Gender Affirming Care, All You Need to Know

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Session 4: Gender Affirming Care, All you need to know

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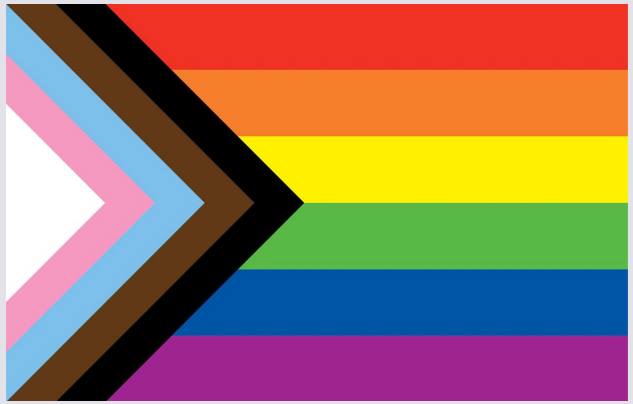
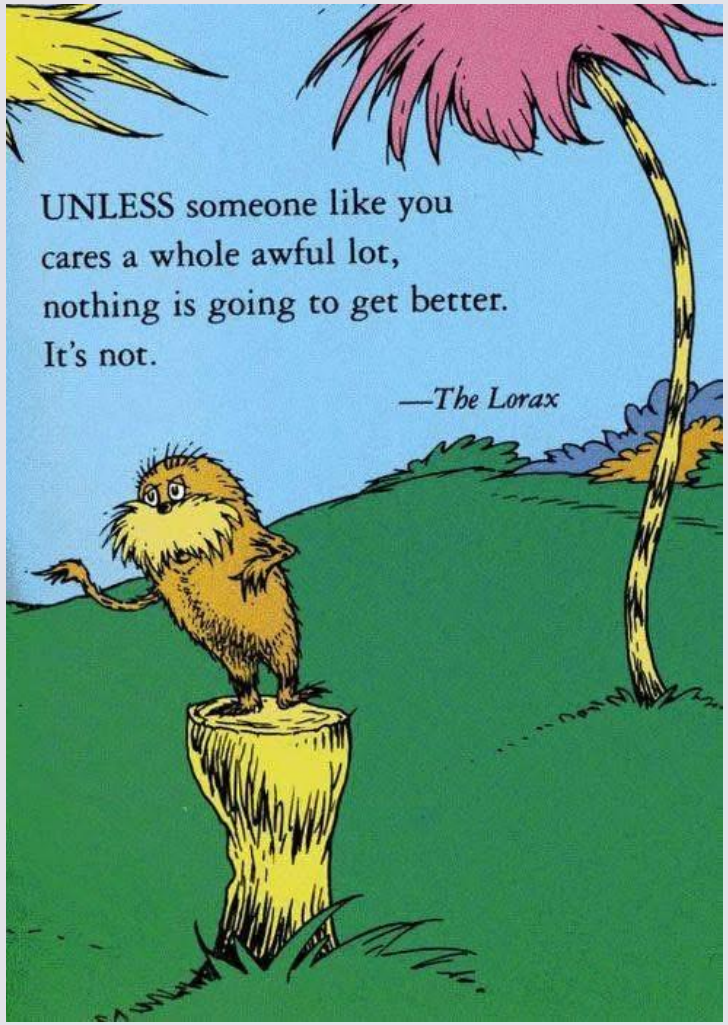
OBJECTIVES



- At the end of the presentation participants will be able to identify two gender affirming care evidenced based guidelines to utilize in treatment.
- At the end of the presentation participants will be able to prepare a letter of support for a client for starting hormones for gender affirming surgery.
- At the end of the presentation participants will be able to apply three alternative charting documentation methods in a non-binary client chart

About us


UNLESS someone like you
cares a whole awful lot,
nothing is going to get better.
It's not.
—The Lorax

PROVIDING AFFIRMING CARE, WHY IS IT IMPORTANT?

- Risk of suicide
- Is college their first supportive environment?

PROVIDING AFFIRMING CARE

- Training all staff to ask preferred name and pronouns
- Staff/providers wear pronoun pins
- EMR should have preferred name, possible that patient could change this through portal
- Create an environment that “yells” we support you.

Medical Organizations that Support Gender Affirming Care

Major organizations

American Medical Association

Supports access to quality health care for all pe orientation

American Academy of Pediatrics

Supports age-appropriate gender-affirming care

American Psychiatric Association

Supports age-appropriate gender-affirming care

Endocrine Society

The world's oldest and largest organization of sc hormone research

Other Organizations

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American College of Obstetricians and Gynecologists
- American Nurses Association
- GLMA: Health Professionals Advancing LGBTQ Equality
- National Association of Nurse Practitioners in Women's Health
- National Association of Social Workers
- Pediatric Endocrine Society
- Society for Adolescent Health and Medicine
- World Medical Association

Guidelines

- WPATH
- Endocrine Society
- USCF
- Transline

International Journal of Transgender Health

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Standards of Care for the Health of Transgender and Gender Diverse People, Version 8

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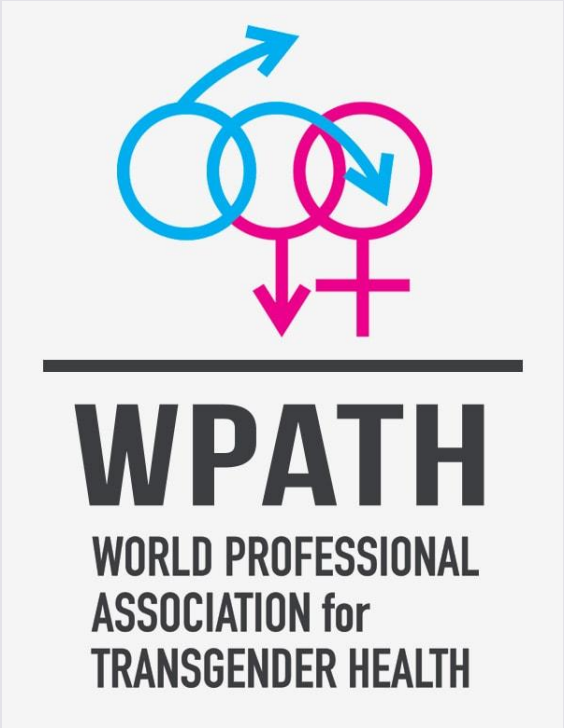
WPATH STANDARDS OF CARE

- World Professional Association of Transgender Health



Coleman, 2022

Endocrine Society

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

Hembree et al, 2017

USCF

- University of California, San Francisco

UCSF Transgender Care

Deutsch, 2017

TransLine

- Transgender Medical Consultation Service

transline, n.d.

Think, Pair, Share

- Does your college provide Gender Affirming Care?
- Is your administration supportive of this?

GENDER AFFIRMING HORMONES

- Transmasculine Patients
  - Menstrual suppression
  - Hopes for transition, hormones versus surgery

- Transfeminine Patients
  - Anti androgen medications “blockers”
  - VTE risk factors

GENDER AFFIRMING HORMONES TRANSFEMININE PATIENTS

- Suppression of testosterone
  - Allows for lower estrogen dosing
  - Minimizes male secondary sexual characteristics (although much of these are irreversible following male puberty)

TESTOSTERONE BLOCKERS

- Anti androgens
  - Spironolactone, blocks receptors, possible suppressive effect on testosterone synthesis
  - Finasteride- helps with conversion of testosterone to higher androgenic dihydrotestosterone (can help with male pattern balding, or trying to lessen masculine characteristics without full feminization
  - GnRh antagonist

GENDER AFFIRMING HORMONES

TRANSFEMININE PATIENTS

Table 1. Estrogen preparations and dosing (Grading: T O M)

Hormone	Initial-low[b]	Initial	Maximum[c]	Comments
a.Available as standard U.S. Pharmacopeia (USP) as well as compounded products b.Initial-low dosing for those who desire (or require due to medical history) a low dose or slow upward titration. c.Maximal effect does not necessarily require maximal dosing; as such maximal doses do not necessarily represent a target or ideal dose. Dose increases should be based on patient response and monitored hormone levels.				
Estradiol oral	1mg/day	2-4mg/day	8mg/day	if >2mg recommend divided bid dosing
Estradiol transdermal	50mcg	100mcg	100-400 mcg	Max single patch dose available is 100mcg. Frequency of change is brand/product dependent. More than 2 patches at a time may be cumbersome for patients

- Permanent changes seen estrogen are breast development and long term fertility implications.
- Always discuss sperm banking prior to starting blockers/estrogen.
- Labs
  - Prolactin, estrogen, testosterone, CMP (if on Spironolactone)

Deutsch, 2016

Gender-affirming hormone treatment with feminizing effects

Effect	Onset	Maximum
Redistribution of body fat	3 to 6 months	2 to 3 years
Decrease in muscle mass and strength	3 to 6 months	1 to 2 years
Softening of skin/decreased oiliness	3 to 6 months	Unknown
Decreased sexual desire	1 to 3 months	3 to 6 months
Decreased spontaneous erections	1 to 3 months	3 to 6 months
Male sexual dysfunction	Variable	Variable
Breast growth	3 to 6 months	2 to 3 years
Decreased testicular volume	3 to 6 months	2 to 3 years
Decreased sperm production	Unknown	>3 years
Decreased terminal hair growth	6 to 12 months	>3 years*
Scalp hair	Variable	—¶
Voice changes	None	—Δ

* Complete removal of male sexual hair requires electrolysis or laser treatment or both.

¶ Familial scalp hair loss may occur if estrogens are stopped.

Δ Treatment by speech pathologists for voice training is most effective.

GENDER AFFIRMING HORMONES TRANSFEMININE PATIENTS

GENDER AFFIRMING HORMONES

TRANSMASCULINE PATIENTS

- Menstrual suppression
  - Progesterone OCPs
  - Nexplanon
  - Depo (why/why not)
- Testosterone Administration
  - Permanent effects of testosterone include voice deepening, facial hair, body hair and clitoromegaly
  - Fertility implications
  - Temporary effects include muscle development, fat redistribution
  - Labs
    - CBC, lipids, testosterone

GENDER AFFIRMING HORMONES TRANSMASCULINE PATIENTS

Transmasculine regimens		
Testosterone[Δ]		
Parenteral		
Testosterone enanthate or cypionate	50 to 100 mg IM or SQ every week **or** 100 to 200 mg IM every two weeks	Weekly injections produce less peak-trough variation in effect (eg, mood); injection site reaction may occur.
Testosterone undecanoate[◇]	1000 mg IM every 10 to 12 weeks	Produces stable physiologic testosterone levels over 10 to 13 weeks.
Transdermal		
Testosterone gel 1% and 1.6%	5 to 10 grams of gel per day (equivalent to 50 to 100 mg/day testosterone)	Less variation in serum testosterone levels than injectable preparations; gel formulations can result in interpersonal transfer if contact occurs before fully dried (rare).
Testosterone patch	2.5 to 7.5 mg/day transdermal	Transdermal patch may produce lower serum testosterone levels and more skin irritation compared with gels.

Suggestions shown in table are based upon case descriptions and experience. Regimen and dose must be carefully individualized based upon patient age, goals of therapy, whether pre- or postgonadectomy, and comorbid medical conditions and risks. Refer to UpToDate topics on transgender men and transgender females.

Deutsch, 2016

Masculinizing effects in female-to-male transgender persons

Effect	Onset	Maximum
Skin oiliness/acne	1 to 6 months	1 to 2 years
Facial/body hair growth	6 to 12 months	4 to 5 years
Scalp hair loss	6 to 12 months	—*
Increased muscle mass/strength	6 to 12 months	2 to 5 years
Fat redistribution	1 to 6 months	2 to 5 years
Cessation of menses	1 to 6 months	—¶
Clitoral enlargement	1 to 6 months	1 to 2 years
Vaginal atrophy	1 to 6 months	1 to 2 years
Deepening of voice	6 to 12 months	1 to 2 years

* Prevention and treatment as recommended for biological men.

¶ Menorrhagia requires diagnosis and treatment by a gynecologist.

Reproduced from: Hembree W, Cohen-Kettenis P, Gooren L. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2017; 102(11):3869-3903. By permission of Oxford University Press on behalf of the Endocrine Society. Copyright © 2017 Oxford University Press. Available at: https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/gender-dysphoria-gender-incongruence.

GENDER AFFIRMING HORMONES TRANSMASCULINE PATIENTS

SEXUAL HEALTH IMPLICATIONS

- Gathering a sexual history
  - Sexual identity, make sure you understand their “lingo!”
  - Gender identity of their partner
  - What body parts have gone where?
  - ALWAYS ALWAYS ALWAYS ASK IF SEX WAS CONSENSUAL
  - Pre-exposure prophylaxis

Think, Pair, Share

- What experiences have you had on your campus with Gender Affirming Patients, positive or negative. What did you learn from that experience?
- How do you handle transphobic people (students or staff/faculty)?

DSM 5 CRITERIA AND SUPPORTING MENTAL HEALTH LETTER

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two or more of the following:
  - incongruence with primary or secondary sex characteristics
  - strong desire to be rid of sex characteristics
  - a strong desire for the sex characteristics of the other grender
  - a strong desire to be of the other gender
  - a strong desire to be treated as the other gender
  - one has the typical feelings and reactions of the other gender

APA, 2013

Documentation Guidance

- Discuss documentation with patients including if they would like their pronouns in the chart or not.
- Consider updating names for cisgender clients if they use a name other than their full legal name (Ex: Michael goes by Mike, update this in Mike's chart to normalize use of non-legal names across genders).
- Inform patients who can or cannot see their pronouns, gender identity, sexual orientation, and other personal identifying information in their chart.
- Inform patients of how to change this information (i.e., who do they ask to update their name, pronouns, etc.).
- Avoid using Gender Dysphoria (F64.0) as a diagnostic code unless it is required for access to treatment.
- If possible, avoid use of pronouns for any patient when writing notes, instead using, "patient," "student," or "client," depending on your role and setting.
- Focus documentation on mental health, how client is coping, and how you supported them, not on policies or specific threats.
- When possible, refrain from disclosing transgender status in documentation.

Medical Documentation Tips	
Diagnostic codes Initial	
(z 71.9) Health Counseling Health counseling	General counseling about GAC.
F64.8 Other gender identity disorders	if someone **does** want gender care on their chart (or requires it for coverage)
F64.9 Gender identity disorder, unspecified	if someone **does** want gender care on their chart (or requires it for coverage)
F64.0 (ICD-11) Gender incongruence	
E34.9 Endocrine disorder NOS	- endocrine disorder nos **plus** testosterone deficiency or estrogen deficiency if they **do not** want gender care in their chart.
Diagnostic codes Follow-up appt	*Z-code generally NOT a primary code
Z79.899 long term monitoring for high-risk medications	usually a secondary dx when managing a chronic condition requiring medication therapy.
Z79. 899 Medication management	
Z79.890 Personal history of ongoing treatment with hormonal therapy	
Z79.890 Other long term (current) drug therapy, hormone replacement therapy	used for current or long-term hormone replacement therapy.
Z79.80 Hormone replacement therapy	
Z51.81 therapeutic drug level monitoring	
Diagnostic codes other	*** specific dx code
E 29.1 low serum testosterone	diagnosis for testicular hypofunction. -condition occurs when the testes don't produce enough testosterone.
E28.39 low estrogen levels	used when estrogen production is insufficient due to defects in the ovary
N93.9 Abnormal uterine bleeding (AUB)	anything bleeding related.
other (ie PCOS, dyspareunia, atrophic of skin unspecified, dysuria)	
Hypogonadism	post surgical

*** if using z code as primary code, indicate in chart pt does NOTwant a gender code so coding team knows; some insurance carriers may deny z code claims
***Use the most specific diagnosis code for the problems addressed at the office visit.

Mental Health Documentation Tips	
Topic	**Documentation Example**
Loss or fear of loss of access to hormones or surgical procedures	Client discussed concerns/stress/fears related to losing medical care. Writer explored coping strategies and ways to build resiliency and develop a plan.
Issues related to being misgendered by others	Client discussed concerns about unmet needs in interpersonal relationships. Writer helped client develop coping strategies to effectively self-advocate.
Issues related to family disowning because of being trans	Client discussed family relationships and a need to have no contact with family due to values differences. Writer supported client to develop a plan for… (housing, finances, etc.)
Issues related to losing housing/job due to being transgender	Client discussed recent loss of job/housing and experiencing extreme distress related to this. Discussed ways to increase safety and apply to (jobs, housing) that Writer supported client to develop a plan for… (housing, finances, etc.)
Concerns about traveling due to being transgender	Described feelings of overwhelm and lack of safety. Discussed ways to increase safety and develop a plan to manage stress
Concerns about being outed in the workplace	Client reported fears of privacy concerns in workplace. Client reported feelings of vulnerability due to workplace dynamics. Discussed ways to establish boundaries for self-protection.

Tips learned

- Importance of shared decision making
- Don’t be scared, learn with your students/patients
- Build your network

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Questions

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Session 4: Gender Affirming Care, All you need to know

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