LGBTQ+ Healthcare Needs

Diana Currie MD she/her
Chelsea Unruh MD they/them

October 21, 2020
Olympia, WA

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- Please ask your questions in the chat box throughout the presentation.
  - We will answer questions at the end of the presentation.
  - If clarification is needed for your question, I will unmute you so that you can provide additional details.
- The webinar slides and a recording will be available shortly after its conclusion.
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- The following indicates the declaration of intent to reference unlabeled/unapproved uses of drugs or products and the drugs or products to be referenced:
  - Name of Speaker: Diana Currie, MD
    Drugs/Products to be Referenced: Hormones and other medications used for transition. Use based on nationally accepted evidence-based guidelines. Non FDA approved.
  - Name of Speaker: Chelsea D. Unruh, MD
    Drugs/Products to be Referenced: Estradiol, testosterone (non FDA approved uses)
- No other speakers or persons in control of content reported intent to reference unlabeled/unapproved uses of drugs or products.

Objectives

- Assess the unique needs of LGBTQ+ patients.
- Address primary care needs for transgender patients.
- Lessen gender and sexual minority patient fear due to stigma, discrimination, and institutional bias in the health care system.

UCLA School of Law Williams Institute

LGBT Data & Demographics
Switch Topic

WASHINGTON ×
Select a State

ALL
Select a Characteristic

Washington
AREA SELECTION

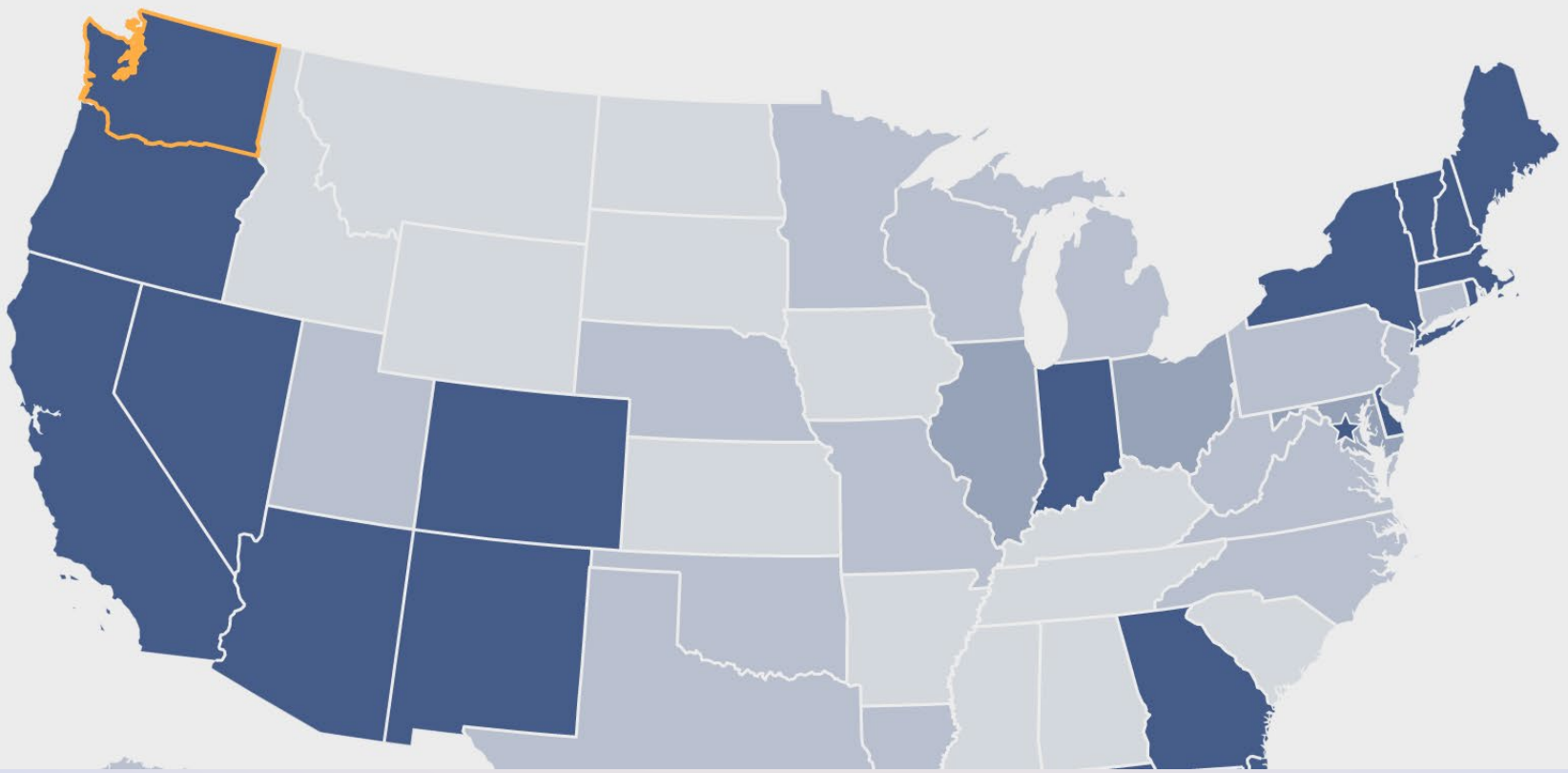
Male 37% Female 63%
LGBT Gender Ratio

22%
Percentage with Income <$24K

5.2%
LGBT percentage of population

28%
Percentage with Children

LGBT Proportion of Population: Washington ×



LGBTQ+ Health Disparities

- LGB people have a 3-6 fold increase in suicide attempts
- Transgender people have a 11 fold increase rate of suicide attempts
- LGB people have increased rates of depression, anxiety, substance use disorder
- LGBT youth have even higher rates
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average

- Discrimination by healthcare providers is strongly correlated with increased rates of suicide thoughts and attempts

- **Access to gender-affirming medical care is associated with a lower prevalence of suicide thoughts and attempts**

https://williamsinstitute.law.ucla.edu/publications/
https://www.transequality.org/sites/default/files/docs/USTS-Executive-Summary-FINAL.PDF

[redacted]

13yr old

[redacted]

4/5/17

Dear Patient,

[redacted] services to at least one

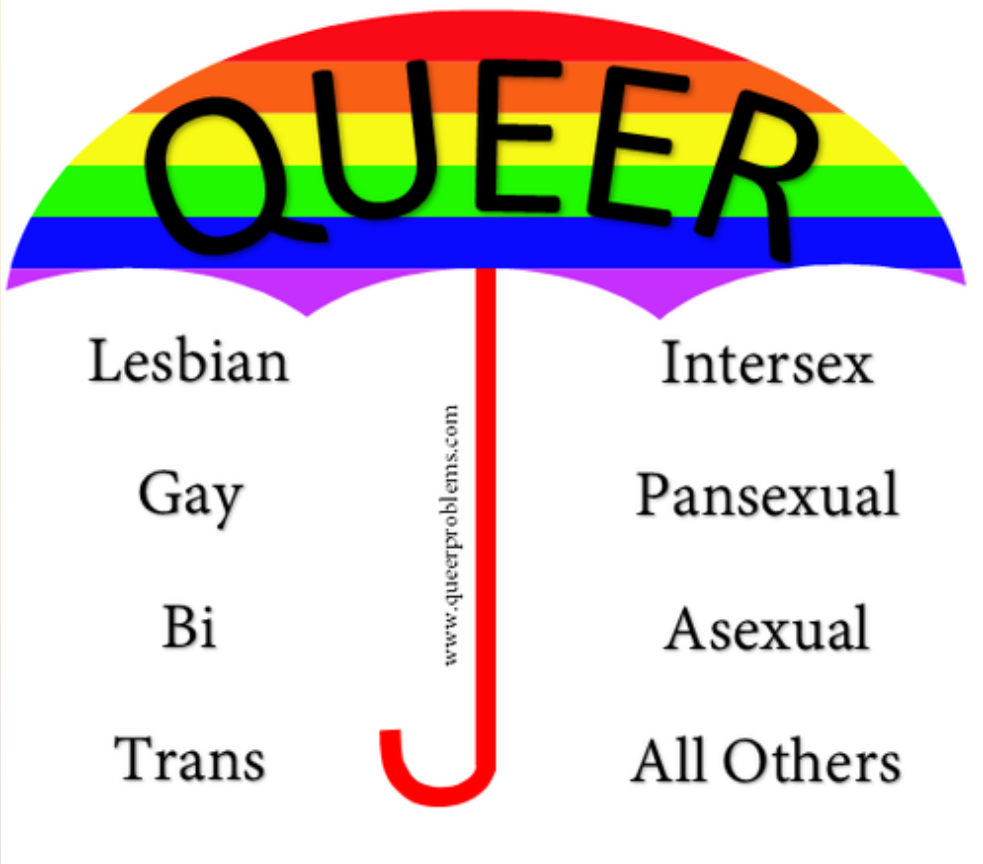
Please describe how our services have impacted you.

Well I don't wanna kill myself anymore.

LGBT as an umbrella term

Mixes populations whose self –identities are based on:

- sexual orientation (LGB) and
- individual gender histories (T)



Orientation ≠ Behavior

- **sexual orientation** and **sexual behavior** based on gender identity or expression is inaccurate.
  - This includes individuals who identify as straight
  - Non-gay identified men have sex with men and women (MSMW)
  - The overwhelming majority of self-described lesbians have had sex with men.
  - great diversity in orientation and behavior in trans*population
    - some identify as both transgender and gay, heterosexual, bisexual, or lesbian.

Who do we ask?

Everyone.

Case #1

- 68 year old female with h/o hypertension, depression, and pre-diabetes presenting to establish care with your primary care office. Currently on HCTZ, Metformin, and Wellbutrin. G3P1 s/p total hysterectomy for fibroids 30 years ago.

What would you like to ask?

(remember your questions and compare to later)

Interviewing Basics

- Patient Centered (Sex positive) Approach
  - It's generally not awkward unless you make it awkward
  - Ask the questions, patients want you to
  - Culturally sensitive
  - Practice your words
  - Know your "Yuck" face
- Practice interviewing skill of NORMALIZING
  - intended to communicate to clients that they are not alone in their experience.

Shindel, A. W., & Parish, S. J. (2013). CME Information:Sexuality Education in North American Medical Schools: Current Status and Future Directions (CME). *The Journal of Sexual Medicine, 10*(1), 3-18. doi:10.1111/j.1743-6109.2012.02987.x

Interviewing Basics

What we're taught:

- Are you sexually active?
- Do you have sex with men, women, or both?

Six P's

Assessing Sexual, Gender and Reproductive Health

- Patient Preferences
- Partners
- Practices
- Protection from STIs
- Past History of STI
- Prevention of Pregnancy

GLMA
Health Professionals Advancing LGBT Equality

Six P's

Assessing Sexual, Gender and Reproductive Health

Hidden P = Preface/Permission

– "Now I am going to ask you some questions about your sexual health. I ask these questions of all my patients, and they are just as important as other questions about your physical and mental health. Like the rest of this visit, this information is strictly confidential. Is that ok?"

Six P's

Assessing Sexual, Gender and Reproductive Health

- **P**atient Preferences -
  - What's your preferred name?
  - What do most people call you?
  - What's your preferred pronoun?
  - Do you have a preferred pronoun?
  - How do you identify? (Straight, gay, lesbian, bisexual, other)

Six P's

Assessing Sexual, Gender and Reproductive Health

- Partners –
  - One partner or multiple partners in the last year?
  - Are you and your partner monogamous?
  - What is / what are the gender(s) of your sexual partners?
    - Any vagina/sperm contact?

  - Have you ever had sex with someone you didn't know or had just met?
  - Have you ever traveled internationally, to places such as Thailand or Africa, to have casual sex?
  - Have you ever experienced physical, sexual, or emotional violence from someone you were involved with?

Six P's

Assessing Sexual, Gender and Reproductive Health

- Practices –
  - What kind of sex are you having? (Oral, Anal, Vaginal, toys)
  - What do you know about your partner(s) past or other sexual activities?
  - Do you have any concerns about your sex life?

    OR
  - In the past year have you had:
    - Anal sex? Condoms: always, sometimes, or never?
    - Vaginal sex? Condoms?
    - Oral sex? Condoms/dental dams?

Six P's

Assessing Sexual, Gender and Reproductive Health

- **P**rotection from STIs –

  What barrier method(s)* and other risk reduction** strategies does your patient use? Did you review correct use and efficacy rates of different methods?

  - Can you tell me when you use condoms? With which partners?
  - Have you or any of your partners ever injected drugs/shot drugs in their bodies?
  - Have you or any of your partners ever received or given money, shelter, or drugs for sex?
  - Have you or any of your partners ever been in jail?

* *Barrier methods* refers to male and female condoms, diaphragms, contraceptive caps, PrEP and PEP

** Risk reduction strategies include barrier methods, abstinence, monogamy, partner selection (i.e. serotyping) and STI testing

Six P's

Assessing Sexual, Gender and Reproductive Health

- Past History of STI –
  - Have you ever had a sexually transmitted infection?
    - i.e. gonorrhea, chlamydia, herpes, genital warts, and syphilis
  - Have you ever been tested for Hepatitis C
  - When were you last tested for HIV? Can you tell me the test result?
  - Consider if candidate for PrEP (Preexposure Prophylaxis)

Six P's

Assessing Sexual, Gender and Reproductive Health

- **P**regnancy Planning or Prevention –
  - Do you have any plans or desires to have (more) children?
  - Are you doing anything to prevent yourself or your partner from getting pregnant?
  - Do you want information on birth control?
  - THERE ARE MANY WAYS TO MAKE A FAMILY

The pregnancy question is important.

https://s-media-cache-ak0.pinimg.com/originals/75/62/e8/7562e86e87b4756e24e5f70d8ed1c972.jpg
https://s-media-cache-ak0.pinimg.com/236x/27/bc/c4/27bcc4b95fc9b3b67a9c167fece9da05.jpg

10 Tips for Doctors in Talking about Sex with Patients

1) Patients often want to talk about sexual issues but wait and watch for signs that their doctors are open to such a discussion.
   - It's your responsibility to take the lead.
2) Routinely include questions about sexuality in your patient encounters.
   - Consider amending your Review of Systems to include a section on sexuality.
3) Communicate in plain, everyday language.
   - Avoid the use of jargon.

Meyers, D. Albert Einstien College of Medicine. http://blogs.einstein.yu.edu/promoting-the-sex-talk-between-doctors-and-patients/

10 Tips for Doctors in Talking about Sex with Patients

4) Exhibit a nonjudgmental attitude through your responses and questions.

5) Try not to phrase a question so that a negative answer is the easiest response.

   – Example: “When was the last time . . .” or “How often . . . .”

6) Be prepared for some embarrassment or awkwardness, but don’t allow it to be a deterrent.

7) Be forthcoming about potential sexual side effects related to medications or treatments.

Meyers, D. Albert Einstien College of Medicine. http://blogs.einstein.yu.edu/promoting-the-sex-talk-between-doctors-and-patients/

Tips for Doctors in Talking about Sex with Patients

8) Reward and encourage patient initiative
   - "I'm glad you brought up this important issue."

9) Keep the door open for further discussion.
   - "Let's talk about this more next time," or "This is an essential topic to revisit in the future; let's agree to bring it up again."

10) Practice, practice, practice having these discussions with most of your patients until sexuality becomes a routine topic.

Meyers, D. Albert Einstien College of Medicine. http://blogs.einstein.yu.edu/promoting-the-sex-talk-between-doctors-and-patients/

Case #1 (continued)

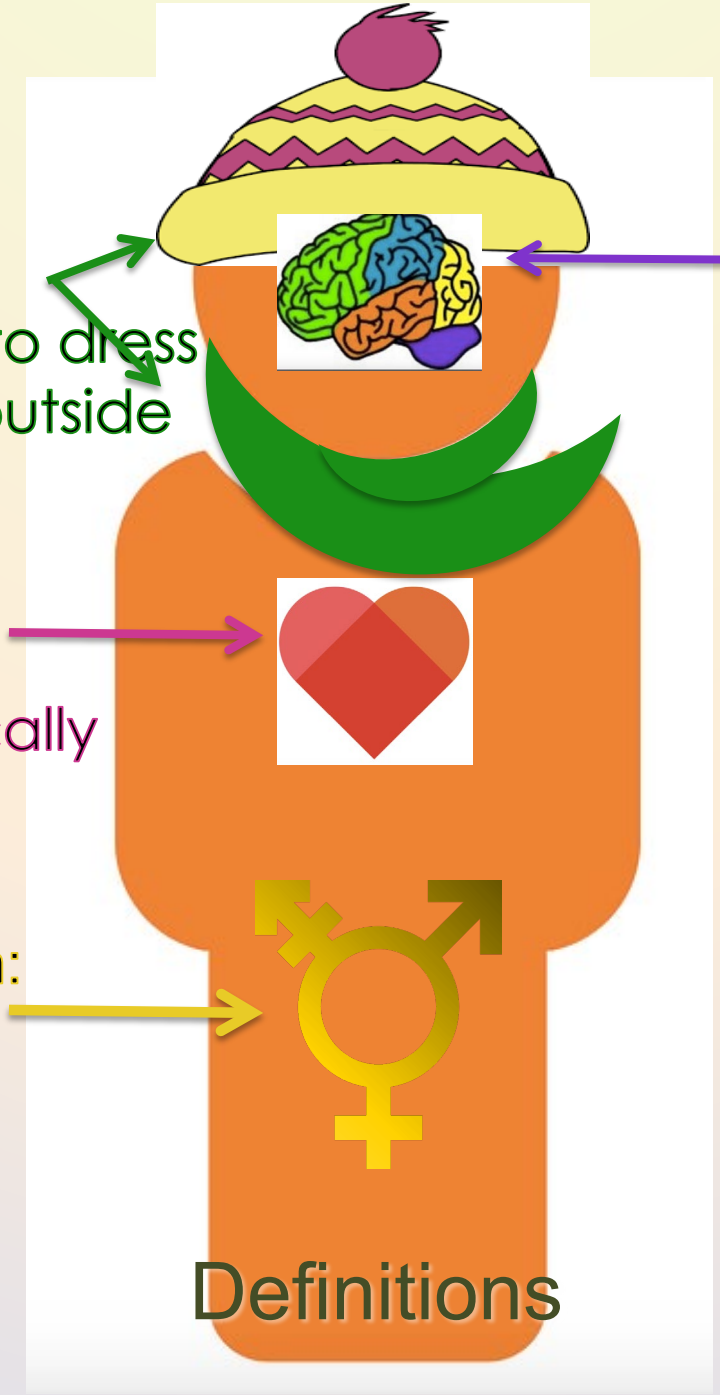
- 68 year old female with h/o hypertension, depression, and pre-diabetes presenting to establish care with your primary care office.
- Social history: married 50 years, retired, worked in tech industry
- Sexual History
  - Bisexual, she/her pronouns, goes by nickname
  - 12 partners in the past year, 10 men, 2 women, most met through friends/internet
  - Receptive vaginal intercourse, gives/receives oral sex
  - Not using condoms
  - No history of STI, never been tested

Transgender Health in Primary Care

Gender Expression:
How one chooses to dress or appear on the outside

Sexual orientation:
Who a person feels attracted to physically or romantically

Sex assigned at birth:
External genitalia



Gender Identity:
Internal sense of oneself as masculine or feminine, or somewhere in between

Not determined by external genitalia or by external appearance

Definitions

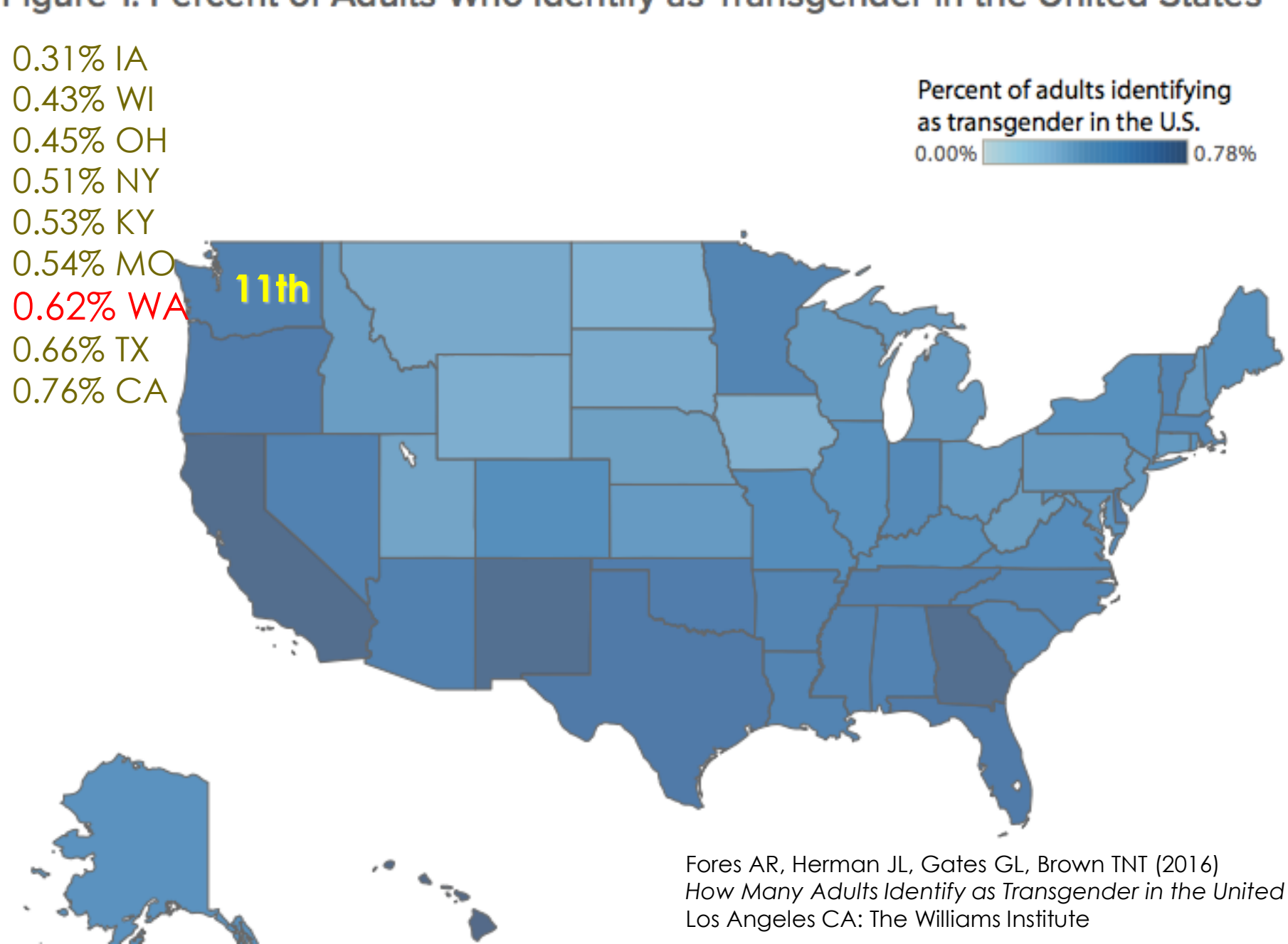
Prevalence

- 1.55 million people in the US are transgender *
  - By comparison:
  - Multiple sclerosis: 400,000
  - Parkinson's: 1 million
  - Alzheimer's: 5.4 million
- * Being transgender is not itself a disorder or medical condition that needs treatment. *Gender Dysphoria* is.

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

Figure 1. Percent of Adults Who Identify as Transgender in the United States

0.31% IA
0.43% WI
0.45% OH
0.51% NY
0.53% KY
0.54% MO
0.62% WA
0.66% TX
0.76% CA



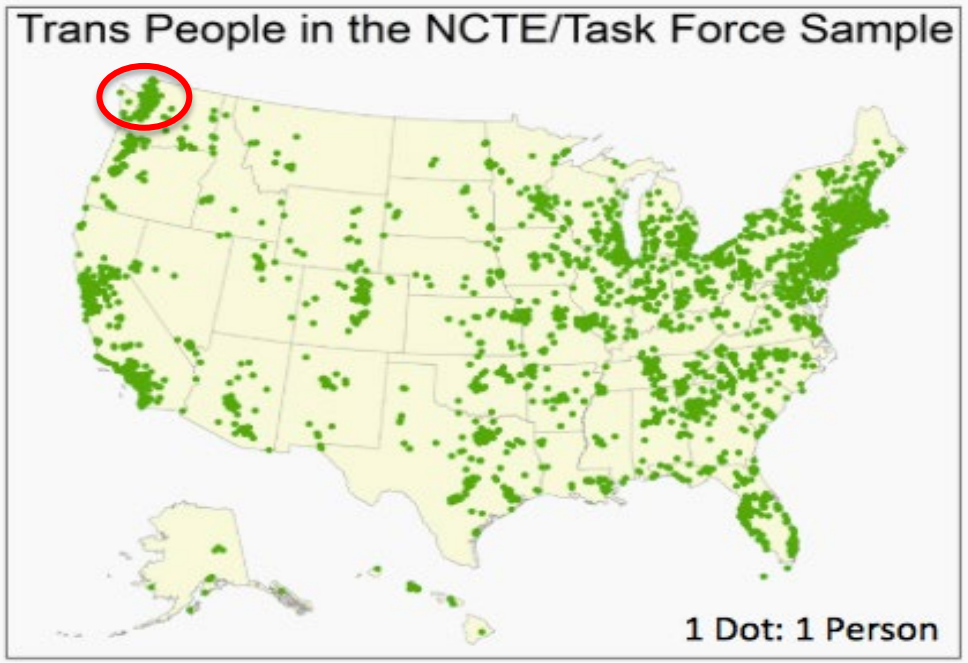
Fores AR, Herman JL, Gates GL, Brown TNT (2016)
How Many Adults Identify as Transgender in the United States?
Los Angeles CA: The Williams Institute

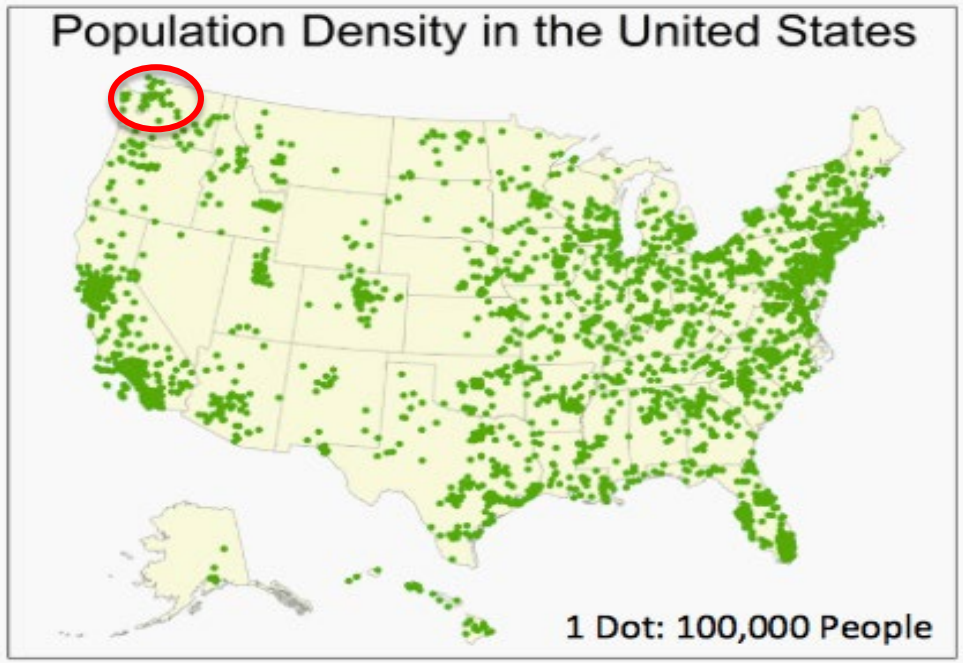
National Transgender Discrimination Survey Report on health and health care

Findings of a Study by the National Center for Transgender Equality and the National Gay and Lesbian Task Force

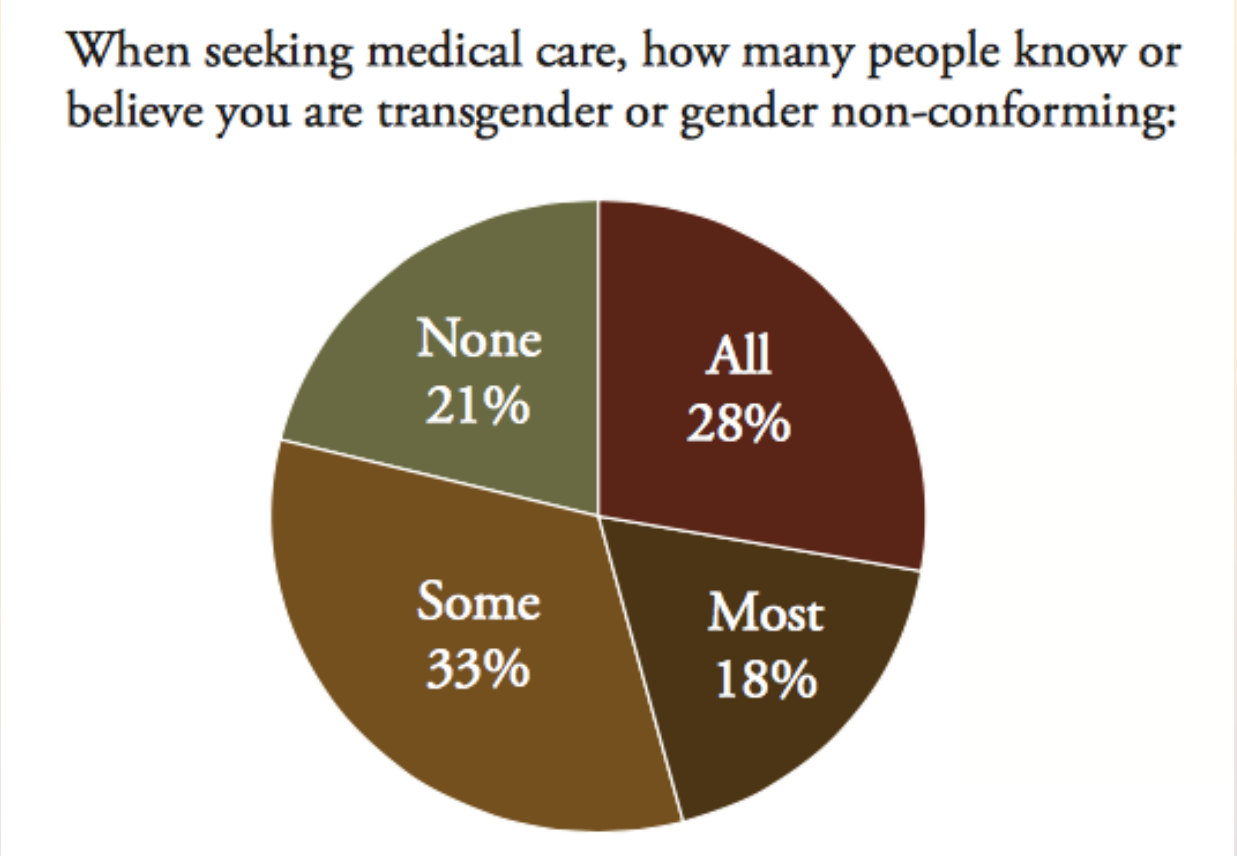
By Jaime M. Grant, Ph.D., Lisa A. Mottet, J.D., and Justin Tanis, D.Min.
With Jody L. Herman, Ph.D., Jack Harrison, and Mara Keisling

October 2010





Do we always know who our patients are?



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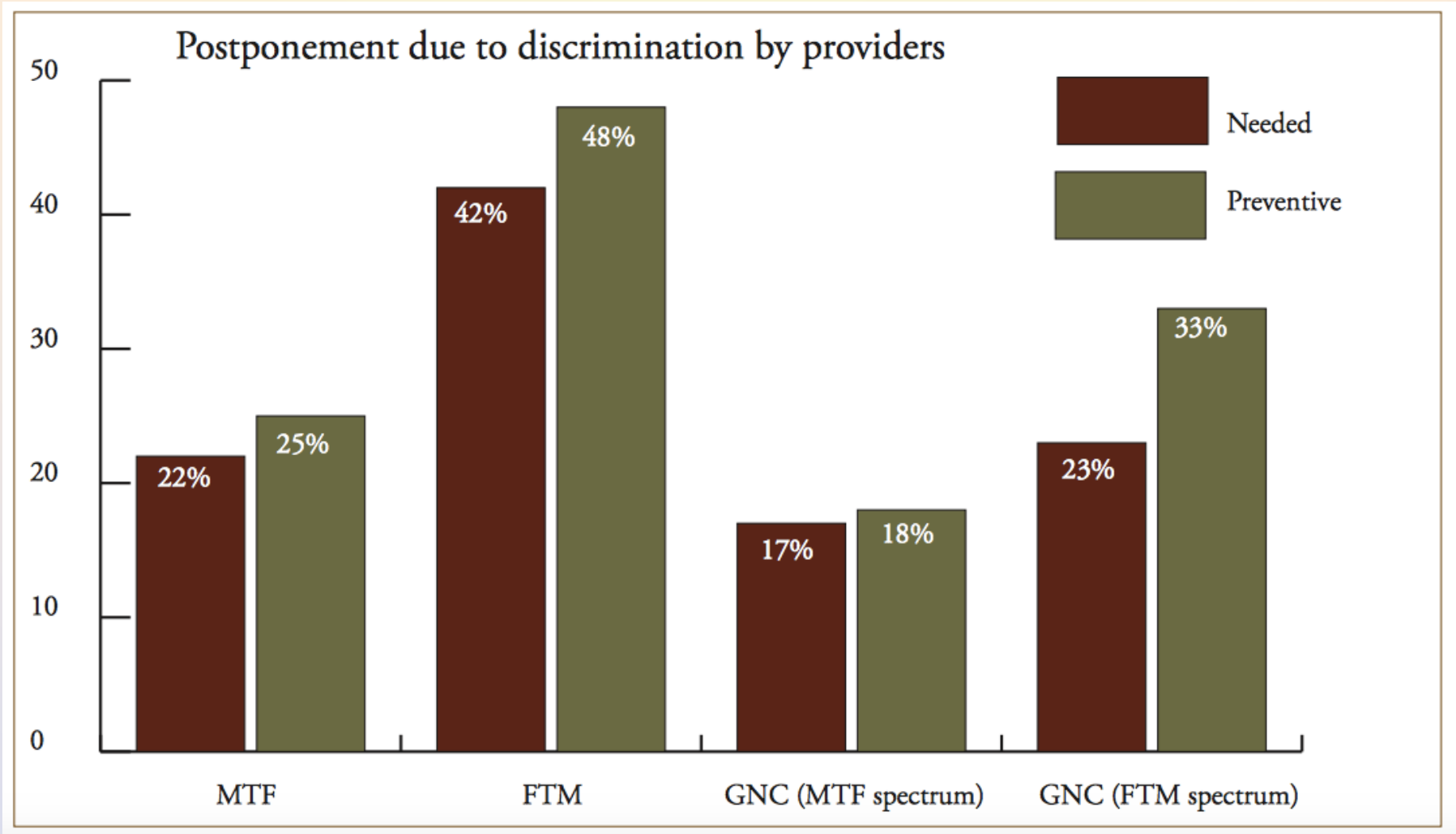
% of respondents who reported not getting timely care due to *Provider* discrimination



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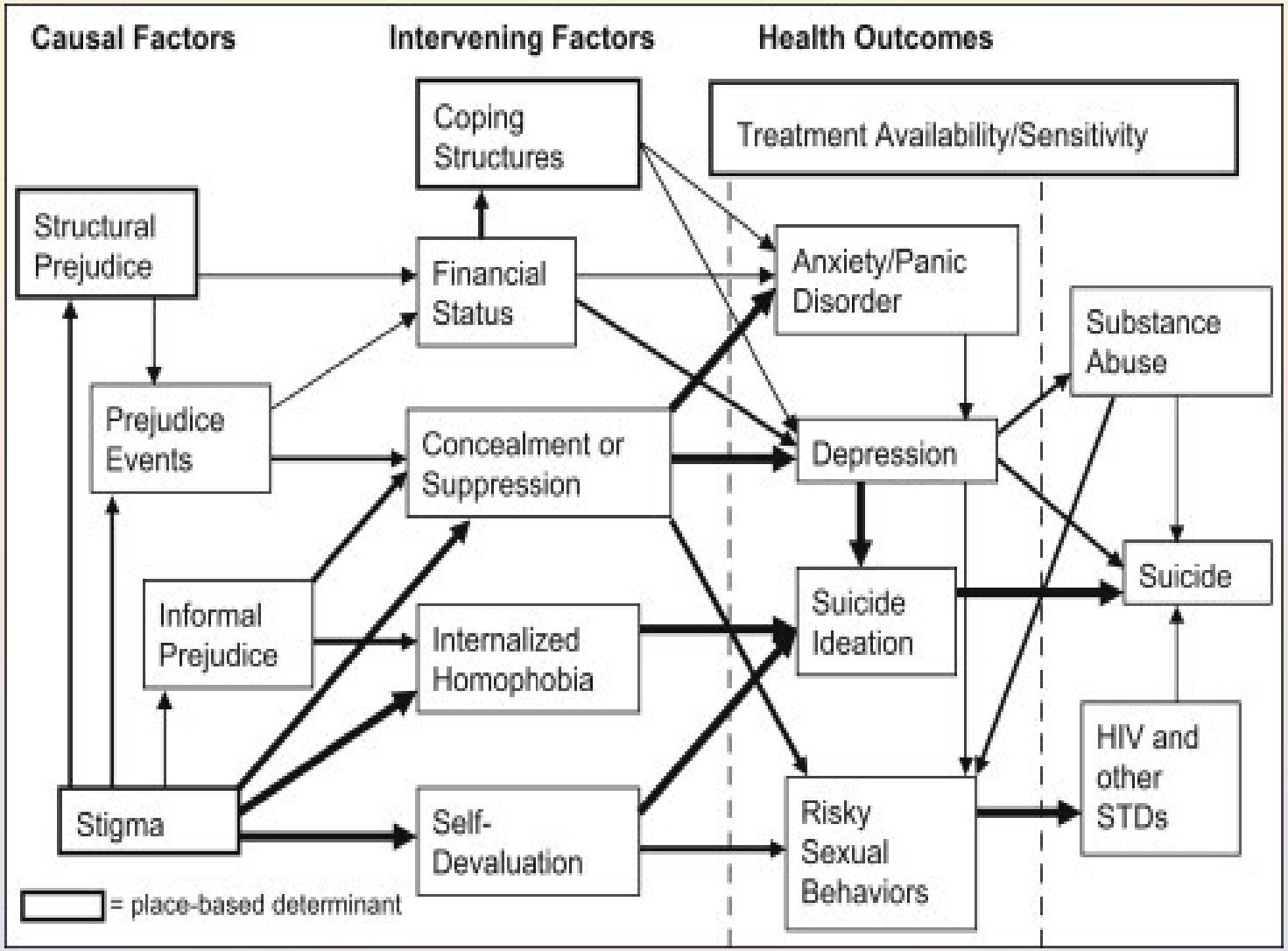
Why do transgender people avoid getting healthcare?

- Microaggressions
  - Not using preferred names and pronouns
  - “you’re not a real woman/ man”
  - Binary gendered bathrooms
- Intersectional Microaggressions
  - Race/ income or employment status / gender/ sexual orientation/ immigration status/ non-English speaking/ body habitus
- Implicit Bias
- Discrimination

Minority Stress Model



Levels of Transgender Medical Care

- **Level 1 – Routine Primary Care (All PCPs)**

  Trans-informed, trans-positive primary and preventive care without specific expertise. Staff sensitivity - EMR, Pronouns

- **Level 2 – Basic Transgender Care**

  Pre- or non-op breast/ chest / pelvic care – screen the anatomy that is there

  "Bridging" hormone therapy

- **Level 3 – Comprehensive Transgender Care (Team)**

  Pre & post-op breast/ chest/ pelvic care

  Managing all hormone therapy, new starts

  Administrative services – validation letters, etc.

Screen and treat the anatomy (not the gender)

- Cervix cancer screening / Pap test in transmen
  - Self swabbing and HPV based screening may be preferred
- Contraception for transmen who may be exposed to sperm
  - Progestin only methods preferred: depo-medroxyprogesterone, levonorgestrel intrauterine system, norethindrone only pills, etonogestrel implant
- Breast cancer screening / mammogram
  - Standard guidelines in transwomen; consider US/MRI in transmen s/p chest surgery
- Prostate screening in transwomen
  - Follow standard guidelines
- Prenatal care
  - Use inclusive patient education materials
  - Recognize implicit bias

Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society
Fontham et al July 30, 2020

Gender Affirming Hormones

- Goal: to allow acquisition of secondary sex characteristics in alignment with one's gender identity.
- Takes time – several years, similar to going through a second puberty
- Some changes are permanent and some may depend upon ongoing hormone treatment
- FtM: Testosterone (+/- contraception)
- MtF: Estradiol & Testosterone blocker
- Trans youth- GnRH analogues

Masculinizing Hormones

- Testosterone – injection (cypionate, enanthate) or topical
  - Usually every 7-14 days
  - Start low & slow: 25-50 mg Q 14 d -> 60-100 mg Q 7 d
  - Goal: physiologic range 300-800 ng/dL
    - Mid-cycle: 400-550 ng/dL
- Masculinization: increased facial and body hair, deeper voice (permanent changes) oily skin, acne, possible male pattern hair loss, increased muscle mass
- Full affect takes 3 + years

– DEA Schedule 3N – requires Rx every 6 months

Feminization

- Estradiol – oral, sublingual, topical, injections
  - Goal: physiologic range 100-200 pg/ml
  - Estradiol 2 mg tabs SL (2-8 mg per day, divided dose)
  - Estradiol valerate 5-10 mg IM Q 7-14 days
- Testosterone blockers –
  - Spironolactone
    - anti-androgen receptor activity & direct suppression of testosterone synthesis
  - 5-alpha reductase inhibitors
    - finasteride and dutasteride
- Feminization: softer skin, less facial hair growth, improved mood, redistribution of body weight, decreased muscle mass, breast development (permanent)

Monitoring

Assess masculinization or feminization

- **FtM**
- T= 300-800 ng/ml – Q 3 mo, adjust. Q 6mo, then yearly or prn
- Estradiol < 50 pg/ml
- T mid-cycle 400-550 ng/dL
- Labs: Baseline or 3 mo -> CMP, CBC +/- lipids, HgbA1c
- 6 mo, yearly, prn -> H&H, T
  - Polycythemia common side effect
- Consider ASA for > 40 yo

- **MtF**
- T level < 55 ng/ml
- Estradiol level 100-200 pg/ml
- Labs: Baseline CMP, CBC, +/- lipids, HgbA1c
- 6 mo, yearly, prn Cr/ K+/E & T
- PRN prolactin
- If on spironalactone – K+ 4-6 weeks after start or change in dose then Q 3-12 months

At each visit:

- Review medication use, side effects
- Monitor mood cycles, levels, and adjust medication as indicated
- Discuss social impact of transition, safety
- Safe sex, relationships, contraception if needed
- Review surgical options if applicable
- Plans for change of name and gender marker on legal forms
- Review, mitigate CV, DM, cancer risk factors

Surgeries

- For affirmed men
  - Mastectomy with masculine chest reconstruction
  - Hysterectomy +/- oophorectomy
  - Genital reconstruction
    - Metoidioplasty
    - Phalloplasty
- For affirmed women
  - facial feminization, tracheal shave
  - Hair removal with laser or electrolysis
  - Breast augmentation
  - Genital reconstruction
    - Vaginoplasty, labioplasty

Resources – Transgender Healthcare

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care
https://www.wpath.org/publications/soc

center OF excellence FOR TRANSGENDER health

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People
https://transcare.ucsf.edu/guidelines

CLINICAL PRACTICE GUIDELINE

Gender Dysphoria/Gender Incongruence Guideline Resources

September 01, 2017

The 2017 guideline on endocrine treatment of gender dysphoric/gender incongruent persons.

Full Guideline: Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline

***JCEM* September 2017**

Resources

- Sexual Medicine in Primary Care. Available as free PDF at: https://kinseyinstitute.org/collections/archival/sexual-medicine-in-primary-care.php
- CDC, A Guide to Taking a Sexual History, https://www.cdc.gov/std/treatment/sexualhistory.pdf
- WHO, Sexual and reproductive health Core competencies in primary care, http://apps.who.int/iris/bitstream/10665/44507/1/9789241501002_eng.pdf
- WHO, Defining sexual health http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf