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Addressing transgender patients' barriers to access care

Abstract: The transgender population faces several barriers to accessing quality medical care in the US healthcare system. This article examines the challenges that prevent this marginalized group from obtaining high-quality healthcare services and discusses how NP advocacy can help create a welcoming environment for transgender patients.

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Transgender people have experienced significant progress in recent years. Some countries, including the US, have passed laws to protect the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) community from discrimination.[1] Human rights activists have led campaigns that helped shift public opinion on transgender people toward greater acceptance. Civil rights organizations have created new forums to foster societal understanding and equality between transgender and other populations.[2] Despite these positive steps forward, the transgender population still faces multiple barriers to obtaining quality healthcare.

Barriers include stigmatization, discrimination in insurance coverage, and a lack of experience among medical professionals in treating the unique healthcare needs of transgender patients.[3] This article examines the effects of healthcare disparities among the transgender population and the importance of creating a welcoming environment for transgender patients receiving care, and emphasizes the vital role NPs can play in delivering gender-affirming care, including cross-sex hormone therapy (CSHT).

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Keywords: advocacy, cancer, cross-sex hormone therapy (CSHT), healthcare disparities, HIV/AIDS, LGBTQ, mental health, stigmatization, transgender

Healthcare disparities

The US census and other demographic studies currently do not collect data on gender identity, so the exact number of transgender people in the US is unknown. However, studies estimate that transgender individuals account for 0.3% of the US population.[4] In 2011, there were about 9 million transgender people in the US. Given the recent federal antidiscrimination measures passed to protect the LGBTQ community, more transgender people may choose to disclose their sexual orientation in the future.[5] Thus, the transgender population is expected to rise to over 10 million by 2020.[5]

Stigmatization and limited research contribute significantly to the healthcare disparity between transgender people and other patient populations.[6,7] Recent studies indicate that few health institutions collect data on gender identity, making it difficult to measure the quality, treatment decisions, and outcomes of the healthcare provided to transgender patients.[8-10] Programs such as Healthy People 2020 indicate that HIV, STI, psychiatric disorders, victimization, and suicide prevalence rates are significantly higher among transgender individuals than heterosexuals and other LGBTQ groups.[11]

A systematic review and meta-analysis found that transgender women (male to female) represent approximately 20% of the existing HIV infection rate throughout the world.[12] One study conducted in the US found that the three most prevalent concerns among more than 1,000 surveyed transgender people were clinical depression (44%), anxiety (33%), and somatization (28%).[13] The 2015 US Transgender Survey (USTS) of 27,715 transgender people noted that 29% of respondents consumed illicit drugs, used prescriptions inappropriately, or used drugs prescribed to others, at a consumption rate three times higher than the general US population.[13] Serious psychological distress was prevalent among 39% of respondents compared with 5% of the general population and resulted in a staggering 40% of respondents having attempted suicide in their lifetime—almost nine times the attempted suicide rate in the US population (4.6%).[14]

Care access challenges

Transgender patients require customized services to fulfill their personal healthcare and gender identity needs. Although some may require an uninterrupted supply of hormones, others may need regular voice and communication therapy, mental health care, and substance use disorder counseling services. Few transgender individuals who seek these services from public hospitals attain high satisfaction levels.[15] Surveys show that many transgender patients do not record satisfactory encounters at their mainstream healthcare facilities. Roberts and Fantz's review of barriers to transgender care concluded that medical practitioners are not adequately trained to deliver the healthcare services required by transgender patients.[16] Patient dissatisfaction included healthcare providers' use of inappropriate pronouns. (See *Terminology*.) The USTS also found that 25% of transgender individuals were denied health insurance coverage for gender transition care or routine care because of their reported transgender status.[14] Yehia and colleagues reported that within their retention and health outcomes of people living with HIV, nontransgender men and nontransgender women achieved a better retention in care as compared with their transgender counterparts.[17]

According to the 2011 National Transgender Discrimination Survey conducted by Shires and Jaffee, 50% of the 6,450 respondents expressed dissatisfaction with the healthcare services they received.[22] This finding was further supported in the 2015 USTS, in which 33% of respondents seen by a healthcare provider (HCP) reported a negative experience such as harassment or refusal of care because of gender identity.[14] Consequently, 23% reported they declined to seek care in the year before being surveyed because of fear of mistreatment.[14] Nineteen percent of the respondents experienced denial of care, while 28% rarely sought healthcare because of the fear of discrimination. Furthermore, the USTS revealed that 33% of respondents provided teaching on transgender people to their HCP in order to receive care that was appropriate.[14]

Listen to the authors discuss barriers to transgender health in this month's episode of *The Nurse Practitioner* podcast at www.tnpj.com.

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HIV/AIDS. Among the general population with HIV, most HIV research has been conducted on transgender women.[23] A systematic review of available data in the US and 14 countries from 2000 to 2011 revealed that 19.1% of the world's transgender people are currently living with HIV/AIDS.[12] The median HIV prevalence was 3% higher in the US (21.6%) than low- and middle-income countries (17.7%).[12] The rate was significantly greater than other vulnerable populations such as men who have sex with men (MSM), sex workers, and individuals who inject drugs. Transgender women and MSM account for more than half of the people living with HIV/AIDS in the US and exceed the general population's HIV prevalence rates in middle-income countries as well. These vulnerable individuals also contribute to 63% and 30% of the syphilis and gonorrhea infection rates, respectively.[18,24]

Mizuno and colleagues reported that transgender women are 40 times more likely to be diagnosed with HIV than the general population.[25] Nevertheless, most healthcare systems do not systematically record data concerning transgender patients. The high HIV/AIDS prevalence rates are attributable to the negative perceptions or discriminative stereotypes targeting transgender patients. The perceived negative environment induces stress and promotes unnecessary school or work absenteeism. As a way of coping, many transgender people turn to alcohol, drugs, and promiscuous sexual behavior for consolation. Having unprotected intercourse with multiple partners increases their risk of contracting HIV.[20,21]

Mental health. Research demonstrates that many transgender people have low self-esteem. Many factors may contribute to these feelings. Given that many families reject their transgender family members, the individuals are reluctant to protect themselves from discrimination or physical abuse and often engage in self-destructive behaviors.[26] The LGBTQ population is two times more likely to smoke and use other harmful substances than the general population.[27] Ard and Harvey found that the real or expected discrimination or abuse results in internalized depression, anxiety, and homophobia.[28] This may explain why mental health disorders are significantly higher among the transgender population than among minority ethnic groups. Lapinski and colleagues cite that

Terminology

Cisgender—people whose gender identity is congruent with the gender assigned at birth and who perform gender roles that society considers appropriate.[5]

Gender—the attitudes, feelings, and behaviors a society expects a particular gender to possess.[17] Characteristics that are consistent with such cultural expectations are classified as gender-normative. In contrast, those who contradict such norms are referenced as gender nonconformive.

Gender dysphoria—a feeling experienced by an individual that a person is not the gender he or she appears to be.[17] For example, individuals with the male reproductive system and other physical traits attributable to men feel that they are female. Dysphoria may lead to dissociation, depression, and anxiety.[18] Gender dysphoria is the current diagnosis used in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5).[19]

Gender expression—the outward presentation or display of one's gender.[17]

Gender identity—the gender to which a person identifies.[17] An individual may be male, female, or transgender. According to Orel and Fruhauf, transgender people acquire identities that are not congruent with the gender that their parents or caregivers assigned during birth. For example, an individual may be assigned female but identify as male.[8,17]

Gender incongruence—when gender identity and/or gender expression differ from what is associated with the designated gender.[20]

Genderqueer—a gender expression that is not male or female but on the gender continuum.[17]

Sex—a person's biological status of either male or female. In most cases, biological factors such as sex chromosomes, reproductive organs (penis or vagina), and external genitalia determine whether an individual is male or female.[17]

Sexual orientation—the gender to which a person is sexually attracted.[17]

Transgender—a person whose gender identity or expression is different than the gender assigned at birth.[21]

Transman—an individual who was assigned female at birth but identifies as male.[21]

Transsexual—a person who seeks to change gender assigned at birth through medical intervention (hormones or surgery).[21] The term "transsexual" is an older diagnostic term that originated in the medical community and was used in a previous edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) prior to use of the diagnostic term "gender identity disorder" in the DSM-IV, which was updated in 2013 to the current diagnostic term of "gender dysphoria" in the DSM-5. NPs should avoid the use of "transsexual" and use "gender dysphoria."[19]

Transwoman—an individual who was assigned male at birth but identifies as female.[21]

transgender people express such experiences through suicidal ideation and attempted suicide.[29] However, those who receive consistent social support are 82% less likely to harm themselves. Ybarra and colleagues also found that 41% of the transgender respondents had attempted suicide.[30]

Cancer. Tabaac and colleagues found significant gender disparities in screening behaviors among transgender people with significantly lower rates of lifetime screenings for colorectal, breast, cervical, and prostate cancer compared with cisgender individuals.[31] Contributory factors may be increased vulnerability, discrimination, and stigma that lead transgender individuals to postpone cancer screening. Clinicians may also inadvertently fail to order appropriate cancer screenings based on transgender patients' natal anatomy.[31] Tanner and colleagues report that transgender people are less likely to visit their primary care provider for routine screening compared with other populations.[32] Mammograms may need to be ordered on transgender women who obtain elective breast augmentation because of increased incidences of denser breasts, which can increase rates of false-negative mammograms.[33] The prevalence rates of breast cancer among transgender women were reported as higher among those who had been taking hormonal therapy for over 5 years.[34] Transgender men should follow the same cervical and breast cancer screening guidelines as nontransgender women.[35,36] Therefore, it is important for transgender populations to have routine mammography screening every 1 to 2 years. Transgender people face greater exposure to cancer from modifiable risk factors such as smoking, alcohol consumption, and obesity.[37] However, a lack of large-scale prospective studies limits high-quality data assessment of cancer incidence in this population.[38]

Barriers to care

Structural and financial obstacles in the current healthcare system pose significant threats to the transgender population. In addition to the concerns facing the general population, this marginalized group experiences several other serious health risks. The landmark study by the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine, Health and Medical Division) reviewed the state of the science on the health status of LGBTQ populations and found that the major barriers denying the transgender community access to equitable health resources included inadequate medical insurance, stigmatization, and a knowledge gap by healthcare professionals.[39] Harley and Teaster emphasized that transgender people have their own unique needs.[2] They also further recommended that authorities redefine and revitalize the current system so that practitioners do not exclusively link the care given to transgender patients to their gender alone, but also include their gender identity.

Health insurance coverage. Gender reassignment procedures sought by transgender patients are costly, and more insurance companies have begun to provide coverage for transgender individuals who meet the criteria for gender reassignment surgery.[40] For example, insurance companies such as Aetna, Cigna, and Blue Cross Blue Shield have expanded transgender-related coverage. This was in direct response to the Affordable Care Act (ACA) regulations that prohibit insurance organizations from discriminating against clients based on sexual orientation and gender identity. However, many transgender patients who have not pursued health insurance via the ACA exchanges state that they have been denied insurance coverage.[41] The ACA laws vary among states and the insurance framework should not consider surgical interventions that have more significant impact on the transgender population as cosmetic procedures that are not covered by most public insurance companies.[41] The trend points to loopholes in current policies that promote inequitable distribution of financial resources between the cisgender and transgender populations. Despite the inequities, the Human Rights Campaign maintains a list of insurance carriers that offer to negotiate transgender-related care without blanket exclusions.[40]

Transgender men should follow the same cervical and breast cancer screening guidelines as nontransgender women.

Stigmatization. Ard and Harvey argue that despite recent social successes and acceptance, there has been a long history of anti-LGBTQ bias that continues to influence health-seeking behavior even today.[28] Similarly, there are also controversies over transgender mental

health. Although new laws prohibit discriminatory practices, there are still negative attitudes harbored by a percentage of healthcare professionals toward transgender patients.[6] Consequently, many transgender patients are resistant to disclose their gender identity to caregivers, especially those they do not trust. According to Reisner and colleagues, a Minnesota health seminar concluded that 45% of the transgender population do not inform their personal HCPs of their true gender identity.[9] Because of such behavior, it may not be possible for vulnerable patients to receive services that meet their needs and expectations.

Furthermore, virtually all transgender people experience discrimination in public places such as bathrooms, restaurants, shopping malls, airports, public transportation, libraries, cinemas, and learning institutions.[42] Levi and Monnin-Browder found that members of the transgender community may encounter severe harassment and abuse.[21] Statistics indicate that hate crimes have resulted in 128 deaths of transgender individuals across 32 states in the US from 2013 to 2018.[43]

Professional knowledge gap. Existing literature documents several scenarios in which the providers relied on patients'opinions of how to meet their treatment needs.[2,10,44] The findings in the USTS indicated that more than half (54%) of respondents were not sure what HCPs knew about healthcare for transgender people; 16% said HCPs knew "some things," 24% said the HCP knew "almost nothing," and only 6% said the HCP knew "everything" or "most things" about caring for transgender people.[42] Consequently, 86% of respondents stated that training HCPs in transgender health should be an important policy priority.[14]

Creating a welcoming environment

Creating a welcoming and gender-affirming environment is essential for ensuring equality for access to healthcare for all populations. HCPs should combine regulatory frameworks with evidence-based practices to achieve such objectives. These should include incentives such as training, nondiscrimination policies, and inclusive language.

Education. NPs and other HCPs need to be prepared to respond to the specific needs of the transgender community. The American Nurses Association published a position statement recognizing the need for nurses to advocate for and deliver culturally congruent care to LGBTQ populations. The statement recommends that nursing educators address the gaps in knowledge by integrating LGBTQ education into nursing curriculums.[45]

Because many NPs have had limited education in transgender care, Andrews and Lyon advise that medical colleges and universities incorporate the unique challenges and conditions experienced by the transgender community into their curriculum.[46] Currently, medical schools devote a median of 5 hours to LGBT issues.[47] Practitioners who are already in the workforce should turn to recent guidelines and research. Institutions such as the CDC and National LGBT Education Center have developed free online programs to enable providers to deliver quality services that meet the needs of the transgender population.[5]

Transgender people may also struggle to secure and maintain well-paying jobs. Healthcare organizations can organize regular forums to provide platforms for the transgender workforce to voice their grievances.[48] Hospital management can then use the collected information to develop and disseminate educational brochures to serve as self-assessment tools for their staff. Evidence-based educational resources for addressing the needs of gender-dysphoric/gender-incongruent adults and youth include the Endocrine Society, the National LGBT Health Education Center, the Center of Excellence for Transgender Health, and the *Journal of Clinical Endocrinology and Metabolism*.[20,35,49-51]

Nondiscriminative policies. Regulations should emphasize that discrimination against a patient because of his/her sexual orientation or gender identity is a crime punishable by law. The policies should provide respectful ways of engaging transgender patients in conversations concerning their health and care. One example would be for the framework to specify that all staff, including receptionists, clerks, medical assistants, and HCPs, address patients using their preferred names and pronouns.[52]

Building trust. New practices such as revising intake forms to include more sexual orientations and gender identities will go a long way in fostering trust and building a sense of community and belonging for transgender patients and other stakeholders. Ard and Harvey recommend including such demographic data in the electronic health record (EHR) systems for all patients.[28] For example, when seeking healthcare services, transgender patients could enter their sexual orientation and gender identity information into the EHR through a patient intake portal at home or in a healthcare setting. This process of disclosure

could help patients feel safer about discussing health behaviors and risks and provide a convenient way for providers to collect data critical to identifying, tracking, and eliminating the health disparities that prevent transgender individuals from accessing healthcare services.

Hospitals should further create a multidisciplinary team comprised of specialists such as endocrinologists and mental health professionals. The team should focus on providing psychological support, especially for young children. Lelutiu-Weinberger and colleagues argue that such services offer young transgender individuals the opportunity to discuss their thoughts and cope with any emotional distress.[3] At the same time, the approach will bridge the knowledge gap that reflects and characterizes the current healthcare system.

Inclusive office practices. US policy makers and administrators at health organizations as well as other public agencies should introduce simple incentives to foster respect between the cisgender and transgender populations. These may include gender-neutral washrooms, offering transgender people options on registration forms, and using neutral terms such as "partner" rather than "husband" or "wife." These types of changes can better allow the transgender population to be more open about their lives.[4] Policy makers should work toward equality for the transgender community by supporting nondiscriminatory policies against the use of offensive language and abusive conduct that deny transgender individuals the right to fair treatment.[53]

Increasing access to treatment options

NPs should discuss with transgender patients the treatment options available, such as hormone therapy and surgical procedures. The potential risks and benefits of the different treatment options also need to be explained to the patient. Gonadotrophin-releasing hormone (GnRH) analogues help suppress the hormones that the body produces when a person reaches puberty. The male body generates testosterone, which stimulates penis growth, and females produce estrogen, which is responsible for body changes such as hip enlargement. These changes can trigger distress to a transgender individual who does not want to identify with their natal gender. According to Ettner and colleagues, GnRH is advisable for young individuals who are not only experiencing distress known as gender dysphoria, but also have a desire to maintain their gender identity.[4] GnRH hormone therapy is an option to relieve gender dysphoria. This therapy is reversible and patients may stop it at any time.

Transgender women experience positive changes, such as a decrease in size of the penis and testicles, development of more fat on the hips, an increase in the size of the breasts, and a reduction in facial and body hair. Transgender women may undergo surgical procedures including breast augmentation, orchiectomy, penectomy, vaginoplasty, vulvoplasty, and trachial cartilage shaving.[54]

In contrast, transgender men who are taking hormone therapy experience changes such as an increase in facial and body hair, more muscle development, and menstrual period cessation. The individuals may also need masculinizing chest surgery, hysterectomy, metoidioplasty, testicular implants, and phalloplasty.[54] Hormonal therapy and surgical procedures are costly procedures and many transgender patients, especially those from low-income backgrounds, may not be able to afford the treatments they feel are necessary for their physical, social, and mental well-being.[10] A study by Lapinski and colleagues demonstrated that hormone therapy is essential for the patients who want to maintain personal comfort with both their physical appearance and feelings.[29] It also improves the transgender person's self-esteem and ability to cope with associated stressful conditions.

There is also limited availability of providers to offer these types of specialty services.[55] There is a strong need to invest in focused education on CSHT for NPs managing the care of transgender patients. Research should also prioritize and seek cost-effective methods for ensuring that transgender patients receive the surgery and related care at the most appropriate time.

Before recommending that a patient initiate CSHT, NPs should conduct a thorough physical exam, including weight, height, and BP. Baseline lab tests should include fasting blood glucose, complete blood cell count, a lipid profile, liver function, hemoglobin A1C for patients with diabetes mellitus, and testosterone and estradiol levels.[35,54,56] The inclusion criteria for CSHT for adults include:

- fulfillment of the diagnostic criteria for gender dysphoria (DSM-5) by a qualified mental health provider or other qualified professional with expertise in the treatment of transgender patients[19]

- assessment and management of other concurrent psychiatric or medical comorbidities
- affirmation of the desire and readiness to live and be accepted as a member of the opposite gender and wish to make the body as congruent as possible with the self-identified gender
- the capacity to provide informed consent
- age of the majority (18 years or older) that varies among states.[57,58]

Exclusion criteria for female-to-male CSHT are being pregnant, currently breastfeeding, history of active breast cancer or hormonally sensitive cancer, and unstable or severe cardiovascular disease. Exclusion criteria for male-to-female CSHT are history of active venous thromboembolic events, active breast cancer or hormonally sensitive cancer, significant kidney impairment, and hyperkalemia (if taking spironolactone).[35] (See *Treatment options for CSHT*.)[28,35]

Lab monitoring is recommended at 3 months for the first year during hormonal transition, then one to two times annually.[35]

For transgender women, serum testosterone and estradiol should be performed every 3 months for the first year, and every 6 to 12 months after the first year of therapy. Transgender women on spironolactone should have electrolytes monitored every 3 months in the first year and then annually.[35] Transgender men should have hematocrit or hemoglobin monitored at baseline, then every 3 months for the first year, followed by one to two times annually. Lipids should also be checked annually.[35] A bone mineral density screening for osteoporosis is recommended at baseline, after stopping testosterone therapy, or if nonadherent to hormone therapy.

Conclusion

The findings listed above confirm that limited information, inadequate policies, and barriers within legal structures present challenges to enhancing the transgender patient experience. Most researchers attribute the health disparity to the knowledge gap between real-time experiences and the outcomes of care services LGBTQ patients receive during visits to hospitals, clinics, or community health units. However, as much as primary HCPs perceive that addressing the challenges requires massive restructuring of the existing national framework, NPs and other primary care HCPs will make tremendous strides by just sitting down with and listening to members of this marginalized population. Transgender organizations are in the initial stages of providing useful resources such as the Fenway Guide to LGBT Health.[51] This guide

Treatment options for CSHT[28,35]

Drug	Indications	Considerations
Transgender woman (Male to Female [MtF])		
Estrogens:	Feminization therapy	
Oral estradiol		Higher thrombotic risk; use sublingually to avoid first pass effect
Transdermal estradiol patch		Lower thrombotic risk than oral estradiol
Estradiol injectable:		Lower thrombotic risk than oral estradiol
• estradiol valerate injection		
• estradiol cypionate injection		
Antiandrogens:	Androgen deprivation	
Spironolactone (an aldosterone antagonist with antiandrogen properties)		Lower testosterone levels
Finasteride (5-alpha-reductase inhibitor)		Lower testosterone levels
Goserelin acetate (GnRH agonist)		Lower testosterone levels
Transgender man (Female to Male [FtM])		
Testosterones:	Masculinization therapy	
Parenteral: testosterone enanthate injection or testosterone cypionate injection		Titrate slowly based on tolerance and adverse reactions
Transdermal testosterone patch		Skin irritation
Transdermal testosterone gel 1%		Skin irritation, interpersonal secondary transfer of testosterone possible

*All drugs noted in table are used off-label for CSHT

contains detailed information concerning the vital aspects of care for these unique patient groups. This article recommends that all healthcare organizations educate their employees in effective patient-provider communication. Such a technique should and could emphasize and focus on qualities such as compassion, empathy, and responsiveness to all patients' needs and personal values. Combining these elements into healthcare delivery will not only identify future challenges, but also provide sustainable solutions to the barriers that have hindered transgender patients from accessing high-quality healthcare.

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