A Review of Clinical Guidelines for Creating a Gender-Affirming Primary Care Practice

Brian Bizub; Brittany Allen, MD

ABSTRACT

Introduction: Transgender, nonbinary, and gender-nonconforming (TNG) patients experience many health disparities compared to the cisgender population. Despite numerous recommendations for working with TNG populations in health care, many TNG patients report having negative health care experiences in and are unable to access competent and affirming primary care.

Objective: To review the literature and current recommendations for primary care clinicians to make the clinic setting more affirming for TNG patients.

Methods: We conducted a literature review of existing recommendations and research surrounding creating affirming primary care environments for TNG patients.

Results: Clinicians can make clinic environments more affirming by making the physical space TNG friendly, documenting gender identity properly, addressing patients according to how they identify, ensuring confidentiality, understanding insurance issues, using affirming language and clinical approaches, and accessing training about working with TNG patients.

Conclusions: In cooperation with clinic administration, clinicians should utilize guidelines available to advocate within their own clinic to make recommended desired changes to the clinic environment. While current literature and recommendations exist, they often lack specific guidance on how to accomplish many of these changes. Future guidelines should include specific examples and implementation methods. Many changes to the clinic environment necessitate cooperation from clinic administration.

INTRODUCTION

There are numerous health disparities among transgender, nonbinary, and gender-nonconforming (TNG) people compared to the cisgender population.[1] (See Table 1 for definitions.[2,3]) Depression is much more common in TNG populations, with estimated rates as high as 4 times that of the general population.[4] A recent study of TNG adolescents found that 14% of all respondents had attempted suicide, with half of transmasculine adolescents reporting suicide attempts.[5] In TNG adults, 41% report at least 1 suicide attempt in their lifetime.[6] Risk behaviors, such as smoking and substance use, are also more common in the TNG population,[7] and TNG people are more likely to have multiple chronic conditions and higher rates of disability.[7] The burden of HIV is higher in the TNG population, with rates of HIV infection as high as 16% to 25%.[8] Gender-based rejection, victimization, discrimination, and lack of identity affirmation contribute greatly to health disparities among the TNG population,[9,10] and this minority stress is thought to be the etiology for poor mental and physical health outcomes in TNG populations.[1]

TNG patients also have difficulty accessing quality health care. In a 2015 survey of TNG individuals, only 6% of respondents indicated that their routine care clinician knew almost everything or most things about TNG care.[11] Nearly one quarter of respondents that sought health care reported having to teach their provider about TNG health care, and more than one third of TNG adults have experienced more than 1 negative experience in health care in the last year.[11] One in 5 (21%) of TNG adults experienced verbal harassment in the health care setting,[12] while others have been outright denied care by clinicians.[13] Based on this data, it is no surprise that nearly one third of TNG adults reported that they had not revealed their gender to any of their health care providers, and 23% of TNG respondents

• • •

Author Affiliations: University of Wisconsin School of Medicine and Public Health, Madison, Wis (Bizub, Allen).

Corresponding Author: Brian Bizub, University of Wisconsin School of Medicine and Public Health, 2310 Keyes Ave, Madison, WI 53711; phone 262.527.7060; email bizub@wisc.edu.

did not see a doctor when they needed to because of fear of being mistreated.[11] In a study among Canadian TNG youth, 68% of respondents reported forgoing needed mental health care and 33% reported forgoing needed physical health care in the last 12 months.[13] More than half of those who chose to forgo care cited being afraid of what the doctor would say or do as a reason for not getting care.[13]

To address these barriers to care, numerous recommendations now exist as a reference for clinicians to make their practice more affirming to TNG patients. Despite this, physicians still perceive numerous barriers to providing care to TNG patients, among them the lack of educational and training resources.[14] We aimed to review the recommendations available for clinicians to improve their ability to provide affirming care for their TNG patients.

Table 1. Terms Providers May Use or Hear When Talking With Patients About Gender Identity[2,3]

Cisgender	A person whose gender identity aligns with their sex as signed at birth.
Gender-affirming surgery (GAS)	Surgery that changes a person's body to more closely align with the gender they identify with.
Gender binary	The idea that there are two genders: male and female. This concept is often challenged as there are people with gender identities that do not fall within the gender binary.
Gender dysphoria	Distress experienced by some individuals from conflict between assigned sex or gender and their gender identity.
Gender fluid	A person who does not identify with a single, fixed gender. This may mean that their gender identity changes from day to day.
Gender identity	A person's internal sense of being male, female, both, neither, or another gender.
Gender nonconforming	When gender expression differs from societal norms of boy/girl or man/woman.
Nonbinary	A person whose gender identity is something other than strictly man or woman.
Transgender	An umbrella term to describe when a person's gender identity differs from the sex assigned at birth.
Trans man/transgender man/female-to-male (FTM)	A person whose gender identity is male or masculine; generally their assigned sex at birth was female.
Trans woman/transgender woman/male to female (MTF)	A person whose gender identity is female or feminine; generally, their assigned sex at birth was male.
Transition	The process of coming to recognize, accept, and express one's gender identity.
Transphobia	The fear of, discrimination against, or aggression toward TNG people.

OBJECTIVE

To synthesize existing literature and recommendations for how clinicians can make their clinic environments more affirming to facilitate positive health care experiences and improve accessibility to health care for TNG patients.

METHODS

An initial literature search of existing recommendations for improving primary care environments for TNG patients was done using Google, Google Scholar, Pubmed, and Web of Science searches. Search terms included "affirming environments for LGBTQ (lesbian, gay, bisexual, transgender, queer/questioning) patients," "affirming environments for transgender patients," "affirming environments for LGBTQ youth," "affirming environments for transgender youth," "transgender youth primary care," "transgender primary care," "transgender health care," and "LGBTQ youth primary care." Selected articles from the literature search included recommendations, review articles, and primary research on creating affirming environments for LGBTQ and TNG populations. These came from advocacy organizations, professional organizations, nonprofit organizations, and academic research from any country. Excluded articles included articles published before 2000, recommendations on medical management of TNG patients, and recommendations that were not intended for primary care or health care environments. After the initial literature search, references from 3 prominent guidelines[2,15,16] were used to supplement the articles found in the first search.

The authors excluded articles from the study if they failed to provide unique, novel, or useful information compared to other articles. The authors accepted recommendations based on expert opinion, observational studies, or randomized clinical trials. During the literature review, the authors noted common themes that the reviewed articles focused on and used these distinct domains to organize results.

RESULTS

Following the literature search, one of the authors identified a total of 44 articles; 24 met inclusion criteria for full review. Themes identified as areas for intervention included the physical clinic environment, clinic policies, documenting sex and gender, confidentiality, insurance coverage, clinical interactions with TNG patients, and training for staff and clinicians.

The Physical Environment

A primary theme identified was recommendations for creating an affirming clinical space for TNG patients, with recognition that these visual cues can send a message that increases TNG patients' comfort[17] and signals to TNG patients that it is safe to disclose their gender identity. Considerations in creating an affirming physical space include reviewing visible cues in clinical and waiting spaces, language used on forms or intake paperwork, and patient facilities, such as bathrooms and changing rooms.

Media available in public and waiting spaces can send a powerful message. Signage and artwork prominently displayed in the clinic should represent diverse experiences,[17] including artwork that depicts LGB couples, TNG individuals, or LGBTQ-friendly symbols such as rainbows or safe space terminology.[18] Informational handouts and posters should avoid assuming the reader is cisgender or heterosexual.[19] Clinics should have informational materials specifically for TNG patients, such as information

on talking about gender identity with clinicians and family, social transition, safe practices for tucking genitals so that they are less visible, safe uses of binders to conceal breast tissue, and information on gender-affirming hormones.[16] LGBTQ-themed magazines and handouts should also be included in waiting areas literature.[20] Clinicians and staff can indicate that they are LGBTQ friendly by wearing LGBTQ-friendly pins or lanyards.[19] They can also indicate their preferred pronouns on their nametags or identification badges, promoting the discussion of gender identity with patients.[21]

Forms or other paperwork are often one of the first interactions that patients have in a clinical setting, and the questions asked can lay the framework for patients' expectations about whether a clinic is a safe place for TNG people. Language in forms or intake paperwork should be designed to be open and affirming, Examples of affirming language include using "partner" instead of "boyfriend" or "girlfriend" and "parents" instead of "mother" and "father."[16,20,22,23]

Bathroom access is a particularly important opportunity to provide an affirming physical environment for TNG patients. Single stall unisex restrooms provide optimal privacy for patients.[16] If restrooms must be separated by gender, clinics should implement a policy that allows patients to use whichever restroom they are most comfortable using. Restrooms should be prominently display this policy so that patients are aware of it. Installing stalls with walls that reach all the way down to the floor can also provide more privacy in shared bathrooms.[19,21]

These steps to ensure affirming space should not just be limited to waiting rooms and common areas. Exam rooms should also contain affirming physical elements such as artwork, safe space stickers, or informational materials.[16,17,24] Spaces outside the clinic that patients commonly use while entering or exiting the clinic should also be affirming. This includes parking lots or shared spaces with other offices in the same building. Interactions with staff of nearby establishments, signage inside and outside of shared physical space, and interactions with other users of nearby spaces should all be considered as potential impacts on patient experience.[17]

Clinic Policies

In order to communicate to patients and staff that serving patients of all gender identities is a priority, all clinics should have a nondiscrimination policy that explicitly states that it welcomes all patients regardless of gender identity or sexual orientation.[19,20] Additionally, clinics should establish a patient Bill of Rights that ensures patient privacy and confidentiality for all patients.[25] This should outline a patient's right to refuse care from any medical personnel that are not essential, such as medical students or residents. While all patients should be encouraged to welcome learner participation, it is important to recognize that it may be important to have protected avenues to minimize any unwanted contact with staff, particularly for populations with a history of negative experiences in health care.[25] Clinics should establish a policy for addressing inappropriate behavior or comments in the clinic by staff, learners, or other patients.[26] Outside of specific posted policies, clinics can actively show their support for the LGBTQ community by observing, supporting, and participating in days such as LGBTQ Pride Day or Pride Month, National Transgender Day of Remembrance, and Day of Silence.[20]

Documenting Gender Identity

Collecting gender identity information can contribute to establishing an affirming environment for TNG patients in a number of ways: (1) identifying for clinic staff how each patient would like to be addressed; (2) providing clinicians information about gender identity that is necessary to provide the highest quality care; and (3) enabling the collection of population health data to further research on LGBTQ health and health disparities.[27] Collecting gender identity on intake forms is a convenient way to gather information in a way that allows patients to self-identify their own chosen name and pronouns, gender identity, sex assigned at birth, and, if appropriate, sexual orientation.[22] While there is sometimes the concern that patients will be offended by adding gender identity as a item on intake forms, a distinct minority (only 3%-11%) of all LGBTQ and non-LGBTQ patients reported being offended by such questions.[28]

Forms should allow for patients to record their legal name in addition to a name that they choose to be called (chosen name).[26] The chosen name should be used in any communication with or about the patient if the patient notes that as their preference.[2] The patient's legal name should be used only when necessary, such as billing the patient's insurance or labeling lab orders and prescriptions, or if requested by the patient due to safety or other concerns.[15,27,29] In addition to listed options, forms also should have spaces for patients to write in responses to questions about gender identity or sexual orientation so that they can self-identify with a term or label that best describes them.[29] Some patients may not be comfortable with disclosing sexual orientation or gender identity, so questions about these preferences should include an option to decline to answer.[17] Patients may be more comfortable with disclosing this information if provided with information on how the clinic plans to use and store their responses; this can be described in a patient education handout or a description on the intake form.[17]

While collecting gender identity and other patient information is useful for clinic staff, staff still must use patients' chosen names and pronouns correctly for this practice to be affirming. To encourage these practices, it is critical to incorporate gender identity information properly in the electronic health record (EHR).[29,30] The chosen name and pronouns of each patient should, if possible, be displayed on the EHR banner at the top of each patient chart so that staff utilize the correct patient identifiers,[29] and all

staff should be trained on using these tools for this purpose. EHR systems can also support clinicians in the preventive medical care of TNG patients, as decision support tools in some EHRs can remind clinicians to do routine health screenings on patients based on their anatomy.[29]

A common barrier identified in collecting and using gender identity information is the inflexibility of EHR systems.[31] A workaround to EHR limitations is to use communication tools in the EHR to remind staff members to address a patient properly. For example, EHR tools such as FYI flags, sticky notes, banners, comment fields, and the patient problem list are all places where a patient's chosen name or pronouns could be stored, as long as staff are oriented to that workflow.

Clinics can achieve change by organizing a team of staff members to serve as "champions" to implement collection of gender identity. Such a team might consist of an administrator, representatives from health information technology, and clinical and nonclinical staff, and also would be responsible for ongoing quality improvement of the implementation process.[28] Clinics may want to initially test and evaluate gender identity collection on the EHR in a single clinician's patient panel and then expand this to multiple clinicians after identifying and addressing barriers to implementation and finding appropriate workarounds where needed.

Legal Issues and Confidentiality

Clinicians should be prepared to provide support in processes around legal documentation of gender when caring for TNG patients. To change legal gender on federal documents such as passports, clinicians are required to certify that the patient has undergone "necessary" medical or psychological treatment for transition. Since there is no definition of what these treatments are, clinicians are free to interpret what "necessary treatment" is.[32] For state documents such as driver's licenses and birth certificates, requirements vary depending on the state.[32]

Ensuring confidentiality is critical for building trusting relationships with all patients and is essential when asking patients to disclose their gender identity.[19,33] If a clinician divulges confidential information such as gender identity to an employer, parent, school, or others, it may result in significant harm or distress to the patient.[34] Gender identity should be treated as confidential information; it should not be shared with anyone else beyond health care personnel who need to know this information for patient care, including parents if the patient is an adolescent.[32] It is not the duty of clinicians to inform parents of their child's gender identity,[34] however, clinicians should be ready to assist families with accepting their child's gender identity, if the patient would like the clinician to be involved in this discussion.[30,35]

Clinicians also must be aware of how patients would like sensitive information to be shared with them outside the clinic. Patients may request that their gender identity not be shared with certain entities, such as their family, school, or work. If this is the case, it may be helpful to make a specific plan with the patient about how to best honor their confidentiality when trying to reach them.[19] In cases where clinicians must divulge confidential information, such as in the cases of abuse or significant risk of harm to self, the minimal amount of information necessary should be shared. The patient's gender identity need not be included in a report if it is not relevant to the reason for having to report patient information.[19] It is important to be aware that there are conflicting opinions regarding the confidentiality of gender identity outside of the medical community. House Bill 658 is a proposed policy in Ohio that would require clinicians working with TNG minors to report the child's gender identity to their parents,[36] despite the direct conflict that this offers to widely recognized tenets of medical professionalism and ethics.[32]

Insurance Coverage

Coverage for gender-affirming care such as hormone therapy and gender-affirming services varies among insurance providers. While Medicare does cover hormone therapy and gender-affirming surgery deemed medically necessary by clinicians, Medicaid coverage of these services varies from state to state, and private insurance coverage varies between insurance providers.[37] Private insurance providers may deny coverage of preventive services based on patient anatomy if it does not correlate with the patient's listed gender. Clinicians should be aware of this issue and be ready to appeal coverage denials.[14] They should be able to access information about what gender-affirming interventions a patient's insurance will likely cover, how patients can meet the criteria for coverage of an intervention, and changes to the patient's policy that may affect their coverage for gender-affirming care.[31]

In 2016, the Department of Health and Human Services extended a provision in the Affordable Care Act so that private insurers could not change covered services based on gender identity.[38] This means if an insurance provider covers a service for cisgender patients, such as hormone therapy or breast implants, they must also cover the same services for TNG patients. However, this policy has been targeted recently by both local and federal entities.[38] In response, many states have passed their own health insurance gender discrimination laws. Because of the ever-changing landscape of health care policy and gender-affirming services, it is important that clinicians pay attention to federal and state policies that affect insurance coverage for TNG patients. As navigating insurance issues for TNG patients places an increased administrative burden on the clinician, clinics may consider designating a staff member to do this.[31]

Interacting with TNG Patients in the Clinic

To best treat TNG patients, clinicians need to be aware of their own misconceptions, bias, and stereotypes, as well as other communication barriers that may influence the care of these patients.[16,17] Displaying discomfort when treating TNG patients may result in

Table 2. Examples of Terms and Phrases Providers Can Use to Talk to Patients in a Gender-Affirming Way[2,43]

Asking for a patient's preferred name and pronouns	What do you prefer to be called? What name would you like us to use? Pronouns are the words that others use to describe us when we're not there. What pronouns do you use?
Asking about names if they do not match health records	Could your chart be under another name? What is the name on your insurance?
Apologizing for using a name or pronoun that are not the patient's preferred name or pronoun	I apologize for using the wrong pronoun: I work hard to make sure I address all my patients appropriately and did not mean to disrespect you. How would you like to me to refer to you?
Asking patients what their gender identity is	What is your current gender identity?
Asking younger patients what their gender identity is	Some of my patients feel as though they're more of a boy, or a girl, or even something else. How would you identify yourself?
Asking patients for their assigned sex at birth	What sex were you assigned at birth as shown on your original birth certificate?

lower quality care and cause patients to feel uncomfortable with seeking medical care.[33] Clinicians that have bias against TNG patients have less knowledge of TNG care independent of amount of education they receive on the subject.[39] Trainings and activities around the TNG population and addressing unconscious bias are essential for clinicians. When speaking with patients, the use of hetero- or cisnormative statements or questions—those that assume that the patient is cisgender and heterosexual—should be avoided. For example, a person that identifies as female may be asked if she has a partner rather than a heteronormative question around whether she has a husband or boyfriend. Clinicians should also refrain from referring to cisgender patients as "normal" when comparing them to TNG patients, knowing that TNG patients have normal, healthy gender identities.[15,16,26] While some TNG patients may be eager to provide information, some patients may prefer to build a relationship with their clinician before sharing personal information about their gender identity.[19,40] Clinicians should honor and respect a patient's decision to provide information about their gender identity and be mindful that TNG patients may have had prior negative experiences in health care.[16]

Primary care clinicians should ask about gender identity on a regular basis.[41] While clinics may ask about gender identity on intake forms, some patients may be more comfortable disclosing this information to only the clinician.[42] When asking about a patient's gender identity, clinicians should not assume the patient's gender identity based on appearance and, if unsure about the patient's gender identity, should ask open-ended questions for clarification.[16] Because this is often a sensitive topic for patients, clinicians must be intentional about asking about gender identity in an appropriate manner that includes affirming language.[16,41] Terms that assume gender identity such as "sir" or "ma'am" should also be avoided and replaced with words such as "the patient" (in 3rd person) or "you" (when talking to the patient).[2] *(See Table 2 for examples.)*

TNG patients may use varying terminology to describe their gender identity. For example, TNG patients in Native American communities may refer to themselves as "Two-Spirit," a term for people who are both masculine and feminine.[44] When clinicians know common terminology used by TNG populations, this can help signal knowledge and experience to TNG patients.[15,18] When discussing a patient's gender identity with the patient or with other staff, clinicians should use the terminology that a patient uses to identify themself.[16,19] For example, if a patient refers to themself as "gender non-conforming," this is the term that should be used when discussing their gender identity; in this case, terms such as "transgender" or "nonbinary" may not be appropriate to describe this patient's gender identity. Clinicians also should do the same with the patient's chosen name and pronouns. To obtain a patient's chosen name, clinicians should ask patients what they prefer to be called.[16] Clinic staff that do not use a patient's chosen name or pronouns should be corrected even if the patient is not present.[2,19]

As with any patient, a thorough history is necessary to provide quality primary care for TNG patients. Clinicians also must decide what is appropriate to ask TNG patients depending on the context of the visit. For example, an anatomical inventory is not appropriate to obtain if the patient is presenting with an upper respiratory infection.[15] In providing primary care, a thorough social and sexual history should be taken as it should be for all patients to screen for risk factors for depression, suicidality, trauma, exposure to violence, HIV, sexually transmitted infections, and substance use. Primary care providers should take an inventory of a patient's anatomy and be ready to provide screenings and treatment based on anatomy rather than assumptions about gender identity or sex assigned at birth.[31] A patient's history or plans for gender-affirming surgery should be elicited as well. While many TNG patients benefit from gender-affirming surgery, clinicians should not assume that all patients will want or pursue gender-affirming surgery.[45] Clinicians should also ask about a patient's plans for hormone therapy. If a patient reports that they are receiving hormone therapy, the clinician should inquire the source of the hormones they are taking. Patients may obtain hormones from a source other than their clinician and inject these hormones on their own,[46] which increases risks related to injection and impure medications. Clinicians also should ask about practices such as tucking genitals so they are less visible, using binders to conceal breast/chest tissue, and injecting silicone into breast tissue to make the breasts appear larger.[31] Clinicians should become aware of the potential sequelae of these practices, and be ready to treat and counsel patients experiencing these.[15]

If they have avoided health care settings, TNG patients may have not had a complete physical exam in years. As for all patients, a physical exam may be uncomfortable, traumatic, or embarrassing for some TNG patients, and they may have intense emotional reactions to parts of an exam.[45] To relieve anxiety, clinicians should discuss the aspects of the physical exam with the patient and explain why sensitive parts of the exam are necessary. A chaperone should be offered when sensitive exams are to be performed.[32] Physicians should give all patients extra autonomy during the exam. For example, clinicians may allow a patient to insert the speculum themselves when performing a cervical exam.[31] During an exam, the use of anatomical terms associated with a gender such as breasts or testicles should be avoided and replaced with gender neutral terms such as chest and genitalia or the words that the patients uses to describe their anatomy.[45] Physicians should be able to recommend resources to patients, such as gender-affirming surgeons, behavioral health providers, hair removal providers, and social support resources that are competent in working with TNG patients.[31]

Training

By training staff on providing affirming care for LGBTQ patients, clinics can prevent future mistreatment of TNG patients.[2,16] All clinicians and clinic staff should receive training so that TNG patients receive appropriate care when with any clinic staff.[18,40] While some TNG patients may be willing to teach their clinician about TNG care, they do want their clinician to have basic knowledge of care and resources for patients.[47] As discussed in this review, training topics may include TNG health issues and cultural competency, gender-affirming care, collection and use of gender identity, and confidentiality. Inviting local TNG community members to discuss their experiences and treatment in health care settings may be a powerful training method that connects real-life experience with recommendations,[24] though care should be taken to compensate people appropriately for their time and expertise. The Human Rights Campaign recommends that staff receive, at minimum, 1 hour of training on working with LGBTQ populations annually.[48]

Training for working with LGBTQ patients should become standard practice for all new employee hires.[15,27,29,49] Because health care for TNG patients is a rapidly developing field, regular trainings on health topics for TNG patients are recommended. Clinicians should familiarize themselves with both local and electronic resources for TNG patients so that they are able to refer patients appropriately.[16,18] See Appendix 1 for trainings and resources that can be used in health care settings.

CONCLUSIONS

Current literature and recommendations on creating affirming clinic environments for TNG patients have a very clear consensus with consistent themes that involve addressing the physical environment of the clinic; collection and use of patients' gender identity information, chosen names, and pronouns; clinic policies around nondiscrimination and confidentiality; health insurance issues related to gender-affirming care; affirming language and clinical interactions; and training for all staff.

Many recommendations and policies that are suggested in this review are beyond the control of a single staff person or provider. Creating an affirming environment for TNG patients necessitates not only the cooperation of clinicians, but also staff and clinic and organizational leadership. Despite this challenge, providers and staff can act as advocates to promote affirming practices at the clinic level while advocating for system-wide change. To evaluate areas for improvement, a needs assessment of clinic practices with regard to standards of care for TNG patients should be conducted,[31] and clinic teams may also reach out to TNG community members to understand their primary care needs and involve them in advocating for clinic changes.[31] There are many checklists available for use to evaluate the primary care environment (see Appendix 1). To encourage involvement of clinic leadership, clinicians can meet to describe the rationale of change toward gender-affirming care, goals for clinical interventions, and potential costs. If greater support is needed, clinicians can build support by inviting TNG individuals to come speak about their experiences, showing videos or films about TNG experiences, and encouraging other clinicians to do educational activities on TNG health for continuing education credits.[31]

For more information on how to start a TNG health care program at your clinic, refer to "Creating a Transgender Health Program" by the LGBT Health Education Center included in Appendix 1. Current literature and clinical guidelines on TNG health care often lack concrete examples for implementation. For this reason, we have included resources that clinicians and clinic staff can utilize to access specific instructions and trainings on working with TNG patients (see Appendix 1). Future research on creating affirming environments for TNG should address how to implement changes for a more affirming clinic environment and measure impact on the experiences of TNG patients. Further development of interactive trainings Band educational opportunities for clinicians, clinic leadership, and clinic staff help ensure that these are universal and accessible.

Despite these shortcomings, there are many accessible resources available for clinicians to provide affirming primary care for TNG patients. If clinicians commit to turning their practice into an affirming space, they can provide access to quality, gender-affirming primary care that TNG communities need and deserve.

Funding/Support: None declared.

Financial Disclosures: None declared.

Appendix: The Appendix is available online at www.wmjonline.org.

REFERENCES

1. Mink MD, Lindley LL, Weinstein AA. Stress, stigma, and sexual minority status: the Intersectional Ecology Model of LGBTQ health. *J Gay Lesbian Soc Serv.* 2014;26(4):502-521. doi:10.1080/10538720.2014.953660

2. *Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-Line Health Care Staff*. Boston, MA: National LGBT Health Education Center. Published Fall 2016. Accessed August 28, 2019. https://www.lgbthealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf

3. PFLAG National Glossary of Terms. PFLAG website. Updated July 2019. Accessed August 18, 2019. https://pflag.org/glossary

4. Witcomb GL, Bouman WP, Claes L, Brewin N, Crawford JR, Arcelus J. Levels of depression in transgender people and its predictors: results of a large matched control study with transgender people accessing clinical services. *J Affect Disord*. 2018;235:308-315. doi:10.1016/j.jad.2018.02.051

5. Toomey RB, Syvertsen AK, Shramko M. Transgender adolescent suicide behavior. *Pediatrics*. 2018;142(4):e20174218. doi:10.1542/peds.2017-4218

6. Hass AP, Rodgers PL, Herman JL. *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*. Los Angeles, CA: American Foundation for Suicide Prevention, The Williams Institute; 2014:1-18. Accessed July 1, 2018. https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf

7. Downing JM, Przedworski JM. Health of transgender adults in the U.S., 2014–2016. *Am J Prev Med*. 2018;55(3):336-344. doi:10.1016/j.amepre.2018.04.045

8. Becasen JS, Denard CL, Mullins MM, Higa DH, Sipe TA. Estimating the prevalence of HIV and sexual behaviors among the US transgender population: a systematic review and meta-analysis, 2006-2017. *Am J Public Health*. 2019;109(1):e1-e8. doi:10.2105/AJPH.2018.304727

9. Mereish EH, Poteat VP. A relational model of sexual minority mental and physical health: the negative effects of shame on relationships, loneliness, and health. *J Couns Psychol*. 2015;62(3):425-437. doi:10.1037/cou0000088

10. Testa RJ, Michaels MS, Bliss W, Rogers ML, Balsam KF, Joiner T. Suicidal ideation in transgender people: gender minority stress and interpersonal theory factors. *J Abnorm Psychol*. 2017;126(1):125-136. doi:10.1037/abn0000234

11. James SE, Herman JL, Rankin S, Keisling M, Mottet LA, Anafi M. *The Report of the 2015 U.S. Transgender Surve*y. Washington, DC: National Center for Transgender Equality. Published December 2016. Accessed 7, 2019. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

12. *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*. New York, NY: Lambda Legal. Published 2010. Accessed July 1, 2018. https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf

13. Clark BA, Veale JF, Greyson D, Saewyc E. Primary care access and foregone care: a survey of transgender adolescents and young adults. *Fam Pract.* 2018;35(3):302-306. doi:10.1093/fampra/cmx112

14. Roberts, T.K., Fantz, C.R. Barriers to quality health care for the transgender population. *Clin Biochem*. 2014;47(10-11):983-987. doi:10.1016/j.clinbiochem.2014.02.009

15. Deutsch MB, ed. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. 2nd ed. San Francisco, CA: Center of Excellence for Transgender Health, Department of Family & Community Medicine, University of California. Published June 17, 2016. Accessed July 1, 2018. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf

16. The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*. Oak Brook, IL: The Joint Commission. Published 2011. Accessed March 15, 2018. https://www.jointcommission.org/-/media/enterprise/tjc/imported-resource-assets/documents/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=1EC363A65C710BCD1D4E14ED120CB237.

17. Wilkerson JM, Rybicki S, Barber CA, Smolenski DJ. Creating a culturally competent clinical environment for LGBT patients. *J Gay Lesbian Soc Serv*. 2011;23(3):376-394. doi:10.1080/10538720.2011.589254

18. *Recommended Curriculum Guidelines for Family Medicine Residents: Lesbian, Gay, Bisexual, Transgender Health.* Leawood, KS: American Academy of Family Physicians. Updated August 2016. Accessed July 1, 2018. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint289D_LGBT.pdf

19. Hadland SE, Yehia BR, Makadon HJ. Caring for lesbian, gay, bisexual, transgender, and questioning youth in inclusive and affirmative environments. *Pediatr Clin North Am*. 2016;63(6):955-969. doi:10.1016/j.pcl.2016.07.001

20. *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*. San Francisco, CA: Gay and Lesbian Medical Association. Published 2006. Accessed July 1, 2018. http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf

21. *LGBTQ Health Care Report and Recommendations.* Seattle, WA: Dr. Robert Bree Collaborative. Published September 2018. Accessed July 1, 2018. http://www.breecollaborative.org/wp-content/uploads/LGBTQ-health-care-recommendations-Final-20-02.pdf

22. *Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients.* Boston, MA: National LGBT Health Education Center. Published 2018. Accessed July 1, 2018. https://www.lgbthealtheducation.org/wp-content/uploads/2017/08/Forms-and-Policy-Brief.pdf.

23. *SPARK Script: Confidentiality Best Practices.* Ann Arbor, MI: Adolescent Health Initiative, University of Michigan. Published 2017. Accessed July 1, 2018. http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/12/confidentiality-best-practice-spark-script-1.pdf

24. Kano M, Silva-Bañuelos AR, Sturm R, Willging CE. Stakeholders' recommendations to improve patient-centered "LGBTQ" primary care in rural and multicultural practices. *J Am Board Fam Med*. 2016;29(1):156-160. doi:10.3122/jabfm.2016.01.150205

25. *Creating Equal Access to Quality Health Care for Transgender Patients: Transgender-Affirming Hospital Policies*. New York, NY: Lambda Legal, Human Rights Campaign, Hogan Lovells, New York City Bar. Accessed July 1, 2018. https://www.lgbtagingcenter.org/resources/pdfs/fs_transgender-affirming-hospital-policies.pdf.

26. 10 tips for working with transgender patients. Transgender Law Center. Published 2016. Accessed June 14, 2018. http://transgenderlawcenter.org/wp-content/uploads/2011/12/01.06.2016-tips-healthcare.pdf

27. Do ask, do tell: talking to your health care provider about being LGBT [patient brochure]. Boston, MA: National LGBT Health Education Center. Accessed July 9, 2018. https://www.lgbthealtheducation.org/wp-content/uploads/COM13-067_LGBTHAWbrochure_v4.pdf

28. Grasso C, McDowell MJ, Goldhammer H, Keuroghlian AS. Planning and implementing sexual orientation and gender identity data collection in electronic health records. *J Am Med Inform Assoc*. 2019;26(1):66-70. doi:10.1093/jamia/ocy137

29. Deutsch MB, Buchholz D. Electronic health records and transgender patients--practical recommendations for the collection of gender identity data. *J Gen Intern Med*. 2015;30(6):843-847. doi:10.1007/s11606-014-3148-7

30. Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Trangender Health and Wellness. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4): e20182162. doi:10.1542/peds.2018-2162

31. *Creating a Transgender Health Program at Your Health Center: From Planning to Implementation.* Boston, MA: National LGBT Health Education Center. Published September 2018. Accessed July 1, 2018. https://www.lgbthealtheducation.org/wp-content/uploads/2018/10/Creating-a-Transgender-Health-Program.pdf

32. Whitlock BL, Duda ES, Elson MJ, Schwab PP, Uner OE, Wen S, Schneider JS. Primary care in transgender persons. *Endocrinol Metab Clin North Am.* 2019;48(2):377-390. doi:10.1016/j.ecl.2019.02.004

33. Committee on Health Care for Underserved Women. Committee Opinion no. 512: health care for transgender individuals. *Obstet Gynecol.* 2011;118(6):1454-1458. doi:10.1097/AOG.0b013e31823ed1c1

34. Committee on Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 2013;132(1):198-203. doi:10.1542/peds.2013-1282

35. Society for Adolescent Health and Medicine. Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: a position paper of the Society for Adolescent Health and Medicine. *J Adolesc Health.* 2013;52(4):506-510. doi:10.1016/j.jadohealth.2013.01.015

36. To enact sections 2131.14, 2131.141, 2131.142, 2131.143, 2131.144, 2131.145, 2131.146, 2131.147, 2131.148, 2131.149, and 2919.30 of the Revised Code to prohibit a court from using a parent, guardian, or custodian's refusal to allow a child to undergo gender-based treatment as a basis for determining custody of the child, HB 658, 132nd General Assembly (OH 2017-2018).

37. *Medicare and Transgender People*. Washington, DC: National Center for Transgender Equality; 2014.

38. Baker KE. The future of transgender coverage. *N Engl J Med*. 2017;376(19):1801-1804. doi:10.1056/NEJMp1702427

39. Stroumsa D, Shires DA, Richardson CR, Jaffee KD, Woodford MR. Transphobia rather than education predicts provider knowledge of transgender health care. *Med Educ*. 2019;53(4):398-407. doi:10.1111/medu.13796

40. Hinrichs, A., Link, C., Seaquist, L., Ehlinger, P., Aldrin, S., Pratt, R. Transgender and gender nonconforming patient experiences at a family medicine clinic. *Acad Med*. 2018;93(1):76-81. doi:10.1097/ACM.0000000000001837

41. Feldman JL, Goldberg J. T*ransgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*. Vancouver, BC: Transcend Transgender Support and Education Society, Vancouver Coastal Health's Transgender Health Program. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.212.5537&rep=rep1&type=pdf. Published January 2006. Accessed July 1, 2018.

42. Dunne MJ, Raynor LA, Cottrell EK, Pinnock WJA. Interviews with patients and providers on transgender and gender nonconforming health data collection in the electronic health record. *Transgend Health*. 2017;2(1):1-7. doi:10.1089/trgh.2016.0041

43. Altarum Institute. *Sexual Health and Your Patients: A Provider's Guide.* Washington, DC, 2016. Accessed January 21, 2020. https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/document/ProviderGuide.pdf

44. Beemyn G. Transgender terminology. Accessed August 1, 2018. https://hr.cornell.edu/sites/default/files/trans%20terms.pdf

45. Williamson C. Providing care to transgender persons: a clinical approach to primary care, hormones, and HIV management. *J Assoc Nurses AIDS Care*. 2010;21(3):221-229. doi:10.1016/j.jana.2010.02.004

46. Jessica MP, Honnold JA, Bradford J, Bradford J. *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians.* Richmond, VA: Virginia Department of Public Health. Published January 2007. Accessed July 1, 2018. http://www.vdh.virginia.gov/content/uploads/sites/10/2016/01/THISFINALREPORTVol1.pdf

47. Bell J, Purkey E. Trans individuals' experiences in primary care. *Can Fam Physician.* 2019;65(4):e147-e154.

48. Healthcare equality index. Human Rights Campaign website. Published 2018. Accessed August 1, 2018. https://www.hrc.org/hei/

49. Gridley SJ, Crouch JM, Evans Y, et al. Youth and caregiver perspectives on barriers to gender-affirming health care for transgender youth. *J Adolesc Health.* 2016;59(3):254-261. doi:10.1016/j.jadohealth.2016.03.017

advancing the art & science of medicine in the midwest

WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

© 2020 Board of Regents of the University of Wisconsin System and The Medical College of Wisconsin, Inc.

Visit www.wmjonline.org to learn more.