IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY

JANE DOE 1; *et al*., *Plaintiffs*, v. WILLIAM C. THORNBURY, JR., MD, in his official capacity as the President of the Kentucky Board of Medical Licensure; *et al.*, *Defendants*.	**DECLARATION OF SUZANNE KINGERY, M.D.** Civil No. 3:23-cv-230-DJH

EXPERT DECLARATION OF SUZANNE KINGERY, M.D.

I, Suzanne Kingery, M.D., hereby declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. INTRODUCTION

A. Background and Qualifications

3. I am a licensed physician in Kentucky and I am Double Board certified by the American Board of Pediatrics in General Pediatrics and Pediatric Endocrinology.

4. I am a pediatric endocrinologist at Norton Children's Endocrinology in Louisville, Kentucky. I am the Director and co-founder of the Pediatric and Adolescent Gender Education ("PAGE") program at Norton Children's.

5. I am an Associate Professor of Pediatric Endocrinology at the University of Louisville School of Medicine. I am speaking on behalf of myself as a subject matter expert and not as a representative of the University or any hospital.

6. I graduated Davidson College in North Carolina in 2000 with a bachelor of science in biology.

7. I graduated the Medical College of Georgia in 2005.

8. I completed my Residency in Pediatrics at University of Louisville in 2008.

9. I completed my Fellowship in Pediatric Endocrinology from Nationwide Children's Hospital in 2011.

10. I trained under Dr. Robert Hoffman, M.D., and David Repaske, M.D., at Nationwide Children's in Columbus, Ohio. They have each trained hundreds of medical providers, participated in the development of national and international guidelines, treated thousands of children, held numerous grants and published numerous peer reviewed papers.

11. As a pediatric endocrinologist working in Norton Children's Hospital's PAGE program, I have extensive experience providing treatment for gender dysphoria to transgender minors through a multidisciplinary care model. The PAGE Clinic uses evidence-based standards and practices and has provided social, medical, and mental health support for transgender and gender diverse patients across the Commonwealth of Kentucky since 2015.

12. During my time practicing medicine at Norton Children's and University of Louisville, I received numerous scholarly awards. Most recently, I won the Faculty Peer Clinician-Teaching Excellence Award at the University of Louisville in 2023. At the University of Louisville, I have also won the Golden Apple Teaching Award (2022); Student Champion Award (2022); Outstanding Educator (2021); Faculty Favorite (2021, 2020); Trailblazer Innovation Award for the eQuality Toolkit (2021); Faculty Peer Clinician-Teaching Excellence Award (2020, 2019, 2016); American Medical Women's Association (AMWA) Gender Equity Award (2019); LGBT Center Ally Award (2018); Mid-Career Faculty Award (2018); Fitzbulter Award

Humanism in Medicine (2018); Top Ten Teaching Faculty of the Year (2018, 2016 and 2015) and Top Five Teaching Faculty of the Year (2017); American Medical Women's Association (AMWA) Gender Equity Award (2016). I won the Healthcare Hero award through Business First Louisville in 2022 and the Leonard Tow Humanism in Medicine Award through the Arnold P. Gold Foundation in 2018.

13. I am a member of the Pediatric Endocrine Society, and the American Academy of Pediatrics.

14. I am a member of the American Board of Pediatrics Endocrinology Subboard and I am a ScholarRx Faculty Advisor.

15. I have co-authored thirteen articles published in peer-reviewed journals and conducted numerous clinical trials.

16. In 2011, as a pediatric endocrinology assistant professor I began working with transgender children, adolescents and young adults. In 2015, I developed a multidisciplinary youth gender program. I have provided care for approximately 350 transgender young people for gender dysphoria. The best current estimate of the number of transgender patients under my care is 250. The number of adolescent patients who are prescribed hormone blocking medications and/or hormone therapy represent only a portion of all young people who are seen by the clinical team. Some adolescents are seen in clinic and never receive these treatments, and others are not ready for, or are not candidates for, these medications.

17. Multidisciplinary youth gender clinics provide social, medical and mental health support to gender-diverse youth and young adults and their families. We educate our patients and their families about gender identity development and gender nonconformity, and help empower our patients and families to make informed decisions with accurate information. Teams of

professionals include pediatric endocrinologists, psychologists (Licensed Clinical Social Workers and Licensed Marriage and Family Therapists), adolescent medicine physicians, and nurses. The care provided is consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care and focuses on the biological, psychological, as well as social (biopsychosocial) components of transgender health. Services provided include consultation, psychotherapy, and assessment of medical indication for hormone blocking medications and/or hormone therapy. In addition to providing expert care, one goal is to provide a safe environment where patients and their families can receive social and emotional supports.

18. In my practice, I strive to provide the highest quality, evidence-based, individualized and compassionate care for my patients and their families. Ultimately, I strive to empower each patient to achieve their optimal physical, mental, emotional and social health, and want each person to feel that they are accepted and valued for who they are.

19. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Bases for Opinions

20. In preparing this report, I have relied upon my training and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. I have also reviewed the materials listed in the attached bibliography, **Exhibit B**. The sources cited therein are authoritative, scientific per-reviewed publications. These are the same types of materials that experts in my field of study regularly rely upon when formulating opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the basis for them if any new information

becomes available in the future, including as a result of a new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

21. In addition, I have reviewed SB 150, Section 4.

C. Compensation

22. I am not compensated for my work on this matter for preparation of declarations and expert reports, and deposition and trial testimony. Compensation does not influence the opinions I express, or the testimony I may provide.

II. STANDARDS OF CARE FOR TREATING GENDER DYSPHORIA ARE WELL-ESTABLISHED

23. According to the 2022 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Text Revision*, gender dysphoria is a diagnosis defined as an individual having clinically significant psychological distress or impairment in social, occupational or other important areas of functioning that results from a marked incongruence between their sex assigned at birth and the person's gender identity (the gender with which the individual identifies). Gender dysphoria may manifest in childhood, at the onset of puberty, or in adulthood, and when left untreated it can result in adverse mental health outcomes such as severe anxiety, depression, suicidal ideation and self-harm.

24. I stay updated on the latest medical science and treatment protocols for the treatment of gender dysphoria in adolescents and young adults to ensure that I am providing the highest quality evidence-based care for my patient population. The available treatments for gender dysphoria are well established in the medical profession and the potential benefits of treatment are well-documented in the literature.

25. Comprehensive standards of care and clinical practice guidelines directing this treatment have been developed by the World Professional Association for Transgender Health

(WPATH)[1] and the Endocrine Society.[2] These guidelines have been adopted into practice by the profession as a standard of care. These standards of care are based on decades of scientific and medical research representing the best evidence-based practice information available for treating this condition. The treatment of gender dysphoria with transition-related care is recognized by nearly ever major medical professional association, including the American Medical Association, American Academy of Pediatrics, Society for Adolescent Health and Medicine, American Psychiatric Association, and the American Academy of Family Physicians, among others.

26. The current version of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8), was released in September 2022. The prior SOC, Version 7, had been in place for more than a decade. Standards of care for treating gender dysphoria differ for prepubertal children (minors who have not started puberty), adolescents, and adults.

27. Treatment for gender dysphoria is aimed at eliminating the clinically significant distress that patients suffer by helping them explore, define, and express their gender identity openly and respectfully. This care model is referred to as "transition-related care," or "gender transition."

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[1] WPATH was founded in 1979 and aims to promote evidence-based care, education, research, public policy, and respect in transgender health. Internationally accepted Standards of Care (SOC) for health professionals are updated and revised as new scientific information becomes available. SOC8 was informed by a systematic review of the evidence and assessment of benefits and harms of alternative care options. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health.* 2022 Sep 6;23(Suppl1):S1-S259.

[2] Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2017 Nov 1;102(11):3869-3903.

28. Medications for treating gender dysphoria are not recommended for or prescribed to prepubertal children. Instead, support for a prepubertal transgender child may include social transition, which means allowing a child to live and be socially recognized in accordance with their gender identity rather than their sex assigned at birth. The social transition may include allowing the child to choose clothing, hairstyle, name, pronouns, and activities that correspond to that individual's gender identity.

29. Many transgender minors experience exacerbation of gender dysphoria when puberty begins. The development of secondary sex characteristics- breast development, body fat redistribution, facial changes, and onset of menses for transgender boys; androgenized hair growth, voice deepening, facial changes and increased musculature for transgender girls- has caused significantly heightened stress and anxiety in many of my transgender adolescent patients. In my experience treating transgender adolescents, without treatment for their gender dysphoria many patients can experience anxiety, interpersonal conflicts, depression, academic decline, social withdrawal, disordered eating patterns, and suicidal thoughts and attempts.

30. Once a transgender adolescent begins puberty, medications can be prescribed to temporarily halt the physical changes of puberty, avoiding the exacerbation of gender dysphoria and mitigating harms that can accompany the development of secondary sex characteristics. The temporary halt to puberty can be completely reversed if medication is stopped. However, if later in adolescence the patient, parents, and healthcare team decide that initiation of hormone therapy is in the patient's best interest, they may be able to avoid physical changes inconsistent with their gender identity.

31. Puberty is initiated by the pulsatile release of the hormone GnRH from the hypothalamus. GnRH then stimulates the pituitary gland to produce Follicle Stimulating Hormone

(FSH) and Luteinizing Hormone (LH). These hormones, FSH and LH, then lead to the production of estrogen and testosterone in individuals with ovaries and testes, respectively. Pubertal suppression involves the administration of a medication that prevents the release of FSH and LH, thereby inhibiting the production of estrogen and testosterone. By inhibiting that production, the further development of secondary sex characteristics halts. This pause in puberty limits the further influence of a person's endogenous sex hormones on the body. Stopping the medication resumes the production of FSH and LH and allows puberty to resume with no residual effects on fertility or secondary sex characteristics.

32. For some transgender adolescents, undergoing pubertal development consistent with their gender identity through hormone therapy may also be medically necessary and in their best interest. When prescribed hormone therapy- testosterone for transgender boys, and estrogen in combination with a testosterone-suppressing medication for transgender girls-adolescents experience physical changes consistent with their gender identity.

A. Mental Health Evaluations are Conducted Prior to Initiating Medical Treatment for Transgender Adolescents

33. WPATH SOC-8 recommends a multidisciplinary assessment that involves several domains for the patient seeking treatment for gender dysphoria. A licensed mental health professional with expertise in the treatment of transgender and gender diverse adolescents assessed the patient's gender identity development, social development, and the support structure for the patient, including an investigation of the effects of gender minority stress, family dynamics and any other aspect that might contribute to the individual's social development. Additionally, co-occurring mental health and/or developmental concerns are addressed. The mental health professional also assesses whether the minor has the emotional and cognitive maturity to provide informed assent for any treatment. This process of consent and assent involves an evaluation of

the minor's and guardian's understanding of the medical information and treatment, including the option to not receive treatment, risks and reversible and irreversible effects of treatment, and fertility options and considerations during an open discussion about the patient's goals and expectations of treatment.

34. Endocrine Society Guidelines specify that mental health clinicians who diagnose gender dysphoria should be trained "in child and adolescent developmental psychology and psychopathology," competent in using the DSM diagnostically, and able to understand the individual's mental health, social conditions and ability to consent. This process is highly individualized; a nuanced approach is indicated as each patient has unique medial needs.

B. Extensive Requirements Must Be Met Before Medical Interventions are Initiated for Transgender Adolescents

35. Medications for the treatment of gender dysphoria are not appropriate for every patient. The WPATH SOC-8 advises that "it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones…"[3] Similarly, the Endocrine Society Guidelines provides that prior to the initiation of any medical intervention, "transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life."[4]

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[3] Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S60.

[4] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1;102(11): 3876.

36. Pursuant to the Endocrine Society Guideline, transgender adolescents with gender dysphoria may be eligible for pubertal blocking medication if a qualified mental health professional has confirmed that: (i) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); (ii) gender dysphoria worsened with the onset of puberty; (iii) any coexisting psychological, medical, or social problems that could interfere with treatment; and (iv) the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

37. Further, the adolescent must: (i) have been informed of the effects and side effects of treatment (including potential impacts on fertility if the individual subsequently continues with life-long sex hormone treatment) and options to preserve fertility; and (ii) has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

38. Lastly, a pediatric endocrinologist or other clinician experienced in pubertal assessment should: (i) agree with the indication for GnRH agonist treatment; (ii) confirm that puberty has started in the adolescent; and (iii) confirm that there are no medical contraindications to GnRH agonist treatment. [5]

39. For a transgender adolescent to be eligible for hormone therapy, the Endocrine Society Guideline directs that a qualified mental health professional confirms: (i) the persistence of gender dysphoria; (ii) any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed,

[5] Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2017 Nov 1;102(11):3869-3903.

such that the adolescent's situation and functioning are stable enough to start hormone therapy; and (iii) the adolescent has sufficient mental capacity to estimate the consequences of this treatment, weigh the benefits and risks, and give informed consent to this treatment. [6]

40. Further, the adolescent needs to have: (i) been informed of the effects and side effects of treatment (including options to preserve fertility); (ii) given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. And lastly, a pediatric endocrinologist or other clinician experienced in pubertal induction: (i) agrees with the indication for hormone therapy; and (ii) has confirmed that there are no medical contraindications to hormone therapy. [7]

III. THE MULTIDISCIPLINARY TREATMENT TEAM MODEL

41. I treat transgender patients as part of a multidisciplinary treatment team which includes mental health providers, pediatric endocrinologists, adolescent medicine physicians, and nurses, all of whom are experienced in providing care to transgender minor patients.

42. We follow the process outlined in the WPATH SOC-8 and the Endocrine Society Guidelines.

43. Keeping with the American Medical Association's Code of Medical Ethics, I follow a comprehensive informed consent process prior to initiating treatment.

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[6] Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2017 Nov 1;102(11):3869-3903.

[7] *Ibid*.

44. Some patients are referred to the clinic by a mental health provider with expertise in transgender health, while others are referred by their pediatrician or other provider. If the patient does not already have a mental health provider and is under the age of 18, I refer the patient to one to begin the mental health evaluation prior to providing any treatment. If the mental health provider is not affiliated with the PAGE clinic, I ensure the provider has a detailed account of the patient's symptoms of gender dysphoria and a pre-existing relationship with the patient. The mental health provider and I then work together collaboratively to assess the patient in accordance with the WPATH standards and Endocrine Society guidelines.

45. The mental health provider assesses the patient then I review the mental health assessment and confirm that there is a diagnosis of gender incongruence and that it has been consistent, persistent and insistent, along with confirming other relevant criteria. For many of my patients, gender dysphoria has been present for years prior to their visit. I further assess the patient for any medical or psychosocial conditions that might affect treatment. My interview with the patient and parent or guardian includes a thorough discussion of the patient's individual needs, goals, and their process of coming to understand and live in accordance with their gender identity.

46. Once both a mental health professional and I have each confirmed the diagnosis of gender dysphoria, I meet with the patient and parent or guardian as many times as is necessary for them to fully understand the risks and benefits of treatment options in their individual circumstance and come to an informed decision. As part of my evaluation, I order bloodwork to confirm puberty has started, and other necessary evaluation to assess the general health of the patient prior to initiating therapy. I also thoroughly discuss the potential impacts on fertility, fertility preservation options, and make appropriate referrals as necessary.

47. As part of my informed consent process with the patient and guardian, I discuss in detail the risks, benefits, and reversible and long-term effects of the relevant medications (pubertal suppressants and/or hormone therapies), and alternatives to treatment. As part of this process, I ask detailed questions to the patient and guardian to ensure understanding of the range of potential treatment options and outcomes. During this discussion, I discuss the options and types of medications used, and we offer to provide patients and their parents with additional research based articles and handouts to make an informed decision.

48. Once a full evaluation has been completed; the patient, family, and healthcare team are all in agreement that a treatment is in the best interest of the patient; and risks and benefits are well understood, informed consent and assent are obtained and treatment can commence. I obtain informed consent from the patient's parents in writing. I obtain informed consent from the patient verbally if they are under 18 and from the patient in writing, if they are over 18. My consent form specifically states the expected effects of medication, the possible risks and side effects of medication, and requires the parent agree to regular periodic check-ups after starting puberty blockers or hormones. I have never prescribed puberty blockers or hormones to a patient when the patient or patient's parent/guardian did not consent to treatment.

49. Consistent with the established treatment guidelines described above and as required by insurance companies, I perform a blood test to confirm the patient is undergoing puberty prior to prescribing puberty blockers. Additionally, I do not prescribe puberty blockers prior to Tanner Stage II. It can be a year or more after a patient initially comes to see me and before I will prescribe them puberty blockers or hormone therapy because they do not physically or psychologically meet the necessary criteria.

50. Once the patient begins their medical treatment as prescribed, I meet with the patient and family for follow up on a regular basis and their progress is monitored at regular intervals. I assess the patient's progress, presence of gender dysphoria, physical and mental health, efficacy of the treatment, satisfaction with the treatment, side effects, and hormone levels and laboratory screening for treatment side effects. At these follow-up appointments, we carefully reassess patient progress and make medication adjustments as appropriate. The patients are strongly encouraged to remain in therapy with a mental health provider throughout this process.

51. Depending on the needs of the patient, the pubertal stage they are in, and any changes that may have already resulted from endogenous puberty, patients may first initiate puberty blocking medication, followed by hormone therapy *if and when* it is medically indicated and the patient and family desire this treatment; or they may initiate hormone therapy alone or in conjunction with androgen receptor antagonists or pubertal suppressants at later stages of puberty. The goal of the treatment is to minimize the patient's gender dysphoria and to allow the patient to experience secondary sex characteristics consistent with their gender identity if medically indicated and agreed upon by the healthcare team, patient and family.

52. In my clinical experience, I have witnessed first-hand the significant and substantial benefits that access to puberty blocking, hormone antagonists, and hormone therapies, when medically necessary for the individual, can have on an adolescents' overall health and well-being.

IV. PUBERTY BLOCKING, HORMONE ANTAGONIST, AND HORMONE THERAPIES ARE SAFE AND EFFECTIVE TREATMENTS FOR TRANSGENDER YOUTH

53. I have read the SB150 Section 4 rules that bar doctors from prescribing puberty blocking, and hormone therapies for transgender youth. These bans stand in direct contrast to the authoritative standards of care for the treatment of gender dysphoria. Based on my expert opinion,

unless enjoined these rules will continue to cause harm to my patients and countless other transgender youth in the Commonwealth of Kentucky.

54. The Endocrine Society's and WPATH's treatment protocols for prescribing puberty blocking medications and hormone therapies provide an evidence-based, safe and effective treatment approach for gender dysphoria. The American Academy of Pediatrics, which was founded in 1930 and represents more than 67,000 pediatricians in this county, is one of many reputable medical associations in the United States which supports the use of puberty blocking medications and hormone therapy to treat gender dysphoria in adolescent patients when medically indicated.

55. Puberty blocking treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the further influence of endogenous hormones until the treatment is ended. Puberty blocking medications are not new for the treatment of gender dysphoria, as their use began in Amsterdam in 1998 and expanded to the United States in 2010. Puberty blocking medications are safely used to treat precocious puberty in non-transgender youth. There is over 30 years' worth of data on the safety of puberty blockers regarding children who experience precocious puberty that can be applied to the transgender population.

56. In appropriate candidates, the benefits of treating gender dysphoria with puberty blocking medication can greatly outweigh the small potential for short- or long-term side effects. Moreover, for youth with gender dysphoria, as compared to those treated for precocious puberty, the treatment is typically used for a much shorter period to pause development before either initiating puberty with hormone therapy or resuming endogenous puberty.

57. Pubertal development has a wide variation among individuals. The onset of puberty in individuals whose sex assigned at birth is male begins, on average, at age 11-12 but can range

from age 9 to 14. In those whose sex assigned at birth is female, the onset of puberty typically begins at age 10-11, but can range from age 8 to 13. Once puberty begins, completion on average occurs 3.5-4 years later. Generally speaking, pubertal suppression occurs for up to 2-3 years. The use of puberty blockers in transgender males (whose sex assigned at birth is female) allows for decreased chest development, reducing the need for breast binding and potential surgical intervention in adulthood. The use of puberty blockers in transgender females (whose sex assigned at birth is male), limits facial and body hair growth, voice deepening, and testosterone-driven cartilage and bone structure changes, which greatly reduce distress both at the time of treatment and later in life reduce the need for future interventions such as voice therapy, hair removal, and facial feminization surgery.

58. The use of puberty blocking medications are safe and effective, and the rare side effects are thoroughly discussed with the patient and their family prior to starting any treatment. To address the risk of lower bone mineral density that can be associated with prolonged use of puberty blockers, we advise adequate intake of Vitamin D and calcium (and screen for deficiencies with lab-work and bone mineral density scans when deemed appropriate), regular weight-bearing exercise, and limit the number of years a patient is on puberty blocking medication. Decades of data on the use of puberty blockers as treatment for precocious puberty has demonstrated that puberty blocking medication does not have long-term implications for fertility. [8,9]

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[8] Guaraldi F, Beccuti G, Gori D, Ghizzoni L. MANAGEMENT OF ENDOCRINE DISEASE: Long-term outcomes of the treatment of central precocious puberty. Eur J Endocrinol. 2016 Mar;174(3):R79-87.

[9] Martinerie L, de Mouzon J, Blumberg J, di Nicola L, Maisonobe P, Carel JC; PREFER study group. Fertility of Women Treated during Childhood with Triptorelin (Depot Formulation) for Central Precocious Puberty: The PREFER Study. Horm Res Paediatr. 2020;93(9-10):529-538.

59. Puberty blocking medications may also be used by transgender females (whose sex assigned at birth is male) in conjunction with estrogen therapy to suppress that individual's endogenous production of testosterone. It is standard protocol to include a testosterone-suppressive agent when an individual begins estrogen. Hormone receptor antagonist therapies can also be used to suppress the endogenous action of testosterone. There are some instances where puberty-blocking medications are used in the latter stages of puberty to prevent unwanted secondary sex characteristics such as an Adam's apple, increased facial hair, a lower voice or late-stage breast development, depending on the individualized needs and assessment of the patient.

60. In a 2020 study published in the American Academy of Pediatrics' official journal *Pediatrics*, researchers queried a group of 20,619 transgender individuals and found a lower odds of lifetime suicidal ideation for those who received pubertal suppression when they were adolescents compared with a group that desired pubertal suppression when they were adolescents compared with a group that desired pubertal suppression but did not receive it. [10] Suicidality is of particular concern because the estimated lifetime prevalence of suicide attempts among the transgender population is as high as 40%- nearly nine times the attempted suicide rate in the U.S. population. [11]

61. Under the Endocrine Society Guidelines and WPATH SOC-8, hormone therapy is appropriate for transgender adolescents with gender dysphoria when their experience of gender incongruence is marked and sustained over time, the adolescent demonstrates emotional and

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[10] Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics. 2020 Feb;145(2):e20191725.

[11] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

cognitive maturity required to provide informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, and the adolescent has discussed reproductive options with their provider. For adolescents who meet these criteria, it may be in the patient's best interest to provide hormone therapy to initiate puberty consistent with the patient's gender identity. The parent or guardian is critical to the assessment and treatment process for minors and must provide informed consent for any individual under the age of majority.

62. Hormone therapy is safe and has been used in non-transgender patients for reasons unrelated to the treatment of gender dysphoria. The main types of medical conditions in childhood where estrogen or testosterone are prescribed for non-transgender youth are (i) Disorders of Sex Development (DSD), which amounts to approximately 5% of all endocrinology patients, and (ii) panhypopituitarism, which accounts for 2-5% of all endocrinology patients and (iii) disorders of puberty, which accounts for 8% of all endocrinology patients. Common examples of diseases that fall under these disease categories where hormones are prescribed include, but are not limited to, polycystic ovary syndrome, menorrhagia (heavy menstrual bleeding), acne, contraception, post-chemotherapy or radiation therapy, premature ovarian failure, pubertal delay, Kallman syndrome, and testosterone deficiency. Additionally, patients with various intersex or DSD conditions, such as Turner Syndrome, Klinefelter Syndrome, congenital adrenal hyperplasia, androgen insensitivity syndrome, gonadal dysgenesis, and ovotesticular DSD also often receive hormone therapy. Those individuals with the conditions described often need hormone therapy for the duration of their entire lives.

63. As with puberty blocking medications, I discuss the risks and benefits of hormone therapy at length with adolescent patients and their families prior to the initiation of treatment.

Potential impact on fertility is always discussed along with fertility preservation options. If desired after our discussion, patients are referred to a reproductive endocrinologist for further discussion of fertility preservation, a procedure that also may be recommended prior to certain chemotherapy regimens or due to ovarian or testicular toxicity.

64. Many transgender adults have been on hormone therapy for decades. No reputable medical organization or reliable study has concluded that the risk of any negative outcome would categorically outweigh the substantial benefit of treatment in appropriate candidates for therapy.

65. The goal of hormone therapy is to lessen gender dysphoria, improve functioning and avoid unwanted secondary sex characteristics while developing characteristics that align with gender identity. Studies have showed improved psychological functioning, body image and mental health, and less gender dysphoria, suicidality, depression and anxiety with treatment for gender dysphoria. Some of my patients who are receiving medical treatment for gender dysphoria experienced suicidal ideation and attempts prior to beginning treatment. I have witnessed patients transform from individuals with significant levels of psychological distress to functional, psychologically stable, thriving individuals. I fear that categorically denying puberty blockers, hormone antagonists, and hormones to transgender adolescents who meet criteria for care will lead to distress and psychological harm.

66. After medications are initiated, the patient's functioning, psychosocial situation, physical changes, satisfaction with therapy, hormone levels, and treatment side effects are assessed every 3 to 6 months. Patient care is individualized and in consultation with their medical provider, patients may decide to stop therapy, continue, or be evaluated for adjustment of their medication in response to medical need.

67. In summary, the interventions described above are effective and safe, and access is essential for the wellbeing of those transgender adolescent patients for whom they are indicated. The treatments are provided only with assent from the patient and consent from the parent or guardian. My patients who receive medically necessary treatment for gender dysphoria often experience significant improvement in their mental health and quality of life. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the potential need for later, more invasive treatments. Access to medications to treat gender dysphoria is vital and can improve the short- and long-term health outcomes for transgender adolescents.

V. HARMS OF WITHHOLDING OR TERMINATING TREATMENT FOR TRANSGENDER ADOLESCENTS WITH GENDER DYSPHORIA

68. I have reviewed SB 150 Section 4 and I understand those rules to prohibit board-certified physicians like myself from following accepted standards of care in providing medical treatment for gender dysphoria for minors after June 29, 2023.

69. Puberty blocking medications and hormone therapies have improved the physical and mental well-being of many of my patients. Withholding this well-established, necessary medical care from patients will worsen their mental health outcomes. Being denied the only medical therapies that can legitimately treat their gender dysphoria will render their conditions more recalcitrant. Refusing medical care in this way without a sound medical basis violates my professional and ethical obligations by forcing me to withhold necessary treatment from my patients.

70. Since the passage of SB150, I have met with new patients who were candidates for puberty blocking medication and hormone therapy, but physicians, including myself, will not be permitted to prescribe them after June 29, 2023. The parents of these adolescents are angry and

concerned for their children. They want to ensure their children get the medical care they need to live happy, productive, and healthy lives. There are several families who are taking active steps to move out of Kentucky as a result. It is devastating that these parents feel that they have no other option but to leave and find a safe place for their children, who will be denied critical medical treatment if they remain in Kentucky.

71. Many of my patients who were previously mentally stable prior to SB150, have experienced increased anxiety since the passage of SB 150 because their entire focus has shifted back to what happens to them if their medical care is taken away. Additionally, many of these patients have expressed fear of being in school, fear of being erased from society, and fears about not being able to stay alive. Overall, my patients are devastated by the passage of SB 150.

72. In my clinical experience, I can attest that medications to treat gender dysphoria significantly improve the health and well-being of adolescents who are transgender patients, including developing improved relationships with their family members and peers, improved academic performance and feelings of belonging at school, the ability to develop healthy romantic relationships with their partners, and feeling hopeful about their future and the opportunities life has to offer.

73. Many of my transgender patients' anxiety, depression, suicidality and self-harming behaviors have improved following the initiation of treatment for gender dysphoria. I have witnessed myriad patients transform from being withdrawn, sullen, and unable to connect, to thriving socially, developing self-confidence, and developing close friendships. Not only have I seen this growth in my patients during our clinical visits, but many of my patients' parents have expressed to me how their child blossomed and came out of their shell after receiving treatment for gender dysphoria. Many patients' parents have expressed to me that their children improve in

school, engage more in extra-curricular clubs and activities, and laugh and smile more after starting treatment because they are no longer as preoccupied with their gender dysphoria.

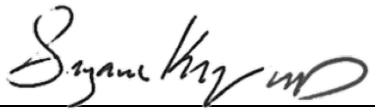
74. Many of my patients' parents have also shared with me how crippling and painful it was as a parent to watch their child struggle before receiving necessary medical care, and it haunts me to know that under SB 150, so many more parents are going to have to watch their children suffer without access to effective treatment for their gender dysphoria.

75. Transgender persons account for 0.6% of our population in the United States. This marginalized population has had the misfortune of having their medical care targeted and banned despite the existence of evidence-based medical standards that have been reviewed and adopted by major medical organizations and providers with extensive expertise in this field of medicine. As with any treatment for a minor, treatments for gender dysphoria rely on an open informed consent discussion between a qualified medical provider, their patient, and the patient's parent or guardian. There is no sound medical justification for prohibiting the medical treatment provided to this one particular population, and no basis upon which to deny parents the right to determine appropriate medical treatment for their child and to deny qualified medical providers the right to provide evidence-based treatment aligned with authoritative standards of care. The mental health disparities present in this population that are exacerbated by untreated gender dysphoria are significant and well-documented. SB 150 prohibits doctors from caring for their patients and abiding by the Hippocratic Oath.

VI. SIGNATURE

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 22nd of May, 2023.



SUZANNE KINGERY, M.D.

Exhibit A

Curriculum Vitae

Suzanne E Kingery, M.D.
571 S. Floyd Street Ste 128
Louisville, KY 40202
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Fax: (502) 852-4189
Suzanne.kingery@louisville.edu

EDUCATION

5/2000	Bachelor of Science in Biology, Davidson College, Davidson, NC
5/2005	M.D., Medical College of Georgia, Augusta, GA
6/2006	Pediatric Internship, University of Louisville, School of Medicine, Louisville, KY
6/2008	Pediatric Residency, University of Louisville, School of Medicine, Louisville, KY
7/2011	Pediatric Endocrinology Fellowship, Nationwide Children's Hospital, Columbus, OH

ACADEMIC APPOINTMENTS

8/2011 – 6/2017	Assistant Professor Pediatric Endocrinology University of Louisville, School of Medicine Louisville, KY
7/2017 – Present	Associate Professor Pediatric Endocrinology University of Louisville, School of Medicine Louisville, KY

Educational Program Leadership Positions

2016-Present	Program Director, Pediatric Endocrinology Fellowship University of Louisville, School of Medicine Department of Pediatrics Graduate Medical Education Louisville, KY
2018-Present	Course Director, Human Systems in Health and Disease 1 and 2 University of Louisville, School of Medicine Undergraduate Medicine Education Louisville, KY

CERTIFICATION AND LICENSURE

2005	National Board of Medical Examiners
2008	Diplomat, American Board of Pediatrics (ABP) – General Pediatrics
2/2008-2012	Ohio Medical License # 35.091161 (Inactive)
2011	Diplomat, American Board of Pediatrics (ABP) – Pediatric Endocrinology
6/2011	Kentucky Medical License #44436 (Active)

PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

2001-2008	American Medical Association

2005-2008	Kentucky Medical Association
2005-2008	Greater Louisville Medical Society
2005-2008	Kentucky Pediatric Society
2003-present	American Academy of Pediatrics
2001-2005	American Medical Student Association, Chapter President 2002-2003
2008-2017	The Endocrine Society
2008-present	Pediatric Endocrine Society (formerly Lawson Wilkins)
2011-2017	Greater Louisville Medical Society
2013-present	American Academy of Pediatrics

HONORS AND AWARDS

2000	Cum Laude, Bachelor of Science
2000	Beta Beta Beta Biological Honor Society
2000	All-American Collegiate Award
2000	National Collegiate Natural Sciences Award
2009	Kenny Award at the Midwest Society for Pediatric Research
2009	REACH Fellows Scholarship to attend LWPES/ESPE Meeting
2009	LWPES Travel Award
2010	Clinical Fellows Travel Grants supported by Genentech
2015	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2016	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2016	Faculty Peer Clinician-Teacher Excellence Award for Mid-Career Faculty Department of Pediatrics, University of Louisville, voted by faculty colleagues
2016	American Medical Women's Association (AMWA) Gender Equity Award University of Louisville School of Medicine
2016	Louisville Top Doc Award Published in Louisville Magazine, voted by peers
2017	Top Five Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2018	Top Ten Teaching Faculty of the Year Department of Pediatrics, University of Louisville, voted by residents
2018	Fitzbulter Award Humanism in Medicine University of Louisville, voted by medical students in the Gold Humanism Honor Society and Student Government Association

2018	Mid-Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2018	Leonard Tow Humanism in Medicine Award Arnold P. Gold Foundation
2018	LGBT Center Ally Award University of Louisville School Health Sciences
2019	Faculty Peer Clinician- Teaching Excellence Award Mid-Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2019	American Medical Women's Association (AMWA) Gender Equity Award University of Louisville School of Medicine
2020	Faculty Favorite Nominated by students as a favorite teacher at the University of Louisville
2020	Faculty Peer Clinician- Teaching Excellence Award Established Career Faculty Award Department of Pediatrics, University of Louisville, voted by peers
2021	Trailblazer Innovation Award for The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care Awarded by the Commercialization EPI-Center at the University of Louisville
2021	Faculty Favorite Nominated by students as a favorite teacher at the University of Louisville
2021	Outstanding Educator Faculty Excellence Awards, University of Louisville School of Medicine
2021	Student Champion Selected by students at the University of Louisville for going above and beyond my duties during the pandemic
2022	Healthcare Hero Health Equity Champion Nominee, Business First Louisville
2022	Student Champion Selected by students at the University of Louisville for going above and beyond my duties during the pandemic
2022	Golden Apple Teaching Award Selected by students in the University of Louisville School of Medicine graduating class of 2024
2023	Faculty Peer Clinician- Teaching Excellence Award Establish Faculty Award Department of Pediatrics, University of Louisville, voted by peers

COMMITTEE ASSIGNMENTS AND ADMINISTRATIVE SERVICES

Local Activities

2012 – Present	University of Louisville, School of Medicine Department of Pediatrics Pediatric Residency Program Interviewer
2012 – 2020	Norton Children's Hospital Pediatric Critical Care Advisory Committee
2013 – Present	University of Louisville, School of Medicine Department of Pediatrics Clinical Competency Committee
2014 – Present	University of Louisville, School of Medicine Department of Pediatrics Peer Mentor
2014 – 2015	University of Louisville, School of Medicine Department of Pediatrics Telemedicine Committee
2014 - 2019	University of Louisville, School of Medicine Curriculum Development eQuality Project: Integrating AAMC new guidelines for the care of LGBT and DSD-affected individuals in medical school curriculum Committee Member
2014 – Present	University of Louisville, School of Medicine Department of Pediatrics Medical Student Education Committee Member
2015	University of Louisville, School of Medicine Department of Pediatrics Summer Externship Sub-Committee Member
2015 – 2019	University of Louisville Physicians Health Sciences Campus LGBTQ Working Group
2016 - 2022	University of Louisville, School of Medicine Department of Pediatrics Resident and Faculty Wellness Committee
2017-Present	University of Louisville, School of Medicine Undergraduate Medical Education M1-M2 Sub-Committee
2017-Present	University of Louisville, School of Medicine Department of Pediatrics Diversity and Inclusion Committee

2018—Present	University of Louisville, School of Medicine Department of Pediatrics Promotion and Tenure (PAT) Committee
2019- 2021	University of Louisville, School of Medicine Undergraduate Medical Education LCME Basic Sciences Committee
2019-2020	University of Louisville, School of Medicine Undergraduate Medical Education Undergraduate Medical Education (UME) Assessment Committee
2019, 2021-2022	University of Louisville, School of Medicine School of Medicine Celebration of Faculty Excellence Educator Awards Selection Committee
2019-2021	University of Louisville, School of Medicine Strategic Planning Committee Undergraduate Medical Education (UME) Subgroup
2020-Present	University of Louisville, School of Medicine Undergraduate Medical Education Educational Program Committee (EPC)
2020-Present	University of Louisville, School of Medicine Undergraduate Medical Education Academic Technology Subcommittee (ATS)
2020-Present	Norton Children's Medical Group Executive Medical Council
2020-Present	Norton Children's Medical Group Clinical Leadership Council
2021-2023	Norton Children's Hospital Medical Executive Committee

Regional Involvement

2014 – 2016	American Academy of Pediatrics, Kentucky Chapter Obesity Task Force
2015 – 2017	YMCA of Greater Louisville Diabetes Prevention Program Steering Committee
2015 – 2018	YMCA of Greater Louisville Heathy Weight and Your Child
2015 – 2018	Region 4 Newborn Screening Collaborative Congenital Hypothyroidism Follow-up Program

Endocrine Lead

National Activities

2015 – 2019 Association of American Medical Colleges
Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development
Member, Axis Committee

2020 – Present American Board of Pediatrics
Member, Endocrinology Subboard

2021 – Present ScholarRx Faculty Advisor
USMLE Step Series Educational Resource
Qmax question back and Bricks

EDUCATIONAL ACTIVITIES

Educational Positions

Local/Regional

2012 – Present Medical Education - Division of Endocrinology
Department of Pediatrics, University of Louisville
Divisional Medical Education Director
Our Elective service averages 40-50 students/residents/fellows that I supervised annually. They follow a scheduled curriculum which includes an inpatient and outpatient experience, weekly lectures and study assignments. This experience includes direct patient evaluation and management as well as additional nutrition and diabetes education teaching sessions.

2015 - Present University of Louisville, School of Medicine
Undergraduate Medical Education
Endocrinology Clinical Lead Thread Director
Responsible for the developing the endocrinology curriculum for the 2nd year medical students within the School of Medicine. This involves directing lectureships, team based learning (TBL), problem based learning (PBL), teaching material, providing endocrine lectures, and assessment of all material for both individual and team based learning assignments and with final multiple choice examination.

2016-Present University of Louisville, School of Medicine
Department of Pediatrics
Graduate Medical Education
Pediatric Endocrinology Fellowship Director
Designed, developed, and submitted application an ACGME approved pediatric endocrinology fellowship which received initial accreditation in April 2017 and continued accreditation in September 2021. Direct, supervise and participate in all aspect of fellow education, assessment and evaluation in compliance with ACGME guidelines. Program is approved for 3 total positions, and have filled all 3 fellowship positions, 1 per year for the 3 year program.

2017-Present University of Louisville, School of Medicine

Undergraduate Medical Education
Problem Based Learning (PBL) Instructor
Mentor medical students in year one and year two during PBL case discussions throughout the semester. Facilitate and monitor the discussion and interactions and gently guide students to involve each other more deeply in the conversation, ask each other questions, and give each other feedback. Each session runs approximately two hours for a total of 10 sessions each semester.

2018-2022 University of Louisville, School of Medicine
Undergraduate Medical Education
Humanism and Compassion in Medicine (HCM) Instructor formerly named Interdisciplinary Clinical Conference (ICC)
Mentor medical students in year one and year two during HCM sessions throughout the semester. Facilitate, monitor, and provide feedback on verbal case presentations, patient interview skills, assess challenges in ethics, patient communication, culture and diversity, and explore real work issues of translating classroom information to clinical practice. Each session lasts for a total of two hours for a total of 4-5 sessions a semester.

2018-Present University of Louisville, School of Medicine
Undergraduate Medicine Education
Course Director, Human Systems in Health and Disease 1 and 2
Direct all faculty, teaching, and assessments for these two very large, 15-to 18-credit hour courses required of all second year medical students. Courses that encompass the foundational Physiology, Histology, Pharmacology, Microbiology, Pathology, Pathophysiology of the major body systems, spanning the second year of the MD program. Nearly 100 clinical and basic science teaching faculty from twelve departments participate in teaching these major courses under my leadership and direction as course director. Multiple forms of teaching are used, including lecture, flipped classrooms, Team-Based Learning (TBL), Problem-Based Learning (PBL), simulation, and patient interviews

2021-2022 Norton Children's and University of Louisville
Norton Children's Endocrinology
Course Director, Wendy Novak Diabetes Symposium
Organize, plan, and implement the annual diabetes symposium in collaboration with Norton Healthcare Continuing Medical Education. In this role, I oversee the planning committee and participate identifying topics and presenters for this educational event. I am responsible for submitting for CME credit, confirming presenter available and coordinating the symposium's schedule of events.

National/Regional Meetings - Invited Lectureships

2012 Pediatric Grand Rounds, University of Louisville: Turner Syndrome Update
2012 OB/GYN Grand Rounds, University of Louisville: Care of Women and Girls with Turner Syndrome
2013 Pediatric Surgery Grand Rounds, University of Louisville: Multiple Endocrine Neoplasia
2013 Endocrine Grand Rounds, University of Louisville: Turner Syndrome: The X Factor

2013 JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Sports Care Management and Nutrition
JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Diabetes and the School System

	JDRF 2nd Annual Diabetes Conference, Muhammad Ali Center: Parents Dealing with Child's Diabetes
2015	JDRF Summit, Bellarmine University: Teens and Diabetes
2015	Pediatric Grand Rounds, University of Louisville: Gender Non-conforming Youth
2016	Kentucky Perinatal Association Annual Meeting, Lake Cumberland KY: Ambiguous Genitalia and Disorders of Sexual Development
2016	Endocrine Grand Rounds, University of Louisville: Gender Variant and Gender Dysphoric Youth
2017	Ob/Gyn Grand Rounds, University of Louisville: What I wish I knew when caring for LGBTQ patients
2018	JDRF Summit, Louisville KY: Diabetes Burnout
2018	American Academy of Pediatrics, Kentucky Chapter, Annual Meeting, Berea KY: Understanding Children and Adolescents with Gender Dysphoria
2018	Staying Alive Kentucky 2018: Building Youth for the Future, Lexington KY: TRANSformative Healthcare: Gender Expansive and Transgender Adolescents
2018	Pediatric Behavioral and Mental Health Symposium: Addressing Mental Health Disparities in Diverse Populations, Louisville, KY: Complex Cases: Ethics, Diversity and Legal Issues in Transgender Care
2018	Family Medicine Grand Rounds, University of Louisville: TRANSformative Healthcare: Gender Expansive Youth and the Role of the Primary Care Provider
2019	Just for Kids-Norton Healthcare Pediatric Symposium, Louisville KY: Endocrine Short Stature
2019	Wendy Novak Diabetes Symposium, University of Louisville: Type 1 Diabetes, Type 2 Diabetes and Beyond!
2019	Undergraduate Medical Education Faculty Development Series, University of Louisville: Evidence-Based Care of LGBTQ Patients Using The eQuality Toolkit
2019	LGBTQ Health Certificate Series, University of Louisville: Variations in Sex Development and Intersex Conditions: Shifting Paradigms
2020	Undergraduate Medical Education Faculty Development Series, University of Louisville: Dismantling White Supremacy and Undoing Race Based Medicine in ULSOM Undergraduate Medical Education Curriculum
2022	Pediatric Grand Rounds, LSU and Oshner Children's Hospital: Gender Dysphoria
2022	AAP Advocacy Conference, Virtual Meeting: Advocacy for Pediatric Subspecialists-Leveraging Your Expertise
2022	Just For Kids-Norton Healthcare Pediatric Symposium, Louisville, KY: Creating an Inclusive Environment for LGBTQ+ patients
2022	Norton Healthcare and Bellarmine University Pelvic Health Symposium, Louisville, KY: Gender Affirming Healthcare for Pelvic Floor Providers
2022	Norton Primary Care Symposium, Louisville, KY: Monitoring for Adverse Effects of Gender Affirming Hormone Therapies
2022	Pediatric Behavioral and Mental Health Symposium, Louisville, KY: LGBTQ+ Youth: The Impact on Pediatric Mental Health

Local/Regional – Health Care Professional Lectures

2009	Nurses Education Day, Nationwide Children's Hospital, Columbus OH: Diabetes and Electrolyte Management
2009 – 2011	Nurses Quarterly CME Series, Nationwide Children's Hospital, Columbus OH: Diabetes and Diabetes During Times of Stress
2012	General Pediatric Division Lectureship, University of Louisville: Precocious Puberty
2012	Endocrine Grand Rounds, University of Louisville: Gene CNVs and protein

	levels of complement C4A and C4B as novel biomarkers for partial disease remissions in new onset type 1 diabetes patients
2014	Pediatric Hospitalist Lectureship, University of Louisville: Hypoglycemia in the Pediatric Patient
2014	LGBTQ Health Certificate Series Session, University of Louisville: LBGT-affirming Care panel expert
2015	Endocrine Grand Rounds, University of Louisville: Hypoglycemia in Childhood
2015	PICU Nurse Lectureship, March Potpourri, University of Louisville: DKA
2016	Child and Adolescent Psychology Lectureship, University of Louisville: Differences in Sex Development for the Psychologist
2016	LGBTQ Health Summit, University of Louisville: Transgender Hormone Protocols
2019	Norton Healthcare Nursing Grand Rounds, Norton Children's Hospital: TransCare 101
2021	Norton Prevention and Wellness, Louisville, KY: Let's Talk: Caring for the LGBTQ Child
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Introduction to Gender Identity
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Mental Health in Transgender Youth
2021	Norton NPRIDE and PAGE Webinar, Louisville, KY: Navigating the Real World with Transgender Youth
2021	Grow502 Health Disparities Series, Louisville, KY: Digging Deeper into Diabetes
2022	Child and Adolescent Psychology Lectureship, University of Louisville: Medical Aspects of Transgender Care
2022	Norton Healthcare NPRIDE Webinar, Louisville, KY: Wellness in the LGBTQ+ Youth Community
2022	Transgender Wellness Summit, Louisville, KY: Youth Gender Affirming Hormone Therapy
2023	LGBTQ Health Certificate Series, University of Louisville: Providing LGBTQ+ Affirming Healthcare in Difficult Climates
2023	LGBT Center and Office of Diversity & Inclusion, University of Louisville: The State of Gender Affirming Healthcare in Kentucky
2023	Transgender Wellness Summit, Louisville, KY: The Truth about Gender Affirming Hormone Therapy

Local-Resident/Student Lectures

2008 –2011	Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Metabolic Bone Disease in Children Resident/Student Lecture, Nationwide Children's Hospital: Thyroid Disorders in Children Resident/Student Lecture, Nationwide Children's Hospital: Congenital Adrenal Hyperplasia Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Adrenal Crisis Resident/Student Lecture, Nationwide Children's Hospital: Precocious Puberty Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Hypoglycemia in Infants and Children Pediatric Resident/Student Lecture, Nationwide Children's Hospital: Growth Disorders in Children
2012	Pediatric Neonatology Fellow Lecture, University of Louisville: Thyroid Disorders in Neonates
2012 - 2013	First Year Medical Student Lecture, University of Louisville: Interdisciplinary Clinical Cases: Diabetes Mellitus
2013 -Present	Pediatric Resident Lecture, University of Louisville: Obesity, Type 2 Diabetes Mellitus and Metabolic Syndrome in Pediatrics
2013 -Present	Pediatric Resident Lecture, University of Louisville: Thyroid and Adrenal Disorders in Infants, Children, and Adolescents

2013 –2018	3rd – Year Medical Student Core Lecture Series, University of Louisville: General Pediatric Endocrine Disorders (every 6 week lecture)
2014 -Present	4th-Year Medical Student Practical Pediatrics Course, University of Louisville: DKA
2015 -Present	1st- year Medical Student Core Lecture, University of Louisville: Differences of Sex Development
2015 -Present	1st year Medical Student Core Lecture, University of Louisville: Differences of Sex Development Patient Panel
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Cross Gender Hormone Therapy
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Overview of the Pituitary Gland Disorders
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Thyroid Disorders and Thyroid Cancers
2016 -Present	2nd year Medical Student Core Lecture, University of Louisville: Calcium and Bone Homeostasis
2016 -2019	2nd year Medical Student Core Lecture, University of Louisville: Child and Adolescent Sexuality
2016 –Present	Pediatric Resident Lecture, University of Louisville: Gender Variant and Gender Dysphoria Youth
2017 -Present	2nd year Medical Student Core Lecture, University of Louisville: Agents Affecting Bone Mineralization SoftChalk
2017	Medicine/Pediatric Resident Lecture, University of Louisville: Pediatric Obesity
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Type 1 Diabetes Mellitus and Insulin Therapies
2018, 2021	2nd year Medical Student Core Lecture, University of Louisville: Type 2 Diabetes Mellitus
2018-Present	4th year Medical Student Practical Pediatrics Course, University of Louisville: Endocrine Emergencies
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Overview of Diabetes Mellitus SoftChalk
2018	Pediatric Neonatology Fellow Lecture, University of Louisville: Differences in Sexual Differentiation, a Multidisciplinary Approach
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Insulin Management and Applications
2018-Present	2nd year Medical Student Core Lecture, University of Louisville: Medications for the Treatment of Type 2 Diabetes Mellitus SoftChalk
2018	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: DSDs: A Patient Centered Paradigm
2019- Present	2nd year Medical Student Core Lecture, University of Louisville: Adrenal Axis Disorders
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: Sleep Disorders SoftChalk
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: Sexuality Over a Lifespan SoftChalk
2020-Present	2nd year Medical Student Core Lecture, University of Louisville: NSAIDs, Analgesics and Anti-Inflammatory Medications SoftChalk
2020, 2022	Pediatric Resident Lecture, University of Louisville: Communicating with LGBTQ Patients and their Families
2021	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: DSDs: Hypothalamic Pituitary Hormones, Storage, Regulation and Disorders
2021-Present	2nd year Medical Student Core Lecture, University of Louisville: Oxytocics and Tocolytics SoftChalk
2021	Pediatric Neonatal Intensive Care Fellows Lecture, University of Louisville: A Neonatologist's Guide to DSDs and Intersex Conditions

2021	LGBTQ Medical Student Interest Group, University of Louisville: Improving the Mental Health of Youth with Gender Dysphoria
2022	Educational Core Conference, Division of Pediatric Endocrinology, University of Louisville: Congenital Adrenal Hyperplasia
2023	Psychiatry Resident Lecture, University of Louisville: Gender Affirming Hormone Therapy

Advising and Mentoring

Students

2015-2018	Adam Neff, MS2-MS4, University of Louisville School of Medicine. Distinction in Medical Education (DIME) track. With my mentorship, he developed a Problem Based Learning (PBL) module on Androgen Insensitivity Syndrome, created evaluation tools to assess effectiveness of the PBL, and implemented the PBL as part of the integrated LGBTQ and DSD curriculum. The PBL focused on gender identity, sexual orientation, and differences in sexual development. Our PBL with evaluation tools and data collected on effectiveness was published on the MedEd Portal. Additionally, several abstracts were presented at nationally meetings, including the *International Meeting of Pediatric Endocrinology* and *Gay and Lesbian Medical Alliance (GLMA).*
2017 – 2020	Destiny Duvall, MS2-MS4, University of Louisville School of Medicine. Distinction in Medical Education (DIME) track. With my mentorship, she developed on-line learning modules in SoftChalk for housestaff regarding differences in sex differentiation, gender identity and sexual orientation. In additional to developing the SoftChalk curricula, she also developed evaluation tools to assess the effectiveness of these learning modules for housestaff in different fields of medicine, including pediatrics, internal medicine, surgery, and ob/gyn.
2017- 2018	Lauren Logan, MS3-MS4, University of Louisville School of Medicine. With my mentorship, she wrote, revised and submitted a case report for Index of Suspicion which was published in *Pediatrics in Review*.

Residents

2013-2014	Prasanthi Pasala, PGY3, University of Louisville Department of Pediatrics. With my mentorship, she developed and completed and quality improvement project regarding thyroid function tests obtained in the NICU on premature infants. This scholarly project effectively decreased the labs obtained on the premature infants which is more cost effective. Finding were presented as an abstract and poster presentation at the pediatric resident awards day.
2016 - 2018	Shanna Sharber, PGY2-PGY3, University of Louisville Department of Pediatrics. With my mentorship, she created an IRB approved scholarly project to assess the knowledge, comfort and experience of pediatric trainees regarding gender non-conforming and transgender youth in a primary care setting. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.
2017 – 2019	Courtney Sumner, PGY3, University of Louisville Department of Pediatrics. With my mentorship, she created an on-line, interactive learning module on gender non-conforming and transgender youth during SoftChalk curricula. Following IRB approval, these modules were implemented by during an adolescent medicine and endocrinology rotation and the effectiveness of this learning module were assessed formally. Finding

were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

2018- 2020 — Jeremy Brown, PGY2-PGY3, University of Louisville Department of Pediatrics. Mentoring a retrospective study on CGM use in patients with type 1 diabetes mellitus, hospital admissions, and demographics. Following IRB approval, data collected from chart reviews. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

2018-2020 — Katie Bruenger, PGY2-PGY3, University of Louisville Department of Pediatrics. Mentoring a prospective study using quality of life metrics to evaluate psychological comorbidities in transgender youth undergoing gender affirming therapies. Following IRB approval, patients were consented and data collected from surveys. Finding were collected and analyzed and abstract and poster presented at the University of Louisville Department of Pediatrics Poster Day.

CLINICAL ACTIVITIES

DIRECT CLINICAL SERVICE AND LEADERSHIP ACTIVITIES

2011 – Present — **Pediatric Endocrinology Attending - Hospital/Call Service:**
Provide endocrinology consultation and admitting patient care service for hospitalized children, and 24 hour pager call service for patients, physicians, and hospital staff. Inpatient admitting and consultation services are provided at Norton Children's Hospital with additional consultation services provided to Norton/Norton Suburban Hospital, and University of Louisville Hospital. (1 week/12 weeks).

2011 – Present — **Outpatient Clinic Service**
Provide endocrinology consultation/referral/on-going outpatient patient care on Tuesdays of each week at the 601 South Floyd Street office Louisville, KY (2 clinics/week).

Additional Duties to improve clinical service:

- *Outpatient Medical Observation Unit (OMO): Assisted in updating testing and treatment protocols/order sets used in OMO (Growth Hormone Stimulation Testing, ACTH Stimulation Test, Pamidronate Infusion Order Set).*

Additional Clinical Duties*: Medical records management, patient/family/physician phone call communications. Approximately 5-10 patient related phone contacts/day while fulfilling clinical duties.*

2011 – 2013 — **Physician Champion/Endocrine Lead, Electronic Health Record/Allscripts Liaison, Louisville, KY**
Championed the division's go-live on Allscripts EHR, creating templates for new patients, follow-up patients, and diabetes patients. Also served as a resource for the division for questions and concerns, and acted as the liaison between Allscripts developers and members of the division.

2011 – 2017 — **University of Louisville, Children's Metabolic Bone Center, Louisville, KY**
Associate Director

Multi-disciplinary clinical effort in conjunction with Dr. Kupper Wintergerst from Pediatric Endocrinology and Dr. Laura Jacks from Norton Healthcare, Pediatric Orthopedic Surgery. This clinic specializes in the care of children with nutritional, metabolic, and genetic bone disease and is located at Old Brownsboro Crossing in Louisville, KY

2012-Present **Physician Champion/Endocrine Lead, Electronic Health Record/ EPIC Liaison, Louisville, KY**
Championed the division's go-live on EPIC EHR, creating templates for inpatient consultations and follow-up notes as well as creating smartphrases. Created order sets for outpatient medical observations procedures as well as inpatient admission orders. Also served as a resource for the division for questions and concerns, and acted as the liaison between EPIC developers and members of the division.

2014 – 2019 **Wendy Novak Diabetes Care Center, Diabetes Adherence Resource Team (DART) Clinic, Louisville, KY**
Director
Multi-disciplinary clinical effort comprised of a pediatric endocrinologist, diabetes nurse practitioner, certified diabetes educator, dietician and pediatric psychologist. This multi-disciplinary clinic allows for more comprehensive management of high risk patients with type 1 diabetes who often face a number of obstacles and challenges in their disease management. DART clinic is offered 2 mornings a month at the Wendy Novak Diabetes Care Center in Louisville, KY.

2015 – Present **Norton Children's Pediatric Endocrinology Pediatric and Adolescent Gender Education (PAGE) Program, Louisville, KY**
Director
Direct the DSD and transgender clinic within the division of endocrinology and also direct the multi-disciplinary clinical effort in conjunction with University of Louisville pediatric psychologist. This clinic specializes in the care of infants, children, and adolescents born with a disorder of sexual development as well as youth who are gender nonconforming, gender diverse or transgender. This clinic is offered 1 day each week in Louisville, KY.

2016 – Present **Norton Children's Pediatric Endocrinology, Louisville, KY**
Medical Director, General Pediatric Endocrinology with University of Louisville
Responsible for all operational aspects of clinical pediatrics endocrinology services, from clinic flow, organization, scheduling, staffing, and EHR for improved efficiencies and RVU generation. I also direct all mid-level providers in the division and evaluate their performance. Additionally, work to implement new processes such as centralized scheduling, and ensure providers are meeting certain metrics, both billing and meaningful use. I work closely with both the practice manager and division chief of endocrinology to increase functionality and satisfaction of both patients and providers.

GRANTS AND CONTRACTS

Past Clinical Trials

1. **Increlex Growth Forum Database – IGFD Registry**
   Past, OICN070695
   Ispen Biopharmaceuticals (a company formerly named Tercica, Inc.)
   $5,000.00, **Direct:** 3,700.00, **Indirect:** 1,300.00
   Co-I, 1% Effort, 10% Collaboration

04/2007 – 04/2015

2. **A Randomized, Multi-Center, Parallel Group, Single-Dose, Pharmacokinetics and Pharmacodynamics Study of Dapaglifozin in Children and Adolescents Aged 10 to 17 Years With Type 2 Diabetes Mellitus**
   Past; NCT02325206; Account Active
   Parexel International Corporation, OICN121519
   $49,551.00 Direct: $39,326.00, Indirect: $10,225.00
   Co-I, 1% Effort, 50% Collaboration
   11/2012 – 01/2015

3. **A multicenter, observational study of pediatric female patients with Central Precocious Puberty receiving SUPPRELIN® LA (histrelin acetate), a hydrogel subcutaneous implant Short Title: CCP Patient Registry**
   Past, OICN120128
   OICN120128
   $192,325, **Direct:** $152,639, **Indirect:** $39,686
   Co-I, 1% Effort, 25% Collaboration.
   9/2011 – 09/2016

4. **B9R-EW-GDFC(b)**
   Past
   Eli Lilly, Inc., GRNT030163
   $163,127.00, **Direct:** $123,976.52, **Indirect:** $39,150.48
   Co-I, 1% Effort, 10% Collaboration
   08/2002 – 06/2016

5. **NNPI/Norditropin National Registry Program**
   Past
   Novo Nordisk Pharmaceuticals, Inc., GRNT021068
   $84,912.00, **Direct:** $64,702.4, **Indirect:** $20,209.06
   Co-I, 1% Effort, 10% Collaboration
   03/2002 – 05/2016

6. **A Phase IV, Multicenter, Open-Label Study of the Immunogencity of Nutropin AQ V1.1 [Somatropin (rDNA Origin) Injection] Administered Daily to Maive Growth Hormone-Deficient Children**
   Past; NCT02311894
   Genentech, Inc., CCDN160120
   $40,620, Direct: $32,238, Indirect: $8,382
   Co-I, 1% Effort, 5% Collaboration
   9/2015 – 9/2017

7. **Validation of two measures for growth hormone deficiency in children, the Treatment Related Impact Measure of Childhood Growth Hormone Deficiency (TRIM-CGHD) and the Treatment Burden Measure of Childhood Growth Hormone Deficiency (TB-CGHD)**
   Past
   Novo Nordisk Pharmaceuticals, Inc.
   $11,250, Direct: $8,929 Indirect: $2,321
   PI, 1% Effort, 85% Collaboration
   03/25/2016 – 12/31/2017

8. **Post-Approval Safety Study (PASS) to Monitor the Long-term Safety and Efficacy of Omnitrope® in**

Infants, Children and Adolescents (Observation Plan: EP00-501)
Past
Sandoz Inc.
$84,365.60, **Direct:** $66,956.83, **Indirect:** $17,408.77
Co-I, 1% Effort, 10% Collaboration
12/2012 – 04/2018

9. **Louisville Metro LGBT Healthcare Survey**
   Past
   Investigator Initiated, Unfunded
   PI, 1% Effort
   9/2016-5/2018

10. **SIMPONI® to Arrest β-cell Loss in Type 1 Diabetes – A Phase 2 Study**
    Past; NCT02846545
    Janssen Research & Development, LLC, CCDN161110
    Co-I, 1% Effort, 45% Collaboration
    $90,389.00; Direct: $71,738.00 Indirect: $18,651.00
    8/2016 – 8/2018

11. **Hyperglycemic Control in Critically Ill Children**
    Past
    Investigator Initiated QA, Unfunded
    Diabetes Control in a Pediatric Diabetes Clinic
    Co-I, 1% Effort
    12/20011 – 11/2018

12. **TN-18 CTLA-4 (Abatacept) for Prevention of Abnormal glucose Tolerance and Diabetes in Relatives At-Risk for Type 1 Diabetes Mellitus**
    Past; NCT01773707
    University of South Florida/NIH, CCDN151441
    $98,003, Direct: $77,780, Indirect: $20,223
    Co-I, 1% Effort, 10% Collaboration
    12/23/2015 – 03/30/2019

13. **A Multicenter, Randomized, Partial-Blinded, Placebo-Controlled Study to Evaluate the Safety and Efficacy of a Human Plasma-Derived Alpha1-Proteinase Inhibitor in Subjects with New-Onset Type 1 Diabetes Mellitus**
    Past; NCT02093221
    Grifols Therapeutics, Inc., OICN140565
    $461,686, Direct: $366,417, Indirect: $95,269
    C0-I, 1% Effort
    5/2014-5/2019

14. **eQuality: Leading Medical Education to Deliver Equitable Quality Care for all People, Regardless of Identity, Development, or Expression of Gender/Sex/Sexuality**
    Past
    Investigator Initiated, Unfunded
    Co-PI, 1% Effort
    1/2016-3/2020

15. **Assessing Pediatric Residents' Training and Confidence In Caring For Children Presenting With Gender Dysphoria In A Primary Care Setting**
    Past
    Investigator Initiated, Unfunded
    PI, 1% Effort
    4/2017-7/2020

16. **Evaluating Use of Continuous Glucose Monitoring and Its Effect on Hospital Admissions**
    Past
    Investigator Initiated, Unfunded
    PI, 1% Effort
    8/2019-7/2020

17. **TransCon hGH CT-301 Admin Once a Week Vs Standard Daily**
    Past
    Premier Research Group, CCDN170215
    PI, 1% Effort, 50% Collaboration
    $136,742, Direct: $108,525; Indirect: $28,217
    8/2017-8/2022

18. **IAA- Hybrid Closed Loop Insulin Delivery System Data Collection (HYCLO)**
    Past
    Jaeb Center for Health Research, CCDN180816
    PI, 1% Effort, 85% Collaboration
    $4,125, Direct; $3,750; Indirect: $375
    1/2018-12/2019

19. **TN-20 Exploring Immune Effects of Oral Insulin in Relatives at Risk for Type 1 Diabetes Mellitus**
    Past; NCT0258077
    University of South Florida/NIH, CCDN160338
    $13,600, Direct: $10,794, Indirect: $2,806
    Co-I, 1% Effort, 70% Collaboration
    12/2014 – 06/2017

20. **A Randomized Clinical Trial to Assess the Efficacy and Safety of Continuous Glucose Monitoring in Youth < 8 with Type 1 Diabetes: Strategies to Enhance New CGM use in Early childhood (SENCE)**
    Past; (NCT02912728
    Indiana University, CCN161481 & CCDB161481
    Co-I, 1% Effort, 50% Collaboration
    $232,500, Direct: $184,524; Indirect: $47,976
    07/2016 – 05/2018

21. **A Phase 3, Double-Blind, Placebo-Controlled, Randomized, Multi-Center Study To Assess The Safety And Efficacy Of Exenatide Once Weekly In Adolescents With Type 2 Diabetes**
    Past; NCT01554618
    AstraZeneca LP, CCDN 161293
    Co-I, 1% Effort, 5% Collaboration
    $15,608, Direct: $12,387, Indirect: $3,221
    08/2016 – 08/2021

22. **A study to Assess Continuous Glucose Sensor Profiles in Healthy Non-Diabetic Subjects**
    Past

Jaeb Center for Health Research, CCDN171314
Co-PI, 1% Effort, 25% Collaboration
$20,213, Direct: $18,375; Indirect: $1,838
6/2017 – 1/31/2018

CONTRACTS

Current

1. **T1D Exchange Type 1 Diabetes Network**
   Current (Closed to Enrollment)
   Jaeb Center for Health Research, CCDN151043
   $419,250, Direct: $381,136, Indirect: $38,114
   Co-I, 1% Effort, 5% Collaboration
   7/2015 – 3/2016

CLINICAL TRIALS

1. **TN-01 TrialNet Natural History Study of the Development of Type 1 Diabetes**
   Current; NCT00097292
   University of South Florida/NIH, OICN111097
   $286,971, Direct: $227,755 Indirect: $59,216
   Co-I, 1% Effort, 80% Collaboration
   06/2011 – 06/2018

2. **Zinc and Nutrient Deficiency in Children with Diabetes Mellitus**
   Current
   Investigator Initiated, Unfunded
   Co-PI, 1% Effort
   3/2017-Present

3. **A double-blind, randomised, placebo-controlled, parallel group trial to evaluate the efficacy and safety of empagliflozin and linagliptin over 26 weeks, with a double-blind active treatment safety extension period up to 52 weeks, in children and adolescents with type 2 diabetes mellitus Di**abetes study of li**N**Agliptin and e**M**pagliflozin in children and ad**O**lescents (**DINAMO**)
   Current; NCT03429543
   Boehringer Ingelheim, CCDN161072
   Sub-I, 1% Effort, 25% Collaboration
   $69,503, Direct: $63,185; Indirect: $6,319
   09/2018 – 03/2022

4. **TN22 - Hydroxychloroquine For Prevention Of Abnormal Glucose Tolerance And Diabetes In Individuals At-Risk For Type 1 Diabetes Mellitus**
   Current; NCT03428945
   University of South Florida/NIH, CCDN190267
   Co-I, 1% Effort, 70% Collaboration
   $10,205, Direct: $8,099; Indirect: $2,106
   07/01/2018 – 06/30/2022

5. **Quality of life and psychological comorbidities in youth with gender dysphoria**

Current
Investigator Initiated, Unfunded
PI, 1% Effort
9/2019-Present

6. **Effects of Prescribed Cross Gender Hormone Therapy on Maximal Rate of Oxygen Consumption**
Current
Investigator Initiated, Unfunded
PI, 1% Effort
1/2020-Present

EDITORIAL WORK

Ad hoc Reviewer

2013	*Journal of Adolescent Health*
2014-Present	Pediatric Academic Society Annual Meeting Abstract Reviewer
2015-Present	*Current Diabetes Reviews*
2017	International Meeting of Pediatric Endocrinology Abstract Reviewer
2017-Present	*Translational Pediatrics*
2020	*Teaching and Learning in Medicine*
2020	Pediatric Academic Society Annual Meeting Workshop Reviewer

ABSTRACTS AND PRESENTATIONS

ORAL PRESENTATIONS

Local/Regional Meetings

1. Type 1 diabetes, HLA, Complement and Gene Copy Number Variation. Presented translational component at Bench to Outcomes Seminar Series, Columbus OH, December 2008

National/International Meetings

1. **Kingery SE**. Lower Complement C4 Gene Copy Number is a Genetic Risk Factor for Type 1 Diabetes Mellitus in Pediatric Patients. Midwest Society of Pediatric Research, Chicago IL, October 2009

2. Weingartner L, Holthouser A, Noonan E, **Kingery SE**, Potter J, Shaw MA, Sawning S. Direct Practice with Medical Students to Develop LGBTQ Clinical Skills and Identify Barriers to Implementation. Southern Group on Educational Affairs (SGEA) Conference. Orlando, FL, March 2019.

3. Weingartner L, Noonan E, Sawning S, **Kingery SE**, Holthouser A. Teaching Specific LGBTQ Clinical Skills Using The eQuality Toolkit. Workshop. Southern Group on Educational Affairs (SGEA) Conference. Orlando, FL, March 2019. ***2019 MESA Award winner in the category Outstanding Presentation Award for Undergraduate Medical Education (UME)**

4. Weingartner L, Noonan E, Holthouser A, **Kingery SE**, Sawning S. Toolkit LGBTQ Clinical Skills Workshop. AAMC Central and Southern Group on Student Affairs/Organization of Student Representatives Joint Regional Spring Meeting. Louisville, KY, April 2019.

5. Weingartner L, Noonan E, Holthouser A, Potter J, Steinbock S, Bohnert C, **Kingery SE**, Sawning S. Developing Clinical Skills for LGBTQ Patient Care with Direct Practice. Oral Presentation at the LGBT Health Workforce Conference. New York, NY, May 2019.

6. Weingartner L, Noonan E, Holthouser A, Potter J, Bohnert C, **Kingery SE**, Sawning S. Teaching and Assessing LGBTQ Clinical Skills with The eQuality Toolkit. Workshop at the Association of American Medical Colleges (AAMC) Meeting. Phoenix, AZ, November 2019.

Posters

Local/Regional Meetings

1. Akintola KO, Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. Behavioral Disorders associated with GnRH agonist therapy. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2013.

2. Pasala P, **Kingery SE.** Evaluation of Congenital Hypothyroidism Screening Infants at Kosair Children's Hospital NICU. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2014.

3. Myers WT, **Kingery SE**, Foster MB, Wintergerst KA. Sudden Generalized Edema in a 15 year-old diabetic girl. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2015.

4. Sharber S, **Kingery SE**. Assessing a pediatric residency program's training and confidence in caring for children presenting with gender dysphoria in a primary care setting. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2018

5. Sumner C, **Kingery SE**. Improving a Pediatric Residency Program's Training and Confidence in Caring for Children Presenting with Gender Dysphoria in a Primary Care Setting. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2019.

6. Bruenger K, **Kingery SE.** Quality of Life and Psychological Comorbidities in Youth with Gender Dysphoria. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2020.

7. Brown J, **Kingery SE**. The Effect of Continuous Glucose Monitoring on Admissions for Diabetic Ketoacidosis. Abstract/Poster Presentation. University of Louisville, Pediatric Grand Rounds, Louisville KY, June 2020.

National/International Meetings

1. **Kingery SE**, Wu YL, Yang Z, Chung EK, Zipf W, Germak JA, Hoffman RP, Yu CY. Monomodular RP-C4-CYP21-TNX (RCCX) Haplotype with a Short Gene for Complement C4B is a Genetic Risk Factor for Type 1 Diabetes Mellitus with the Age of Onset Modified by C4A Gene Copy Number Variation. American Diabetes Association Annual Scientific Meeting, New Orleans LA, June 200. *Diabetes*. 2009; 58 (Suppl 1)

2. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, and Yu CY. Lower Complement C4 Gene Copy Number Is A Genetic Risk Factor For Type 1 Diabetes Mellitus In Pediatric Patients. Pediatric Research, vol. 66, no. 4, pp. 472-472. 2009.

3. **Kingery SE** and Nicholson Y. Diagnostic challenges in children with parathyroid adenomas: a case report. Lawson Wilkins Pediatric Endocrine Society/ European Pediatric Endocrine Society Joint Meeting, New York NY, September 2009. Hormone Research, vol. 72, pp. 226-226. 2009.

4. **Kingery SE,** Wu YL, Hoffman RP, Yu CY. Higher Complement C4 Protein Levels Are Positively Correlated with β-Cell Preservation in New Onset Type 1 Diabetes Mellitus. Endocrine Society Annual Meeting. San Diego CA, June 2010. *Endocrine Reviews*. 2010; 31 (Suppl 1)

5. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, Yu CY. Complement C4 as Novel Biomarkers for Partial Disease Remissions in New Onset Type 1 Diabetes Patients. American Diabetes Association Annual Scientific Meeting, San Diego CA, June 2011. *Diabetes*. 2011; 60 (Supp1)

6. Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. A Case Report of Neonatal Diabetes Mellitus in Schinzel-Giedion Syndrome. Endocrine Society Annual Meeting. Houston TX, June 2012.

7. Kuhl EA, Foster MB, Omoruyi AO, **Kingery SE**, Wintergerst KA. The Impact of Insurance Coverage and the Family on Pediatric Diabetes Management: A 4 Year Experience. Diabetes Technology and Therapeutics Meeting, Bethesda MD, Nov 2012.

8. Omoruyi AO, Foster MB, **Kingery SE**, Wintergerst KA. A Case of Mayer-Rokitansky-Hauser Syndrome in a 6 Year-Old Female With Precocious Puberty. Academic Pediatric Society-Society for Pediatric Research Meeting, Vancouver, Canada, May 2014.

9. Omoruyi AO, Foster MB**, Kingery SE**, Wintergerst KA. A Case of Mayer-Rokitansky-Hauser Syndrome in a 6 Year-Old Female With Precocious Puberty. Endocrine Society Annual Meeting, Chicago, IL, June 2014

10. **Kingery SE**, Spurling S, Foster MB, Omoruyi AO, Watson SE, and Wintergerst KA. Multi-disciplinary team approach improves glycemic control and health behaviors in high risk youth with type 1 diabetes mellitus. Endocrine Society Annual Meeting. Boston MA, April 2016. Endocrine Reviews. 2016; 37(2)

11. Neff A, **Kingery SE**. Evaluation of first year medical students' knowledge and attitudes regarding differences in sexual development using a problem-based learning case on complete androgen insensitivity syndrome. GLMA Annual Conference. St Louis, MO, September 2016.

12. Neff A, Steinbock S, Sawning S, **Kingery SE**. Teaching 1st Year Medical Students about Complete Androgen Insensitivity Syndrome: Curriculum methods to teach about Differences in Sex Development (DSD). Southern Group on Educational Affairs (SGEA) Conference. Charlottesville, VA, April 2017.

13. Neff A, Steinbock S, Sawning S, **Kingery SE.** Teaching 1st Year Medical Students about Complete Androgen Insensitivity Syndrome: Curriculum methods to teach about Differences in Sex Development (DSD). Pediatric Endocrine Society Annual Meeting. Washington DC, September 2017.

14. Peterson E, **Kingery SE**, Watson S. Pediatric Mixed Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Syndrome. Pediatric Critical Care Summit of the Americas. Houston, TX, November 2019.

15. Bohnert C, Brady C, Bush B, Cash E, Combs R, Compton D, Decker H, Holthouser A, Jones VF, **Kingery SE**, Latta G, Martin L, Neff A, Noonan EJ, Sawning S, Shaw MA, Stephens J, Weathers A, Weingartner LA. eQuality: Resources from Five Years of an Integrated LGBTQ Health Curriculum Initiative. AAMC National Meeting. Virtual. November 2020.

16. **Kingery SE**, Folsom LJ. Quality of Life and Psychological Comorbidities in Youth on Gender Affirming Hormone Therapy. Pediatric Endocrine Society Annual Meeting. Virtual. May 2021.

17. Komeswaran K, Watson S, **Kingery SE**, Peterson E. A case series: Mixed Presentations of Hyperglycemic Hyperosmolar Syndrome and Diabetic Ketoacidosis. Society of Critical Care Medicine. San Juan, Puerto Rico. February 2022.

PUBLICATIONS

Articles Published in Peer-Reviewed Journals

1. Rutherford A, Zhou B, Wu YL, **Kingery SE**, Germak J, Bowden S, Yu CY. Analysis of the human amylase locus revealed extensive copy number variation of salivary and pancreatic amylase genes in type 1 diabetes patients. Pediatric Research. 2011, 70 (4): 429.

2. **Kingery SE**, Wu YL, Zhou B, Hoffman RP, Yu CY. Gene CNVs and protein levels of complement C4A and C4B as novel biomarkers for partial disease remissions in new-onset type 1 diabetes patients. Pediatric Diabetes. 2012; 13 (5): 408-418. doi: 10.1111/j.1399-5448.2011.00836.x. PMID: 22151770

3. Akintola KO, Omoruyi AO, Foster MD, **Kingery SE,** Wintergerst. Behavioral Disorders associated with GnRH agonist therapy. Experimental and Clinical Endocrinology & Diabetes Reports. 2014 *2*(01), e1-e3.

4. Farrell R, Foster MB, Omoruyi A, **Kingery SE**, Wintergerst KA. Hashimoto's Encephalopathy: A rare cause of neurologic disease in children. J Pediatr Endocrinol Metab. 2015; 28(5-6):721-4. doi: 10.1515/jpem-2014-0205. PMID: 25581742

5. **Kingery SE**, Wintergerst KA. Turner Syndrome and Klinefelter Syndrome. Adolescent Medicine: State of the Art Reviews. 2015; 26(2): 411-427. PMID: 26999880

6. Myers, WT, Wintergerst KA, **Kingery SE,** Foster, MB**.** Generalized anasarca in 15 year old girl with Type 1 diabetes mellitus. Pediatrics in Review. 2016; 37(2):81. doi: 10.1542/pir.2015-0088. PMID: 26834228.

7. Watson S, Kuhl E, Foster MB, Omoruyi A, **Kingery SE**, Woods C, Wintergerst KA. The Impact of Insurance Coverage and the Family on Pediatric Diabetes Management. Pediatric Diabetes. 2016 May 10. doi: 10.1111/pedi.12394. PMID: 27161659.

8. Neff A, **Kingery SE.** Complete androgen insensitivity syndrome: a problem-based learning case. MedEdPORTAL Publications. 2016;12:10522. https://doi.org/10.15766/mep_2374-8265.10522ortal. PMID: 30984864

9. Wintergerst, KA, **Kingery SE**, Gembel G, Kriepe T, Zeller P, Eugster E, Young W, Andruszewski K, Kleyn M, Cunningham T, Fawbush S, Vanderburg N, Sockalosky J, Menon R, Linard S, Hoffman G, Gorman L. Congenital Hypothyroidism (CH) 3-Year Follow-Up Project: Results from the Region 4 Midwest Genetics Collaborative. Int. J. Neonatal Screen. 2018, 4, 18; doi:10.3390/ijns4020018

10. Logan L, **Kingery SE.** Breast Development in a 2 Year Old Girl. Pediatrics in Review. 2018; 39(12):612-613. doi: 10.1542/pir.2017-0133. PMID: 30504253

11. Weingartner LA, Noonan EJ, Holthouser A, Potter J, Steinbock S, **Kingery SE**, Sawning S. The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care. Lexington, KY: University Press of Kentucky; 2019. doi: 10.18297/faculty/391

12. DiMeglio LA , Kanapka LG, Woerner S, Laffel LM, **Kingery SE**, et al. A randomized clinical trial assessing continuous glucose monitoring (CGM) use with standardized education with or without a family behavioral intervention compared with fingerstick blood glucose monitoring in very young children with type 1 diabetes. Diabetes Care 2021; 44(2):464-472. PMID: 33334807 DOI: 10.2337/dc20-1060

13. CichoskiKelly, E, **Kingery, SE**, Sawning, S, Stepleman, L. Incorporating Sexual and Gender Minority Patient Care Competencies: A Case Based Curriculum Caring for Gender Diverse Youth. (In-progress)

Continuing Medical Education and Professional Development Courses Published:

1. Weingartner LA, Noonan EJ, Holthouser A, Potter J, Steinbock S, **Kingery SE**, Sawning S. Evidence-Based Care of LGBTQ-DSD Patients Using The eQuality Toolkit. 3.0 AMA PRA Category 1 Credits. Course Originally Released on August 2019. *http://louisville.edu/medicine/cme/credits/eQuality19*

Articles Published in Non Peer-Reviewed Journals:

1. **Kingery SE**, Wintergerst KA. Clinical Practice Guidelines on the Management of Newly Diagnosed Type 2 Diabetes Mellitus in Children and Adolescents. Kentucky Diabetes Connection. 2013 March.

2. **Kingery SE**. Childhood obesity—A medical concern. Posted in Children, Family, Wellness on uoflphysicians.com/blog on April 19, 2016. http://www.uoflphysicians.com/blog/2016/04/19/childhood-obesity-a-medical-concern/

Audio Publications:

1. **Kingery SE.** Presenter. "Addressing the LGBTQ Pediatric Patient." MedChat. 2021 May. https://medchat.libsyn.com/addressing-the-lgbtq-pediatric-patient

Video Publications:

1. **Kingery, SE.** Presenter. "Engage on Inclusive Health Care for the LGBTQ+ Community." Engage. 2021 October.

Exhibit B

Bibliography

BIBLIOGRAPHY

Achille, C., Taggart T., Eaton N., Osipoff J., Tafuri K., Lane A., Wilson T. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Heath and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*. 2020:8. doi.org/10.1186/s13633-020-00078-2

De Vries ALC, Steensma TD, Doreleijers TAH, and Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *J Sex Med.* 2011;8:2276–2283.

Rafferty J. (2018). AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 142(4):e20182162.

Tordoff D., Wanta J., Collin A, Stephney C, Inwards-Breland D, Ahrens K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open* 2022;5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE* 17(1): e0261039.

Turban JL, King D, Carswell JM, et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020;145(2):e20191725.