GENDER AFFIRMING PRIMARY CARE FOR TRANSGENDER AND NONBINARY ADULTS







DISCLAIMER



There will be discussion of off-label use of FDA approved medications.



I have no conflicts of interest to disclose.

LEARNING OBJECTIVES

01

Review affirming language for care of transgender and nonbinary adults

02

Understand medical and surgical options for gender affirmation, including risks and benefits 03

Utilize preventive care recommendations per guidelines in well-person care for transgender and nonbinary adults

TERMINOLOGY







WHAT IS AFFIRMING CARE?

LANGUAGE

KNOWLEDGE

DOCUMENTATION



CLINIC ENVIRONMENT



POLICY



Understanding Gender

SEX ASSIGNED AT BIRTH

Male

Female

Intersex

GENDER IDENTITY

Man

Woman

Non-Binary

A persons deepseated, felt sense of gender, or how a person feels on the inside regardless of what their body looks like.

Cisgender, adj. (pronounced /sis-gender/)

Transgender, adj. (pronounced /trans-gender/)

The sex that someone is labeled at birth, usually based on the appearance of their genitals.

HOW DO I KNOW

- What are your pronouns?
- What pronouns do you use?



GENDER IDENTITY TERMINOLOGY

USE

- Transgender/trans man/woman
- Sex designated/assigned at birth
- Gender affirming hormone therapy (GAHT)
- Genital gender affirming surgery
- Nonbinary, genderqueer, bigender, agender, pangender, gender fluid, transfeminine, transmasculine

AVOID

- FTM/ MTF, M-F, F-M, transfemale, transmale
- Natal/biological sex
- Cross-sex hormone therapy
- Sex reassignment surgery
- Gender nonconforming

TWO-SPIRIT PEOPLE



- Native American two spirit people are male, female, and sometimes intersex individuals who combine activities of both men and women with traits unique to their status as two spirit people. In most tribes, they are considered neither men nor women; they occupy a distinct, alternative gender status. - IHS
- Two-spirit people may or may not have gender dysphoria and need/desire medical treatment

Robinson, 2019

STIGMA AND DISCRIMINATION



STIGMA & DISCRIMINATION

When surveyed, transgender Americans report being harassed or disrespected or physically assaulted









37% 3% IN RETAIL STORES

35% 2%
IN HOTELS OR
RESTAURANTS

25% 2%
IN HEALTH
CARE SETTINGS

29% 6% BY POLICE

> Grant et al. 2011; James et al. 2015

STIGMA & DISCRIMINATION

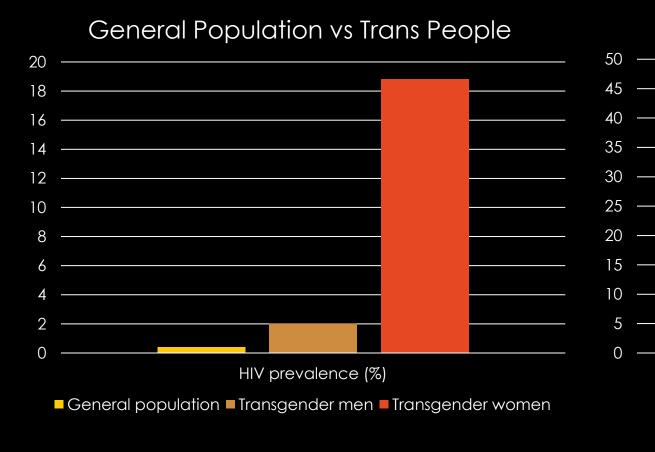


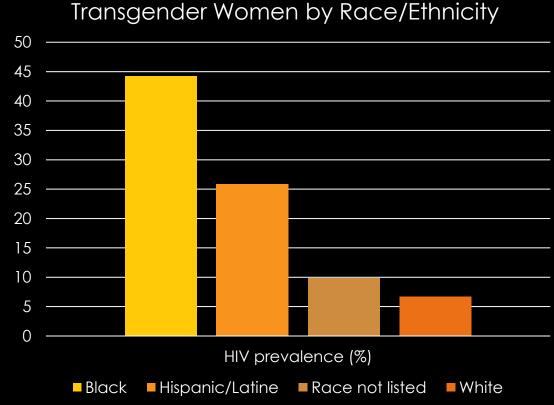
Because of fear of discrimination, one-in-five transgender people postponed or did not try to get health care in the past year.² 29%



of trangender people reported having to teach their health care provider about transgender health issues.²

HIV PREVALENCE IN THE US





NONMEDICAL GENDER AFFIRMING INTERVENTIONS

BINDING



Binding best practices (click here!)

GENDER AFFIRMING TOOLS



- 'Packing' for penile prosthetics and stand-topee devices
- Risks: Blistering, vaginal infections, and abscesses, contact dermatitis.



 Risks for silicone breast inserts: skin breakdown if taping, acne, contact dermatitis.

Method 1 Front View Side View Method 2 Front View Side View

TUCKING/GAFFING



COLORADO NAME CHANGE PROJECT:

www.namechangeproject.org/



Change Your Legal Name

Update Records & Gender Marker

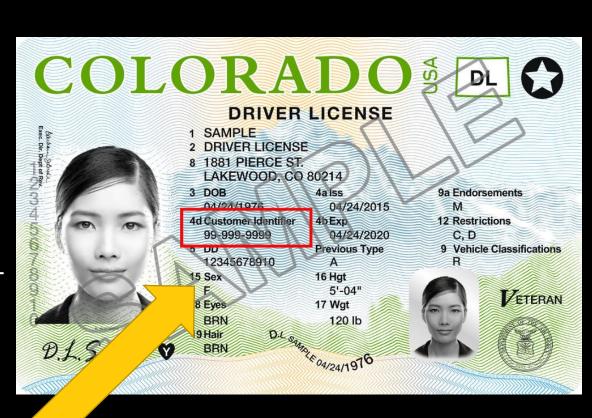
Calendar

Contact Us



GENDER MARKER ON LICENSE OR ID

- DMV Gender Marker Change Form
- Adults can complete without a medical provider. Minors require medical provider authorization.
- Decide whether to do at same time as name change – risks for discordant name/gender marker.
- 3rd gender marker (X) allowed on CO driver's licenses



SILICONE INJECTIONS



- What: Often done in "pumping parties" or in some salons by unlicensed people, using non-FDA approved materials, like industrial grade silicone. Inexpensive way to obtain feminine curves
- Implications: Dangerous! Can lead to local necrosis/ulceration, emboli, infection, sepsis, chronic granulomatous pneumonitis, ARDS, and death
- Important to document, but typically surgical excision is not possible or safe. NSAIDs/tetracyclines can help with inflammation.
- Could impair absorption of injectable medications if injecting at a site where silicone is located

VOICE TRAINING

- For all gender identities
- Local voice therapy resources
- Denver Health, UCH and Kaiser offer voice therapy
- Apps available for voice coaching online



GENDER AFFIRMING HORMONE THERAPY (GAHT)

GENDER DYSPHORIA –DSM 5 VS GENDER INCONGRUENCE – ICD-11

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender from one's assigned gender).

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

GUIDELINES

- Fenway Institute Guideline (2021)
- UCSF Guidelines (2016)
- World Professional Association of Transgender Health (WPATH) - Standards of Care version 8 (2022)
- Endocrine Society Guidelines (2017)

APPROACHES TO PROVIDING HORMONE THERAPY

Traditional Model

- Assignment of mental health diagnosis (GID)
- Assignment of diagnosis of Transsexualism
- Evaluation and clearance for transition by mental health provider
- Mandated psychotherapy
- Necessity of Real Life Experience (RLE)

Informed Consent Model

- Pathologizing diagnoses not necessary
- No clearance from mental health needed
- No mandated psychotherapy
- No RLE
- Prescription after medical evaluation and obtaining informed consent

HORMONE THERAPY: INDICATIONS AND CONTRAINDICATIONS

Indications

 Treating and alleviating sx of Gender Dysphoria

Absolute Contraindications

- Hormone-sensitive cancers
- Pregnancy
- End-stage liver disease
- Inability to consent

REASONS TO CONSIDER TEMPORARILY HOLDING GAHT

- Acute thromboembolic condition, e.g. ACS, pulmonary embolism
- Acute condition for which thrombotic risk is elevated, e.g. sepsis, severe Covid
- Acute organ failure, e.g. kidney, liver

Stabilize the patient, treat the underlying condition, mitigate ongoing risks for complications, then re-start GAHT when safe with shared-decision making between the patient and medical team

RISK LEVEL OF GENDER AFFIRMING HORMONE THERAPY

RISK LEVEL	Testosterone-based Regimens		
Likely increased risk	 Polycythemia Infertility Acne Androgenic Alopecia Hypertension Sleep Apnea Weight Gain ↓ HDL cholesterol and ↑ LDL cholesterol 		
Likely increased risk with presence of additional risk factors	Cardiovascular Disease Hypertriglyceridemia		
Possible increased risk with presence of additional risk factors	Type 2 DiabetesCardiovascular Disease		
No increased risk or inconclusive	 Low Bone Mass/ Osteoporosis Breast, Cervical, Ovarian, Uterine Cancer 		

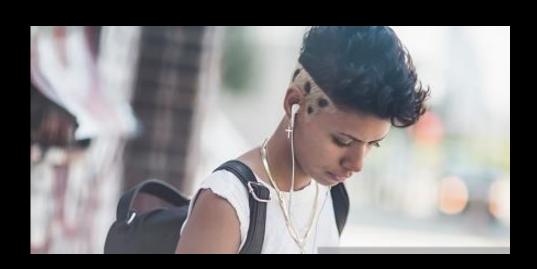
WPATH SOC v 8 Coleman, et al. 2022

RISK LEVEL OF GENDER AFFIRMING HORMONE THERAPY

RISK LEVEL	Estrogen-based regimens	
Likely increased risk	 Venous Thromboembolism Infertility Hyperkalemia Hypertrigyceridemia Weight Gain 	
Likely increased risk with presence of additional risk factors	Cardiovascular DiseaseCerebrovascular DiseasePolyuria/DehydrationCholelithiasis	
Possible increased risk	HypertensionErectile Dysfunction	
Possible increased risk with presence of additional risk factors	Type 2 DiabetesLow Bone Mass/OsteoporosisHyperprolactinemia	
No increased risk or inconclusive	Breast and Prostate Cancer	

WPATH SOC v 8 Coleman, et al. 2022

PATIENTS ALREADY TREATED WITH HORMONES



- Many patients may already be taking hormones due to lack of access to affirming providers, insurance, etc
 - Find out what they are taking
 - Screen for side effects
 - Ensure appropriate dosing/formulation
 - Informed Consent
 - Check monitoring labs
- Minimize interruptions in therapy, even if using nonprescribed hormones

TRANSITIONING IN NONBINARY/ GENDERQUEER PEOPLE

- Some nonbinary people may choose to do all, some or none of social, medical and surgical gender affirming options available to them.
- Important to support them in transition to their target gender.
- Document when medical or surgical treatments may be harmful or counteract gender transition goals.
- Okay to start with lower doses of hormones and titrate to effect, or treat for desired period of time and discontinue per patient goals



GAHT FOR TRANSMASCULINE PATIENTS

EFFECTS OF TESTOSTERONE

Irreversible

- Deepened voice
- Increased coarse, thick hair
- Facial hair growth
- Possible hair loss
- Clitoromegaly

Reversible

- Amenorrhea
- Central weight gain
- Increased muscle mass/strength
- Increased physical energy
- Acne
- Increased libido
- Mood changes
- ?Fertility affected

TESTOSTERONE PREPARATIONS

Medication	Usual Dosage	Titration	Comments
 Testosterone cypionate (cottonseed oil) Testosterone enanthate (sesame oil) 	100mg SC/IM weekly or 200mg every 2 wks	40-80mg weekly, may increase by 20- 40mg q 2-4 weeks. Max dose 200mg/wk.	Rx w/ 23-25G needles with 1-3mL syringe +/- 18G needle for drawing up testosterone
Testosterone gel	50mg daily, applied to upper arms or thighs	May start at 12.5mg daily and increase by 12.5-25mg q 2-4 wks, max 100mg daily	Need to keep skin covered and avoid contact for at least 2 hours after administration
Testosterone patch, 2mg or 4mg	4mg patch applied daily to upper arm, thigh, abdomen or back. Change every 24 hours	May start at 2mg daily and increase after 2-4 wks, max 6mg daily	Risk of contact dermatitis, rotate patch sites.

Thompson et al. 2021; UCSF 2016

LAB MONITORING

Baseline Labs

- LFTs, CBC, hCG, HbA1C, Lipids
- Consider total testosterone level if evidence of androgenizing condition
- Indicated screening tests, ie: cervical Pap, STI screening if applicable

Monitoring Labs

- Check Hb/Hct at 3-6 months, then q 6-12 mo
- Consider lipids and HbA1c q 12 mo depending on risk factors
- Total testosteronelevel, goal 400-700ng/dL
 - Check midway between injections

WHICH OF THE FOLLOWING IS FALSE REGARDING TESTOSTERONE AND PREGNANCY?

- A. Testosterone reliably suppresses ovulation when administered regularly in people born with ovaries.
- B. Transgender men treated with testosterone who are amenorrheic can still become pregnant.
- C. Testosterone is teratogenic in pregnancy.
- D. Non-hormonal and progesterone-based contraceptive methods will reliably prevent pregnancy in transgender men treated with testosterone and will not interfere with masculinizing effects.

Which of the following is false regarding testosterone and pregnancy?

Testosterone reliably suppresses ovulation when administered regularly in people born with ovaries.

Transgender men treated with testosterone who are amenorrheic can still become pregnant.

Testosterone is teratogenic in pregnancy.

Non-hormonal and progesterone-based contraceptive methods will reliably prevent pregnancy in transgender men treated with testosterone and will not interfere with masculinizing effects.

TESTOSTERONE AND PREGNANCY

- Light, et al., 2014: 41 trans men
 - 2/3 had planned pregnancy
 - 1/3 had unplanned pregnancy
- 61% used testosterone before pregnancy
 - 80% resumed menstruation after stopped testosterone
 - 20% conceived while still ameorrheic
- Only 15% had preconception counseling.
- Most common contraception: Condoms or none



CONTRACEPTION & TESTOSTERONE



- Testosterone is not birth control and it is harmful (teratogenic) in pregnancy.
- Any method that is non-hormonal or progesterone-based method is acceptable and will not interfere with testosterone, including:
 - Etonogestrel implant
 - Levonorgestrel IUD
 - Copper IUD
 - Medroxyprogesterone injection

PATIENT CASE #1

A 19yo nonbinary transmasculine patient (they/them) has been treated with testosterone and comes in for a physical. Their CBC shows Hb/Hct of 18.5/54.2 (normal range for cis men is Hb 13-18g/dL and Hct 38-52%). Testosterone level 700mg/dL. (Normal 300-700mg/dL).



Which of the following is in the differential diagnosis for this patient?

- A. Obstructive sleep apnea
- B. Erythropoietin-secreting tumor
- C. Erythrocytosis secondary to testosterone
- D. All of the above

Which of the following is in the differential diagnosis for this patient?

Obstructive sleep apnea

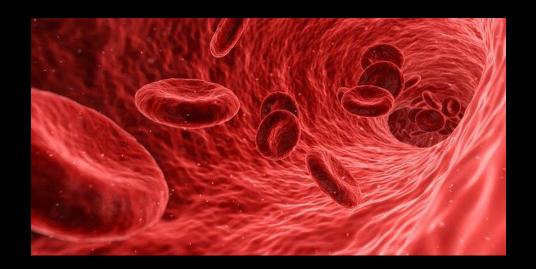
Erythropoietin-secreting tumor

Erythrocytosis secondary to testosterone

All of the above

POLYCYTHEMIA AND TESTOSTERONE

- Differential diagnosis: Erythrocytosis secondary to testosterone, chronic hypoxia, OSA, smoking, polycythemia vera, EPO-secreting malignancy (rare)
- Risks: 2-5% risk of thrombotic event, depending on age.
- Management: Reduce testosterone dose or switch to topical formulation, sleep study (if risk factors), smoking cessation. If severe, consider phlebotomy or donate blood.



PATIENT CASE #2

24yo trans man (he/him) who has been injecting testosterone he bought off the street and has had several recurrent inflammatory abscesses. He reports drinking up to a pint of liquor daily. Labs show ALT 110 and AST 150, total bilirubin 3.6, normal alkaline phosphatase, INR and platelets. He wants to be prescribed testosterone for gender affirmation.

The patient's transaminitis is most likely secondary to his nonprescribed testosterone use:

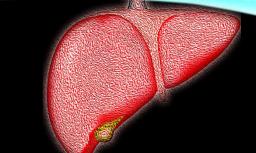
- A. True
- B. False

The patient's transaminitis is most likely secondary to his non-prescribed testosterone use:

True

False

TESTOSTERONE THERAPY AND ABNORMAL LIVER FUNCTION TESTS



- Testosterone has not been associated with abnormal LFTs in GAHT.
- Harm reduction approach encouraged. Consider contaminants of non-prescribed testosterone and potential for shared needles.
- Workup abnormal liver function tests as with any patient (e.g. hepatitis B/C, HIV, ferritin, RUQ US, etc).
- If hepatic synthetic function is not impaired (e.g. elevated INR, low albumin) then testosterone can be continued, in safe dosages and with sterile injection supplies.
- If hepatic synthetic function is impaired, then testosterone is contraindicated.

 Benotsch 2013; Lexicomp; Stangl et al 2021



GAHT FOR TRANSFEMININE PATIENTS

EFFECTS OF ESTROGENS AND ANTI-ANDROGENS

Irreversible

- Breast growth
- Testicular atrophy
- Oligospermia, eventual infertility (?)

Reversible

- Loss of muscle mass/strength
- Wt gain (butt, hips, thighs)
- Softer skin
- Less facial/body hair
- Decreased libido
- Erectile dysfunction
- Mood changes

CARDIOVASCULAR RISK WITH FEMINIZING HORMONE THERAPY

- Increased rates of DVT/PE: Incidence rate 2.3 events/ 1,000 person years
 - Higher likelihood with estradiol PO in first year of hormone therapy
 - Usually present with other risk factors, e.g. older age, smoking, HIV, undiagnosed thrombotic disorder
 - Ethinyl estradiol highest risk estrogen (not used any more!)
- Increased risk of CAD/CVD
 - Increased deaths from ischemic heart disease OR 1.64 (1.43 1.87)
 - Ethinyl estradiol OR 3.64 (1.52 8.73)
 - Fatal stroke <65yo SMR 2.11 (95% CI: 1.32 3.21)
- Prevention: Avoid ethinyl estradiol and conjugated estrogens, use transdermal estradiol in high-risk patients, encourage smoking cessation, avoid supratherapeutic estradiol levels

Weircx 2014; Asscheman 2011; Dhejne 2011; Wilson 2009; Khan et al 2019

Slide content credit: Tonia Poteat

ESTRADIOL PREPARATIONS

Medication	Usual Dosage	Titration	Comments
 Estradiol cypionate (cottonseed oil) Estradiol valerate (sesame oil) 	 5mg IM/SC q 2 wks 20mg IM/SC q 2 wks 	 2.5mg q 2 wks, max dose 10mg q 2 wks Start 10-20mg q 2 wks, max dose 40mg q 2 wks. 	 Halve dose for weekly dosing Rx w/ 23-25G needles with 1- 3mL syringe +/- 18G needle for drawing up
Estradiol tablet	6mg daily PO/SL	 Start 2mg daily, increase by 2mg q 4-12 wks . Max dose 8mg. 	 Can dissolve PO tabs SL Divide dosing for 4mg or >
Estradiol patch	0.2mg patch twice weekly	Start 0.05-0.1mg patch once or twice weekly, titrate up q 4-12 wks to max dose of 0.4mg.	 Risk of contact dermatitis, rotate patch sites. Twice weekly patches stick better. Preferred for pts with high CVD risk

ANTI-ANDROGENS

Medication	Usual Dosage	Titration	Comments
Spironolactone	200mg daily (or 100mg BID)	50mg PO daily, titrate up q 4-12 weeks for testosterone suppression, max dose 300mg	 Monitor serum Cr/ K+ Use cautiously in CKD and with ACEI/ARB Higher doses are unlikely to give more benefit and are more likely to result in side effects
FinasterideDutasteride	5mg PO daily0.5mg PO daily	No titration necessary	 Counsel about possible risk of higher grade prostate cancer
Leuprolide	11.25mg IM q 3 mo	Can titrate up to max dose of 30mg for testosterone suppression	Prior auth is difficult

Orchiectomy

Thompson et al. 2021; UCSF 2016; Micromedex



MONITORING

Baseline Labs

- BMP, +/- LFTs.
- Consider lipids, A1c if risk factors

Monitoring Labs

- For spironolactone: check BMP 2-8 wks after starting or changing dose then q12mo
- Lipids, A1c q 6-12 months if risk factors
- Estradiol levels, target range 100-200 pg/ml and total testosterone <50mg/dl
 - Mid-way between injections or 3-4 hours after PO dose

PROGESTERONE?

- Most protocols recommend against using, but patients often desire for breast growth and/or libido
- Can paradoxically increase androgenic effects
- Women's Health Initiative data (not high quality) in postmenopausal cis-women on use with conjugated estrogens showed an increased risk of VTE, CVA and MI
- Harm reduction approach if patients desire:
 - Provera 2.5 to 10 mg daily
 - Prometrium 100-200 mg daily

32yo trans woman who presents to establish care.

Past History:

- DVT three years ago after surgery for femur fracture, treated x 3 mo with AC.
- GAHT x 5 years, estradiol 6mg PO and spironolactone 100mg daily.
- No FH blood clots or d/o
- Smokes occ 2x/mo



PATIENT CASE #3

Which of the following is **true** regarding this patient's hormone therapy?

- A. Her estradiol should be stopped because of her recurrent VTE risk.
- B. Her estradiol is safe to continue because her DVT was provoked in the setting of a fracture.
- C. Transdermal estradiol has a superior safety profile to oral estradiol for patients with a history of VTE.
- D. B&C
- E. None of the above

Which of the following is true regarding this patient's hormone therapy?

Her estradiol should be stopped because of her recurrent VTE risk.

Her estradiol is safe to continue because her DVT was provoked in the setting of a fracture.

Transdermal estradiol has a superior safety profile to oral estradiol for patients with a history of VTE.

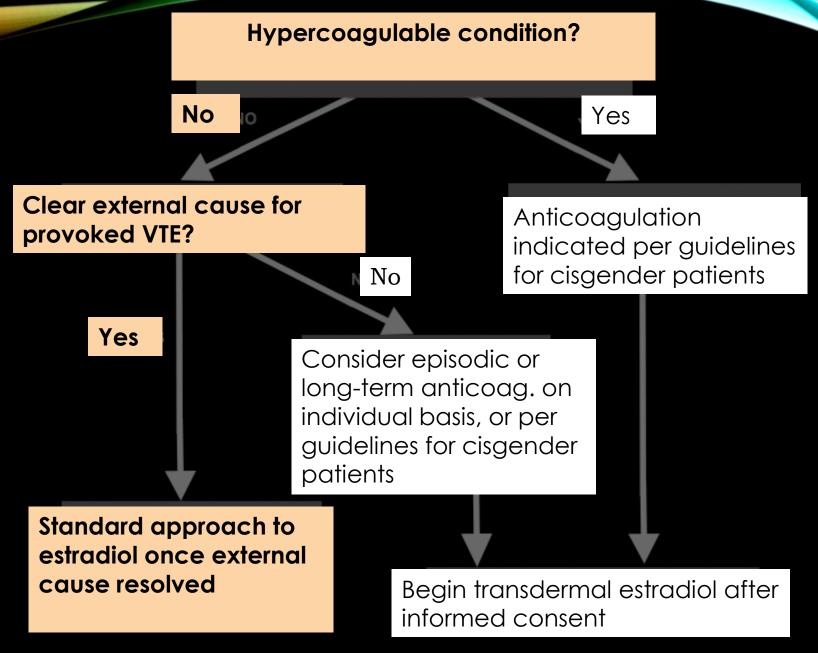
B&C

None of the above

ESTRADIOL THERAPY FOR TRANS PATIENTS WITH HISTORY OF VTE

For this patient:

- Likely no need for coagulability workup, ok to cont estradiol in setting of provoked VTE
- Encourage smoking cessation
- If unable to quit, consider switch to transdermal estradiol





PATIENT CASE #4

A 45yo transgender woman who has been taking estradiol and spironolactone for a year presents and complains that she has been having difficulty getting and maintaining erections with her partner. What are management options for this?

- A. Decrease her dose of spironolactone.
- B. Prescribe a medication like tadalafil or sildenafil
- C. Switch from spironolactone to finasteride
- D. None of the above
- E. All of the above

A 45yo transgender woman who has been taking estradiol and spironolactone for a year presents and complains that she has been having difficulty getting and maintaining erections with her partner. What are management options for this?

Decrease her dose of spironolactone.

Prescribe a medication like tadalafil or sildenafil

Switch from spironolactone to finasteride

None of the above

All of the above

If you have it, check it

GENDER AFFIRMING PREVENTIVE CARE

INTERPRETING SEX-BASED RISK ESTIMATES

- ASCVD Risk
 - Consider age of hormone initiation and total length of hormone exposure
 - Can choose to estimate sex at birth, affirmed gender or average of the two
- Osteoporosis risk (e.g. FRAX tool)
 - BMD already attained if initiated hormones in adulthood
 - Expert consensus is to use sex at birth
- Renal impairment (estimated GFR)
 - Serum Cr increased in trans men and decreased in trans women after GAHT
 - Can consider cystatin C based eGFR



PATIENTS ASSIGNED FEMALE SEX AT BIRTH: PREVENTIVE HEALTH CARE CONSIDERATIONS

Breast cancer screening

- If no top surgery, screen as patients assigned female at birth (AFAB) per USPSTF guidelines
- If s/p top surgery, develop individualized screening plan based on patient's risk factors

Cervical cancer screening

• Paps per ASCCP Guidelines. Obtain before initiation of testosterone when possible

Sexual Health and Family Planning

Assess need for contraception, anal Pap based on risk factors

Bone Mineral Density

- If oophorectomy, need testosterone at least until age 50 to maintain BMD
- Begin DXA age 65 per USPSTF guidelines or ≥5 years after oophorectomy and off testosterone

PATIENT CASE #5

40yo trans woman (pronouns: she/her) who presents to establish care and get a refill on her GAHT

- PMH: Has been on estradiol patches and spironolactone for the past 12 years.
- FamHx: Mother (age 55) and sister (age 50) with breast cancer

Should a mammogram be offered to this patient?

- A. Yes
- B. No



Should a mammogram be offered to this patient?

Yes

No



PATIENTS ASSIGNED MALE SEX AT BIRTH: PREVENTIVE HEALTH CARE

Breast Cancer Screening

 If >50yo and on hormones ≥5 yrs with enough breast tissue, perform screening mammogram per USPSTF guidelines for cis women

Prostate Cancer Screening

- Screen/monitor based on risk factors. Consider PSA cutoff lower at 1.0ng/mL
- If s/p vaginoplasty, examine prostate through anterior wall of the neovagina

Anal Cancer Screening

Anal Pap (if indicated based on risk factors)

Bone Density

- If orchiectomy, need estradiol to age 50. If contraindicated screen 5 years after orchiectomy and stopping estradiol.
- Otherwise, no indication for screening.

Source: WPATH SOC8 2022; UCSF Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

TIPS FOR AFFIRMING GENITAL EXAMS IN TRANSGENDER AND NONBINARY PEOPLE

- Do not perform genital exams if they are not medically indicated and have only necessary personnel in the room. Limit learners.
- Ask what language patients use to describe their genital area and use that language during the exam
- Use a trauma-informed approach
- Consider offering self-collected Pap and STI screening
- Work with specialists if needed to allow for exams to be conducted under sedation if severe dysphoria, discomfort or anxiety is present. (Consider offering a one-time anxiolytic prescription)

HIV PREEXPOSURE PROPHYLAXIS (PREP) IN TRANSGENDER PEOPLE

- Trans people are less likely to be included in PrEP marketing and to have heard about PrEP than cis MSM
- Having a relationship with an affirming provider and offering gender affirming care (including GAHT) at visits where PrEP is prescribed increases persistent use of PrEP in trans people



(Wilson et al 2020; Golub et a 2019; Storholm et al, 2022; Sevelius et al, 2016)

PREP AND GAHT



- Estradiol (E2) may slightly lower levels of tenofovir, but this has not been found to be clinically significant with PrEP as measured levels have all been in the range found to be effective in larger trials (Yager et al 2022).
- In contrast, PrEP does NOT impact gender affirming hormone levels.



GENDER AFFIRMING SURGERIES



GENDER AFFIRMING SURGERIES

Surgeries for Transfeminine People

- Orchiectomy
- Vaginoplasty
- Penectomy
- Breast Augmentation
- Reduction
 Chondrothyroidplasty
 (Tracheal shave)
- Body Contouring (facial feminization)

Surgeries for Transmasculine People

- Mastectomy/chest reconstruction
- Hysterectomy/BSO
- Metoidioplasty
- Phalloplasty
- Scrotoplasty (+ testicular implants)
- Urethroplasty
- Vaginectomy

EXPANDED INSURANCE COVERAGE OF GENDER AFFIRMING SURGERIES IN CO IN 2023



Search

Q

Division of Insurance Home

For Consumers >

Insurance Products >

Insurance Industry >

Statutes, Regulations & Bulletins

Newsroom & Announcements

DORA Home

Biden Administration Announces Approval of Colorado's Inclusive Health Care Plan to Set Colorado's Essential Health Benefits

Tuesday, October 12, 2021

Media Contact:

Vincent Plymell vincent.plymell@state.co.us

Benefits to explicitly include services to address substance use disorder and mental health

DENVER - Today, the Centers for Medicare & Medicaid Services (CMS), announced it has approved the Colorado health insurance plan that will set the minimum health care coverage requirements starting in 2023. The plan establishes the essential health benefits (EHBs) within Colorado for individual plans (meaning not from an employer) and small group plans (for small employers with less than 100 employees).

CMS Administrator Chiquita Brooks-LaSure and Deputy Administrator Dr. Ellen Montz joined Governor Jared Polis, Lieutenant Governor Dianne Primavera, Colorado Insurance Commissioner Michael Conway and Senator Brittany Pettersen to announce the approval at the Governor's Residence at the Boettcher Mansion.

Recent

Insurance Commissioner Conway Honored with Prism Award

Aug. 22, 2022 - One Colorado award recognizes his effort in advancing genderaffirming care.

<u>Division of Insurance Project</u> <u>Manager Recognized by National</u> <u>Organization</u>

August 12, 2022 - NASHP selects Leilani Russell for its 2022 Rising Star Award

Polis Administration's Insurance

PREOPERATIVE CONSIDERATIONS

- No evidence supporting need to hold GAHT prior to surgery to reduce perioperative risk, though some surgeons still require this.
- Common pre-operative requirements:
 - Nicotine cessation at least 4 weeks before surgery. Many surgeons require negative nicotine testing.
 - BMI <35
 - A1c <8% (for diabetic patients)
 - HIV VL undetectable, CD4 count >200
 - Other medical conditions have been addressed. Any necessary preop cardiopulmonary testing has been performed/cleared.

On official letterhead, dated and signed ideally within 6-12 months of surgery

- Topics to address:
 - Meet criteria for gender dysphoria
 - Length of time on GAHT
 - Medical and mental health conditions are reasonably well controlled,
 - Ability to consent and adhere to perioperative care requirements
 - Stable housing for recovery
 - Support system for recovery

SURGERY SUPPORT LETTER CONSIDERATIONS



POSTOPERATIVE CONSIDERATIONS

For transfeminine patients who undergo orchiectomy (alone or as part of vaginoplasty), anti-androgen therapy can be discontinued postoperatively.

For any patient undergoing gonadectomy at least low-dose hormone therapy should be continued until at least ~50 years old to maintain bone mineral density.

The prostate is still present in trans women s/p vaginoplasty and can be examined through the anterior wall of the neovagina.

The gynecologic examination of the transfeminine person after penile inversion vaginoplasty Grimstad et al 2020

CARING FOR TRANSGENDER AND NONBINARY PEOPLE: SUMMARY

- Take into account stigma and discrimination that many transgender and nonbinary people face in health care settings
- Employ a harm-reduction approach to GAHT based on known and presumed risks an individual patient has
- Offer preventive Care Screenings based on organs that are present
- Most of the care for transgender and nonbinary people has nothing to do with their gender identity





NATIONAL RESOURCES

- <u>Fenway Institute</u> (Harvard)
- National LGBTQIA Health Education Center free CME webinars
- UCSF Center of Excellence for Transgender Health
- Callen Lorde Community Health Center
- World Professional Association of Transgender Health
- TS Roadmap: Resources for patients, especially on surgery (though caution-transgender woman-specific and uses outdated language)
- <u>Transline</u>: free online consultation

RESOURCES - COLORADO

- <u>Transgender Center of the Rockies</u> (Denver)
- Youth Seen (Denver/Boulder)
- The Center on Colfax (Denver)
- Out Boulder County
- Colorado Name Change Project
- One Colorado
- Colorado Crisis Services
- Colorado Statewide Resources
- Northern Colorado Resources
- Southern Colorado Resources
- Western Slope Resources

REFERENCES

- Asscheman, H. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. European Journal of Endocrinology, 164, 635-642. doi:10.1530/EJE-10-1038
- Assefa, H. (2015, August 14). Study estimates cost of care for transgender troops. Cnn Wire Service. Retrieved from http://search.proquest.com.contentproxy.phoenix.edu/docview/1706514761?accountid=458
- Benotsch, E. G., Zimmerman, R., Cathers, L., McNulty, S., Pierce, J., Heck, T., Perrin, P. B., ... Snipes, D. (2013). Non-medical use of prescription drugs, polysubstance abuse and mental health in transgender adults. *Drug and Alcohol Dependence*, 132(1-2), 391-394. doi:10.1016/j.drugalcdep.2013.02.027
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., & Feldman, J. (2012). World Professional Association for Transgender Health Standards of Care, Version 7 (7th ed.). Retrieved from http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf
- Deutsch, M., & Feldman, J. (2013). Update recommendations from the World Professional Association for Transgender Health Standards of Care. America Family Physician, 87 (2), 92-95. Retrieved from
- Deutsch, M., Bhakri, V., & Kubicek, K. (2015 (Santos, Wilson, Rapues, Macias, Packer, & Fisher-Raymond, 2012)). Effects of Cross-Sex Hormone Treatment on Transgender Women and Men. Obstetrics and Gynecology, 125, 605-610. doi:0.1097/AOG.000000000000692
- Dhejne, C., Lichtenstein, P., Boman, M., & Johansson, ALV. (2011). Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *Plos One*, 6(2), 1-9. doi:doi:10.1371/journal.pone.001688
- GLAAD. (2015). GLAAD Media Guide. Retrieved from Gay & Lesbian Alliance Against Defamation: http://www.glaad.org/reference/transgender
- Gomez-Gil, E., Zubiaurre-Elorza, L., Esteva, I., Guillamon, A., Godas, T., Cruz-Alm (Stehens, Bernstein, & Phillip, 2011)araz, M., Halperin, I., ... Salamero, M. (2012). Hormone-Treated Transsexuals Report Less Social Distress, Anxiety, and Depression. Psychoneuroendocrinology, 37, 662-670. Retrieved from: http://dx.doi.org/10.1016/j.psyneuen.2011.08.010
- Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (Eds.). (2011). Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and the National Gay and Lesbian Task Force.

REFERENCES

- Khan J, Schmidt RL, Spittal MJ, Goldstein Z, Smock KJ, Greene DN. Venous Thrombotic Risk in Transgender Women Undergoing Estrogen Therapy: A Systematic Review and Metaanalysis. Clinical chemistry. 2019 Jan 1;65(1):57-66.
- Maycock, L. B., & Powell-Kennedy, H. (2014). Breast Care in the Transgender Individual. Journal of Midwifery and Women's Health, 59, 74-81. doi:10.1111/jmwh.12066
- Meriggiola, M. C., & Berra, M. (2012). Long-term cross-sex hormone treatment is safe in transsexual subjects. Asian Journal of Andrology, 14, 813-814. doi:10.1038/aja.2012.89
- Mizuno, Y., Frazier, E., Huang, P., & Skarbinski, J. (2015). HIV/AIDS; Transgender HIV-infected women in U.S. have poorer disease control and unmet basic needs. Aids Weekly. Retrieved from http://search.proquest.com/docview
- National Center for Transgender Equality. (September 11, 2012). Injustice at Every Turn: A report of the national transgender discrimination survery. In J. M. Grant, L. A. Mottet, & J. Tanis (Eds.), Executive Summary. Retrieved from http://www.transequality.org/issues/resources/national-transgender-discrimination-survey-executive-summary
- Olson, J., & Garafolo, R. (2014). The Peripubertal Gender-Dysphoric Child: Puberty Suppression and Treatment Paradigms. *Pediatric Annals*, 43.6, 132-139. doi: 10.3928/00904481-20140522-0
- One Colorado Education Fund. (2014). *Transparent: The State of Transgender Health in Colorado*. Retrieved from http://www.one-colorado.org/wp-content/uploads/2014/11/OC_Transparent_Download2mb.pdf
- Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care. Social Science and Medicine, 84, 22-29. doi.org/10.1016/j.socscimed.2013.02.019
- Quiros, C., Patrascioiu, I., Mora, M., Beatriz-Aanda, G., Hanzu, F. A., Gomez-Gil, E., Godas, T., ... Halperin, I. (2015). Effect of cross-sex hormone treatment on cardiovascular risk factors in transsexual individuals. Endocrinología Y Nutricion, 62(5), 210-216. Retrieved from
- Santos, Wilson, E. C., Rapues, J., Macias, O., Packer, T., & Fisher-Raymond, T. (2012). HIV treatment cascade among transgender women. Sexually Transmitted Infections, 90, 430-433. doi:10.1136/sextrans-2013-051342

REFERENCES

- Shields, J. P., Cohen, R., Glassman, J. R., Whitaker, Franks., H., & Bertolini, I. (2013). Estimating Population Size and Demographic Characteristics of Lesbian, Gay, Bisexual, and Transgender Youth in Middle School. Journal of Adolescent Health, 12(2), 248-250. doi:10.1016/j.jadohealth.2012.06.016
- Stephens, S. C., Bernstein, K. T., & Phillip, S. S. (2011). Male to Female and Female to Male Transgender Persons have Different Sexual Risk Behaviors Yet Similar Rates of STDs and HIV. Aids and Behavior, 15(3), 683-686. doi:10.1007/s10461-010-9773-1
- Tangpricha, V. (2015). The safety of transgender hormone therapy. Journal of Clinical & Translational Endocrinolog, 2, 130. doi.org/10.1016/j.jcte.2015.09.001
- Torres, M., & Sylvester, B. (2015, March 24). 14 Stunning Portraits of Beautiful, Diverse Transgender Teens. Retrieved November 6, 2015, from Cosmopolitan Web site: http://www.cosmopolitan.com/sex-love/news/a38146/we-are-the-youth-photo-series/
- U.S. Census Data. (2015). World Population Review. Retrieved from
- University of California San Francisco Transgender Center of Excellence Primary Care Protocols. (2011, April). Retrieved from http://www.transhealth.ucsf.edu/trans?page=protocol-hormones
- Vancouver Coastal Health. (2015, October 25). Transgender Health Information Program. Retrieved from http://transhealth.vch.ca/medical-options/hormones/puberty-blockers
- Wierckx, K., Mueller, S., Weyers, S., Van Caenegem, E., Roef, G., Heylens, G., & T'Sjoen, G. (2012). Long-term evaluation of cross-sex hormone treatment in transgender individuals. *Journal of Sexual Medicine*, 9, 2641-2651. doi:10.1111/j.1743-6109.2012.02876.x
- Wilson, E., Rapues, J., Jin, H., & Raymond, H. F. (2014). The Use and Correlates of Illicit Silicone or "Fillers" in a Population-based Sample of Transwomen in San Francisco 2013. Journal of Sexual Medicine, 11, 1717-1724. doi:10.1111/jsm.12558
- Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. Current psychiatry reports. 2018 Dec 1;20(12):110.