a question is truly necessary. Questions historically viewed as part of a sexual history, such as “How many partners have you had in the past three months?” may seem intrusive or judgmental to some patients, and are unnecessary if the answer to this question will not change medical management; all patients with recent unprotected exposures are likely candidates for STI testing, regardless of the number of partners they have had.

### *Inclusive Medical Services*

Inclusive primary care considers the varied needs of a diverse patient population, including those that may be more prevalent in the LGBTQ+ population. Q Clinic prescribes pre-exposure prophylaxis (PrEP) to prevent HIV transmission, as some of our patients are at high risk of exposure to HIV. PrEP, or tenofovir-emtricitabine, is

safe to use, and highly effective when used daily, reducing the risk of HIV transmission by >90%. Q Clinic determines which patients are candidates for PrEP, and monitors patients on PrEP according to CDC guidelines, which includes regular follow-up for HIV testing. Q Clinic providers gauge the interest of patients who may be at a higher risk for HIV transmission, by asking, “What do you know about PrEP?”

Some transgender or GNC-identified individuals may desire hormone therapy as part of gender-affirming medical care. Prescribing hormone therapy is well within the clinical scope of a primary care practice. Q Clinic does not initiate hormone therapy at this time due to financial limitations as a free clinic, but has a pilot program currently under development. Q Clinic facilitates treatment by bridging prescriptions to avoid treatment disruption and administering IM injections for those who are unable to administer their shots at home. Providers are educated in the effects of masculinizing therapy (testosterone), and feminizing therapy (estrogen and/or spironolactone), focusing on patient goals when discussing these therapies, remaining aware that some patients may desire a traditional binary gender presentation, and others may not. Providers may discuss the expected effects, including which effects may be permanent (such as breast development, or change in hair growth pattern), and which effects depend on continued therapy (such as changes in muscle mass), as well as associated risks, which are similar to those in cis-men and cis-women on hormone replacement therapy. Additional information on hormone therapy is included elsewhere in this issue.

Inclusive care also requires practitioners to recognize when a patient’s LGBTQ+ identity is not relevant to their medical complaint. Some activists have described a phenomenon called “Trans Broken Arm Syndrome,” which originated with the publicized experience of one person, in which their fractured arm, broken in a bicycle crash, was inappropriately attributed to hormone therapy. Focusing on an individual’s gender identity to the exclusion of more salient medical history can result in low-quality medical care and/ or patient distrust of medical providers.

## **Perspective From Patients**

*Question: Would you refer your friends to Q-clinic? Why or why not?*

Out of 257 patient encounters, post-encounter forms have been completed for 119 encounters (46.3%) as of September 2018. Of the 115 responses to this question, all 115 patients responded “Yes” to this question. With regard to the reasons patients would refer their friends, several themes emerged:

*“I felt like the students were very approachable and the environment was very inclusive.”*

The most frequently cited reason for referral of Q clinic were the staff members, addressed in 59 comments. The most common words used were “friendly” (18), “helpful” or “informative” (11), “thorough” (7), “inclusive” or “welcoming” (6), “LGBT friendly” or

“culturally competent” (5), and “respectful” or “non-judgmental” (5). In 13 instances, the word “comfortable” was used to describe the environment, interaction with staff members, or the experience as a whole.

### Recommendations for Providers

Aspects of the practices outlined above can be incorporated into any family medicine practice, even those without an explicit LGBTQ+ focus. We offer the following recommendations:

#### Clinic space & intake:

- Statements about who is welcome or non-discrimination statements
- Brochures/posters describing specific services that patients may be interested in but afraid to ask about, such as PrEP, hormone therapy
- Imagery including non-heterosexual couples
- Gender neutral bathrooms, whether single-stall, gender neutral multi-stall, or with signage such as “Please use the bathroom that most aligns with your gender identity”
- Inclusive intake forms (see Figure 1)

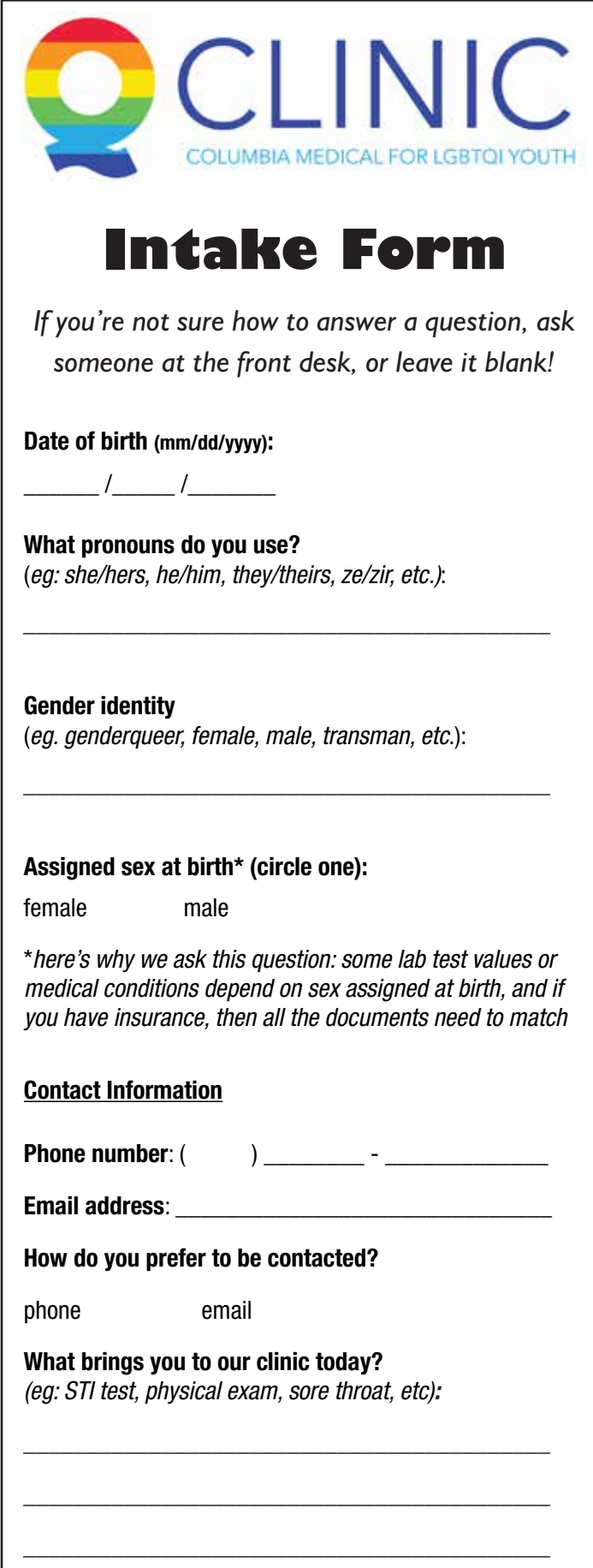
Patient-provider interaction (see “Our Best Practices” for specific examples):

- Interview questions should avoid assumptions and remain open-ended
- Avoid “curiosity questions” or excess focus on a patient’s identity or sexuality
- When discussing potentially sensitive topics, such as sexual history, begin by asking permission
- Indicate awareness and limitations of medical terminology and the provider’s own knowledge
- During interview, pay close attention to language that the patient uses and mirror this language
- Use gender inclusive language with all patients, such as “partner” instead “boyfriend” or “girlfriend”
- Actively discuss and prescribe PrEP to interested patients at-risk for HIV transmission
- Become familiar with gender-affirming hormone therapy and potential side effects and consider prescribing these therapies
- Maintain list of referral resources for LGBTQ+-competent care for concerns outside your scope of practice

### Resources

- Center of Excellence for Transgender Health (<http://transhealth.ucsf.edu/>)
- GLMA Health Professionals Advancing LGBTQ Equality (<http://www.glma.org/>)
- AMA Physician Resources for an LGBTQ-inclusive Practice (<https://www.ama-assn.org/delivering-care/physician-resources-lgbtq-inclusive-practice>)
- National LGBT Health Education Center (<https://www.lgbthealtheducation.org/>)
- CDC Guidelines on PrEP (<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>)

Figure 1 - Q Clinic Intake Form



The image shows a form titled "Q CLINIC COLUMBIA MEDICAL FOR LGBTQI YOUTH Intake Form". It includes a rainbow logo and the text "CLINIC COLUMBIA MEDICAL FOR LGBTQI YOUTH". The form asks for the date of birth, pronouns, gender identity, assigned sex at birth, contact information, and how to be contacted. It also includes a note about why the assigned sex at birth question is asked.

**Q CLINIC**  
COLUMBIA MEDICAL FOR LGBTQI YOUTH

## Intake Form

*If you're not sure how to answer a question, ask someone at the front desk, or leave it blank!*

**Date of birth (mm/dd/yyyy):**  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**What pronouns do you use?**  
(eg: she/hers, he/him, they/theirs, ze/zir, etc.):  
\_\_\_\_\_

**Gender identity**  
(eg. genderqueer, female, male, transman, etc.):  
\_\_\_\_\_

**Assigned sex at birth\* (circle one):**  
female                      male

*\* here's why we ask this question: some lab test values or medical conditions depend on sex assigned at birth, and if you have insurance, then all the documents need to match*

**Contact Information**

**Phone number:** (        ) \_\_\_\_\_ - \_\_\_\_\_

**Email address:** \_\_\_\_\_

**How do you prefer to be contacted?**  
phone                      email

**What brings you to our clinic today?**  
(eg: STI test, physical exam, sore throat, etc):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

continued on page 32

## Acknowledgements

*Q Clinic is grateful for the support of the Columbia University Vagelos College of Physicians and Surgeons, the New York-Presbyterian Center for Family and Community Medicine, the Metropolitan Community Church of New York and the Dr. Isaac Golde Kramer Education Fund.*

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# UNIQUE DIFFERENCES IN SCREENING AND PREVENTION FOR LGBT ADOLESCENTS

By Samuel Sandowski, MD and  
Mark Maloof, DO

## Introduction and Need for Screening

While the US has moved forward with the acceptance and rights of the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, there remains significant gaps in the healthcare provided to this vulnerable community. LGBT adolescents especially endure significant health disparities such as increased health risks, limited health care access, and lack of provider knowledge and comfort when caring for this population. There are approximately 9 million adults<sup>1</sup> and 1,285,000 high school teenagers<sup>2</sup> in the US who identify as LGBT; however, we must recognize that there are many more people who engage in same-sex activity and do not identify as LGBT. In fact, more than double the number of people who identify as LGBT have, at one point, had same-sex partners (approximately 19 million in the US).<sup>1</sup> For high-schoolers, 25% of those who have had same-sex partners identify as straight.<sup>2</sup> Reasons for this vary and include religion, fear of others' reactions, lack of acceptance by family and community, and fears of shame, isolation, and physical harm, just to name a few.<sup>3</sup> During adolescence, teens are still experimenting with their sexuality and may not have drawn conclusions as to their sexual identity. Additionally, physicians may not elicit a history that will reveal if patients are engaging in same-sex behavior or if a patient self-identifies as gay. Nearly 78% of clinicians thought patients would refuse to provide their sexual orientation, when in fact only 10% of patients reported that they would refuse.<sup>4</sup> Asking a non-judgmental question is more likely to reveal an honest response from patients. Equally concerning is that many physicians do not feel adequately educated to care for the LGBT community and there are no objective measures to assess competency.<sup>5</sup>

Even when accurate history taking occurs, providers need to be aware that insurance plan explanations of benefits (EOBs) can sometimes reveal confidential information (such as STI screening and treatment) to parents, so providers should plan accordingly.<sup>6</sup>

The Center for Disease Control (CDC) and the United States Preventive Services Task Force (USPSTF) offer different guidelines for screening, preventive care, counseling, and treatment for adolescent men who have sex with men (MSM) when compared to adolescent men who exclusively have sex with women (MSW) for certain STIs, as they may be a high-risk group.<sup>7</sup> WSW have the same recommendations for sexually transmitted illness (STI) screening as women who have sex with men (WSM). The LGBT adolescent community has also been identified to be at risk for depression, suicide, bullying, and drug and alcohol use.<sup>2</sup> Even recommendations for vaccinations differ for MSM compared to MSW.<sup>8</sup>



## Screening for Depression and Suicide

The USPSTF recommends that adolescents be screened for depression. They list this as a “B” recommendation, and note “uncertainty of sexual orientation” as a psychological risk factor for depression. In a recent survey of gay and straight adolescents, gay adolescents report feeling sad or hopeless 60.4% vs 26.4% in straight adolescents.<sup>2</sup> Though the USPSTF was inconclusive (“I” recommendation) about screening for suicide in adolescents, they noted “important risk factors for suicide attempt include . . . prejudice or discrimination associated with being lesbian, gay, bisexual, or transgender”. They further conclude that it is best to address this in those who present with suicide attempts or ER visits for hurting themselves. Physicians should be aware that gay adolescents report suicide related behaviors, including a plan, 38.2% vs 11.9 % in straight adolescents.<sup>2</sup> Table 1 below, shows the incidence of health behaviors based on sexual orientation.

<b>Risk Factor</b>	<b>LGBT</b>	<b>Straight</b>
Depression	60.4%	26.4%
Suicidality	38.2%	11.9%
Alcohol	40.5%	32.1%
Hallucinogens	11.5%	5.5%
Heroin	6.0%	1.3%
Methamphetamines	8.2%	2.1%

Zaza, S., Kann, L., & Barrios, L. C., “Lesbian, Gay, and Bisexual Adolescents Population Estimate and Prevalence of Health Behaviors,” *Journal of the American Medical Association*, Vol 316 (22), December 13, 2016, 2355-2356.

## Screening for Sexually Transmitted Illnesses

CDC recommendations for screening for STIs in adolescent MSM are significantly different from the recommendations for adolescent MSW. It should not be presumed that WSW have a lower rate of STI's, and CDC screening recommendations for WSW are the same as MSM. See Table 2 for screening recommendations.<sup>10</sup>

When interviewing the patient, practitioners should distinguish sexual identity from behavior. Adolescent males who identify as gay, but have never had a same-sex partner, should not be categorized as MSM for the purposes of risk stratification. Conversely, a MSM may not identify as gay.

The following are the CDC recommendations:<sup>7</sup>

The recommendation for adolescent males who have never had a same-sex partner is that they should be screened for HIV at least once between ages 13-64; however, if they are MSM, then they should be screened annually if their HIV status is unknown or negative and the patient himself or his partner(s) have had more than one sexual partner since their most recent HIV test.

The CDC does not have any recommendations for screening for syphilis in adolescent MSW. In contrast, the recommendation for MSM is that they be screened for syphilis at least annually or every 3-6 months if at increased risk such as engaging in high risk behaviors or having multiple partners. About two-thirds of primary and secondary syphilis diagnoses in the US are in MSM.<sup>7</sup>

The screening recommendation for chlamydia for MSW adolescents is that young men in high prevalence clinical settings or in populations with high burden of infection should be screened. For MSM, the recommendation is at least annually at sites of contact (urethra, rectum, pharynx) or every 3-6 months if at increased risk. The screening should occur regardless of condom use.

For gonorrhea, there is no screening recommendation for MSW, but MSM should be screened at least annually at sites of contact (urethra, rectum, pharynx) or every 3-6 months if at increased risk. Again, this recommendation is regardless of condom use.

Screening for herpes in MSW, as per the CDC, should be type-specific HSV serologic testing for men presenting for an STI evaluation. For MSM, the recommendation by the CDC for herpes screening is type-specific HSV serologic testing if infection status is unknown with a previously undiagnosed genital tract infection. The USPSTF does not offer screening recommendations on herpes screening.

Recommendations from the CDC for screening for Hepatitis B and Hepatitis C also differ between MSM and MSW. Screening for Hepatitis B in MSW should only occur in high risk individuals; however, all MSM should be screened for Hepatitis B. For Hepatitis C, there are some differences as well. All men (MSW and MSM) should be screened at least once for Hepatitis C if they were in the birth cohort between 1945 and 1965. MSM with HIV should be screened for Hepatitis C annually.

## Screening for Drug Use and Alcohol Use

Intuitively, while one may think the recommendation for screening for drug use and alcohol use in adolescents would be a strong recommendation, the USPSTF is inconclusive (“I” recommendation). Screening should be done when results of a positive screen can be acted upon and resources are available. However, the use of alcohol and drugs is more prevalent in gay youth.<sup>2</sup> Gay adolescents report using alcohol more frequently than straight adolescents (40.5% vs. 32.1%). They also report using the following more frequently: hallucinogens 11.5% vs. 5.5%; heroin 6% vs. 1.3%; and methamphetamines 8.2% vs. 2.1%.<sup>2</sup>

## Immunizations

The CDC recommendations for immunizations for many diseases may be different for MSM. For Hepatitis A, all at-risk populations should be vaccinated. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; MSM; users of injection and non-injection illicit drugs; persons who work with HAV-infected primates or with HAV in a

**Table 2**

**Recommendations for Sexually Transmitted Infections Screening in Adolescent Males based on Sexual Behavior**

Infection	MSW			MSM		
	CDC	USPSTF	AAFP	CDC	USPSTF	AAFP
HIV	All men 13-64 at least once, then intermittently based on risk. All men who seek evaluation/treatment for STIs	All men from 15-65 at least once with repeated screening for those at risk for infection (risky behavior, high seroprevalence setting). Testing may be every 1, 3 or 5 years as needed.	Screening of All men from 18-65. May screen younger or older if at increased risk. Use Clinical consideration for screening intervals	Annually if HIV unknown or negative and the patient himself or his partner(s) have had more than one sex partner since most recent HIV test	MSM and Active IV Drug Use is considered very high risk.	Supports USPSTF
Syphilis	No Screening Recommendation	Screening in this population may result in high false-positive rates and overtreatment.	Supports USPSTF	At least annually. Every 3-6 months if at increased risk. (Two-thirds of new cases are in MSM)	Optimal screening frequency is not established, but MSM and HIV+ will benefit from more frequent screening. Every 3 months may improve detection vs annually.	Supports USPSTF
Chlamydia	Young men in high prevalence settings or populations with high burden of infection	Insufficient evidence to make recommendation. (Offers that infection rates are highest among those aged 20-24 years old.)	Supports USPSTF	At least annually at sites of contact (urethra, rectum, pharynx) Every 3-6 months if at increased risk. Screen regardless of condom use	Insufficient evidence to make recommendation. MSM is not a listed risk factor but is acknowledged in Research Needs and Gaps	Supports USPSTF
Gonorrhea	No Screening Recommendation	Insufficient evidence to make recommendation. (Offers that infection rates are highest among those aged 20-24 years old and concentrated in particular geographical locations and communities)	Supports USPSTF	At least annually at sites of contact (urethra, rectum, pharynx) Every 3-6 months if at increased risk. Screen regardless of condom use	Insufficient evidence to make recommendation. MSM is not a listed risk factor but is acknowledged in Research Needs and Gaps	Supports USPSTF
Hep B	Screening only for those at increased risk secondary to factors irrespective of sexual behavior.	Screening only for those at increased risk secondary to factors irrespective of sexual behavior.	Supports USPSTF	All MSM should be screened.	MSM are considered to be at high risk and should be screened.  Periodic screening is recommended for MSM who are not vaccinated	Supports USPSTF
Hep C	One-time screening of men born 1945-1965 Screen in the presence of risk factors irrespective of sexual behavior	One-time screening of men born 1945-1965 Screen in the presence of risk factors irrespective of sexual behavior	Supports USPSTF	One-time screening of men born 1945-1965 Screen in the presence of risk factors irrespective of sexual behavior	One-time screening of men born 1945-1965 Screen in the presence of risk factors irrespective of sexual behavior	Supports USPSTF
Herpes	Type specific serologic testing for men presenting for STI testing	Recommends against routine screening in asymptomatic adolescents.	Supports USPSTF	Type specific tests if infection status is unknown in an MSM with previously undiagnosed genital tract infection	Recommends against routine screening in asymptomatic adolescents.	Supports USPSTF
HPV	No Screening Recommendation	No Screening Recommendation	No Screening Recommendation	Routine screening for HPV is not recommended by the CDC for anal, penile, or throat cancers in men. The CDC does recognize that some healthcare providers offer anal Paps to men who may be at increased risk for anal cancer.	No Screening Recommendation	There is no HPV test for use in men. Anal cytology via Anal pap may underestimate the degree of high-grade anal intraepithelial neoplasia; therefore, patients with abnormal findings should be referred for high resolution anoscopy and biopsy.

<https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations>

research laboratory; persons with clotting-factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. As per the CDC, all MSM should be vaccinated for Hepatitis A. For Hepatitis B, again, the recommendation is to vaccinate at-risk populations. MSM is an at-risk population for Hepatitis B, so all MSM should be vaccinated for Hepatitis B.

Vaccination for meningococemia and human papillomavirus (HPV) differs between adolescent MSM and those who are not. A meningococcal vaccine that covers strains A, C, W, Y should be given to all adolescents and at-risk adults. In the recent past, in certain locations throughout the US, there were outbreaks of meningococcal infection, and MSM were considered an at-risk population based on geographic location. It was recommended that these males be given the meningococcal vaccine. Meningococcal B vaccine is recommended for at-risk adolescents and adults, such as MSM.

The CDC recommends that all adolescents are vaccinated for HPV. The HPV vaccine is recommended for young women through age 26 and young men through age 21. It is also recommended for men through age 26 if they are MSM, identify as gay or bisexual and plan on having sex with men, or are transgender. The vaccine itself can be used in men and women until age 45.<sup>9</sup>

## Conclusion

The adolescent LGBT community, as well as MSM who do not self-identify as LGBT, are vulnerable populations at higher risk for depression, suicide, drug use, and STIs. The first step in addressing these populations is to identify them. Physicians need to be comfortable with sexual history taking in a non-judgmental way and address the needs of these populations once they are identified. It is important to remember that screening recommendations and preventive measures, such as counseling and vaccinations, vary by sexual identity and activity.

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# Transgender Patients: Considerations for the Family Physician

By Diane M. Bruessow, PA-C; Lisa M. O'Connor, MD; Elizabeth Eaman, MD and Jason N. Chamikles, DO, JD

## Introduction

The World Professional Association for Transgender Health (WPATH) has long stated that transgender (TG) health is primary care; and there is a small but growing body of relevant research which translates well into clinical practice. Family physicians can become comfortable providing transition-related medical care for their TG patients across the lifespan. A basic understanding of gender diversity, treatment goals, and the formulations and use of medically necessary feminizing and masculinizing hormone therapies and puberty blockers are foundational to caring for TG patients within your practice.

## Gender Diversity

Gender identities and gender expressions that are not stereotypically associated with one's assigned sex at birth have long been observed as being a common and culturally-diverse human phenomenon that occur across all cultures and should not be judged as inherently pathological or negative.<sup>3,4</sup> For context, other common, culturally-diverse and non-pathological human phenomenon are left-handedness and homosexuality. In 2013, the American Psychiatric Association agreed, stating "It is important to note that gender nonconformity is not in itself a mental disorder."<sup>5</sup> It is the patient's distress that we seek to resolve with medical, surgical, social and/or legal interventions.<sup>7,8</sup> Efforts to change a person's gender identity and expression are no longer considered ethical.<sup>9</sup> The number of TG adults in the United States has been estimated at 1.4 million or 0.6%, and an estimated 78,600 in New York State.<sup>1</sup> There are an estimated 149,750 TG 13-17 year olds in the United States.<sup>2</sup>

## Gender Diversity Within the Health Care Setting

There are four critical opportunities when knowing your patient's gender identity matters most: during patient intake, within the clinical interaction, patient satisfaction questionnaire, and tracking of health outcomes.<sup>10,11</sup> Table 1 identifies four foundational questions that will allow your intake process to set you up for success with your TG patients. When the CDC shifted to a two-question system (asking gender identity as well as sex assigned at birth) they experienced a 64% increase in the number of transgender patients identified.<sup>22</sup> Misgendering and deadnaming (the act of using a name that was connected to one's assigned sex at birth [ASAB] rather than the name that's associated with one's gender identity) a patient are not conducive to health and wellness as they can exacerbate gender dysphoria and trigger a reactive depression.<sup>12</sup> Electronic records now include these fields.

It is no longer necessary to know the gender marker that the patient's insurance company has on file as the PPACA requires nondiscrimination based on gender identity from healthcare providers as well as third party payers, with one of a few exception being self-insured plans.

Table 1<sup>1,2</sup>

What is the Patient's assigned sex at birth? (e.g., assigned female at birth [AFAB], assigned male at birth [AMAB])
What is the Patient's gender identity?
What name does the patient use?
What pronouns does the patient use?

## Gender Dysphoria Incongruence

"Gender dysphoria" is the terminology used in the DSM-5. It refers to the distress experienced as a result of the incongruence between one's physical body and gender identity.<sup>7</sup> "Gender incongruence" is the terminology utilized by the World Health Organization in the ICD-11 in an attempt to depathologize gender dysphoria akin to how pregnancy is not considered an illness or pathology.<sup>13,14</sup> In adolescent and adult patients that meet the DSM-5's diagnostic criteria for gender dysphoria (an insistent, consistent and persistent gender identity for at least 6 months and significant distress or problems functioning), therapeutic interventions may include gender-affirming hormone therapy, puberty blockers, procedures, social transition and/or legal transition.<sup>6,8,15,16</sup>

While most TG patients will identify in binary "male or female", "boy or girl" and "man or woman" paradigms, it is important to note that a significant number of individuals' identities might fall in between or outside these categories. 31% of TG adults in the US identify as non-binary. Awareness of one's gender identity can occur at any age, although most individuals' gender identity will be formed before puberty.<sup>17</sup>

Among adolescents, gender dysphoria reliably becomes more debilitating as secondary sex characteristics develop. During puberty we see a spike in suicides and suicide attempts. Two factors are more common among adolescents whose gender identity persists into adulthood: Consistent, insistent and persistent gender identity, and early cognitive (e.g., I am a girl) rather than affective (e.g., I feel like a girl) assertion of gender. Presentation depends entirely on whether the patient's environment is restrictive or permissive, and the patient's developmental stage. In other words, the patient's subjective experience of gender identity across time - not the observations of their gender expression by others, while the presentation of a transgender or gender expansive child with affirming parents will look differently than those with restrictive parents.

## Treatment Goals

The goals of treatment are to improve quality of life by reducing distress and improving function.<sup>18</sup>

In peri-pubertal adolescents, this is achieved by suppressing endogenous puberty with gonadotropin releasing hormone (GnRH) analogs which, after an initial spike in LH and FSH secretion referred to as a “puberty flare,” will desensitize the pituitary resulting in subsequent suppression of LH and FSH secretion, and suspension of germ cell maturation, i.e. puberty. This has been shown to reduce the need for future medical interventions, reduce depression and risk taking behavior, and allow for the establishment of early and strong social supports.<sup>18</sup> Initiation of GnRH analogs during Tanner Stage 2 will completely prevent undesirable secondary sex characteristics. Later initiation will suspend further development. GnRH analogs have the added benefit of being fully reversible and offer more effective suppression to progestins and lynestrenol monotherapy. There is consensus among the guidelines that pre-pubertal initiation of pubertal suppression is not recommended.<sup>6,15,16,18</sup>

Suppression of endogenous puberty is commonly followed by co-administration of exogenous hormone therapy (HT) to initiate puberty congruent with gender identity and transition to a physical state that most closely resembles the individual’s sense of themselves.<sup>18</sup>

## Medical Necessity and Effectiveness

The WPATH has long stated that, when indicated, therapies including puberty blockers, hormone therapy and gender-affirming surgical procedures are medically necessary, not experimental, and essential to wellbeing.<sup>19</sup> Consensus from US medical and mental health professionals soon followed, including the American Academy of Family Physicians in 2007.

In 2016 the University of California San Francisco, Transgender Health Center of Excellence (UCSF COE) published guidelines that take an evidence-based medicine approach, providing reference to the quality of the evidence that supports their guidelines. The authors find the UCSF COE guidelines as the most useful at the point of care, and we find the 2017 guidelines from the US Endocrine Society (ES) to be useful when seeking prior authorization from third party payers.<sup>15,16</sup>

## Eligibility Criteria for Puberty Blockers and Hormone Therapy

The WPATH SOC, UCSF COE and ES guidelines recommend assessment by a mental health professional (MHP) with competence in the DSM, and the ability to recognize concurrent mental health diagnoses and differentiate from gender dysphoria/gender incongruence (GD/GI).<sup>4,6,16,23</sup> The MHP should be knowledgeable about gender identities and expressions, the assessment and treatment of GD/GI, and participate in continuing education in the assessment and treatment of GD/GI. Psychotherapy is not an absolute requirement.<sup>4,6,16</sup>

Eligibility criteria for puberty blockers in a minor adolescent are a persistent and intense pattern of gender incongruence or gender dysphoria (whether expressed or suppressed) that worsened with the onset of puberty, mental health and social concerns are reasonably well controlled, and the patient and all parents and legal guardians must provide consent to treatment and support for the adolescent’s care. In addition, the family physician or other provider experienced in pubertal assessment has confirmed the patient is at Tanner stage G2/B2, there are no medical contraindications, and agrees with the MHP’s recommendation.<sup>4,6,15,16</sup>

In minor adolescent patients, eligibility for HT includes GD/GI (whether expressed or suppressed), mental health and social concerns are reasonably well controlled, and the patient and all parents and legal guardians must provide consent to treatment and support for the adolescent’s care. In addition, the family physician or other provider has confirmed, there are no medical contraindications, and agrees with the MHP’s recommendation.<sup>4,6,15,16</sup>

In patients who are over the age of majority, eligibility for HT includes persistent and well documented GD/GI, the capacity to make a fully informed decision and consent to treatment, and any mental health concerns that are present must be reasonably well controlled.<sup>6,16</sup>

## Preparing for Puberty Blockers

During the first office visit for a patient seeking puberty blockers after the patient history, PE, baseline labs (Table 2) and the MHP’s referral letter have been reviewed, contraindications have been ruled out (Table 3), and an informed consent process is undertaken. We review potential adverse effects (Table 4), and we set a number of expectations to include that a patient can stop their medications at any time.<sup>15,16</sup> Other expectations include office visits every 3-6 months, and labs and radiology, timed at the provider’s discretion, are required. We explicitly mention the puberty flare that occurs during the first few weeks.<sup>15</sup>

## Puberty Blocker Dosing

Dosing is noted in Table 5.<sup>15,23</sup> For patients on monthly or Q3mo injections, emphasis is placed on weight-based dosing, as well as the frequency of dosing which may need to be shortened to maintain hypothalamic-pituitary-gonadal axis suppression.

continued on page 38

**Table 2**

Baseline Evaluation	Drug Manufacturer	Guidelines
Height, Weight	6-12mo	3mo (ES)
FSH/LH	6mo	3mo (ES)
Total Testosterone (in those with testes), Estradiol (in those with ovaries)	6mo	3mo (ES)
LFT	no recommendation	as appropriate (UCSF COE) 12mo (ES)
BUN/CR	no recommendation	as appropriate (UCSF COE) 12mo (ES)
Lipids	no recommendation	as appropriate (UCSF COE) 12mo (ES)
Glucose/Insulin	no recommendation	as appropriate (UCSF COE) 12mo (ES)
HbA1C	no recommendation	as appropriate (UCSF COE) 12 mo (ES)
Bone Density	6-12mo	12mo (ES) as appropriate (UCSF OCE)
Bone Age	6-12mo	12mo (ES) no recommendation (UCSF DOE)
25-OH Vitamin D	no recommendation	as clinically indicated (UCSF COE) 6-12mo (ES)
sitting height, blood pressure, tanner stage	no recommendation	3-6m (ES) no recommendation (UCSF COE)

**Table 3**

Contraindications to GnRH analog
sensitivity to medication

**Table 4**

Adverse Effects
Suboptimal bone mineral density accrual
Increase in fat mass and decrease in lean body mass
Arterial hypertension
Hot flashes
Fatigue
Mood alterations
injection site reactions when given IM

**Table 5**

Pubertal Suppression Dosing <sup>23,15</sup>		
Type/Weight		
Lupron Depot-Ped (monthly)		
<25kg	7.5mg IM	Monthly
25-37.5kg	11.25mg IM	Monthly
37.5kg	15mg IM	Monthly
Lupron Depot-Ped (3-month)	11.25mg IM	Every 3 months
	30mg IM	Every 3 months
Leuprolide Acetate	50mcg/kg SC	Daily
Histrelin implant	50mg implant	Every 12-24 months
	65mcg/day	Every 12-36 months (UCSF COE)

IM = intramuscular, SC=subcutaneous

**Table 6**

Baseline Labs	
Masculinizing	Feminizing
H&H*	H&H
AST & ALT*	AST & ALT*
Fasting lipids*	Fasting Lipids
Fasting glucose, HbA1c, TSH	Fasting Glucose, HbA1c, TSH
Estradiol* (target <50 pg/ml)	Estradiol* (target 100-200 pg/ml)
Testosterone *(target 350-700)	Testosterone (target <55)
SBHG & Albumin^	+/- Prolactin*
	BUN/CR, U/A, +/-K*#
*monitored Q3m during the first year, Q6-12m years 2-5 ^ to calculate bioavailable Testosterone	*monitored Q3m during the first year, Q6-12m years 2-5 #only if on spironolactone +/- lack of consensus between guidelines

**Table 7**

Contraindications to Testosterone	Contraindications to Estradiol
Pregnancy	Thromboembolism while on therapeutic anti-coag
	Severe thrombophlebitis while on therapeutic anti-coag
	Estrogen-dependent cancer

**Table 8**

Conditions that can be exacerbated by HT	
Masculinizing	Feminizing
<b>VERY HIGH RISK</b>	<b>VERY HIGH RISK</b>
Erythrocytosis (Hct>50%)	Thromboembolic Disease
<b>MODERATE RISK</b>	<b>MODERATE RISK</b>
Severe Liver Dysfunction (transaminases >3x upper limits)	Microprolactinoma
Breast or Uterine cancer	Severe Liver Dysfunction (transaminases >3x upper limits) PO > topical
	Breast Cancer
	Coronary Artery Disease
	Cerebrovascular Disease
	Severe Migraine Headache

## Preparing for Hormone Therapy

In our practice, as is done when seeing a new patient for puberty blockers, patients seeking HT must present a referral letter from a MHP and baseline labs (Table 6) prior to being scheduled for an office visit. Absolute contraindications to HT are noted in Table 7.<sup>16</sup> While contraindications to HT are rare, they do not necessarily preclude the use of certain anti-androgens.<sup>15</sup> Conditions that can be exacerbated by HT are noted in Table 8.<sup>16</sup> Patients with these conditions may be co-managed by an experienced gender specialist along with the patient's other specialists. In these cases, transdermal delivery may be preferred for its slow release and relatively steady blood levels as compared to PO, SL, IM or SC routes.

Once contraindications are ruled out, and plans to address comorbidities are initiated, an informed consent process is undertaken. We review the content in Table 9<sup>15,16</sup> including desirable effects, the timeline when effects are anticipated to begin, and possible adverse effects, and we set a number of expectations to include that a patient can stop their medications at any time, but dose increases require a discussion.<sup>15,16</sup> Our expectations for follow up appointments typically include office visits every 3 months for the first year, every 6 months through the 5th year, and annually thereafter. We explicitly state our priority is to give the patient the best clinical results in the safest manner possible which means using the smallest possible dose of sex steroids that deliver physical and psychological results, and that larger doses are associated with greater side effects and do not necessarily result in faster or greater degree of masculinization/feminization.<sup>15</sup>

Major side effects from HT are uncommon. Findings from fifteen gender centers globally saw virtually no side effects when the ES guidelines were followed, noting a thrombus rate of one percent.<sup>20,21</sup> In our private practice over the course of 12 years and a patient census of over 650, we note one patient with a blood clot. In this case, the thrombus appeared at the tip of the chemotherapy port of a 55 year-old patient who was being actively treated for a recrudescence of lymphoma and who also had lifestyle risk factors. To further optimize outcomes, we encourage daily activity and a tobacco-free lifestyle in all HT patients.

continued on page 40

**Table 9**

Desirable Effects	
Masculinizing	Feminizing
Growth & coarseness of body & facial hair 6-12m	Gynecomastia 3-6m
Deepening of voice 6-12m	Enlarged areola and nipple 3-6m
Increased muscle mass 6-12m	Decreased spontaneous genital activity 1-3m
Clitoromegaly 1-6m	Softened skin 3-6m
Vaginal atrophy 1-6m	Redistribution of body fat 3-6m
Redistribution of fat 1-6m	Reduced testicular volume 3-6m
Scalp hair loss 6-12m	Decreased sperm production unknown
	Voice change, none- speech therapist Prominent facial features- none- facial feminization surgery Laryngeal prominence- none- tracheal shave
Undesirable effects	
Masculinizing	Feminizing
Very High Risk of Adverse Outcomes	Very High Risk of Adverse Outcomes
Erythrocytosis (Hct >50%)	Thromboembolic disease
Moderate Risk of Adverse Outcomes	Moderate risk of Adverse Outcomes
Severe Liver Dysfunction (Transaminases > threefold the upper limits of normal)	Macroprolactinoma
Coronary Artery Disease	Breast Cancer
Cerebrovascular Disease	CAD
Hypertension	CVD
Breast or Uterine Cancer	Cholelithiasis
	Hypertriglyceridemia

## Hormone Therapy Dosing

HT dosing for adults is noted in Table 10<sup>15,16</sup> and adjusted clinically every 3 months during the first year. Other than avoiding oral estradiol in patients over 45 years old, delivery is determined by patient preference. Clinical effects of spironolactone include inhibition of spontaneous genital activity (therapeutic in patients whose dysphoria is exacerbated by erections) followed by dry or almost dry orgasms. Most patients achieve this with up to 200mg/day.<sup>15</sup> For specific recommendations on initial dosing of HT and anti-androgens, the UCSF COE Guidelines are available online at [www.transhealth.ucsf.edu/guidelines](http://www.transhealth.ucsf.edu/guidelines).

There is a lack of consensus on how to best integrate clinical and lab monitoring. In our practice, we titrate dosing based on safety and the patient's clinical response at 3 month intervals. Keep in mind that early breast development may be seen at 3-6 months after initiating feminizing HT, and deepening of the voice, body and facial hair are usually seen 6-12 months after initiating masculinizing HT. Patients may describe an improved psychological sense of wellbeing from the first dose. It's common for sex steroid lab levels to be low by cisgender standards.<sup>15,16</sup>

In patients on feminizing HT, we ask them to advise us when they begin to experience soreness behind their nipples. The intensity or duration doesn't matter, just as long as it happens. If not, and no breast growth is determined on physical exam, the estradiol dose should be increased if it can be done safely.

In our office, we commonly see elevated prolactin levels up to 40-60 ng/mL and on rare occasions as high as 80-100 ng/mL. As long as the prolactin level plateaus, and the patient does not report symptoms consistent with a prolactinoma: headache, vision disturbances, etc., we continue to monitor. Conversely, if a patient complains of headache, vision changes, nausea and vomiting, we initiate a work up regardless of their prolactin level.

Although hyperkalemia was never detected in our practice, in patients on spironolactone, monitoring serum potassium is recommended by ES and UCSF COE in patients who are concurrently taking potassium-sparing medications.<sup>15</sup>

After orchiectomy and oophorectomy, doses of exogenous HT are decreased and anti-androgens are discontinued. Bone density requires that HT is maintained.<sup>15,16</sup>

In adolescent patients who are concurrently on a GnRH analog for puberty suppression, consider starting with 25% of the lowest adult dose when initiating HT. For a transdermal estradiol dose of 6.25mcg, 25mcg patches may be cut into quarters or estradiol cream may be compounded. In adolescent patients receiving exogenous estradiol, in addition to lab monitoring for toxicity, we aim to keep estradiol levels under 60 pg/ml while the patient's height catches up to the growth curve as estradiol stimulates closure of epiphyseal plates. Anti-androgens are unnecessary while on GnRH<sub>a</sub>.<sup>15,16</sup>



**Table 10**

HT Dosing	
Masculinizing	Feminizing
Testosterone cypionate or enanthate 100 or 200mg/ml, 100->200mg IM or SC Q2Wk or 50% Q1Wk (ES) 40->200mg IM or SC Q2wk or 50% Q1Wk (UCSF COE)	Estradiol PO or SL, 2 -6mg QD (ES) 1->8mg (UCSF COE)
Testosterone transdermal patch 2.5->7.5mg/d (ES) 1->8mg/d (UCSF COE)	Estradiol transdermal 0.025-0.2mg/d (new patch placed Q3-5d) (ES) 0.05-0.4mg/d (new patch placed Q3-5d) (UCSF COE)
Testosterone gel or cream 10->103.5mg/d (UCSF COE) 50->100mg/d (ES)	Estradiol valerate or cypionate IM 5->30mg Q2Wks or 2-10mg Q1WK (ES) Estradiol Cypionate up to 5mg IM Q2wk (UCSF COE) Estradiol Valerate up to 40mg IM Q2Wk (UCSF COE)
	<b>Anti-Androgen:</b>
	Spironolactone (in divided doses) 100-300mg/d (ES) 25-400mg/d (UCSF COE)
	+/- 5a-Reductase inhibitors not supported (ES) Dutasteride 0.5mg QD, or Finasteride begin at 1mg, may adjust, 5mg common. (UCSF COE)

Our HT patients expect to be asked “the 10 questions” at every office visit. While not exactly 10, our review of systems is designed to capture the gravest as well as the most common adverse effects in addition to gathering information necessary to determine whether HT dosing needs to be adjusted. We ask every patient if they are experiencing any unusual: headache, vision change, nausea or vomiting, chest pain, shortness of breath, pain or swelling of arms, legs, hands or feet, rashes, fever, bruising or bleeding. In patients AFAB we ask about LMP, and in patients AMAB we ask about breast discharge, frequency of spontaneous genital activity (e.g., morning erections), as well as the volume, color and thickness of any ejaculate.

## Conclusion

Initiating and managing puberty suppression and HT are aligned with every family physician’s core medical knowledge. Family physicians all have a basic understanding of gender diversity, treatment goals, and the formulations and the use of medications such as sex steroids, anti-androgens, GnRH analogs which are foundational to care for TG patients within our practice. Despite the lack of a consensus, clinical guidelines exist to support family physicians in caring for their TG patients. Perhaps the greatest challenge to your practice is inquiring about a patient’s pronouns and name within the intake process and applying that information during the clinical encounter.

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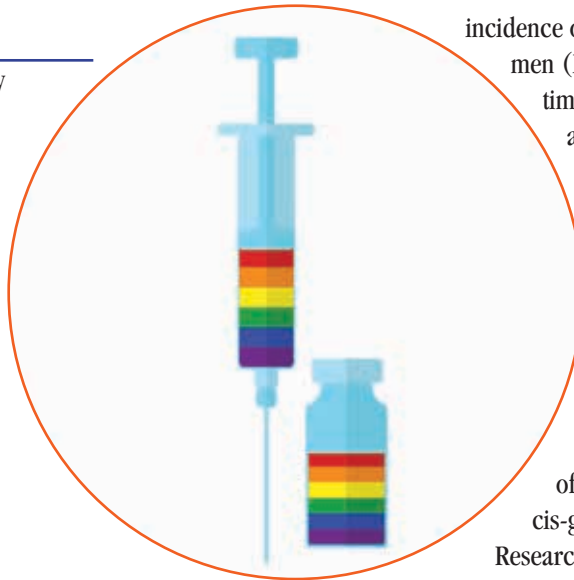
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# Cervical and Anal Cancer Prevention for the LGBTQ Population

By Sarah Hudson, MD and Caroline Donohue, MD

## Introduction

Cancer incidence has dropped precipitously in many segments of the population since the advent of regular cervical cancer screening in women. Anal squamous cell carcinoma, although more prevalent since the beginning of the AIDS epidemic, is still considered an uncommon cancer. Anogenital cancers, however, are significantly more prevalent in LGBTQ community.<sup>1</sup> Understanding why prevalence is increased in this population as well as how clinicians might increase screening is critical to reducing cancer incidence in this group.



incidence of anal cancer in men who have sex with men (MSM) who are HIV negative is about 3 times higher than in the general population, and in MSM who are HIV-positive it is about 30 times higher than the general population.<sup>1</sup> Moreover, in a study of anal HPV prevalence, 26% of HIV negative MSM were positive for high risk HPV in the anal canal.<sup>3</sup>

There are a variety of reasons why this might be the case. People in the LGBTQ community tend to be under-utilizers of healthcare when compared to their cis-gendered heterosexual counterparts.<sup>1</sup>

Research and surveys have identified barriers to care including experiences of homophobia and stigmatization by medical professionals, lack of insurance, misperceptions of susceptibility to cervical cancer, and fewer contacts with routine gynecologic care due to not needing routine contraception. The 2015 US Transgender Survey reported that 33% of respondents who had seen a clinician in the past year reported at least one negative experience related to being transgender (verbal harassment, refusal of treatment, insufficient clinician knowledge), and 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person.<sup>14</sup> Transgender patients are at risk of feeling especially traumatized or have uncomfortable gender-discordant experiences with genital exams and are therefore more likely to avoid screening. In addition to these barriers, there are misconceptions that exist. Some lesbian women may believe that they do not need to get pap smears if they do not have sex with men.

## Pathophysiology of Cervical and Anal Cancer

Human papillomavirus (HPV) is a sexually transmitted infection spread through contact of mucous membranes. There are over 170 different types of HPV, divided into low risk and high risk groups.<sup>1</sup> HPV has the potential to cause cell changes in various anatomical sites, including the cervix, anal canal, oropharynx, penis, and vagina. Low risk HPV serotypes are associated with anogenital warts and low grade squamous intraepithelial changes, while the high-risk types are associated with high grade changes and cancer. HPV is responsible for 100% of cervical cancers and 88% of anal cancers.<sup>2</sup> The widely available quadrivalent (Gardasil) and 9-valent (Gardasil-9) HPV vaccines protect against the two highest risk serotypes (HPV-16 and -18), as well as several lower risk serotypes including 6 and 11 which cause genital warts. Because HPV transmission occurs through skin-to-skin contact of mucous membranes or shared use of sex toys that have not been adequately cleaned, patients of all sexual orientation and gender identity may be at risk of infection whether or not they have ever had penile-vaginal penetrative sex.

## Population Based Risk

According to the CDC, in 2015 the incidence of cervical cancer in the US was 7.6 per 100,000 women.<sup>22</sup> In one large California survey of over 70,000 women, self-reported prevalence of cervical cancer in heterosexual women was 14%, 16.5% in lesbian women, and an astonishing 42.4% in bisexual women.<sup>1</sup> Multiple studies show that cervical cancer screening rates are significantly lower among bisexual women, which may be the cause for this disparity. The

For MSM and transgender women who have anal receptive sex, there are no formal guidelines for anal pap screening, so these patients (and their treating clinicians) may be unaware that an option for screening exists. One survey of transgender patients showed a perceived low risk for anal cancer and lack of knowledge about the disease or screening despite many having higher risk factors.<sup>5</sup> Our work to increase screening and preventive care in the LGBTQ population should involve education of both patients and healthcare professionals in the specific healthcare needs of this population, and how to treat them in a way that makes them feel comfortable and accepted.

## HPV Immunization

The best primary prevention of HPV-related cancers is the HPV vaccine. HPV vaccination is available in bi-valent, 4-valent, and 9-valent formulations, which were FDA approved in 2009, 2006, and 2014 respectively. This vaccine was previously FDA approved for both cervical and anal cancer prevention for ages 9 to 26 and was recently FDA approved up to age 45<sup>4</sup>, which may provide an opportunity for protection for a high risk group of individuals who pre-date the release of this vaccine. Vaccination schedule recommendations are listed below in Table 1. One survey found that in women aged 18 to 24, 45% of women who identified as lesbian or bisexual had received one dose of the vaccine compared to 51% of women in this age group who identified as heterosexual.<sup>1</sup> Routine vaccination is recommended by ACIP (the Advisory Committee on Immunization Practices) for all females ages 9-26 and all males ages 9-21, as well as for homosexual and HIV positive males ages 22-26. Failure to assess sexual orientation may cause a significant missed opportunity to recommend vaccination to groups most likely to benefit.

**Table 1:**  
**CDC/ACIP Human Papillomavirus vaccination schedule<sup>23</sup>**

Ages 9-14*	2 doses	1st dose: today 2nd dose: 6-12 months after the first shot
Ages 15-26	3 doses	1st dose: today 2nd dose: 1-2 months after the first shot 3rd dose: 6-12 months after the first shot
Ages 27-45**	3 doses	1st dose: today 2nd dose: 1-2 months after the first shot 3rd dose: 6-12 months after the first shot

\*3-dose vaccination in this age group is recommended if immunocompromised.

\*\* FDA approved, but as yet insurances do not cover for this age group.

Contraindications to HPV vaccination include current pregnancy, current moderate to severe illness, and severe allergic (e.g. anaphylactic) reaction to prior administration of the HPV vaccine.

## Cervical Cancer Screening

Secondary prevention of cervical cancer includes screening for HPV or cellular changes, most commonly by a Pap smear (Papanicolaou test) with or without testing for high risk HPV. Well defined screening recommendations exist for cervical cancer and vary only slightly among different organizations. These guidelines are shown in Table 2. Screening recommendations for individuals who have had a hysterectomy are of special interest for the transgender population and highlight the importance of accurate organ inventories as well as up-to-date screening prior to any surgical interventions. There are

no recommended alterations in screening for women who identify as LGBTQ or in patients who have received the HPV vaccine. In 2018 the USPSTF updated its recommendation statement to include high risk HPV testing alone every 5 years as a screening option for women age 30-65.<sup>6</sup> The other organizations listed have not updated their formal guidelines since this USPSTF update, but ACOG did issue a practice advisory endorsing the new recommendation.<sup>10</sup> There is limited but growing research about self-swabbing for HPV testing. Guidelines approving HPV testing alone as adequate cancer screening may pave the way for the use of the HPV self-swab (as opposed to clinician-obtained HPV testing and/or Pap smear) as a screening option for those uncomfortable with pelvic examination. Recent feasibility and preference studies suggest that this would be a favorable method among trans masculine individuals (gender identity male but biologically female); self-collected HPV swabs (as compared with Pap tests) were perceived as less invasive, provoked less gender discordance, and promoted a greater sense of agency.<sup>15,16</sup>

## Anal Cancer Screening

While cervical cancer screening is well taught in most fields of medicine, there is relatively little training in methods for anal cancer screening. However, this process is quite straightforward. The main methods of screening for anal cancer include anal Pap smears, high risk HPV testing, digital rectal exams (DREs) and high resolution anoscopy. Anal Pap smears are a simple office-based procedure, typically performed in the lateral lying position. A Dacron or polyester-tipped swab, pre-moistened with water, is inserted two to three inches into the anus. The swab is then rotated while applying firm lateral pressure (to ensure sampling of the mucosa rather than the rectal contents), and then the swab is placed in a cytology preservative vial. The University of California at San Francisco (UCSF) hosts a website with a detailed information to help guide test result interpretation and follow up (see Table 3). Digital anal rectal examination should be performed *after* collection of cytology specimens, so that the lubricant does not obscure visualization of cells by the cytologist. High resolution anoscopy (HRA), similar to colposcopy of the cervix, is a means of visualizing the squamocolumnar junction of the anus using magnification and, if needed, staining of the area to better visualize cell changes to obtain biopsies. Patients with abnormal rectal examination or anal Pap screening results should be promptly referred for HRA, and results will guide subsequent follow up recommendations.

Unfortunately, national guidelines do not exist for anal cancer screening similar to those that exist for cervical cancer screening. The New York State Department of Health was one of the first agencies to offer guidelines specifically for this group. Because the disease prevalence is higher in HIV-positive patients and in patients who are the receptive partner of anal intercourse, much of the current data focuses on individuals with these risk factors. A 2010 study of MSM patients who are HIV-positive found that using cytology or HPV testing on these patients had high sensitivity but rather low

continued on page 44

**Table 2:**  
**Cervical Cancer Screening Guidelines by Organization<sup>6,7,8,9</sup>**

<i>Age group/ population</i>	<b>USPSTF</b>	<b>ACS</b>	<b>AAFP</b>	<b>ACOG</b>	<i><b>SORT grade</b></i>
<b>Under 21</b>	no screening	no screening	no screening	no screening	A
<b>21 to 30</b>	Cytology alone every 3 years	Cytology alone every 3 years	Cytology alone every 3 years	Cytology alone every 3 years	A
<b>30 to 65</b>	cytology alone every 3 years OR cytology with hrHPV testing every 5 years OR hrHPV testing alone every 5 years	Co-testing with cytology and hrHPV every 5 years (preferred) OR cytology alone every 3 years (acceptable)	Co-testing with cytology and hrHPV every 5 years OR cytology alone every 3 years in women 25 years of age or older is acceptable	Cytology alone every 3 years OR cytology with hrHPV every 5 years <sup>*</sup>	A*/B**
<b>Older than 65<sup>‡</sup></b>	no screening	no screening	no screening	no screening	C
<b>Women who have had a hysterectomy with removal of cervix and no history of CINII</b>	no screening	no screening	no screening	no screening	C

\* co-testing every 5 years or cytology alone every 3 years

\*\* hrHPV alone every 3-5 years

\*- Practice Advisory Update by ACOG does endorse new USPSTF guidelines

‡ (no prior history of abnormal or >20 yrs. out from \_\_\_\_\_)

hrHPV = high risk HPV

(A- consistent, good quality, patient-oriented evidence; B- Inconsistent or limited quality evidence; C- consensus, disease-oriented evidence, usual practice, expert opinion, or case series)

specificity for significant cellular changes, leading many patients to require further testing with high resolution anoscopy.<sup>11</sup> An older study in JAMA analyzed the cost effectiveness per quality-adjusted life year saved with anal pap smears in HIV positive MSM and found both yearly and every other year screening to be beneficial in this patient group and comparable in cost to other disease preventive measures.<sup>12</sup> Although they do not have formal guidelines, the ACS website states that people at increased risk should consider screening with DRE and anal Pap smears and that this group includes MSM regardless of HIV status.<sup>13</sup> It is clear that more research needs to be done on this topic to better establish structured guidelines for patients and clinicians. However, healthcare professionals should be aware of the research that has already been done and be able to educate their patients who are at increased risk about the option of screening for this disease.

## Breast and Ovarian Cancer Screening

Though our focus is primarily on HPV-mediated cancers of the anogenital tract and not a comprehensive review of all types of cancer, here, we briefly summarize recommendations for breast and ovarian cancer screening in the LGBTQ population.

As a population, lesbian and bisexual women may be increased risk for breast cancer due to a higher prevalence of some risk factors such as lower number of pregnancies, higher percentage of

smokers, and higher BMI; however, there has not been data showing that this translates into higher prevalence of breast cancer in lesbian and bisexual women.<sup>1, 19</sup> While there are no current differences in recommendations for women in this population, there is some concern that this may be under-reported as the national cancer registries do not yet collect data on sexual identity or orientation. Screening rates for breast cancer have been equivalent in this population, but rates of pap smear screening, however, have been shown to be lower in this population.<sup>19</sup> As with cervical cancer screening, there are recommended guidelines for breast cancer screening in the general population by USPSTF, ACS, and AAFP. The USPSTF recommends biennial screening mammography for women aged 50 to 74.<sup>17</sup> The ACS has more conservative recommendations, to start screening mammography yearly at age 45-54 with an option to screen starting at age 40, and to either continue yearly screening or switch to biennial screening at age 55<sup>18</sup>, and continue for as long as they have a life expectancy of at least 10 years. The AAFP supports the recommendation of the USPSTF.

None of the major organizations have specific recommendations on screening for transwomen or transmen, and there is limited data on this population. One Dutch cohort study found the incidence of breast cancer in both transwomen and transmen receiving hormone therapy to be similar to that of cis-men.<sup>20</sup> However, given the unknown risk of hormone therapy, The Center of Excellence for Transgender Health at University of California San Francisco states

it is reasonable to recommend biennial mammograms for transwomen age 50 and older who have had 5 years or more of feminizing hormone therapy.<sup>21</sup> Transmen who have not had bilateral mastectomy should undergo screening according to guidelines for cis-women. Transmen who have had bilateral mastectomy however, are at rather low risk for breast cancer<sup>20</sup> as most of the breast tissue has been removed, and useful mammography images may be difficult to obtain due to insufficient tissue present. If a palpable mass is felt, it would seem reasonable to visualize it with MRI or ultrasound. The Center of Excellence for Transgender Health recommends clinicians have a conversation with their transmen patients about the lack of data about their specific risks for breast cancer and the technical difficulty of mammography when there is little to no breast tissue present.<sup>20</sup>

There are no standard guidelines for ovarian cancer screening in the general population. The USPSTF recommends specifically *against* routine screening for ovarian cancer in average-risk individuals. As with other forms of cancer, national registries do not consistently assess sexual or gender orientation, so overall data on prevalence and incidence is limited. However, according to the National LGBTQ Cancer Network, transmen in particular may be at higher risk for ovarian cancer due to both decreased clinician awareness and decreased access to medical surveillance.<sup>24</sup> There are also myriad increased risk factors in this population, including higher smoking rates, BMI, decreased pregnancies and use of estrogen-containing contraceptives.<sup>24</sup> The impact of testosterone therapy on the risk for ovarian cancer is unknown and under-studied. As primary care providers, it is important for us to make sure that we maintain an up to date organ inventory and gender-identity awareness, as this will allow us to more accurately triage our patients' medical concerns.

**Table 3:**  
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- National LGBTQ Health Education Center. <https://www.lgbthealtheducation.org/>
- Anal cancer screening: UCSF Anal Cancer Information Center. <https://analcancerinfo.ucsf.edu/>
- NYS DOH Anal Dysplasia and Cancer Guidelines. <https://www.hivguidelines.org/hiv-care/anal-dysplasia-cancer/>

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## Project TEACH/Update on Prevention Science

Mental health concerns for children and youth can hinder behavior, academic performance, and relationships with family members and peers. Untreated mental health concerns are also associated with negative impacts over the course of the lifespan, such as unemployment, disability, and homelessness. These consequences have notable impact to society, including financial pressures on a variety of institutions such as schools, hospitals, inpatient mental health facilities, and juvenile detention centers. In 2015, there were nine New York counties with zero child serving psychiatrists per 10,000 children under the age of 18.<sup>1</sup>

This article provides a brief overview of how prevention science can help address these critical impacts. It also lets you know how Project TEACH, a project funded by the New York State Office of Mental Health (OMH), can help you address mild-to-moderate mental health concerns for children in your practice.



### Prevention is Critical

The field of prevention science is one of the leads in practice transformation to integrate behavioral and physical health care for children and adolescents. Prevention science is a framework for research on how to prevent and/or moderate negative medical, socioeconomic, environmental, and emotional impacts as early as possible.

A child's brain grows quickly during the early years of life. Nearly a million neural connections are produced each second. This brain development is impacted by the experiences that children have during these years. This includes positive factors such as parental affection, family stability, proper nutrition, social supports, housing, and many more. It also includes negative factors that have been studied in recent years under the heading of Adverse Childhood Experiences or ACES.

There is a growing body of research on the profound impact that ACES like abuse, neglect, hunger, danger, and loss have on children; especially children from underserved communities and/or at-risk families. Research shows a strong link between ACES and a wide range of subsequent physical and mental health problems across the life span including increased risk of substance use, obesity, heart disease, financial difficulties, relationship problems, and even early mortality.<sup>2</sup> According to the National Survey of Children's Health, approximately 43.7% of children in New York State experienced one or more traumatic events.<sup>3</sup>

Studies have shown that the socioeconomic and environmental determinants of health are large contributory factors to health disparities and inequities but that preventive interventions can have profound, measurable, and long-lasting positive effects on the health and mental health outcomes of children and adolescents.

### The Important Role of Family Medicine and Primary Care

Despite the high incidence of mental health concerns as a result of ACES and other factors, many children and families are unable to access the mental health services that could help them to achieve more positive outcomes. Due to this continuing



shortfall – especially in rural areas – it is important that pediatricians and family physicians remain on the frontlines of children's mental health. These pediatric primary care providers (PCP) are often the only healthcare providers some children have access to, a challenge that is often difficult to meet given the many competing time demands on PCPs. PCPs often do not have the time to stay current with the latest evidence-based treatments in mental health,<sup>4</sup> and they also frequently encounter barriers to reimbursement for screening or time spent on preventive care.

### Project TEACH – A Program that Helps

Project TEACH provides PCPs with the support they need to address mild-to-moderate mental health concerns in children, adolescents and young adults ages 0-21. These concerns may include depression, anxiety, ADHD, and aggression. Project TEACH supports the importance of the integration of mental health into pediatric primary care settings, including the practical implementation of prevention science. "Prevention science clearly establishes the vital role of PCPs in preventing negative health and societal outcomes in children and adolescents," says Matthew Perkins, MD, Medical Director, Division of Integrated Community Services for Children and Families at OMH.

## Project TEACH Services

Project TEACH allows PCPs to:

- Call a regional warm line to speak with a Project TEACH child and adolescent psychiatrist to ask questions, discuss cases, and/or review treatment options.
- Request face-to-face consultations with Project TEACH child and adolescent psychiatrists for children and families in their practices.
- Find linkages and referrals for families to help them access community mental health and support services. These includes clinic treatment, care management, and family support.
- Access to educational trainings on multimedia platforms, including online training courses, attendance at live trainings, and attendance at intensive trainings offered several times annually in different regions of the state. All trainings are free, and provide CME credits.

These services are outlined on the Project TEACH website at [www.projectteachny.org](http://www.projectteachny.org). The site also offers links to many mental health screening tools that assist in assessing mild-to-moderate mental health concerns such as aggression, ADHD, anxiety, and depression.

Project TEACH provides services to PCP's statewide within three service regions. Learn more about the service regions covered by Project TEACH on the map you can find here-- <https://projectteachny.org/consultation/> The child and adolescent psychiatrists who provide services for Project TEACH in each region come from renowned institutions and medical schools across the state, including SUNY Upstate Medical University, University of Buffalo, Rochester University, Zucker School of Medicine at Hofstra/Northwell School of Medicine, Columbia University Medical Center/New York State Psychiatric Institute, and the Four Winds Foundation. Learn more about the Regional Providers at [projectteachny.org/regional-providers/](http://projectteachny.org/regional-providers/).

Prevention science emphasizes the importance of early, evidence-based, mental health interventions to achieve better long-term overall health outcomes for children. Through Project TEACH, PCPs can access the most current guidance on these evidence-based interventions. To specifically address the need to include early preventative interventions for children and their families, Project TEACH recently launched a page on its website that provides an overview of prevention science, [projectteachny.org/prevention-science/](http://projectteachny.org/prevention-science/).

## A Call to Action

Project TEACH and OMH hosted the first Annual Forum on prevention science on September 14, 2018, in Albany. The goal for the conference was to incubate strategies and solutions for moving prevention science from policy to practice in the primary care setting across New York State. An announcement for the second forum on prevention science will be posted soon.

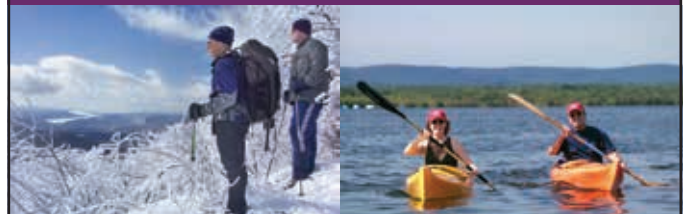
We invite you to take a moment now to learn more about how to receive consultations, education, and training from Project TEACH at [projectTEACHny.org](http://projectTEACHny.org).

## Endnotes

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**For more information about these, or other opportunities, contact:** Denise Romand, Medical Staff Recruiter/Liaison, Saratoga Hospital; [dromand@saratogahospital.org](mailto:dromand@saratogahospital.org). Call: (518) 583-8465.

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