Integrated Behavioral Health Clinical Pathway Proposal:

Transgender-affirming care in the United States

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Transgender people experience a gender identity different from their sex assigned at birth (Baker & Restar, 2022; Valente et al., 2022). Transgender is an umbrella term that often includes additional gender identities; however, some gender-nonconforming people prefer to use more precise terminology to identify their gender (Mason et al., 2022). Herein, transgender healthcare refers to the healthcare practice and experiences of transgender people, not those who identify as non-binary, genderqueer, agender, and other gender-nonconforming identities.

Expressing gender characteristics inconsistent with one's sex assigned at birth is common and natural (Coleman et al., 2022). According to the Williams Institute, a research group at the University of California, Los Angeles School of Law, approximately 1.6 million people in the United States identify as transgender. Of this total, 1.3 million are adults (Herman et al., 2022). Across the United States, transgender people belong to all racial and ethnic identities. However, transgender people are less likely to report a Caucasian racial identity and more likely to report a Latinx identity (Herman et al., 2022). Of the 1.3 million adults reporting a transgender identity, Herman et al. (2022) estimate that 38.5% are transgender women and 25.9% are transgender men. Additionally, these researchers indicated that younger people aged 13 to 17 are more likely to report a transgender identity than older adults (Herman et al., 2022), which may signify the cultural, legal, and healthcare advances in the United States. Baker and Restar (2022) make clear that transgender people may seek gender-affirming care, thus requiring clinical pathways to support transgender people across the lifespan.

This research seeks to identify the most effective integrated behavioral health clinical pathways to deliver effective, efficient healthcare to the transgender population. EBSCO,

Google, Google Scholar, and PubMed Central were used to identify articles under five years old. However, older articles were evaluated and, in some cases, included when said articles provided crucial transgender healthcare guidance. Keywords included transgender, pathway, law, assessment, diagnosis, and healthcare.

Transgender Healthcare Discrimination and the Law

Across the United States, transgender patients and their healthcare providers exist in a hostile political and legal system. Currently, lawmakers and governors in 19 states have collaborated to ban gender-affirming care, with 16 bans enacted in 2023. Lawmakers and the governors of Idaho, North Dakota, Oklahoma, Alabama, and Florida have made healthcare delivery a felony for clinicians who provide gender-affirming care (Choi, 2023). As a result of these laws, discrimination, and other factors related to the delivery of transgender healthcare, transgender patients have a range of healthcare experiences in the United States (Kattari et al., 2019), leaving transgender healthcare delivery inconsistent at best.

In addition to targeting transgender healthcare providers, transgender youth and their families are also objects of hostile legislation in many States (Mason et al., 2022). When this document was constructed, the American Civil Liberties Union (2023) tracked 130 healthcare bills associated with the LGBTGEQIAP+ community in the United States. Of the 130 bills, 56 have been defeated, 24 passed into law, 10 are challenged in court, and 49 have advanced in their respective legislative bodies. By design, many of these bills seek to limit transgender-affirming healthcare for youth, punish providers, and block Medicaid funding and facilities from delivering care to transgender youth, as well as, in some cases, block insurance coverage of transgender-

affirming care (American Civil Liberties Union [ACLU], 2023). Most major healthcare associations oppose these restrictions (Mason et al., 2022).

Transgender patients expect discrimination. Compared to those experiencing a cisgender identity, transgender people experience incomparable rates of harassment and rejection (Holt et al., 2021). Mason et al. (2022) facilitated a study to identify discrimination experienced by transgender people during their childhood. Of the 134 transgender people participating in the study, 39% reported healthcare discrimination. When coupled with poor healthcare provider knowledge, discrimination becomes a barrier to healthcare delivery for transgender patients, contributing to this population's healthcare disparities (Eisenberg et al., 2020).

Furthermore, Chiang and Bachmann (2023) reported that nearly one in five transgender patients experienced persuasion to discontinue the expression of their transgender identity when the said identity was discussed with a professional. In addition, some states have legalized a provider's right to refuse healthcare treatment due to the provider's religious beliefs. Coleman et al. (2022) confirm that transgender people are often confronted with a healthcare provider's ignorance, transphobia, and stigmatization.

Valente et al. (2022) point to stigma as the underlying cause of transgender health disparities, which can lead to internalized transphobia and other mental health concerns. As a result of transgender discrimination in the healthcare system and among providers, transgender patients often expect negative healthcare experiences, which can lead to the avoidance of healthcare services beyond those associated solely with one's gender identity (Mason et al., 2022). Coleman et al. (2022) note that discrimination such as that experienced by transgender people in the United States healthcare system can contribute to a transgender patient's

development of minority stress, which they describe as a unique form of socially-based, chronic stress that can contribute to a transgender person's experience of psychological distress.

Although support for transgender-affirming healthcare is improving (Coleman et al., 2022), there is a significant opportunity to develop parity with end-to-end cisgender healthcare delivery. Transgender-affirming healthcare information deficits and few structures to protect transgender patients lead to vulnerability in the system for transgender people (Mason et al., 2022). One such structure to enable healthcare delivery and protect the health of transgender patients is healthcare insurance. However, transgender patient claim denial is common and transgender people are more likely to be uninsured (Baker & Restar, 2022). As a result of exclusion, discrimination, and other barriers to healthcare access, transgender people may take their healthcare interventions into their own hands, such as using non-prescribed hormones, which may cause even more significant risks to the person's health due to unknown quality standards of said products (Coleman et al., 2022).

Transgender-affirming Healthcare

Inherent in transgender-affirming healthcare is the transition from gender identity associated with one's sex assigned at birth to the gender identity of one's experienced gender. The transition is divided into social transition and medical transition. However, a transgender person's transition is non-prescriptive and follows no standard plan since transgender-affirming healthcare depends on the patient's goals (Baker & Restar, 2022). The University of California, San Francisco (UCSF) is considered a leader in transgender healthcare in the United States. UCSF (n.d.) includes hormone therapy, hair removal, speech therapy, and fertility preservation in the medical transition and demonstration of gender identity in public, gender identity

verbalization to others close to the patient, and legal document confirmation of gender identity in the social transition. Baker and Restar (2022) add the rejection of internalized transphobia and gender-affirming surgery, such as facial, chest, and genital surgeries, to the transgender transition process.

The World Health Association for Transgender Health publishes Standards of Care, which defines quality transgender healthcare. The Standards of Care is in its eighth version (SOC 8). The SOC 8 identifies social support and stress management as crucial to the success of a transgender patient's transition (Verbeek et al., 2022). Because transgender patients can lose the support of important people in their lives (Mezzalira et al., 2023), including social support opportunities and coping skills is crucial to the successful transition of transgender patients (Verbeek et al., 2022).

Adolescent Transgender Healthcare

The primary medical concern related to transgender-affirming adolescent care is puberty. However, inherent in treating transgender adolescents is their ability to consent to treatment, which may vary from state to state (School House Connection, 2023). Hembree et al. (2017) note that at age 16, most adolescents can consent to treatment. Should the transgender adolescent not have the legal authority to consent to treatment, the child's legal custodian can provide treatment consent. In cases such as these, Sales-Humara et al. (2019) recommend engaging in a developmentally appropriate conversation with the patient to explain options.

For those patients with consent for treatment, puberty blockers are available once the patients enter Tanner Stage 2 (Salas-Humara et al., 2019). The Tanner Stages 1 through 5 describe the average course of puberty for both those assigned male and female at birth, starting

with Tanner Stage 1 pre-pubertal characteristics and ending with Tanner Stage 5 characteristics that demonstrate the conclusion of puberty (Emmanuel & Bokor, 2022). SOC 8 endorses puberty suppression as an appropriate treatment for transgender adolescent patients (Coleman et al., 2022). The Endocrine Society, a world leader in transgender health standards of care (Hembree et al., 2017), concurred. Hembree et al. (2017) and Salas-Humara et al. (2019) agree that puberty suppression is reversible and that by suppressing puberty, the patient has the opportunity to experience a more extended period in which gender identity can be explored without the development of secondary sex characteristics that may prove challenging to resolve in adulthood.

Adolescents can receive feminizing and masculinizing hormones (Salas-Humara et al., 2019). The Endocrine Society recognizes the potential need to prescribe sex hormones before the age of consent and recommends using a multidisciplinary team of mental and medical healthcare professionals to manage treatment (Hembree et al., 2017). For those transgender adolescents who seek gender-affirming surgical intervention, the SOC 8 standards recommend at least one full year of gender-affirming hormone use to support the achievement of desired outcomes unless the hormone use is medically contraindicated or undesired by the patient (Coleman et al., 2022).

Adolescent transgender care highly depends on the patient's gender identity and treatment goals. To that end, the relationship between transgender adolescents and their healthcare providers is essential. Transgender youth seek to partner with knowledgeable providers who see, hear, understand, value, and validate them (Eisenberg et al., 2020). Mason et al. (2022) suggest that when transgender adolescents work with disputing healthcare providers, they may feel discriminated against, which can diminish their trust in healthcare providers and, in turn, result in poor health outcomes across their lifespan. The SOC 8 recommends that

healthcare providers simply facilitate gender identity exploration respectfully and in no favor of any specific gender identity outcome (Coleman et al., 2022)

Adult Transgender Healthcare

Regarding adult transgender healthcare, the most common interventions are gender-affirming hormone therapy and gender-affirming surgery. Family practice and endocrinology specialist prescribers collectively write the majority of gender-affirming hormone therapy prescriptions, 28% and 18%, respectively. Gender-affirming hormone therapy suppresses hormones associated with the sex assigned at birth and maintains gender-affirming hormones within the normal range (Hembree et al., 2017). Transgender men are prescribed testosterone to masculine their appearance. Transgender women are prescribed estradiol and spironolactone to feminize their appearance (Salas-Humara et al., 2019). Verbeek et al. (2022) note that testosterone is rarely associated with psychosis or hypomania, and fatigue is associated with androgen suppression. However, these rare side effects are manageable with effective hormone monitoring.

Transgender health is often missing from healthcare education, resulting in a lack of clinical competency in delivering transgender healthcare (Chiang & Bachmann, 2023; Ingraham et al., 2022). Although clinicians have expressed worries about the effects of hormones on mood (Verbeek et al., 2022), Sales-Humara et al. (2019) and Chiang and Bachmann (2023) endorse the relative safety of gender-affirming hormone therapy and gender-affirming surgery, respectively, and suggest that such gender-affirming healthcare can improve the mental health and quality of life of transgender patients experience. However, due to mental health practitioners being tasked

with gatekeeping responsibilities, the transgender identity continues to be treated and reinforced as a mental illness (Chiang & Bachmann, 2023).

Clinical mental health therapists are often responsible for clinical documentation attesting to their transgender patient's readiness for these medical interventions and procedures. Ashley (2019) suggests that clinical documentation is unethical and dehumanizing and that informed consent can be used to establish parity with other healthcare interventions. Still, transgender adults experience barriers to gender-affirming care, such as gender-affirming hormone therapy and surgery, often limited by healthcare gatekeepers (Chiang & Bachmann, 2023). Transgender patients are experts on themselves, whereas clinicians can only serve as external consultants. This concept reinforces the opportunity to discontinue healthcare gatekeeping in favor of informed consent (Chiang & Bachmann, 2023).

Inclusive Clinical Healthcare Settings

Healthcare clinics provide the environmental context in which transgender-affirming care is delivered. As a result, a focus on transgender-affirming healthcare training and inclusive practices is necessary (Mason et al., 2022). With first contact with any given healthcare provider or clinic, patients are often required to complete paperwork. Forms that include the patient's legal and preferred name, pronouns, sex assigned at birth, and gender identity are considered inclusive and can help to develop a productive patient relationship starting with treatment initiation (Ingraham et al., 2022). Furthermore, once patients have disclosed their identities and expectations via inclusive forms, Mason et al. (2022) reinforce the importance of using their gender identity, preferred name, and pronouns when addressing the patient.

Reisner et al. (2016) identify two healthcare practices that have successful models for treating transgender patients; Callen-Lorde Community Health Center in New York and Fenway Health in Boston. Both practices use an informed consent model, which renders transgender clinical documentation by a mental health provider an unnecessary barrier to transgender-affirming healthcare delivery. Although the Callen-Lorde Community Health Center clinical pathway was not discoverable, Fenway Health's clinical pathway is available in Appendix D (Thompson et al., 2021).

Family planning offers patients an additional clinical setting where transgender-affirming care can be delivered. In a national study, transgender patients reported satisfaction with the transgender-affirming care they received at family planning clinics (Ingraham et al., 2022). Study participants reported surprise with the use of informed consent and the ability of clinic staff to support their healthcare needs. However, barriers to care in rural areas still exist (Ingraham et al., 2022).

Ingraham et al. (2022) described increased transgender-affirming care provided at family planning clinics over the past ten years. However, the authors cautioned about seeking care from Catholic-affiliated family planning providers because these establishments often deny care to transgender people. Ingraham et al. (2022) noted that Catholic providers are often banned from providing transgender-affirming care. This prejudicial denial of care limits access to care.

Additional Barriers to Care

Barriers to transgender-affirming care are built into the medical and insurance healthcare system, primarily based on the binary view of gender (Ingraham et al., 2022). To provide quality care to the transgender population, many clinics utilize policies and practices that circumvent

barriers to transgender-affirming care (Dowshen et al., 2019). The ingenuity of the professionals who utilize mechanisms to overcome the binary system to find solutions to care delivery deferrals likely saves lives. Treatment delays are associated with worsening mental health symptoms, such as suicidality (Verbeek et al., 2022).

According to Healthcare.gov (n.d.), doctors are tasked with determining medical necessity, and insurance companies are prohibited from limiting sex-specific services because of the patient's transgender identity. However, to access transgender-affirming care, such as those healthcare services described above, insurance companies often require clinical documentation from mental health professionals, which can serve as an additional barrier to treatment (Baker & Restar, 2022). Some insurance plans expressly exclude some or all aspects of transgender-affirming care (Healthcare.gov, n.d.). Because of variances in health insurance coverage, the National Center for Transgender Equality (n.d.) advises patients to fully understand the specific requirements of their plan to ensure the patient can receive treatment and share the policy with the appropriate providers to fulfill plan requirements.

Assessment and Diagnosis

In those situations where mental health clinicians must perform the gatekeeping role, assessment and diagnosis require focused attention. The University of California, San Francisco, considered a leader in transgender-affirming care, recommends gender exploration conversations with a skilled therapist as a first step to understanding one's gender (UCSF, n.d.). As with all therapeutic situations, the clinician's role is to avoid harming the patient and recognize that not all patients presenting for gender-affirming treatment automatically qualify for a gender dysphoria diagnosis (Hembree et al., 2017). However, for those who verbalized readiness to

move forward with their gender-affirming transition, gender identity validation may be required to socially and medically transition (UCSF, n.d.)

Verbeek et al. (2022) noted that the World Professional Association for Transgender Health Standards of Care version seven recommended a well-documented diagnosis of gender dysphoria to support transgender patients accessing gender-affirming care. However, in the most recent version, the SOC 8 shifted toward depathologizing transgender identities. Furthermore, Chiang and Bachmann (2023) note that emphasizing the evaluation and diagnosis of gender dysphoria is necessary at most large healthcare institutions.

Mental health clinicians in the United States must apply diagnostic standards described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), published by the American Psychiatric Association (APA) in 2022. According to the DSM-5-TR, an adolescent or adult patient generally qualifies for the gender dysphoria diagnosis when the patient experiences incongruence between their sex assigned at birth and their experienced gender for a minimum of six months (American Psychiatric Association [APA], 2022). Additionally, the DSM-5-TR (APA, 2022) require at least two additional criteria, such as incongruence between the patient's experienced gender and their sex characteristics; the desire to be rid of or prevent incongruent sex characteristics; desire for the acquisition of sex characteristics of the other gender; the desire to be or to be affirmed as another gender; and resolute understanding that the patient's feelings and reactions are typical of the other gender. Verbeek et al. (2022) advise that a detailed gender history can support the clinician in assessing the patient's gender experience.

Standard in the clinical mental health diagnostic process is the consideration of differential and co-morbid diagnosis. Several differential and co-morbid diagnoses include shifts in identity, as evidenced by the DSM-5-TR diagnostic criteria for borderline personality disorder or dissociative identity disorder (APA, 2022; Verbeek et al., 2022). Additionally, the DSM-5-TR instructs clinicians to rule out nonconformity to gender roles, transvestic disorder, body dysmorphic disorder, schizophrenia, and other psychiatric disorders (APA, 2022). Other differential diagnoses and co-morbid disorders requiring clinical exploration include anxiety, attention-deficit hyperactivity disorder, autism spectrum disorders, depression, conduct disorder, eating disorders, post-traumatic stress disorder, and substance use disorders (Mezzalira et al., 2023; Soares Da Costa & Mota, 2022). In addition to the list of differential diagnoses, mental health clinicians receive limited training to support their ability to diagnose gender incongruence, which is coupled with often unavailable or undefined clinical documentation standards that can be used for transgender-affirming care insurance or Medicaid approval. Verbeek et al. (2022) suggest referral for psychiatric referral in those cases in which diagnosis proves difficult.

To support mental health clinicians in the diagnosis of gender dysphoria, the use of a reliable, valid assessment instrument can prove helpful. To that end, the Gender Minority Stress and Resilience Scale (GMRS), see Appendix A, and Gender Minority Stress and Resilience Measure for Adolescents Scale (GMRS-A), see Appendix B, for adults and adolescents, respectively (Hidalgo et al., 2018; Shulman et al., 2017). The 58-item GMRS measures gender minority difficulties and psychological protective factors contributing to psychological well-being (Shulman et al., 2017). Testa et al. (2015), the developers of GMRS, report adequate reliability and validity based on a study of 884 participants. Likewise, the GMRS-A indicated

high internal consistency and construct validity with minor adjustments to the adult assessment (Hidalgo et al., 2018).

This team of developers identified limitations of the tool related to test-retest reliability and the need to study the assessment for use with people of color (Testa et al. (2015). Another assessment limitation is the scoring, which a clinician does manually. However, the assessment developers do not specifically instruct results interpretation in the literature or via the assessment instructions (See Appendix A). The GMRS and GMRS-A were designed using the minority stress model (Shulman et al., 2017), and Testa et al. (2015) endorse the GMRS alignment to this model.

The minority stress model seeks to explain the sources of stress experienced by the transgender community as unique and different from everyday stress experienced by humans in the context of their environment (Valente et al., 2022). This unique form of stress is often chronic and complex and results from the stigma and discrimination experienced by transgender people (Mason et al., 2022; Valente et al., 2022). The experience of minority stress can result in mental health concerns (Mason et al., 2022).

The frequent outcome of the assessment is often a diagnosis. In the case of transgender-affirming care, providing evidence of marked and sustained gender incongruence via diagnostic criteria is often necessary to access treatment (Chiang & Bachmann, 2023). Per the DSM-5-TR (APA, 2022), the adequate diagnosis is gender dysphoria. Baker and Restar (2022) suggest that the International Classification of Diseases, 11th Revision (ICD-11) incorporate a new diagnosis of gender incongruence that better clarifies the experience and positions the patient for transgender-affirming care rather than additional mental health counseling.

Transgender-affirming Clinical Standards and Pathways

Transgender-affirming healthcare has garnered more attention in recent years, both in developing standards and within politics. Several organizations provide standards of care, including the World Professional Association of Transgender Health (WPATH), the Endocrine Society, UCSF, and more (Salas-Humara et al., 2019). These standards vary from exceptionally detailed, as evidenced in the SOC 8, to more loosely defined standards, such as those outlined by UCSF, which does not specify the treatment order. Instead, UCSF requires behavioral evaluation and preparation before transgender-affirming surgery, in addition to living in one's transgender identity full time and compliance with hormone therapy for one year before genital surgery, forgoing a medical issue preventing the patient's achievement of said requirements (UCSF, n.d.). The Endocrine Society suggests the need for confirmation of gender dysphoria or gender incongruence diagnosis before beginning treatment (Hembree et al., 2017).

Fenway Health offers a publicly available, well-defined clinical pathway (see Appendix D). The model includes a transgender-affirming intake process, consent verification, behavioral and medical assessments, and details of the medical process. Furthermore, Fenway Health provides clinical documentation and treatment-specific informed consent templates, including patient education content (Thompson et al., 2021). However, this publicly available pathway favors the medical side of the clinical pathway, as evidenced by the specificity of the medical pathway descriptions. Additionally, no specific clinical pathway nor standard articulates the integrated behavioral healthcare consultant role, although these standards speak to the role of mental health clinicians.

Integrated Behavioral Health Clinical Pathway Proposal

The existing transgender-affirming healthcare standards and pathways provide incredible direction to clinicians regarding the appropriate delivery of services. However, the extensive information therein is more complex than any clinician can manage in a small to medium-sized clinical setting, and clinical documentation standards vary from state to state. This proposed clinical pathway seeks to place transgender patients at the center of the process and wrap their team of providers around them. To that end, the proposed pathway simplifies the process, enables care coordination across multiple practices, and defines the role of the integrated behavioral health consultant. Furthermore, in addition to designing a pathway that achieves clinical standards, this proposed pathway is informed by transgender-affirming healthcare research, Fenway Health's model (see Appendix D), and the Biodyne Model of Psychotherapy (Cummings & Cummings, 2013).

Integrated Behavioral Healthcare Team

Regardless of the entity in which a healthcare provider works, integrated behavioral health serves as the core of the proposed clinical pathway. While the specific healthcare business may include various support roles, such as front office administration or insurance verification, this proposed pathway defines roles as physician, mental health therapist, and behavioral health consultant. However, in small and medium-sized practices, unintegrated healthcare practices, or specialty healthcare practices, the behavioral health consultant role may be filled by a clinical mental health therapist, social worker, or other helping professional.

Behavioral Health Consultant

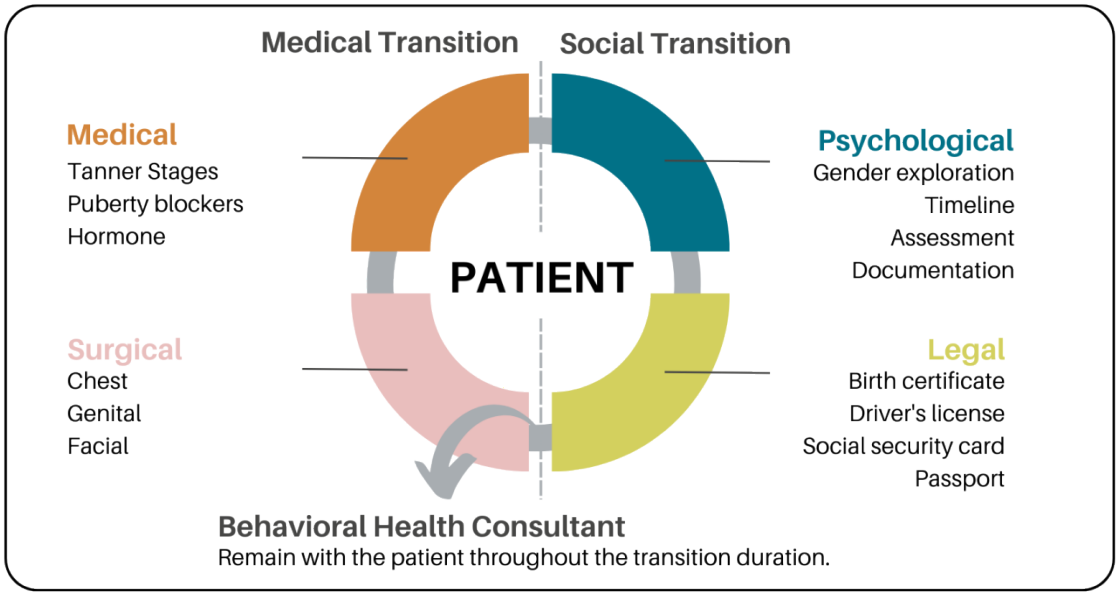
The behavioral health consultant (BHC) role assumes responsibility for end-to-end coordination of the clinical pathway in support of transgender-affirming patient care. The BHC's stance is based on principle two of the Biodyne Model of Psychotherapy, which articulates the BHC's commitment to the patient as long as needed and invites the patient to render the BHC obsolete as soon as possible (Cummings & Cummings, 2013). Additionally, within this proposed model, the BHC establishes inclusive environments and documentation, provides education and training to staff and clinicians, and advocates for patients. To that end, the BHC can:

- proactively plan to overcome cisgender barriers implicit in the medical system to ensure care is accessible, as well as establish a supportive healthcare environment free of discrimination, stigmatization, and harassment (Mason et al., 2022).
- establish a working alliance with transgender patients to identify their unique healthcare desires (Coleman et al., 2022).
- develop and train the healthcare team regarding the appropriate use of pronouns and coach providers to improve their comfort and competence in treating transgender patients (Eisenberg et al., 2020; Inman et al., 2023; Kattari et al., 2019).
- provide easy-to-understand education to the patient who may not have the education or experience to understand complex medical or psychological terminology (Salas-Humara et al., 2019).
- curate a competent, transgender-affirming provider network that provides medical, surgical, mental health, and legal services (Coleman et al., 2022).
- coordinate the care team, advocate for the patient, and produce clinical documentation for treatment approval (Ashely, 2019).

- participate throughout the patient's transition duration (Hembree et al., 2017).

Figure 1 visualizes the underlying and supportive BHC role. This model places the patient at the center of their healthcare and wraps the various transgender-affirming services that may be necessary around them. The model requires adherence to evidenced-based treatment by all clinicians and a requirement to operate as a collaborative team while delivering treatment restrained by their scope of practice. To that end, the BHC provides coordination and connection among the providers to ensure that the patient does not feel alone and receives the necessary support to achieve their gender-affirming goals without having to educate and manage the healthcare system for themselves.

Figure 1
Transgender-affirming Integrated Behavioral Health Model



Proposed Clinical Pathway

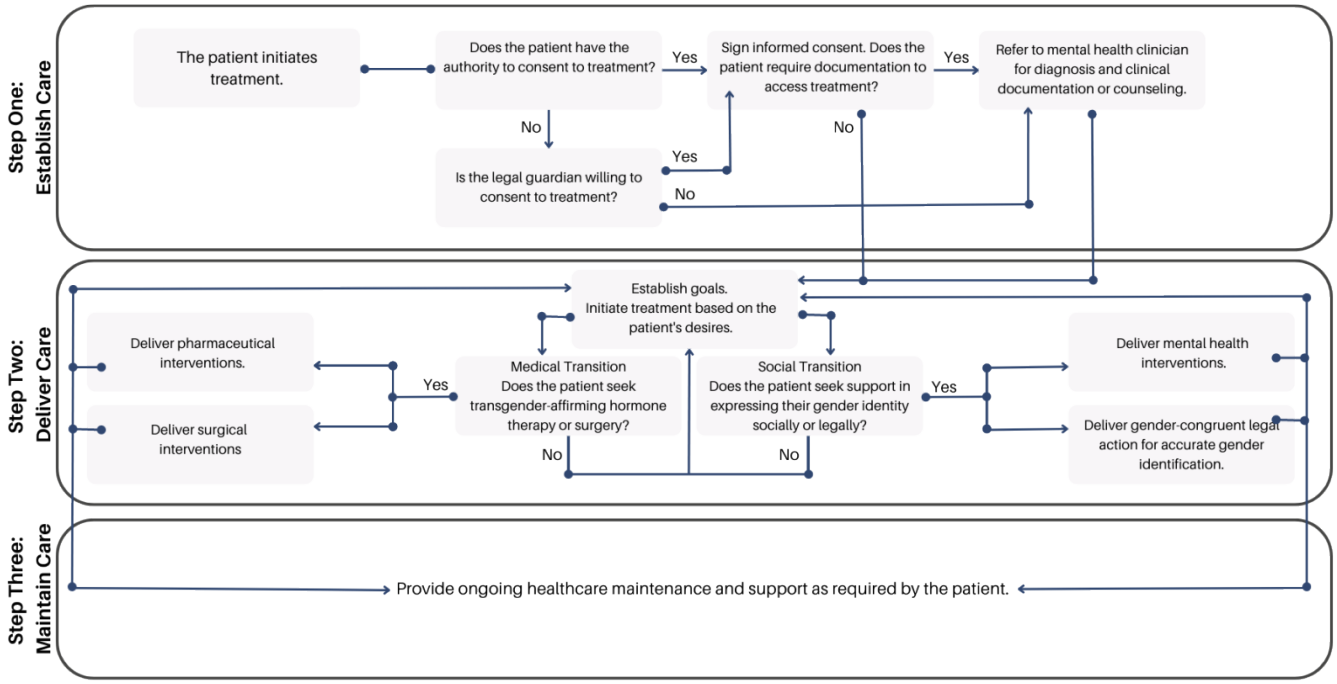
The Biodyne Model of Psychotherapy informs the clinical pathway, in addition to standards set forth by the various entities described herein and Fenway Health's model (see

Appendix D). The first principle of the Biodyne Model articulates the therapist's obligation; however, this model applies the obligation to the BHC. To that end, the BHC should coordinate this proposed pathway to help the patient experience harm-free gender affirmation in the least amount of time while applying the least intrusive interventions (Cummings & Cummings, 2013).

Because a patient's transgender-affirming care is non-linear and dependent on their desires, they can enter the medical or social transition at any point (Baker & Restar, 2022). Figure two illustrates the high-level clinical pathway for use across disciplines regardless of the providers' work locations. Furthermore, this pathway clarifies patients' bodily autonomy in directing their treatment according to their unique goals. The four medical ethics pillars of autonomy, nonmaleficence, beneficence, and justice are respected by intentionally designing the clinical pathway with the patient at the center of their healthcare (Chiang & Bachmann, 2023).

Figure 2

Integrated Behavioral Health Clinical Pathway



Proposed Clinical Pathway Action Sequence

The proposed clinical action sequence outlines the high-level healthcare process experienced by transgender patients in delivering their gender-affirming care. The sequence is as follows:

1. Patient initiates treatment.
2. Treatment consent is established and secured.
3. Treatment goals are defined.
4. Based on the patient's treatment goals, referrals are made to transgender-affirming providers who provide care per well-established standards.
5. After achieving the patient's healthcare goals, healthcare maintenance is provided as requested.

Proposed Clinical Pathway Details

Although this pathway depends on clinicians' effective, evidenced-based practice, describing item expectations and offering direction to clinicians may prove helpful in integrating small and medium-sized practices that may work in disparate clinical systems. Training and supervision may be required to facilitate effective outcomes efficiently. Furthermore, in addition to patients desiring to collaborate with well-trained clinicians and clinicians desiring a greater depth of education, spelling out certain clinical aspects of this pathway may help to fulfill the needs of all people involved in this process (Coleman et al., 2022; Eisenberg et al., 2020; Hembree et al., 2017; Ingraham et al., 2022; Kattari et al., 2019; Mason et al., 2022; Reisner et al., 2016). Establishing transgender-affirming clinical policies, procedures, standardized forms,

and clinical documentation templates and integrating these into the electronic health record can help to facilitate operational effectiveness and efficiency.

Patient initiates treatment: Before a transgender patient initiates care, the BHC develops a network of transgender-affirming providers. The BHC audits the clinical environment and forms for these providers to improve and enhance transgender patient inclusion. Additionally, the BHC delivers provider training to develop alignment to the pathway across clinicians regardless of where the provider delivers services. By preparing to deliver inclusive, intentional services to the transgender community, patient treatment integration across the network of providers can be welcoming, comfortable, and seamless.

Treatment consent is secured: As is standard practice in clinical settings, consent to treatment is established. For those patients who have not reached the age of majority or do not have the legal authority to consent to treatment, consent must be secured by their legal guardian. In these cases, legal guardianship should be verified. Furthermore, in some states, minors of a certain age may have the legal authority to consent to treatment. In these cases, the BHC verifies the age of consent for healthcare treatment before services are delivered. Additionally, the BHC determines the need for a mental health evaluation based on the client's specific needs, such as an insurance plan requirement to access transgender-affirming care. If no mental health evaluation is required to deliver transgender-affirming care, informed consent is considered adequate to deliver care.

Should a minor's legal guardian refuse to consent to treatment, the minor is referred to a culturally competent licensed counselor for individual and family therapy. Since it is well-established that this population is at high risk of suicide, clinical mental health counseling

focused on providing support is crucial, as is establishing an environment supportive of their mental health. Family counseling focuses on education, acceptance, and allyship to create an environment where one may not exist.

Diagnosis and documentation: In those cases where a diagnosis and documentation are required, the least intrusive interventions are applied to fulfill exogenous requirements. In this case, the BHC may serve in the clinical mental health counselor role, should the BHC be licensed to practice in this capacity. Otherwise, the BHC refers the patient to a licensed, competent provider to perform the evaluation.

The mental health evaluation must include a biopsychosocial clinical interview, which allows the clinician to learn about the patient and their gender-related experiences. Consistent with any mental health evaluation, the clinician can assess for differential diagnoses, which may be required to strengthen the patient's evidence for treatment approval. The clinical interview can help to articulate impairment, thus establishing medical necessity, which is often crucial to treatment approval. Most major medical companies require a diagnosis of gender dysphoria to be a candidate for transgender-affirming care (Chiang & Bachmann, 2023), even if the client is not experiencing distress due to their gender incongruence experience.

A gender identity timeline may prove helpful in establishing marked and sustained gender incongruence. The gender identity timeline is a technique the patient can primarily perform independently and includes documenting the chronological history of the patient's gender identity. Patients are instructed to identify the age at which the first instance of gender awareness occurred through the present. The gender timeline is a novel concept not identified in the literature. This timeline can be used as evidence to fulfill treatment barriers based on gender

identity longevity. Specifically, articulating the patient's persistent and sustained gender awareness may provide the evidence necessary for treatment approval. See Appendix E for an example timeline.

As is often considered best practice in a clinical setting, a reliable, valid assessment can reinforce clinical evidence supporting the client's gender identity. The Gender Minority Stress and Resilience Scale (GMRS) and Gender Minority Stress and Resilience Measure for Adolescents Scale (GMRS-A) can be used with adults and adolescents, respectively. An objective assessment may enhance the evidence required for treatment. Although the GMRS and GMRS-A are not diagnostic tools, the results can be used to support a diagnosis of 302.85 (F64.1) gender dysphoria in adolescents and adults, 302.6 (F64.8) other specified gender dysphoria, or 302.6 (F64.9) unspecified gender dysphoria.

Clinical documentation supporting care is often a necessary outcome of the mental health evaluation. Such documentation serves as a clinical attestation of medical necessity. However, the patient knows themself best, which means that the clinician can only attest to the patient completing an evaluation that confirms the evidence required to receive treatment. The clinician's documentation, typically a letter, simply describes the clinical evaluation and results. Appendix C offers a letter template aligned with this clinical pathway. This template can be updated or revised as needed to comply with legal or insurance policy requirements.

Patient-directed treatment plan: As is implicit in the informed content model, patients are relied on to make the best treatment decisions for themselves. They receive treatment information, including potential risks and benefits (Ingraham et al., 2022). Developing a treatment plan is patient-directed and can be revised at any time per the patient's desired

treatment outcomes. The BHC supports the client in developing the treatment plan, including the patient's transgender-affirming goal, treatment objectives, milestones and timeline, and measures.

Medical and Social transition: Patients can engage in medical or social transition. The BHC's role is to support the patient in achieving their stated transgender-affirming treatment goal. In addition to encouraging and navigating the healthcare system on the patient's behalf, the BHC can engage their transgender-affirming healthcare provider network via patient referrals. Once a provider accepts the referral, it is suggested that the BHC perform a warm hand-off. Before the warm hand-off, the BCH and patient determine the role the patient would like the BHC to perform. This role may include a brief introduction, attending the first meeting to serve as the patient's advocate or be as extensive as walking the provider through the mental health evaluation results, treatment plan, or both. The warm hand-off ensures that the patient is comfortable with the provider.

Maintenance care: Upon achieving the patient's treatment plan, the BHC and patient can collaborate to establish a plan to maintain the patient's health care. Like the treatment plan, the maintenance plan is patient-directed and based on informed consent and care delivery by well-trained, competent, licensed practitioners. The maintenance plan is highly dependent upon the patient's treatment plan objectives, which inform maintenance care such as ongoing hormone monitoring or mental healthcare and can include additional long-term care activities, such as cancer screening that may be recommended as a result of the patient's sex assigned at birth (Chiang & Bachmann, 2023; Hembree et al., 2017).

Costs and Return on Investment

The costs described below exclude those related to employment, facility maintenance, and other clinic-related costs, such as general liability insurance or workman's compensation, because this clinical pathway is designed to unite small and medium-sized practices. Management decisions across various organizations can result in an operational expense variance. As such, only transgender-affirming care costs and return on investment are described.

Costs

The costs associated with transgender-affirming care can be significant, especially for those patients who cannot secure treatment approval. Salas-Humara et al. (2019) state that insurance companies cover puberty blockers 72% of the time. An estimated three-month out-of-pocket cost for pediatric leuprolide, a sex hormone suppressant, is roughly $9,500, and $39,000 for histrelin, which inhibits the production of hormones associated with the patient's sex assigned at birth, namely testosterone and estrogen.

Baker and Restar (2022) identify the payer costs for gender-affirming hormones and characterize those costs as generally low, with testosterone costing $121 per year and estrogen costing $153 per year. However, they priced puberty blockers at a much lower cost than did Salas-Humara et al. Baker and Restar (2022) state that the average annual cost of puberty blockers is $2,410. Furthermore, Baker and Restar (2022) identified average costs for gender-affirming surgeries, including

- orchiectomy, which is the removal of the testes, costs $6,927;
- vaginoplasty, which is the construction of the vagina, $53,645;
- phalloplasty, which is the construction of the penis, $133,911

In a study reported by Turban et al. (2021), detransition was examined. The authors reported that 13.1% of the study participants reported detransitioning. However, of those who detransitioned, 82.5% reported doing so due to exogenous factors, such as stigma and family pressures. Only 15.9% of those who detransitioned reported doing so due to an internal factor, such as uncertainty of gender identity. Although the frequency of detransitioning is relatively low among the transgender population, enabling patients with information, the opportunity for gender exploration and transition risks and benefits can help to decrease costs associated with detransitioning. However, detransitioning frequency alone must not be used as a disqualification by providers seeking to persuade patients against achieving their desired transgender-affirming healthcare goals.

Return on Investment

In contrast to the 13.1% of those who reported detransitioning, 86.9% sustained their gender transition (Turban et al., 2021). Calculating a return on investment resulting from the clinical pathway is incalculable as it is difficult to accurately address the value of one's quality of life or sense of fulfillment. However, it is well-documented that transgender people experience heightened levels of anxiety, depression, substance misuse, suicide, and other forms of psychological distress (Baker & Restar, 2022; Coleman et al., 2022; Mason et al., 2022; Mezzalira et al., 2023; Shulman et al., 2017; Valente et al., 2022; Verbeek et al., 2022). Regarding suicide, the Centers for Disease Control and Prevention (n.d.) calculate the economic burden of suicide in the United States at $70 billion. To that end, the costs of providing transgender-affirming care are inconsequential compared to the potential to reduce or resolve these mental health disorders, which may prove priceless.

Conclusion

Transgender healthcare in the United States provides ample opportunity to establish clinical pathways for use across small and medium-sized healthcare organizations, especially in rural areas. The delivery of care is threatened by legislative hostility. The proposed transgender clinical pathway can be implemented across organizations to unite the patient's healthcare providers in one team. Using the proposed clinical pathway, the healthcare team can implement the healthcare model necessary to the patient's unique requirements and establish a plan that fulfills the patient's gender-affirming treatment goals. By achieving the patient's healthcare goals, the clinical pathway may be a lifesaving mechanism for generations of transgender patients.

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Appendix A: Gender Minority Stress and Resilience Measure (GMSR)

GMSR

Page 1

Please check all that apply. (For example, you may check both "after age 18" and "in the past year" columns if both are true). *In this survey gender expression means how masculine/feminine/androgynous one appears to the world based on many factors such as mannerisms, dress, personality, etc.

D		Never.	Yes, before age 18.	Yes, after age 18.	Yes, in the past year.
1	I have had difficulty getting medical or mental health treatment (transition-related or other) because of my gender identity or expression*	O	O	O	O
2	Because of my gender identity or expression, I have had difficulty finding a bathroom to use when I am out in public.	O	O	O	O
3	I have experienced difficulty getting identity documents that match my gender identity.	O	O	O	O
4	I have had difficulty finding housing or staying in housing because of my gender identity or expression.	O	O	O	O
5	I have had difficulty finding employment or keeping employment, or have been denied promotion because of my gender identity or expression	O	O	O	O

R		Never.	Yes, before age 18.	Yes, after age 18.	Yes, in the past year.
1	I have had difficulty finding a partner or have had a relationship end because of my gender identity or expression.	O	O	O	O
2	I have been rejected or made to feel unwelcome by a religious community because of my gender identity or expression	O	O	O	O
3	I have been rejected by or made to feel unwelcome in my ethnic/racial community because of my gender identity or expression.	O	O	O	O
4	I have been rejected or distanced from friends because of my gender identity or expression.	O	O	O	O
5	I have been rejected at school or work because of my gender identity or expression.	O	O	O	O
	I have been rejected or distanced from family because of my gender identity or expression.	O	O	O	O

V		Never.	Yes, before age 18.	Yes, after age 18.	Yes, in the past year.
1	I have been verbally harassed or teased because of my gender identity or expression. (For example, being called "it.")	O	O	O	O
2	I have been threatened with being outed or blackmailed because of my gender identity or expression.	O	O	O	O
3	I have had my personal property damaged because of my gender identity or expression.	O	O	O	O
4	I have been threatened with physical harm because of my gender identity or expression.	O	O	O	O
5	I have been pushed, shoved, hit, or had something thrown at me because of my gender identity or expression.	O	O	O	O
6	I have had sexual contact with someone against my will because of my gender identity or expression.	O	O	O	O
na	I have heard negative statements about transgender or gender nonconforming people.	O	O	O	O

Please indicate how much you agree with the following statements.

NA		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	I have to repeatedly explain my gender identity to people or correct the pronouns people use.	O	O	O	O	O
2	I have difficulty being perceived as my gender.	O	O	O	O	O
3	I have to work hard for people to see my gender accurately.	O	O	O	O	O
4	I have to be "hypermasculine" or "hyperfeminine" in order for people to accept my gender.	O	O	O	O	O
5	People don't respect my gender identity because of my appearance or body.	O	O	O	O	O
6	People don't understand me because they don't see my gender as I do.	O	O	O	O	O

IT		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	I resent my gender identity or expression.	O	O	O	O	O
2	My gender identity or expression makes me feel like a freak.	O	O	O	O	O
3	When I think of my gender identity or expression, I feel depressed.	O	O	O	O	O
4	When I think about my gender identity or expression, I feel unhappy.	O	O	O	O	O
5	Because my gender identity or expression, I feel like an outcast.	O	O	O	O	O
6	I often ask myself: Why can't my gender identity or expression just be normal?	O	O	O	O	O
7	I feel that my gender identity or expression is embarrassing.	O	O	O	O	O
8	I envy people who do not have a gender identity or expression like mine.	O	O	O	O	O

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P		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	My gender identity or expression makes me feel special and unique.	O	O	O	O	O
2	It is okay for me to have people know that my gender identity is different from my sex assigned at birth.	O	O	O	O	O
3	I have no problem talking about my gender identity and gender history to almost anyone.	O	O	O	O	O
4	It is a gift that my gender identity is different from my sex assigned at birth.	O	O	O	O	O
5	I am like other people but I am also special because my gender identity is different from my sex assigned at birth.	O	O	O	O	O
6	I am proud to be a person whose gender identity is different from my sex assigned at birth.	O	O	O	O	O
7	I am comfortable revealing to others that my gender identity is different from my sex assigned at birth.	O	O	O	O	O
8	I'd rather have people know everything and accept me with my gender identity and gender history.	O	O	O	O	O

Do you currently live in your affirmed gender* all or almost all of the time?
(*Your affirmed gender is the one you see as accurate for yourself.)

If NO, answer questions in section A and C, and skip section B.

If YES, skip section A, and answer questions in section B and C.

SECTION A: Please indicate how much you agree with the following statements.

NE		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	If I express my gender identity, others wouldn't accept me.	O	O	O	O	O
2	If I express my gender identity, employers would not hire me.	O	O	O	O	O
3	If I express my gender identity, people would think I am mentally ill, "crazy."	O	O	O	O	O
4	If I express my gender identity, people would think I am disgusting or sinful.	O	O	O	O	O
5	If I express my gender identity, most people would think less of me.	O	O	O	O	O
6	If I express my gender identity, most people would look down on me.	O	O	O	O	O
7	If I express my gender identity, I could be a victim of crime or violence.	O	O	O	O	O
8	If I express my gender identity, I could be arrested or harassed by police.	O	O	O	O	O
9	If I express my gender identity, I could be denied good medical care.	O	O	O	O	O

ND		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	Because I don't want others to know my gender identity, I don't talk about certain experiences from my past or change parts of what I will tell people.	O	O	O	O	O
2	Because I don't want others to know my gender identity, I modify my way of speaking.	O	O	O	O	O
3	Because I don't want others to know my gender identity, I pay special attention to the way I dress or groom myself .	O	O	O	O	O
4	Because I don't want others to know my gender identity, I avoid exposing my body, such as wearing a bathing suit or nudity in locker rooms.	O	O	O	O	O
5	Because I don't want others to know my gender identity, I change the way I walk, gesture, sit, or stand.	O	O	O	O	O

SECTION B: Please indicate how much you agree with the following statements.

NE		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	If I express my gender history, others wouldn't accept me.	O	O	O	O	O
2	If I express my gender history, employers would not hire me.	O	O	O	O	O
3	If I express my gender history, people would think I am mentally ill, "crazy."	O	O	O	O	O
4	If I express my gender history, people would think I am disgusting or sinful.	O	O	O	O	O
5	If I express my gender history, most people would think less of me.	O	O	O	O	O
6	If I express my gender history, most people would look down on me.	O	O	O	O	O
7	If I express my gender history, I could be a victim of crime or violence.	O	O	O	O	O
8	If I express my gender history, I could be arrested or harassed by police.	O	O	O	O	O
9	If I express my gender history, I could be denied good medical care.	O	O	O	O	O

ND		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	Because I don't want others to know my gender history, I don't talk about certain experiences from my past or change parts of what I will tell people.	O	O	O	O	O
2	Because I don't want others to know my gender history, I modify my way of speaking.	O	O	O	O	O
3	Because I don't want others to know my gender history, I pay special attention to the way I dress or groom myself .	O	O	O	O	O
4	Because I don't want others to know my gender history, I avoid exposing my body, such as wearing a bathing suit or nudity in locker rooms.	O	O	O	O	O
5	Because I don't want others to know my gender history, I change the way I walk, gesture, sit, or stand.	O	O	O	O	O

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SECTION C: Please indicate how much you agree with each statement.

C		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	I feel part of a community of people who share my gender identity.	O	O	O	O	O
2	I feel connected to other people who share my gender identity.	O	O	O	O	O
3	When interacting with members of the community that shares my gender identity, I feel like I belong.	O	O	O	O	O
4	I'm not like other people who share my gender identity.	O	O	O	O	O
5	I feel isolated and separate from other people who share my gender identity.	O	O	O	O	O

INFORMATION FOR CLINICIANS AND RESEARCHERS:

The Gender Minority Stress and Resilience (GMSR) Measure was developed to assess aspects of minority stress and resilience faced by people whose gender identity or expression is different in any way from that socially expected based on their sex assigned at birth. The scale consists of the following constructs:

D

Gender-related discrimination. This measure was created by combining (a) themes identified from a previously conducted focus group of trans adults focusing on minority stress (Balsam, Beadnell, Simoni, & Cope, 2008) with (b) items created based on other prevalent forms of discrimination described by TGNC respondents in a large national studies of TGNC people's experiences (Beemyn & Rankin, 2011; Grant, et al., 2010). For scoring purposes, responses are coded as 1 if "Yes" at any point, and 0 if "Never" (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

R

Gender-related rejection. This measure was created by combining (a) themes identified from a previously conducted focus group of trans adults focusing on minority stress (Balsam, Beadnell, Simoni, & Cope, 2008) with (b) items created based on other prevalent forms of rejection identified by trans respondents in national studies of TGNC people's experiences (Beemyn & Rankin, 2011; Grant, et al., 2010). For scoring purposes, responses are coded as 1 if "Yes" at any point, and 0 if "Never" (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

V

Gender-related victimization. Items were developed by adapting those from the Sexual Minority Negative Events Scale (SMNE; Goldblum, Waelde, Skinta, & Dilley, unpublished manuscript) such that items would refer to gender identity or expression instead of sexual orientation. For scoring purposes, DO NOT include the last item. This item was retained here as a potentially useful clinical prompt for discussion. However, because almost all respondents answer affirmatively, the item is not included in the final validated measure. All other responses are coded as 1 if "Yes" at any point, and 0 if "Never" (Testa, Habarth, Peta, Balsam, & Bockting, 2014). For research purposes, the last item (7) is not included in scoring, but has been retained for clinical purposes.

NA

Non-Affirmation. This scale was created based on prevalent experiences reported by TGNC people in national surveys related to gender identity non-affirmation in various settings (Beemyn & Rankin, 2011; Grant, et al., 2010). For scoring purposes, response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

IT

Internalized transphobia. Internalized transphobia was evaluated with the 8-item Shame subscale from the Transgender Identity Survey (TGIS; Bockting, in press). This scale has demonstrated internal reliability, Cronbach's alpha = .89. Response options were adjusted from a 7-point to a 5-point Likert-type scale from "strongly disagree" to "strongly agree." For scoring purposes, response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

P

Pride. Pride regarding TGNC identity was measured by the Pride subscale of the Transgender Identity Scale (Bockting, Miner, Swinburne Romine, Robinson, Rosser, & Coleman, 2014). Reliability has been established with an alpha of .88. Response options were adjusted from a 7-point to a 5-point Likert-type scale from "strongly disagree" to "strongly agree." For scoring purposes, response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

NE*

Negative Expectations for future events. For this scale, items were adapted from a measure of negative expectations for rejection among LGB people (Goldblum, Waelde, Skinta, & Dilley, unpublished manuscript). Several items were also added to reflect unique concerns identified in a focus group and national surveys with TGNC people (Balsam, Beadnell, Simoni, & Cope, 2008; Beemyn & Rankin, 2011; Grant, et al., 2010). For scoring purposes, response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

ND*

Non-Disclosure. Items were developed to reflect means of non-disclosure utilized by TGNC people identified in a national survey of TGNC people, and autobiographical material of TGNC writers (Beemyn & Rankin, 2011; Feinberg, 1993; Green, 2004). For scoring purposes, response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

CC

Community Connectedness. This scale was created utilizing both (a) themes from a previously conducted focus group of trans adults focusing on minority stress (Balsam, Beadnell, Simoni, & Cope, 2008) and (b) items from the Alienation subscale of the Transgender Identity Survey (TGIS; Bockting, in press). Items from the latter were modified to primarily reflect affiliation instead of isolation. For scoring purposes, the response options are coded as (0) Strongly Disagree, (1) Somewhat Disagree, (2) Neither Agree/Disagree, (3) Somewhat Agree, and (4) Strongly Agree, with the exception of the last two items, which are reverse scored (Testa, Habarth, Peta, Balsam, & Bockting, 2014).

* Both NE and ND constructs are measured with slightly different wording depending on whether individuals do or do not live in their affirmed gender all or most of the time. (Affirmed gender means that which the individual sees as accurate for themselves.)

CITATION

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1) 65-76.

Appendix B: Gender Minority Stress and Resilience Measure for Adolescents (GMSR-A)

Gender Minority Stress and Resilience Measure for Adolescents (GMSR-A)

Adapted from Testa et al., 2014

For each item on this page, please check ALL BOXES THAT APPLY. (For example, you may check both "within the past year" "before the past year" boxes if both are true). *In this survey "gender expression" means how masculine/feminine/androg one appears to the world based on many factors such as mannerisms, dress, personality, etc.

		Never	Yes, within the past year	Yes, before the past year	
D1	I have had difficulty getting medical or mental health treatment (transition-related or other) because of my gender identity or expression*	0	1	1	
D2	Because of my gender identity or expression, I have had difficulty finding a bathroom to use when I am out in public.	0	1	1	
D3	I have experienced difficulty getting identity documents that match my gender identity.	0	1	1	Doesn't apply to me
D4	I have had difficulty finding housing or staying in housing because of my gender identity or expression.	0	1	1	Doesn't apply to me
D5	I have had difficulty finding employment or keeping employment, or have been denied promotion because of my gender identity or expression	0	1	1	Doesn't apply to me
R1	I have had difficulty finding someone to date or have had a relationship end because of my gender identity or expression.	0	1	1	
R2	I have been rejected or made to feel unwelcome by a religious community because of my gender identity or expression	0	1	1	
R3	I have been rejected by or made to feel unwelcome in my ethnic/racial community because of my gender identity or expression.	0	1	1	
R4	I have been rejected or distanced from friends because of my gender identity or expression.	0	1	1	
R5	I have been rejected at school or work because of my gender identity or expression.	0	1	1	
R6	I have been rejected or distanced from family because of my gender identity or expression.	0	1	1	
V1	I have been verbally harassed or teased because of my gender identity or expression. (For example, being called "it.")	0	1	1	
V2	I have been threatened with being outed or black-mailed because of my gender identity or expression.	0	1	1	
V3	I have had my personal property damaged because of my gender identity or expression.	0	1	1	
V4	I have been threatened with physical harm because of my gender identity or expression.	0	1	1	
V5	I have been pushed, shoved, hit, or had something thrown at me because of my gender identity or expression.	0	1	1	
V6	I have had sexual contact with someone against my will because of my gender identity or expression.	0	1	1	
V7	I have heard negative statements about transgender or gender-nonconforming people.	0	1	1	

2

	From here on, circle the best answer for each item. Note these labels have changed!→	**Strongly Disagree**	**Somewhat Disagree**	**Neither**	**Somewhat Agree**	**Strongly Agree**
NA1	I have to repeatedly explain my gender identity to people or correct the pronouns people use.	0	1	2	3	4
NA2	I have difficulty being perceived as my gender.	0	1	2	3	4
NA3	I have to work hard for people to see my gender accurately.	0	1	2	3	4
NA4	I have to be very masculine or very feminine in order for people to accept my gender.	0	1	2	3	4
NA5	People don't respect my gender identity because of my appearance or body.	0	1	2	3	4
NA6	People don't understand me because they don't see my gender as I do.	0	1	2	3	4
IT1	I resent my gender identity or expression.	0	1	2	3	4
IT2	My gender identity or expression makes me feel like a freak.	0	1	2	3	4
IT3	When I think of my gender identity or expression, I feel depressed.	0	1	2	3	4
IT4	When I think about my gender identity or expression, I feel unhappy.	0	1	2	3	4
IT5	Because of my gender identity or expression, I feel like an outcast.	0	1	2	3	4
IT6	I often ask myself: Why can't my gender identity or expression just be normal?	0	1	2	3	4
IT7	I feel that my gender identity or expression is embarrassing.	0	1	2	3	4
IT8	I envy people who do not have a gender identity or expression like mine.	0	1	2	3	4
P1	My gender identity or expression makes me feel special and unique.	0	1	2	3	4
P2	It is okay for me to have people know that my gender identity is different from my sex assigned at birth.	0	1	2	3	4
P3	I have no problem talking about my gender identity and gender history to almost anyone.	0	1	2	3	4
P4	It is a gift that my gender identity is different from my sex assigned at birth.	0	1	2	3	4
P5	I am like other people but I am also special because my gender identity is different from my birth-assigned sex.	0	1	2	3	4
P6	I am proud to be a person whose gender identity is different from my sex assigned at birth.	0	1	2	3	4
P7	I am comfortable revealing to others that my gender identity is different from my sex assigned at birth.	0	1	2	3	4
P8	I'd rather have people know everything and accept me with my gender identity and gender history.	0	1	2	3	4
C1	I feel part of a community of people who share my gender identity.	0	1	2	3	4
C2	I feel connected to other people who share my gender identity.	0	1	2	3	4
C3	When interacting with members of the community that shares my gender identity, I feel like I belong.	0	1	2	3	4
C4	I'm not like other people who share my gender identity.	4	3	2	1	0
C5	I feel isolated and separate from other people who share my gender identity.	4	3	2	1	0

3

Do you currently live in your *affirmed gender** all or almost all of the time?
(*Your *affirmed gender* is the one you see as accurate for yourself.)

NO | YES

If NO, continue to SECTION A (page 4)
If YES, skip to SECTION B (page 5)

4

SECTION A – Answer these items if you answered NO to the item on page 3.

		Strongly Disagree	Somewhat Disagree	Neither	Somewhat Agree	Strongly Agree
NFE1	If I express my gender identity, others wouldn't accept me.	0	1	2	3	4
NFE2	If I express my gender identity, employers would not hire me.	0	1	2	3	4
NFE3	If I express my gender identity, people would think I am mentally ill, "crazy."	0	1	2	3	4
NFE4	If I express my gender identity, people would think I am disgusting or sinful.	0	1	2	3	4
NFE5	If I express my gender identity, most people would think less of me.	0	1	2	3	4
NFE6	If I express my gender identity, most people would look down on me.	0	1	2	3	4
NFE7	If I express my gender identity, I could be a victim of crime or violence.	0	1	2	3	4
NFE8	If I express my gender identity, I could be arrested or harassed by police.	0	1	2	3	4
NFE9	If I express my gender identity, I could be denied good medical care.	0	1	2	3	4
ND1	Because I don't want others to know my gender identity, I don't talk about certain experiences from my past or change parts of what I will tell people.	0	1	2	3	4
ND2	Because I don't want others to know my gender identity, I modify my way of speaking.	0	1	2	3	4
ND3	Because I don't want others to know my gender identity, I pay special attention to the way I dress or groom myself.	0	1	2	3	4
ND4	Because I don't want others to know my gender identity, I avoid exposing my body, such as wearing a bathing suit or nudity in locker rooms.	0	1	2	3	4
ND5	Because I don't want others to know my gender identity, I change the way I walk, gesture, sit, or stand.	0	1	2	3	4

GREAT JOB! You have finished completing this questionnaire.

5

SECTION B – Answer these items if you answered YES to the item on page 3.

		Strongly Disagree	Somewhat Disagree	Neither	Somewhat Agree	Strongly Agree
NFE1	If I express my gender history, others wouldn't accept me.	0	1	2	3	4
NFE2	If I express my gender history, employers would not hire me.	0	1	2	3	4
NFE3	If I express my gender history, people would think I am mentally ill, "crazy."	0	1	2	3	4
NFE4	If I express my gender history, people would think I am disgusting or sinful.	0	1	2	3	4
NFE5	If I express my gender history, most people would think less of me.	0	1	2	3	4
NFE6	If I express my gender history, most people would look down on me.	0	1	2	3	4
NFE7	If I express my gender history, I could be a victim of crime or violence.	0	1	2	3	4
NFE8	If I express my gender history, I could be arrested or harassed by police.	0	1	2	3	4
NFE9	If I express my gender history, I could be denied good medical care.	0	1	2	3	4
ND1	Because I don't want others to know my gender history, I don't talk about certain experiences from my past or change parts of what I will tell people.	0	1	2	3	4
ND2	Because I don't want others to know my gender history, I modify my way of speaking.	0	1	2	3	4
ND3	Because I don't want others to know my gender history, I pay special attention to the way I dress or groom myself.	0	1	2	3	4
ND4	Because I don't want others to know my gender history, I avoid exposing my body, such as wearing a bathing suit or nudity in locker rooms.	0	1	2	3	4
ND5	Because I don't want others to know my gender history, I change the way I walk, gesture, sit, or stand.	0	1	2	3	4
GREAT JOB! You have finished completing this questionnaire.						

GMSR-A Scoring and Interpretation

Follow the instructions below to calculate subscale scoring and interpretation.

DISTAL STRESSORS (4 subscales): Discrimination (D), Rejection (R), Victimization (V), and Non-affirmation (NA)
[a higher counts indicate a greater degree of these distal stressors]
Sum all 5 subscale item responses to get ***D score=*** ____ [possible range: 0-10]

Sum all 6 subscale item responses to get ***R score=*** ____ [possible range: 0-12]

Sum all 7 subscale item responses to get ***V score=*** ____ [possible range: 0-14]

Sum all 6 subscale item responses to get ***NA score=*** ____ [possible range: 0-24]

PROXIMAL STRESSORS (3 subscales): Internalized Transphobia (IT), Negative Expectations for the Future (NFE), Gender Identity/History Non-disclosure (ND)
[a greater score indicates a greater degree of these proximal stressors]

Sum all 8 subscale item responses to get ***IT score=*** ____ [possible range: 0-32]

Sum all 9 subscale item responses to get ***NFE score=*** ____ [possible range: 0-36] Indicate NFE
Indicate whether score is related to Gender Identity *(if Section A completed)* or Gender History *(if Section B completed)*

Sum all 5 subscale item responses to get ***ND score=*** ____ [possible range: 0-20]
Indicate whether score is related to Gender Identity *(Section A completed)* or Gender History *(Section B completed)*

RESILIENCE FACTORS (2 subscales): TGNC Pride (P), TGNC Community Connectedness (CC)
[a greater score indicates a greater degree of these resilience factors]

Sum all 8 subscale item responses to get ***P score=*** ____ [possible range: 0-32]

Sum all 5 subscale item responses to get ***CC score=*** ____ [possible range: 0-20]

Appendix C: Gender-affirming care documentation

Date

Name
Street
Address

Re: (patient name)

Name:

With the patient's expressed permission, as evidenced by a signed release of information for treatment coordination, please consider this letter to fulfill your request to assess the patient's marked and persistent gender incongruence experience. The patient has been under this writer and clinician's care since [date]. The client presented for [number] of individual sessions since the initial intake and continues to express enthusiasm for gender-affirming therapy and movement toward [medical, hormone, surgical, other] affirming intervention.

The client completed a gender timeline describing the client's enduring experience of gender incongruence. The client completed the [Gender Minority Stress and Resilience Measure (GMSR) or Gender Minority Stress and Resilience Measure for Adolescents (GMSR-A)], which reinforced the client's gender incongruence experience. As a result of the assessment and clinical observation, this patient qualifies for [302.6 (F62.2) Gender dysphoria in children; 302.85 (F64.1) Gender dysphoria in adolescents and adults; 302.6 (F64.8) Other specified gender dysphoria; 302.6; or, (F64.9) Unspecified gender dysphoria]. The clinician ruled out [states any mental health disorders which were ruled out.] The clinician diagnosed [no or the following] comorbid conditions: [add any additional mental health diagnosis here]. Resulting from the client's gender incongruence experience, the client describes impairment in [activities of daily living, social functioning, occupational function, relationship, function]. Thus, the client has met the medical necessity criteria for gender-affirming treatment.

Should you require further information in your service determination for this client, please do not hesitate to discuss this with the client. I am available to offer assistance with the client's endorsement as needed.

Regards,

Name, credentials
Address

Phone
Fax
Email
Website

Appendix D: Fenway Health: Medical Care of Gender Diverse Children and Adolescents

Appendix D: Fenway Health: Medical Care of Gender Diverse Children and Adolescents

Fenway Health: Medical Care of Trans and Gender Diverse Adults documentation can be found via this link: https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf

Appendix E: Gender Timeline Example

Because transgender-affirming care might require evidence of a persistent and sustained gender identity, articulation of the patient's gender timeline may prove useful for treatment approval in gatekeeping models. Below, please find an example timeline.

Age	Thought	Feeling	Behavior
5	I am a girl.	I feel peaceful with other girls.	I love to play with dolls.
10	I am not a boy.	I feel scared.	I avoid rough play.
15	I am a young woman.	I feel confident when wearing makeup.	I wear makeup.
16	I am a young woman.	I am proud of my style.	I wear skirts.
19	I am a woman.	I feel fulfilled in my gender.	I live fully in my gender.
22	I am a woman.	I feel at peace as a woman.	I live fully in my gender.