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Assessing the Healthcare Needs of Transgender and Non-Transgender Communities Accessing Care in Safety-Net Clinics in Washington State and Washington, D.C.

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Safety-net systems in the United States are crucial in ensuring that low-income, low-resourced and marginalized communities have access to healthcare. Many patients of safety-net clinics are from minoritized racial, ethnic and gender communities who are subject to unique challenges when accessing care, particularly transgender patients. This study aims to understand the needs of transgender and non-transgender safety-net patients accessing care at community health centers, so those needs can be considered and implemented in future healthcare frameworks. An in-depth content analysis was performed on a free response question targeting perceptions about healthcare delivery from patients obtaining care at community and human services centers in Washington, D.C. and Washington State. Themes that emerged from analyses include: (1) safety-net patients seek more accessible and affordable healthcare services, and transgender patients require gender-affirming care, (2) transgender patients require access to providers and specialists with knowledge of their needs and (3) safety-net patients seek improved resources to support their healthcare decision making. Consistent with previous literature, our findings imply that even with access to healthcare, patients from low-resourced populations and patients who identify as transgender continue to face significant barriers to achieving positive health outcomes within the safety-net healthcare system.

AUTHOR SUMMARY

A part of the United States' healthcare system, safety-net systems deliver a significant amount of care to members of vulnerable populations. These populations often face unique challenges in accessing healthcare due to lack of insurance, limited income and marginalization by their race, ethnicity and gender identity. This study aims to understand how these individuals perceive their healthcare support within the current safety-net framework. A qualitative analysis was performed on a single questionnaire item that asked participants to openly state a belief or opinion regarding how safety-net systems in Washington, D.C. and Washington State could better support their healthcare needs. Our findings imply that even with access to healthcare through the safety-net system, patients from low-resourced populations, particularly those who identify as transgender, continue to face significant barriers to achieving adequate healthcare resources and support that could impact health outcomes.

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INTRODUCTION

Safety-net healthcare systems provide comprehensive healthcare services to low-income, uninsured and other vulnerable populations, services which include emergency and routine preventive care. These systems are necessary to assure quality healthcare and positive health outcomes for marginalized populations in the United States. However, safety-net clinics frequently struggle to secure the resources necessary to meet the needs of the communities they serve (Taylor, 2008). Additionally, many safety-net patients are low-income racial, ethnic and gender minoritized members of communities presenting with healthcare needs that are often unique from those of the general population. In particular, although the safety-net system supports the transgender population, there is insufficient data regarding the availability, affordability and acceptability of gender-affirming care, making it difficult to ascertain the efficacy of care provision by safety-net clinics to their community.

The underrepresentation of the transgender community in research and health monitoring has created barriers to understanding their unique health needs and assuring care equity, according to Wanta and Unger (2017). As a result, much of the current research on transgender healthcare barriers relies on their self-reporting (Safer et al., 2016). Such studies have found that transgender patients face barriers in accessing gender-affirming care and resources due to various socioeconomic barriers such as fear of discrimination and financial strain (Glick et al., 2018; Safer et al., 2016). When transgender patients access healthcare, negative care experiences appear common. One study found that over half of transgender patients reported that clinic staff members refused to use their preferred pronouns, 45.7% witnessed staff gossiping or mocking them, and 8.6% were purposely outed by a healthcare staff member (Chisolm-Straker et al., 2017).

Structural and organizational barriers have also prevented transgender individuals from accessing quality healthcare, including lack of provider knowledge and standardized guidelines on transgender medicine (Roberts and Fantz, 2014). Additionally, providers have reported feeling uncertain about the management of transgender healthcare and have experienced obstacles in finding reliable treatment information and specialists (Snelgrove et al., 2012). Addressing these existing inequities in transgender healthcare is needed to improve health outcomes and the adequacy of care delivery (Meerwijk and Sevelius, 2017).

Although safety-net clinics are designed to address the barriers that transgender communities face to accessing care, there is limited research on whether the care provided within safety-net clinics is sufficiently addressing transgender patients' health needs. Given that most of the previous literature focuses on healthcare delivery systems with fewer financial challenges than safety-net clinics, it is important that research expands to represent safety-net populations (Sugarman et al., 2014). The purpose of this study is to evaluate care delivery for both transgender and non-transgender safety-net patients. The study applies a content analysis model to a free response question about patients' perceptions of healthcare services received at community and human services centers in Washington State and Washington D.C.

METHODS

Techniques

This study is part of a larger research investigation that evaluated the digital healthcare practices of community safety-net clinics in Washington State and Washington, D.C.. More details on this larger study, including study design and recruitment, can be reviewed in the parent study, Laing et al. (2018). The original study team partnered with five Community Health Centers (CHCs) in Washington, D.C. and Washington State to sample a total of 164 respondents. For the current initiative, 79 of the collected surveys were randomly selected for analysis, and nine were not included due to missing information. In total, 47 surveys from Community and Human Services Centers in Washington, D.C. and 23 instruments from a community health center in Washington State were analyzed.

The Community Health Center in Washington D.C. provided specialized services to transgender Hispanic members of the D.C. community while the CHC in Washington State provided support to all community members requiring assistance. Therefore, the sample from both sites comprised of transgender and non-transgender respondents without actively recruiting for these community members. The survey used in the original study was a 47-item instrument of mostly closed-ended questions to evaluate the knowledge, attitudes and practices of the Community Health Center patients and their perceptions of health care services received. The items on the instrument were derived by the investigators of the parent study based on research conducted on the healthcare needs of safety-net communities; the instrument was not a standardized questionnaire. For the current study, we isolated one question from the items presented, which permitted an assessment of the relationship between respondents and healthcare systems. The question was, "In what ways do you think the healthcare system can help you make the best decisions about your healthcare?"

The patients who agreed to participate and met the eligibility criteria were taken to a private room where they completed a written informed consent document and the 47-item self-administered questionnaire. To meet eligibility requirements, participants must have been 18 years of age or older, must have had at least two face-to-face contacts with a healthcare professional at the selected center within the last 12 months, must have been able to read and speak English or Spanish or both and must have been in possession of a smartphone. At the conclusion, each participant received a $10 gift certificate, was debriefed about the study and had all questions answered. The Institutional Review Board's participating facilities approved all study procedures and protocols.

Researchers recorded and transcribed responses offered by all respondents to the free-response item. The survey was available in English and Spanish to support the majority of the populations served by the CHCs. Additionally, Spanish-speaking research assistants translated surveys delivered in Spanish.

Data Analysis

In order to provide a more focused analysis of safety-net patients' perceptions of healthcare delivery, manual data analyses were performed. Three affiliate researchers were provided copies of participant questionnaires. They initiated a manual data analysis of responses by identifying codewords or short phrases that captured the essence of quantitative data that were repeated at least two times across survey responses. Once no new codewords were identifiable, researchers grouped related codewords that communicated similar ideas into codeword clusters. The affiliate researchers then assessed codeword clusters to derive common themes across the survey question. After each analysis step, an inter-rater reliability check was performed by two additional affiliate researchers not involved with the original analyses. Those reviewers were consulted and were responsible for reviewing the codewords, the clusters and the consistency of identified themes. They also aided in the establishment of final themes. The research team then reviewed the study responses and extracted text to reflect the final themes using procedures outlined in a write-up by S Linneberg and Korsgaard (2019).

Statistical analyses of demographic characteristics were performed using R statistical software version 1.3.1093 to describe the total sample of respondents from both the Washington State and Washington D.C. locations. Demographic information collected from the questionnaires included gender status (male, female or other-specified), age (categorized by 18-29, 30-49 and over 50 years), race (white, African American, Asian, American Indian, Alaska Natives, Mixed White Indigenous, Native Hawaiians, Pacific Islanders and other-specified) and ethnicity (Hispanic or non-Hispanic). Other information collected to help shape the population included household income, categorized as less than $20,000 per year and over $20,000 per year and employment status defined as full-time, part-time, unemployed, student, disabled, homemaker or retired.

RESULTS

Description of Population

From the 70 questionnaires analyzed, the population mainly consisted of females (72.86%), persons of the 30-49 years age group (54.29%), African Americans (37.14%) and non-Hispanics (64.29%). In comparing the Washington State and Washington D.C. groups, most demographic indicators were similar aside from race, employment and household income. At the Washington D.C. site, there were substantially more respondents who identified as African American (55.32% vs. 0% in Washington State), more unemployed patients (36.17% vs. 4.35%), fewer patients with a household income above $20,000 per year (12.77% vs. 30.43%) and almost 13% of respondents identified as being transgender (**Table 1**).

Qualitative Findings

Among participant responses to the survey question, “In what ways do you think the healthcare system can help you make the best decisions about your healthcare?,” the researchers identified four common themes (Table 2).

These themes are described below and separated by non-transgender patients within the safety-net clinics and responses offered by transgender patients.

Themes Identified for Non-Transgender Safety-net Patients

Among non-transgender safety-net patients in Washington State and Washington D.C., access to care, including affordability of care was one of the major themes to arise. Non-transgender patients at both sites indicated that they struggled to afford medical care within their clinics and that care must be made affordable. One patient at the D.C. site noted that they would ask that clinics “provide (them with) affordable healthcare.” Another patient from the Washington State site requested that their facility should offer “more affordable health insurance plans” to support the patient population. Additionally, patients from both sites reported they wanted increased availability of providers and other care staff to support healthcare needs. To illustrate, one D.C. patient stated in their interview that they would benefit from clinical staff “letting me contact them freely and letting me have more than 5 minutes to talk.” This alludes to their dissatisfaction with the time allotted for provider-patient communication. Another patient requested that staff should “be available to make appointments (and) answer the phone” so that patient needs can be met. A patient in Washington State wrote that there is a “lack of communication, [and] hard to call and talk to anyone able to help.” Additionally, patients at both sites suggested using the internet and electronics to overcome the barrier of limited providers or appointment availability. For example, one patient in Washington State wrote that clinics needed to provide “an easier way to make appointments” and use reminders as a way to “keep track of doctor appointments.”

A second theme that emerged for non-transgender respondents at both sites was the need for additional resources to improve healthcare decision-making. In Washington State, several participants mentioned wanting more detailed information about the medical care being provided, including “information about making healthy lifestyle choices.” One respondent noted that providers must “discuss varying treatment options” while another requested “information about medications and doctors/clinics around me.” One D.C. respondent noted that their provider can support their healthcare decision-making by ensuring that they are “aware of (the) illness I may be at risk for and educate me on how to stay healthy.” Some respondents specifically noted they often know that there is health information they want online or in clinics but need assistance finding that information. Finally, patients in Washington State and Washington D.C. reported a need for mental health care and counseling services such as “more support groups,” “speaking with a

Table 1. Demographic Characteristics of Patient Respondents

Demographic Characteristic	Total Cohort (n=70)	Washington State (n=23)	Washington, D.C. (n=47)	p -value
Gender, n (%)				0.71
Male	18 (25.71)	7 (30.43)	11 (23.4)	
Female	51 (72.86)	16 (69.57)	35 (74.47)	
Other/Refused to Answer	1 (1.43)	0 (0.0)	1 (2.13)	
Age Category, n (%)				1.0
18-29 years	25 (35.71)	8 (34.78)	17 (36.17)	
30-49 years	38 (54.29)	13 (56.52)	25 (53.19)	
50+ years	7 (10.0)	2 (8.7)	5 (10.64)	
Race, n (%)				<0.0001
White	20 (28.57)	15 (65.22)	5 (10.64)	
African American	26 (37.14)	0 (0.0)	26 (55.32)	
Asian	2 (2.86)	1 (4.35)	1 (2.13)	
American Indian	1 (1.43)	1 (4.35)	0 (0.0)	
Native Hawaiian/Pacific Islander	1 (1.43)	0 (0.0)	1 (2.13)	
Mixed White Indigenous	4 (5.71)	0 (0)	4 (8.51)	
Other/Refused to Answer	16 (22.86)	6 (26.09)	10 (21.28)	
Ethnicity, n (%)				0.60
Hispanic	25 (35.71)	7 (30.43)	18 (38.3)	
Non-Hispanic	45 (64.29)	16 (69.57)	29 (61.7)	
Employment, n (%)				0.002
Full-time	16 (22.86)	6 (26.09)	10 (21.28)	
Part-time	19 (27.14)	10 (43.48)	9 (19.15)	
Unemployed	18 (25.71)	1 (4.35)	17 (36.17)	
Student	4 (5.71)	2 (8.7)	2 (4.26)	
Disabled	3 (4.29)	3 (13.04)	0 (0.0)	
Retired	0 (0)	0 (0.0)	0 (0.0)	
Homemaker	2 (2.86)	1 (4.35)	1 (2.13)	
Other/Refused to Answer	8 (11.43)	0 (0.0)	8 (17.02)	
Household Income, n (%)				0.15
At or below $20,000/year	47 (67.14)	13 (56.52)	34 (72.34)	
Over $20,000/year	13 (18.57)	7 (30.43)	6 (12.77)	
Refused to Answer	10 (14.29)	3 (13.04)	7 (14.89)	

Table 2. Research Concepts and Themes Presented by Transgender and Cisgender Respondents

Research Concept	Themes	Quotes
(1) Barriers	**(a) Inaccessible and unaffordable healthcare**	”Provide affordable healthcare.” ”Better and faster attention from healthcare staff.” ”Letting me contact them freely. Letting me have more than 5 minutes to talk.”
	(b) Additional resources to improve healthcare decision making	”Provide more online assistance.” “[Need] an easier way to make appointments.” ”They [should] make sure I am aware of illness I may be at risk for and educate me on how to stay healthy.”
(2) Barriers to care	**(c) Inaccessible and unaffordable gender-affirming healthcare**	”It’d be great if the MULTIPLE specialists I see didn’t cost so much money so I could afford more healthcare.” ”More therapy more frequently, hormonal education + usage.”
	(d) Lack of knowledge of transgender healthcare	”They have to know about necessities of trans people. It’s difficult to find specialist doctors”

mental health specialist” and “more therapy more frequently.”

Themes Identified for Transgender Safety-Net Patients

The third theme addresses issues found specifically among patients identifying as transgender in the Washington D.C. safety-net clinics. The theme involves addressing the lack of accessible and affordable gender-affirming medical care. Several transgender respondents from Washington D.C. noted that they believed the safety-net system could best support them by making hormones and other gender-specific healthcare available. For example, one patient requested that clinics “give me my T, my therapy, and all my surgeries!” This quote speaks to the patient’s need for testosterone hormone therapy and gender reassignment surgery. A second respondent reaffirmed this by asking for “more medication, cheaper cost, more therapy more frequently, hormonal education and usage,” mentioning not only the need for medications and care that are financially obtainable, but for educational resources as well. The fourth and final theme that emerged from the study and among transgender respondents in the Washington D.C. clinics was related to provider knowledge of transgender needs and healthcare. Several surveys from transgender patients highlighted a lack of access to knowledgeable care providers, including specialists who understand their specific healthcare needs. For example, one respondent stated that providers from the community health center “have to know about the necessities of trans people.” They also added “It’s difficult to find specialist doctors,” implicating an increased barrier in the specialist referral process for transgender patients. Finally, another respondent stated “It’d be great if the MULTIPLE specialists I see didn’t cost so much money so I could afford more healthcare.”

DISCUSSION

This research identified barriers for safety-net patients in Washington State and Washington, D.C. that were largely associated with a lack of accessible and affordable care resources, which is corroborated by previous literature findings (Cruz, 2014). Patients in this sample identified a lack of affordability of their safety-net care. Since safety-net clinics are designed to make care more affordable and accessible to uninsured people, it is important to understand the presence of these barriers. Though affordability of healthcare is a systemic issue that cannot often be addressed at the clinic level, clinics can assure that the healthcare they provide is available to all patients.

Patients reporting on their experiences in the current study also emphasized the importance of being able to communicate with providers and staff not only to discuss their health but to schedule appointments and manage their care. The issue of readily accessible care can be addressed by providing opportunities for patients to freely communicate with their providers about their health conditions and assuring access to information and resources that can lead to positive health outcomes (Kullgren and Mclaughlin, 2010). Patients recommended that clinics deploy online systems and health applications to enhance communication, which is consistent with findings from previous literature on electronic communication in safety-net clinics (Schickedanz et al., 2013). Additionally, patients put heavy importance on their healthcare decision-making and personalized care. Many of those in the study wanted care staff to provide healthcare education and resource-specific information, thus suggesting a need for more time and focus on the patients when seen by providers.

The concept of personalized care appeared to be especially relevant to patients who identify as transgender in the sampled safety-net clinics. Study findings revealed that concerns of affordability and accessibility were exacerbated within the context of gender-affirming care and that, in many cases, the needs of transgender individuals were unmet. Transgender patients rely on specific medical services including hormone therapy, gender-affirming surgeries and mental health support (Austin and Goodman, 2017). These identified essentials which support gender-affirming care were unmet among the sampled transgender patient group.

Lastly, insufficient knowledge of transgender needs within the safety-net clinics was identified by transgender patients in the sample as an issue. Lack of knowledge of transgender care has been identified in previous research, as a reason why providers report a feeling of discomfort or inadequate preparation to engage in care provision for their transgender patients (Sineath et al., 2016). Uncertainty and lack of confidence can impact patient confidence in their providers and unfavorably affect health outcomes. Several studies have traced a provider's lack of knowledge and negative attitudes towards transgender healthcare to inadequate education and training in medical school (Dubin et al., 2018; Heesewijk et al., 2022). This reasoning is further corroborated by studies that found that lectures and educational sessions on transgender medicine improved a physician's attitudes, comfort and knowledge of transgender health issues (Cherabie et al., 2018; Click et al., 2019; Congdon et al., 2021).

Addressing these barriers is imperative for transgender individuals struggling with gender dysphoria since their risk for suicidal ideation and death by suicide is higher than the average population (Garcia-Vega et al., 2018). The reported lifetime suicide attempt rates among transgender individuals can be as high as 41%; under-reporting of suicidality and lack of demographic information on gender minorities means that this number could be higher (Williams, 2017). Knowing the risks associated with untreated gender dysphoria makes it especially important to address the barriers preventing transgender patients from accessing proper transition-related care and support.

Despite their overwhelming need for care, individuals who identify as transgender remain underrepresented in research, more than many other minoritized communities. This makes it difficult to estimate the extent of their health-care needs and identify the best ways to support the community. We believe that the first step to improving access to care for the transgender community is to enhance representation in health services research, including sensitivity-worded questionnaires that ask for a reporting of gender identity. In the parent survey on which the current analysis is based, the investigators did not have a gender identity selection, and thus, transgender identity was only counted for participants who chose to report this information. Therefore, there might have been an underreporting of transgender patients in the sample analyzed. The small sample size and even smaller representation of transgender individuals was a limitation of this study. It made it difficult to explore the themes fully and perform stratified analyses by race and ethnicity, which could have further characterized safety-net healthcare disparities.

In summary, the study implicates a significant need for improved access and affordability for all low-resource patients utilizing safety-net clinics, particularly those who identify as transgender who indicated barriers to gender-affirming care and competent providers. Access to adequate gender-affirming care is necessary to ensure positive physical and mental health outcomes among transgender communities. However, since their needs are less widely assessed and addressed by care systems that serve them, much more is needed to close the gap in care for this population. Advancements must include the promotion of future health services research to investigate and identify ways to deliver reliable, healthful and effective care to transgender individuals seeking care from safety-net healthcare systems. Additional research may also include the implementation of healthcare guidelines and educational resources that provide concrete guidance to staff in supporting clinical care decision-making.

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