Assessing the Health Needs of Northcentral Wisconsin's Transgender Population

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ABSTRACT

Introduction: The body of literature surrounding transgender health care primarily focuses on metropolitan populations and resource-rich areas. This qualitative study examines the perspectives of transgender patients in northcentral Wisconsin to identify recommendations for more comprehensive, inclusive health care practices.

Methods: A series of semistructured interviews was conducted with recipients of gender-affirming care residing in northcentral Wisconsin. A mixed deductive-inductive approach was used for qualitative thematic analysis.

Results: A total of 10 interviews were completed. Qualitative analysis revealed 3 key themes contributing to positive and negative experiences with health care providers: education, cultural competency, and access.

Discussion: Patients reported feeling supported by health care providers but not always that providers were well equipped to address their specific health needs. The attitudes of all members of the health care team contributed to participants' feelings of acceptance and comfort in the health care environment. Participants living in rural areas cited transportation challenges and provider scarcity as barriers to gender-affirming care.

Conclusions: Health care providers play an important role in mitigating health disparities among transgender patients. Experience providing gender-affirming care, nonjudgmental attitudes, and visible displays of allyship are associated with positive clinician-patient relationships.

INTRODUCTION

Despite increasing representation and acceptance of transgender people, defined by the World Professional Association for Transgender Health as those whose gender identities or expressions differ from those attributed to their sex assigned at birth,[1,2] transgender individuals in the United States continue to report unequal treatment or harassment in health care settings.[3] With increasing politicization of transgender identities and efforts to curtail or restrict access to gender-affirming care (GAC),[4] transgender patients experience social, institutional, and financial obstacles to obtaining necessary health care—particularly in rural settings. In Wisconsin, a 2019 study found that transgender patients were 2.76 times more likely to receive poor-quality health care compared with their heterosexual cisgender counterparts and 2.78 times more likely to report lifetime experiences of unfair treatment in health care.[5] Nationally, transgender individuals are more than twice as likely as cisgender individuals to delay health care due to cost, particularly in rural areas.[6] For some transgender patients, health care may be associated with negative emotions such as anxiety and depression.[7] Mental illness, illicit substance use, and risky sexual behaviors—which are more prevalent among transgender than cisgender persons, even in rural areas—pose additional burdens to patients seeking care.[8]

Recent advancements, including the establishment of GAC in areas such as northcentral Wisconsin—loosely defined as the region north of Adams and Marquette counties and extending from Iron to Florence counties—have made health care more accessible for transgender patients. However, whether these changes have led to measurable improvements in perceived health outcomes and experiences remains unclear. This study sought to assess current health needs among transgender individuals in northcentral Wisconsin, including needs for GAC and attitudes toward GAC providers.

While numerous health care facilities serve northcentral Wisconsin, there are few clinicians trained specifically to meet the

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needs of transgender patients. The Aspirus Wausau Family Medicine Residency program in Wausau, Wisconsin, founded in 2019, includes GAC in its curriculum, including management of hormone therapy (HT) based on an informed consent model. This makes it one of the few institutions in northcentral Wisconsin that does not require referral from a mental health professional attesting to gender identity/dysphoria.[9] As with most rural programs, the residency program's reach extends beyond Wausau, and it relies heavily on larger health systems for specialized services such as gender-affirming surgery (GAS). However, its patient population—which includes residents of both urban and rural areas—provides an opportunity to examine the intersection of rurality and transgender identity. Previous qualitative studies have explored rural-urban differences in transgender health care,[6,7,10] but northcentral Wisconsin is unique because of its connection to sparsely populated northern counties and reliance on large academic health care institutions in the southern half of the state. This study offers an opportunity to evaluate the health needs of transgender patients who are within reach of rural outreach efforts but are overlooked in favor of urban populations.

Box. Semistructured Interview Script

1. How would you describe your gender identity? Sexual orientation?
2. How would you describe your educational background?
3. How would you describe your current socioeconomic status?
   a. How does this affect your health care decisions?
4. What are the most important parts of your identity (race, gender, sexuality, etc.)?
5. What is your gender transition timeline? How would you describe your story/process of transition?
6. Who/what is your primary resource for health concerns (PCP, Internet, friends)?
7. Have you previously disclosed your gender/sexual identity to your health care provider(s)?
   a. If so, what prompted it?
   b. If not, why?
8. Have you ever felt uncomfortable disclosing your gender/sexual identity to a health care provider?
9. Have you ever felt disrespected in a health care setting because of your gender/sexual identity?
10. Have you ever felt supported/respected in a health care setting after disclosing your gender/sexual identity?
11. What made you feel comfortable or uncomfortable about the setting?
12. Do you receive gender-affirming care through your PCP?
    a. If not, from whom do you currently or plan to receive gender-affirming care?
13. Do you receive sexual/reproductive health information or care from your PCP?
14. Do you feel that your PCP is adequately equipped to answer questions about your specific health needs?
15. Do you receive mental health care? If so, from whom? Does your relationship with this provider differ from that with your PCP?
    a. Do you disclose your sexuality to your mental health provider?
16. What are the qualities you most value in a health care provider?
17. Do you think that your gender transition process was supported by your health care provider?
18. Have you ever felt included or excluded by the physical health care environment? What does a "welcoming" space look like?
19. What are some gaps in health care or education in the community that you have personally identified? What could be improved?
20. Is there anything else you'd like to mention?

Abbreviation: PCP, primary care provider.

METHODS

A series of semistructured interviews was conducted among transgender patients at the Aspirus Wausau Family Medicine Residency Clinic to (1) identify recommendations for more inclusive transgender health care in northcentral Wisconsin, (2) identify shared characteristics contributing to positive and negative health care experiences, and (3) identify gaps in health care provision for this community. This project was reviewed and approved by the Aspirus Institutional Review Board (IRB # 23-02-649).

Participant Recruitment

Participants were recruited from a convenience sample of clinic patients who were (1) aged 18 years and older, (2) identified as transgender (eg, diagnosis of gender dysphoria or similar), (3) had an established primary care provider (PCP), and (4) had seen their PCP between January 2022 and December 2024 (N = 115). Snowball sampling was also used. Participants were contacted via documented phone numbers and email addresses (N = 16, response rate = 13.9%) to voluntarily opt-in. No incentives were provided.

Data Collection

A 20-question interview guide (Box) was developed based on a preliminary review of literature on transgender health disparities[10,11] identifying gaps such as sexual and reproductive health, mental health care, and clinician knowledge of transgender health care.[11] The investigators drew on Fredriksen-Goldsen et al's Health Equity Promotion Model—which examined the intersectionality of transgender identity with education, socioeconomic status, and race—and Meyer's Minority Stress Model—which proposed that negative mental health outcomes in minorities are prompted by internal and external stressors.[12,13] Questions addressing these factors were included to contextualize participants' lived experiences and investigate their effect on health care encounters. Most questions were open-ended, per Consensual Qualitative Research recommendations,[14] to allow follow-up probes and elicit personal experiences.

Interviews ranged from 15 to 60 minutes and were conducted by study team member LK between October 2023 and March 2025 via telephone, video conference, and in person. Participants consented to audio recording for transcription. All identifiers were removed from the transcripts before analysis; only gender and age were available to coders.

Table. Qualitative Themes on Transgender Health Care Experiences

Key Theme/Subtheme	Mentions n (%)	No. of Mentions	Representative Quote
Education			
Provider expertise	10 (100)	41	"[My doctor] has even asked me things that I didn't even think about; for example, if I wanted to freeze my sperm and if I had any plans for kids in the future."
Rural representation	9 (90)	28	"I just feel like right now gender-affirming care, even these days, is severely lacking in rural communities and that's where most care needs to be focused and updated."
Continuing medical education	5 (50)	12	"She was supportive, but she didn't feel comfortable with the actual medicine side of it. She acknowledged a gap in knowledge on her part, and she just felt really intimidated by that."
Cultural Competence			
Community stigma	9 (90)	51	"I often feel pretty uncomfortable just living in Wausau and in Wisconsin. It's not like some places I've been, for sure, but I've been harassed. I've had people threaten me. I definitely think twice about a lot of stuff."
Provider stigma	8 (80)	23	"I was asked the question 'Are you sexually active…What was your partner's gender?' I said, 'I'm a lesbian.' And she said, 'Well when's the last time you had straight sex?'"
Symbols of allyship	8 (80)	14	"As far as what stuff that I might look for [in the physical health care environment]…even those little pride stickers that say, 'this is a safe space'…goes a long way."
Use of correct pronouns	6 (60)	8	"You can tell when people are having trouble doing it. You can tell when people are comfortable with it, and they use my name and pronouns without hesitation."
Documentation of name	5 (50)	13	"I had a psych admission due to a suicide attempt…They took me into the hospital, and they put a band on my wrist that said my deadname – or my birth name – and that just made me feel worse."
Misgendering	4 (40)	5	"I am aware that to most people I look 'trans'…because people who are trying to be supportive still misgender you. It's not like they're trying to hurt me; it's just somewhere in the back of their head they think 'boy.."
Access			
Cost	9 (90)	27	"I had all this hope that I was going to get top surgery relatively soon, but now I learned I can't, and I have to pay out of pocket for it."
Autonomy	9 (90)	41	"I don't think anybody wants to be told 'I'm the doctor, I know everything, you can't have an opinion.' That doesn't feel great."
Informed consent model	4 (40)	5	"I know some people have had to see somebody for mental health first before being given a diagnosis of gender dysphoria so they could get treatment."
Transportation	3 (30)	11	"I notice that there's still a lack of HRT [hormone replacement therapy] doctors, because I still have to go to Wausau to see one, and that's 45 minutes away from me."

Data Analysis

Transcripts were analyzed by 4 independent coders and 1 auditor (undergraduate and medical students). Coders met prior to analysis to discuss potential biases. Preliminary themes were identified inductively and iteratively refined through reduction and merging until consensus was reached. This process generated a pooled preliminary codebook (domains), which was further refined to create a revised version containing themes (core ideas) and subthemes. An independent auditor reviewed the codebook and discussed reconciliation and refinement of themes with coders. Themes were then applied across all interviews for cross-analysis.[14] A mixed deductive-inductive approach was used to categorize core ideas: inductive identification of themes followed by categorization within the study framework.

RESULTS

Of 16 interested participants, 11 interviews were scheduled, and 10 were completed. Participants were aged 19 to 75 years. Five identified as transgender women, 3 as transgender men, 1 as transmasculine nonbinary, and 1 as transfeminine nonbinary. Eight participants were current residents of northcentral Wisconsin and 2 were former residents. Nine identified as lesbian, gay, bisexual, or queer in addition to transgender. No participants identified race as central to their identity. Education ranged from high school diploma to some undergraduate education, and 8 described their socioeconomic status as "low."

Qualitative analysis identified 3 major themes: education, cultural competence, and access (Table).

Education

Most participants cited gaps in provider and community education as barriers to GAC, particularly in rural areas. One participant, a 75-year-old transgender woman, stated that her transition was suppressed for most of her life due to a lack of transgender visibility in her community.

> *"I didn't plan on coming out. I really didn't understand what transitioning was. I didn't even know the word. I hadn't even met a trans person until I was 72 years old. I didn't know anybody. I didn't read anything about it. All I knew is that I wanted to be a girl and it just wouldn't go away."*

Participants who received GAC at the clinic endorsed satisfaction with provider knowledge of hormone therapy and other GAC procedures and specifically sought clinicians advertising themselves as LGBTQ+ friendly. However, several noted generational differences in training:

> *"When there are providers that see fewer trans people…they don't*

really encounter them that often, so they have a lot of misconceptions and they don't keep themselves updated, things like that."

Due to this knowledge gap, participants often felt compelled to research their own health conditions and educate their clinicians about their health needs.

Cultural Competence

Nearly all participants reported antitrans stigma from community members or health care providers. Community stigma often involved overt harassment, according to a transgender woman:

"Twice, people have yelled things at me. One person shouted at me across a whole restaurant and [my dad] chased him out to the parking lot. And someone else mumbled something under their breath and ran out [right after]...people occasionally shout something out of their car."

Meanwhile, provider-related stigma was often subtle and nonverbal.

"As a trans person, you learn how to read people's body language; because it's a professional setting, they're not going to say anything. But to know how they really feel, you just read their body language. Whether they wince away from you or seem kind of grossed out by you, not wanting to look at you, or on the flipside staring at you, acting strange."

Supportive behaviors included correct use of names and pronouns and visible signs of allyship, such as pride flags and badges. Clinicians perceived as "supportive" also demonstrated open, nonjudgmental body language.

Access

Patients faced multiple barriers to GAC, including financial difficulties and/or insurance coverage, particularly for GAS and sterilization procedures.

"My health insurance has something specifically written in their policy about how they won't cover anything gender-affirming. I was looking at getting top surgery...I found out my insurance covers the surgery, but with the diagnosis code of gender dysphoria, they won't cover it."

However, the most frequent complaint was limited patient autonomy, with clinicians perceived as exerting a disproportionate amount of power, gatekeeping care that participants felt was necessary to their health and well-being.

"You're all alone in this sterile little room with this person that—based on what kind of impression you, this vulnerable patient, [make] on them—can decide whether or not to treat you...You're at the whim of this one person who has a lot of power over you."

Conversely, patients praised the informed consent model, which improved access to medically assisted transition by removing requirements for a gender dysphoria diagnosis from a mental health care provider.

DISCUSSION

Although participants praised GAC providers' efforts at the Aspirus Wausau Family Medicine Residency, limited clinician knowledge remains a barrier to accessing local care. Because GAC is not universal in residency or continuing medical education, these knowledge gaps are likely to persist without intervention or curricula revision. However, pilot programs have demonstrated improvements in clinician empathy and awareness toward transgender patients.[15]

GAC management is an emerging skillset, and health care for LGBTQ+ patients extends well beyond the physical. Cultural competency is essential as clinician attitudes towards gender identity significantly influence the patient-provider relationship. Documentation of gender, sex assigned at birth, and sexuality in electronic medical records may provide quantitative insight into health disparities within this population,[16] while displays of allyship—such as using a patient's correct name and pronouns and minimizing gendered language—can foster an atmosphere of acceptance and support, as can recognition of microaggressions (ie, acts of unconscious discrimination that may convey hostile or derogatory attitudes).[17] Importantly, this commitment must be upheld by all members of the care team, as interactions across the care team shape the overall experience.[18] While this study focused primarily on the attitudes of health care providers, valuable insight can be gained by examining the behaviors of nurses, medical assistants, social workers, and other professions involved in patient care.

Access to care for transgender patients in rural areas is particularly challenging due to financial strain and provider scarcity. GAC is more accessible to patients with high health literacy who understand the informed consent model and can independently identify GAC providers, underscoring the need for proactive communication by clinicians with GAC experience.[19] However, as transgender identity becomes increasingly politicized, there are potential social and financial costs of openly advertising such information, highlighting the importance of system-level support. Although Wisconsin has relatively supportive policies,[4] challenges with insurers and clinician availability often prevent patients from obtaining care in a timely manner.

Our findings with prior research showed that systemic factors—such as insurance exclusions and rural health care access—shaped transgender patients' health care experiences just as much as patient-provider interactions.[18,20] While many of these factors are beyond individual control, clinicians play a key role in facilitating access and affirming patients' identities.

Limitations

This study was limited by a small sample size (N = 10), representing a fraction of patients who receive GAC from Aspirus Health. While this study captured perspectives of transgender patients of lower socioeconomic status, it did not explore the impact of other

marginalized identities such as race. Self-selection bias may have influenced participation due to concerns of prejudice or confidentiality and may reflect more polarized attitudes toward health care systems. Participants varied in transition stage and experience with GAC, potentially affecting their perspectives. Further research is needed to assess the degree of comfort with individual members of the health care team and which professions within the clinic are most or least likely to provide support.

CONCLUSIONS

Semistructured interviews (N = 10) conducted with transgender patients in northcentral Wisconsin identified 3 primary themes: education, cultural competence, and access. Provider knowledge gaps remain a major barrier to obtaining local care. Positive experiences were associated with culturally competent practices, including correct use of names and pronouns and displaying symbols of allyship in the clinic. External factors – including transportation, financial burden, and insurance coverage – limit GAC access despite informed consent models removing the need for mental health referral.

Expansion of GAC services in rural settings is encouraging but remains limited. Improving health outcomes for transgender patients will require enhanced provider education and integration of transgender health into broader health care systems. Clinicians can support transgender patients by incorporating continuing medical education into their practice and upholding cultural competence across all members of the care team.

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