Transcript

Across the Sexual Orientation and Gender Identity Spectrum_ A Call to Action

February 23, 2022

Presenters: Margaret-Mary Wilson, MD, MB, MRCP, Executive Vice President and Chief Medical Officers, UnitedHealth Group and Michelle Garrido, MD, MS, Family Medicine Physician, Valley Medical Center, Van Nuys, California

Sarah Chart: Hello. Good afternoon. My name is Sarah Chart. on behalf of OptumHealth Education, I would like to welcome you to today's activity across The Sexual Orientation and Gender Identity Spectrum - A Call to Action. Before we begin, I would like to review a few items. A question-and-answer session will be held at the end of the presentation. Upon conclusion of the webcast, the post activity assessment evaluation, credit claiming, and certificates of attendance will become available. Visit optumhealtheducation.com for more information. I would now like to turn the program over to Chris Mayne.

Chris Mayne: Thank you Sarah. Afternoon, everybody. Thanks so much for joining. My name is Chris. May I work with Optum and support our care delivery teams in California, and just really appreciate all of you taking your time out to be with us today. Welcome to our continuing education series for how we can better support our LGBTQ+ patients and community. Really appreciate your time and interest here. We had a great session last week and we're excited to bring it back today. I'm here to kick things off and quickly pass it to our two distinguished speakers. For context, before we go there just, we've talked in the past sessions about how the LGBTQ+ patients can feel marginalized and often C ties in healthcare settings, and these individuals often have increased risk of certain

physical and mental conditions versus the general population, which is important for us to focus on that today.

They can also often receive suboptimal care and avoid care for fear of discrimination. And you can see some really striking stats on this slide that reinforce those points. And so that brings us here today and what this session is about, and it's really about increasing awareness to help us communicate in an appropriate and respectful way. We also want to impart some really practical knowledge to you all to ensure that we do things like take a full history that is documented accurately and provide appropriate screening and risk prevention recommendations, and much more. And to do that, let me introduce our two wonderful speakers, two individuals that are amazing people and also amazing physicians.

First, Dr. Margaret Mary Wilson, who's the executive vice president and chief medical officer for United Health Group. In this position, Dr. Wilson leads efforts to develop a high performing health system at United Health Group that addresses critical needs and opportunities around improving health equity, expanding access, lowering costs, and improving outcomes for patients, payers and providers. Along with her really many impressive academic, medical, and business credentials, Dr. Wilson has received numerous awards in medicine. A couple I'll call out here, the Kathy Humphrey award for excellence in promotion of cultural diversity in medical education. And also last year, Dr. Wilson was named one of the top 100 most influential African Americans in business by the National Diversity Council. So we're honoured to have her with us today.

Our second speaker is Dr. Michelle Garrido. Dr. Garrido is a primary care physician at Optum's Venice clinic in Los Angeles. Born to Cuban immigrants before becoming a

physician who was actually a high school science teacher, which I'm sure allows her to relate with all sorts of different audiences. She went to medical school at the university of Illinois, Chicago. She completed her family medicine training at a Harbor UCLA in Los Angeles. She lives in LA with her wife and five-year-old son, and her biggest clinical interest is the LGBTQ+ health. And so that's why we're lucky to have her with us today. So without further ado, let me pass it over to Dr. Wilson.

Dr. Wilson: Thank you so very much, Chris. And it's a pleasure to be here and thank you to everyone for taking the time to join us in this conversation today. I think it's important that as we begin the conversation, we take a moment to understand the comparative complexities of this population. So almost 6% of the population identify as LGBTQ+, but it's important to recognize that the population is broader than those who self-identify. So that 6% translates into about 9 million Americans who self-identify as LGBTQ. Beyond that though, 19 million Americans actually engage in same sex behaviour. And even further beyond that, about 26 million Americans acknowledge same sex attraction. So this is important because the risks to mental and physical health for lesbian, gay, bisexual, transgender and queer plus individuals extends beyond self-identification. And awareness of this nuance and the added layer of complexity that this factors in are helpful in informing the nature of our clinical interaction as providers with patients.

The other piece that I'd like us to reflect on is just the number. So for comparison, and please note that this comparison is not intended to categorize LGBTQ+ individuals as having a disease. It's just intended to give you a sense of how many lesbian, gay, transgenders, queer individuals you actually are coming across in your waiting rooms and in your offices today. So if you think of congestive heart failure, for example, about seven million Americans have heart failure. And then if you think about the number of

patients with heart failure you see in your office, or the number of patients with diabetes, for example, and 34 million Americans have diabetes. So if you reflect on that, and if you think about the fact that 19 million Americans engage in same sex behaviour, it will give you a sense of how many of these individuals lesbians, gay, transgenders, bisexuals that you come across in your office, some will self-identify and others won't. Next slide, please.

The other piece of information that's interesting is the generational trend in the percentage of LGBTQ people within the population. What we see is that with each generation, there's an increase in percentage of individuals who appear to feel more comfortable self-identifying as LGBTQ. So if you think about the baby boomers for example, just 2% of baby boomers, and those are people born between 1946 and about 64, self-identified as LGBTQ. Fast forward to Generation Z, people born between 1997 and 2002, that percentage has increased eight times, 16% of that population will identify as LGBTQ. And this trend is likely to continue, thereby underscoring the need for providers to increase our understanding of the complexities of this population, their life experiences, and the challenges that they face related to attitudes, interactions, and engagement with providers and healthcare systems, care delivery settings in both the clinical and the nonclinical space. Next slide, please.

The other piece of information that's interesting is how the LGBTQ population is represented across the country. Now, it's interesting that when you actually look at the data, it runs counter to some of the stereotypes that portray the LGBTQ community as being heavily represented in specific states. So for example, most people assume that you have higher numbers of LGBTQ people in California or in New York. However, when you look at the numbers with the exception of DC, where about 10% of the population in

DC is LGBTQ+, the range in percentage between the other states is really just about 3%. So, North Dakota has probably the lowest percentage, and this is self-identification by the way, of about 2.7% and California, New York, Nevada, Washington, Oregon are just about 5.3, 5.5%. While this variation appears small, it's important to remember this is self-identification. There are many LGBTQ individuals who are in the closet, so the numbers are the definitely higher than these self-identification rates will imply. Next slide, please.

What's really concerning, as we look at this through a clinical lens, are the disparities in care and disparities in outcomes. So within the LGBTQ+ community, individuals in that community are twice as likely to have a behavioral health disorder or disease diagnosed in their lifetime. The rate of suicide in that group, the young adults in that group, is four times greater than their peers. From the chronic condition standpoint, LGBTQ individuals are more likely to have chronic conditions and are more likely to have functional impairment resulting from their chronic conditions. In addition, LGBTQ individuals are more likely to inappropriately use the emergency room or actually access the emergency room for standard care. And they're more likely to delay care, which poses a threat to their preventive services and to health outcomes.

Transgender health is also an issue. Transgender persons are twice as likely to report impaired functional status that impacts their activities of daily living. And about half, actually more than half of transgender who sought coverage for gender affirming surgery in the past year were denied care. The other piece, I think it's important for us to recognize as we move further into this discussion, are the trends in fertility management, right, within this population. And among millennials of about half of LGBTQ individuals report that they are planning to build families and to have children. And about two thirds

of LGBTQ people are planning to use assisted reproductive technology to become parents or turn to foster care or adoption. Next slide, please.

What's also concerning are the trends in youth mental health. So if we look amongst the young LGBTQ individuals, incidents of depression, suicide, isolation are higher. They experience significant rates of bullying and rejection from their families, and this all translates into increased suicide rates. The other piece that's important to recognize are the impacts of social determinants of health. So about 40% of all young LGBTQ adults have experienced or are experiencing homelessness. And then you think about challenges that they encounter within the he healthcare system, Dr. Garrido is going to speak to some of this with her cases, challenges around end-of-life care, challenges around their identities being inappropriately disclosed to family by care providers, financial institutional legal barriers within the healthcare system that preclude or interfere with decision making or with access to care. And very often, particularly in situations where a spouse, an LGBTQ spouse, might be supporting their partner through a challenging illness, they very often encounter invalidation of their relationship by healthcare professionals, within care delivery systems. And in a way at the moment when they truly need compassionate support, they find that their grief is disenfranchised.

I think the other piece that we really should, should, should, should think about is the reason why we're having this session today. When we look at medical education, be it undergraduate, postgraduate, right, residency, on the job training, continuing medical education, regardless of discipline, the amount of time actually spent training and teaching around LGBTQIA issues leaves a lot to be desired. And in fact, the median amount of time in most medical school curriculum is five hours throughout the entire span of training. And all this sort of bleeds in and ends up impacting quality of care. And

generally, issues around stigma, just simply lack of awareness and in sensitivity to the unique needs of this population drive several of these gaps in care. So, at this point, I'm going to hand it over to Dr. Garrido who's going to go deeper into the clinical aspect of this topic today.

Dr. Garrido: Thank you so much, Dr. Wilson for that captivating -- your captivating insights into why this is so important to discuss, to continually bring up in conversation and within our offices. Okay. So we're going to now go through some cases, and first we need to review basic terminology. So last module from last year, we focused on terminology. So, what's the difference between sexual orientation and gender identity. So those two get confused a lot so I'm going to hone in on it. The verbiage of LGBTQ, what do those words mean? And then the approach in the clinical office, how do you approach a patient? It should be no different based on what they look like or sexual orientation or gender identity. But I'm going to just reemphasize this with non-gender greetings. So really focusing on, hello, how are you today? You don't have to say Mr., Miss, et cetera. Okay? And then making sure that you provide the respect and privacy, that patient, all patients should be expected from us. And then I'm going to go over three clinical scenarios. Okay?

So let's start right now with just basic terms. Dr. Wilson talked about this, and then I'm just going to review, L is for lesbian, G is for gay, B is bisexual, T transgender, Q is queer, and plus includes other sexual and gender minority people. Now, the difference between gender identity and sexual orientation. So gender identity is who I think I am, who I feel I am, sense of self. So, I am a woman. Okay. I feel I am a woman. I was born or assigned a female at birth. I have female genitalia and I identify as a female, so that's my gender identity. Sexual orientation is my attraction to others, so who I am attracted

to. So in my instance, I identify as a lesbian, I'm attracted to other women, females. Okay. So examples of sexual orientation are heterosexual, homosexual, but you don't want to use homosexual because that's a term that is antiquated and actually quite offensive, because just the historical reason for that.

So some people identify as gay. I say I'm gay, sometimes I say I'm queer, I'm lesbian, I'm pansexual, asexual. There's so many terms that it's hard to keep up honestly. But just asking questions to people will enlighten you. So personally, I don't know all the terms. And the younger people are, the more terms there tends to be. And I just ask them, what does that mean? Because a term for me could mean something different than a term for you. Okay. And as you can see here between gender identity and sexual orientation, you have queer in both. So somebody could identify as queer as their identity, as like the gender they feel, and then as their sexual orientation. Okay. So let's start with our cases.

So the first case, you are working in an urgent care, all right. I just want you to be working in an urgent care and you see -- somehow you know that the patient you're going to see is a gay man here for URI. Okay. How you know this person's a gay male? I have no idea. You just know that. Okay. So I want you to imagine what this person looks like, because we all have stereotypes. Let's be honest. We have stereotypes of what a gay man looks like. All right. So you knock, knock, go in the door and you walk in and you look at your paper, there's male, and you look at the person and they have long hair, long nails, all makeup and you are a little flustered. You're not sure if you're in the right room. Right? So you're like, oh, what's your name? Am I in the right room? So the first thing I want to emphasize is be aware of your stereotypes. But more importantly, this is a routine URI. Okay? Don't be stumped by the person you see, because people appear

differently, have their own sense of style, and you cannot assume what that person kind of sexual orientation or gender identity is unless you ask.

So what I wanted to focus in on is, what do you do? So first thing you do is ask their name. Hi, good afternoon. What's your name? You look at your paper. Okay. Does that name match? If not, just say, oh, is that your preferred name? Just so I put it in the computer. Okay? Number one. Number two is don't use a -- try to avoid using gendered greetings. So hi, sir, how can I help you? Just say hello. No sir is needed. Okay? Okay. So you go about asking this patient what they're there for and you just focus on the URI. Okay? So the whole point of this case is, what information do you need to know? I want you to focus on need. You need to know their name, and what they're there for. You don't need to know their sexual history. You don't need to know who their partners are. Nothing. You just need to know what their main issue is, which is the URI, and their identifying information. Okay?

Now for me, when I have a patient, for example, I always ask a patient what their name is. I don't always do this actually, but I try to. Once I know patients, I call them by their name. But I remember a patient that I have come to, because I'm a PCP, I've known for several years. And after some time, I would call her name, referred to her name on the chart, and she would like kind of like would be irked by me saying her name. She'd wince a little bit like I was hurting her when I said her name. So I said one day, "Is this name okay that I say, and can I call you by another name? I'm concerned I might be hurting your feelings." She said, "Actually, yes, thanks for asking. I would like to be referred by this name because my birth name, my assigned name, I have a lot of trauma associated with it." So since then even more so I emphasize asking the patient their name, the way they want to be called. Okay? So especially like, let's say you're calling a

patient, the staff is like -- MA is calling a patient in the waiting room. Don't look at the paper and say the name. I don't recommend that. I would say if you know the person, go up to them and say, what's your name, ask them what their name is and then see if it matches. Okay.

All right. We're off to the second case. Okay. So the second case has to do with a 40 year old transgender male here for an outpatient visit. So this is just a routine annual visit, and you know a little bit about this patient, but not that much. Okay? So first of all, let's get terms -- let's orient ourselves with the terms. Transgender male. So this person is a transgender male, so he identifies as a male. Okay? Male, and is transgender. So, because transgender is there, this person was assigned birth as female, the gender female at birth, but now identifies as male. Okay? Now he reveals that he's in a monogamous relationship with a cisgender male partner. Cisgender means that's the same gender. You identify as you were assigned at birth. So this person was assigned a male at birth and identifies as male. Okay?

So, and this patient identifies as queer. So queer, in this case, you would have to ask the patient, what does mean to you? Right? Because the person is transgender male and is in a relationship with a cisgender male. Okay? So again, what do you need to know, need to know? In this case, I would recommend asking, well, how's your relation? How long have you been-- just like a normal relationship, right? Because when I was younger and I came out to a PCP and I said, I was a lesbian dating a woman, I mean, the conversation ended. The doctor did not ask me any additional questions. It was like, I stumped the doctor. But you know, and when a patient tells me, oh, they're in a relation with whomever, I just ask, how long have you been together? Are you using any sort of

contraception? Right? Or safe sex practices? It doesn't matter who you're having sex with. These are the questions I ask.

So in this case for a physical exam, is a 40 year old transgender male, so what I want you to do is remember that although the patient identifies as presents as male, right, that's their gender identity. They look like a male to you, right? But internal organs, that person may have a uterus, cervix, you know, breasts. So what you want to do is do what we say is a general organ inventory where, okay, this patient has a cervix, is it time for a pap smear? If so, it's a routine pap smear every three to five years, unless a normal prior. Okay? You should ask when the last LMP, last menstrual period was regardless. Okay? Just like routine, ask for a urine sample, always check for pregnancy. In this case, this patient has a uterus, this patient is having sex with a patient that has a penis. So they could in fact, get pregnant, this patient.

Now let's say a patient in this case, in another case, had a mastectomy, bilateral mastectomy, so breasts were removed. You don't need to do a mammogram. If the patient had a hysterectomy complete, you don't have to do pap smear, no indication. So I have a patient on the first visit as a transgender male had both top mastectomy, hysterectomy. So for routine preventative care, no indication for mammogram, no indication for cervical cancer screening. Okay? So we kind of reviewed this a little bit. So just remember what somebody looks like on the outside may not necessarily mean what they have on the inside. Okay. So I, for example, I have very short hair. With a mask on, I get called sir almost every single day. Right? I don't identify as male and my internal organs are female. So I would need a pap smear, mammogram.

This number three is very important because sometimes I think we may overlook on checking for pregnancy. So, I'm not offended as a lesbian, when I go see my PCP, if that person gets a urine sample to check for pregnancy, even though I'm a lesbian and I have a wife. Okay? Like, by all means, I'm not insulted. You're doing your due diligence. Okay? Now, if this patient was a trans female, meaning a patient identifies as female, right, presents as female, but is trans female, that means they were assigned male at birth. They have male genitalia, and they present as female. So therefore, you screen them for prostate. You do prostate screening when age appropriate. Okay? You don't do pap smear because they do not have a cervix. You don't do anal paps because we don't do that. And that's pretty much it. Okay. So let's go to the last case.

So the last case has to do with more advanced directives end of life care. So you have a patient coming to your office for hospice services. This is a female in her sixties with metastatic breast cancer. You've known this patient for a long time. Now this patient happens to come into the office with another female. So how many times has this happened, where you see two women together and you assume they're friends, they're friends, they're friends? So this happened recently to me where a patient came in, was a female patient came in with her partner, female partner, and the partner was referred to as a friend. And I know these patients. So, the patient's partner told me, you know, "I was just called friend." And I said, "Did you correct them?" And she said, "No, I just feel that, you know, I don't want to embarrass them." And then I talked to my staff later and I said, you know what, it's just important just to be standard with everyone. So, when you see a patient that has a significant other with them, no matter what gender or race or any demographic you just ask, "Oh, what's your relationship to this patient?" That's it. Don't assume. Okay?

So in this case, this patient has a female partner and they've been together for 40 years. Now, this has happened to me where I didn't know a patient identified as LGBTQ. Okay? It's like Dr. Wilson was saying, how hard sometimes it could be for us patients to open up to our providers because we don't know how that provider and staff will treat us thereafter. So I've had patients who I've known for several years and I was the first person they came out to. And this person that I'm referring to had a female partner for 30 years, didn't tell anyone. They were friends. They lived together, and they were going actually through a breakup and she opened up to me and disclosed that to me. So if you give patients, people, just a little bit of time and you try to get to know them, they might feel comfortable enough asking or disclosing that information.

So in this case, what do you need to know? So, I want to focus again on what do you need to know? So you need to know this patient has terminal cancer, right? You want to talk about when they're lucid. When somebody is well enough, it doesn't matter their age or where they're at in their prognosis, you want to talk about end-of-life care. And so you want to see if there's advanced directives, power of attorney, any person that could have surrogate decision making abilities. I've had this, I personally -- it doesn't even matter if you're old or young. I went through this when I gave birth to my son, with my wife. I had issues with putting my wife on the birth certificate, you know, and it all depends on who you interact with, if they are aware of what our rights are or not. And if they feel like not helping, they could just say no, and you could be helpless.

So when I was postpartum, just like trying to survive, the person in charge of completing the birth certificate came into our room, just the two of us with our baby and said, "So, who who's the father of the baby?" And no one. Parents. So, parents, we're both parents, and mother and mother. And it took a little bit of forceful talking to by my wife,

demonstrating the marriage certificate. How many of you bring your birth certificate of your kids with you when you fly? Like we do that because, you know, you never know who's going to question our parenting, you know, if we're parents. So at this point I would like to bring in Dr. Wilson to also share her story in the medical system and highlight the importance of this. Dr. Wilson you're on mute.

Dr. Wilson: Thank you. Thank you. Thank you so much, Dr. Garrido and thank you for going over the cases. Really very insightful. Before I share my story, I do want to preface that by saying that several of these breakdowns that you've referred to are not intentional. And it's really a question and that's why training sessions such as this are important. So just wanted to say that we are all impacted by unconscious bias and I think approaching this with intentionality and recognizing bias, I think is a good first step. So Dr. Garrido, I'm a lesbian, married to a lesbian, legally married. And this happened about three years ago. I was out of the country on business and my wife was back home in Houston. My phone rang and when I picked it up, my cell phone, all I could hear was my wife screaming on the other end of the phone all the way from Houston. And I wasn't quite sure what she was saying, but I could tell she was in pain. I could also tell she was driving. So I asked her to stop and I asked a friend of mine to call the ambulance, right?

So I was doing this from outside the country. Didn't really have any idea of what had happened. And my wife ended up being taken to an emergency room. So you can imagine I was pretty distraught. Somehow, we were able to track down what emergency room she'd been taken to. And I called the emergency room from out of the country, introduced myself. I said, "This is Dr. Margaret Wilson. My wife has just been brought in. I don't know what's happened to her. I mean, I really would appreciate some information." I went on to say really quickly that I am aware that you cannot provide me

with the information. I was speaking to a nurse in the emergency room, so I'm going to send you my durable power of attorney for healthcare. "Could you give me your fax number and email so I can send that, and that way you can speak to me?" And she said to me, "Who are you again?" I said, "That's my wife." And she said, "Do you mean your husband?" I said, "No, we're a lesbian couple. That's my wife." And she said, "Well, I can't give you any information." I repeated again that I would send her my durable power of attorney for healthcare, at which point she cut me short and said, "I'm not interested in that."

I still gave her the grace and thought, well, we're 10% of the population, she may not be familiar with how to manage couples. So like you, Michelle, I carried my marriage certificate in my phone. I offered to email that to her as proof that we were legally married. And she said to me again, "I'm not interested in any of that information." It took me calling our attorney in Houston who then called the hospital and got them to accept the documents. I've done a lot of reflection after that. And, you know, we had breakdowns, I think in three areas. One, I am a physician. So I had done my due diligence and made absolutely certain that I had a will in place, advanced directives, durable power of healthcare for both my wife and myself. And I was carrying my marriage certificate in my phone. Not a lot of people may know to do that in the LGBTQ community, especially if they're not clinical. So that's one point at which it could break down. And I think that it's our role as providers to ensure that those discussions have been had with our patients who are members of the community.

The second area where I think that broke down also is really around unconscious bias mitigation. I think it's important that we have training such as this, both in and outside care delivery, and we have processes in place that help guide the staff in how to deal

with LGBTQ couples or people. And I think the third is recognizing that sometimes it's all about a human factor and recognizing that these relationships look different. I of often ask myself what it would've taken for the nurse to just walk across to my wife and say to her, "Someone's on the phone, Margaret Wilson, is that your wife? And can I speak with her?" But that never happened. Thank you, Michelle.

Dr. Garrido: Thank you, Dr. Wilson. All right, well, we're going to go to Sarah and go over Q&A.

Sarah Chart: Yeah. Great. Thank you. Thank you, Dr. Garrido and Dr. Wilson for sharing this information with us and also for sharing your personal experiences. And we're grateful for this educational session today. Clearly there is a lot of education needed in this area. I'm going to go into -- we've had a number of questions here. One of the questions here, I'm going to address this to you, Dr. Garrido, because I know you're going to be providing us with some resources. There's a question here about, are there any guidelines or resources that you would recommend reviewing that would improve care for the LGBTQ+ population?

Dr. Garrido: Yes. So there are so many resources online. We're going to collate them, but Stanford Medical School has a great -- basically all the resources I could think of is in this -- on their website. So we'll provide that at another time. I also like UCSF med school, WPATH Gay and Lesbian Medical Association, and also for transgender health, which is what I do with my patients, is I like the Endocrine Society of Clinical Guidelines. It's an app. And so on that app, you go -- it's for to initiate hormones, routine kind of follow ups, what to look for, surveillance and things like that. So I would definitely recommend that app. I even tell my patients to download it just for their information.

Sarah Chart: Great. Thank you very much. And I know you'd mentioned before we got on the call that you have some resources. So if you are able to send those to us, what we can do for the learners is make sure we post those with the on demand webcast when that's available.

Dr. Garrido: Perfect.

Sarah Chart: Another question, Dr. Garrido, I'm going to address to you, what is -- this is related to pronouns. What is the appropriate way to ask a person how you should address them?

Dr. Garrido: Oh, okay. So how do you address -- like what pronouns to address another individual?

Sarah Chart: Yes, yes.

Dr. Garrido: So basically what I do is I just introduce myself. I'm Michelle Garrido and I use she/her as pronouns, and I have my little sticker on my ID that has those pronouns. We have them for our staff. And what are your pronouns? How do you identify? Some people use, she/they, or he/they interchange -- they could use it interchangeable. And so I just ask, what's your preferred? You know, how would you want me to call you? And if you're just not sure, just don't use a gender, just don't use it. That's kind of my recommendation.

Sarah Chart: Okay. Thank you. Dr. Wilson, do you have anything to add?

Dr. Wilson: Yes. Just to add to that Sarah, you know, pronouns are evolving. So, they're different pronouns. We're familiar with he/him, she/her, they/them I came across a person recently who wanted to refer to as we/us, right. I've come across it/any. They're evolving. And I think the thing to remember is another individual's pronouns are not up for negotiation. So whatever pronouns they offer up to me are the pronouns they choose to be their preferred pronouns. Now the reality is that sometimes it can be difficult to string those pronouns into a sentence, right. So we/us for example, it can be a bit challenging. So then Dr. Garrido's solution is really what I do. I use names. So, Sarah left the room, Sarah's come back in, I'm going to examine Sarah. And that way it's just so much easier and more comfortable for both, particularly if one is challenged with how to string the pronouns together.

Sarah Chart: Great advice. Thank you. On that note, another question here, what does it mean to identify as they? So if a patient identifies as they or them, should you address the patient as Mr or Mrs.?

Dr. Wilson: I'll be happy to take that. The whole sort of concept behind pronouns is that gender's not binary, right? So historically, gender was believed to be binary. You were either he or she. And the feeling now is that it's fluid and there's a spectrum, and that's where they and them come in. The challenge with that is that titles are still binary, other than titles like doctor, which are non-gender specific. And so essentially again, and I think Dr. Garrido referred to these earlier on, I think what I tend to practice is staying away from the binary construct. So Sarah, I would go for Sarah as opposed to trying to figure out if you are Miss, Mrs., or Miss, right. It's complicated enough in that space. Right? So I think just setting the titles aside and going with the person's preferred name.

Sarah Chart: Great, thank you. Dr. Garrido, I have a clinical question, a clinical guideline question here. So for patients who have had gender affirming surgery, how do we address their issues on an annual physical? So for example, a trans female who may want to have a breast exam and another example, if we have a patient who identifies as male but was born female and has a male partner, do we need to perform a pap smear?

Dr. Garrido: Okay. So we'll do the first question first. Okay. So a patient who has had gender affirming surgery, we'll start with a trans, are we going to do trans male? So let's just do both. Okay. So if a trans male, so this is a patient, a person who identifies as male, gender identity is male, presents as male, was assigned female at birth and had surgery, okay, whatever surgery that is. First of all, you need to ask what surgery it is. It's just a routine question, you should know. So, the surgeries that this individual could have is a bilateral mastectomy, which is remove all the breast tissue, and/or hysterectomy, which is the uterus, cervix, ovaries. Okay. So in the event that a trans male had a mastectomy, do you do a mammogram? So this is a good question. And something that I would say would depend because reflexively, I would say no, like they don't need a mammogram, they don't have any more breast tissue. The possibility exists that if a patient would like a mammogram, probably wouldn't even be a mammogram, honestly, because if there's no tissue, it would probably -- but we could, you know, if the patient would like, order that ultrasound or whatnot.

And then if they still have a cervix, you do s pap smear, if it's indicated within their age range. Now, if you go to the trans female, which is a female identifying person with assigned male at birth, with male genitalia, so do you do a mammogram? Let's say the patient had breast augmentation surgery. Well, as far as I would -- I wouldn't do a

mammogram because they're implants. If there's any concerns about it, you address it with that patient individually. And then with that individual, if they have any like considered bottom surgery, I mean, there's no cervix to do, a pap smear, you would just check for PSA for the prostate. Did that answer that question?

Sarah Chart: Yeah, I think so. Thank you very much. That was very helpful. Thank you.

Dr. Garrido: Okay. Then I don't remember the second question, Sarah.

Sarah Chart: I think you actually got the -- the second question was -- yeah, because you did the male and female. The second question was if you have a patient who identifies as male, but was born female and has a male partner, do we need to perform a pap smear?

Dr. Garrido: Oh yes, yes, yes. If they have a cervix, yes. Just remember, what someone looks like may not necessarily be what organs they have inside. So you have to remember that if I present as male, right, like I could pass like a male, but I still have a cervix, you got to do the pap smear.

Sarah Chart: Absolutely. Got it. Thank you. Dr. Wilson, I have a question here I wonder if you could help with. As a medical assistant, how can we go about educating our patients as far as documentation, advanced directives, marriage license, et cetera? You referenced this as you were talking about your personal experience. Is this something we bring to our doctor's attention to address during a visit?

Dr. Wilson: Absolutely. I would say that should be addressed no different from the way we address it with anyone else. A critical part of primary care is really speaking not just to

medical issues and preventive service, but also thinking about other aspects of robust healthcare, such as, you know, what happens with impaired decision making, advanced directives, who's your durable power of attorney for healthcare. So just the same way we would address that with any other person would essentially be the same way we address it with LGBTQ adults. We often find in primary care that somehow that discussion is often linked with the older adults, but it really should be a standard part of all our healthcare. So I would say exactly the same way. And to the medical assistants, busy primary care clinics, providers are busy, that would really, really be I think a really good practice as you are engaging your patient, to remind the provider or remind the person that they may want to bring that up with the physician and vice versa.

Sarah Chart: Thank you. Great advice. And you're right, we do tend to think of that with older adults. And we should be thinking more broadly. So thank you for that recommendation. Dr. Garrido, a question here, could an example of how you would ask the questions that we sometimes refer to as organ inventory, and what's an appropriate way to raise this?

Dr. Garrido: Okay. Sure. So what I would say is, what you would routinely do with any patient, try to have your practice of asking questions the same. It shouldn't matter what somebody's sexual orientation, gender identity is. So organ inventory essentially just means what an individual's inside organs are. So if you see a patient that is male, for example, right, you're automatically thinking that person is male. You put them in that category of, okay, so for preventative care, prostate and that's it, right? And then you see a female, you say breast and cervix. Now, like what Dr. Wilson brought up is, the terminology of kind of gender of the binary male/female is kind of we're now looking at it as non-binary. So just what someone looks like doesn't mean that's how they identify,

doesn't mean that's what's inside. So that's why it's so important to really get to know patients and ask them who they are.

So for example, I have a patient who is yeah, similar to that first case of the URI, was a female appearing. I walk in, long hair, like beautiful. She's beautiful. Right? And I was like, "Oh, hello, nice to meet you, Michelle Garrido. What's your name? How do you identify? What pronouns do you use?" And this person is transitioning, Right? And so this person's very comfortable talking to me, and it also depends on your relationship. So I was like, "Okay, so have you had any surgeries?" Just like that, like you would ask anybody, have you had any surgeries? If so, what are they? When was your last -- if the patient's older, when was your last PSA for a male that has a prostate? Or when was your last pap smear, if you have a cervix? So I think it could be easy to put somebody in a category when we're so rushed. Right? It's like, okay, you know, I did my due diligence. But it's important to really remember, be present, and just routinely go over those preventative care measures.

Sarah Chart: Thank you. And what I hear you saying is essentially it's normalizing the discussion, ask these questions that you are asking of an individual and rather than making it awkward, it's just a normal, regular discussion. You are with your patient.

Dr. Garrido: Exactly. And if you make a mistake, I mean, that is okay. If you assume that somebody is one gender just based on what they are, and they're like, "No, but thank you," it's fine. It's absolutely okay, as long as you recognize that.

Sarah Chart: A question here actually that kind of leads into what you were just talking about, the example you just provided about transitioning. Do you have any recommendations

for engaging in discussions with patients that are currently transitioning, such as asking about their experience, response to medications, et cetera?

Dr. Garrido: Yeah. And like you were mentioning, just normalizing everything. So what I do is, I start someone on medicines and I see them within a month and I ask them, how are you? Are you taking your medications? Just like any other patient. Are you taking your meds? If so, how do you feel? Do you feel any different? What's changed? What hasn't changed? What would you like to change? Having an open-ended conversation, and oftentimes the patients will just more be excited to share that they're starting to feel like they've always wanted to feel. So it's just an opportunity to get to know that person better. Very grateful usually, my experience.

Sarah Chart: Dr. Wilson, do you have anything to add to that question?

Dr. Wilson: No. I agree with Dr. Garrido's comments.

Sarah Chart: Okay. Thank you. We have a question here. It says, I have friends from the LGBTQIA+ community who do not go to a doctor. Are there any resources that you are aware of for how to find physicians that take care of, or that are LGBTQAI physicians?

Dr. Garrido: Such a good question. So, the question is how does one find a LGBTQ+ friendly physician?

Sarah Chart: Yes. Well, I think what they're specifically looking for is -- I think the question is a resource for actually finding a physician that is within the LGBTQ+ community, but I think

the way you phrase it is, LGBTQ+ physician kind of maybe like where it's like an environment they know where they're going to be treated respectfully.

Dr. Garrido: So, there's two I could think of off the top of my head is Included Health, which I think they're just like mostly telemedicine, and they are all considered I think queer providers. And then OutCare Health is kind of like -- has LGBTQ, I think, self-identified maybe friendly providers on there. So it's tricky because if you want someone who is like -- my PCP is not LGBTQ, but very understandable, very open, and that's perfectly okay with me. My PCP is perfect. To know what they are, I think it would be tricky depending on your insurance status also because in Optum, we're trying to do that, but how can I put I am a lesbian? It's like, I put it when I say I have a wife, but -- so it would take a lot of kind of digging. So those are the two I would think of. Dr. Wilson, you have --

Dr. Wilson: Yes. If I could just add real quick at least one of the things that we have in our United Healthcare provider network, we do have providers who declare, who actually states LGBTQ populations as an area in which they have expertise or interest. So that's one way that we can go about identifying providers who are LGBTQ friendly. So that's one. The second thing that I would say is, unconscious bias runs both ways. And there are many providers who may not declare that as an interest but are actually very open and very affirming. So I would say to the person who asked that question and to her friend, we recognize that many LGBTQ people defer care based on one experience. But Dr. Garrido says it really well when Dr. Garrido says for every poor experience one may have had when they encounter the healthcare system, there are many providers out there who are truly intent on delivering good care.

Sarah Chart: Yes, that's great. Very true. Very well said. Thank you. I know we're at the top of the hour. I'm just going to ask this one last question I saw just come through which I think is a good question. It says many of us are telephonic case managers. Do you have any suggestions as to how to approach an individual when you can't make any physical assessment on the phone, in terms of how to evaluate a patient on the phone when you can't actually see them? I mean, would you recommend, maybe, as you said before, asking how you identify, introduce yourself, and -- or how would you, how would you get that conversation started on the phone?

Dr. Garrido: Yes, that's a great question. I would say, if you don't mind, Dr. Wilson could follow, if you'd like, but I would say, just use kind of like a routine script of course, with everyone. "Hello. My name is so and so. I use she/her pronouns. What is your name? What pronouns do you use?" and go from there. I would just do it with everyone. And if you do it with everyone, you'll just reflexively do it. I don’t know if that helped.

Dr. Wilson: I would agree with that. I would agree with Dr. Garrido. And sort of, I would add a word of caution that when it comes to misgendering, we're more likely to misgender over the phone. Right? We read the voices and because of the pitch, we go with a sir or with a ma'am. I would say phone conversations are probably -- that's a setting in which we need to be even more conscious of the fact that the only cues we have are auditory. And so we're more likely to misgender, just wanted to point that out.

Dr. Garrido: Perfect.

Sarah Chart: Absolutely. That's a great point. We are over the hour. I just want to thank everybody. I'm going to conclude the call now. Thank you all for joining us today on

behalf of OptumHealth education, I would again like to thank Dr. Garrido and Dr. Wilson for their participation and education today. I would also like to thank Optum California for their support of this activity. If you do have any additional questions, please contact us at moreinfo@optumhealtheducation.com. Thank you very much and goodbye. This concludes our webcast.