GUIDELINES FOR PROVIDING COMPASSIONATE, AFFIRMING CARE FOR THE

TRANSGENDER, NONBINARY, OR GENDER EXPANSIVE INDIVIDUAL

Components:

- Understanding Gender and the Gender Affirming Care Model
- Social Transition
- Medical Transition
- Surgical Transition
- Reproductive Health
- The care team: Primary Care Provider, Mental Health Provider, Obstetrician/gynecologist, Specialists (pediatric endocrinologist, adolescent medicine specialist), Surgeons
- DSM 5 Diagnosis of Gender Dysphoria, ICD10 diagnosis
- Social/Legal Considerations
- References
- Appendix

Understanding Gender and Why it Matters:

Body, expression, and identity are three distinct but interrelated components that comprise a person's gender. Each of these dimensions can vary greatly across a range of possibilities. A person's comfort in their gender is related to the degree to which these three dimensions feel in harmony.

Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of individuals, families, and society.

Gender Affirming Care Model

- Developmentally appropriate care for youth
- Oriented toward understanding and appreciating the individual's gender experience.
- Nonjudgmental partnership with individuals and their families to facilitate exploration of complicated emotions and gender-diverse expressions.
- Allow questions and concerns to be raised in a supportive environment.
- Provide a consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

Some Terms (see *Appendix A* for a link to a more exhaustive list of terms):

Gender identity: one's internal sense of one's gender (keep in mind that it is more validating to say that "this patient is…" rather than "this patient identifies as…")

Gender nonconforming: gender expression different from conventional expectations (not a synonym for transgender)

Gender-expansive: umbrella term for those who broaden their culture's commonly held definitions of gender identity, expression, roles, norms

Transgender (never "transgender*ed*"): umbrella term for people whose gender expression differs from what is typically associated with the sex assigned at birth
Nonbinary: one term people use to describe genders that do not fall into male or female.
Genderqueer: gender identity and/or expression falling outside the categories of man and woman or another definition
Trans man/trans boy: assigned female at birth, identifies as male
Trans woman/trans girl: assigned male at birth, identifies as female
Cisgender: nontransgender person
Gender dysphoria: a psychiatric diagnosis (may not always apply to a trans, nonbinary, or gender expansive person's journey)
Intersex: person whose sexual anatomy or chromosomes do not fit the traditional physical phenotypes of sex identification
Transition: complex process including some or all of personal, medical, surgical, and legal steps (exact steps vary by individual)

Social Transition:

- Reflects a change in gender expression and role
    - May involve living part time or full time in another gender role that is consistent with one's gender identity
    - Counseling during this period should include helping the individual understand their feelings about this transformation, including coping with the responses of others (family, friends, schoolmates, teachers and principal, church family, coworkers, etc.)
    - Optimal timing differs between individuals (often happens before initiation of gender-affirming hormones, but may not occur until after hormones have been started, or in certain circumstances, not at all)

Medical Transition

- Guidance regarding gender affirming hormone therapy is based on research from several decades of experience, research that has evolved over time, and continues to evolve with more research and understanding. For gender expansive and nonbinary people in particular, the treatment may be more individualized than the general guidelines below.
- Criteria for gender affirming hormone therapy for adults
    - Persistent, well documented gender dysphoria/gender incongruence
    - The capacity to make a fully informed decision and to consent for treatment
    - The age of majority in a given country (if younger, follow the criteria for adolescents)
    - Mental health concerns, if present, should be reasonably well controlled
- Criteria for gender affirming hormone therapy in adolescents
    - GnRH agonist treatment (puberty blockers)
        - A qualified mental health professional has confirmed that:
            - The adolescent has demonstrated a long lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed)

        - Gender dysphoria worsened with the onset of puberty
        - Any coexisting psychological, medical, or social problems that could interfere with treatment (such as those that may compromise treatment adherence) have been addressed such that the adolescent's situation and functioning are stable enough to start the reversible treatment
        - The adolescent has sufficient mental capacity to give informed consent to this treatment
    - The adolescent has also:
        - Been informed of the effects and side effects of treatment (including potential loss of fertility if the individual continues with sex hormone treatment) and options to preserve fertility
        - Has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent) the parents or caretakers or guardians have also consented to the treatment and are involved in supporting the adolescent through the treatment process
    - A pediatric endocrinologist or other clinician experienced in pubertal assessment:
        - Agrees with the indication for GnRH agonist treatment
        - Has confirmed that puberty has started in the adolescent (Tanner stage II breasts or Tanner stage II testicles)
        - Has confirmed that there are no medical contraindications to GnRH agonist treatment
- <u>Gender Affirming Hormone Treatment (testosterone or estrogen)</u>
    - A qualified mental health professional has confirmed:
        - The persistence of gender dysphoria
        - Any coexisting psychological, medical, or social problems that could interfere with treatment (for example, because that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment
        - The adolescent has sufficient mental capacity to estimate the consequences of the partially reversible treatment
    - The adolescent has:
        - Been informed of the (potentially reversible and irreversible) effects and side effects of treatment, including potential loss of fertility and options to preserve fertility
        - Has given informed assent and (particularly when the adolescent has not reached the age of legal medical consent) parents or other caretakers or legal guardians have consented to the treatment and are involved in supporting the adolescent through the treatment process
    - A pediatric endocrinologist or other clinician experienced in pubertal induction:
        - Agrees with the indication for gender affirming hormone treatment
        - Has confirmed that there are no medical contraindications

Hormone therapy in Adolescents

- GnRH Agonists (puberty blockers)
    - Completely reversible
        - If this therapy is stopped, and sex hormone therapy is not started, the individual will continue pubertal progression with secondary sex characteristics consistent with the natal sex
    - Most commonly used and best studied include leuprolide acetate depot injections (30mg/3mo Lupron Depot Ped), triptorelin (Triptodur 22.5mg/6mo) and histrelin implant (Supprelin LA 50mg, change every 1-2 years)
        - Not currently FDA approved for this indication (off-label)
        - Are approved for use for the indication of gender dysphoria by several insurance companies
        - Are FDA approved for use in children when indicated for precocious puberty
    - Expectations with this therapy
        - In earlier phases of puberty, the slight development of secondary sex characteristics may regress; in later phases of puberty, progression will stop
    - Primary risks
        - Adverse effects on bone mineralization (which theoretically can be reversed with sex hormone treatment)
        - Compromise fertility if the person subsequently treated with sex hormones
        - Unknown effects on brain development
    - Baseline and follow-up protocol
        - Every 3-6 months: Height, weight, sitting height, blood pressure, Tanner stage
        - Every 6-12 months: LH, FSH, estradiol or testosterone, 25-hydroxyvitamin D
        - Every 1-2 years: DXA scan, bone age x-ray (if clinically indicated)
- Gender affirming hormone therapy/Protocol induction of puberty (see table below)
    - Baseline and follow-up protocol during induction of puberty
        - Every 3-6 months: Height, weight, sitting height, blood pressure, Tanner stage
        - Every 6-12 months
            - When using testosterone: Hemoglobin, hematocrit, lipids, testosterone, 25-hydroxy vitamin D
            - When using estrogen: Prolactin, estradiol, 25-hydroxy vitamin D
        - Every 1-2 years: DXA scan (monitored into adulthood – 25-30yo—or until peak bone mass has been reached), bone age x-ray of left hand (if clinically indicated)
- See Table below (on next page)

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
- 5 μg/kg/d
- 10 μg/kg/d
- 15 μg/kg/d
- 20 μg/kg/d
- Adult dose = 2–6 mg/d
- *In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:*
  - 1 mg/d for 6 mo
  - 2 mg/d

Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
- 6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
- 25 μg/24 h
- 37.5 μg/24 h
- Adult dose = 50–200 μg/24 h
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).*

Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
- 25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
- 50 mg/m^2/2 wk
- 75 mg/m^2/2 wk
- 100 mg/m^2/2 wk
- Adult dose = 100–200 mg every 2 wk
- *In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:*
  - 75 mg/2 wk for 6 mo
  - 125 mg/2 wk
- *For alternatives once at adult dose, see Table 11.*
- *Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).*

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

(Reference 1)

Hormone therapy in adults

- Two main goals:
  - Reduce endogenous sex hormone levels to reduce the secondary sex characteristics of the individual's assigned sex
  - Replace endogenous sex hormone levels with hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients
- Timing: determined in collaboration with both the individual pursuing transition, their family (when appropriate), and healthcare providers
- Treatment team should include a medical provider knowledgeable in transgender hormone therapy, a mental health professional knowledgeable in gender dysphoria/gender incongruence in the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals
- Recommended that before beginning treatment, clinicians:
  - Confirm the diagnostic criteria of gender dysphoria/gender incongruence and the criteria for the endocrine phase of gender transition
  - Evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment of sex hormones of the affirmed gender
- Hormone regimens (see table below, on next page)

Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

(Reference 1)

- Individuals receiving testosterone
  - Either parenteral or transdermal preparations can achieve testosterone levels in the normal male range (typically between 320-1000 ng/dL)
    - Suggest that the patient take their injection medication on the same day of the week and try to get blood levels on the same day of the following week in between doses; if possible, may try to have 3 consistent values before making big dose changes
  - Supraphysiologic testosterone levels can increase the risk of adverse reactions and should be avoided
  - Expectations: Increased muscle mass, decreased fat mass, increased facial hair and acne, male pattern baldness, increased sexual desire, clitoromegaly, temporary or permanent decreased fertility (but not complete infertility), deepening of the voice (may not be reversible), cessation of menses (usually), increase in body hair
- Individuals receiving estrogen
  - Transdermal, parenteral, or oral options for estrogen therapy are available, but the risk of thromboembolic events is lower with transdermal estrogens than oral, specifically ethinyl estradiol; injectable and sublingual estrogens can result in more rapid peaks with greater overall periodicity and are more difficult to monitor than transdermal or oral preparations

        - Goals are estradiol levels in the 100-200 pg/mL range and testosterone levels less than 50 ng/dl
    - Estrogen alone is insufficient to suppress testosterone levels into the normal range for females and adjunctive therapy is needed to reduce the testosterone levels. These include GnRH agonists, spironolactone and cyproterone. GnRH agonists are typically more effective than spironolactone (directly blocks androgens at the androgen receptor). Spironolactone is more widely used in the US than cyproterone.
        - Spironolactone dosing is generally better tolerated and monitored by starting low and going up slowly; suggested dose titration: 25mg twice daily for 1 week, then increase by 25mg BID at 1-2 week intervals based on response and tolerability to a usual dose of 150mg BID
        - Mechanical therapies for hair distribution (shaving, waxing, laser hair removal, etc) may be an added benefit, especially initially
        - GnRH agonists include leuprolide (Lupron) and triptorelin (Triptodur) injections and histrelin implants (Supprelin for peds or Vantas for adults). In pediatrics, dosing is 11.25mg/3mo or 30mg/3mo Lupron Depot Ped or 22.5mg/6mo Triptodur. In adults, dosing is typically 2.5mg/3mo or 30mg/4 mo or 45 mg/60mo Lupron.

- Medical risks associated with hormone therapy
    - Testosterone
        - Erythrocytosis
        - Severe liver dysfunction
        - Coronary artery disease
        - Cerebrovascular disease
        - Hypertension
        - Breast or uterine cancer
    - Estrogen
        - Thromboembolic disease
            - Encourage tobacco cessation, avoid supraphysiologic estrogen dose
        - macroprolactinoma
        - Breast cancer
        - Coronary artery disease
        - Cerebrovascular disease
        - Cholelithiasis
        - Hypertriglyceridemia

- Monitoring recommendations
    - On testosterone therapy:
        - Evaluate every 3 mo in the first year then 1-2 times per year

- Measure serum testosterone levels every 3 mo until levels are in the normal physiologic range
    - Measure T levels midway between injections when on testosterone enanthate or cypionate and target level is between 400-700 ng/dl
    - If on testosterone undeconate, measure the T level just before the next injection
    - If on transdermal T, the T level can be measured after 1 wk of daily applications, at least 2hrs after application
- Measure Hb/Hct at baseline and every 3 mo for the first year, then 1-2 times a year
- Monitor weight, BP, lipids, diabetes screening at regular intervals
- Screen of osteoporosis in those who stop T, are not compliant with T, or who have other risks for bone loss
- If cervical tissue is present, monitor per ACOG guidelines
- Ovariectomy can be considered, if desired, after hormone titration has been completed
- If breast tissue is present, mammograms as recommended by American Cancer Society
- If no breast tissue present, sub- and periareolar annual breast exams

▪ On estrogen+ therapy:
- Evaluate every 3 mo in the first year, then 1-2 times per year
- Measure serum testosterone and estradiol every 3 mo
    - Serum T levels should be less than 50ng/dl
    - Serum estradiol levels should not exceed the peak physiologic range (100-200 pg/ml)
- Monitor prolactin at baseline and then at least annually during the transition phase, then every 2 years after that
- If on spironolactone, measure electrolytes (primarily potassium) every 3 mo in the first year, then annually
- Monitor wt, BP, lipids, diabetes screening at regular intervals
- Routine cancer screening based on tissues present (ie, prostate screening)
- Consider DXA at baseline and screen for osteoporosis at age 60yo if low risk or in those who are not compliant with hormone therapy

Surgical Transition:

- Hormone therapy is not a prerequisite for gender affirming surgery
- No minimum age requirement for “top” surgery – typically considered 2 yrs after beginning hormone therapy if hormone therapy is desired/indicated
- Surgeries that affect fertility are not recommended prior to 18 years of age

- After age 18yo, surgeries that affect fertility are recommended in those who fulfill the following criteria:
    - Have a persistent and well-documented gender dysphoria
    - Have had successful continuous full-time living in the affirmed gender role for 12mo
    - If significant medical/mental health concerns are present, they must be well-controlled
    - Have a demonstrable knowledge of all practical aspects of surgery
    - Have continuously and responsibly used gender-affirming hormones for at least 12 mo (if gender affirming hormone treatments are being used)
- Other surgeries may also be considered – feminizing surgeries for the face, removal of facial hair, laryngeal surgery, etc.

Reproductive Health

- Important to discuss prior to and during each phase of hormone and surgical transition
    - Pubertal blockers temporarily suppress ovarian/testicular function
        - testicular or ovarian tissue cryopreservation ideally should be done prior to puberty blockers being started if desired (expensive)
    - Estrogen can decrease or eliminate spermatogenesis, prolonged use can cause testicular damage
        - sperm banking or testicular tissue cryopreservation, hCG injections may cause spermatogenesis
    - Testosterone can cause anovulation (NOT A CONTRACEPTIVE)
        - oocyte, embryo, ovarian tissue cryopreservation
        - may have teratogenic effects
    - Some surgeries remove the organs necessary for reproduction
- Discussing contraception: Trans men can become pregnant while on testosterone
    - Progesterone containing long acting reversible contraceptives are good options both for efficacy and because of possible amenorrhea
    - Nexplanon (etonorgestrel 68mg) implant - inserted subdermally, remains in place for 3 years, over 99% effective, reversible
        - ~22% of people develop amenorrhea
    - Mirena or Kyleena (levonorgestrel 52mg or 19mg) intrauterine device - inserted into the uterus via vagina and cervix, remains in place for 5 years, over 99% effective, reversible
        - ~20% of people develop amenorrhea

The Care Team:

Primary Care Provider (Family Practice provider, Pediatric provider, Internist)

- Primary care providers provide definitive care to the patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care; they can address patient barriers to accessing appropriate and culturally competent care that may contribute to health disparities in trans, nonbinary, or gender expansive people. (These disparities can include increased

rates of certain types of cancer, substance abuse, mental health conditions, infections, and chronic diseases.)

- Are qualified to provide gender affirming care, which may or may not include hormone treatment, for all patients.
- Pediatric providers can assess gender concerns and providing evidence-based information to assist youth and families in medical decision-making in a developmentally appropriate way, thus avoiding the prolongation or exacerbation of gender dysphoria which can contribute to abuse and stigmatization.
- Depending on their scope of practice, may manage gender affirming hormone treatment, monitor well-being, and provide primary care; when indicated, can provide referrals to a specialty or mental health provider with more expertise.
- As part of medical care, provides preventive care and cancer surveillance based on the organs that are present, medication use, and behaviors.
- Providers can identify and treat mental health conditions while avoiding the assumption that such conditions are necessarily related to gender identity.

<u>Obstetrician/Gynecologist, Reproductive Endocrinologist</u>

Trans, nonbinary, and gender expansive patients may seek primary care in gynecologic practices for various reasons:

- Gynecologists are qualified to provide gender affirming care, which may or may not include hormone treatment.
- Trans females may prefer to see a gynecologist for their annual health care as this helps them to affirm their gender and also gives them the opportunity to share any gynecologic concerns such as recurrent neovaginal and urinary tract infections, problems with voiding, pain with intercourse, or more rare problems like neovaginal prolapse or anatomic urinary tract dysfunction.
- Some patients may prefer to have their annual breast examination with a gynecologist.
- Trans men may seek gynecologic care for routine screening such as Pap smears and bimanual pelvic examinations, or for consultation regarding removal of pelvic organs
- Patients may seek gynecology care for counseling on contraception and/or fertility options
- Reproductive endocrinologists may help with pre-treatment fertility counseling (ie sperm banking, oocyte preservation prior to the start of hormone treatment), or fertility and/or reproductive care once an individual has started treatment

<u>Pediatric Specialist (ie, pediatric endocrinologist or adolescent medicine specialist)</u>

- Pediatric endocrinologists and/or adolescent medicine specialists have experience with examination and diagnosis of pubertal stages and can provide gender affirming hormone therapy including pubertal suppression and sex hormones, manage medications, and monitor for side effects in children, adolescents and young adults as a part of their scope of practice and specialty training.
- Many providers in these specialties may be involved as part of a larger Trans/Nonbinary/Gender Expansive care team.

Surgeons

This may include top surgeons and/or bottom surgeons. Currently in Alaska, there are few surgical resources for transgender, nonbinary, or gender expansive patients. Additionally, cost or lack of insurance/Medicaid coverage can be a barrier. (*See Appendix E below*)

Mental Health Professionals

Avoiding stigma: gender identity evolves as an interplay of biology, development, socialization, and culture; if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the individual

- This includes: BHC/BHS, Clinical psychologist, Psychiatrist
    - Criteria of the MHP
        - Competent in using DSM for diagnostic purposes
        - Able to diagnose gender dysphoria/gender incongruence and make a distinction between gender dysphoria/gender incongruence and conditions that have similar features (e.g., body dysmorphic disorder)
        - Trained in diagnosing psychiatric conditions
        - Undertake or refer for appropriate psychological treatment when needed
        - Able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender affirming hormone therapy
        - Regularly attend relevant professional meetings
    - Criteria for working with children/teens: all of the above plus:
        - Training/experience in child and adolescent psychology, psychopathology, and gender development
        - Knowledge of the criteria for puberty-blocking and gender-affirming hormone treatment in adolescents
- When should mental health evaluation occur?
    - Not everyone needs a mental health evaluation but for those who do, before and/or during transition process as needed (in pediatric patients under 18yo, the mental health evaluation is considered to be more of a "requirement" than in adults; every effort should be made to avoid a mental health evaluation as a "gatekeeper" to appropriate treatment)
- Purposes of mental health evaluation
    - Given the psychological vulnerability of many individuals who are transgender, provide support and affirmation of that individual's self-understanding and self-knowledge
    - Establish and confirm diagnosis of gender dysphoria based on DSM 5 criteria
        - Psycho-diagnostic assessment and an assessment of the decision-making capability of the individual
        - Required for children/adolescents prior to undergoing medical transition; not required for adults (18yo+)
    - If presence of psychopathology or circumstances that might interfere with the diagnosis or medical treatment, assist the individual in managing those issues

        - Individual must be stable from a psychological standpoint prior to beginning medical transition
    - Assess family's ability to endure stress, give support, deal with the complexities of the individuals' situation
    - Assist and support the individual and their family in social transition, if/when that individual desires social transition
    - Assist and support the individual and their family during medical and/or surgical transition, if/when that individual desires to pursue those options
    - Write patient support letter for hormone therapy (when needed, ie, under 18yo or if patients or providers have concerns) and surgical therapy
        - Confirmation of diagnosis of gender identity disorder
        - Assessment/discussion of patient's expectations regarding pubertal suppression and/or hormone therapy and/or surgical treatment
        - Assessment of the patient's mental health (i.e. is it stable or improving)
        - Assessment of any other psychological comorbidities and whether these may interfere with diagnosis or treatment
        - That the patient has/will have adequate psychological and social support during treatment

DSM 5 Criteria for Diagnosis: Gender Dysphoria in Adolescents and Adults

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults. It is important to recognize that not all trans or nonbinary people will feel that "gender dysphoria" describes their experience. It may be useful to counsel people about this diagnosis. (Univ of Washington has a helpful patient guide: https://www.uwhealth.org/files/uwhealth/docs/gender_services/DI-165839-18_Gender_Services_Patient_Coding_Booklet.pdf).

A. In adolescents and adults gender dysphoria diagnosis involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:
    1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
    2. A strong desire to be rid of one's primary and/or secondary sex characteristics
    3. A strong desire for the primary and/or secondary sex characteristics of the other gender
    4. A strong desire to be of the other gender
    5. A strong desire to be treated as the other gender
    6. A strong conviction that one has the typical feelings and reactions of the other gender

B. In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months.
    1. A strong desire to be of the other gender or an insistence that one is the other gender

2. A strong preference for wearing clothes typical of the opposite gender
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. A strong rejection of toys, games and activities typical of one's assigned gender
7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender

ICD 10 Criteria for Diagnosis: (F64.0 – F64.9, Z87.890). *The ICD-10 drew language from the DSM-4, the most updated version available when the ICD-10 was written -much of the terminology is outdated and may be offensive. The definitions below have been altered in this guideline -- some from the original text of ICD10 was changed to reflect more inclusive and compassionate language; in some places, the offensive language will be in quotes. It may be useful to counsel or forewarn patients that the visit may be billed as "gender identity disorder". Refer to the Univ of WA guide above (*under DSM5*). For the original definitions, see (www.who.int/classifications/icd/en/GRNBOOK.pdf)

- F64 "Gender Identity Disorders" *(inaccurate, offensive term*):
  - F64.0 "Transsexualism" (often *an offensive term*)
    A. Desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make one's body as congruent as possible with one's sex identification through surgery and hormonal treatment.
    B. Presence of the different gender identity for at least two years persistently.
    C. Not a symptom of a mental disorder, such as schizophrenia, or associated with chromosome abnormality.
  - F64.2 "Gender identity disorder of *childhood*" (*inaccurate, offensive term*)
    - For those assigned female at birth:
    A. Persistent and intense distress about being a girl, and a stated desire to be a boy (not merely a desire for any perceived cultural advantages from being a boy), or insistence that the child is a boy.
    B. Either (1) or (2)
        1) Persistent marked aversion to normative feminine clothing and insistence on wearing stereotypical masculine clothing, e.g. boys' underwear and other accessories.
        2) Persistent repudiation of female anatomic structures, as evidenced by at least one of the following:
            a) an assertion that the child has, or will grow, a penis
            b) rejection of urinating in a sitting position
            c) assertion that the child does not want to grow breasts or menstruate
    C. The child has not yet reached puberty.
    D. The distress and/or insistence must have been present for at least six months.

- <u>For those assigned male at birth:</u>
    A. Persistent and intense distress about being a boy and an intense desire to be a girl or, more rarely, insistence that the child is a girl.
    B. Either (1) or (2):
        1) Preoccupation with female stereotypical activities, as shown by a preference for either dressing in or simulating female attire, or by an intense desire to participate in the games and pastimes of girls and rejection of male stereotypic toys, games and activities.
        2) Persistent repudiation of male anatomic structures, as indicated by at least one of the following repeated assertions:
            a) that the child will grow up to become a woman (not merely in role)
            b) that the child's penis or testes are disgusting or will disappear
            c) that it would be better not to have a penis or testes.
    C. The child has not yet reached puberty.
    D. The distress and/or insistence must have been present for at least six months.
- F64.8 Other gender identity disorders
- F64.9 Gender identity disorder, unspecified

<u>Legal/Social concerns:</u>

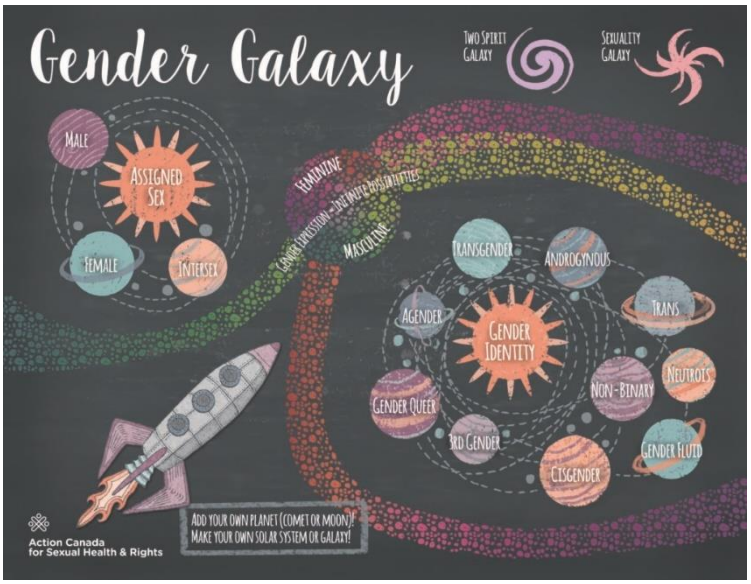
- *See Appendices B and C below*
- Name/gender change on legal forms: www.transequality.org
- Name/gender change in Cerner – once a birth certificate is updated, this can be changed
- Consent forms used for minors with consent of parents/guardians and assent of the minor
- Consent form for adults can be used
- Gender-affirming, culturally sensitive clinic spaces are important to improve access to care.
    - Diversity training for staff across all disciplines that encompasses sensitivity when caring for youth who identify as transgender/gender expansive and their families
    - Ensure that patient asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.
        - The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.
    - Explain and maintain confidentiality procedures
    - Clearly display nondiscrimination policy
    - Display gender, sexuality, race, ethnicity, disability inclusive brochures and posters
    - Have accessible, all-gender restrooms available

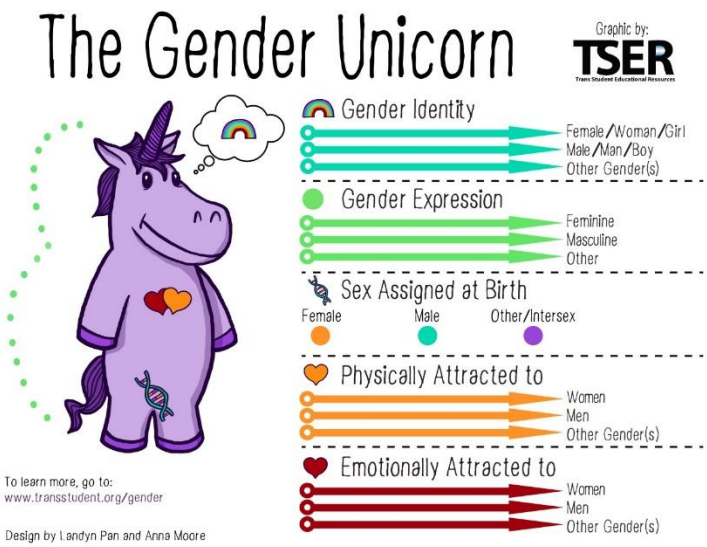
References:

1. Hembree WC, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab, November 2017, 102(11):3869–3903
2. Coleman E, et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. 7th Version. Intl J of Trans. 2012. 13(4):165-232. www.wpath.org
3. Whitlock BL et al. Primary Care in Transgender Persons. Endocrinol and Metab Clin, Jun 2019, 48(2):377-90.
4. Klein D, et al. Caring for Transgender and Gender-Diverse Persons: what clinicians should know. Am Fam Physician. Dec 2018. 98(11):645-53.
5. Rafferty J et al. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. Oct 2018. 142(4):e20182162.
6. Ugner C. Care of the transgender patient: the role of the gynecologist. Expert Review General Gynecology. Jan 2014, 210(1):16-26
7. ICD10: https://icd.who.int/browse10/2019/en
8. DSM: V: https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

Appendix A: LGBTQ2+ Terminology:

- https://www.glaad.org/reference/transgender
- https://identityalaska.org/programs/gender-identity/terminology/
- It is never appropriate to put quotation marks around either a transgender person's chosen name or the pronoun that reflects that person's gender identity.





Appendix B: Creating a welcoming clinical environment for LGBTQ2+ patients
(see also: http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf**):**

- Introduce yourself, offer your name & pronouns, then ask 'what is your name?', 'what is your pronoun?' (when appropriate & necessary for the person's medical care). If unable to ask, avoid pronouns
- Ask questions about genitalia, surgeries, etc on a need to know basis (will it change medical care?) and explain why information is needed
- Don't assume. When in doubt, ask (when it's appropriate and necessary for the person's medical care)
- Mimic the patient's own language, ask for clarification if a patient uses a term you don't understand
- When you make a mistake, acknowledge the mistake and correct yourself quickly and move on
- Intake forms: 'Legal name__', "Name I prefer to be called__', 'Pronouns__', 'Gender ___' (rather than 'male or female' checkboxes on forms)
- Update electronic health record "banner bar" to include gender, pronoun, preferred name
- Explain that patient-provider discussion is confidential, display confidentiality statements
- Use gender-inclusive language when talking about sexual/relationship partners and other screening
- Gender, sexuality, race, ethnicity - inclusive brochures and posters
- Develop resource lists and guidelines, be aware of LGBTQ2+ resources in the community
- Educate staff across all disciplines (front desk, scheduling, medical assistants, nurses, support staff, providers, etc.)
- All gender bathrooms: these are available throughout the ANPCC, VNPCC, HCB, and ANMC hospital
- Nondiscrimination policy posted in the clinic spaces (in multiple languages)

Appendix C: Name and gender change on legal documents; https://transequality.org/documents

Appendix D: Medical/mental health resources for trans care in Alaska: https://identityalaska.org/programs/gender-identity/trans-resources-list/anchorage-medical-clinics/

Appendix E: List of surgeons for gender affirming surgeons;

- https://callen-lorde.org/transhealth/
- https://www.transhealthcare.org/

Appendix F: Resources:

Trans Lifeline: www.translifeline.org, 877-565-8860

Identity Alaska (Alaska-wide, based in Anchorage) https://identityalaska.org/

Gender Pack (Fairbanks): https://genderpack.org/

SEA-GLA (SouthEast) https://www.seagla.org/

I Know Mine https://www.iknowmine.org/for-youth/lgbtq

Trevor Project (National) https://www.thetrevorproject.org/#sm.0000qf0n2pdr9egazqm15c2bkvqay

TransYouth Family Allies (National) http://www.imatyfa.org/

Trans Kids Purple Rainbow (National) http://www.transkidspurplerainbow.org/

Parent/Youth Education: www.genderspectrum.org/resources, www.pflag.org/transgender

Legal Needs and Advocacy:, www.transequality.org, www.lamdalegal.org

GLMA Health Professionals Advancing LGBTQ Equality: www.glma.org

UCSF Center of Excellence for transgender health: http://transhealth.ucsf.edu/

Seattle Children's Hospital Trans Health Clinic: https://www.seattlechildrens.org/clinics/gender-clinic/education-resources-healthcare-professionals/

World Professional Association for Transgender Health: (https://www.wpath.org/)