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## Exploring Current Practices of Pediatric Providers Serving Transgender/Gender Non- Conforming (TGNC) Youth 12 Years of Age and Under in the Washington, Alaska, Montana, Idaho Region

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**Exploring Current Practices of Pediatric Providers Serving Transgender/Gender Non-Conforming (TGNC) Youth 12 Years of Age and Under in the Washington, Alaska, Montana, Idaho Region**

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A DNP project submitted in partial fulfillment of the requirements for the degree of

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### **Abstract**

Transgender and gender non-conforming (TGNC) youth 12 years of age and under, often present first to their pediatric primary care providers for needs related to their gender identity. Primary care providers are uniquely positioned to address needs for these individuals and their families. Many primary care providers have no additional training for this special population, especially for pre-pubescent TGNC patients, and have varied levels of comfort and strategies regarding signaling acceptance, screening and assessing practices, referral practices, and discussing gender and physical characteristics topics. This project explores current practices of primary care providers in the Washington, Alaska, Montana, Idaho (WAMI) region who have provided care to TGNC youth. Interviews were conducted with eight (n = 8) primary care providers. Thematic analysis was utilized to guide the analytic process via an adapted deductive approach to coding. The themes we identify reflect current practices of how these eight primary care providers serve individuals in this population and may represent similar themes of providers in other regions.

*Keywords: Transgender and gender non-conforming (TGNC), pediatric, primary care providers, pre-pubescent, signaling acceptance, screening, assessing, referral, gendered topics, Washington, Alaska, Montana, Idaho (WAMI) region, thematic analysis*

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**Exploring Current Practices of Pediatric Providers Serving Transgender/Gender Non-conforming (TGNC) Youth 12 Years of Age and Under in the Washington, Alaska, Montana, Idaho Region**

Visits with pediatric providers account for the majority of child and adolescent primary care office visits and these providers are uniquely positioned to normalize diversity in gender identity during well-child visits (American Academy of Pediatrics, 2010; Gridley et al., 2016; Vance Jr. et al., 2017, 2020). Transgender and gender non-conforming (TGNC) individuals account for 0.7% to 3.2% of adolescents, age 13-17, within the United States population, according to national population-based and school-based surveys (Katz-Wise et al., 2017; Lau et al., 2020). For specific definitions of how we employ terms, see Table 1. Youth who are TGNC often avoid contact with medical providers because of experienced or anticipated stigma and discrimination within the health care setting (Gridley et al., 2016; Guss et al., 2019; Katz-Wise et al., 2017; Sequeira et al., 2020b). This decreases the number of mental health screenings and preventative care services that TGNC youth receive, and negatively impacts long term health outcomes (Guss et al., 2020; Rider et al., 2018; Sequeira et al., 2020b).

**Table 1**

*Definitions of Terms*

Term	Definition
Gender expression	The external way a person expresses their gender such as clothing, hair, mannerisms, activities, or social roles. <sup>a</sup>
Gender identity	A person's intrinsic sense of being female, male, an alternative gender, or no gender. <sup>b</sup>
Transgender	Adjective to describe individuals whose gender identity and/or gender expression are opposite to the cultural norms of the sex assigned at birth.

Gender non-conforming	Adjective to describe individuals whose gender identity, role, or expression differ from what is normative for their assigned sex in a given culture and historical period. <sup>b</sup>
Agender	Adjective to describe individuals who does not identify as having a particular gender. <sup>a</sup>
Gender affirming care	Providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. <sup>a</sup>
Gender affirming medical intervention	Interventions that require medical supervision and monitoring and affirm a person's gender.
Cisgender	Adjective to describe individuals whose gender identify and gender expression are the same as the culturally norms of the sex assigned at birth. <sup>a</sup>
Assigned sex at birth	The sex male or female assigned by doctors or midwives based on external genitalia.
Transphobia	[Negative] bias towards transgender people including discrimination and harassment. <sup>c</sup>

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*Note.* The definitions offered here are limited to clarifying how terms were employed in this paper and are not meant to be invalidating of the ever-evolving language used to discuss gender identity and gender expression.

<sup>a</sup> (Rafferty, 2018)

<sup>b</sup> (World Professional Association for Transgender Health [WPATH], 2012)

<sup>c</sup> (Stroumsa et al., 2019)

TGNC youth have a higher risk of depression, anxiety, and suicidal ideation compared to cisgender peers. The lifetime prevalence of major depressive episodes in the TGNC populations continues to disproportionately increase with age, indicating an opportunity for early intervention (Budge et al., 2018; Greytak et al., 2009; Miller, 2006; Reisner et al., 2016; Stroumsa et al., 2019; WPATH, 2012). A longitudinal study of young adults who received puberty suppression and gender affirming medical interventions (GAMI), found that their psychological functioning improved over time, with symptom severity “indistinguishable from the general population sample” (De Vries et al., 2014, p. 7). Pediatric primary care providers are positioned to impact TGNC youth health outcomes in three major ways: creating a more positive healthcare

experience, assessing for gender, and referring for mental health services when needed, and offering guidance and referral to GAMI as appropriate.

### **Background & Significance**

Providers can increase the likelihood that TGNC youth will continue seeking primary care by providing a positive, patient centered health care experience, and showing acceptance and support of the youth's gender identity (Puckett, 2019; Reisner et al., 2015). Increasing points of contact will increase the opportunity to screen for and identify mental health concerns for prompt referral if necessary. Providing gender affirming, patient centered care will increase the number of social domains within which the child's gender identity is affirmed. Important social domains include family, school, friends, work, and health care settings (e.g., primary care, urgent care and emergency departments, school-based health centers) (Edward-Leeper & Connelly, 2019). Each social domain that affirms a child's gender identity acts as a protective factor, decreasing their risk of depression, with family acceptance being the most predictive protecting against suicide, depression, and homelessness (Connolly et al., 2016, Oransky et al., 2019). When black transgender youth had their gender affirmation needs meet within their family and community, they were more likely to access health care (Goldenberg et al., 2019).

Pediatric primary care providers are a trusted source of health information and can influence the attitudes of parents and guardians. For parents and guardians working to understand their child's experience, providers can answer questions and offer education that normalizes diverse gender identity/expression (Gridley et al., 2016; Guss et al., 2019; Katz-Wise et al., 2017). Primary care providers are commonly a gate keeper to receiving referral for GAMI or to a pediatric gender clinic (Gridley et al., 2016; Guss et al., 2019; WPATH, 2012). There has also been noteworthy evidence that children who identify as transgender and are supported in

transitioning to live their self-determined identity experience mental wellbeing equivalent to their cisgender peers (De Vries et al., 2014).

### **Problem Statement**

TGNC youth avoid contact with medical providers because of experienced or anticipated stigma and discrimination (Guss et al., 2019). This can delay access to gender affirming care which negatively impacts immediate and long-term mental health outcomes for TGNC youth (De Vries et al., 2014; Tordoff et al., 2022). Literature presents evidence-based practice (EBP) that can guide providers to offer TGNC youth a more positive and gender affirming healthcare experience. However, if providers are unaware of current EBP, or have not been educated or trained to utilize EBP for TGNC youth 12 years of age and under, the quality of care is negatively impacted.

## **Literature Review**

### **TGNC Patient Interactions with Providers**

Beginning with a review of local information in Washington state, gender diverse patients of all ages faced several issues with primary care experiences. 38% of transgender Washingtonians in the last year reported at least one negative healthcare experience related to their gender identity: “being harassed, being refused treatment, being assaulted, or having to teach their provider about transgender people in order to receive care” (King County Public Health, 2019, p. 11). While the Seattle area has providers who are competent to work with pediatric gender diverse patients, these providers are often not taking new patients and are difficult to access for patients who live far from Seattle (King County Public Health, 2019). Washingtonian providers reported having few opportunities to learn how to work effectively



with transgender and gender diverse patients, citing three specialty areas: “especially in pediatrics, family practice, and primary care” (King County Public Health, 2019, p. 7).

Information on transgender populations in Alaska, Idaho and Montana was more difficult to locate. The 2015 US Transgender Survey Report, a national survey of all ages, offered information on transgender residents of Alaska and Idaho experiences with health care, however transgender residents of Montana were not discretely discussed (James et al., 2016). Of gender diverse respondents in Alaska, 44% reported having at least one negative experience with health care providers related to being transgender within the past year, while 39% of transgender Idaho residents had a negative experience (James et al., 2016). Further, 28% of respondents in Alaska avoided seeing a doctor when they needed care due to concern about being mistreated because they were transgender while 27% of transgender respondents in Idaho stated they avoided care (James et al., 2016).

### **Gender Assessing Barriers**

Considering the structure of research, a review of literature shows that research has only recently begun to consider gender outside of the sexual binaries of male/female, cisgender/transgender, but has begun to include gender non-conforming, gender diverse or agender identification as a unique data point (Burgwal et al., 2019; Hayes, 2017; Koehler et al., 2018; Matsuno, 2019; Rider et al., 2018; Scundurra et al., 2019). Historically, gender has been acknowledged as a binary construct in research but is still often conflated with sexual orientation, assuming a heterosexual identification (Kessler & McKenna, 1978). Over time there has been a recognition that gender expression “is an aspect of personality development; an aspect protected by human rights conventions” and is separate and independent from sexual orientation or sex assigned at birth (Suess Schwend et al., 2018, p. 1589). There are significant differences

in perception of health between cisgender and gender diverse youth populations. Only one third of surveyed youth who identify as transgender or gender non-conforming reported their general health as very good or excellent compared to two thirds of matched cisgender youth (Rider et al., 2018). There are different risk assessments, mental health screenings and anticipatory guidance needed by people with different gender identities, thus increasing the need for pediatric primary care providers to be aware of gender identity (Edwards-Leeper & Connelly, 2019; Forcier et al. 2018; Rafferty, 2018; Rider et al., 2018). TGNC youth should be screened for anxiety, depression, homelessness, physical violence, eating disorder, self-harm behaviors and suicidal ideation (Rafferty, 2018).

### **Identifying Best Practices for TGNC Youth**

#### ***Patient Centered Pediatric Care***

A common theme in the literature, presented by TGNC youth, was the desire to be treated like every other patient, to not be an “outsider,” “sexual deviant,” “science experiment,” or “spectacle” (Gridley et al., 2016, p. 258; Guss et al., 2019). Stigma and discrimination contributed to TGNC youth avoiding contact with medical providers, including black transgender youth (Goldberg et al., 2019; Katz-Wise et al., 2017; Rider et al., 2018; Sequeira et al., 2020b). Surveyed TGNC adolescents stated that the office space, the office staff, and the primary care provider all contribute to the primary care experience (Guss et al., 2019). To provide a positive health care experience, providers need to make a deliberate effort to implement gender affirming practices and training throughout the clinical experience (Gridley et al., 2016; Guss et al., 2019; Puckett, 2019; Rafferty, 2018).

### *Signaling Gender Acceptance*

Research has shown that TGNC youth are more likely to discuss their gender identity or gender expression within a medical setting that they view as supportive of their gender identity. (Guss et al., 2019; Lau et al., 2020; Sequeira et al., 2020b). One signal that the medical setting is safe and welcoming was the structure of the intake forms including multiple gender choices: female, male, transgender, gender diverse, agender or other: (followed by space to fill in descriptors of their choosing). Including questions about gender and correct name and pronouns on forms allowed medical groups to directly signal that their providers see diverse gender expression and identity as a normal part of human development (Gridley et al., 2016; Guss et al., 2019; Sequeira et al., 2020b; Suess Schwend et al., 2018). Having a gender identity question within a well-child intake form was found to be non-offensive to parents, guardians, and youth. Gender identity questions were also recognized as vital information for a provider to have (Lau et al., 2020). TGNC adolescents previously recommended providers ask every patient, every time, about gender identity, correct name, and pronouns (Guss et al., 2019, 2020; Reisner et al., 2015).

TGNC youth frequently avoided sharing their gender identity because they were concerned that their health care provider would not approve (Gridley et al., 2016). This is unlike lesbian, gay, or bisexual youth who have reported being more comfortable sharing their sexual orientation if providers just asked. TGNC youth found more comfort in supportive cues from intake forms that included questions about correct name, pronouns and had gender options including transgender, gender diverse or non-gender conforming check boxes as well as positive waiting room experiences (Conner, 2019; Gridley et al., 2016; Sequeira et al., 2020b).

Characteristics of a welcoming atmosphere included visible stickers, signs, and staff nametag and lanyard decorations with pronouns or rainbows (Oransky et al., 2019; Rafferty, 2018).

Providers can use “The Gender Unicorn” for teaching and exploration of gender identity, gender expression, sex, sexual attraction, and romantic attraction (Physicians for Reproductive Health [PRH], 2018). Using a graphic with linear measures offered the patient the ability to self-express their identity visually in a way that is accessible to young children. This tool gave providers the opportunity to explain and name the language of gender identity and sexuality, clarifying definitions (PRH, 2018).

### ***Gender Identity Assessment***

If youth did not share their gender identity, providers remained unaware that they were making inaccurate assumptions about a transgender or gender diverse patient’s gender identity. Not only did providers miss patient education and screenings, misperception of a youth’s gender caused harm by invalidating, negating, and not affirming their gender identity (Gridley et al., 2016; Reisner et al., 2015; Rider et al., 2018). Conversely, healthy coping strategies of self-assertion were reinforced when a youth shared their gender identity, and a provider was positive and validating (Budge et al., 2018).

### ***Electronic Health Records***

The primary strategy TGNC youth recommended to create positive experiences and increase their comfort was using their correct name and pronouns in the waiting room (Gridley et al., 2016; Guss et al., 2020; Sequeira et al., 2020b). Noting this information within the Electronic Health Record (EHR) made it clearly and readily available to office staff and providers and increased the opportunity for the correct name and pronouns to be used for every patient. The EHR may limit the ability of practices to clearly notate correct name and pronouns

without creating a new record (Rafferty, 2018). Altering the EHR to include a banner at the top of the screen, clearly noting correct name and pronouns was recommended to be gender affirming to TGNC patients (Guss et al., 2020; Oransky et al., 2019). Most youth attending gender specialty clinics wanted to have their names and pronouns documented system-wide within the electronic health records (Sequeira et al., 2020a).

### ***Patient Interview***

Patient interviews conducted by providers represented another barrier. One study found that most physicians did not include sexual orientation, sexual attraction, or gender identity while taking a sexual history from a sexually active adolescent due to discomfort (Kitts, 2010). This illustrates how providers' discomfort leads to the omission of pertinent questions from patient interviews. Gender identity assessment is recommended as part of a primary care basic patient history starting at 5 years old (Reisner et al., 2015). Parents, guardians, and TGNC youth have expressed a desire for providers to be more knowledgeable and confident in their communication and care (Gridley et al., 2016; Guss et al., 2020; Vance Jr. et al., 2015). Providers need to assess if patients are using non-medical body modifications (NMBM) such as tucking and binding to ensure safety, provide education, and facilitate access to high quality products (Lynch et al., 2019).

Providers have reported that learning how to discuss topics such as sexuality and pubertal changes without stumbling over binary gender terms is intimidating and difficult (Vance Jr. et al., 2015). The opportunity for providers to dialogue about gender issues during training, or interact with a standardized patient, offered a safe opportunity to practice (Stroumsa et al., 2019; Vance Jr. et al., 2015). Pediatric providers were significantly more comfortable discussing gender identity issues with adolescents than with the adolescent's parent or guardian (Lau et al.,

2020). Well-child visits for adolescents 13 years and older include one-on-one time with youth when parents and guardians are asked to leave which allows the provider and adolescent to speak privately. TGNC youth were more likely to share their gender identity if they understood that the provider would keep the information confidential and that the provider understood how much of their gender identity the youth had shared with their family: “Protecting confidentiality and understanding the level of family acceptance from the adolescent’s perspective are paramount. Adolescents expressed high comfort levels with questions about their gender, but only if their confidentiality could be assured” (Lau et al., 2020, p.6).

### ***Referral Practices***

Many cities are fortunate to have gender clinics, which function as an excellent referral resource for providers serving gender diverse pediatric patients, however, this is not the case for those in rural communities (Eisenberg, 2019; Reirdan & Glover, 2019). This structural issue further supports the universal need for non-specialist pediatric providers to be able to provide appropriate care for gender diverse patients to increase access for this population outside of gender clinics. This is predicated on providers having the willingness to care for patients in this population, which is not universal, and is correlated with provider age, physician specialty, exposure to transgender people, and varying levels of transphobia (Shires et al., 2018).

Barriers which restrict access include lack of self-referral options for pediatric gender diverse patients (Colvin et al., 2019), and lack of providers with enough knowledge to adequately provide care to this population (Moon, 2016; Spencer et al., 2017). Gender non-conforming patients are often unknown to, or misunderstood by health care providers, and often have difficulty obtaining access to GAMI (Burgwal et al., 2019). TGNC youth often do not access mental health care because they have not discussed mental health concerns with their

primary care provider (Colvin et al., 2019). As many as 60.7% of transgender patients in one study were significantly more like to self-refer than to follow through with a formal medical referral from their primary care provider, as a way of self-empowerment (Colvin et al., 2019). Allowing TGNC youth to decide how and when to access services also reduces barriers accessing care (Oransky et al., 2019). Many common referrals recommended for TGNC youth include adolescent medicine specialists, psychiatrists, clinical psychologists, clinical social workers, health educators, paralegals, and lawyers, as well as to support or social groups, and to gender affirming surgeons (Oransky et al., 2019). Additional barriers identified by TGNC youth include few accessible providers trained in gender-affirming health care for youth, lack of consistently applied protocols, inconsistent use of patients' chosen name/pronoun, uncoordinated care and gatekeeping, limited/delayed access to pubertal blockers and cross-sex hormones, and insurance exclusions (Gridley et al., 2016).

A case study involving a ten-year-old transgender patient published in two separate articles, captured the issue of referral barriers (Eisenberg, 2019; Reirdan & Glover, 2019). In this case study the TGNC youth's provider admitted to not having enough training to treat the patient, and therefore, referred to specialized care. However, specialized care was unavailable within 300 miles due to the patient living in a rural community. This case study showed how to utilize an ethics consultant to discuss appropriate timelines for medical intervention (Eisenberg, 2019; Reirdan & Glover 2019).

### ***Provider Knowledge***

There are several studies from the health care providers' perspective about barriers that impacted their ability to care for transgender and gender diverse patient populations. Pediatric medical providers, including adolescent medicine and pediatric endocrine providers, have been

found to “lack confidence in their ability to provide care to this [transgender] population” due to a lack of medical training, education, and exposure to transgender patients (Gridley et al., 2016; Lau et al., 2020; Rafferty, 2018; Vance Jr. et al., 2015, p. 253; Vance Jr. et al. 2020). It is well documented in the literature that pediatric providers have training deficits, including lack of skills, tools, knowledge, appropriate attitudes and approaches, and evidence-based solutions to effectively care for gender diverse pediatric patients (Weiselberg et al., 2019). Providers who received transgender specific training most often did so through post-training educational programs and were interested in receiving additional training in the future (Vance Jr. et al., 2015). This education should include deliberate teaching of diagnostic and pharmacological issues, and a refresher on terminology, and may be enhanced with pharmacist driven educational sessions (Congdon III et al., 2021; Turban et al., 2018).

Standard medical education is commonly thought to have a ‘hidden curriculum,’ the informal instruction which perpetuates implicit bias among medical providers and directly impacts the level of care that transgender and gender diverse individuals receive (McPhail et al., 2016; Stroumsa et al., 2019). A provider’s level of transphobia directly impacted the amount of knowledge they retained about healthcare for transgender individuals (Stroumsa et al., 2019). Research has shown that increasing provider education of TGNC health care services alone found no correlation between the number of educational hours about TGNC health care and a medical students’ knowledge about TGNC health care provision. Not only is there a need for additional education, but due to the ethically charged nature of the gender affirming care within pediatric patient population, there is a need for education that goes beyond didactic lectures. By including patient contact or interactive discussions, medical providers would have the



opportunity to personally resolve their ethical beliefs around hormonal interventions for transgender adolescents (Turban et al., 2018).

### ***Parent and Guardian Experience***

Parents and guardians of prepubertal TGNC youth, compared to parents and guardians of adolescent TGNC youth, were found to be more likely to hide their child's gender identity from others out of fear of ridicule (Hidalgo & Chen, 2019, p. 868). These parents and guardians also worried about their child's physical and emotional safety and the way their child would be treated by society in the future (Hidalgo & Chen, 2019). Some parents and guardians attempted to protect their TGNC child from transphobia by limiting and discouraging their child's authentic gender identity or expression, which often led to marital conflict and parent-child attachment problems (Hidalgo & Chen, 2019, p. 868). Primary care providers can help address this barrier by providing education to parents and guardians of TGNC youth about gender development, explaining how and why identity and expression may change, and encouraging exploration (Hidalgo & Chen, 2019).

The American Academy of Pediatrics (AAP) acknowledged the fluidity of gender identity development and emphasized instilling worth: "valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family" (Rafferty, 2018, p. 4). The AAP encouraged gender identity and expression exploration and condemned reparative approaches such as conversion therapy (Rafferty, 2018). Katz-Wise et al. (2017) found it was important for parents and guardians to understand the complex, fluctuating, and non-linear progression of TGNC youths' gender development. Katz-Wise et al. (2017) utilized a figure in their article to illustrate the complexity of transactional pathways a transgender or gender non-conforming youth's gender identity development may take,

concluding with gender affirming surgery, a positive experience with identifying as trans, and puberty blockers/cross sex hormones. We suggest this model's conclusion left out TGNC youth who did not want surgery, TGNC youth who did not fall within the binary of male and female, and agree with the AAP which states in its policy statement, there is "no prescribed path, sequence, or end point" (Rafferty, 2015, p. 5).

### ***Legal Considerations***

Pediatric providers must consider federal and state laws around consent, dissenting parents or guardians, and medical interventions. This requires pediatric providers to do their own research or attend training courses which supply this information. Major legal issues revolve around consent and ethics, especially for pediatric patients under the age of 18. One area within the broader context of consent is widespread debate regarding at what age young people have the capacity to autonomously make health-related decisions with or without their parents' or guardians' participation in consent (Brunskell-Evans, 2019; Coleman, 2019). Though these topics are controversial and politically saturated, it is necessary because pediatric providers will inevitably be faced with legal, ethical, and moral dilemmas when providing care to gender diverse pediatric patients. Examples include providing access to puberty blockers without parents' or guardians' permission and religious objections and scenarios that could be considered child abuse or neglect (Coleman, 2019). On April 8<sup>th</sup>, 2022, a senate bill in Alabama (S.B.184) went into effect (Alabama Vulnerable Child Compassion and Protection Act, 2022). This bill made prescribing puberty blocking medication or other GAMI to TGNC youth under 19 years of age a violation of a Class C felony, punishable by 366 days to 10 years in prison and a fine of up to \$15,000 (Alabama Vulnerable Child Compassion and Protection Act, 2022). S.B.184 is being challenged under 42 U.S.C. § 1983 and U.S. Const. Amend. XIV.

### **Purpose of Project**

This quality improvement project was designed to explore current practices of well-child visit providers caring for transgender and gender non-conforming (TGNC) youth 12 years of age and under within the Washington, Alaska, Montana, and Idaho (WAMI) region. The purpose of this project was to explore how care is being delivered to this population, compare this data with EBP, and identify recommendations to providers caring for TGNC patients to improve equitable and welcoming care provided to their TGNC patients. After data was collected and analyzed, recommendations were disseminated to the participants. The three aims were specifically designed to explore three areas regarding how care is delivered to this population. The first aim was to assess signaling of gender acceptance through visual cues such as entrance area or waiting room décor, and EHR fields including correct name and pronouns. The second aim was to assess current screening, assessing, and referral practices of TGNC youth. The final aim was to assess how providers discuss gender and physical characteristics topics in well-child visits.

### **Theoretical Framework**

This project was best informed by the Donabedian Model translational science theory framework where a project goes through three categories: structure, process, and outcome (Donabedian, 1988). The structure, or setting, was where the project was implemented, and who was involved: multiple providers who conduct well-child visits across several states including WAMI. The process was what the project aimed to do and how it was effectively delivered: conducted interviews with these providers. The outcome was measured, reviewed, and assessed: a comparison of interview content and EBP via thematic analysis, which resulted in

recommendations for dissemination, to indirectly improve well-child visits for TGNC youth 12 years of age and under.

## **Methods**

### **Design**

This project was submitted to the Seattle University Institutional Review Board of Seattle University and determined to be exempt. Survey and interview questions were designed to be answered through two online Qualtrics surveys and one semi-structured interview which contained questions directly related to this project's aims. The first survey was sent via email to personal and professional contacts. The second survey was sent via email to interested participants. This survey included informed consent and consent was obtained from each participant prior to being interviewed (see Appendix B). After scheduling interviews via email communication, interviews took place remotely on Zoom as participants were located across several states in the WAMI region. Once the interviews were transcribed, qualitatively analyzed, and compared to evidenced-based practices for care of TGNC youth, recommendations were created and disseminated.

### **Setting**

Given participants were interviewed across a large region and interviewed via Zoom, to protect confidentiality, providers were intentionally not asked about where (e.g., name of hospital system or clinic) they work. Instead, providers were asked to describe the setting in which they work (see Appendix C).

### **Participants**

Recruitment was conducted using snowball sampling and word-of-mouth strategies via community and professional contacts. Emails were sent to key community and professional

networks, and 11 providers expressed interest. Participants were chosen based on responses to the first Qualtrics survey which included questions related to inclusion criteria (see Appendix A). Participants chosen were nurse practitioners and medical doctors who practice in the WAMI region who conduct well-child visits including at least one known TGNC patient in the last five years. Exclusion criteria were providers who did not conduct well-child visits, providers who have not conducted well-child visits to at least one known TGNC patient, or providers who worked in specialty care such as endocrinology. Two interested survey respondents were pediatric endocrinologists who did not conduct well-child visits and were excluded. One interested survey respondent met inclusion criteria but was unable to find time to interview.

### **Intervention and Data Collection**

Interviews took place between January 2022 and April 2022. All eight participants were well-child visit providers that have cared for at least one known TGNC patient within the WAMI region. Four participants practiced in the Seattle area, one participant practiced in central Washington, two participants practiced in Alaska, one participant practiced in Montana, and no participants practiced in Idaho. For a breakdown of providers' experience with TGNC patients, see Table 2. Participants completed a brief survey which included closed-ended question about forms used in their places of employment and closed-ended questions about their EHRs (see Appendix B). Principal investigators conducted semi-scripted interviews which included open-ended and closed-ended questions (see Appendix C). Interviews were audio-recorded and subsequently transcribed.

### **Measures and Instruments**

The surveys and interview guide were developed by the principal investigators with feedback from expert advisors and included questions across five topical areas which were based

on the findings in the existing literature. Appendix A contains questions asked of providers relating to the number of TGNC patients served, states and zip codes in which providers practiced, formal training, and informal training. Appendix B contains consent request and questions asked of providers related to patient intake forms and EHR systems. Appendix C contains semi-structured interviews questions asked of providers within three distinct sections relating to each of the project's three aims: visual cues, screening, assessing, and referrals, gender and physical characteristics topics, as well as areas of need.

### **Data Analysis**

Thematic analysis was utilized to guide the analytic process. The primary goals were to identify current practices among participants and identify knowledge gaps in relationship to EBP in existing literature. An adapted deductive approach to coding was used. This involved both identifying existing themes in the literature (e.g., deductive coding) and coding via a more inductive approach where themes were identified purely from the data we collected (Willig, 2008). The analysis was structured based on steps outlined in Braun and Clarke (2006): looking over data, generating initial codes, looking for themes in initial codes, reviewing themes to group similar themes into sub-themes, and defining and naming final themes. The two principal investigators served as data analysts for this study. One principal investigator identifies as a gay, white, cisgender male. The other principal investigator identifies as a queer, white, pansexual, nonbinary mother. Interview data was then compared with EBP and was used to discover gaps in current provider practice during well-child visits.

## Results

### Participant Characteristics

**Table 2**

*Participant Characteristics*

Provider	1	2	3	4	5	6	7	8
State of Practice	WA	WA	WA	WA	AK	MT	WA	AK
Distance from SCH-GC (miles) <sup>a</sup>	6	3	4	4	1997	680	156	1997
License	MD	MD	PNP	FNP	FNP	PNP	MD	DO
# of TGNC Youth 0-12 Years Old	1-2	1-2	3-10	None	1-2	1-2	1-2	3-10
# of TGNC Youth 13-18 Years Old	3-10	10-30	3-10	10-30	3-10	1-2	1-2	3-10
Training	Yes	No	Yes	Yes	Yes	No	No	Yes
CME	X		X	X	X			
Workplace Training			X	X				
In-person Training			X					X
Online Training	X		X	X				
Pharmacy Training								

*Note.* SCH-GC = Seattle Children's Hospital Gender Clinic; MD = Medical Doctor; PNP = Pediatric Nurse Practitioner; FNP = Family Nurse Practitioner; DO = Doctor of Osteopathy; TGNC = Transgender and Gender Non-Conforming; CME = Continuing Medical Education.

<sup>a</sup> Distance was measured in miles from zip code to zip code traveling by car.

## **Seattle Area Results**

### ***Signaling Acceptance***

The first theme among the four providers interviewed from the Seattle area, regarding signaling acceptance, centered around patient forms, EHR systems, and visual cues. Some providers discussed inclusive patient forms such as fill-in-the-blank options, while others had standard forms. Most providers had EHR systems with options such as: assigned sex at birth, pronouns, correct name the patient uses, and patient name as it appears on their insurance card. One provider had an EHR system with flags or banners to assist all staff to be aware of and correctly use the same names and pronouns for TGNC patients.

On the topic of visual cues, all four providers indicated some representation of gender acceptance. Individual themes included: provider wearing pins, provider verbal disclosure of own pronouns, pamphlets, forms, resource boards, handouts, visual statements about pronouns, inclusive photos, flags, posters, visuals in the hallways, and safe space signs. All four providers indicated room for improvement. One provider commented: “Actually can't even think of a single information, policy, picture, or welcoming flags of any kind that I've ever seen in our office...I don't think I can say that we do a good job of that.” Individual themes regarding improvement included: flags only being up in June, unawareness of what lobby looks like, bland exam rooms, too many posters allowing LGBTQIA+ posters to get lost, no control over design, and hope about pending future changes.

### ***Screening and Assessing***

The second theme regarding screening and assessing centered around organizational protocols, self-initiated protocols, and lack of protocols both for identifying gender and after TGNC gender identified. Three providers ask all patients about their gender identity starting at



different ages such as five and nine. One provider had a protocol to ask all patients, while two providers taught others in their organization to ask all patients about their gender identity. One provider gave anticipatory guidance about this assessment to the patient and families:

“We usually try to at least give families or our guardians a heads up ‘hey, we’re going to talk about this. Are you okay with it?’ But just to try to get people prepared so they’re not in a sort of defensive mode or anything.”

Some providers have made it a goal to incorporate introducing themselves with their pronouns at every appointment and asking every patient their pronouns and about their gender identity. One provider did not have a protocol, except for a questionnaire for patients over 12 years of age, asked some patients using their discretion, and would talk about it if a patient brought it up.

After a patient’s gender was identified as TGNC, providers had different strategies about next steps. Some providers used the validated HEADSS assessment: home, education, activities, drugs, sex, and suicide; one provider added gender identity assessment to the sex portion of the screening. Others screened for related topics as well as social support, school support, disclosure assessment, and safety. Many providers emphasized provider/patient rapport, asked about the patients’ individual journeys, and emphasized comfort and safety. Some providers then transitioned topics to discuss next steps such as exploration, resources, NMBM and GAMI. Two providers discussed lack of protocols besides the standard HEADSS assessment for all pediatric patients: “No, we do not have any standardized screenings at this point.”

### ***Referrals***

The third theme regarding referrals, centered around not only referring out, but also connecting to community resources, mental health services, resources, referring out, and warm handoffs. All four providers discussed topics regarding not referring out: collaboration with

specialists, utilization of transgender healthcare navigators, balancing fear of legal issues with wanting to provide care, and several topics related to comfort. Topics related to comfort included overall comfort with most topics, self-initiated research for unfamiliar topics such as NMBM treatments, medical interventions including hormone and puberty blockers, privilege to have received training by specialists, and training others to instill comfort keeping patients.

All four providers discussed connecting patients and families to community resources. Providers emphasized internal resources, mental health resources, connecting families with one another, and connecting colleagues to resources so they may also share such as a “sex positive parenting” social media account. Some providers assumed responsibility for mental health care, while recognizing limitations, due to lack of access and to provide timely interventions considering 4-to-6-month waitlists. Those who had internal mental health resources, referred to their colleagues. Barriers discussed included: insurance dependent support letters for pubertal blockage, ethical guidelines requiring psychiatric assessments, lengthy waitlists, access barriers depending on insurance, recent loss of community resources, and lack of confidence in others’ trans competency: “normally I have a firm policy of not sending any gender nonconforming folks to a provider I haven't myself known.” Two providers referred out for mental health services for several reasons: by patient request, safety concerns, lack of training, lack of expertise, and reconnection to previous established providers.

Referring out was discussed by two providers especially regarding medical interventions. Reasons included lack of expertise, lack of specific training, utilization of available local resources, knowledge of referral resources, and the belief GAMI belonged in specialty care, not primary care: “Uhm, I don't (do) medical transgender care and unfortunately that was not part of my training. And so, I refer out for that part of it.” Other topics included not having protocols,

lack of internal resources, and orthopedic specialty care referrals. Many providers referred patients to Seattle Children's Gender Clinic despite knowing they had a long wait list, limitations related to age requirements, and communication barriers. One provider critiqued this referral process: "Unfortunately it seems to be the trend at Seattle, that people are like go to Seattle Children's Gender clinic...Thank you and goodbye...I call it the gay dump: 'Oh, you look a little bit gay, you should go over there.'" Resources were often discussed in the context of referring out, such as: limited resources for TGNC youth under age eight, supportive parents and guardians already utilizing limited resources, parental lack of openness to resources leading to feeling stuck, and not having a robust referral list of safe providers. Many providers discussed dissatisfaction with warm handoff processes while others felt confident with internal warm handoffs or receiving referrals due to other providers' lack of confidence providing care to TGNC youth.

### ***Gender and Physical Characteristics Topics***

The fourth theme regarding gender and physical characteristics topics centered around medical terminology, anticipatory guidance, exploration, changing mind, gender, sex, and orientation as separate entities, gender development, and NMBM. Many providers discussed asking how patients refer to their anatomy and followed the patients' lead, used their language, while one provider utilized anatomical language. Providers emphasized facilitating comfort such as asked questions about comfort, invited feedback, and used neutral terminology such as "chest" instead of "breasts." All four providers discussed providing anticipatory guidance including what change looks like, used parents or guardians as examples, explained biological reasons, and provided clarification of future changes, with or without GAMI. Some explained the dangers

and difficulties of waiting until after puberty to intervene, importance of earlier intervention, and parent or guardian education to instill confidence.

Many providers discussed exploration and patients changing their minds. One major topic was parent and guardian education: exploration is normal, universal, and non-linear, provided relatable examples, encouraged allowing patients to make changes and choices, consequences of not supporting such as suicide, and when parents or guardians were mourning, provided perspective, and encouraged acceptance. Other exploration topics included: affirming exploration, rapport building, and freedom to explore safely. Many providers discussed validating changing mind: acceptable to change mind about identity, transitioning, and medication regimens including education and permission about adjusting doses.

All four providers shared how they discuss and separate gender, sex, and orientation with patients. Many providers emphasized education such as patients teaching providers too, and two providers utilized the Gender Unicorn infographic. Gender identity topics included: variations of identity alignment with sex assigned at birth, parent and guardian education about separate entities, and general education such as addressing the complexity of these topics, “not a 101 answer.” Some provided analogies and one provider used themselves as example via self-disclosure. One provider shared that gender development is rarely discussed unless patient led, or if there is a family concern, and if gender appears congruent and not brought up, the provider saw no need to bring it up.

All four providers discussed NMBM including comfort assessing this area. Topics included assessing for support, safety, answering questions, providing resources, and addressing despite lack of training: “But those topics do come up and I try to address those when it's like within my wheelhouse, which it isn't always.” Two providers educated about social transitioning

options: altering documents like license, IDs, and birth certificates, and aligning expression and identity with non-permanent methods. One of these providers called NMBM the “mainstay of gender nonconforming treatment, especially before like age 13.”

### *Areas of Need*

The fifth theme, regarding areas of need, centered around legal needs, information needs, education and training needs, and resource needs. Legal need themes included: education, consent, and legal ramifications. Providers discussed nervousness and licensure risk fears with providing GAMI, and mitigating ramifications through desired continuing education via interprofessional collaboration. Information needs included organizational protocols, insurance protocols, regional standards, and current EBP. Education and training needs discussed included what should be covered in education and training, wanting basic competency, and barriers. Topics desired included: being able to provide accurate, appropriate, and positive information, NMBM including binding and tucking, GAMI including medications and menstrual suppression, ability to explore and discuss in general instead of shutting down, referring, and avoiding topics, TGNC youth 12 years of age and under in general, and interprofessional collaboration and education. Barriers to education and training needs included: provider lack of time and capacity, burnout, varied provider desire to learn more, lack of protocols for training and education, and no national certification programs:

“So, I don't think we even give medical trainees like the basic understanding of any of this before we launch them out into practice, and then we ask them to kind of learn how to do this stuff on top of everything else.”

Many providers discussed resources needs, such as mental health referrals, where to refer besides gender clinics, educational resources for puberty, needing more transgender health navigators, and better ways to identify other providers with whom they can confidently refer.

## **Greater Washington, Alaska, and Montana Results**

### ***Signaling Acceptance***

The first theme among the four providers interviewed from the greater Washington, Alaska, and Montana area, signaling acceptance, focused on patient forms, EHR and visual cues. All four EHRs had a data field to enter the name a patient uses, however only two had a separate entry for the name as it appears on the insurance card. One practice had all the fields for data entry yet did not use banners or flags to assist all staff to be aware of and correctly use the same name throughout the appointment. One practice stood out, asking for the patients “perfected name and pronouns” at the registration desk. Signaling of acceptance of TGNC youth through visual cues was varied between and within practices. Often specific providers were choosing to wear pronoun pins, while the reception area and patient rooms often did not have any TGNC specific stickers or resources. The most decorated practice had rainbow stickers displayed on the reception desk glass and multiple rainbow pins that the interviewed provider wore.

A sub-theme of signaling was the providers’ or practices’ reputation within the larger community. One group within a practice was known within the medical community and LGBTQAI+ community to be welcoming and TGNC patients were referred through word of mouth. One provider had TGNC youth preferentially steered towards them by other providers and the reception desk, another provider was predominantly known within the Spanish speaking community. They have had multiple families approach them with questions about their TGNC youth.

### *Screening and Assessing*

The second theme, screening and assessing, centered self-initiated practices, privacy and parent and guardian support. None of the four practices had a protocol in place to screen or assess gender in well-child appointments. One provider was viewed as “gutsy” to attempt a self-initiated protocol:

“I actually tried to and... I really practiced starting to ask it in a very... neutral, very open way and I had some families that were like, ‘oh, I’m so glad you asked that question’ and then others ‘I don’t ever want you to ask that ever again. We’re Christian faith.’”

There was a significant amount of parental pushback, and now the provider asks based on her own discretion and relies on her relationship with families to bear the strain that may occur, and worries, “I don’t hit the families that need it most.” Between the other three practices, one provider stated that they always ask pediatric patients about their gender as part of their standard intake history. The other two delayed asking until patients are 13 and parents or guardians were not present.

A concern expressed was not knowing a TGNC patient's gender identity: “If we had anything else that affected...3-8% of the population we would ask about it.” Providers expressed that gender needs to be discussed with every kid, “some of the people that you really need to catch are the parents of the child and the children of the parents that can’t talk about it.” Once providers were aware of a youth's gender identity, they would gather a gender history and current gender goals, allowing the patient to lead the discussion about gender affirming care. All four providers emphasized screening TGNC youth for safety at home. Multiple providers focused on TGNC youth having at least one supportive adult who is aware of their gender and who they could talk with:

“I’m going to look for... how safe is the child and where are they at, because even if the parents are supportive and they are going to school and getting bullied, or they have depression 'cause they don't feel like they have friends.”

Regarding mental health screening, three stated youth were screened for anxiety and depression. Two providers directly cited using assessment tools related to anxiety and depression, while only one discussed also using the validated tool, HEADSS. Protocols for standard screening and resource referral were not present at the provider or organizational level.

### ***Referrals***

The third theme explored provider referral practice, and centered on retained care, referred care, connecting to mental health and other community resources, and referral complications. Providers did not refer out due to comfort providing care and in-house support, or conversely, a lack of alternative service options. Reasons providers referred were a lack of skills or comfort with care, and parent or guardian desire for specialist involvement. All providers associated referral to a more specialized provider with giving the patient and their parents or guardian a “point person” who would be able to assist with; anticipatory guidance, answering questions, current resources, community groups and referrals to supportive mental health services.

A sub-theme for the two providers willing to maintain care for the TGNC patients including later management of gender affirming hormone therapy, was having TGNC supportive medical professionals within their organizations. Both providers minimized the amount of travel to pediatric endocrinology appointments by monitoring labs, using virtual appointments and “curbside” consultation. The two other providers who referred all the TGNC youth’s health care to providers viewed as more resource connected and informed on TGNC care. One of these



providers referred to Seattle Children's Gender Clinic if patients wanted, stated there was a long delay, and expressed concerns: "I don't know if I've had success with my patients getting in."

A sub-theme all providers contributed to, was the need for parent or guardian support and permission before a TGNC child could be referred to and access gender affirming care outside of the practice. Providers stated that they frequently offered support walking kids through how to share their gender identity with their parents or guardian, or facilitated conversations between the youth and family, answered parent or guardian questions, and even conducted impromptu family therapy to assist the family navigating to acceptance and support of their child:

"But I said listen, your kiddo has probably struggled with this all their life...I asked the kid in front of the parents...when were some of the first signs that you knew that you were different...and they usually will say...some childhood age. That sometimes can be really hard for parents, but it also helps them understand."

A strong sub-theme was connecting TGNC youth with mental health care emphasizing that the referral is to address the minority stress of being TGNC and transitioning, not due to anything being wrong with them, that the issue is with society:

"It's because... society...may not accept them and it's difficult and they may try to hide it, and that's internally difficult. So no, it's not 'cause they're transgender, 'cause people aren't ready. There's nothing wrong with what your kid is, it's just everybody else isn't ready."

All four providers preferred to refer out for psychotherapy if youth were interested. Providers were comfortable with and frequently offered mental health medication management and brief intervention due to long wait times for psychotherapy. Referrals to local community resources and online resources varied greatly. One referred parents and guardians to PFLAG and

LGBTQAI+ websites. Multiple providers had specific community support groups to refer teenage patients to but no recommendations for younger kids or their parents or guardian. All providers expressed a desire for more information about community resources, specific online support sites for both parents or guardians and TGNC kids, and culturally specific resources.

Each provider discussed referral complications due to barriers to care which created a situation where providers and families had to make do with what was available. Barriers to care included lack of resources, travel over a great distance, lack of provider comfort, prolonged waitlists, and need for parent or guardian involvement. One provider, who did have access to specialists, lacked a care system for GAMI services and was currently working within their greater organization to construct one which would still be at minimum, a two-and-a-half-hour plane ride away. Other providers spoke about filling the lack of advocates using personal contacts, referred to a local teen clinic with uncertain transgender services which was not accessible to children younger than 13 years old.

### ***Gendered Topics and Physical Characteristics***

The fourth theme, regarding gender and physical characteristics, centered on consent, validating language, provider discomfort, exploration and educating patients and parents or guardians. The importance of consent was defined as practices like asking permission to talk about bodies, menses, and whether to have parents or guardians present during an appointment. Another topic providers obtained consent for was which pronouns to use when addressing the TGNC patient in front of their parents or guardians. One provider felt it was easier for the TGNC patient to discuss their body when they were not in the same room and offered to call the patient after the appointment to discuss periods. When discussing physical characteristics and body parts, one provider used medical words and emphasized that they maintain the “standard of

care” and purposely would work with the TGNC youth to determine how navigate meeting these standards. One provider used anatomical words, specifying that they talked in non-personalized language: “Do you wanna discuss menstrual health? And I try to stay away from saying your menstrual health or your period and just make it kind of a little bit removed.”

All the providers recognized the importance of their language choices and acknowledged impact on patients when providers made mistakes such as using invalidating names or pronouns. One provider discussed the difficulty of speaking in Spanish because it is a gendered language. This created difficulty navigating the language when the TGNC patient was not out to her parents. The provider wanted to honor her identity, however there are few gender-neutral words in a gendered language, and the parents were expecting male gender language. Another cultural consideration of gendered language discussed by a provider was non-binary/two spirit patients. One provider expressed anxiety about language:

“I want to be respectful and open as I can be, but I feel there’s so many language minefields and then you layer on top of it cultural aspects and it just gets really [hard], you just got to be really careful where your words fall.”

Providers also discussed NMBM working with patients and families to decide “how far and how fast” the TGNC youth wants to transition. Discussions under this sub-theme included educating parents and guardians that NMBMs were reversible, with the simple first steps often being hair and clothing and increasing parent or guardian support of youth’s gender identity exploration. One checked in at well-child appointments to monitor what modifications the child was exploring and another mentioned allowing the youth to explore at home until they were comfortable going out in public. Multiple providers stated that they did not bring up the youth’s NMBM unless the patient did, which limited education on binding or tucking safely.

The strongest sub-theme discussed was providers being primary educators for both the parents or guardians, and TGNC youth. Providers discussed educating TGNC youth on self-advocating in the health care setting, how to assess people and situations for safety prior to sharing gender identity, and being comfortable talking with others about their transition. However, most of the discussion focused on teaching parents and guardians how to accept and support their kids. All providers mentioned that gender identity was not a choice. One provider stated:

“I would tell them to listen, listen to their child and know that it's probably taken years to reach this point and it's something that they have thought about and feel so confident in that we should trust that and if they change their mind then we're there to support them...But just kind of reminding them that it's not an overnight switch or decision, it's something that's been developing over a lot of time usually.”

When asked about gender development and exploration, providers spoke about educating parents and guardians to normalize gender expression, and that gender is a social expectation, different across cultures, a performance with clothing as costumes. They acknowledged that gender identity forms early and may change over time. One provider discussed that gender is fluid and parents and guardians struggle with seeing it as not a binary. Woven into this sub-theme, providers linked educating parents and guardians specifically with decreasing the parents' and guardians' fears. Providers talked about parents and guardians grieving the loss of their son or daughter and stated that it is not a loss, “this is who they always were.” One provider answered parent or guardian questions about how much the youth was influenced by what was being taught at school. One provider stated, “there is no harm in doing

things in a way that are not stereotypically one gender,” and another stated that being transgender is “not abnormal and it’s not anybody’s fault.”

### *Areas of Need*

The last theme, areas of need, centered on being unable to gain skills with this population due to lack of contact with TGNC youth, having less experience with trans kids going through puberty and not having opportunities to provide anticipatory guidance. The need for more resources was also discussed. One provider focused on peer support, wishing that there were more locally available for TGNC kids of all ages: “it doesn't mean as much as like when it's coming from someone who's gone through these experiences.” This same provider acknowledged that though they are good at mental health they are untrained in transgender issues. Multiple providers suggested training using mock patient scenarios which would allow providers to practice language choice and navigating situations and would decrease the fear around saying the wrong thing. One provider advocated for more exposure during education to different social situations and family dynamics: “knowing that there's such a broad range of normal.” One provider discussed teaching medical students self-awareness and acceptance, to help providers be more supportive and ask good questions. This provider also wondered if the providers that TGNC patients were steered away from were aware of their negative reputation.

### **Discussion**

This exploration of current practices compared to EBP regarding the three aims of signaling gender acceptance, screening, assessment, and referral practice, and discussion of gender and physical characteristics, identified strengths and areas for improvement for most of the providers both in the Seattle area and the Greater Washington, Alaska, and Montana area. Many of the gaps between current practices and EBP were related to barriers. Parents and

guardians represented one of the biggest barriers, especially if they were unsupportive, getting in the way of providers offering high-quality gender affirming care. The other major barrier was lack of training, education, or expertise.

Regarding signaling gender acceptance, there were many aspects which were not in the providers' control, such as patient forms, EHR data fields, décor and what happened in the lobbies before patients were in the providers' rooms. Seattle providers discussed hope for improvements, while greater Washington, Alaska, and Montana providers had doubts that signaling gender acceptance would improve in their practices outside of their own personal contributions. Many providers did not assess every patient for gender identity because of provider discomfort with verbiage, discomfort with this assessment, negative rapport repercussions, only asking older youth when parents or guardians were no longer present, lack of training, and lack of protocols. Once TGNC youth shared their gender identity, seven of the eight providers assessed safety, however, next steps were non-standardized rather than according to protocols. Further, many providers were unaware of EBP such as literature recommending all patients should be assessed for gender identity, as well as subsequent questions and topics which should be explored after TGNC youth are identified. Without parent or guardian support or a way for a TGNC youth to share their gender identity, further assessments and referrals could not be conducted.

Regarding referrals, many providers desired to keep patients but made referrals because they were not provided additional training with TGNC youth, did not feel like they could provide adequate care, and/or parental desire for specialist involvement. Some Seattle area providers felt comfortable providing TGNC youth with mental health care and GAMI because of additional training. Other providers kept TGNC patients knowing they could not provide local high-

standard gender affirming care because they were limited by available resources, transportation, and parent or guardian support. Issues identified when referring out included dissatisfaction with others' care, lack of follow-up and warm handoffs, and lengthy waitlists. Due to lack of education, resources, and training, high quality of care was compromised by both keeping patients and referring out.

For gender and physical characteristics topics, most providers felt comfortable discussing these topics with patients educating patients and families, especially around exploration and changing mind within the context of gender development diversity. Providers felt confident and adjusted medical interviews to accommodate TGNC youth discomfort with their bodies including asking consent, using neutral and patient-led language, facilitating a comfortable environment, and flexibility such as making follow-up phone calls. Barriers to discussing gender and physical characteristics included providers' inability to discuss NMBM with TGNC youth exhibiting discomfort with the medical interview, parent or guardian presence, and lexicon barriers with other languages and cultures.

Training and education backgrounds with TGNC youth varied among providers, revealing wide variations of knowledge regarding caring for TGNC youth 12 years of age and under. One of the Seattle area providers discussed a clear differentiation in their practices before and after they were trained by a specialist team from Seattle Children's Gender Clinic, suggesting increased confidence and competence after receiving this training. Additionally, this provider began initiating new protocols based on training incorporating current literature and EBP. Most other providers did not have protocols or unified organizational efforts for signaling gender acceptance, screening, assessing, referring, or for discussing gender and physical characteristics topics. Instead, providers individually utilized personal strategies based on what

they had learned or experienced to be helpful with this population as well as initiation of topics based on provider discretion. Some of the providers who indicated receiving training with TGNC youth, especially a variety of training settings, seemed to have more confidence and competence providing care to TGNC youth. Similarly, providers with less exposure and experience with TGNC youth seemed to have less confidence and competence providing care to TGNC youth.

Many providers were easily and passionately able to identify areas of need and strongly desired more education and training in those areas. Several providers discussed recommendations for future students and new providers especially in the context of what they wish they would have learned before working with TGNC youth. This suggests gaps in education and training which contributes to lack of confidence and competence with TGNC youth. This also suggests the most appropriate time to be trained in TGNC youth care is during medical education. Several Seattle area providers anticipated future training and pending changes within their organization to allow providers to provide GAMI instead of needing to refer to specialists and gender clinics.

### **Conclusions**

The literature provided overwhelming evidence about what does and does not constitute an affirming environment for TGNC youth 12 years of age and under in primary care settings. However, EBP was not consistently taken up in clinical practice. This is problematic because TGNC youth 12 years of age and under were not receiving timely and high-quality gender affirming care. Many of the gaps identified in these interviews between current practices and EBP were related to barriers. We suggest this can be improved and addressed by interventions at distinct levels: individual, organizational, and systemic (see Table 3). On an individual level,



providers can take responsibility for self-initiating improvements, and when it is in the provider's control, remove barriers to accessible high-quality care experienced by TGNC youth and their families. On an organizational level, organizations can consistently initiate protocols and training for their primary care providers, including insurance coverage and exclusion, referrals, and clear decision-making processes regarding ethical and legal situations. On a systemic level, there are many areas for advocacy among various settings such as education, training, and community resources. Regarding research, there needs to be more research on TGNC youth 12 years of age and under and non-GAMI options for TGNC 12 years of age and under. More research is needed that conducts analysis including gender or sex-based data points to expand beyond the binary male or female to create health related knowledge of transgender and gender diverse populations. Also lacking is intersectional research considering the multiple forms of stigma experienced by black transgender youth.

Education and training about serving TGNC youth is lacking for primary care providers. We recommend providers receive additional high-quality training for TGNC youth 12 years of age and under including exposure to this population, pharmacy training, scripting and verbiage suggestions, NMBM techniques, gender-affirming medical interventions, and experiences with role-play. This will help increase the number of primary care providers who are culturally competent, who utilize standardized screening tools, have awareness of legal complications, have sufficient training, have the appropriate technology, and use gender-affirming care, names, and pronouns. Once properly trained, providers will feel more confident identifying TGNC youth at earlier ages, providing earlier interventions and high-quality care, and relying less on referrals. This will lessen the burden on gender clinics and allow timely NMBM recommendations and gender-affirming medical interventions to be provided within primary care settings.

Additionally, this will lessen experienced or anticipated stigma and discrimination in primary care settings and improve immediate and long-term outcomes for TGNC youth.

Training could be provided at an organizational level, through a specialist team based out of a local gender clinic, through continuing medical education, at conferences, or through the introduction of a national certification program, which currently does not exist for TGNC care. If this were created, such a program could help train providers consistently and represent a certain level of training and expertise. Given the many areas of need which were discussed, including legal, information, education and training, and resources, these topics should be incorporated in these trainings, with interprofessional collaboration. The process of the training is also important, such as providing training during formal education, residency programs, or within the first three months of a new provider's training. This prevents already overwhelmed providers from being asked to participate in more training.

This research focused on exploring current practices in the WAMI region to identify potential gaps between current practices and EBP, with the intention of using this information to provide recommendations to participants and use the analyzed data to inform future training and advocacy efforts to improve the quality of care provided to TGNC youth. Recommendations provided to participants included an evidence-based practices table (see Table 3) and select recommendation-oriented articles which helped inform this project. This project served as a good starting place for this effort, a rich data set was collected and analyzed. However, limitations related to recruitment and the population sample warrant further research. The plan for sustainability for this project is to provide training to primary care providers utilizing EBP to improve the quality of care for future care provided to TGNC youth 12 years of age and under. At the conclusion of this training, information and resources for practice implementation should

be provided so providers can share with other providers. Additionally, information and resources for patients and their families should be disseminated for providers to share with their patients and their families.

**Table 3**

*Evidence-Based Practice for Primary Care Providers Serving TGNC Youth Aged 12 and Under*

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Evidence-Based Practice

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**Electronic Health Records (EHRs)<sup>a</sup>**

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Data fields recommended for EHRs data entry:

- Correct name
- Name as it appears on the insurance card without duplicating health records
- Correct pronouns
- Assigned sex at birth

Banners and alerts recommended for use in an EHRs:

- Notify if pronouns are different from assigned sex at birth
- Notify if correct name is different from name on insurance card

**Intake Forms<sup>b</sup>**

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Write-in areas recommended for intake forms:

- Name patient uses
- Name as it appears on the insurance card

Checkbox options recommended to also have a write-in option:

- Correct pronouns: she/her, he/him, or they/them.
- Assigned sex at birth
- Write in option:
- Instead of labeling write-in option as “Other” use “Write-in option:”

**Visual Cues Signaling Acceptance of TGNC Gender Identity<sup>c</sup>**

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Within the waiting room display:

- Safe space posters
- Transgender pride Stickers
- LGBTQAI+ Pride flag pins

- TGNC specific resource posters or pamphlets
- Supportive decorations including pride flags

Staff and provider attire:

- Pronoun pins
- Transgender pride pins
- LGBTQAI+ pride flag pins
- Supportive pins or stickers on ID badges

Patient exam room:

- Safe space posters
- Transgender pride Stickers
- LGBTQAI+ pride flag pins
- TGNC specific resource posters or pamphlets

### **Assessing, Screening and Referrals during Well-Child Visits<sup>d</sup>**

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Assessing patients 12 years old and younger for gender identity:

- Ask patients questions about their gender identity, as this is supported by patients and their parents or guardians
- Include gender identity in every patient’s history during well child exams

Screening TGNC patients with age-appropriate tools:

- Anxiety – Screen for Child Anxiety Related Emotional Disorders (SCARED) for 8-18 years of age
- Depression – Weinberg Screening Affective Scales (WSAS and WSAS-SF) for 7-17 years of age
- HEADSS – Home, Education, Activities, Drugs, Sex (include gender) and Suicide
- Suicide – Columbia Suicide Severity Rating Scale (C-SSRS) 12 years and older
- Verbal and physical abuse at home and school including “bullying”
- Comfort accessing restrooms at school

Referring TGNC patients:

- Pediatric primary care maintains all care that they are trained and confident providing
- Offer patients information about affirming specialty providers to empower TGNC patients and their families to self-refer at their own pace
- Provide warm-handoffs directly connecting TGNC patients with the provider to ensure continuity of care, access, and to provide records as appropriate
- Refer TGNC patients, parents, and guardians to education resources about TGNC topics
- Refer parents and guardians to online and community based social support groups
- Refer TGNC youth to age appropriate online and community social support groups

- Referrals to offer when appropriate: pediatric endocrinology, gender affirming medical intervention specialists or gender clinic, adolescent medicine specialists, psychiatrists, clinical psychologists, clinical social workers, health educators, paralegals, and lawyers

## **Discussing Gender Specific Topics and Physical Characteristics<sup>e</sup>**

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### Anticipatory Guidance

- Inquire about non-medical body modifications such as haircuts and clothing choices
- Ask about chest binding and genital tucking to promote open discussion and allow for education
- Discuss social transitioning including name, pronouns, and mannerisms
- Talk about how the child will access restrooms in school and in public
- Discuss puberty, signs of onset, and development of secondary sex characteristics
- Explore what puberty would look like with hormone blockers and hormone replacement therapy
- Remind TGNC patients, parents, and guardians these interventions are reversible

### Modifying Language during Well-Child Exams

- Ask permission to talk about a gender specific topic or physical characteristic before starting that portion of the medical exam
- Ask the TGNC patient what language they use to talk about their body
- Defer to using gender neutral, medical, or anatomical language as developmentally appropriate if the patient does not have preferred descriptive language

### Gender Identity and Development

- Clarify and define sex, sexual orientation, gender identity and gender expression
- Educate that gender identity development is fluid and may change over time; it is important to value children at all points during their gender development
- Children who assert a TGNC identity at a young age know their gender as clearly and consistently as their developmental peers
- Affirm gender exploration and allow children to freely express themselves in safe spaces

### Engage with Parents and Guardians

- A non-supportive parent or guardian is more likely to change their mind when asked about their concerns regarding their TGNC child in an open and nonjudgmental way
- Answer parent and guardian questions in an open and accepting manner, allow them to express their fears to you, make sure they feel heard
- Provide high-quality online and community resources to allow parents and guardians to access information at their own pace

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*Note.* The recommendations offered here are reflective of the literature review conducted for this project, not from a meta-analysis.

<sup>a</sup> (Guss et al., 2019, 2020; King County Public Health, 2019; Oransky et al., 2019; Puckett, 2019; Sequeira et al., 2020a)

<sup>b</sup> (Gridley et al., 2016)

<sup>c</sup> (Oransky et al., 2019; Weiselberg et al., 2019)

<sup>d</sup> (Colvin et al., 2019; Edwards-Leeper & Connelly, 2019; Gridley et al., 2016; Lau et al., 2020; Oransky et al., 2019; PRH, 2018)

<sup>e</sup> (Edwards-Leeper & Connelly, 2019; Gridley et al., 2016; Oransky et al., 2019; Weiselberg et al., 2019; WPATH, 2012)

## **Limitations**

The data from this project was limited by the sample size of eight providers and only represented three of the four states of the WAMI region, because no providers from Idaho were interviewed. This had limitations for generalizability and was not a thorough representation of the sample population. The recruitment strategy relied on networking with personal and professional contacts, and only represented providers who were willing to volunteer to interview with no incentive. This could have led to bias such as providers who had specific reasons for wanting to participate including desire to learn more and share experiences, and providers who were enthusiastic about TGNC youth. This project was conducted during the COVID-19 pandemic which limited recruitment efforts. All recruitment efforts were virtual, the interviews were virtual, and there were no incentives for providers who were particularly burnt-out providing care during a pandemic. Offering incentives may have amplified recruiting efforts. A larger sample size representing all four states and providers with diverse opinions about care for TGNC youth could have yielded more representative current practices and would be an appropriate next step toward the continuation of this research.

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## Appendix A

**Question 1:** Within the past 5 years has your practice included providing well-child-appointments to patients under 12 years of age?

1a: Yes

1b: No

**Question 2:** In your well-child visits, please estimate how many Transgender or Gender Non-Conforming (TGNC) youth you provide care for within each age group:

2a: none

2b: 1 or 2

2c: 3 to 10

2d: 10 to 30

2e: 30 or more

**Question 3:** Would you be able to complete an interview, 1-hour maximum, with us via Zoom in the next 3 months?

3a: Yes

3b: No

**Question 4:** In what state(s) do you practice (please select all that apply)?

4a: Washington

4b: Wyoming

4c: Alaska

4d: Montana

4e: Idaho

**Question 5:** In what zip code(s) is your practice located:

**Question 6:** What degree(s) (education) do you have and under which license do you practice?

6a: MD/DO

6b: PA

6c: NP

6d: Other:

**Question 7:** Have you received any additional training in caring for transgender or gender non-conforming youth?

7a: Yes

7b: No

**Question 8:** If so, please select the answers that best apply (Congdon III et al., 2021; King County Public Health, 2019; Turban et al., 2018; Vance Jr. et al., 2017, 2020):

8a: CME

8b: Work place training

8c: Included pharmacy training

8d: In person

8e: Online

8f: Role-play training

8g: Other:

**Question 9:** What is the best way to contact you for scheduling? Please check all that apply:

9a: Email me!

9b: Text me!

9c: Phone me!

**Question 10:** Best contact information is:

10a: Email:

10b: Phone number for calls:

10c: Phone number for texting:



## Appendix B

**Question 1:** Please enter the unique identifier listed in the email that contained this link:

**Question 2:** Please acknowledge that you have received and reviewed the consent forms for participation in the “Exploring current practices of providers serving Transgender/Gender Non-Conforming youth under 12 in the Wyoming, Washington, Alaska, Montana, Idaho region” study:

2a: Yes, I have received and reviewed the form and give my consent to the data gathering described.

**Question 3:** On well child visit forms that patients/parents/caregivers complete before their appointment, is there a space to indicate (select all that apply) (Gridley et al., 2016):

3a: The name the patient uses

3b: Which pronouns the patient uses

3c: What do the options listed look like (i.e., write-in, binary, multiple options)?

**Question 4:** Does the EHR used by the practice have data-entry fields to enter (select all that apply) (King County Public Health, 2019; Oransky et al., 2019; Puckett, 2019; Sequeira et al., 2020a):

3a: ASAB (assigned sex at birth)

3b: Pronouns

3c: Name patient uses

3d: Name as it appears on insurance card

**Question 4:** Does the EHR utilize flags/banners to assist all staff to be aware of and correctly use the same names and pronouns for Transgender/Gender Non-Conforming (TGNC) patients throughout their appointment (Guss et al., 2019, 2020; King County Public Health, 2019; Oransky, et al., 2019; Puckett, 2019; Sequeira et al., 2020a)?

4a: Yes (option to explain further below):

4b: No (option to explain further below):

## Appendix C

Like we said in the email, before we start interviewing, please change the name in your Zoom box to your unique identifier listed in the email that contained this link.

**Question 1:** Please describe the setting in which you practice.

**Question 2:** In what ways does the office or patient rooms display welcoming visual cues such as non-discrimination policies, flags, flyers for LGBTQIA+ resources, etc.? (Oransky et al. 2019; Weiselberg et al., 2019)

**Question 3:** During well-child visit appointments, are youth under 12 asked about their gender identity? (Lau et al., 2020)

**Question 4:** How and when are patients asked about gender identity? (Lau et al., 2020)

**Question 5:** What determines if a youth under 12 will be asked about their gender identity?

5a: Are all youth asked about their gender identity, or only some youth by provider discretion? (Lau et al., 2020; Physicians for Reproductive Health, 2018)

**Question 6:** When Transgender/Gender-Non-Conforming youth are identified within your well-child visit appointment, what comes to your mind about information and topics you want to make sure are covered?

**Question 7:** When TGNC youth are identified, what screenings are conducted? (Gridley et al., 2016; Oransky et al. 2019)

**Question 8:** When TGNC youth are identified, what aspects of their care and education are you comfortable continuing with?

8a: What aspects of their care and education are you not comfortable continuing with?

**Question 9:** Are there referral protocols in place for TGNC patients?

**Question 10:** If referring, what are the most common referrals made? (Gridley et al., 2016; Oransky et al. 2019)

**Question 11:** What does the referral process look like?

11a: Are lists of providers given to the patient to self-refer? (Colvin et al., 2019)

11b: Is a warm hand-off approach used?

**Question 12:** Are there specific resources commonly recommended to TGNC patients and their parents/care givers? (Edwards-Leeper & Connelly, 2019; Oransky et al, 2019)

12a: Local or national resources?

12b: Educational resources about TGNC topics?

12c: Social support for both patients and parents/care givers?

**Question 13:** Within well-child visits specific gender topics are typically discussed with children at given ages. How have you discussed gender specific topics and physical characteristics with patients that have openly identified as a TGNC patient? (World Professional Association for Transgender Health, 2012)

13a: How have you discussed anticipatory guidance about hormones, puberty, and development of secondary sexual characteristics with parents/care givers and TGNC patients? (Oransky et al. 2019; Weiselberg et al., 2019)

**Question 14:** What information have you shared with parents/caregivers and patients about gender norms and gender identity development? (Edwards-Leeper & Connelly, 2019; Oransky et al. 2019)

**Question 15:** How have you discussed the progression of gender identity development throughout childhood and entering adolescence? (Oransky et al. 2019)

**Question 16:** How have you discussed the differences between sex, gender, and sexual orientation discussed? (Gridley et al., 2016)

**Question 17:** How have you discussed non-body modification treatment options and social transitioning options/questions addressed with parents/care givers and patients? (Edwards-Leeper & Connelly, 2019; Gridley et al., 2016; Weiselberg et al., 2019)

**Question 18:** If a concerned parents/caregiver of a TGNC patient has asked you one of the following questions, what was your response? If not, how would you answer? (Edwards-Leeper & Connelly, 2019)

18a: How do I know they are not going to change their mind?

18b: Is it just a phase?

18c: Do I need to get my kid therapy?

**Question 19:** What else should we be considering while exploring current practices (quality improvement)?

**Question 20:** In post graduate training, what do you think are the most important topics to learn about for well child visit providers caring for TGNC youth under 12 years of age?

**Question 21:** Are you open to being contacted for further research on topics similar to the ones discussed today?

That concludes our interview. Do you have any questions at this time?

We have your preferred contact method as: \_\_\_\_\_. Is this correct?