"Clinicians Working Together Effectively Across Healthcare Systems"

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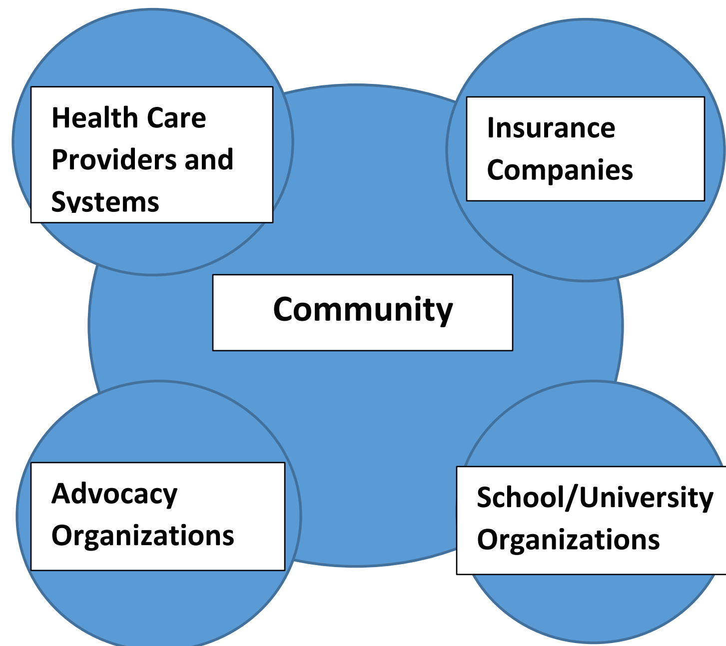
The "panel discussion" today is actually a discussion for everyone in the organizations and roles that are represented at the conference.

The "Community" of people is everyone, regardless of sexual orientation or gender identity, we are here today to support. Around the community are those of us (organizations) who are trying to come together to support the community- both being part of the community and supporting the community.

- Health care organizations, insurance companies, advocacy organizations, school/college organizations:



Discussion:

How do we coordinate care/work together to piece together patient's care (patients with gender dysphoria-transgender/gender non-conforming)? How can we work together to coordinate care? Are we providing the same standards of care (same management of hormones)? How do we know and how do we do that?

Transgender/gender non-conforming patients have multiple providers. For example patients receive medical care through multiple providers:

- Primary Care Provider
- Gender Services Provider for hormones
- Surgeon
- Mental Health Providers
- Substance Abuse Treatment

Barriers to coordinating care:

- Medical records- piecemealed records together, time-consuming process.
  - Big safety issues with providers not being able to see information from mental health providers, medications prescribed.
- Insurance coverage changing who patient can see for providers/health systems and what is covered for treatment, medication, surgery.
  - Prior Authorizations for gender conforming surgeries- communication between surgeon and provider (gender provider) of what is going to be done for surgery to be able to submit Prior Authorization.
- Providers not wanting to/don't know how to deal with a specific dimension of care/medications.
- Patients having to negotiate between different health systems and processes.
- Patients not disclosing medical health, mental health or substance abuse concerns- so provider may not even be aware of patient's full history or know that they need to communicate with each other about patient's care.

Suggestions for improving coordination of care:

- Having an open release of medical records (good for 1 year) to increase communication between Providers/health systems- encourage patients to have open ROIs for faster communication, less burdensome process.
  - Encouraging it for comprehensive, safe patient care
- Having mental health visit encounters open to viewing in the health system (instead of being non-viewable/"sensitive" visits that can't be viewed even by providers in the same health system).

Do we as a community of providers agree on when to begin/how to manage hormone therapy?

Follow the WPATH standards for starting hormone therapy, however still gray areas with serious mental health concerns (uncontrolled bipolar, schizophrenia, serious substance abuse) and the pediatric population.

How do you decide to start hormones?

- Looking at it from harm reduction perspective- risk of continuing in gender dysphoria versus risk of hormones and the potential to actually help the patient. Some patients are so distraught to not have hormones that it puts them at risk for harm/suicide.
- Making sure the patient really understands what the risks are for the hormones and have mental health support when hormones are given (close psychiatric follow up).
- Lines of communication between Mental Health Provider and Provider who is prescribing/going to prescribe:
  - Waiting for hormone therapy during a manic episode/time until it is under control. Or limiting dosage of hormone therapy until under control.
  - Waiting for hormone therapy until chemical dependencies treatment is stabilized.
  - From a Mental Health Provider- writing the letter of support for hormone therapy using **WPATH** standards to assess if psychiatric concerns are controlled and whether or not use of hormone therapy will affect their psychiatric concerns and what mental health follow up is needed if concern that hormones will make .

Surgeons outside of the U.S. don't require a letter of support from mental health provider, so patients may pursue surgery on their own. What do we do to help the patients who have done the surgeries outside of the U.S. (i.e. bottom surgery) and then have post-op concerns and regrets for having completed surgery?

- Helping patients be more informed about what to expect from the surgery and post-op.
- Having a mental health provider already set up before surgery.

How do we deal with limited mental health care access?

- Integrated mental health providers within primary care setting (HCMC has this model) for more immediate referrals/visits.
  - Mayo Clinic has done this, however the barrier becomes ongoing mental health services after initial consultation in clinic.
- List of mental health providers in the Twin Cities who see Transgender patients, which has been created by a local group of community providers.

- Difficult to find a mental health provider who will see transgender youth/young children- even more limited access than transgender teens/adults. Makes it very difficult for these children to have to wait (like for a 1 year waitlist) for the mental health provider when so much growth/development can happen during that time.
- Is there a way to have some type of collaborative between health care organizations, community mental health providers, and insurance companies to always have an on-call provider who specializes in transgender to be able to see patients in an emergency/short-term situation until there is availability/access with the patient's covered mental health provider (covered through insurance)?
- **YSNMN- Youth Services Network MN** has an app for download that provides a means for people/youth to reach out to a crisis network, through the app, to get immediate assistance to crisis services.