

The Transformer: the UW Medicine Podcast

Episode 11: Transitioning to Gender Awareness

Opening Soundbite: Folks are still mistrustful and hesitant when trying to access care because of that long history of both discrimination, economically in terms of insurance coverage, but also the treatment they received when trying to access care with staff or providers that were just not knowledgeable or kind of outright blatantly opposed to their identity, and you know, verbally said so.

[Musical interlude begins playing]

Josh Kerns: Greetings and welcome to another edition of The Transformer: the UW Medicine Care Transformation podcast. I'm your host Josh Kerns. In several past episodes we've explored our Healthcare Equity Initiative and various aspects of inequities and disparities. And in this issue we're focusing on how gender bias along with the intersections of race economic status and sexual orientation is affecting the care of transgender and gender non-binary patients and the program helping our workforce become more gender aware and medically informed about how to take care of our gender-diverse patients.

Josh: And welcome. I think this is going to be such a valuable conversation and I'm thrilled to be a part of it and why don't we just go around the table. First, introduce yourselves and describe what you do.

Corinne: Hi I'm Corinne Heinen and I'm a clinical associate professor in family medicine, internal medicine at the University of Washington. I've been here 26 years. I work primarily in primary care but got a bee in my bonnet a few years ago to try to move the system along and trying to improve our care of gender diverse patients. So I'm now a physician lead of our Transgender and Gender Non-Binary (TGNB) health program.

Bobbi: Hi I'm Bobbi Dalley. I'm an associate professor of radiology and I've been at University of Washington since 1987. I transitioned from male to female in 2011 and shortly thereafter became more active in various advocacy organizations. And in 2014, I created a transgender health care class for the University of Washington postgraduate students. I've also been involved in a variety of advocacy organizations. I'm a member or have been a board member of GLMA which is the Gay and Lesbian Medical Association but now goes by Health Professionals Advancing LGBTQ Equality, and then also been on the board of the Transgender Law Center and on the board of Gender Justice League which is a local advocacy organization of trans people working on various health care issues and as well as just general trans issues.

Sean: My name is Sean Johnson. I am a social worker and the new Transgender & Gender Non-Binary health program coordinator here at UW. I also began my transition from female to male in 2010, so definitely seen the system kind of evolve as we come along the last 10 years and been a part of a number of community organizations and activist organizations trying to get trans folks access to healthcare.

Josh: Obviously I mean this has been your life work if you will, your work for many many years but the issues around this area really just coming into the forefront, I would argue in the mainstream, where we're getting a lot more awareness. One of those things that's like the band that just came out of nowhere, well no, they've actually been practicing and playing for the last two decades. All of this work that has gone on. Maybe first before we

really dive into the work here at the UW in general, just set the stage for why this work is so important, why the University of Washington is so committed to work in this field.

Corinne: So certainly as you say, this is not out of nowhere. Trans feminine individuals are recorded in the most ancient texts from India and there's over three dozen indigenous populations around the world where there has been actually a societal role for either trans feminine or people of a third gender. So as it really has been there the entire time and I've taken care of transgender patients my entire career. It's just that often people, because of discrimination, have had to stay undercover in order to not be overtly discriminated against and the healthcare system has not been very friendly. So as there has been more insurance coverage, which is all a side effect of the change in our cultural awareness that this is a thing and it has been a thing, there has been a great deal of need becoming manifest about people requiring the care for both gender affirming care but also just access to general health care for all their medical conditions

Josh: And Bobbi, it's really twofold, isn't it? Not only denial of care but just a tremendous lack of knowledge, awareness, understanding or outright bias by health care providers.

Bobbi: I think one thing that's increased that knowledge is the Internet. People have become much more aware. There've been all sorts of websites that support trans health and you know transgender transition and other types of trans related topics. In terms of health care coverage, up until about 2014 there are only six states that banned transgender exclusions from the health insurance programs: California, Colorado, Connecticut, Oregon, Vermont and the District of D.C. , Washington D.C. And so in 2014 we started working on getting Washington State, a coalition of different professionals within the legal and medical and social work realm, around together and worked on getting trans health care coverage in Washington State.

Josh: Sean, we've talked a lot on this this podcast over the last two years about equity in various issues but I'm just looking at some of the numbers: 33,000 individuals within Washington State that identify as transgender or gender non-binary, and then as I start to read down the very troubling statistics about negative experience, discrimination, I mean these numbers are appalling what people have experienced over the years and the lack of access or the outright discrimination.

Sean: Absolutely. And I think that history speaks to kind of why folks are still mistrustful and hesitant when trying to access care because of that long history of both discrimination, economically in terms of insurance coverage, but also the treatment they received when trying to access care with staff or providers that were just not knowledgeable or kind of outright blatantly opposed to their identity, and you know, verbally said so.

Josh: So here at the University Washington, at UW Medicine then, what is going, you all mentioned the different roles that you have, maybe talk from the 40,000 foot view. What's sort of starting to be put in place or what is in place now, what are you working on and then we'll talk specifically more about the details of the work that's being done.

Corinne: So, my initial and main goal has been to get our primary care workforce both gender aware and appropriate, but also medically competent to take care of gender diverse patients. Reason being is that a lot of people feel like they're tolerant but they don't really understand the life experiences. And certainly for instance, trauma within the medical system, is one of them. But also, all of the medical finessing and specifics that apply to gender diverse patients.

Josh: Bobbi, is it, I'm just thinking about, going back to conversations we've had here. It's gotta be exponentially difficult in this community. I think about conversations I've had with various leads here at UW Medicine around gender, around race and all that, so now you start adding more and more layers, and this just must be even exponentially more challenging and more issues that we have to overcome here.

Bobbi: Yeah, I mean, there's all sorts of interconnectivity between, you know, all these different race and gender, sexual orientation, and all that, and you know it gets to be quite challenging to educate people about the different things because it seems like there's so many different facets.

Corinne: And one thing that strikes me is that all of us, being human, try to pigeonhole people as far as, ok, well, your're gender diverse or you're African-American or you're gay. But then, when you get into the intersectionality, that's when it really requires an open mind. And unfortunately, that group of people have the greatest disparities of all because they kind of get it from all sides.

Josh: Well, and Sean, I'm again going back to some of these numbers: 38 percent reported negative health care experience, 16 percent refused care, 50 percent had to teach providers about transgender care. You guys mentioned already a number of people just avoiding care altogether out of an outright fear, suicide, poverty. My heart breaks when I hear that and I'm going to go back to the doctor here, use the word human. We're all just human. And so it'd be nice if we didn't have to pigeonhole all these labels but for now we have them and we have to figure out how we break those silos down, right.

Sean: I mean I think that's definitely a challenge. I had the opportunity to listen to the "Toxic Stew on Microaggressions" [previous podcast episode] with Pat [Dawson] and Paula [Houston] and Jonathan [Kanter]. And I think as they talked about the health disparities among folks of color, that certainly isn't unique to just CIS [cisgender] folks. I mean, the trans community also experiences those same kind of disparities in terms of trans, plus trans woman, trans woman of color, and you're looking at like all of those coming together and of course the disparities are larger, the needs are higher, because they're also more likely to experience homelessness or unemployment, or a number of assaults. So I think we have to do our due diligence and I'm glad that we're working with Health Equity with Paula and Pat and Keith [Vensey] to really try to look at those things as a joint care issue versus silos of separate need.

Josh: How would you assess where UW Medicine is now and then we can start to look at the road ahead?

Corinne: So we have had this wonderful care transformation approach spearheaded by Dr. Pellegrini, our previous Chief Medical Officer, who really is launching a look at all of these things simultaneously, which is what you need to do. And so I think in that way, actually the University of Washington has been particularly gifted. Certainly, when it comes to some specific pieces to gender-affirming care, we have a ways to go, but I think that looking at it from a system is key, and especially in an academic setting you sort of have to start from the top.

Bobbi: UW Medicine has in recent years been part of the Healthcare Equality Index, which is a nationwide evaluation of hospitals, in terms of how they support the LGBT community, and UW has always been on that list of those that are 100 percent compliant

with the HDI index. And so it's been a big priority of UW Medicine from the administrative side.

Josh: So where do we go then, what is the vision? What are the overarching goals and really the mission, if you will, of the TGNB program?

Corinne: So we want to make every aspect of care that people get at the University of Washington accessible and safe feeling for all of our LGBTQ patients, but because gender-diverse patients have really been in the hot seat as far as being the most discriminated against, that's of course our focus. What that entails is meaning training not only our primary care staff, our front desk people, our back office staff, all of our providers, how to be gender aware and appropriate, but also now starting we've given a talk to Northwest Hospital's emergency department staff and we'll be working on the inpatient side to try and make all places where people interact with health care because trans people need all kinds of health care and so that is one of our main focuses right now, as well as trying to get gender-affirming hormone therapy readily available in our multi-focal primary care system.

Josh: How much does insurance companies, how much does the current system make that difficult to provide that kind of medical care?

Sean: Well thankfully with actually the ACA, one of the clauses in the ACA is I think what allowed the Washington State Office of Insurance Commission, they were one of the I think first state to kind of jump on that clause and really demand that the providers, the carriers, whether it be Medicaid, state carrier, or your private carriers, would have to kind of follow Medicare's lead and provide access. Now on paper, that looks amazing, and certainly that's allowed a lot more folks to access things, and you know start seeking out care that's covered. They can't, you know, there's no riders anymore where companies just won't, you know, "everything but that kind of thing." But on the ground, you'll hear definitely about still folks having, they've changed drugs and now it's taken them two months and they have to call the insurance commission and say, hey, I still can't get my hormones covered. So on paper, it looks good, but I think we're still at a very crucial time in making sure that the insurance carriers kind of live up to that, and that all the things, all of the boxes they need everybody to check, are kind of well known, so there's no kind of barrier there, as well as just trying to make sure that there's enough services, right. If you kind of flood a system with thousands and thousands of people that prior were not able to access specific procedures or services, now you've got systems trying to really take that on and provide that care which is going to take some time.

Josh: And Sean, I wanna go back to you, you were talking a moment ago, in the clinics and that access to care, I mean it seems to me, that you have to educate, first of all, patients as to what their rights are, what services actually are covered and available, because I know what it's like when you call your insurance company and you know, will put you on hold for six days, never get back to you, and it's very easy to just give up and all of that and figure out, OK I'm screwed here basically, but then also, to have staff, front desk staff, that are knowledgeable, empathetic and are there to be advocates for the patients as well, whether it's pronouns, or a number of issues, single bathrooms, things like that. So a number of issues we have to deal with here.

Sean: Yeah. And I like that you termed it like, "advocate," right. I think that you know my vision, especially in the primary care setting, would be that staff are, they have the resources they need. They have the training they need to be those advocates so they

know what resources are local that folks may need outside of that clinic and they know what insurance, kind of carriers cover what and what needs to happen and so that's part of my role right now is really trying to streamline that because I think in the past a lot of folks have been doing it like an individual by individual case so you get these kind of patchwork, but it feels like everybody's trying to start from scratch every time. So the idea that we could kind of make it as easy as possible so that that responsibility isn't placed on the patient, which typically has been, that we get these system things in line to kind of support that, for example, billing, right, like if your identity documents do not all line up you may get a bill for something that you shouldn't have gotten a bill for. So then that means the patient is spending significant amount of time after a visit really trying to work that out. And so I think there's both training for staff and you know what's available locally and what's going on, but also I think our systems are still kind of trying to evolve and catch up to make sure that we're providing the same kind of access for like everybody else.

Corinne: Yeah. For instance, a trans man may have a cervical Pap, and in the past we get stuck with that bill, even though it's completely physiologically appropriate

Bobbi: Or a trans woman would have a prostate.

Corrine: Exactly, a PSA or...

Josh: Well, call me Pollyanna-ish, but I would hope that my medical staff is an advocate, regardless of my condition, my gender, my race. So that's the idealist in me

Corinne: But they need tools.

Josh: Pragmatically speaking, so the work that you were doing, what does that look like? How are you trying to make this work as part of the system?

Bobbi: I think one part is trying to get some education for the medical students and the health professional students. So that's why we started creating, there's an LGBT elective and there's also the trans healthcare elective that I do. But it's only a one quarter part of their elective schedule and it's usually for the first or second year students. And we really need to get it integrated into the full medical curriculum.

Corinne: And I gave a presentation on that to our curriculum committee this year and we're really making some progress along that line and partially it's because the medical students are woke and they want to hear about this information. We have an LGBTQ health student pathway which is the first in the nation here where people can have extra training including those classes Bobbi referenced, and then also get specific clinical experiences throughout their medical school career. Also we have greatly increased, just in the last year, the availability of both clinical and didactic availability to some of our residents. And so I think that's going to be also a positive trend for the future.

Sean: For me, I think that in general, I mean medical providers or mental health providers or providers in general are both people and providers. I mean I think most folks go into health to serve, you know because they're compassionate, they want to help folks, but at the same time, they're not divorced from kind of the societal norms and expectations and all of these cultural kind of norms that we've created. So I think for me, especially on the inpatient side, I think there are good intentioned folks that are looking for ways to be better because they want to care for their patients. And then I think you know, just like everybody

else, you have folks that are going to be more resistant because they're carrying those unintentional or intentional biases around, you know it follows them to the office.

Bobbi: UW Medicine has a LGBT Clinical Care Committee that both Corinne and I have been on and their purpose is to try to improve those health care disparities throughout our UW system in terms of gender neutral bathrooms and signage and teaching people pronouns, access to learning modules online where people can learn you know a variety of different areas of you know how to deal with trans folks and other types of people.

Josh: You mentioned pronouns and that's an interesting one. I know over the last year or two I know more and more people that include that for example in their email signature and other people well why are you doing that. And I think that's important again for the lay people who may not know much, why especially around pronouns is it important to declare that and to have that be part of our conversation?

Bobbi: As part of the electronic medical record, we record the patient's legal name but when a person comes into clinic and they get called, people have their preferred name and so now within our electronic medical record there is a place where they'll usually ask you at the front desk, you know, what your preferred name and what are your pronouns as part of their new openness to this type of information. I recall that when I was first transitioning I went to get a mammogram and I was dressed as a man at that time and when they called Roberta in the press clinic, or they asked for Bob, and I thought, well that's kind of embarrassing. You know they didn't use my preferred name. So it really can make it a lot more comfortable if you're given the respect of using the right pronouns and your preferred name.

Corinne: And that's been one success of our program is we really rolled that out in the last year. We actually, because we have open front desks, there isn't a lot of privacy, so when people come up we have like a laminate sheet that people can write their preferred name and circle their pronoun to help preserve their privacy. But then it's in the medical record and actually the person's name in use is at the top and the legal name is in smaller print below, which I greatly prefer.

Josh: So medically speaking, what are the actual service capabilities here at UW Medicine? What are the range of medical services that are provided?

Bobbi: In terms of, you know, coverage, we have pretty good coverage, I think in terms of the medical services, in terms of, you know, access to hormones, access to just basic health care services for the gender diverse community. Where it gets a little bit tricky is when it comes to surgical coverage because there's really nobody in the UW system that does the variety of gender-affirming surgeries. There's some people in the plastics department that will do some of the facial surgeries but in terms of top surgery for trans men, removing the breasts and creating a masculine chest, or breast augmentation for trans women, or particularly the genital reconstruction surgeries, there's one person in Yakima who does it in Washington State but that's the only person; the next closest is in Oregon, in Portland, but otherwise a person has to go to either California or to Scottsdale, Arizona or somewhere else in the country because there's not that many people that do that kind of surgery and the coverage for that is fairly limited in terms of insurance coverage.

Corinne: Now, independent of this program, definitely our gynecologists and urologists had been very active before at making sure people could get hysterectomies and removal

of their ovaries and testes, without regards even to this revolution in insurance care. And so, those surgeries have been available and are, and in a pretty sensitive way. And I am not responsible for that. That is all on their good effort. And we had had some traction in improving top surgery but then we had a loss of staff. And so we're kind of trying to recreate some momentum there. But you have to have someone who both has the right skill set and can try to effect change in our big system and that momentum is nothing to sneeze at as far as taking quite a bit of effort to start

Josh: Well, it strikes me, you mentioned how little education there is in med school around these, one or two electives, not not a full rotation etc. How do we get more skilled providers into this area or more and more skill to those current providers that are already out there in these various areas?

Corinne: Right, well I think it's coming down the pipeline, and as I said, we've made a lot of progress in general in our medical school and residency efforts. We have postgraduate trainees who want to make this their life's work and they have been certainly allowed to pursue that. It is, as you say, a little more challenging to teach old dogs like me new tricks. This is not a new trick to me. And so that's why I can do it. But there has to be sort of a will and that's why it's been great for this to come top down. And I think we are going to get traction on it but it isn't an overnight process unfortunately.

Josh: Sean, when you go out, when you talk to other providers, specialists, a surgeon etc., are there many out there who are willing to just say, oh, I would like to learn that, I would like to advance my skills, I'd like to be able to provide more of those services? Is that even a reality at this point? To the doctor's point, is it too hard to teach an old dog new tricks, and you try and make a generational change from the ground up, if you will, from med school into residency, etc.?

Sean: I mean, I think there's so much involved with that. I think think it really varies across departments and different facilities given their capacity. Sometimes you just run into, you know, folks are short staffed, like which we're looking at recruiting for another provider right now. As we've talked about, kind of, what is the insurance going to pay? So that also impacts the system on taking on I think surgical care. But in terms of like the younger folks in particular really getting on board with this, I mean, like we've mentioned, some of the what we call bottom surgery isn't available really locally. However, when folks go wherever they go and they have complications when they get home, we're the ones seeing those folks. So I think about one of the surgical residents, Dr. Shane Morrison, who just published recently around what it looks like in acute centers...so in your E.D. or your urgent care, like what does it look like, but also what does it look like when there's post complications and we're working now and publishing around techniques we've kind of looked at to try to fix those things. So I think there's interest, but it will kind of come down to system support, like how much the institution is going to support that as well as like the financial part that the insurance carriers really have to like deem it, you know, pay for it basically.

Corinne: I will say our urology department really are stars compared to anywhere as far as repairing some of the complications. They are tremendously good. Also, our reproductive health team have been helping again outside of any programmatic efforts to provide fertility care and also management of things like periods which can cause great distress to trans masculine individuals to help with amenorrhea. So those things also are available within our system.

Bobbi: Sort of along those lines within for the pediatric population, there's also a lot of great people here in the community that are taking on young people who are early in their transition and doing hormone blocking medications, you know, to delay puberty and you know counseling and just giving them support in terms of making their transition at an early stage.

Corinne: Yes, and Children's has a gender clinic that provides those services and they're actually working toward surgical services as well.

Josh: Sean, maybe talk a little bit more specifically about some of the ways in which this work is manifesting. What are you working on, what are some of those touch points, those milestones, the flags in the ground if you will, that you're using to help further this work?

Sean: Well, in addition to social work, I also have a background in public health so I like numbers and I've always been a firm believer that being able to really depict accurately in numbers to folks kind of increases folks buy in. And so I think in terms of, we're just, you know, this year very recently started to collect this data so we're starting to see like how many people we have in our system, what those needs are, where the need is in terms of like what geographical area, etc. So I think, you know, that's what I'm taking a look at as well is how many people do we have and what are those needs continuing to train. The numbers I pulled most recently is that just in the kind of like overall basic 101 training for front office staff, etc., is close to 2,000. Joey, my predecessor, you know diligently worked and trained a significant amount of people. That's huge, 2,000 people in a year. It's been almost 100 providers trained in the Tier 2 training with Corinne. So I think we're starting to get there but I think as we get data we can really start to parse out these needs more specifically, then we will have numbers in hand and a kind of an action plan on how to address them once we can kind of see what they are. I think on the primary care or outpatient kind of setting as we've kind of discussed earlier, my hope is that we really get the resources to the clinic staff whether they be medical or more like ancillary or supportive staff so that the patient isn't burdened. And I think that in general we're really trying to support folks so while we can't necessarily offer this specific surgery right now, we can get that referral process started. We can start to talk to the insurance and get folks set up and get them to the right place as we don't have it right now. So I think that's essentially when really trying to build rapport with the community because for so long they've just been kind of openly denied. So if we can't do it, how can we best help you to get that done. I think it's an important step we need to take in rebuilding that rapport with our patients.

Josh: Obviously you want to be the gold standard. Would the goal though be that at some point this becomes the model for the rest of the country, not just that UW Medicine is known as that but that you actually become the seeds that sprout all over the country and ultimately the world when it comes to that or is that too grandiose and ambitious at this point to even think that way?

Bobbi: I think so. There's a lot of great people all throughout the country who are doing great work in this area.

Corinne: I agree.

Josh: You're all too humble.

Corinne: Oh no, we're not.

Josh: You're just pragmatists, realists?

Corinne: I'm a real pragmatist. Believe me, I grew up on a farm, I'm a pragmatist. But what I would say is that as our role as an academic institution, I give talks regularly at our primary care conferences, including urology and gynecology, to help bring people who look to the university for training and have an interest in this information about both approach to the patient and being gender aware, but also the concrete information that people need to be medically competent, which is something I'm going to keep coming back to all the time, because that is really the critical piece for helping people be as healthy as possible. It's not just to be tolerant, which I think are in our general area here, people are quite tolerant, although they may not know their own blind spots, but to know that there is a there there when it comes to medical knowledge is critical and inadequately understood. So, that is our goal in part of the primary care network is actually to be able to label on our websites the people who've had the extra training for trans health care, and I take this idea of being medically competent very seriously and so people are participating in a Zoom meeting where they learn more about the medical side and also people can bring cases when they don't know what to do. I'm sort of an informal support person to all of our primary care staff when they have a question that comes up, that I give them some tips online about how to manage these things. And so I am very much committed that people can't just say hey I'm into this without having a knowledge base and I'm kind of assessing people as we go as to who has kind of the critical tools that they need to do this in a more accurate way. There are a lot of finesse points and you have to be very flexibly minded that when someone comes in with a beard and looks quite burly that they could have pelvic inflammatory disease or be pregnant and that is not common sense at all. And so you have to really train your mind to be able to think in that way.

Josh: So, Sean, then where do we go from here? What are the next milestones, the goals -- both short-term, long-term, some of the resources perhaps that you're developing?

Sean: I mean, I think one of our priorities is to again be able to have a list of providers that we know are both respectful, but also can provide quality care on the medical side. So I know that's something that we're actively trying to work on so when folks call in to see doctors, we have kind of a list and we know what to send them in terms of this provider is someone you can see, etc., like, you know, we've talked about throughout this segment. We're looking to try to get more surgical options and have that kind of streamlined. We're gonna be having a community conversation along with, under like, the health equity. They've had several community conversations out in public. I think they had three or four and we'll be working one on October 22nd it's gonna be at Lifelong from 6 to 8 p.m. I think it's a Tuesday or Wednesday. And so that's going to be an opportunity to outreach to the community and kind of hear back about what their needs may be or what their experiences with the UW health system has thus far been. And I think that being able to have that rapport and that trust build with the population locally is gonna be essential to really move us forward and have folks both see us and have confidence that they will have a good encounter with us.

Josh: Doctor, for you looking ahead, some of the goals, the next milestones, either short or long- term, where do we go from here?

Corinne: So our efforts at education are going to be an ongoing effort because we have new staff. There are always details that haven't been thought of. And so, for instance, now we're working with the LGBTQ Clinical Care Advisory Committee to try and get pronouns on our I.D. badges in some way, shape, or form. So there's all these details, all these ways

and interaction with the system, especially a big system like ours, can be perceived by a patient. One real accomplishment, I think, was just to get our contact center, when people call for an appointment for the first time, that they are asked about their pronouns and how they would like to be called. That is no small feat. And that's not a very common accomplishment, for instance. And then moving forward, we would like to see more breadth of services.

Josh: Sean, you've been in this role just for a little while but you've obviously been around UW Medicine for some time here. Are you noticing changes, are you hearing from patients, from providers, from staff, that hey things are getting better? What's the word on the street, if you will?

Sean: Yes, the word on the street is that we are kind of changing and that, to my surprise, once our inpatient-specific records, kind of updated, and now a preferred name and pronoun are listed, it's been interesting to watch that six to nine month change: 1) to get the enormous requests for training because folks are really seeing that hey we don't really know what we're doing all the time so can we get some training. So that's been encouraging versus folks just, you know, moving on and not having an interest in making sure that care is better. But I think, 2) I mean, I've heard on the floors, I've been kind of not sidebarred, been walking on a floor and watched a physical therapist and a nurse talk about this person using they pronouns and kind of making sure each one of them understand what's going on and address the patient correctly, but also both understand kind of what that gender identity is. So it's been interesting to see the staff reaction as it's just been kind of placed upon them of sorts. So I think that we're moving in the right direction and as someone that tried to like as a staffer, that was employed here and could not get insurance coverage for my health needs at that time, I mean, just in these what, eight, nine years to see kind of where we're at now is super significant from where I saw myself as a both an employee and as a patient really, really move. I would also say in terms of changes, just the support we can offer the clinicians. Just the other day, I was on a meeting with the social workers that are housed in the various clinics and we were discussing what it would look like to train folks in the clinics to have assessments, to be able to provide the assessments, the letters of support needed by mental health providers in the case of surgery like specifically. And making sure that we are trained and are comfortable doing that but are open to doing that and in certain cases, a PhD level mental health provider needs to kind of write a letter of support, especially as is the case now, there are so many kind of gatekeeping provisions, especially like really attached to with the insurances that you've got to have this kind of letter of support within this timeframe of a surgical intervention or a visit that really can snag, you know, really be a barrier for folks especially as we've already talked about. Resources are lower in our community in terms of unemployment and shelter and all of these things so having to have to ask someone to jump through another hoop to get kind of like a letter of endorsement from a provider can be really difficult.

Corinne: Our primary care force here when they prescribe gender-affirming hormones work from an informed-consent model, meaning, if a person comes in and says that they are in need of gender-affirming hormone therapy, that we go through and list, you know, the risks and benefits, the implications, and if the person is competent and of age, then we just go ahead and work with them to do that. They don't require any kind of mental health evaluation as used to be the standard a few years ago. Some providers, though, still require a letter from a therapist, which is so 1999.

Sean: And so we're currently working on trying to utilize our consulting psychiatrist that travel around to our clinics and trying to get them up to speed and kind of see what their interest is in helping us provide those letters so that folks can go on to get care, whether it be with us or not, because at the end of the day, the surgical need is essential and necessary for the overall health of those patients and we're gonna see this patient back in the primary care settings ongoing.

Josh: So lastly, Doctor, obviously we've identified tremendous work being done but a long way to go. How do you feel about the future when you look ahead? Are you optimistic that this will be, that the future is very bright here at UW Medicine in this area?

Corinne: I think that as people come to understand this, they can't unknow it, and that will just kind of build on the trainings we've been working on and the cultural changes throughout society. So I'm very hopeful. I would like everything to be perfect now, but that is where tenacity comes in. And so I think we've got a lot of that on our side too.

Josh: And you have a fabulous team around you and the commitment of the leadership, which, I mean, you guys could be doing this work, I've worked in many corporate environments where this kind of work is going on and then somebody at the top's, nah, I'm done, I'm moving on, or that person gets fired. It seems like institutionally, you have, they have your backs.

Corinne: That is critical and wonderful.

Sean: Yeah, I'm hopeful of the future in terms of like, in Seattle, the community itself is collaborating. I think that's so essential as there are resources that are scarce and the knowledge is still kind of up and coming, that the various institutions really work together, including the mental health systems, to kind of help us provide what we can't get to capacity-wise, or what we don't have access to, to really help the patients overall in the community, overall really get to a thriving model from a surviving model.

Bobbi: I'm quite optimistic about the future. I've noticed that the changes in our healthcare system, from being a patient myself within the system for various things, and I think we are making progress and I think some committees like the LGBT Advisory Committee and other groups within the medical center and within UW Medicine are really working on trying to make this an inclusive environment.

Josh: Dr. Corinne Heinen is a family medicine physician at the UW Neighborhood Belltown Clinic and the physician lead for UW Medicine's Transgender & Gender Non-Binary program. Bobbi Dalley is a neuroradiologist at UW Medical Center and a board member of The Gender Justice League, and Sean Johnson is the health program coordinator for UW Medicine's Transgender & Gender Non-Binary program. Thank you all for such an enlightening and inspiring conversation. I really appreciate it. Thank you.

All: Thank you. Thank you. Thanks for having us.

[Music break]

Josh: And that's gonna do it for another episode of The Transformer. I'm Josh Kerns. We'll talk again soon as we explore more of the transformative work you and your UW Medicine colleagues are putting into practice. Thanks so much for listening and take care.