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Transgender women's satisfaction with healthcare services: A mixed-methods pilot study

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Abstract

Background: Many transgender women are dissatisfied with healthcare services

Purpose: (a) To describe satisfaction/dissatisfaction with healthcare services; and (b) to describe barriers/facilitators of satisfaction with healthcare services among a sample of transgender women.

Design and Methods: A mixed methods design collected quantitative data ($n = 50$) and qualitative data ($n = 25$) from transgender women.

Findings: Quantitatively, satisfaction with healthcare services was high among the participants, with lower areas related to healthcare systems issues. Qualitatively, participants identified barriers and facilitators of healthcare satisfaction. Implications: This study provides clinical, research, educational, and policy implications for improving healthcare satisfaction among transgender women.

Keywords

healthcare services; mixed methods research; satisfaction; transgender women

1 | INTRODUCTION

Client satisfaction with healthcare services has been an important factor in clinical care. This issue became even more important in 2012 when patient satisfaction with hospital inpatient services affected Medicare reimbursement. Hospitals received financial rewards or penalties because of scores in the Hospital Consumer Assessment of Healthcare Providers and

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

Systems.[1] Hospital administrators became more interested in patient satisfaction scores because satisfaction scores affected finances.[2] Data on client satisfaction with healthcare services outside of hospitals (ie, primary healthcare) are currently lagging behind inpatient services.[3,4]

Primary healthcare services are often the point of entry into the healthcare system for many clients. Client satisfaction is important in primary care because client satisfaction is a predictor of quality of life, mortality, and healthcare costs. Client satisfaction has the potential to affect a client's health status and costs associated with healthcare.[4]

Although all healthcare organizations advocate for quality services and equality for all clients, one group of clients has reported differential care: lesbian, gay, bisexual, and transgender (LGBT) persons.[5] Among this group, differential treatment by healthcare providers is a common theme reported, especially by transgender women. This may include verbal abuse, physical attacks, discrimination, overt insensitivity and denial of care, resulting in dissatisfaction with care.[6-9]

Transgender is a term used to describe an individual whose gender identity does not align with the sex assigned at birth.[10] Some transgender people desire gender-affirming medical interventions, such as cross-sex hormones, gender-affirming surgeries, and other body modifications.[11] There are several terms that are used in the literature to describe transgender persons (eg, trans person, trans woman or transgender woman). For consistency, the authors have elected to use the term transgender woman.

1.1 | Review of the literature

Transgender adults experience challenges and barriers to equitable healthcare, which can negatively affect healthcare utilization and health status. Barriers to care include, but are not limited to affordability, limited health insurance coverage, the scarcity of available, competent, gender-affirming clinicians, and unsafe public spaces that create life-threating conditions.[9,12-14] Within healthcare environments, transgender adults encounter insensitive healthcare professionals and clinicians, stigma and discrimination, inappropriate care approaches, and care refusal.[15-17]

Several studies documented the healthcare experiences of transgender women within the context of human immunodeficiency virus (HIV) care and treatment. Due to unsafe public spaces and public transportation, Sevelius et al[16] discovered that transgender women living with HIV infection would prioritize personal safety over traveling to healthcare appointments. Transgender women in this study stressed the importance of accessing gender-affirming medical interventions such as cross-sex hormones because this treatment reduced the threat of harassment and violence. However, when transgender women were unable to access cross-sex hormones from a clinical provider, nonprescribed hormones from friends, from the “Black Market,” or the Internet were used.[16,18,19]

While the discrimination encountered within healthcare settings is well documented, there are a limited number of studies that focus on facilitators of care and care retention among transgender people. Transgender people report that gender-affirming language and

communication approaches (eg, using the correct name and pronouns) increases healthcare utilization and improves therapeutic relationships with providers.[20] Additionally, transgender adults suggest the integration of primary and mental health services, as well as the incorporation of legal support for name and gender marker changes within a multidisciplinary and comprehensive transgender health center.[19] Researchers also note the dearth of transgender-related curricular content for health profession students across disciplines.[12,21,22] The incorporation of this content will empower healthcare professionals to use gender-affirming, sensitive communication approaches, conduct an appropriate psychosocial and physical assessment, and render adequate and equitable care.[23]

Gaps are evident in the existing knowledge base on healthcare access and healthcare experiences among trans women. First, the literature on satisfaction with healthcare services among transgender women has focused on barriers but has not included facilitators that may improve satisfaction. Second, transgender women's satisfaction with healthcare services has not been studied using a mixed method approach. Therefore, this mixed method pilot study was warranted to address these identified gaps in the research literature.

2 | METHOD

2.1 | Design, setting, and sample

The present study used a sequential mixed method design, which allowed for the collection of both quantitative and qualitative data in one study. The quantitative data were collected first, with qualitative data collected after the quantitative data to support or refute the study's quantitative findings.[24] Data reported in this paper are unpublished data from a larger study that studied health risk factors (eg, substance use, mental health, and child/adult violence) among transgender women.

Both the quantitative and qualitative data collection phases used descriptive designs. The descriptive quantitative design is useful to collect data from participants at a single point in time using standardized surveys.[24] The qualitative descriptive design is used when a researcher wants to collect qualitative data from participants and wants to use the data in its collected form without interpretation. This allows the researcher to remain closer to the original meaning of the data.[25]

Data were collected in the South Florida counties of Broward, Miami-Dade, and Palm Beach. These three counties comprise the southeastern-most counties in the state of Florida also contain a large number of transgender populations.[26] This study's sample consisted of 50 community-dwelling transgender women residing in the South Florida area of the United States. Data were collected from the participants in their preferred setting, which included a community-based agency, a university research office, or the participant's home.

2.2 | Instruments

For the quantitative portion, one research instrument and a demographic questionnaire were used. The Satisfaction with Transgender Healthcare Services Scale[27] was used, a measure of satisfaction with healthcare services designed specifically for trans women. This scale was developed over the course of five surveys conducted during the years of 1993 to 2002. The

scale contains 17 questions that use a 7-point Likert scale that allow participants to rate the health care experience from “very dissatisfied” to “very satisfied.” The scale contains five categories of questions: overall satisfaction, management of the perceived health problem, satisfaction with the provider, satisfaction with office staff and services, and a final question on recommendation of the particular healthcare site to others. Reliability and validity data on this scale was not provided.[27]

For the qualitative portion, a semistructured interview guide was used. This interview guide contained questions that allowed participants to describe experiences with healthcare that were unique for transgender women. The goal of the qualitative portion of the study was to identify facilitators and barriers to healthcare for transgender women. Participants were asked two main questions about healthcare satisfaction/experiences, and additional probes were used to encourage participants to provide examples. The two main questions were: (a) “Tell me about your most recent experience or experiences with healthcare services in which you were satisfied with the experience. Please tell me what contributed to your satisfaction with the services you received” (facilitators) and (b) “Tell me about your most recent experience or experiences with healthcare services in which you were dissatisfied with the experience. Please tell me what contributed to your dissatisfaction with the services you received (barriers).”

The demographic questionnaire asked participants to self-report age, educational level, employment status, monthly income, and race/ethnicity. This questionnaire also contained four questions regarding healthcare, which included health insurance status, and regular healthcare provider status. Two questions assessed emergency room visits for healthcare and a self-reported general health status from the previous 3-month period (*poor, fair, good*, or *very good*).

2.3 | Procedure

The University's Institutional Review Board provided approval for this study (IRB # 20150009). To recruit study participants, the first author traveled to community-based organizations (CBOs) that provided services for transgender women. These CBOs included an HIV testing and counseling center, and mental health centers. Recruitment posters were posted at these CBOs that contained information about the study and provided a contact phone number for participants to call to enroll in the study.

When participants called to schedule an appointment for an interview, each participant was screened for eligibility. To enroll in the study, participants were required to: (a) be age 18 years or older, (b) speak and understand English, (c) self-identify as a transgender woman, and (d) live in the South Florida counties of Broward, Miami-Dade or Palm Beach. If participants met all study criteria, an appointment was given for consenting and data collection. Participants could complete the study at the CBO, the researcher's office, or in the participant's home setting. At the completion of data collection, participants were reimbursed with $50 in cash for participation, and provided with five business cards to distribute to other transgender women for study recruitment.

2.4 | Data collection

The demographic data form and the Satisfaction with Transgender Healthcare Services Scale survey items[27] were completed on paper. These paper forms were transported to the first author's office and stored in a double-locked research storage room until the time of data entry. Data were entered into a password-protected computer for data analysis.

The qualitative data were collected using a digital audio recorder. Taped interviews were downloaded to the researcher's password-protected computer. The interviews were then transcribed verbatim by student research volunteers, which were checked for accuracy by the first author.

2.5 | Protection of human subjects

Due to the sensitive nature of the data collected in this study, protection of human subjects was a priority throughout the research process. In addition to the signed informed consent that each participant provided before enrolling in the study, participants were assured that confidentiality would be protected throughout the research process.

2.6 | Data analysis

Quantitative data were analyzed using descriptive statistics and analyzed using Statistical Package for Social Sciences (SPSS) version 22.0.[28] Descriptive statistics were used to describe the study's sample, and to calculate scores on the Healthcare Satisfaction Scale.[27] Qualitative data were analyzed using content analysis. The use of content analysis is consistent with the research method of qualitative description. Content analysis involves the analysis of data that are manifest and latent. Manifest content involves data that are explicitly stated in the interviews. Latent content is not explicitly stated but can be interpreted or derived from the participants' interviews.[29]

Two methods to ensure rigor and data validation for the qualitative data were used. Rigor allows researchers to evaluate the transferability of the qualitative findings for use in additional settings.[30] The two methods to ensure rigor were clarifying researcher bias and peer review/debriefing.

Clarifying researcher bias is necessary when researchers have previous research and/or clinical experience that may influence data interpretation.[30] In this study, all authors, except for the fourth author, had research and/or clinical experience with transgender women. To decrease bias, the fourth author verified the study's findings by comparing the findings to the data in the interview transcripts. This author confirmed all study findings.

The second method used was peer review/debriefing. This method involves the use of research and/or clinical experts to verify the study's findings.[30] All authors with research and/or clinical experience with transgender women participated in peer review/ debriefing. Findings from this study were compared with the authors' research and/or clinical experience, and all authors confirmed the study's findings.

3 | RESULTS

3.1 | Sample demographics

The sample consisted of 50 transgender women for the quantitative portion, and 25 transgender women drawn from the quantitative participants for the qualitative portion. A complete demographic profile of the participants can be found in Table 1.

3.2 | Quantitative results

The Satisfaction with Transgender Healthcare Services Scale[27] was completed by all 50 participants. The introductory section of These instrument contains three items on healthcare services, provider of care, and purpose of the healthcare visit. Because of the relatively small sample size, the responses to the satisfaction questions were condensed into three categories: *satisfied* (*very satisfied, satisfied*, and *somewhat satisfied*), *neutral*, or *not satisfied* (*very dissatisfied, dissatisfied*, and *somewhat dissatisfied*).

Participants reported receiving healthcare services from a variety of locations. These included clinics (n = 18; 36%); private physician offices (n = 15; 30%); a community-based healthcare organization (n = 11; 22%); emergency rooms (n = 3; 6%); and a substance abuse treatment facility (n = 1; 2%). Two participants (4%) elected not to answer this question.

The majority of the participants (n = 42; 84%) received care from a physician. Four participants (8%) received care from a nurse practitioner. One participant (2%) received care from a physician assistant. Three participants (6%) elected not to provide an answer for this question.

The most common reason for the healthcare visit was an acute care problem. Fourteen participants (28%) reported that a healthcare issue such as pain, influenza, or shingles was the reason for healthcare visit. An annual exam or regular visit was reported by 12 participants (24%). Laboratory testing (n = 13; 26%), gender affirming hormone therapy (n = 6; 12%), and a consult for gender affirming surgery (n = 1; 2%) were other reasons for a healthcare encounter. Four participants (8%) elected not to provide an answer for the question.

The remaining questions on this instrument asked participants to rate satisfaction with specific services received at the healthcare facility. These questions focused on general satisfaction, healthcare provider's understanding, and so forth. An additional question asked participants if participants would recommend this healthcare facility to a friend or relative. The majority of the participants (78%; n = 39) endorsed that a recommendation would be provided; however, four participants (8%) were unsure. Two (4%) reported that a recommendation of the healthcare facility to a friend or relative would not be given. Five participants (10%) elected not to provide a response to this question. A complete description of the participants' satisfaction with healthcare services can be found in Table 2.

3.3 | Qualitative results

During the qualitative portion of the study, participants (n = 25) were encouraged to share healthcare experiences that served as facilitators and barriers to healthcare satisfaction for

trans women. Demographic information about the participants in the qualitative phase can be found in Table 3.

Participants were asked to qualitatively describe the most recent healthcare encounter. Participants were then asked to describe barriers and facilitators of satisfaction with healthcare services. These experiences were placed into categories that described the facilitators of satisfaction with healthcare services for transgender women, and barriers to satisfaction. To illustrate the facilitators and barriers, selected quotes from participants were included in each category.

Facilitators of Satisfaction with Transgender Healthcare Services

All participants (n = 25) were able to describe at least one healthcare encounter in which participants were satisfied with services rendered. From this experience, participants described facilitators of satisfaction with healthcare services. These suggestions were then grouped into categories, with each category further explained using direct quotes from the participants.

3.3.1 | Preferred treatment—The first category that emerged was termed *Preferred Treatment*. This category described how transgender women desired or preferred to be treated during healthcare encounters. One participant summed up how she preferred and expected to be treated during every healthcare encounter:

> Doctors and nurses: I think that, you know…that if you see a transgender individual (in clinical practice), see people for who they are. If you see them in a dress, they're obviously not a guy. Treat them as a female… Everything about them is female except for one thing that you can't see unless you're examining them, and even then, you should still have enough professional courtesy to be polite. And, um, you know I think that that will go a long ways. (This is) the way that you treat a trans-individual when you see them…

3.3.2 | Transgender people as "Regular" clients—Participants were quick to identify instances of *Preferred Treatment*, but many participants reported that no additional treatment was necessary just because the participants identified as transgender women. Although, there were unique healthcare needs for some of the transgender women. Overall, study participants desired not to be treated as "special" clients," but as "regular" clients. One participant described how she wanted to be treated as a "regular" client:

> …And what that means is that when a nurse or a doctor or a technician encounters a patient who is transgender, who is gender variant in any way, or (who may be) cross-dressing… These individuals will not react to the patient in a negative way and will be able to be emotionally supportive as they would be to any other individual. What I am saying is that, um, we, we should not receive special treatment, not when it comes to just regular healthcare. I mean obviously our diagnosis requires special treatment just as any diagnosis would require some special treatment, but outside of that, we should not be getting any special treatment. We should be treated exactly like everyone else.

3.3.3 | Connection and communication—Participants reported that a connection and open communication with a healthcare provider is necessary to facilitate satisfaction with healthcare services. Participants reported a need to feel "connected" to the healthcare provider. This connection facilitated open, honest communication that included partnering with the client for a mutually developed plan of care. One participant talked about the need to connect and communicate with a counselor, an important member of the healthcare team:

> Counseling is extremely important, with someone, with a counselor who connects with you and cares about you, where you're just not a number and they're just not going through (the motions). No, they have to really connect with you.

Another participant described how healthcare was avoided until a provider could be located who was able to connect with the participant. However, when the participant identified a satisfactory healthcare encounter with a provider, the provider connected with the client using appropriate communication skills and provided the participant with referrals to additional providers:

> And now I can't get rid of the doctors! They're all over the fricking place! I don't need all of them now, but (these physicians) have had been good about it. They've been, they've been good. I have had no (other) problems. Now the problem's more with the (healthcare) system in this country. That sucks! It's not fair; it's not right.

3.3.4 | Trust in providers—All participants believed that an important facilitator of healthcare satisfaction among transgender women was trust in the provider. Much like all clients in healthcare, transgender women wanted to be able to trust the healthcare provider, the provider's care recommendations, and trust that the healthcare provider would advocate for the client's health and well-being. One participant highlighted the importance of trust in healthcare providers:

> Once you find it (a competent provider), you need to figure out whether you trust the doctor or not… Because if they say they will do something, they can do it! But you need to trust them because this is basically your life, your transition. If you don't trust them, you really don't have much of a choice because there are not many more (competent providers) that you can go to.

3.3.5 | Provider willingness to be educated—Many of the transgender women in this study reported difficulty in finding competent, caring healthcare providers. Often the women would locate a caring provider with whom a healthcare relationship could be developed, but at times, the healthcare provider was not competent in gender affirming/transgender-related care. Participants in this study reported that healthcare providers were willing to be educated by transgender-identified clients and continuing education programs on how to provide gender-affirming/competent care for transgender women. As described by one study participant, the willingness on the part of the provider to learn about the unique healthcare needs of transgender women promoted satisfaction with healthcare services:

> I've been to medical personnel and I'm the first transgender they've ever met, that they knew they met…My dentist, I've known her for like 30 years and I called and had an appointment. I called told them my name difference and made an

> appointment and when I went there, obviously, there was a slight change of gender. She (the dentist) wanted to talk to me after work, just to ask me about things, and I agreed to it. She (the dentist) says, "I don't know any transgenders. So at least I should know you." … So, I was able to talk to them and they were asking questions. She said, "If I say… If I ask a question too personal, let me know." Which is good. I appreciate that…

3.3.6 | Healthcare personnel as advocates and educators—The last facilitator of satisfaction with healthcare services among transgender women involved the employment of patient/client advocates and educators. Ideally, these advocates and educators would be transgender women. However, if this was not possible, the women suggested that a gay or lesbian identified advocate or educator would be needed. One participant described the value of an assigned person to serve as an advocate or educator:

> Well, the purpose, what I am doing is working to mitigate those situations (where substandard healthcare occurs), specifically by going in, working to speak to as many of such individuals as possible…and allowing people the opportunity to ask questions…It enables them to know that this exists and then when they encounter it in the field or encounter it in the hospital, they're not surprised and they're able to deal with it…What any institution can do is bring someone like me onboard (to) speak to their people so that they have experienced interacting with a transgender individual and know what is appropriate and what is not appropriate beforehand.

3.4 | Barriers to satisfaction with transgender healthcare services

Participants identified a number of ways that satisfaction with transgender healthcare services could be impeded. These barriers had the potential to not only impact satisfaction with services, but also impact the client-provider relationship. Participants identified more barriers to satisfaction as compared to facilitators of satisfaction.

Three barriers to satisfaction with care services involved payment for healthcare services, including healthcare insurance coverage, gaps in healthcare insurance coverage, and health insurance issues. Nearly all participants reported some issue with payment, whether it involved a lack of healthcare coverage because of employment, or finances, gaps in healthcare coverage, or refusal of coverage to pay for certain healthcare services.

The first area that was a barrier to healthcare satisfaction involving payment for healthcare services is *Healthcare Insurance Coverage*. There were a number of issues that were included in this topic, such as the inability to obtain coverage because of finances, lack of employment, or even denial of coverage by participant's health insurance. Some of the issues surrounding healthcare insurance coverage and the impact on healthcare satisfaction were described by a study participant:

> …I was getting, or I'm still getting regular PSA (prostate specific antigen) tests… and, every time that I have a PSA test, the insurance doesn't want to pay for it, because they regard me as a female. The first time after transition that I had a PSA test, I must have had my urologist submit it five or six times, and, each time, I got into an argument with somebody from the (insurance company). And one night I

> was talking to a supervisor, and, uh, he, he referred to me as a freak and told me that they didn't insure “freaks” and I should stop resubmitting for coverage!

3.4.1 | Gaps in healthcare insurance coverage—Some of the participants reported having healthcare insurance coverage but found that often times there were gaps in coverage. These gaps did not allow for certain services to be covered, or the services were partially covered. Those services that were only partially covered required participants to provide payment for these services. If payment could not be provided, then participants reported that these healthcare services were not obtained. This issue was described by one study participant, who was frustrated with the higher copay for mental health services when compared to a lower copay for physical health services:

> The access to care is, is extremely difficult, but (gaps in health insurance coverage) is another thing. Under my plan, it, it, it's $40 every time I want to see a mental health professional…It would seem to me that they would just pay 100 percent, at least lower it to the $25 that I have, you know, the same copay for everything else.

3.4.2 | Health insurance issues—Even when health insurance was provided by an employer or government healthcare funding, some participants reported that certain insurance plans refused to provide payment for gender-affirming medical interventions, such as gender-affirming surgeries and gender-affirming hormone therapy. This was a source of frustration for participants, and sometimes resulted in participants forgoing these services because of a lack of health insurance coverage. This factor impacted satisfaction with the overall healthcare system, as described by a participant:

> …And then I decided that I want to go through my (gender-affirming) transition, and I didn't know where to begin. I looked online. I couldn't find a therapist. I looked online. I couldn't find a therapist that specialized in transition (care) that took Medicare or Medicaid, and I had no money to pay for anyone on a regular basis. You know, I could maybe get in one visit, but what good is that?

3.4.3 | Fragmented healthcare services—Another barrier to satisfaction with transgender healthcare services was fragmented healthcare services. Fragmentation of healthcare services required participants to receive primary care with one provider, gender-affirming medical interventions with another provider, and mental health-related services with a different provider. Also, participants who were living with HIV infection required an additional provider for HIV-related care. Participants reported traveling distances to receive services from various providers. Fragmentation in services is summarized by a participant who had HIV infection, other physical illnesses, and a mental health condition. The participant was able to receive all HIV care and primary care in one location, but because health insurance coverage did not include coverage for mental health services, the client had to travel to another county where free services could be obtained:

> It (my insurance) doesn't pay for psychotherapy. The only one (that provides free or reduced services) that I know of…that does psychotherapy, but the only problem is that they are all by students and none of them are licensed. So, it really, it's kind of a catch 22. I mean it'll help, but it doesn't fulfill any of the requirements set forth by

> standards of care because they can't get them to sign off on anything. So, it's kinda like I'm wasting my time and money because they're…I can't use them for anything.

3.4.4 | Lack of visible LGBT-Identified people in healthcare—Participants in this study voiced concern that many healthcare organizations did not have visible LGBT-identified people employed within these facilities. As reported previously, the participant wanted an LGBT-identified person employed as an advocate and educator at the health care facility. Because many facilities did not have people who were "like me," as described by one participant, this had an impact on satisfaction with services provided at this facility. One participant described the need to have visible LGBT-identified persons at each healthcare facility:

> I think that the LGB community is being served more adequately, not a hundred percent adequately but more adequately than the 'T' community…I think that in my particular case expanding in the mental health industry to the 'T' community is important. And I think that it is nowadays more important that it has been for counselors and people like that to actually be trans themselves… because there are no transsexual or transgender people who do gender counseling.

3.4.5 | Provider-Client relationship—Participants were extremely vocal about how a relationship with a healthcare provider might impact satisfaction and may serve as barriers to healthcare. The subcategories for the theme *Provider-Client Relationship*, include *Refusal of Services, Discrimination, Unstable Relationships*, and *Poor Communication*.

3.4.6 | Refusal of services—Many participants reported various examples of healthcare providers refusing to provide services to transgender women. These examples ranged from healthcare providers refusing to provide all types of healthcare, to refusing to provide certain aspects of healthcare. For instance, some transgender women reported no difficulty in receiving needed primary healthcare services from a provider, but the provider refused to provide prescriptions for gender-affirming hormone therapy. Although there may be a number of reasons that a provider might have for refusing to provide a prescription for gender-affirming hormone therapy, some transgender women may personalize this refusal, thinking that the healthcare provider is attempting to prevent gender-affirming medical interventions. This was described by a study participant:

> They (healthcare providers) just said that they don't deal with transgenders. If you try and pin them down, they'll tell you that they're not qualified, they don't have the knowledge. They don't have the training. Um, but, you know, from the tone of their voice, you, you can't help but feel that, you know, that that they just…don't want to get involved…I don't think they want to provide the care…They go out of their way not to be helpful in any way, shape or (form)…

3.4.7 | Discrimination—Discrimination from providers and other staff at healthcare facilities impacted healthcare satisfaction. Although providers and healthcare facilities are required to provide nondiscriminatory care to all clients, nearly every participant in this study reported discrimination from either a provider, a staff member at healthcare facilities,

or from the policies and procedures of the healthcare facility. This experience of discrimination was described by a participant:

> Well, it's the same way that anyone would be treated differently by any individuals who do not understand what it means to be transgender. So, a nurse might come in and see their patient, um, who is supposed to be a man. On the chart it says that they're a man, but by all means I mean this person looks female. So, or it could be the other way around. So, they react, they think, “Well, this is weird.” They might giggle. They might, you know, treat this person like they're a freak and make them feel awkward or, um, you know, distant or like they're not getting the medical care that they're supposed to be getting…and that severely hinders their recovery process, especially on an emotional level.

3.4.8 | Unstable relationships with healthcare providers—Many of the participants reported long-term professional relationships with providers, especially mental health providers. Participants reported that these extended relationships sometimes were related to healthcare access reasons, not based on choice. Because it was often difficult for some transgender women to locate providers willing to provide services for transgender people, some participants believed that it was necessary to continue receiving healthcare services despite unstable relationships with the providers. These unstable relationships included moving from collaborative, communicative relationships between the healthcare provider and the trans woman, to relationships that were conflictual and often hostile. Participants were able to describe examples of unstable relationships with providers and the impact of these relationships on satisfaction:

> (Because of the unstable relationship with healthcare providers) I stayed away from doctors themselves, and I'm talking medical now. Uh, I never had a doctor (since) when I first got on Medicare and they said, “Well, we need your medical records.” I said, “There are none.” “What do you mean there's no medical record?” “I don't have any…” I avoided that (healthcare) just like the plague.

3.4.9 | Poor communication with healthcare providers—Many participants in this study were able to describe instances during healthcare encounters when poor communication occurred. Participants reported that poor communication happened when participants did not communicate with providers, providers did not communicate with participants, or both providers and participants had difficulty communicating with each other. Poor client-provider relationships have the potential to impact the quality of services received, as well as satisfaction. Examples of poor communication with HCPs were described by a participant:

> …In the hospital, …they knew on my record, it said “transgender,” but nobody addressed it, and… one of my doctors saw it and said, “What is this?… Would you like to see a therapist?”, and I'm like, “Yes.” You know, like thinking, “Therapist, that's what I need. They're going to help.” And then they (the rest of the healthcare team) became like, “You know, you can't do this. You're too sick. You have to worry about your health. You can't transition now. It's not worth the risk,” and I got depressed.

4 | DISCUSSION

This mixed method study was designed to describe satisfaction with healthcare services among a sample of transgender women living in Southeast Florida. This is the first study conducted in the South Florida area on this topic. This study supports the work of previous researchers on this topic, while adding some unique findings.

The demographic findings of this study warrant discussion because the demographic composition of the sample may have influenced the study's findings. The findings on health insurance status are an example. Half of the sample (n = 25; 50%) reported some type of funding for health care. The findings of this study support that healthcare coverage continues to be a significant issue among transgender women.[9,22,31] Because half of the participants reported some type of issue with healthcare insurance benefits/coverage, this has the potential to impact healthcare satisfaction overall.

The second demographic characteristic that could have influenced client satisfaction was related to having an established primary care provider. Almost 40% (36%; n = 18) of study participants did not have a primary care provider. It is important for transgender women to have an affirming relationship with a primary care provider who can provide not only transgender-specific care, but also appropriate, sensitive preventative primary care.[32] Overall healthcare satisfaction may have been affected because 60% of the sample did not have a primary care provider. Without an established primary care provider, transgender women may seek care from multiple providers, thus increasing the number of healthcare interactions which may ultimately impact their overall healthcare satisfaction.

In the quantitative portion of the study, participants reported relatively high levels of satisfaction with healthcare services. Overall, satisfaction was rated as *high* by a majority of the study participants (72%; n = 36). This finding was supported by the work of Davies et al[33] in the United Kingdom who reported that satisfaction with healthcare services among transgender individuals is usually rated high, but that there are some areas such as support for the family of clients and mental health services that need improvement. This finding on high levels of satisfaction with care was supported in an online US study of transgender veterans (n = 298). The area with the lowest level of satisfaction was mental health care.[34] More research is needed to study what factors influence satisfaction with mental health services for transgender women, In addition, more research is needed to understand how barriers and facilitators to care are influenced by the type of care rendered and the provider who rendered care.

The remaining areas that are lower in satisfaction involve issues related to the healthcare system and healthcare facilities. These system issues include promptness and timeliness of care delivery, handling patient phone calls, and costs for healthcare services. These areas were among the lowest in satisfaction, as reported by the participants. These findings are supported by the work of Wylie et al[35] in the United Kingdom, but were not explored in detail in research studies conducted in the United States except in the context of HIV care.[8,16] The areas that were rated lowest in terms of satisfaction and need to be explored to see how these areas might be improved.

Despite an overall high level of satisfaction with healthcare services, a few areas were identified that were not rated as “high satisfaction” among the study's participants. The most significant is the provider's knowledge base on transgender-specific care. Only 35 participants (70%) reported high satisfaction in this area. This finding has been described in previous works,[9,22,36] noting that many transgender individuals report lower satisfaction when the healthcare provider is not “competent” in transgender-related health needs.

A possible explanation for the differences between the quantitative and the qualitative findings in the present study can be provided. As previously detailed, participants in the quantitative portion ($n = 50$) reported relatively high levels of satisfaction with healthcare services, while participants in the qualitative portion described some negative healthcare experiences. This discrepancy can be explained by the fact that the quantitative measure asked participant to report satisfaction with the most recent healthcare encounter. According to the participants, the last healthcare encounter was largely positive. In contrast, the qualitative portion asked participants to detail both positive and negative experiences encounter in past healthcare encounter. From these two different findings, it appears that the quantitative results do not support the qualitative results. However, the mixed method inclusion of both portions of the present study allows for healthcare satisfaction among transgender to be studied by both methods, providing richer, more comprehensive results.

This study adds some data to the knowledge base of the primary care needs of transgender women. The current study's findings support the systematic review findings of Edmiston et al.[37] The authors of the systematic review noted that very little research has been conducted on primary care preventative health services for transgender persons. Most of the research has been focused on HIV infection, with fewer studies highlighting primary care and preventative health services, such as cholesterol screenings, tobacco usage, and gynecological care. The authors of the systematic review noted that no studies described chest/breast health, colorectal screenings, or influenza immunization; therefore, more research is needed on transgender women and health needs and experiences with primary care and preventative health services.

This study supports previous research on delayed or avoided healthcare by transgender adults. A large study of 3486 transgender persons reported that 30.8% of the study's participants delayed or avoided healthcare because of previous experiences of discrimination experienced in healthcare settings In addition, delayed or avoided care appointments were four times more likely to occur when transgender persons were needed to teach healthcare providers about transgender-specific care approaches.[38] Changes are needed in the education of students in various disciplines that may provide care to transgender persons so that more competent providers are available to provide appropriate care to transgender persons, without reliance on transgender persons to train or educate providers.[39]

When avoidance of care occurs, clients choose to forego medical care (including emergency care) for a variety of reasons.[6,9,40] In a study of 452 trans women in Argentina, 40.7% ($n = 184$) reported health care avoidance because of transgender identity. Transgender women were mostly likely to avoid health care when discrimination from a health care provider (adjusted odd ratio [aOR] = 3.36) or from other clients (aOR = 2.57) had occurred.[41] A

larger study of 27 715 transgender and gender nonconforming people in the United States reported that 23% did not see a healthcare provider when needed because of potential mistreatment. Also, 33% avoided healthcare when it was needed because of the inability to pay for healthcare services.[8] More research is needed to explore ways to educate healthcare providers about discriminatory behaviors both intentional and unintentional that may have an impact on transgender women's satisfaction with healthcare services.

The current study's participants reported interest in advocacy and teaching/educating healthcare providers about gender-affirming care. Clinicians must be aware that current health care is cis-normative or focused on individuals with a gender identity that matches biological sex, and the responsibility for addressing these issues may be placed on the client.[42] The fact that transgender persons may need to teach clinicians about gender-affirming healthcare may negatively impact the client-provider relationship. More research is needed on the client-provider relationship that will help optimize care while empowering transgender women to become active partners in care without placing a burden on transgender women to educate healthcare providers.

The participants in the present study reported that a barrier to healthcare satisfaction was the lack of LGBT-identified persons employed within healthcare environments. The participants reported that having a transgender person employed by the healthcare organization was ideal, but any LGB-identified person would be helpful. This finding was supported in two qualitative studies of transgender women with HIV infection. The young transgender women reported that hiring a trans woman would increase workforce diversity,[43] and would help to decrease feelings of institutional distrust.[13] More research is needed to understand the impact of workforce diversity on healthcare satisfaction of transgender women.

To address healthcare satisfaction among transgender women, attention must be paid to all staff and clinicians within in healthcare settings. Although previous research has been focused on physicians and nurses, little attention has focused on other staff members that may interact with the client, and/or have the potential to impact client satisfaction with healthcare services. A small qualitative study of trans women in primary care and HIV prevention noted the importance of providing a client-friendly environment that includes staff sensitivity to the healthcare needs of trans women.[44] More research is needed on how to develop and maintain client-centered environments that include supportive, sensitive staff members that provide gender-affirming care for trans women.

Jaffee et al[38] documented that healthcare providers often lack education in providing care for transgender persons. This lack of knowledge of providing gender-affirming care may be related to the fact that this content is not provided in medical and nursing education programs.[45-48] The findings of these studies provide opportunities for healthcare providers employed in academia to ensure that transgender-specific content is included in medical and nursing education programs.

One of the reasons that healthcare providers should be concerned with transgender women's satisfaction with healthcare services involves the potential to be able to intervene to help reduce health risk behaviors. The participants in the present study reported that healthcare

encounters are excellent opportunities to receive health risk reduction education and interventions. This finding is supported by the work of Nemoto et al[49] who found that these encounters provide opportunities for education, health promotion, referrals for other physical and mental health services, and interventions to reduce sexual risk behaviors, depression, and substance abuse. More research is needed to help researchers develop brief educational interventions delivered during healthcare encounters that address multiple, intersecting health risks related to HIV/STIs and mental health, which includes substance use and abuse.

In addition to reducing intersecting health risks, it is important for healthcare providers to think about healthcare access, and how transgender persons may encounter difficulty in navigating and accessing the healthcare system.[6,9] When transgender women lack access, some of women may choose, or possibly be forced to seek, healthcare services from unlicensed providers. For example, medications may be obtained from the Internet, from friends, or purchased from unlicensed providers. These have the potential to result in unsafe care.[50] A large study of transgender women in San Francisco, California reported that nearly half of the 314 participants reported taking hormones that were not prescribed by a healthcare provider. This behavior was related to access to healthcare issues that are unique for transgender women.[18] More policy work needs to be developed to advocate for access to quality, appropriate and gender-affirming care for transgender women.

5 | LIMITATIONS

There are a few limitations of this study that must be addressed. First, the quantitative portion contains a relatively small sample of 50 participants and may not be representative of the transgender population in Southeast Florida. Therefore, the study's results may not be generalizable to the general population of transgender women.

Second, this study used snowballing sampling to recruit participants. This sampling strategy was necessary to ensure that the target number of participants was reached. This may have affected the study's results. Snowballing sampling is often necessary when studying hard-to-reach populations, but may result in homogenous samples with little variability, thereby affecting the study's results.[24]

Third, the sample was limited to English-speaking transgender women. The experiences of trans women who speak languages other than English may be different. More research needs to be conducted with transgender women, especially Spanish-speaking women in the South Florida area. Despite these limitations, this study's results contribute to the knowledge base of satisfaction with healthcare services among transgender women. The results of this study provide the foundation with future work on this topic.

6 | IMPLICATIONS FOR NURSING PRACTICE

The existing research literature and the results of the present study provide some implications for nurses and other healthcare clinicians who provide care for transgender women. First, nurses and other clinicians have the responsibility to become educated on the healthcare needs of transgender women. This could be accomplished by completing self-

study modules or attending conferences that provide information on the care of transgender women.

Second, nurses and other clinicians have the responsibility to advocate for quality care for transgender clients in healthcare settings. Advocacy in healthcare settings includes advocating for institutional policies and procedures that decrease discrimination, promote inclusion, and aim to increase satisfaction with healthcare services among transgender women. Nurses and other clinicians can use the Joint Commission[51] standards on LGBT health to advocate for quality care for transgender women. These standards include requirements for workforce issues, data collection and use, legal issues, and patient, family, and community engagement. Nurses and other clinicians can use these the standards to decrease barriers to care for transgender women.

In addition to the resources from the Joint Commission,[51] nurses and other healthcare clinicians need to provide care for transgender clients using evidence-based best practices. There are some international and national resources on transgender care that can be accessed by nurses and healthcare clinicians to ensure that quality, appropriate care is provided for transgender women. Internationally, the World Association of Transgender Health[52] publishes standards of care for transgender health that are free and available in several languages (see https://www.wpath.org/ for more information). These standards address gender dysphoria, mental health, hormone treatment, surgery, postoperative care, and primary care for transgender persons.

In the United States, there are at least two institutions that have developed standards of care, policies, etc. to ensure quality care for transgender women. The Fenway Institute (see https://www.fenwayhealth.org for more information) in Boston, Massachusetts provides care for LGBT people, and develops policies[53] specific to transgender care. The Fenway Institute also publishes a guide for LGBT health.[54] The University of California San Francisco Center of Excellence for Transgender Health (see https://prevention.ucsf.edu/transhealth for more information) also provides clinical resources and education, and publishes guidelines on transgender health.[55] Nurses and other healthcare clinicians may access these resources to provide quality, evidence-based care for transgender women.

7 | SUMMARY

Transgender women seeking healthcare may be dissatisfied with healthcare services. Despite the advances in societal attitudes towards transgender women, and barriers to healthcare may still exist for some transgender women. More clinical, policy, and research work is needed to address the identified barriers to healthcare services that exist for transgender women.

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TABLE 1

Study participant demographics ($N = 50$)

Variables	*M* (SD) (range or frequency) (%)
Age, y	38.44 (14.78), 20-78
Years of education	12.99 (2.91), 8-20
Employment status	
Employed	15 (30%)
Not employed	35 (70%)
Total monthly income	Range = $0-10 000
<$500	8 (16%)
$501-999	15 (30%)
$1000-1999	9 (18%)
$2000-3999	9 (18%)
$4000 and above	9 (18%)
Race/ethnicity	
Black	9 (18%)
Caucasian	18 (36%)
Hispanic/Latino	23 (46%)
Health insurance status	
Has health insurance	25 (50%)
Does not have health insurance	25 (50%)
Payment method for healthcare services	
Private insurance	8 (16%)
Medicare/Medicaid	11 (22%)
Out of pocket	16 (32%)
Refused to report	15 (30%)
Healthcare provider	
Has a regular provider	32 (64%)
Does not have a regular provider	18 (36%)
Emergency room visit in past 3 mo	
Yes	3 (6%)
No	47 (94%)
Self-reported health status in past 3 mo	
Poor	1 (2%)
Fair	6 (12%)
Good	19 (38%)
Very good	24 (48%)

TABLE 2

Satisfaction with healthcare services[a] ($N = 50$)

Satisfaction topic	Satisfied, *N* (%)	Neutral, *N*(%)	Dissatisfied, *N* (%)	Not applicable or refused, *N* (%))
Overall satisfaction	36 (72)	7 (14)	3 (6)	4 (8)
Provider's understanding of healthcare need	39 (78)	1 (2)	6 (12)	4 (8)
Provider's caring and warmth	42 (84)	1 (2)	3 (6)	4 (8)
Provider's respect for opinions and feelings	43 (86)	1 (2)	3 (6)	3 (6)
Provider's knowledge of healthcare problem	41 (82)	4 (8)	2 (4)	3 (6)
Appointment making or scheduling process	31 (62)	5 (10)	4 (8)	10 (20)
Provider's knowledge of care of transgender persons	35 (70)	6 (12)	4 (8)	5 (10)
Promptness and/timeliness	33 (66)	3 (6)	8 (16)	6 (12)
Services provided at facility	41 (82)	2 (4)	3 (6)	4 (8)
Friendless/courtesy of office staff	41 (82)	3 (6)	3 (6)	3 (6)
Handling of phone calls by staff	29 (58)	4 (8)	4 (8)	13 (26)
Were fees reasonable?	32 (64)	5 (10)	7 (14)	6 (12)
Privacy	45 (90)	1 (2)	1 (2)	3 (6)

[a]Survey items adopted from the Satisfaction with Transgender Healthcare Services Scale.[27]

TABLE 3

Participant demographics of qualitative phase ($N = 25$)

Variables	*M* (SD) (range or frequency) (%)
Age, y	40.52 (13.34), 20-69
Years of education	14.02 (2.21)
Employment status	
Employed	13 (52%)
Not employed	12 (48%)
Total monthly income	
<$1000	14 (56%)
>$1000	11 (44%)
Race/ethnicity	
Black	3 (12%)
Caucasian	12 (48%)
Hispanic/Latino	10 (40%)
Health insurance status	
Has health insurance	14 (56%)
Does not have health insurance	11 (44%)
Healthcare provider	
Has a regular provider	21 (84%)
Does not have a regular provider	4 (16%)
Emergency room visit in past 3 mo	
Yes	0 (0%)
No	50 (100%)