University of Louisville
School of Medicine

The eQuality Toolkit

Practical Skills for LGBTQ and DSD-Affected Patient Care

THIS MANUAL WAS DEVELOPED BY:

Laura Weingartner, PhD, MS[1]
Emily Noonan, PhD, MA[1]
Amy Holthouser, MD[1]
Jennifer Potter, MD[2,3]
Stacie Steinbock, MEd[1]
Suzanne Kingery, MD[1]
Susan Sawning, MSSW[1]

UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

HOW TO CITE THIS MANUAL

Weingartner LA, Noonan EJ, Holthouser A, Potter J, Steinbock S, Kingery S, Sawning S. *The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care*. Lexington, KY: University Press of Kentucky; 2019. doi: 10.18297/faculty/391

ACKNOWLEDGEMENTS

The development of this manual and related research was funded by The National Institute for Health Care Management (NIHCM) Foundation. We thank the institute for supporting novel and critical research into LGBTQ and DSD health care.

We also thank the numerous LGBTQ and DSD-affected community members in Louisville for their invaluable feedback on content. The eQuality project would not have been possible without the generous time, energy, and expertise that LGBTQ and DSD-affected community members and leaders have provided to the University of Louisville School of Medicine (ULSOM).

We would like to thank the eQuality Steering Committee, including Dr. M. Ann Shaw, Vice Dean for Undergraduate Medicine Education of ULSOM, for their time and leadership on the eQuality project. The staff of the LGBT Center have also worked tirelessly to sustain strong community involvement in this project. The ULSOM Standardized Patient Program and the ULSOM Medical Education Research Unit have provided extensive support to eQuality.

Finally, we also acknowledge Dr. Toni Ganzel, Dean of ULSOM, whose leadership and continued support have been vital to the establishment and success of eQuality.

[1] University of Louisville
[2] Harvard Medical School
[3] The Fenway Institute

THE eQUALITY TOOLKIT: PRACTICAL SKILLS FOR LGBTQ AND DSD-AFFECTED PATIENT CARE

CONTENTS

THE EQUALITY TOOLKIT: PRACTICAL SKILLS FOR LGBTQ AND DSD-AFFECTED PATIENT CARE

PREFACE

WHAT IS THE PURPOSE OF *THE eQUALITY TOOLKIT*?

This manual will help providers build a foundation of inclusive clinical skills to competently care for lesbian, gay, bisexual, transgender, and queer-identified (LGBTQ) patients and individuals born with differences of sex development (DSD, sometimes called intersex). Although this toolkit was designed for medical students, any healthcare provider who wants to learn inclusive clinical skills can benefit from this manual. Other published resources address LGBTQ/DSD health and clinical skills comprehensively (see Appendix A). The purpose of this manual is to provide a brief primer that is accessible to all medical students with actionable steps to improve clinical care. It was specifically written for use at the University of Louisville School of Medicine; therefore, some resources or laws may be region/city specific. However, most of the content is applicable to any provider caring for LGBTQ/DSD patients.

The number of people who identify as LGBTQ is growing, including 7.3% of millennials.[1] DSD is estimated to affect 1.7% of births.[2,3] These individuals are our patients, and it is our responsibility to learn how to provide quality care for them.

WHY IS THIS MANUAL NEEDED?

Simply, this manual addresses gaps in healthcare provider training in caring for LGBTQ/DSD communities. These populations experience repeated instances of stigma and discrimination related to their identities, with consequent health and healthcare disparities that knowledgeable

healthcare providers can help to address.[4-9] In 2015, the University of Louisville School of Medicine (ULSOM) established eQuality (louisville.edu/medicine/equality/), an inclusive LGBTQ/DSD health training program that was integrated across the mainstream medical student curriculum.[10] After launching eQuality, we realized our students needed more clinical skills training to translate classroom learning into patient care. Although the focus of this manual is LGBTQ/DSD health, much of this content is applicable to **all** patients and can be incorporated broadly.

LGBTQ/DSD health and healthcare disparities are staggering, including:
—LGB individuals are as much as 2.5x likelier to smoke[11]
—40% of transgender individuals attempt suicide[12]
—Cardiovascular disease risk is 2x higher for LGB adults[13]
—LGBTQ individuals are likelier to be uninsured than others[4]

HOW TO USE THIS MANUAL

This manual has been used to train medical students in a classroom setting. However, it can function independently as a clinical skills supplement for practicing providers. Its five sections address the main sources of provider-driven health disparities and biases for the LGBTQ/DSD communities. This manual could be used as a supplement to a longitudinal clinical skills training course during medical school or in stand-alone LGBTQ/DSD health training. Although it is a primer, it may also be appropriate for graduate medical education (GME) training and as a faculty development tool. As you encounter terminology that is not familiar to you, please see the glossary in Appendix B for definitions.

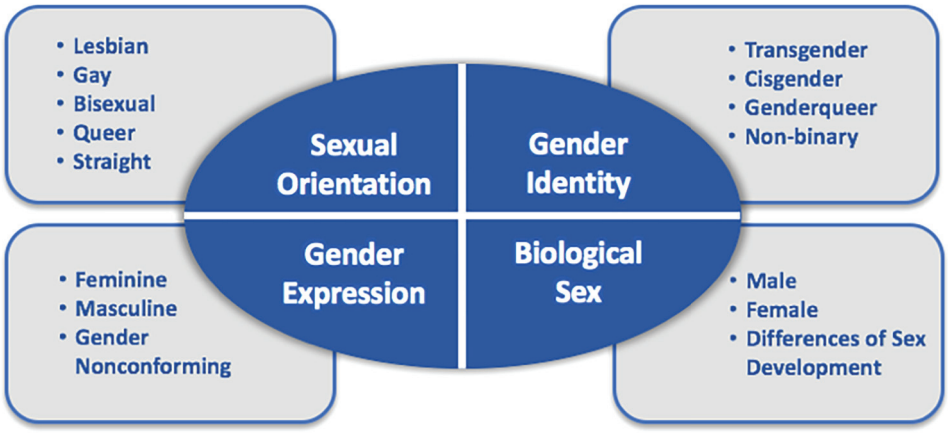
LIMITATIONS

The purpose of this manual is to provide a brief introduction for students, and making this practical necessitates the distillation of many complex subjects. For instance, we use the umbrella terms LGBTQ/DSD in this manual, which do not reflect the vast diversity of sexual and gender minority communities (see figure below and Appendix B for examples of sexual and gender identities). It is important to remember that terminology is fluid and ever changing. Therefore, the best strategy for providers is to have an open dialogue with patients to learn the words they use. Appendix A contains a list of resources for more comprehensive consideration of the topics in this manual.

Supporting research informs our recommendations, but many federal guidelines lag behind the expertise of providers who work extensively in LGBTQ/DSD health. We provide peer-reviewed citations in this manual to help inform your decision-making. Reasons to depart from guidelines include 1) the lack of an apropos guideline for your patient, and 2) the need for shared decision-making with the patient (e.g., to still prescribe estrogen in the context of a history of atherosclerotic cardiovascular disease). If departing from guidelines, a physician should be aware of

how other considerations, such as insurance coverage, may influence these decisions (see Part IV). Finally, LGBTQ/DSD health is an evolving field, and the authors will make efforts to periodically update this manual with current information. The information in the following sections represents best practice as of the time of this writing.

Domains of sexual and gender identities[5]



PART I: INCLUSIVE COMMUNICATION SKILLS

CREATING AN ACTIVE PARTNERSHIP WITH THE PATIENT

Many members of the LGBTQ/DSD-affected community have had previous negative experiences within the healthcare system.[5,12,14,15] One of the provider's responsibilities is to ensure that the patient's previous experiences—both in life and in health care—are considered when discussing different treatment options. LGBTQ individuals comprise approximately 5% of the U.S. population and this proportion is growing,[1] and these best practices can therefore have a substantial impact.

An active partnership can be developed by asking a patient **open-ended questions** such as "Tell me about your pain" versus "Does this hurt?"[16,17] The former allows the patient to elaborate with more insightful responses. Close-ended questions, while more direct, require the provider to infer information about the patient. When provider assumptions about a patient's sexual or gender identity are incorrect, the patient is left having to choose between correcting the provider or leaving the mistake unaddressed, resulting in suboptimal care that contributes to health disparities. The sections below will help providers develop active partnerships will all patients.

Providers can encourage openness with all patients by intentionally explaining provider-patient **confidentiality**, which is particularly important for patients who have previously endured bias and discrimination. Establishing trust by ensuring confidentiality can be especially important for gathering an accurate sexual history, regardless of patient identity. Patients should be explicitly

told what information will be recorded in their medical record, if and how this information will be shared (e.g., with insurance companies), and when confidentiality cannot be protected (e.g., mandatory reporting requirements for some diseases, abuse, and the potential for harm to self and others). Providers should seek permission from the patient to include identifying information in the medical record.

Considerations should be made for LGBTQ and DSD-affected patients, including youth, who may be concerned about being unintentionally "outed" to others or parents.

AVOIDING ASSUMPTIONS

Knowing about a patient is necessary to provide accurate, quality care. A patient's identities, attractions, and behaviors all impact health risks and social-behavioral determinants of health, such as employment or housing access. The LGBTQ/DSD community also intersects with all races, ages, and cultures. When meeting a new patient, it is not possible to know the person's sexual orientation or gender identity by appearance. To avoid assumptions about sexual and gender identity, providers must ask, and research shows that patients want physicians to do so![18,19] (See page 7 for an example of dialogue.) Inclusion is the best way to start a successful relationship with LGBTQ/DSD patients, and these steps are no cost to non-LGBTQ/DSD patients because common questions/discussions can be framed in an inclusive manner that is appropriate for **all** patients.

Furthermore, labels often mean different things to different people, and occasionally identities may not match behavior. Studies have found that some straight-identified men engage in same-sex sexual behavior.[20] Similarly, higher pregnancies have been documented among lesbian-identified youth, possibly because providers do not provide contraceptive counseling to individuals assumed to engage only in same-sex behavior.[21] Behavior that is discordant with identity would not be captured by an intake form asking only for sexual orientation. This highlights the importance of understanding not just the identities but also the behaviors of patients, a best practice that holds true of **all** patients, not just patients who identify as LGBTQ/DSD. Such biases in the healthcare system can impact patient care.

Common Biases	Example of Common Assumptions	How to Avoid Assumptions
Heteronormative biases (heterosexual as the norm)	• A male patient states that he is married, and a provider asks, "Do you have children with your wife?" • Sexual behavior can lead to pregnancy.	• Providers must ask all patients about the identity of a partner or spouse with open-ended questions. • Example: "Will you tell me more about your spouse or partner?" and mirroring the patients' language in follow-up questions.
Cisnormative biases (cisgender as the norm)	• All women can become pregnant. • A man in the waiting room at a gynecologist office is assumed to be a patient's partner rather than a trans male patient.	• Gender identity differs from sex assigned at birth. • Providers should not assume these always match. • Instead, establish both for all patients to provide appropriate preventive and diagnostic care.
Gender binary (male/female-only labeling)	• Women are nurturing while men are aggressive. • Trans men would never want to be pregnant. • Trans women are attracted to men.	• Sexual orientation, gender identity, and gender expression vary by individual. • Providers should avoid making assumptions about feminine/masculine qualities or desires based on gender identity or expression alone.

INCLUSION ON FORMS AND IN CONVERSATION

Inclusive intake forms help to make the collection of this information commonplace and give providers more context to the patient's background. Providers may also rotate or work at locations that do not have inclusive registration forms. We suggest talking to administration to address this—prompt attention can make a meaningful difference—and there are many templates available (see resources in Appendix A). Examples of typical registration form questions and more inclusive options can be seen on the following page.

Collecting and using preferred names avoids unintentionally "outing" transgender patients (to other patients in the waiting rooms, staff not on the care team, etc.).[22]

Asking detailed information on an intake form does not discriminate against the majority because **everyone** has a sexual orientation and gender identity to disclose. During the patient/physician visit, providers will want to ask the patient how they identify. Asking **again** in person is important because some patients will not disclose sexual orientation and/or gender identity on a form that could be linked to their health record because of discrimination concerns.

Some patients will not want to disclose sexual orientation and/or gender identity on a form that could be linked to their health record. Discrimination is real for many LGBTQ community members (the state of Kentucky, for example, does not protect LGBTQ people from employment or housing discrimination at the time this manual was written). Ideally, we are moving toward a society that treats all people equally regardless of identity, but until this point, some patients may be hesitant to put sensitive information on official forms.

Information	Typical Form	More Inclusive Options (adapted with permission from Appendices B and C in *The Fenway Guide to LGBT Health*[7])
Name Preference	Not reliably included	What is your preferred name or nickname? _____ Does your name differ between any ID forms (state, insurance) ☐ Yes ☐ No
Pronoun Usage	Not included	What gender pronouns do you use? ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ _____
Gender Identity	Not included	What is your current gender identity? (check all that apply) ☐ Male ☐ Female ☐ Genderqueer or Nonbinary ☐ Transgender male or female-to-male spectrum ☐ Transgender female or male-to-female spectrum ☐ _____ ☐ Don't know ☐ Prefer not to answer
Sex Assigned At Birth	Sex: ☐ Male ☐ Female	What sex were you assigned at birth on your original birth certificate? ☐ Male ☐ Female ☐ Intersex/DSD ☐ Don't know ☐ Prefer not to answer ☐ _____
Relationship Status	Marital status: ☐ Single ☐ Married	What is your relationship status? ☐ Single ☐ Partnered ☐ Married Would you consider your relationship: ☐ Monogamous ☐ Open ☐ Don't know ☐ Prefer not to answer
Sexual Orientation	Not reliably included	Do you think of yourself as: ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Straight ☐ _____ ☐ Don't know ☐ Prefer not to answer
Sexual Behavior	Not reliably included	Who are you sexually active with currently/previously (check all that apply): ☐ Men ☐ Women ☐ Transgender persons ☐ _____ Are you currently sexually active with: ☐ One person ☐ More than one person ☐ Not applicable

Because discussing this important information is not yet commonplace, providers may want to explain to patients why they ask for it. It is important to ask these questions to every patient—regardless of whether or not a provider thinks the patient is straight, cisgender, gender conforming, or has a history of opposite sex activity. Asking all patients addresses the provider's own biases, assumptions, and stereotypes.[7] Practicing these questions will make the provider feel more at ease asking them over time and will normalize the conversation with all patients. Asking patients about same-sex sexual behavior or attraction typically results in larger population estimates of sexual minority status compared to asking people whether they identify as part of the LGBTQ community.[23]

"I don't want to offend my patients." Many providers hesitate to ask about identities out of concern for offending non-LGBTQ/DSD patients. These concerns are largely unwarranted because 1) all patients have answers to these identity questions, and 2) most patients understand if providers approach this conversation as a routine part of the patient history. If a patient were to respond negatively, providers should reiterate that every patient is asked these questions. Here is an example dialogue:

Provider: "I ask these questions of all of my patients so that I can give you the best care possible. What pronouns do you use?"

Patient: "Don't I look like a woman to you?"

Provider: "Of course. These are questions that I ask all of my patients to make sure I understand who they are. I'll use she," and then continue to the next question.

Below are suggestions for taking an inclusive medical history in person to help avoid assumptions (see Part V for inclusive language choices for specific body parts and bodily processes). These questions also signal to patients that they can talk to a provider in the future about any concerns.

Question/Statement	Rationale for All Patients
"How would you like me to address you?"	When providers ask this question first to all new patients, they avoid mis-identifying or misgendering patients whose legal name differs from the name they actually use. New patients can be misgendered when honorific titles (Ms., Mr., etc.) are used in an introduction. Asking for a patient's "real name" can also be unclear and/or demeaning. The phrasing provided here allows the patient to interpret the question and designate what name and/or title to use. In emergency settings, this is appropriate until a full inclusive history can be taken.
"I ask these questions to all of my new patients so that I can give you the best care possible."	Approaching these topics with patients may seem difficult because they are not always included in medical histories. Introducing identity questions this way may help explain this process to those individuals who have not yet discussed these issues with providers.
"What was your sex assigned at birth?"	Understanding male/female sex assigned at birth (MSAAB/FSAAB) or intersex/DSD is crucial to understand the starting point of any sex-specific care that the patient will need (See Part III).
"What is your gender identity?"	This allows the provider to understand whether the patient's gender identity matches their sex assigned at birth—e.g., whether the patient identifies as cisgender (match) or transgender, on a spectrum, genderqueer, nonbinary, etc.
"What gender pronouns do you use?"	It is unlikely that the provider will refer to the patient with gender pronouns in person, but this information is important to fully represent the patient in later correspondence (chart notes or case presentations) and to educate other providers. Furthermore, asking gender pronouns is one of the most frequently cited steps that providers can take to make their practice more inclusive.[24]
"Do you have sex with men, women, both, or anyone else?"	"Men, women, or both" is a common phrase providers use, but this excludes identities outside of the gender binary—so providers should use the more inclusive wording here or in the next example.
"Can you tell me more about the gender identities of your sex partners?"	This is an open-ended version of the question directly above, with the intent to have the patient disclose rather than offering genders/identities of the patient's partners. This breaks down a cisnormative assumption that gender identity (man/woman) also reveals sex assigned at birth (male/female), and differences can be important when considering preventive care.
"Can you tell me more about the types of sex you are having?"	This question allows the patient to describe the type(s) of sex they engage in. The provider should follow up with specific questions to clarify and fully understand each patient's behaviors and thus risk factors (see next question).
"What parts do you use when you and your partner(s) have sex?"	All patients are capable of having oral and anal receptive intercourse and may therefore need related care/counseling. The only way to know for sure what risks a patient has is to ask about specific behaviors and body parts.
"If your sexual activities change, you may need additional screenings."	People change, and behaviors that the patient does not report during one visit may be relevant in the future. This is true of all patients.
"What is your relationship to the patient?"	When a family member accompanies the patient, this open-ended question replaces questions such as "Are you the patient's husband/wife?" which make assumptions about the patient's relationship status and sexual orientation.

CONVERSATIONS WITH LGBTQ/DSD-AFFECTED YOUTH

Healthcare providers can assist youth who were born with a DSD, identify as LGBTQ, or who are questioning their sexual or gender identities. For DSD-affected individuals, sexual orientation and gender identity cannot be assumed by the provider; this highlights the importance of having these discussions with all patients. Provider support is particularly crucial if the patients have insufficient support at home and/or school. Adverse childhood experiences (ACEs), including abuse, household dysfunction, abandonment, and rejection are common (although not universal) for LGBTQ youth, and these experiences often lead to adverse mental and physical health effects.[25] Providers can help determine if young patients are at risk. Providing a supportive, welcoming environment is the first step. Providers may ask to discuss some more sensitive topics without the parent present to reduce the patient's stress and allow for a more comfortable, honest discussion.[7]

Question/Statement (from *The Fenway Guide to LGBT Health*[7])	Rationale for Youth Patients
"It is normal for young people to sometimes be confused about their feelings and experiences. Do you have any questions you'd like to ask me or things you would like to talk about?"	This gives the patient the opportunity to bring up other concerns or issues, including sexual orientation or gender identity issues that may not be the primary reason for the visit.
"Who do you feel comfortable talking with about personal stuff?" **"Who supports you the most?"**	Many LGBTQ youth are estranged from their family or do not feel comfortable disclosing their identities to family.[26] Supportive people can help provide resilience. If there is a lack of support, referring to supportive counseling or a local youth organization that supports LGBTQ/DSD is very important.
"Have you ever talked to anyone else about this other than me?"	This allows the provider to determine whether the patient has disclosed their LGBTQ identity to others and how the provider should discuss their identity with their parents or within their medical history.
"How are things going at home/school?" **"Do you feel safe? Have you ever not felt safe at home/school/out in the world?"** **"Have you ever been harassed or bullied?"**	An alarming amount of LGBTQ youth experience violence related to their sexual or gender identities.[27] By identifying unsafe environments, the provider can ensure LGBTQ youth access help if needed. Psychological distress and suicide rates are also distressingly high for LGBTQ youth.[28-30]

Before disclosure, providers should understand and explain to the youth patient what obligation they have to notify parents and also what confidentiality a provider can give to the patient. Laws governing minor consent and parental access to health information of minors vary by state. In Kentucky, for instance, patients under 18 years old can seek treatment for STIs, contraception, pregnancy (not including sterilization or abortion), and substance abuse without parental/guardian notification.[31] Age of consent laws also vary by state, but providers are mandated to report minors who disclose sexual activity before this age (as well as any significant safety concerns) to child protective services. Gender identity and sexual orientation are not specifically covered under the law, but are usually regarded by healthcare providers as protected information that would not be discussed with a parent without the consent of the patient. Optimal care for the minor patient usually includes family support and disclosure. However, due to family rejection and domestic violence concerns for LGBTQ youth, the safety of the patient following disclosure has to be balanced with the wish of the provider to inform parents.

REFERRAL NETWORKS AND BEST PRACTICES

Many LGBTQ patients and patients with a DSD have experienced healthcare providers refusing to care for them, refusing requested care, and/or committing micro or overt aggressions that reject their humanity.[12,32] These incidents occur at a time that patients are incredibly vulnerable, such as going to the doctor's office, emergency room, hospital, or operating room.

Harms of Referral	Suggested Compensation
Delayed care	Provider should make every attempt to help patient set up an expedited appointment; this may require a personal phone call to the new provider.
Cost of additional visits	Waive bills for a visit when services were not able to be rendered effectively.
Difficulty scheduling with specialists	For hormone therapy referrals, the provider may consult a specialist initially to establish treatment plan but take over future management.
Perceptions of unwillingness for care	Continue to care for patient in ways that align with the provider's expertise and ability.

Medical students desire to provide effective, evidenced-based, compassionate, affirmative care to LGBTQ patients,[33] but medical education has not traditionally provided an effective framework for physicians to provide LGBTQ health care.[34] This manual is clear in its intent to positively impact patient care by providing those willing and invested in improving health outcomes for LGBTQ/DSD patients the information necessary for them to care for their patients. If providers work with others who choose to refer LGBTQ/DSD patients, they should ensure it is done with the patient's well-being in mind. It is not appropriate for the provider to describe personal beliefs or make judgments that contribute to bias and discrimination, which can thus discourage the patient from seeking future preventive and diagnostic health care and do harm to the patient. Providers should use neutral, nonjudgmental language that assures patients that their needs will be taken into account.

Inappropriate Referral Purposes	Explanation
"I don't have the training for LGBTQ/DSD patients." **"I've never done that before."** **"I don't know enough to be safe managing medications for people with your condition."**	• Referral is appropriate only when additional training is required (e.g., gender-affirming surgery that requires a surgeon with specific training). • Lack of LGBTQ/DSD health knowledge is not an acceptable reason for referral. Lifelong learning is a vital skill for all providers who provide care for all patients.
"I don't work with people like you." **"I don't see LGBTQ/DSD patients."**	• It is inappropriate to refuse services to patients based on their identity.
"I don't provide <u>that</u> kind of service." **"Working with people like you is contrary to my belief system."** **"I'm not comfortable working with someone like you/with your condition."**	• Physicians should not share their personal beliefs with the patient. • It is never appropriate to use judgmental language toward a patient. • Providers should avoid overt aggressions and also microaggressions, which are unconsciously or subtly hurtful comments (see next page).

ADDRESSING MICROAGGRESSIONS

Even if a provider creates an inclusive space, issues with other members of the team—from the front desk to nursing staff to attending physicians—can create a hostile or even dangerous environment for patients. Many patients who are LGBTQ/DSD report experiencing microaggressions (comments that are subtly or unconsciously prejudiced and hurtful) in healthcare offices, as well as overt harassment and discrimination in some instances (such as verbal abuse, rough physical exams, or refusal to treat).[12] Healthcare providers have a responsibility to ensure that patients experience a welcoming environment. As a bystander/upstander and ally, every provider should be ready to intervene on behalf of an LGBTQ/DSD patient (or co-worker, etc.). Providers should practice supporting the person targeted by the microaggression in order to prioritize that individual's well-being, and then address the source (taking advantage of opportunities to educate others). Here are some examples of common microaggressions and possible responses:

Microaggression or Harassment	Possible Response
"It's ridiculous that we have to ask patients all these questions." **"Some of my patients get offended by these questions."**	"It is important for questions about gender identity and sexual orientation be normalized for everyone since the stigma of being a sexual or gender minority leads to increased suicide rates and other health and healthcare disparities in these populations."
"Why do some groups of people think they deserve special treatment—aren't all patients important?"	"We're trying to do better to include groups of people that have traditionally not been fully included in health care. These steps are necessary to work toward a world in which all groups have the same medical outcomes."
"They're just being too sensitive."	"A person's identity is important to them, and not acknowledging their identity demonstrates a lack of respect."
"This is so gay."	"What do you mean? The way you use that phrase is offensive, so please don't say it."
"Who's the woman/man in the relationship?"	Educate the person about the difference between gender identity, gender expression, and sexual orientation.
"Who's the real mom/dad?"	"They're both the real mom/dad." If genetic parentage needs to be established for healthcare purposes (not just curiosity), instead clarify with, "Are either of you a biological parent?" or "Can you tell me how you made your family?"
"I don't want a woman/man in the bathroom with me."	Educate the person about respecting someone's gender identity and the false endangerment narrative of inclusive bathrooms.[35]
"I don't understand why a guy would go to the OBGYN."	Educate the person about the difference between gender identity and sex assigned at birth (e.g., that some trans men have a uterus).

Medical students may have to address microaggressions—often made unintentionally—from higher-ups, such as residents and attending physicians. If a student feels comfortable "teaching up" in a situation, they may explain to the team how the microaggression is offensive and offer more inclusive options. If the student is not comfortable in this role in the setting of the microaggression, it is important to give feedback to a trusted supervisor or administrator in the clinical or educational environment (for example, a clerkship director or coordinator) so that additional education can occur.

PART II: GENDER-AFFIRMING CARE

AVOIDING ASSUMPTIONS ABOUT TRANSITIONING

Gender-affirming care is appropriate and supportive care for the patient's complete gender identity. Establishing whether a patient is cisgender, transgender, or was born with a DSD is best done through the two-step gender identity questions (see Part I) to determine whether gender identity (step one) matches sex assigned at birth (step two), and to determine what pronouns the patient uses. This section discusses additional considerations for effectively providing care for patients whose gender identity does not match their sex assigned at birth. This section will refer to patients seeking this care using the umbrella terms transgender and DSD for brevity, but there are many gender identities that apply here such as nonbinary, genderqueer, gender fluid, and more (See Appendix B).

Below we discuss medical and surgical interventions that can help affirm transgender patients' identities. The starting place for gender-affirming care is to realize, however, that not every patient's transition will be the same. Consider the parallel between transitioning and starting a family—not every person wants children, and sometimes life circumstances take priority. Similarly, some transgender patients never want medical or surgical interventions as part of their transition, and sometimes insurance issues complicate these choices (see Part IV). There is no single path that any transgender patient should follow, so it is best to ask open-ended questions like **"can you tell me about your transition goals?"** when taking a history and discussing gender identity and/or goals of hormone use or surgery. This allows the patient to take charge of their personal aims and allows the provider to address any questions the patient has. With the wide array of online resources for transgender health, many patients are well informed about their options and goals. The provider's responsibility is to help place their transitioning goals into the context of their medical care.

Some care guidelines recommend that a person live openly within the new or desired gender identity for a set period of time and/or provide a referral letter from a mental health professional before providers prescribe medications or surgery for gender-affirming care. However, this recommendation is evolving, and more recent practices focus on enhancing self-esteem and mental well-being by partnering with the patient to prescribe desired treatments earlier to help match the patient's internal experience with their desired external appearance more completely and expeditiously. The **informed consent process** allows providers to develop a plan with the patient who demonstrates an understanding of risks, benefits, and implications of treatment; providers document the conversation in the medical record to indicate informed consent was obtained (patient signature not required).

The World Professional Association for Transgender Health (WPATH), the international body of experts on transgender care, has determined that gender-affirming procedures are medically necessary for those transgender patients who desire them as part of their transition.[8] Ultimately the risks of feminizing and masculinizing therapy need more data to be conclusive, but there is an overwhelming benefit to addressing gender dysphoria for transgender patients. Hormonal interventions used in transition are associated with decreased depression and anxiety.[36] Recent data show that 40% of transgender people attempt suicide,[12] so many LGBTQ providers see suicidal ideation risk as a more pressing health issue than possible side effects of hormone therapy. The key point is for providers to **become informed and prescribe gender-affirming care** based on the transition desires of their patients!

PATIENTS BORN WITH DSD

DSD-affected individuals may not have the anatomy and/or hormonal composition typical of a natal male or natal female. DSDs are diverse, and knowing an individual's anatomy and hormones is necessary to provide appropriate preventive screening and counseling. For some DSD-affected patients, gender identity will have been determined during infancy or childhood by their providers and/or parents, although advocates are working hard to change this.[5] Many DSD-affected individuals have had prior negative healthcare experiences because their family and providers did not explain their condition or failed to discuss all available treatment options,[37] and/or because of voyeurism (unnecessary exams or additional members of the healthcare team present

"to learn").[38-39] Healthcare providers should fully disclose the DSD diagnosis and all potential treatment options from the outset, and ask patients about their prior healthcare experiences. This approach supports the development of a shared decision-making model that is in the best interest of the patient. Finally, it is important to remember that having a DSD does not determine a patient's sexual orientation, attraction, or sexual behavior.

HORMONE THERAPY

The purpose of hormone therapy is to alter secondary sex characteristics to more closely match a person's gender identity rather than their sex assigned at birth. Not all patients desire hormones as part of their transition. For those who do, people who identify on the male-to-female spectrum typically take estrogen and antiandrogens (which reduce the dose of estrogen needed),[40] while people on the female-to-male spectrum typically take testosterone.[41] Some physical changes are irreversible, and thus patients should be informed about this as part of the informed consent process before beginning hormone therapy. Special considerations for transitioning prior to the onset of puberty are addressed separately below. Although the timeline of the physical effects of hormone therapy are variable, most changes occur in two years. The WPATH Standards of Care[8] (SOC) detail expected onset times, maximum effect, and reversibility (and also note that a new SOC revision is expected soon with updates since the 2012 version 7). The Center of Excellence for Transgender Health also has detailed feminizing and masculinizing dosage guidelines.[6]

Gender-Affirming Purpose	Hormone	Overview of Methods *(from WPATH[8])*	Physical Effects (*not reversible) *(from WPATH[8])*
Feminizing Options	Estrogen	• Oral (ethinyl estradiol) • Injection • Transdermal (cream, gel, patch)	• Breast growth* • Decreased libido and erections • Decreased testicular size and reduced sperm production (possible sterility*) • Increased percentage of body fat and decreased muscle mass • Skin softening • Slowed growth of body/facial hair • Slowed male pattern baldness
	Antiandrogens (Testosterone Blockers)	• GnRH agonists • Progestins • Spironolactone • 5-alpha reductase inhibitors	
Masculinizing Options	Testosterone	• Intramuscular injection • Subcutaneous injection • Transdermal • Buccal and implantable preparations also available	• Facial*/body hair growth • Deepened voice* • Scalp hair loss* • Increased muscle mass/strength and body fat redistribution • Menses cease • Clitoral enlargement*/vaginal atrophy

Who can administer hormones? When approaching a general practitioner for a hormone prescription, many transgender patients are "handed off" to endocrinologists because the provider feels they lack the knowledge to administer and monitor hormones. Referrals place a burden on the patient, and many experts assert that hormone therapy does not need to be performed specifically by an endocrinologist.[6] Primary care physicians, obstetrician-gynecologists, nurse prac-

titioners, and endocrinologists have the capacity to administer gender-affirming hormones, and many have experience with the hormones in other contexts (e.g., contraception or menopause).[42]

What are the risks of hormone therapy? A major barrier to care is providers' overestimation of cross-sex hormone therapy risks, which is usually related to a lack of clinical experience or training with this practice. Introducing hormones in any person comes with risks, but risks are not known to be higher for transgender patients. For instance, estrogen carries a risk of blood clots whether it is used in a cisgender female patient (FSAAB) or transgender female patient (MSAAB), with oral hormones being riskier than injections for both.[43] The risks of hormone therapy are often cited as a reason for a provider not to initiate hormone therapy or to refer the patient to an endocrinologist. Often this is unfounded—few data definitely show increased risk. Results from comprehensive studies, such as the recently established Study of Transition, Outcomes and Gender (STRONG),[44] are needed to determine the actual long-term risks of hormone therapy to transgender patients.[6,8]

Gender-Affirming Purpose	Hormone	Overview of possible risks *(from WPATH[8])*
Feminizing Options	Estrogen	• Estrogen use likely increases the risk of venous thromboembolic events (VTE) and risk of cardiovascular events in older patients and those with underlying risk factors; transient elevations in liver enzymes, and cholelithiasis (gall stones) • Oral estrogen (ethinyl estradiol) use likely increase triglycerides • Limited evidence of possible increased Type 2 diabetes, hypertension, and hyperprolactinemia • Not enough evidence to determine effect on breast cancer risk • Fertility and libido may decrease
	Antiandrogens	• Spironolactone (also used in treating hypertension) side effects include hyperkalemia, dizziness, and gastrointestinal symptoms
Masculinizing Options	Testosterone	• Testosterone use likely increases the risk of polycythemia, modest weight gain and/or increase in visceral fat • Possible increased risks include decreased HDL, supraphysiologic serum levels of testosterone, transient elevations in liver enzymes, and hypomanic/manic/psychotic symptoms in patients with underlying psychiatric disorders • There is not enough evidence to determine risk of osteoporosis, cardiovascular events, hypertension, Type 2 diabetes, breast cancer, cervical cancer, ovarian cancer, or endometrial cancer • Testosterone can affect a developing embryo/fetus, reduce fertility with unknown reversibility, enlarge the clitoris, and increase libido

It is the provider's responsibility to inform the patient of possible risks to ensure a patient's informed consent before starting hormone therapy. However, requiring patients to continually see a specialist for gender-affirming care can create healthcare disparities by placing a greater burden on the patient through fractured and delayed care, which can contribute to poor mental health outcomes and even suicide. In some cases, it may be desirable for the provider to consult an endocrinologist or subspecialist to first create an overall plan of care, but a competent primary care doctor can then provide continuing care and monitor the patient's hormone levels and progress.

GENDER-AFFIRMING SURGERY

Some transgender patients may desire irreversible surgical procedures to obtain physical features that more closely align with their gender identity. Note that these surgeries include a wide range of possible procedures, including several that are not specific to transgender patients (e.g., hysterectomy).[40,41] Possible surgical procedures also include more than just genital removal or reconstructive surgeries. A good understanding of each patient's pre- and postsurgical anatomy is crucial to guide routine preventive care, screening decisions, and diagnostic care decisions if problems occur in the future. It is crucial that each patient's medical record reflect that individual's pre- and postsurgical anatomy so that it can be considered by all care providers, such as when an additional provider is covering for the primary provider, or is consulted in some aspect of the patient's care. The effect of gender-affirming surgery on screening and preventive care will be addressed in Part III. Transgender patients may consider any (or none) of the following surgical interventions:

Purpose	Procedure	Brief Description (from *The Fenway Guide to LGBT Health*[7] and the UCSF CoE[6])
Feminizing Options	Breast Augmentation	Saline-filled implants are surgically implanted in the chest (typically after hormonal breast tissue increases); sometimes referred to as "top surgery"
	Vaginoplasty	Creation of a vaginal cavity (requiring dilation to maintain), neoclitoris, and construction of labia—typically paired with a removal or dissection of the penis and testes; a penile inversion is the most common technique in which skin from the penis shaft is inverted and becomes the inner walls of the vaginal shaft; sometimes referred to as "bottom surgery;" note that the prostate will usually remain and must be addressed in preventive/diagnostic care
	Orchiectomy	Removal of the testes, which may be desirable to lower the dosage of feminizing hormones
	Facial	Common surgeries include rhinoplasty, chin/jaw reduction, lip/cheek augmentation, and reduction laryngochondroplasty ("tracheal shave" to reduce the prominence of the Adam's apple)
Masculinizing Options	Mastectomy or Breast Reduction	Reduction of breast tissue or subcutaneous removal of breast tissue with possible reconstruction including reduction/repositioning of nipple; tissue remaining after breast reduction should undergo screening according to guidelines for non-transgender women, while residual tissue after bilateral mastectomy cannot be reliably imaged and unknown risks exist;[6] sometimes referred to as "top surgery"
	Hysterectomy and/or Oophorectomy	Removal of uterus and/or ovaries; these procedures can treat preexisting conditions but may also reduce gender dysphoria by preventing menstrual bleeding, pregnancy, and removing the need for gynecologic exams (depending on whether the cervix is removed)
	Vaginectomy	Eliminating vaginal mucosa to close the vaginal cavity
	Metoidioplasty, Phalloplasty, and Scrotoplasty	Creation of a phallus-like structure out of the hormonally enlarged clitoris (metoidioplasty) or from a tissue graft (phalloplasty), with urethral lengthening available for either option to give the patient the ability to urinate while standing; creation of a scrotum (scrotoplasty) is often done using labia tissue and may include testicular implants; sometimes referred to as "bottom surgery"

CONSIDERATION FOR TRANSGENDER AND DSD-AFFECTED YOUTH

Transgender youth who have not yet experienced puberty may benefit from starting hormone therapy before innate hormones change secondary sex characteristics in a way that does not match the youth's gender identity. Many transgender adolescents will desire puberty blockers and benefit from intensive counseling and support as they consider their desired goals of transition. Puberty blockers can be advantageous since they prevent physical changes associated with innate hormones. They can allow questioning youth time to explore their gender development, and the effects are reversible should a patient choose to discontinue their gender transition.[45]

The process of puberty varies for individual adolescents, so timing of hormone administration can be difficult to determine. It may be more desirable for a pediatric endocrinologist to manage hormones for youth patients since puberty is being initiated with hormones, and hormone levels in children/adolescents differ from those in adults—so standard reference ranges may not apply. However, there are many circumstances in which a highly qualified and experienced primary care provider can manage and/or partner with a pediatric endocrinologist for the care of young patients. Some organizations suggest that hormone therapy for adolescents can be managed by a qualified primary care provider similar to the manner in which it is managed for adults.[6] However, this is not currently the norm.

When a DSD is identified for an infant or child, the individual with the DSD is unable to make an informed decision or consent to treatment. In the past, parents and/or providers have been given the responsibility for making this important decision, but current providers for DSD-affected patients advocate that any nonurgent procedures—particularly those that are irreversible, such as surgery for ambiguous genitalia—be delayed until the child is old enough to make an informed decision about gender identity.[46] Providers treating a child with DSD should consider the current well-being of the child and that of the future adult, the child's future right to be informed and in control of their own healthcare decisions, and the well-being of the child-parent relationship.[46]

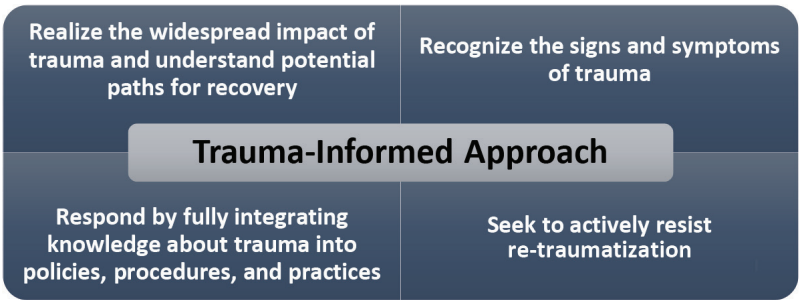
Learning a patient's gender identity is a two-step process: establishing sex assigned at birth and establishing how the patient identifies. Sex assigned at birth is vital for providing sex-specific care. Affirming a patient's identity (e.g., by using the pronouns the patient uses—such as he, she, or they) shows respect and builds a trusting relationship that will keep the patient engaged in the healthcare system. The goal is to reduce health and healthcare disparities, and facilitating a positive patient-centered relationship through understanding and affirming patients' identities supports this goal.

If a provider misgenders a patient, respectfully acknowledge the mistake to indicate that it was noticed and unintentional, correct the mistake, and continue with the patient encounter while ensuring that affirming language is used. The provider can apologize if desired, although lingering on the mistake can be counterproductive because the conversation becomes centralized on the person's gender rather than on the person's care. This process can also be applied to mistaken assumptions about sexual orientation, such as a partner's gender. However, asking all patients about gender identity and sexual orientation helps providers avoid making mistakes rather than needing to correct them.

PART III: PREVENTIVE CARE

FRAMEWORK FOR TRAUMA-INFORMED CARE

Many individuals experience repeated harassment, discrimination, and/or abuse related to their LGBTQ/DSD status.[12,47,48] In addition, many DSD-affected individuals have had unnecessary and/or painful and invasive surgeries, and their DSD status was withheld until well into adulthood. These traumatic experiences can lead to mistrust of the medical community. Caring for LGBTQ/DSD patients requires providers to realize the ubiquity of trauma, recognize the symptoms and signs of trauma, acknowledge its effects, and shift from a pathologizing stance of "What's wrong with you?" to the much more helpful "What happened to you, and how can I help you cope best?" A trauma-informed approach can improve interactions with all patients.[49]



SCREENINGS

No genetic differences predispose members of the LGBTQ community to diseases. Differences in disease burden can thus be linked to adverse healthcare experiences, consequent avoidance of preventive care, provider ignorance about necessary screenings for different populations, lack of insurance, and increased health risk behaviors (which often represent attempts to cope with sex- or gender-related minority stress). Some sex-specific or demographic-specific recommendations do not perfectly apply to LGBTQ individuals due to insufficient research. Best practices must therefore be extrapolated based on a combination of clinical consensus and what is known about the pathophysiology of disease. Providers should therefore have and document "informed consent" discussions with patients (see Part II) in order to choose the best treatment course.[50] Many screening and preventive practices are best guided by reported patient behavior—particularly related to substance abuse, sexual practices, and mental health—rather than by identification with a particular patient population. For example, a gay male patient with the same monogamous male partner for 30 years who does not drink alcohol or use drugs, has no history of depression or anxiety, is stably employed, and reports no current problems may not benefit from some of the additional screenings often recommended for men who have sex with men, which are often based on those with multiple sex partners. The sections below outline best behavior-based practices for the LGBTQ/DSD communities and all patients.

Cancer Screenings – Decisions about cancer screening are complex and require consideration of multiple factors. Patient anatomy and the underlying cancer risk for specific organs are factors to consider. Common cancer screening guidelines for asymptomatic adults without a personal or family history of cancer include:

Cancer	Female Sex Assigned At Birth (FSAAB)		Male Sex Assigned At Birth (MSAAB)	
	Female-to-Male spectrum *(includes trans men, FSAAB genderqueer, and other patients)*	**Cis Women** *(includes cis women who are lesbian, bi, queer, straight)*	**Male-to-Female spectrum** *(includes trans women, MSAAB genderqueer, and other patients)*	**Cis Men** *(includes cis men who are gay, bi, queer, straight)*
Anal	Consider anal Pap test for anyone having anal receptive intercourse with additional consideration for the facility's ability to administer/follow up screening appropriately (capacity for this is rapidly evolving);[51] this applies to cis men and women, trans men and women, and any combination of gender identity when sexual practice includes anal receptive sex; anal warts are strongly associated.[52] Digital rectal exams do not reliably identify abnormalities and are thus not indicated for anal cancer screening.[53]			
Breast	Biennial mammography over age 50 (earlier for high-risk individuals);[54] and clinical breast exam not indicated[54] risk not eliminated with gender-affirming reduction;[6] effects of masculinizing hormone use are unclear.[8]	Biennial mammography over age 50 (earlier for high-risk individuals;[54] and clinical breast exam not indicated.[54]	Without hormone use, consider breast exam for patients at high risk only (e.g., strong family history);[54] over age 50 with 5-10 years of feminizing hormone use: biennial screening mammography.[6]	Consider breast exam for men at high risk only (e.g., strong family history).[54]
Cervical	Pap test every 3 years from age 21 to 65 years[55] or co-test age 30-65 with HPV DNA test every 5 years;[56] lowered risk if cervix removed with a total hysterectomy (as gender-affirming surgery or other conditions, such as fibroids or uterine prolapse), so no Pap test.[55] Bimanual pelvic exams are not indicated.[57]		Not applicable: no cervix, even after vaginoplasty; annual visual inspection of neovagina can identify other issues (warts, ulcers)	Not applicable
Colorectal	Colonoscopy should be considered beginning at age 50 years and every 10 years thereafter continuing until age 75 years, with individual decisions for screening from then on.[58] Digital rectal exams not indicated.[53]			
Lung	Low-dose computed tomography (LDCT) considered in age 55 to 80 years for patients who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.[59]			
Oral	Consider clinical oral-cavity examination based on tobacco/alcohol use, risk of oral HPV exposure.[60]			
Ovarian	No screening recommended; lowered risk if ovaries removed with oophorectomy as part of a total hysterectomy (for gender-affirming surgery or other conditions).[61]		Not applicable	
Prostate	Not applicable		Inform patient aged 55-69 about potential benefits/harms of prostate-specific antigen (PSA)-based screening;[62] note that prostate is intact after gender-affirming surgery.[6]	
Skin	Consider visual skin examination after assessing individual risk factors (familial syndrome, fair complexion, sun exposure, etc.).[63]			
Testicular	Not applicable		No screening recommended but potential risk unless orchiectomy (gender-affirming care, etc.);[64] monthly self-exam for history of cryptorchidism with no or post-puberty orchiopexy advised.[65]	
Uterine/ Endometrial	No routine screening recommended; lowered risk if uterus removed with hysterectomy (for gender-affirming surgery or other conditions);[66] educate patients to report abnormal bleeding. Bimanual pelvic exams are not indicated for this screening.[57]		Not applicable	

Few cancer databases collect data on sexual orientation or gender identity (but see The PRIDE Study in Appendix A for research addressing this gap). However, evidence suggests that the LGBTQ community suffers from higher rates of certain cancers compared to straight, cisgender communities. These disparities may be caused by behavioral differences (such as anal cancer in gay men[67]) or differences in accessing preventive care (such as cervical cancer in lesbian women, who may visit the OBGYN less frequently because of not needing birth control[68]). Whether or not a person with a DSD is at an increased risk for malignancy depends on the specifics of their DSD. Providers must therefore research the needs for specific patients according to their past medical history, hormonal profile, and present anatomy.

Gender-affirming care can affect screening recommendations because some risk factors may be increased (trans women develop increased breast tissue while taking estrogen, requiring routine screening) or decreased (trans men do not need cervical pap tests after having a total hysterectomy removing the cervix). This underscores the importance of establishing a trusting relationship with patients to gather a complete history that includes current anatomy to make appropriate cancer screening recommendations. Patient anatomy and the underlying cancer risk for specific organs should be considered. For example, when considering cervical cancer screening, the first question should be "does this patient have a cervix?" but other factors such as time since last Pap test, prior abnormal cytology, sexual history, and underlying immunosuppressed state are also considered.

When designing a cancer screening strategy for LGBTQ and DSD-affected patients, evaluation of the traumatic versus affirming nature of some invasive exams or procedures must also be considered and discussed with the patient. The clinician should talk through the benefits, risks, and alternatives with each patient, based on their individual anatomy as well as related risk behaviors. A mammogram on a trans man (FSAAB) who uses chest binding and has not had a mastectomy may be very disruptive but necessary if there is a strong family history of breast cancer; the same mammogram may also be medically necessary and seen as an identity-affirming step in gender transition by a trans woman (MSAAB) who has had breast augmentation surgery, and takes hormones to supplement breast development. Note that providers may have to help patients file claims with insurance companies if the patient has changed their gender identity on their identification but screenings do not align with gender identities expected by insurance companies (e.g., a prostate screening for a (trans) woman or a cervical screening for a (trans) man—see Part IV).

Sexual Health Screening and Preventive Prescribing – Preventive health recommendations related to sexual health like regular HIV and STI screening are dependent on taking a full sexual history (see Part I). Nonjudgmentally determine specific types of sexual behavior that the patient engages in ("what goes where?") because vaginal, oral, anal, and other sexual practices carry different health risks for all populations. Many older adults are also sexually active but are often overlooked for sexual health screenings,[69] which may contribute to STI transmission risks.[70] Determine how patients protect themselves from HIV, STIs, and unwanted pregnancies, as well as their (and ideally their partner's) past history with any of these conditions. It is also important to screen all patients for high-risk sexual behaviors, including alcohol/drug use during sex or exchanging sex for money, drugs, or housing. This information is crucial to know for **all** patients, not just LGBTQ patients.

Providers should become comfortable discussing sexual history in a neutral, nonjudgmental way with all patients. A thorough sexual history should be completed for **every new patient** in a primary care setting. Remember to

1) indicate that all patients are asked this information,
2) describe how this information is used to provide them appropriate care, and
3) explain to patients that this information is confidential.

PrEP and PEP – Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are biomedical treatments that lower a person's risk of contracting HIV. PrEP is a daily, oral medication prescribed to HIV-negative patients who disclose high-risk behaviors (e.g., unprotected sex with one or more people who are HIV positive or **whose HIV status is unknown**, sex under the influence of drugs/alcohol, injection drug use) and want to decrease their risk of contracting HIV. PrEP is over 90% effective at preventing HIV transmission, but its effectiveness is greatly reduced if it is not consistently taken.[71] Patients taking PrEP still need to use condoms to prevent transmission of other STIs. PEP is antiretroviral drugs taken as an emergency intervention within 72 hours of exposure to a high-risk event to reduce the likelihood of HIV seroconversion.[72]

When physicians learn about high-risk behaviors, they often counsel the patient to stop the behavior. However, behavioral choices about sex and substance use are extremely complex. Many patients continue high-risk behaviors for a variety of reasons, including pleasure, affection, physical connection, substance addiction, and/or exchange for resources. One recommended strategy is to nonjudgmentally assess how much the patient knows about HIV, then educate that individual as needed about which behaviors carry a higher risk of contracting HIV and how to decrease the risk of infection by taking medication (PrEP) daily. This gives a patient the option to express the desire to try medication as a risk-reducing strategy recommended by their doctor. As with cross-sex hormone therapy, physicians unfamiliar with prescribing HIV-related medications usually overestimate the risk associated with taking PrEP/PEP. The Fenway Institute has a PrEP Action Kit with information about prescribing and monitoring PrEP,[73] and it is crucial for providers to learn about the actual evidence for toxicity or adverse outcomes of PrEP/PEP and realistically contrast this with each patient's risk of contracting HIV related to their exposure behavior. As with all preventive care and risk reduction strategies, providers should use behavioral rather than demographic or sexual/gender identity information when recommending HIV screening, PrEP, and PEP to patients. Cisgender straight patients who engage in the same high risk behavior (unprotected sex with one or more people who are HIV positive or **whose HIV status is unknown**, sex under the influence of drugs/alcohol, injection drug use) also benefit from HIV screening, PrEP, and PEP.

VACCINES

Current vaccination considerations are typically based on cis-normative demographic information that assumes behaviors. Multiple factors influence a patient's personal health risk, including their own practices as well as that of their current and previous partner(s). The use of barrier methods during sexual activity may be low if partners cannot conceive or if an individual uses another form of birth control,[74-76] thus increasing the risk of some disease transmissions. Therefore, rather than assessing risk based on demographic factors (such as whether a person identifies as LGBTQ), providers should determine risk based on the individual patient's history and practices. However, any patient's behavior could change at any time. The provider should have a conversation about the implication of future behavior change if the provider (and/or the patient) were to determine that vaccination is not indicated at this time. Regional recommendations may vary depending on local outbreaks (e.g., current outbreaks of Hepatitis A for the general population in Kentucky[77] and meningitis outbreaks among men who have sex with men in New York City[78]). The following page shows behavior-based recommendations for some common vaccinations.

Vaccine	Transmission	Recommendation
Human Papilloma Virus (HPV)	Transmitted through bodily fluids or skin contact during unprotected sex (including any combination of penile/vaginal/anal/oral sex[79] and/or sex toy use[80]).	Ideally all individuals will be vaccinated before HPV exposure at sexual debut: recommend to anyone age 11-26 regardless of gender identity or sexual orientation.[79] The FDA recently expanded approved ages as vaccination is low risk and may confer protection against infection or cytological abnormalities in older patients (including individuals with HPV infection history),[81] but insurance may deny coverage. Discuss catch-up vaccination with all patients ages 27-45, especially for individuals with limited sexual activity (HPV exposure). This is an evolving area. Vaccination is not contingent on negative HPV DNA tests or negative pap tests for any patient.[79]
Hepatitis A	Transmitted through the fecal-oral route, placing individuals having anal or oral-anal sex at higher risk.	Behavior-based recommendation (anal sex, anyone, and social determinants of health like housing access) versus CDC guidelines of men who have sex with men (MSM) only;[82] other indications for vaccine (international travel) mean that insurance is likely not a factor and benefits outweigh risk.
Hepatitis B	Transmitted through bodily fluids during unprotected sex.	Behavior-based recommendation (unprotected sex, anyone) versus CDC recommendation of MSM or 1+ partners;[83] LGBTQ prevalence drives recommendations but demographic guidelines can perpetuate disparities and miss indications.
Meningococcal	Transmitted through respiratory and throat secretions.	All pre-teens and teens should be vaccinated; unvaccinated adults at higher risk (dormitory-style accommodations, having HIV) should be vaccinated.[84]

REPRODUCTION AND FAMILY PLANNING

Some aspects of reproduction and family planning have special considerations for LGBTQ/DSD individuals. It is important to avoid making assumptions about LGBTQ/DSD patients' parenting desires. Instead, ask about their goals, then help them determine their parenting options. These patients experience multiple obstacles to becoming parents, such as financial burdens (e.g., the cost of fertility treatments, surrogacy, or adoption), social challenges (e.g., discrimination of reproductive endocrinology programs and adoption agencies), and legal hurdles (e.g., adoption rights by LGBTQ people is being litigated in some states, and local laws regarding surrogacy and donor gametes vary). However, all major professional health organizations have issued statements supporting adoption and parenting by LGBTQ individuals.[85] In addition, providers should be aware of the many microaggressions experienced by LGBTQ patients related to family planning (such as asking "Who's the real mother?" or "Did you use a sperm donor?"—see Part I). For LGBTQ families, providers can avoid using the names "mother" and "father" until they establish what terminology the parents use at the first visit. Support, affirmation, and acceptance is crucial in a world that often perceives LGBTQ/DSD people as different or objects of inappropriate and invasive curiosity.

Contraception – Understanding sexual behavior of patients is important to determine what, if any, contraception is needed (in addition to safe-sex practices). For DSD-affected patients, providers must discuss contraception goals and suitability for the specific patient dependent on past medical history, hormonal profile, and present anatomy. Sexual exploration with partners of male, female, or another gender is extremely common (particularly among LGBTQ youth[86,87]), and unplanned sexual encounters can and do occur. Emergency contraception is a critical part of preventive care planning for patients who might conceive and do not wish to become pregnant, and thus **all** patients should be made aware of emergency contraception as an option for current or potential future sexual encounters.

Providers should affirm identities while counseling about contraception. You can address contraception for patients who identify as gay or lesbian and describe a history of only same-sex sexual encounters by validating the patient's current/past sexual behavior and indicating that you tell all of your patients about this option because behavior changes for some patients.

Although testosterone use typically prevents menses in patients on the female-to-male spectrum who retain their natal reproductive organs, an ovulatory state with testosterone use is not uncommon—thus making it is possible for trans men to become pregnant. Progestin and estrogen-progestin hormonal birth control options may interfere with hormone therapy for transgender patients, and many trans men are hesitant to use hormonal birth control even if they are not taking testosterone. Nonhormonal options, such as a copper intrauterine device (IUD), may be the best

option to discuss (although a discussion regarding heavy bleeding associated with copper IUDs is necessary). Barrier methods, including condoms or diaphragms, are other nonhormonal contraception options (keeping in mind that diaphragms do not provide STI protection and have higher failure rates than other listed methods[88]). Similarly, estrogen use typically slows spermatogenesis in male-to-female spectrum patients, but the patient may still produce sperm and theoretically could impregnate a partner with a uterus. Thus, all transgender patients taking hormone therapy should be counseled about contraception to determine the best options for them.

Fertility – DSD is associated with lower fertility, but in practice this will be highly patient-dependent.[89] For transgender patients taking hormones, fertility may be reduced with hormone use, and the reversibility of these effects are not definitively understood. It is advised that the provider explore family planning goals and effects on fertility before the patient transitions.[8] This is challenging for providers caring for transgender youth and will likely require subspecialty and counseling expertise.[6] If a trans man desires to become pregnant, he should be advised to cease testosterone use before attempting to become pregnant because of adverse effects on the fetus. Fertility preservation options for transgender patients desiring to start (and not later cease) hormone therapy include cryopreservation ("banking") of sperm, oocyte, embryo, and ovarian or testicular tissue.[6,90]

Family Planning Options – Like the broader population, LGBTQ/DSD people who want to parent have multiple options for achieving this goal. Unlike many non-LGBTQ/DSD people, they are impacted by "social infertility," as they are unable to conceive because of social, rather than solely medical factors.[91] The following table details concepts of assisted reproduction and the primary ways LGBTQ/DSD people become parents. The diversity of LGBTQ/DSD individuals and families means that a clinician cannot make assumptions about how a given LGBTQ/DSD identity becomes a family. Instead, providers should familiarize themselves with options available and ask for details as appropriate. Providers should be aware that not all options are available in all communities, and many are not covered by most health insurance policies and thus may be cost-prohibitive. New options (e.g., mitochondrial donation/three parent IVF) may become available in the future.

Providers who care for children should be aware of the needs of LGBTQ parents. Historically, LGBTQ parents had difficulty establishing full rights for both parents. When such recognition was possible, it usually involved prohibitively expensive legal procedures. While legal recognition of LGBTQ families has improved, some LGBTQ people do not have access to these processes. Lack of such recognition is problematic in the health care setting, as LGBTQ parents may be asked to "prove" their relationship to their children in order to seek treatment for them. LGBTQ parents are parents regardless of whether they have a genetic link to their children. Some health concerns and questions are related to genetics, but many are not. Communicate with LGBTQ parents on why genetic history may be relevant. Ask questions about genetics and family formation with sensitivity, and remain open and welcoming to the input of all parents, regardless of their genetic link to the child.

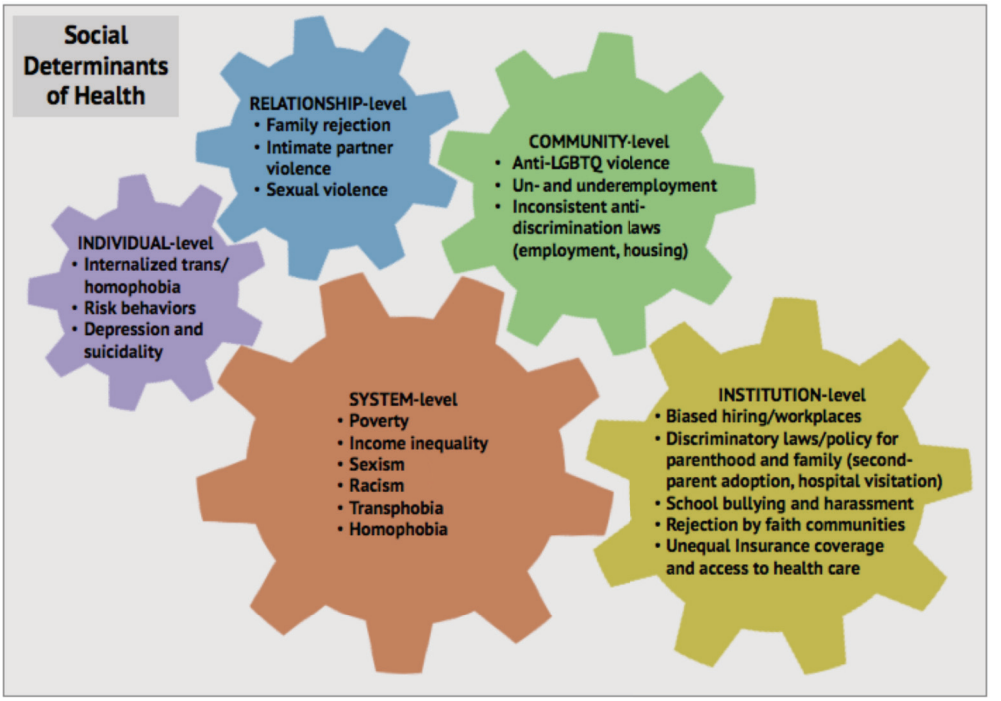
Developing skills around inclusive communication regarding family and reproduction (see Part 1) will benefit all of your patients, as non-LGBTQ parents also form families through adoption, surrogacy, gamete donation, and blending through remarriage.

Method	Description and Key Concepts	Legal, Social, and Financial Considerations
Conception	Some LGBTQ/DSD individuals can achieve pregnancy through penis-vagina sexual intercourse.	Not an option for many LGBTQ/DSD people.
Donor gametes (egg, sperm, embryos)	Use of sperm or eggs from a donor to conceive. Donor gametes can be from known (usually a friend or family member) or unknown donors (usually from a sperm or egg bank). Donor embryos (e.g., remaining from IVF cycles of unrelated people) may also be used.	Financial costs are often an issue. Local regulations about donor gametes vary. Individuals using a known donor may be at legal risk if the donor changes their mind and seeks custody.
Insemination	Insertion of sperm into the vagina, cervix, or uterus using a tool (typically a catheter). Usually performed by a fertility specialist, but individuals can do this at home using a needleless syringe.	Financial costs may be an issue depending on semen sampling processing, storage, and/or shipping expenses.
In-vitro fertilization (IVF)	Procedure in which eggs are harvested and fertilization is done outside the body in a lab and the viable embryo is transferred to the uterus.	Very expensive.
Reciprocal IVF	An egg from one FSAAB person is fertilized and then implanted in the other FSAAB person's uterus. Through this method, one partner is the genetic parent and the other is the gestational parent.	Very expensive. Legality and legal consequences (parental rights, adoption requirements, etc.) vary by state. This is a co-maternity option for lesbian couples and others.
Surrogacy	With "traditional" surrogacy, a FSAAB surrogate's egg is inseminated with sperm of the intended parent. With gestational surrogacy, a FSAAB surrogate is implanted with the embryo created through IVF on behalf of non-gestational intended parent(s). The gestational surrogate does not contribute gametes, and the embryo may or may not be made from gametes from the intended parent(s).	Theoretically available to all people, but cost and legal barriers are significant. Surrogacy is not allowed in all U.S. states. This is one of the few options available to gay men (MSAAB) who want to have genetically related children.
Adoption	Adoption is the legal and social process by which an adult or adults becomes the parent of a genetically unrelated child. Types of adoption include: • Domestic, private: adoption is facilitated by a private agency with the aid of attorneys • Domestic, from foster care: adoption is facilitated by state Child Welfare agencies • Domestic, open adoption: usually private with the goal that the child may continue to have a relationship with birth parent(s) • International: adoption of children born outside of the U.S. by U.S. citizens • Second-Parent Adoption: some states require an LGBTQ partner of the biological or gestational parent to adopt their own child if the couple is not married	Available to all, but cost and legal barriers are significant. Adoption by same-sex couples is very recently legal in all 50 U.S. states, but some local governments and adoption agencies might exhibit discriminatory behavior toward LGBTQ people who want to parent through adoption.[92] Few nations currently involved in international adoption will allow the adoption of children by out LGBTQ couples. Second-parent adoption requirements create legal, financial, and insurance burdens for many LGBTQ parents; this legal area is rapidly evolving.

PART IV: SOCIAL DETERMINANTS OF HEALTH

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are structural factors that impact health, such as conditions in which an individual grows up or lives (see figure for some examples). These factors can influence the psychological and physical well-being of patients. As a physician, it is important to screen **all** patients and determine when it is appropriate to call in housing, social, or other interprofessional support for patients. Providers should educate themselves about what services are available in their city or region and consult these services if they feel that the patient is at immediate risk of hurting themselves or at risk of being hurt by their living conditions. The American Academy of Family Physicians EveryONE project[93] (see Appendix A) has excellent screening resources for social needs.



Much of the information regarding SDOH is related to systemic factors and understanding non-medical influences in LGBTQ/DSD patient health. Every preventive health visit needs to revisit questions of social determinants of health for **all** patients. Providers should avoid the assumption that an individual's living situation, employment, relationships, risk behaviors, or identities remain static from visit to visit. Below are additional considerations that affect the psychological and social aspects of patients' health. Because of the high prevalence of some psycho-social issues in the LGBTQ/DSD population, providers should make LGBTQ/DSD patients aware of the availability of mental health, substance abuse, intimate partner violence, and social support services if they or someone they know ever needs to access these services. Providers who work in

a setting without an up-to-date, single-source list of community resources will need to rely on internet searches and real time networking with other providers and community organizations to find the right resource(s) for patients. If social work and/or case management services through the provider's clinic are available, the provider should attempt to set up a social work consultation and connect to social services to address any SDOH concerns by using healthcare systems tools to provide interdisciplinary support. The following table provides an overview of SDOH that impact all patients, with particular relevance to LGBTQ and/or DSD-affected people. (See Appendix A for follow-up resource links).

SDOH Aspect	Importance to Patients	Screening	Follow-up for LGBTQ/DSD Patients
Mental Health	LGBTQ/DSD individuals are at increased risk for depression, anxiety, and suicidal ideation,[47,94,95] particularly LGBTQ youth[28] and trans individuals.[12]	Perform standard screening regarding mental health for all patients (PHQ2[96] and/or PHQ9[97]).	If yes, depending on severity, provide or refer for counseling; if no, describe resources the office/others provide (National Suicide Prevention Lifeline or Trevor Project for youth) should they/someone they know need help.
Substance Abuse	The LGBTQ community experiences considerable disparities related to elevated smoking,[11] drug use,[98] and alcohol abuse.[99]	Perform standard screening of substance use/abuse for all patients.	If yes, determine patient readiness or motivation for change and refer to applicable support services. If no substance abuse, make patient aware of resources the office provides should they or someone they know need them.
Diet and Exercise	LGBTQ youth are more likely to use hazardous weight-control methods[100] and less likely to be physically active.[101] Obesity rates are higher for lesbian and bisexual women.[102]	Perform standard screening regarding diet, exercise, and body image for all patients.	Attempt to understand the context of extreme or unhealthy behaviors and barriers that prevent healthy behavior, and refer to mental health resources focusing on unhealthy eating/body image behaviors.
Social Support	LGBTQ social support may come from so-called "families of choice" whose support and care roles are similar to blood relatives for non-LGBTQ individuals.[103]	Ask all patients about social support networks.	If the patient lacks social support, refer them to LGBTQ social networks (in Louisville, this includes Louisville Youth Group and trans-specific groups like Louisville Trans Men and Trans Women National).
Poverty	Poverty rates for LGBQ adults are as high/higher than for straight adults,[104] and much higher for trans individuals;[12] health insurance coverage is substantially lower.[105]	Discuss living conditions with all patients.	If yes, identify your community's organizations that can help with basic needs such as public assistance (food stamps), Medicaid, employment assistance, and housing provision.
Housing and Homelessness	40% of individuals served by homeless youth organizations are LGBTQ youth, often related to lack of support at home and family rejection.[26]	Discuss access to housing and housing stability with all patients.	If yes, attempt to refer the patient to an LGBTQ-friendly or LGBTQ-specific housing resources (like YMCA Safe Place).
Intimate Partner Violence	LGBTQ individuals experience high levels of intimate partner violence compared to straight, cisgender individuals.[106,107]	Privately screen all patients for past/ present intimate partner violence (e.g., "Do you feel safe at home?").	If yes, The Network/La Red's 24-hour hotline provides confidential support and safety planning. If no history of current/past intimate partner violence, make patient aware of resources that the office provides should they or someone they know need them.

LEGAL AND INSURANCE CONSIDERATIONS

When making recommendations to patients, insurance coverage or lack thereof is an important consideration. LGBTQ individuals are less likely to be insured than cis/heterosexual counterparts.[12,105] Services based on behavior may also fall outside of demographic-based guidelines (e.g., anal pap tests). Providers should familiarize themselves with coverage policies regarding these recommendations so that they may 1) have an informed conversation with patients to allow them to consider the benefit of screening versus potential out-of-pocket costs and 2) help patients apply to the insurance provider for an exception to noncovered services with an appropriate rationale outside the guidelines. If noncovered services are unaffordable for a patient, providers should consider whether there are other measures that the patient could take to lower their risk. Providers should also reach out to clinic case management services to identify resources. The Centers for Medicare and Medicaid Services (CMS) and The National Uniform Billing Committee have approved a special billing code (condition code 45 - Ambiguous Gender Category) to alleviate situations where claims are incorrectly denied for transgender and DSD-affected beneficiaries because of a mismatch between the gender marker and the billing service.[108]

Structural barriers that affect LGBTQ and DSD health include legal and insurance policies that allow discrimination against LGBTQ and DSD-affected individuals. Many of these policies vary from state to state, but providers should be aware of policies such as unequal, patchwork, and cost–prohibitive insurance coverage for domestic partnerships in private and public sectors; employer-based insurance that allows discrimination for sex and gender minorities; Title IX coverage of gender identity; and state-by-state policies allowing discrimination based on sexual orientation and/or gender identity for job, housing, and some public services. Other public policies have shown growth, including LGBTQ health included as federal priority in Healthy People 2020. Expanded Affordable Care Act (ACA) regulations and insurance access allowed many people who had not previously received coverage to do so, including those with preexisting conditions; protections against insurance discrimination for sex and gender minorities (ACA Section 1557) also improved coverage for many LGBTQ individuals. However, many of these policies are in flux, so providers will need to determine how changes to public policy affect their LGBTQ and DSD-affected patients.

Name and gender-change processes for identification documents can be prohibitively complicated and expensive for transgender patients. One third of transgender people have not updated any IDs after transitioning,[12] and many encounter insurance and legal issues (e.g., starting jobs, traveling) when 1) their used name does not match their legal name or appearance or 2) when ordered preventive/diagnostic care does not match the sex on insurance identification (but see above). For the patient, navigating these systems can be a significant source of stress. Trans social support networks and advocacy groups are excellent resources for advice and supportive services. State-by-state ID policies can be found at the National Center for Transgender Equality (see Appendix A).

To change some identification documents, transgender patients must obtain a letter from their provider confirming their gender transition. Providers should indicate that the patient "has transitioned" under the provider's care rather than "is transitioning." The language used in the letter is consequential, and it is important to refer to the transition in past tense. For example, adult patients with a past-tense letter will be issued a standard 10-year passport, whereas with a present-tense letter only a limited validity 2-year passport is issued.

PART V: SENSITIVE PHYSICAL EXAMS

KNOW YOUR PATIENT

Physical examinations, particularly of sensitive parts of the body, such as genitals or breasts/chest, can be distressing to any patient. These exams can be more challenging for patients who have experienced trauma (e.g., sexual abuse), mistreatment (e.g., voyeuristic or inappropriately curious/intrusive behavior from previous providers), or gender dysphoria (e.g., the existence of body parts that do not match an individual's gender identity).

To prepare for sensitive exams, the provider should discuss why the exam is important and ask about the patient's experiences with previous exams.[7] This enables the provider to address any anxiety the patient feels about proceeding with the exam and discuss options to make their experience less stressful. It is important to note that not all LGBTQ patients and individuals born with DSD have experienced trauma, but the guiding principles of trauma-informed care for physical exams can help build a trusting relationship between providers and **all** patients.[109] They include

1) placing control over consent to the exam and ability to stop the exam with the patient,
2) engaging in shared decision-making of examination options (positioning, chaperones, etc.),
3) explaining the procedure by narrating each step and using preferred terminology,
4) informing the patient that modifications to the procedure are available, and
5) acknowledging and validating a history of trauma and/or previous negative experiences.

INCLUSIVE LANGUAGE FOR EXAMS AND ENCOUNTERS

Mirroring a patient's own language in regard to anatomical terms can facilitate comfort during sensitive exams, particularly for patients who providers have established are not cisgender. During initial discussions, providers should **ask patients how they refer to their body parts** or specific bodily functions since language used will be patient-specific ("What language do you typically use when talking about your body?"). For patients who are on the male-to-female spectrum or female-to-male spectrum, providers should also choose words that are less gendered to provide a less stressful environment for a medical history and/or exam. Examples include:

Gendered Language	More Inclusive or Less-gendered Options *(FtM language from Potter et al. 2015[110])*
Breast	Chest (for FtM spectrum patients)
Chest	Breast (for MtF spectrum patients)
Penis/Testes	Front, Reproductive parts, External genitals
Vagina	Front, Genital opening, Frontal pelvic opening
Vulva, Labia	Outer parts, Outer folds
Uterus, Ovaries	Internal parts, Internal organs
Pap smear	Pap test, Cancer screening
Bra, Panties, Boxers	Underwear
Pads, Tampons	Absorbent product
Period, Menstruation	Bleeding
Breastfeeding	Chestfeeding

Other language choices can help optimize the comfort of patients during sensitive exams:

Negative Language	Neutral Language *(From Potter et al. 2015[110])*
"Open your legs"	"Let your legs drop to either side"
"Speculum blades"	"Bills of the speculum"
"You may feel a poke/prick/pinch"	"You may feel some pressure"

STRATEGIES AND OPTIONS TO OPTIMIZE COMFORT

Trauma-informed care (see Part III) involves empowerment, voice, and choice. In addition to language choices, there are other ways for providers to optimize comfort for all patients during sensitive exams, including offering alternative screening options compared to more invasive clinical screenings (see the following page). General strategies also include allowing other providers (e.g., of a different gender) to perform the test, allowing the patient to bring a support person to the appointment, and ensuring that the patient understands that they can ask to stop the exam.[7] Many postoperative transgender patients and DSD-affected individuals report that providers have allowed students or other providers to watch sensitive examinations or perform an additional examination.[38,39] This is a significant problem because it dehumanizes and objectifies patients. Providers have a responsibility to prevent this voyeuristic behavior, even in the context of teaching. If it is appropriate for a learner to be present, the provider should ask for the permission of the patient and limit the number of learners in the room. Before any exam, the provider should also discuss how the patient can stop the exam if necessary. If an exam is stopped due to patient distress, the provider should ensure that the patient has ample opportunity to reconstitute and has a firm self-care plan before leaving the office.[110]

Trauma-informed care involves empowerment, voice, and choice. This benefits all patients, regardless of their past experiences and medical history. The principles of trauma-informed care can improve all patients' experiences in all exams and medical encounters.

Gynecologic and Genitourinary Exams – Pelvic exams and cervical screenings are part of routine care, but they can feel invasive to many patients. Bimanual exams are indicated in symptomatic patients (e.g., pelvic pain) but not for screening asymptomatic patients.[57] For patients who feel uncomfortable with gynecologic exams, various steps make the experience more comfortable for the patient.[110] The clinic should identify patient preferences toward the gender of the provider and/or chaperone, if desired; it's important to make sure that required chaperones are not

perceived as voyeurs. The provider can make accommodations such as allowing the patient to only partially undress or not requiring use of foot rests or a lithotomy position. If discomfort or pain is a concern, the provider can use a small or pediatric speculum or an anoscope rather than a vaginal speculum. Low-dose topical estrogen can be administered to patients for one to two weeks before the exam to reduce cervical atrophy, although patients on the female-to-male spectrum may not want to introduce estrogen into their bodies. For male-to-female spectrum patients, a gynecologic exam can be affirming for those who have a neovagina. Other patients may "tuck" their testicles into the inguinal canal and penis/scrotum posteriorly in the perineal region, which can cause complications like urinary trauma or hernias.[6] Sensitively asking patients about the role of tucking in their well-being and any concerns allows the provider to educate about safety (e.g., not tucking as tightly).[111]

Anal/Rectal Exams – Comfort can be increased by ensuring that the patient maintains the locus of control during the exam and giving the patient options. Positioning for anal or rectal exams can be done standing, leaning, lying on the side, supine, and supine with the feet together and knees apart to expose the perineum. In practice, clinicians examining cis men usually perform digital rectal exams standing, although studies suggest that these patients actually prefer having the exam lying on their side.[112] Providers should use adequate lubricant, describe all steps of the procedure to the patient, and ask permission prior to proceeding.

Breast/Chest exams – Clinical breast exams are no longer recommended for routine cancer screening in asymptomatic patients,[54] but patients may present with conditions that indicate breast or chest examination. Providers should apply the same principles of trauma-informed care described above to breast and chest exams: explain the purpose and steps of the exam, obtain permission, proceed matter of factly, let the patient stop at any time, and use inclusive language. To create a flat chest appearance, some patients on the female-to-male spectrum may bind their chests with tight fitting sports bras, bandages, or binders created specifically for this purpose. These products may irritate the chest skin, cause fungal infections, and lead to other health issues.[113] Providers are advised to discuss binding practices and work with the patient to mitigate risk (e.g., by recommending "off days" if possible or hygienic practices to avoid infections).[6,113]

Alternatives to Clinical Exams – In some cases, patients may be able to complete routine testing through at-home sample collections rather than at a healthcare facility. These options could be desirable for patients who may feel uncomfortable in certain healthcare settings (e.g., frontal self-swabs for HPV for trans men who may feel uncomfortable visiting a gynecologist's office and would otherwise forego cervical cancer screening).

Disease	At-Home Test	Description
HPV	Various kits use PCR detection of high-risk HPV strains	Vaginal or anal fluid is self-swabbed at home and returned for detection of high-risk HPV strains, with future Pap test scheduling dependent on these results;[114] data is still being collected regarding the efficacy of at-home options, but it is strongly preferred to a cervical Pap test for female-to-male spectrum patients[110,115] and may be a future suitable alternative to assess initial anal/cervical cancer risks from HPV for any patient who feels uncomfortable undergoing annual anal or gynecological exams.
STI	Various kits use PCR detection of chlamydia and gonorrhea	Oral/genital fluid is self-swabbed or urine collected at home and returned to a laboratory for detection gonorrhea and chlamydia in lieu of provider-collected swabbed samples during a pelvic exam or STI screening; positive results should be confirmed by a provider; studies show patients overwhelmingly prefer at-home kits.[116]
HIV	OraQuick In-Home HIV Test	Oral fluid is self-swabbed at home and either tested with a kit at home (results in 20 minutes) or submitted for detection of HIV antibodies with similar accuracy in comparison with blood-based specimens high-prevalence settings;[117] studies show that people prefer the oral method of screening.[118]
	Home Access HIV-1 Test System	Blood is collected at home from a finger prick; this sample is sent anonymously to be processed in a licensed laboratory and results can be available the next business day with counselling and referrals options provided over the phone; these samples have been shown to have complete sensitivity and specificity of venous samples.[119]

CONCLUSION

NEXT STEPS

At the end of the content section of this manual, you should now be ready to employ the best practices that you have learned in this manual. As a reminder, this intervention is meant to provide a nuts and bolts approach to LGBTQ health—you will learn much more by having thoughtful, open conversations with all of your patients.

LGBTQ health is a rapidly evolving area, so providers must be sure to use lifelong learning skills to keep updated as new research findings and best practices emerge. The goal is to always aspire to provide the best possible care for each patient, regardless of sexual orientation or gender identity.

Appendix A includes several nationally-renowned and evidenced-based resources to close any remaining knowledge gaps or to allow for more in-depth exploration of specific topics. One of the best "go-to" resources is The National LGBT Health Education Center (part of the Fenway Institute), which is an established resource for LGBTQ healthcare and has excellent online resources for providers and patients. For specifics on transgender clinical care, The World Professional Association for Transgender Health (WPATH) and The Center of Excellence for Transgender Health out of the University of California, San Francisco provide detailed, evidence-based clinical recommendations and research summaries. You will find links to these and other comprehensive resources on the following page.

APPENDIX A - NATIONAL RESOURCES

LGBTQ/DSD HEALTHCARE RESOURCES FOR PROVIDERS AND PATIENTS

These comprehensive, definitive healthcare resources can supplement your primer on LGBTQ/DSD health, and many provide excellent information for patients as well.

Accord Alliance - http://www.accordalliance.org/
This non-profit supports shared decision making to enhance the care of individuals affected by differences of sex development (DSD). Their online resources include clinical guidelines for managing DSD in childhood, a handbook for parents of DSD-affected individuals, and content for DSD-affected patients.

Center of Excellence (CoE) for Transgender Health – http://transhealth.ucsf.edu/
The CoE at the University of California, San Francisco provides comprehensive resources for gender-affirming care, including dependable evidence-based primary care guidelines. This is a go-to resource for physicians for all aspects of gender-affirming care.

Centers for Disease Control (CDC) and Prevention – https://www.cdc.gov/lgbthealth/
The CDC website provides research, fact sheets, and briefs for providers and patients.

EveryONE Project – https://www.aafp.org/patient-care/social-determinants-of-health/cdhe/everyone-project.html
This project by the American Academy of Family Physicians has excellent screening tools and resources to help family physicians address social determinants of health in their practices and communities.

Gay and Lesbian Medical Association (GLMA) - www.glma.org
This professional association advocates for LGBT health equality for patients and providers. Their site has continuing education opportunities and a directory of accepting, affirming health providers for patients.

Human Rights Campaign (HRC) Foundation Healthcare Equality Index - http://www.hrc.org/hei
HRC advocates for LGBTQ equality and publishes the Healthcare Equality Index (HEI), which evaluates healthcare facilities' policies and practices related to the LGBTQ equity and inclusion. Their site provides free online education and CME credit for facilities in the current HEI survey.

National LGBT Cancer Network - https://cancer-network.org/
The network advocates for LGBTQ cancer survivors, educates LGBTQ community members about cancer risks and screenings, and developed a national directory of LGBT-friendly cancer treatment facilities. For providers, it offers best practices for LGBTQ patients through the stages of cancer.

National LGBT Health Education Center - https://www.lgbthealtheducation.org/
This is part of the Fenway Institute, which is one of the world's largest LGBT-focused health centers. Their acclaimed website provides comprehensive LGBTQ health educational resources, including various online training modules offering continuing medical education (CME) credit.

OutCare Health - http://www.outcarehealth.org
This is a non-profit allowing health providers to identify themselves as being LGBTQ friendly and knowledgeable, and patients can identify providers through their searchable directory. OutCare started in the Midwest, but their membership is expanding nationwide.

Population Research in Identity and Disparities for Equality (PRIDE) Study – https://pridestudy.org/
This is the first longitudinal health study of LGBTQ people. Patients who identify as a sexual or gender minority can enroll and complete the PRIDE study health questionnaire to determine how health in the LGBTQ community changes over time, which will help fill substantial research gaps.

Veterans Affairs (VA) - https://www.patientcare.va.gov/LGBT/index.asp
The VA and Veterans Health Administration provide online education webinars for patient-centered approaches to work with LGBTQ veterans, gender-affirming care, and other health topics. VA policy information concerning LGBTQ veterans can also be found through this website.

The World Professional Association for Transgender Health (WPATH) – https://www.wpath.org
This non-profit, interdisciplinary professional organization is devoted to transgender health and publishes the evidence-based Standards of Care with primary care, gynecologic/urologic care, reproductive options, voice/communication therapy, mental health services, and hormonal/surgical treatments.

LGBTQ/DSD COMMUNITY AND SUPPORT RESOURCES

Below are resources for LGBTQ/DSD patients, including national and regional organizations. Visit the eQuality website (louisville.edu/medicine/equality/) for a full list of local and regional resources for Louisville, Kentucky. For providers and medical educators outside of Louisville, local resources can be found by contacting affiliated campus LGBTQ student services or by contacting a local LGBTQ services center, which can be identified through the CenterLink LGBT Community Center Member Directory (https://www.lgbtcenters.org/LGBTCenters).

AIS-DSD Support Group – **http://aisdsd.org** This non-profit organization provides peer support and education to adults, youth, and families affected by androgen insensitivity syndrome (AIS) and differences of sex development (DSD); resources include an annual national conference for individuals with DSD (and/or their families) to meet and learn more about DSD.
Louisville Trans Men – **https://louisvilletransmen.com/** This peer-led group in Louisville, Kentucky is an informal support system with monthly meetings and resources for anyone who is 18 years of age or older, who was assigned female at birth, and who identifies on the female-to-male spectrum (e.g., trans men, genderqueer, gender non-conforming, and others).
Louisville Youth Group – **https://louisvilleyouthgroup.org/** This local group of community mentors and volunteers aims to provide a safe space for LGBTQ young adults to socialize with LGBTQ peers, to promote personal growth through relationship building and leadership development, and to foster community growth through social justice activism.
National Suicide Prevention Lifeline – **https://suicidepreventionlifeline.org/help-yourself/lgbtq/** This 24/7 network provides free, confidential emotional support for people in distress; the US Substance Abuse and Mental Health Services Administration (SAMHSA) and Vibrant Emotional Health launched the lifeline to also provide best practices for professionals and prevention/crisis resources to individuals and loved ones; the link above has specific resources for the LGBTQ community and allies.
The Network/La Red – **http://tnlr.org/en/** This national survivor-led, social justice organization works to end partner abuse in LGBTQ communities. Their 24-hour hotline provides free, confidential emotional support, information, and safety planning for LGBTQ community members experiencing domestic violence as well as their friends, coworkers, or family.
Transwomen National – **https://www.transwomennational.org/** This local peer-led group in Louisville, Kentucky is an informal support system to empower and support transgender women with group meetings, outings, and resources.
Trevor Project: Saving Young LGBTQ Lives – **https://www.thetrevorproject.org** This national organization provides crisis intervention and suicide prevention services to LGBTQ young people under 25 years of age, including the free 24/7 TrevorLifeline crisis intervention and suicide prevention phone service. Other text, chat, and online support services are also available.
National Center for Transgender Equality – **https://transequality.org/** This social justice advocacy organization works to end discrimination for transgender people. Their site aggregates information on various services (identification, employment, health/Medicare, military, etc.) with state-by-state policies in their ID Documents Center (https://transequality.org/documents).
The Williams Institute – **https://williamsinstitute.law.ucla.edu/** This is a committee at UCLA Law that produces influential, independent research on the intersection of public policy with sexual orientation and gender identity law. The Williams Institute is a reliable resource to learn about LGBTQ discrimination, demographics, and other LGBTQ community and law statistics.
YMCA Safe Place Services – **http://ymcasafeplaceservices.org/** This local service is a branch of the YMCA of Greater Louisville that provides youth, teens, and young adults in crisis somewhere to stay, someone to trust, or someone to listen. Safe Place aims to provide help, hope, and healing to teens and families in crisis, including LGBTQ youth.

APPENDIX B – GLOSSARY

Definitions are sourced and adapted from ***The Safe Zone Project***.[120]

Ally – (*noun*) a (typically straight- or cis-identified) person who supports and respects members of the LGBTQ community. While the word does not necessitate action, we consider active allies to be people who take action upon this support and respect, which also demonstrates to others that you are an ally.

Asexual – (*adjective*) having a lack of (or low level of) sexual attraction to others and/or a lack of interest or desire for sex or sexual partners.

Biological Sex – (*noun*) a medical term used to refer to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female or male or intersex. Often referred to as simply "sex," "physical sex," "anatomical sex," or specifically as "sex assigned [or designated] at birth (SAAB)."

Bisexual – (*adjective*) a person emotionally, physically, and/or sexually attracted to male/men and females/women. Other individuals may use this to indicate an attraction to individuals who identify outside of the gender binary as well and may use bisexual as a way to indicate an interest in more than one gender or sex (i.e. men and genderqueer people). This attraction does not have to be equally split or indicate a level of interest that is the same across the genders or sexes an individual may be attracted to.

Cisgender – (*adjective, pronounced "siss-jendur"*) a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned). A simple way to think about it is if a person is not trans, they are cisgender. The term "cisgendered" is a common mistake.

Cisnormativity – (*noun*) the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans identities or people. Leads to invisibility of noncisgender identities.

Coming Out – (*verb*) (1) the process by which one accepts and/or comes to identify one's own sexuality or gender identity (to "come out" to oneself). (2) The process by which one shares their sexuality or gender identity with others (to "come out" to friends, etc.).

Differences of Sexual Development (DSD) - (*noun*) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female; sometimes referred to as intersex; formerly known as hermaphrodite (or hermaphroditic), but these terms are now considered outdated and derogatory. Some texts still use "Disorders" of Sexual Development for DSD, which patients also find demeaning.

Feminine Presenting; Masculine Presenting - (*adjective*) a way to describe someone who expresses gender in a visibly feminine or masculine way (for example in hair style, demeanor, clothing choice, or style) that is characteristic or associated with the gender concepts in a given society.

FSAAB – (*adjective*) abbreviation for female sex assigned at birth.

FtM/F2M; MtF/M2F – (*adjective*) abbreviation for female-to-male transgender person; abbreviation for male-to-female transgender person.

Gay – (*adjective*) (1) a term used to describe individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex and/or gender. More commonly used when referring to males/men-identified people who are attracted to males/men-identified people, but can be applied to females/women-identified people as well. (2) An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

Gender Affirming Surgery – (*noun*) surgical options that alter a person's biological anatomy. "Sex Reassignment Surgery" was a term used by some medical professionals, but gender affirming surgery is considered to be a more appropriate term. Some people refer to the different surgical procedures as "top" surgery (construction of a male-type chest or breast augmentation for a female-type chest) and "bottom" surgery (various genital reconstruction surgeries that can involve genital removal and/or genital construction) to discuss what type of surgery they are having without having to be more explicit.

Gender Binary – (*noun*) the idea that there are only two genders – male/female (or man/woman) and that a person must be strictly gendered as either/or.

Gender Expression – (*noun*) "gender presentation" or the external display of one's gender through a combination of dress, demeanor, social behavior, and other factors; generally measured on scales of masculinity and femininity. Note that gender expression may not always match a person's actual gender identity (i.e., you can't always know someone's gender identity by looking). Some people may also express a gender because of safety or work/family/social expectations, but may actually have a different gender identity than that presented.

Gender Fluid - (*adjective*) gender fluid is a gender identity best described as a dynamic mix of male and female. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man some days, and more woman other days.

Gender Identity – (*noun*) the internal perception of one's gender, and how they label themselves, based on how much they align, or do not align, with what they understand their options for gender to be. Common identity labels include man, woman, genderqueer, trans, and more.

Gender Non-Conforming (GNC) - (*adjective*) someone whose gender presentation, whether by nature or by choice, does not align in a predictable fashion with gender-based expectations.

Genderqueer - (*adjective*) a gender identity label often used by people who do not identify with the binary of man/woman; or as an umbrella term for many gender nonconforming or nonbinary identities (e.g., agender, bigender, genderfluid).

Heteronormativity – (*noun*) the assumption, individually or institutionally, that everyone is heterosexual, and that heterosexuality is the norm or is superior to all other sexualities; can lead to the invisibility or stigmatizing of other sexualities. Often included in this concept is a level of gender normativity and gender roles, the assumption that individuals should identify as men and women, and be masculine men and feminine women, or that men and women are the expected complementary pair.

Heterosexual – (*adjective*) a person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Also known as straight.

Homophobia/Biphobia/Transphobia – (*nouns*) umbrella terms for a range of negative attitudes (e.g., fear, anger, intolerance, resentment, erasure, or discomfort) and policies that an individual or institution may have against members of LGBTQ community. The term can also connote a fear, disgust, or dislike of being perceived as LGBTQ.

Homosexual – (*adjective*) a [medical] term used to describe a person primarily emotionally, physically, and/or sexually attracted to members of the same sex/gender. This term is considered stigmatizing due to its history as a category of mental illness, and is discouraged for common use (use gay or lesbian instead).

Lesbian – (*noun*) a term used to describe women attracted romantically, erotically, and/or emotionally to other women.

MSAAB – (*adjective*) abbreviation for male sex assigned at birth.

MSM/WSW - (*noun*) initialisms for "men who have sex with men" and "women who have sex with women," to distinguish sexual behaviors from sexual identities (e.g., because a man is straight, it doesn't mean he's not having sex with men).

Nonbinary - (*adjective*) umbrella term for genders that are not exclusively male/female (such as agender, bigender, genderfluid, genderqueer), and for individuals who may identify as nonbinary.

Outing – (*verb*) involuntary or unwanted disclosure of another person's sexual orientation, gender identity, or intersex status.

Questioning – (*verb, adjective*) exploring one's own sexual orientation or gender identity or an individual who is exploring their own sexual orientation and gender identity.

Queer – (*adjective*) used as an umbrella term to describe individuals who don't identify as straight; also used to describe people who have nonnormative gender identities. Queer is not used or embraced by all LGBTQ community members due to its historical derogatory use, but through linguistic reclamation it is indeed self-used by many LGBTQ community members.

Sex Assigned at Birth (SAAB) – (*noun*) a phrase used to distinguish between the sex that was assigned to an individual (typically male or female) and gender identity, which may not be the same.

Same Gender Loving/SGL – (*adjective*) a term traditionally used by members of the African-American/Black community to express an alternative sexual orientation without the perceived social or political implication of the term gay or lesbian.

Sexual Orientation – (*noun*) the type of sexual, romantic, emotional/spiritual attraction one feels for others, often labeled based on the gender relationship between the person and the people they are attracted to (often mistakenly referred to as sexual "preference").

Third Gender – (*noun*) a person who does not identify with either man or woman, but identifies with another gender. This gender category is used by societies, both contemporary and historic, that recognize three or more genders; is also a conceptual term meaning different things to different people who use it as a way to move beyond the gender binary.

Trans/Transgender – (*adjective*) (1) an umbrella term covering a range of identities that transgress socially defined gender norms or (2) a person who lives as a member of a gender other than that expected based on sex assigned at birth.

Transition(ing) – (*noun, verb*) primarily used to refer to the process a trans person undergoes when changing their bodily appearance either to be more congruent with the gender/sex they feel themselves to be and/or to be in harmony with their preferred gender expression.

Two-Spirit – (*noun*) is an umbrella term traditionally used by Native American people to recognize individuals who possess qualities or fulfill roles of both genders.

APPENDIX C – TOOLKIT REFERENCES

1. Gates GJ. In U.S., More Adults Identifying as LGBT. *Gallup*. January 11, 2017; http://news.gallup.com/poll/201731/lgbt-identification-rises.aspx. Accessed March 15, 2019.
2. Fausto-Sterling A. Of Gender and Genitals. *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books; 2000.
3. Blackless M, Charuvastra A, Derryck A, Fausto-Sterling A, Lauzanne K, Lee E. How Sexually Dimorphic Are We? Review and Synthesis. *American Journal of Human Biology : The Official Journal of the Human Biology Council.* 2000;12(2):151-166.
4. Gates GJ. In U.S., LGBT More Likely Than Non-LGBT to Be Uninsured. *Gallup*. August 26, 2014; http://www.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx. Accessed March 15, 2019.
5. AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD.* Washington, DC: Association of American Medical Colleges;2014.
6. Center of Excellence for Transgender Health. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.* Universtiy of California, San Francisco;2016.
7. Makadon H, Mayer K, Potter J, Goldhammer H. *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd edition.* Philadelphia: American College of Physicians; 2015.
8. World Professional Association for Transgender Health (WPATH). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7*th edition*.* 2012.
9. Reisner SL, Bradford J, Hopwood R, et al. Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health. *Journal of Urban Health.* 2015;92(3):584-592.
10. Holthouser A, Sawning S, Leslie KF, et al. eQuality: a Process Model to Develop an Integrated, Comprehensive Medical Education Curriculum for LGBT, Gender Nonconforming, and DSD Health. *Medical Science Educator.* 2017:1-13.
11. Lee JG, Griffin GK, Melvin CL. Tobacco Use Among Sexual Minorities in the USA, 1987 to May 2007 : A Systematic Review. *Tobacco Control.* 2009;18(4):275-282.
12. James S, Herman JL, Rankin S, Keisling M, Mottet LA, Anafi M. *The Report of the 2015 U.S. National Transgender Survey.* Washington, DC;2016.
13. Conron KJ, Mimiaga MJ, Landers SJ. A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health. *American Journal of Public Health.* 2010;100(10):1953-1960.
14. Barbara AM, Quandt SA, Anderson RT. Experiences of Lesbians in the Health Care Environment. *Women and Health.* 2001;34(1):45-62.
15. Mattocks KM, Sullivan JC, Bertrand C, Kinney RL, Sherman MD, Gustason C. Perceived Stigma, Discrimination, and Disclosure of Sexual Orientation Among a Sample of Lesbian Veterans Receiving Care in the Department of Veterans Affairs. *LGBT Health.* 2015;2(2):147-153.
16. Callon W, Beach MC, Saha S, et al. Assessing Problematic Substance Use in HIV Care: Which Questions Elicit Accurate Patient Disclosures? *Journal of General Internal Medicine.* 2016;31(10):1141-1147.

17. Hanyok LA, Hellmann DB, Rand C, Ziegelstein RC. Practicing Patient-Centered Care: The Questions Clinically Excellent Physicians Use To Get To Know Their Patients As Individuals. *Patient.* 2012;5(3):141-145.
18. Cahill S, Singal R, Grasso C, et al. Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers. *PLOS ONE.* 2014;9(9):e107104.
19. Haider AH, Schneider EB, Kodadek LM, et al. Emergency Department Query for Patient-Centered Approaches to Sexual Orientation and Gender Identity : The EQUALITY Study. *JAMA Internal Medicine.* 2017;177(6):819-828.
20. Pathela P, Hajat A, Schillinger J, Blank S, Sell R, Mostashari F. Discordance Between Sexual Behavior and Self-Reported Sexual Identity: A Population-Based Survey of New York City Men. *Annals of Internal Medicine.* 2006;145(6):416-425.
21. Saewyc EM. Adolescent Pregnancy Among Lesbian, Gay, and Bisexual Teens. In: Cherry AL, Dillon ME, eds. *International Handbook of Adolescent Pregnancy: Medical, Psychosocial, and Public Health Responses*. Boston, MA: Springer US; 2014:159-169.
22. Fenway Health. Transgender Health. 2017; http://fenwayhealth.org/care/medical/transgender-health/.
23. Gates GJ. How Many People Are Lesbian, Gay, Bisexual, and Transgender? Los Angeles, CA: The Williams Institute, UCLA School of Law; 2011. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf. Accessed March 15, 2019.
24. Noonan EJ, Sawning S, Combs R, et al. Engaging the Transgender Community to Improve Medical Education and Prioritize Healthcare Initiatives. *Teaching and Learning in Medicine.* 2018;30(2)119-132.
25. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine.* 1998;14(4):245-258.
26. Durso LE, Gates GJ. Serving Our Youth: Findings from a National Survey of Services Providers Working with Lesbian, Gay, Bisexual and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund; 2012. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf. Accessed March 15, 2019.
27. Kosciw JG, Greytak, E A, Bartkiewicz, MJ, Boesen, MJ, Palmer, NA. *The 2011 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools.* New York: GLSEN; 2012. https://www.glsen.org/sites/default/files/2011%20National%20School%20Climate%20Survey%20Full%20Report.pdf. Accessed March 15, 2019.
28. Marshal MP, Dietz LJ, Friedman MS, et al. Suicidality and Depression Disparities Between Sexual Minority and Heterosexual Youth: A Meta-Analytic Review. *The Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine.* 2011;49(2):115-123.
29. Liu RT, Mustanski B. Suicidal Ideation and Self-Harm in Lesbian, Gay, Bisexual, and Transgender Youth. *American Journal of Preventive Medicine.* 2012;42(3):221-228.
30. Mustanski BS, Garofalo R, Emerson EM. Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths. *American Journal of Public Health.* 2010;100(12):2426-2432.

31. Kentucky Revised Statutes. Diagnosis and Treatment of Disease, Addictions, or Other Conditions of Minor. In: *KRS 214.185*2005;2005. https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=8797. Accessed March 15, 2019.
32. Reagan P. The Interaction of Health Professionals and Their Lesbian Clients. *Patient Counselling and Health Education.* 1981;3(1):21-25.
33. White W, Brenman S, Paradis E, et al. Lesbian, Gay, Bisexual, and Transgender Patient Care: Medical Students' Preparedness and Comfort. *Teaching and Learning in Medicine.* 2015;27(3):254-263.
34. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education. *Journal of the American Medical Association.* 2011;306(9):971-977.
35. Steinmetz K. Why LGBT Advocates Say Bathroom 'Predators' Argument is a Red Herring. *Time*. May 2, 2016. http://time.com/4314896/transgender-bathroom-bill-male-predators-argument/. Accessed March 15, 2019.
36. Davis SA, Meier SC. Effects of Testosterone Treatment and Chest Reconstruction Surgery on Mental Health and Sexuality in Female-To-Male Transgender People. *International Journal of Sexual Health.* 2014;26(2):113-128.
37. Indyk JA. Disorders/Differences of Sex Development (DSDs) for Primary Care: The Approach to the Infant with Ambiguous Genitalia. *Translational Pediatrics.* 2017;6(4):323-334.
38. Erickson-Schroth L. *Trans Bodies, Trans Selves : A Resource For The Transgender Community.* Oxford ; New York: Oxford University Press, USA; 2014.
39. Dreger AD. Jarring Bodies: Thoughts on the Display of Unusual Anatomies. *Perspectives in Biology and Medicine.* 2000;43(2):161-172.
40. Wesp LM, Deutsch MB. Hormonal and Surgical Treatment Options for Transgender Women and Transfeminine Spectrum Persons. *Psychiatric Clinics of North America.* 2017;40(1):99.
41. Gorton RN, Erickson-Schroth L. Hormonal and Surgical Treatment Options for Transgender Men (Female-to-Male). *Psychiatric Clinics of North America.* 2017;40(1):79.
42. Deutsch MB, Feldman JL.. Updated Recommendations from The World Professional Association for Transgender Health Standards of Care . *American Family Physician.* 2013;87(2):89-93.
43. Henderson VW, Lobo RA. Hormone Therapy and the Risk of Stroke: Perspectives Ten Years After the Women's Health Initiative Trials. *Climacteric : The Journal of The International Menopause Society.* 2012;15(3):229-234.
44. Quinn VP, Nash R, Hunkeler E, et al. Cohort Profile: Study of Transition, Outcomes and Gender (STRONG) to Assess Health Status of Transgender People. *BMJ Open.* 2017;7(12):13.
45. Edwards-Leeper L, Spack NP. Psychological Evaluation and Medical Treatment of Transgender Youth in an Interdisciplinary "Gender Management Service" (GeMS) in a Major Pediatric Center. *Journal of Homosexuality.* 2012;59(3):321-336.
46. Wiesemann C, Ude-Koeller S, Sinnecker GHG, Thyen U. Ethical Principles and Recommendations for the Medical Management of Differences of Sex Development (DSD)/Intersex in Children and Adolescents. *European Journal of Pediatrics.* 2010;169(6):671-679.
47. Lewis NM. Mental Health in Sexual Minorities: Recent Indicators, Trends, and Their Relationships to Place in North America and Europe. *Health Place.* 2009;15(4):1029-1045.

48. Coulter RW, Birkett M, Corliss HL, Hatzenbuehler ML, Mustanski B, Stall RD. Associations Between LGBTQ-Affirmative School Climate and Adolescent Drinking Behaviors. *Drug and Alcohol Dependence.* 2016;161:340-347.
49. SAMHSA. Trauma-Informed Approach and Trauma-Specific Interventions. 2015; https://store.samhsa.gov/system/files/sma14-4884.pdf. Accessed March 15, 2019.
50. Schmidt E, Rizzolo D. Disease Screening and Prevention for Transgender and Gender-Diverse Adults. *Journal of the American Academy of PAs.* 2017;30(10):11-16.
51. National LGBT Cancer Network. LGBT Cancer Information. 2019. https://cancer-network.org/cancer-information/. Accessed March 15, 2019.
52. Holly EA, Whittemore AS, Aston DA, Ahn DK, Nickoloff BJ, Kristiansen JJ. Anal Cancer Incidence: Genital Warts, Anal Fissure or Fistula, Hemorrhoids, and Smoking. *JNCI: Journal of the National Cancer Institute.* 1989;81(22):1726-1731.
53. Ang CW, Dawson R, Hall C, Farmer M. The Diagnostic Value of Digital Rectal Examination in Primary Care for Palpable Rectal Tumour. *Colorectal Disease.* 2008;10(8):789-792.
54. US Preventive Services Task Force. Final Recommendation Statement - Breast Cancer: Screening. 2016; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1. Accessed March 15, 2019.
55. US Preventive Services Task Force. Final Recommendation Statement - Cervical Cancer: Screening. 2018. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening2. Accessed March 15, 2019.
56. American College of Obstetricians and Gynecologists. Cervical Cancer Screening and Prevention. *Practice Bulletin No. 168:* 2016; 128:e111–30.
57. US Preventive Services Task Force. Final Recommendation Statement - Gynecological Conditions: Periodic Screening With the Pelvic Examination. 2017; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/gynecological-conditions-screening-with-the-pelvic-examination. Accessed March 15, 2019.
58. US Preventive Services Task Force. Final Recommendation Statement - Colorectal Cancer: Screening. 2017; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2. Accessed March 15, 2019.
59. US Preventive Services Task Force. Final Recommendation Statement - Lung Cancer: Screening. 2016; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/lung-cancer-screening. Accessed March 15, 2019.
60. US Preventive Services Task Force. Final Recommendation Statement - Oral Cancer: Screening. 2013; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/oral-cancer-screening1. Accessed March 15, 2019.
61. US preventive Services Task Force. Final Recommendation Statement - Ovarian Cancer: Screening. 2018; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/ovarian-cancer-screening1. Accessed March 15, 2019.
62. US preventive Services Task Force. Final Recommendation Statement - Prostate Cancer: Screening. 2018; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1. Accessed March 15, 2019.63. US Preventive Services Task Force. Final Recommendation Statement - Skin Cancer: Screening.

2016; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/skin-cancer-screening2. Accessed March 15, 2019.
64. US Preventive Services Task Force. Final Recommendation Statement - Testicular Cancer: Screening. 2016; https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/testicular-cancer-screening. Accessed March 15, 2019.
65. Kolon TF, Herndon CDA, Baker LA, et al. Evaluation and Treatment of Cryptorchidism: AUA Guideline. *The Journal of Urology.* 2014;192(2):337-345.
66. UpToDate. Endometrial Carcinoma: Clinical Features and Diagnosis. 2016; https://www.uptodate.com/contents/endometrial-carcinoma-clinical-features-and diagnosis. Accessed March 15, 2019.
67. Johnson LG, Madeleine MM, Newcomer LM, Schwartz SM, Daling JR. Anal Cancer Incidence and Survival: The Surveillance, Epidemiology, and End Results Experience, 1973-2000. *Cancer.* 2004;101(2):281-288.
68. Quinn GP, Sanchez JA, Sutton SK, et al. Cancer and Lesbian, Gay, Bisexual, Transgender/Transsexual, and Queer/Questioning (LGBTQ) Populations. *CA: A Cancer Journal for Clinicians.* 2015;65(5):384-400.
69. Lindau ST, Schumm LP, Laumann EO, Levinson W, O'Muircheartaigh CA, Waite LJ. A Study of Sexuality and Health Among Older Adults in the United States. *New England Journal of Medicine.* 2007;357(8):762-774.
70. Bodley-Tickell AT, Olowokure B, Bhaduri S, et al. Trends in Sexually Transmitted Infections (Other Than HIV) in Older People: Analysis of Data from an Enhanced Surveillance System. *Sexually Transmitted Infections.* 2008;84(4):312-317.
71. Centers for Disease Control and Prevention. Pre-Exposure Prophylaxis (PrEP). 2018; https://www.cdc.gov/hiv/risk/prep/. Accessed March 15, 2019. 72. Centers for Disease Control and Prevention. PEP. 2018. https://www.cdc.gov/hiv/basics/pep.html. Accessed March 15, 2019.
73. National LGBT Health Education Center. PrEP Action Kit. 2017; https://www.lgbthealtheducation.org/prep-action-kit/. Accessed March 15, 2019.
74. Marrazzo JM, Stine K. Reproductive Health History of Lesbians: Implications for Care. *American Journal of Obstetrics and Gynecology.* 2004;190(5):1298-1304.
75. Hubach RD, Dodge B, Goncalves G, et al. Gender Matters: Condom Use and Nonuse Among Behaviorally Bisexual Men. Archives of Sexual Behavior. 2014;43(4):707-717.
76. Saewyc EM, Bearinger LH, Blum RW, Resnick MD. Sexual Intercourse, Abuse and Pregnancy Among Adolescent Women: Does Sexual Orientation Make a Difference? *Family Planning Perspectives.* 1999;31(3):127-131.
77. Commonwealth of Kentucky Cabinet for Health and Family Services. *Acute Hepatitis A Outbreak – Cases Reported in Multiple Counties.*; 2017. https://chfs.ky.gov/News/Documents/Acute%20Hepatitis%20A%20Outbreak%20-%20Cases%20Reported%20in%20Multiple%20Counties.pdf. Accessed March 15, 2019.
78. Centers for Disease Control and Prevention. Notes from the Field: Serogroup C Invasive Meningococcal Disease Among Men Who Have Sex with Men - New York City, 2010-2012. *MMWR Morbidity and Mortality Weekly Report.* 2013;61(51-52):1048.
79. Centers for Disease Control and Prevention. Human Papillomavirus (HPV) Vaccination and

Cancer Prevention. 2016; https://www.cdc.gov/vaccines/vpd/hpv. .Accessed March 15, 2019.
80. Anderson TA, Schick V, Herbenick D, Dodge B, Fortenberry JD. A Study of Human Papillomavirus on Vaginally Inserted Sex Toys, Before and After Cleaning, Among Women Who Have Sex with Women and Men. *Sexually Transmitted Infections.* 2014;90(7):529-531.
81. Wheeler CM, Skinner SR, Del Rosario-Raymundo MR, et al. Efficacy, Safety, and Immunogenicity of the Human Papillomavirus 16/18 AS04-Adjuvanted Vaccine in Women Older Than 25 Years: 7-Year Follow-Up of the Phase 3, Double-Blind, Randomised Controlled VIVIANE study. *Lancet Infectious Diseases.* 2016;16(10):1154-1168.
82. Centers for Disease Control and Prevention. Hepatitis A Vaccination. 2018; https://www.cdc.gov/vaccines/vpd/hepa/. Accessed March 15, 2019.
83. Centers for Disease Control and Prevention. Hepatitis B Vaccination. 2016; https://www.cdc.gov/vaccines/vpd/hepb/. Accessed March 15, 2019.
84. Centers for Disease Control and Prevention. Meningococcal Vaccination. 2017; https://www.cdc.gov/vaccines/vpd/mening/. Accessed March 15, 2019..
85. Lambda Legal and Child Welfare League of America. *What the Experts Say: Position and Policy Statements on LGBTQ Issues from Leading Professional Associations.* 2015. https://www.lambdalegal.org/sites/default/files/what_the_experts_say_2015.pdf. Accessed March 15, 2019.
86. Lowry R, Dunville R, Robin L, Kann L. Early Sexual Debut and Associated Risk Behaviors Among Sexual Minority Youth. *American Journal of Preventive Medicine.* 2017;52(3):379-384.
87. Kann, L, Olsen, EO, McManus, T. Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 — United States and Selected Sites, 2015*. MMWR Surveillance Summaries*. 2016;65(9):1-202.
88. Trussell J. Contraceptive Failure in the United States. *Contraception.*2004;70(2):89-96.
89. Slowikowska-Hilczer J, Hirschberg AL, Claahsen-van der Grinten H, et al. Fertility Outcome and Information on Fertility Issues in Individuals with Different Forms of Disorders of Sex Development: Findings from the dsd-LIFE study. *Fertility and Sterility.* 2017;108(5):822-831.
90. T'Sjoen G, Van Caenegem E, Wierckx K. Transgenderism and Reproduction. *Current Opinion in Endocrinology, Diabetes and Obesity.* 2013;20(6):575-579.
91. Mohiyiddeen L, Cerra C. Biopsychosocial Aspects of Infertility. In: Edozien LC, O'Brien PMS, eds. *Biopsychosocial Factors in Obstetrics and Gynaecology*. New York: Cambridge University Press; 2017.
92. Movement Advancement Project. Equality Maps: Foster and Adoption Laws. http://www.lgbtmap.org/equality-maps/foster_and_adoption_laws, 2019. Accessed March 15, 2019.
93. American Academy of Family Physicians. EveryONE Project. https://www.aafp.org/patient-care/social-determinants-of-health/cdhe/everyone-project.html, 2018. Accessed March 15, 2019.
94. Leidolf EM, Curran M, Scout, Bradford J. Intersex Mental Health and Social Support Options in Pediatric Endocrinology Training Programs. *Journal of Homosexuality.* 2008;54(3):233-242.
95. Meyer-Bahlburg HFL. Introduction: Gender Dysphoria and Gender Change in Persons with Intersexuality. *Archives of Sexual Behavior.* 2005;34(4):371-373.
96. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Medical Care.* 2003;41(11):1284-1292.

97. Spitzer RL, Kroenke K, Williams JB. Validation and Utility of a Self-Report Version of PRIME-MD: The PHQ Primary Care Study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. *JAMA.* 1999;282(18):1737-1744.
98. Kecojevic A, Wong CF, Schrager SM, et al. Initiation into Prescription Drug Misuse: Differences Between Lesbian, Gay, Bisexual, Transgender (LGBT) and Heterosexual High-Risk Young Adults in Los Angeles and New York. *Addictive Behaviors.* 2012;37(11):1289-1293.
99. Ziyadeh NJ, Prokop LA, Fisher LB, et al. Sexual Orientation, Gender, and Alcohol Use in a Cohort Study Of U.S. Adolescent Girls And Boys. *Drug and Alcohol Dependence.* 2007;87(2):119-130.
100. Hadland SE, Austin SB, Goodenow CS, Calzo JP. Weight Misperception and Unhealthy Weight Control Behaviors Among Sexual Minorities in the General Adolescent Population. *The Journal of Adolescent Health.* 2014;54(3):296-303.
101. Calzo JP, Roberts AL, Corliss HL, Blood EA, Kroshus E, Austin SB. Physical Activity Disparities in Heterosexual and Sexual Minority Youth Ages 12-22 Years Old: Roles of Childhood Gender Nonconformity and Athletic Self-Esteem. *Annals of Behavioral Medicine.* 2014;47(1):17-27.
102. Boehmer U, Bowen DJ, Bauer GR. Overweight and Obesity in Sexual-Minority Women: Evidence from Population-Based Data. *American Journal of Public Health.* 2007;97(6):1134-1140.
103. Weeks J, Heapy B, Donovan C. *Same Sex Intimacies: Families of Choice and Other Life Experiments.* New York: Routledge; 2001.
104. Badgett MVL, Durso LE, Schneebaum A. New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community. Los Angeles, CA: The Williams Institute, UCLA School of Law; 2013. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf. Accessed March 15, 2019.
105. Buchmueller T, Carpenter CS. Disparities in Health Insurance Coverage, Access, and Outcomes for Individuals in Same-Sex Versus Different-Sex Relationships, 2000–2007. *American Journal of Public Health.* 2010;100(3):489-495.
106. Ahmed O, Jindasurat C. *Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-affected Hate Violence in 2013.* New York: National Coalition of Anti-Violence Programs; 2014. https://avp.org/wp-content/uploads/2017/04/2013_ncavp_hvreport_final.pdf. Accessed March 15, 2019.
107. Heintz AJ, Melendez RM. Intimate Partner Violence and HIV/STD Risk Among Lesbian, Gay, Bisexual, and Transgender Individuals. *Journal of Interpersonal Violence.* 2006;21(2):193-208.
108. CMS Manual System. Instructions Regarding the Processing of Inpatient Claims for Gender/Procedure Conflict. Centers for Medicare and Medicaid Services (CMS), *Pub 100-20 One-Time Notification Transmittal 693.*2010.
109. Peitzmeier SM, Potter J. Patients and Their Bodies: The Physical Exam. In: Eckstrand KL, Potter J, eds. *Trauma, Resilience, and Health Promotion in LGBT Patients: What Every Healthcare Provider Should Know*. Cham: Springer International Publishing; 2017:191-202.
110. Potter J, Peitzmeier SM, Bernstein I, et al. Cervical Cancer Screening for Patients on the Female-to-Male Spectrum: a Narrative Review and Guide for Clinicians. *Journal of General Internal Medicine.* 2015;30(12):1857-1864.
111. Matsui De Roo J. Addressing Tucking in Transgender and Gender Variant Patients. Smart Sex Resource, BC Centre for Disease Control; 2016. https://smartsexresource.com/health-providers/blog/201610/addressing-tucking-transgender-and-gender-variant-patients. Accessed March 15, 2019.

112. Romero FR, Romero AW, Tambara Filho R, Brenny Filho T, Oliveira Júnior FCd. Patient Positioning During Digital Rectal Examination of the Prostate: Preferences, Tolerability, and Results. *International Brazilian Journal of Urolology.* 2011;37:371-379.
113. Peitzmeier S, Gardner I, Weinand J, Corbet A, Acevedo K. Health Impact of Chest Binding Among Transgender Adults: A Community-Engaged, Cross-Sectional Study. *Culture, Health and Sexuality.* 2017;19(1):64-75.
114. Waller J, Mccaffery K, Forrest S, et al. Acceptability of Unsupervised HPV Self-Sampling Using Written Instructions. *Journal of Medical Screening.* 2006;13(4):208-213.
115. McDowell M, Pardee DJ, Peitzmeier S, et al. Cervical Cancer Screening Preferences Among Trans-Masculine Individuals: Patient-Collected Human Papillomavirus Vaginal Swabs Versus Provider-Administered Pap Tests. *LGBT Health.* 2017;4(4):252-259.
116. Graseck AS, Secura GM, Allsworth JE, Madden T, Peipert JF. Home Screening Compared with Clinic-Based Screening for Sexually Transmitted Infections. *Obstetrics and Gynecology.* 2010;115(4):745-752.
117. Pai NP, Balram B, Shivkumar S, et al. Head-to-Head Comparison of Accuracy of a Rapid Point-of-Care HIV Test with Oral Versus Whole-Blood Specimens: A Systematic Review and Meta-analysis. *The Lancet Infectious Diseases.* 2012;12(5):373-380.
118. Chen MY, Bilardi JE, Lee D, Cummings R, Bush M, Fairley CK. Australian Men Who Have Sex with Men Prefer Rapid Oral HIV Testing over Conventional Blood Testing for HIV. *International Journal of STD and AIDS.* 2010;21(6):428-430.
119. Frank AP, Wandell MG, Headings MD, Conant MA, Woody GE, Michel C. Anonymous HIV Testing Using Home Collection and Telemedicine Counseling: A Multicenter Evaluation. *Archives of Internal Medicine.* 1997;157(3):309-314.
120. The Safe Zone Project. Vocabulary Extravaganza. http://thesafezoneproject.com/wp-content/uploads/2014/09/Vocabulary-Extravaganza-Participant.pdf. Accessed March 15, 2019.


published with the
UNIVERSITY PRESS OF KENTUCKY
PUBLISHING SERVICES CENTER