Practice audit: Inclusive primary health care for gender diverse clients

The clinical audit process has been tested and refined over time. Its purpose is to encourage teams to reflect and act on the best information available to improve clinical practice. The method can be applied to any aspect of practitioner or practice activity to assist with identifying ‘where you are now’, ‘where you could do better’ and ‘how to get there’.

Topic: Inclusive primary health care for gender diverse clients

Transgender is an umbrella term used to refer to people whose natal sex and gender identity differ. While the true prevalence of people who identify as transgender is unknown, data from Youth ’12, a nationally representative survey of secondary school students conducted in 2012, indicated that 1.2% of students identified as being transgender and 2.5% of students were not sure.1 Thus for every 1,000 clients registered in an average GP practice, an estimated 10 to 40 clients may identify as gender diverse.

In the last 10 years there has been a rapid increase in the numbers of transgender people seeking medical transition support through health services. It may be that with the increasing availability of online information, digital community support and societal acceptance people are feeling more confident about expressing themselves.

Existing data suggests that transgender people face a range of issues, especially violence and discrimination, that impacts on their mental health and wellbeing.2-4 Data from the Youth ’12 survey identified significant well-being disparities for transgender school students with regard to depressive symptoms, suicide attempts and school bullying.1

Transgender young people also report significant barriers to accessing appropriate health care at both primary and secondary care levels.1 In response to the question, “in the past 12 months, has there been any time when you wanted or needed to see a doctor or a nurse (or other health care worker) about your health but you weren’t able to?”, 39.2% of the transgender respondents vs. 17.8% of the non- transgender respondents, (OR 2.7;1.8-4.1), *p* <0.0001) answered in the affirmative.1 While there is no NZ data for older transpeople it is likely that they also face barriers. Social stigmatisation and discrimination, including within the health care system, is a barrier to accessing health services and contributes to adverse outcomes.

Health professionals who are affirming of people’s gender expression can have a positive impact on wellbeing. The role of hormonal therapies for transgender people is now well established and there is evidence that early medical intervention during puberty for transgender young people has a positive impact on future health and wellbeing outcomes, especially in relation to mental health and better cosmetic outcomes through pubertal suppression5-7.

General practice teams have an important role in:

* Creating gender diverse friendly primary care services
* Providing a safe and comfortable place for staff to have conversations with clients around gender identity
* Being aware that gender identity is different from sexual orientation and providing appropriate sexual health care as needed
* Being aware that some gender diverse people are also intersex
* Promptly referring younger transgender clients to services that can offer information, support and gender affirming healthcare including puberty blockers and hormonal initiation
* Referring other transgender clients as required to services for support and gender affirming health care services including hormonal initiation (PHO, DHB, NGO services)
* Being aware of the future fertility options for trans clients from preserving fertility (cryopreservation of sperm/eggs) prior to initiation of hormonal treatments through to having a break from hormones and supporting transmen through pregnancy
* Managing maintenance hormone therapy with support from secondary services
* Providing usual health care. Clients who are trans or gender diverse experience the same health problems as other patients and have very few differing needs. Gender diverse people who have not undergone the surgical removal of breasts, cervix, uterus, ovaries, testicles or prostate remain at risk of cancer in these organs and should undergo screening recommended for these cancers. Being aware that this needs to be managed carefully, as many gender diverse people find cancer screening physically and emotionally challenging

The aims of this audit are to review practice systems.

Plan: Identify what you want to achieve

Listed below are evidence based quality standards of a service that welcomes and is respectful of transgender clients. A practice review audit based on 20 of these standards is given as an example at the end. We encourage your team to identify what you want to achieve to improve your service. This gives an opportunity to tailor an audit of medical practice for a more significant outcome.

* That the practice promotes gender diversity inclusion (which might be part of a wider LGBTQI message) in its clinic and on-line information.
* That the waiting room contains at least one poster or image that is inclusive of gender diversity.
* That unisex toilet options are available.
* That the practice has pamphlets visible that provide health messages that are inclusive of gender diversity.
* That all patients are asked about their preferred name, pronoun and title at reception, recognising that these conversations need to occur in a safe space with privacy from being overheard.
* That all staff have training on how to ask sensitive questions around gender identity in a safe and appropriate way. Further to recognise that people present to health services at different stages in their social transition with different levels of comfort around how they wish to describe themselves.
* That staff are aware of the potential negative impact of accepting enrolment forms of gender diverse young people from adults who do not yet accept the young person with their self-identified gender.
* That all patients have their self-identified gender identity registered on PIMS e.g. Medtech/My Practice and updated with the National Health Index. This is easier to do with the patient present in a private space if a phone conversation is required. Note that the Ministry of Health advice is that NHI should reflect the preferred name and gender nominated by the client.
* That staff are familiar with the current terminology people use to describe gender identity (male, female, trans male/transman, trans female/transwoman, takatāpui, fa’afafine (Samoa), fakaleiti (Tonga), akava’ine (Cook Islands), vaka sa lewa lewa (Fiji), and fafafine (Niue), non-binary, gender fluid, gender queer, or other identity. A person may identify with more than one category.
* That clinical staff are aware to ask relevant questions around gender identity. For all patients this will include asking what, if any, supports they would like to access that are linked to their gender identity. For someone who is starting to transition, or where there are concerns about the support the patient has, other potential questions include, who else is supporting them with their gender identity and how comfortable the person is currently living in the gender they identify with.
* That clinical staff recognise additional considerations for transgender young people:
* That all young people should be seen on their own for at least part of the consultation which includes a discussion around confidentiality. Recognition that this needs to be routine practice otherwise young people will not have the opportunity to voice their gender concerns to their health professional.
* That transgender young people may not have the support of their parents/guardians, but this should not preclude them from receiving support and care. That this situation needs a specialist referral.
* That the importance of prompt referral to access early interventions pre/during puberty is understood with regard to long term outcomes.
* That young people are assessed routinely for risks around abuse, bullying, drug and alcohol risk taking, sexual health and mental health concerns
* That clinical staff are mindful of the need to screen for symptoms of anxiety, depression and risk of self-harm recognising that discrimination including violence occurs more frequently for gender diverse people.
* That timely and appropriate gender affirming health care reduces the risk of mental health problems and is associated with better health outcomes.
* That clinical staff are aware of local referral pathways for publically funded gender affirming healthcare services within their DHB and how to access information about other services and supports around the country.
* That primary care clinicians have some knowledge of what Transgender Healthcare services offer:
  1. A discussion about a clients’ goals and needs that may include accessing psychological support, fertility preservation, gender affirming hormonal treatment, voice therapy, hair removal treatments, gender affirming surgical interventions.
  2. A discussion to inform the difference between reversible and irreversible therapies including options for fertility preservation (gamete cryopreservation) prior to the initiation of hormones.
  3. That the client’s understanding of treatment outcomes will be checked and that expectations are realistic.
  4. Evaluation and discussion of any health risks identified.

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| Precautions to hormonal treatment |
| Current or recent smoker |
| Heart failure, cerebrovascular disease, coronary artery disease, AF |
| History of VTE |
| Cardiovascular risk factors: BMI > 30, hyperlipidaemia, hypertension |
| Migraine |
| Past history of hormone sensitive cancers e.g., breast, prostate, uterine, testicular |
| Possible drug interactions |
| Sleep apnoea |
| Some intersex DSD (Disorders of Sex Development) conditions |

* 1. That Transgender healthcare services will manage expectations of hormonal therapy. Physical changes occur gradually and can differ widely between individuals, with most reaching maximal changes around 1 to 2 years (see appendix 1).
* That primary care clinicians have knowledge around the hormones used for maintenance hormone prescribing i.e. oral anti-androgens (cyproterone, spironolactone), oestradiol valerate, testosterone.
* That primary care clinicians are confident to monitor clients taking maintenance hormone therapy (see appendix 2)
* Unless it is clinically necessary to disclose information about their previous gender, that confidentiality regarding gender transition is respected in referrals to other health professionals.
* Review your PIMS systems to ensure that self-identified gender does not revert to previous outdated information especially in relation to cancer screening recalls.

**EXAMPLE OF PRACTICE REVIEW MEASURES**

1. Are all staff aware that social stigmatisation and discrimination of gender diverse people, including within the healthcare system, is a barrier to accessing health services and contributes to adverse outcomes? Yes/No

2. Does the clinic’s webpage or health access page welcome LGBQTI patients? Yes/No

3. Does the waiting room demonstrate that gender diverse people are welcome? Yes/No

4. Is the place where patients talk with the receptionist private from being overheard by the patients in the waiting area? Yes/No

5. Have all reception and practice management staff had training on gender diverse terminology and pronouns? Yes/No

6. Have all clinicians had training on gender diverse terminology and pronouns? Yes/No

7. Is there an agreed team process to registering a new patient’s self-identified gender? Yes/No

8. Is there an agreed team process to update a known patient’s gender on PIMS? Yes/No

9. Is there an agreed team process to update a known patient’s gender with NHI? Yes/No

10. Are all clinicians aware of the health issues that affect people who are not accepted in their gender identity? Yes/No

11. Have all doctors developed knowledge of the relevant questions to ask patients about the health needs linked to their gender identity? Yes/No

12. Is the patient toilet unisex? Yes/No

13. Are gender diverse inclusive patient resources visibly in stock? Yes/No

14. Are mental health screening tools easily accessible within the PIMS? Yes/No

15. Are all clinicians aware of the Transgender Healthcare services available in your region? Yes/No

16. Are all clinicians aware of the referral pathway to information and support for young gender diverse people? Yes/No

17. Are all clinicians aware of the referral pathways for gender diverse adults who would like to explore or start transitioning? Yes/No

18. Does at least one of the doctors have knowledge around the hormones used for maintenance hormone prescribing i.e. oestradiol valerate, oral anti-androgens (cyproterone, spironolactone), testosterone? Yes/No

19. Are those hormone knowledgeable doctors confident to monitor clients on maintenance hormone therapy? Yes/No

20. Does the current version of PIMS maintain the latest self-identified gender, natal sex, and genotype based cancer screening recalls? Yes/No

Do – identify what your practice is doing now.

Study

* Document your findings
* Identify the gap between expected standards and performance.
* Summarise and reflect on what was learned
* Identify solutions

Act

* Meet with the practice team
* Refine changes based on what was learned from the audit
* Identify any barriers or enablers to change e.g. education, resources, skills, IT
* Consider which points to implement in an action plan

Implement changes

* Learning and reflection
* Did you achieve the result you expected?
* Is the change an improvement?
* How can you put the learning into practice?
* Plan a review date to follow up changes

The practice quality improvement plan can be used to record actions identified for ongoing discussion, to monitor progress, and to provide information for team learning and reflection.

**To claim MOPS credits for this activity:**

\* Complete the attached RZNCGP summary sheet outlining the action plan that you intend to implement based on the audit results. This summary sheet does not need to be sent to the College unless you are under MOPS audit.

\* Record completion on the MOPS Online credit summary, under the Audit of Medical Practice section. From the drop down menu select the audit from the list or select "Approved practice/PHO audit" and record the audit name in "Transgender practice audit".

References

1. Clark T, Lucassen M, Bullen P. The health and well-being of transgender high school students: results from the New Zealand Adolescent Health Survey (Youth ’12). J Adol Health 2014;55:93-9.
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4. Veale J, Saewye E, Frohard-Dourlent H et al & the Canadian Trans Youth Health Survey Research Group (2015). Being Safe, Being me: Results of the Canadian Trans Youth Health Survey. Vancouver, BC: Stigma and resilience among vulnerable youth centre, School of Nursing. University of British Columbia.
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7. Kreukels B, Cohen-Kettenis P. Puberty suppression in gender identity disorder: the Amsterdam experience. Nat Rev Endocrinol 20111;7:466-72.

Appendix One

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| Hormone treatment effects and limitations on the body  (varies for each person) | | |
| Typical changes from anti-androgens (prescribed with oestrogen) | | |
| Average time line | | Effect of anti-androgens |
| 1 to 3 months after starting anti-androgens | | •decrease in sex drive  •fewer instances of waking up with an erection or spontaneously having an erection. Some trans women also have difficulty getting an erection even when they are sexually aroused  •decreased ability to make sperm and ejaculatory fluid |
| Gradual changes (At least 2 years) | | •slower growth of facial and body hair  •slowed or stopped balding  •slight breast growth (reversible in some cases, not in others) |
| Typical changes from oestrogen (feminising therapy) | | |
| Average time line | | Effect of oestrogen |
| 1 to 3 months after starting oestrogen | | •softening of skin  •decrease in muscle mass and increase in body fat  •redistribution of body fat to a more “feminine” pattern  •decrease in sex drive  •fewer instances of waking up with an erection or spontaneously having an erection; some trans women also find their erections are less firm during sex, or can’t get erect at all  •decreased ability to make sperm and ejaculatory fluid |
| Gradual changes (1 to 2 years on oestrogen) | | •nipple and breast growth  •slower growth of facial and body hair  •slowed or stopped balding  •decrease in testicular size |
| Typical changes from testosterone (masculinising therapy) | | |
| Average time line | Effect of testosterone | |
| 1 to 3 months after starting testosterone | •increased sex drive  •vaginal dryness  •growth of clitoris (typically 1 to 3 cm)  •increased growth, coarseness, and thickness of hairs on arms, legs, chest, back, & abdomen  •oilier skin and increased acne  •increased muscle mass and upper body strength  •redistribution of body fat to a more “masculine” pattern (more fat around the waist, less around the hips) | |
| 1 to 6 months after starting testosterone | •menstrual periods stop | |
| 3 to 6 months | •voice starts to crack and drop within first 3 to 6 months, but can take a year to finish changing | |
| 1 year or more | •gradual growth of facial hair (usually 1 to 4 years to reach full growth)  •possible male-pattern balding | |

Appendix Two

**To monitor feminising therapy (anti-androgen plus oestrogen):**

1. Check mental health issues – anxiety, depression and refer if needed

2. Check BP, BMI every 6/12

3. Monitor K+ if on spironolactone

4. Check at least annually: FBC, renal function, LFT, HbA1C, Lipids, Oestradiol (avoid supraphysiological levels), Testosterone (aim for < 2 nmol/L)

5. Check prolactin at least every 2 years

6. Monitor for cardiovascular risks e.g. smoking, BP, BMI

7. Consider switching to transdermal oestrogen if > 40 years or other DVT risks

**To monitor masculinising therapy (testosterone):**

1. Check mental health issues – anxiety, depression and refer if needed

2. Check BP, BMI every 6/12

3. Check at least annually: FBC (Polycythemia risk), renal function, LFT, HbA1C, Lipids, Oestradiol, Testosterone (normal male ranges)

4. Monitor for cardiovascular risks e.g. smoking, BP, BMI

5. Monitor for pregnancy risk, if appropriate, as pregnancy is a contraindication to prescribing testosterone



This audit has been approved by the Royal College of General Practitioners and attracts 10

credits per audit cycle in the CPD (MOPS) programme.