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LW: First I would like to ask you a few questions about how you came to work at LM and how you came to work in health care.

0:00:19

ES: Sure! So, I started…(I'll start in California)…I started as a travel nurse down at Stanford Hospital (oh, gosh) seven years ago. I had been doing floor nursing, I was stuck down in ICU Neuro unit. I was talking to a friend of mine who asked 'what do you want to be when you grow up'? I really wanted to get involved in some sort of trans health care because I had just… I guess I had had an expectation that at Stanford there would be a certain level of care, that would be a standard or something. Which in hindsight I can see how naïve that was. But I remember being very disappointed at how anyone who identified as genderqueer or any variance at all was handled on a professional level. I expected a certain level of professionalism that I didn't see… often. My friend asked if I had heard of LM and I had never heard [of them]. I was very new to the area; I had been here less than a year. Basically, she had a friend on the board. She contacted them asking if they had any positions for a nurse. They had been looking for a nurse for two years or so. They hadn't found somebody who was a good fit. I think it was about two or three weeks later I had a job at LM as a nurse here. It was kind of a culmination.

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During that time my partner of, now, fourteen years (Fourteen or fifteen years…but a long time, we met when we were young) had come out to me as trans a couple of years previously, but not really knowing what that meant in terms of identity, knowing that he had a trans identity but not knowing in terms of interventions if he wanted anything. After we moved to San Francisco he definitely was like 'okay, I think it's time for me to transition' .

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And so, it's funny. My interests in trans health care was actually almost at the time unrelated to my partner. I had lived in Northampton [MA] previously and had a few trans friends. It was more around just understanding that this was a marginalized community that really needed advocacy and people to get it in the medical industry. Yeah, it was more just around witnessing so much, uh, so many phobias in general in the medical industry when I went to nursing school. That is more where my passion came from, and then when my partner was like 'oh, I want to transition'[I said] 'oh, well, my clinic can do that

for you.' Because he was uninsured at the time, so he became a patient here. And his experience here definitely informs a lot of how run things, if that makes sense.

LW: uh-huh.

ES: So that is how I got involved at LM. And I consider it at many levels my dream job.

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LW: I am also a patient at LM. It's been a really interesting experience. It has done a lot to bridge care for me, because basically each time I moved, I changed providers and I had to start all over, moving from n. ca to Wisconsin, to s. ca. [garbled]

ES: Yeah, that can be so difficult to manage. There are a lot of silos.

LW: You get established once and then when you change insurance plans or change doctors, you have to start all over again, because they don't understand the records or informed consent or what you got done.

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ES: Totally. Yeah. Yep. Which again, for me, we've reached the point, over time I can't wait for the day where it isn't the case, where it is just implied that your provider knows. And that someday…

LW: That they can at least point you in the right direction.

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ES: Totally. Um, real briefly, sorry, I didn't finish up project health, but the other thing we are doing that I think is really impacting… that impacts a lot is the warm line. We call it the trans line. It's basically a web platform at the national level that providers can submit questions on, so its not for patients. It's for providers. Otherwise you'd have to get special insurances and such if its patient questions. But basically since it is provider to provider their malpractice is covered. There's lots of legal issues around that. So right now we have a partnership with Baystate Health out of MA, Fennway, and…(gosh,me remembering things), it's, uh, Fennway Mizone. It's the queer health centers of Philly and Boston. And we all take shifts between Lyon Martin and them.Providers submit questions and we answer so they are able to provide care to their patients. They have a professional outlet for questions that they may consider silly, or questions that they would normally actually ask patients. That's what we've found in the past, that when they don't know, they ask the patient, when really they need a professional contact in order to not objectify or tokenize their patients.

And it's been really amazing. Some folks who now have the support of the trans line have started their own trans clinics and they are becoming known in their community. There are a few I can think of, one in MI, one in Ohio, um, and I want to say it's in Nebraska. Someone recently who was talking to the medical director. She was saying 'Since I've been using the trans line, I feel so much more confident in

my care (and I know that I have the backup), so I'm fine taking on whomever or whatever. ' I never realized how much of a need there was of competent care.

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LW: So it must have taken a while to get a core group of providers responding, socially speaking.

ES: Totally. We had a launch at GLAMA, the Gay and Lesbian Medical Association Conference, (a yearly conference). Which was a great place to start because they have a lot of folks who have the desire or at least the willingness to do it but don't necessarily have the knowledge base or know how. We also run into the issue of providers saying 'oh yeah, I'm GLBT friendly', but trans health care needs are wildly different than a cisgendered gay male's healthcare needs.

LW: Yeah, that's something I would like to talk about too. Mostly around provider specialty listings saying LGBT when they are trans friendly but no expertise servi trans health care.

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ES: So we've found that to be true too. I've met with Kaiser in the past a few times around…they have GLBT friendly providers, but the providers are self identified. When in fact, you can identify as a cis-gay man or lesbian and have no real experience with the trans community unless you've sought it out or its been a part of your life. Or you've actually realized that you need to educate yourself around it in order to provide competent care. Just because you self-identify as part of the community doesn't make you a provider of that community. So they have started to overhaul some of their processes of how somebody gets into that arena of providing care…that they will refer their patients to.

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LW: so, earlier you were talking about some of the other clinics in the US that LM has basically collaborated with in establishing practices for trans health care. When I first started interacting with trans health care in the bay area, a lot of information was coming from a clinic in British Columbia. And do they also participate in these activities?

ES: They don't…not actively. We have definitely used their resources to create our own. They were just so more advanced than we were, from the beginning, around just creating procedures and policies around stuff that were patient centered. And not provider centered.

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It's different. Medicine in Canada is different than medicine here. And so we've always found that..well, not always…well, what I would say anecdotally:

We also provide a provider rotation here. [It's] a trans clinical rotation for nurse practitioner students, physician's assistants and md students. We used to have international students coming in, but the practice of medicine is just so different that it was creating…it was almost like two different languages in

a way. And so, though they wanted to have access to learning trans care. There were so many other barriers first to overcome, in terms of them just learning US care, that it was too much. Unfortunately.

So no real collaborations with Canada, we're just utilizing the resources that they are providing to create what we've created. Between them and WPATH.

0:10:00 [notetaking pause]

LW: One of the things that I am also looking into is a program being developed by the UCSF Center for excellence in trans health, (I believe that's what it's called). They are developing recommendations for data structures for things like gender markers and preferred names and stuff like that. Is that something that LM has also participated in?

ES: We haven't participated with UCSF specifically around that. They are definitely very much academia. And I think…generally, again, it's different languages. And you know [laughs]… We haven't necessarily always been included in what they are doing. Per se. Though we will; We do stay in tune with what they are doing to see if there are any practices that we need to be changing. Just because we want to be doing what is recommended as well, if we are not making recommendations.

So in terms of collecting [data], they were kind of specific. I am trying to remember what they had come out with. It was around asking your born sex first, which we have always done. I should have grabbed a copy of our intake form. I don't have one here.

LW: At some point I was going to ask if I could have copies of those forms.

ES: Yeah.

LW: Because I have copies from my own records, but I wanted to talk to you about using them.

ES: Yeah, I can give you that. And we've been updating them as well over the years as anything comes out, just to make it better.

LW: I am really interested in some of the processes around updating the forms.

ES: [laughs]

0:12:02

LW: just in terms of how you think about it [as an evolving series of documents].

ES: That's interesting. So, I'm going to be a little bit like 'oh, goodness. What went into that?' Unfortunately, our forms here have always been very loosey-goosey. Right? Where it's no ones particular job description, but it's more like 'a patient has complained about this, this is something we should bring to management and talk about'. Or our staff members. I mean we are community as are a lot of the users of our clinic. It's kinda always that fine line.

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LW: My general question has to do with the inclusion and discussion of input from the bottom up as well as the top down.

ES: Oh definitely.

LW: So in thinking about some of these tensions and how they might scale up for some of the larger organizations. So I was wondering if you could talk about the feedback loops and how they incorporate input.

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ES: So for us it is definitely very much….well, I don't know if I'd say from the bottom up, but those are forms where if we say that we want to be a safe place for people to explore their health and create change that they desire, then that starts right from the beginning. And when you talk to any patient in the past who has ever experienced something other than a warm and welcoming environment, it can start right with the forms. That realization was early on for LM. I know for me, when I came in , a lot of the forms already adopted that in a way. They had already been talked about and discussed to make sure that we were…It's not just about the provider getting the information that they need. It's also about the patient feeling like they are represented among the forms. And learning about that.

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ES: Just recently we've been noticing patients that are choosing other [for gender markers] and only using their first name and no pronoun. Like never [using] a pronoun and only a first name. And I was like 'oh, that's a new trend, we should add that'. It's a growing community in that way; language is growing. So it's just making sure… We don't necessarily have a way to stay on the pulse, but if we have a patient or two doing something different, we definitely note that if we need to update forms. We want to remain as flexible as possible to be able to do that. And not lock ourselves into something from 1988 that only has transsexual and crossdresser. You know? Something that is so irrelevant to how the community is today. Does that make sense?

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LW: Yeah. ☺ It's part of this interesting question of how do organizations think about change and evolving languages of representation. [garbled, something about how they plan for change and adapt]

ES: So for us, we have hit a major, major roadblock. We are still on paper charts. We were supposed to go live with our EHR [electronic health record system] last year, in July. We chose a vendor, they said that they could have it. We told them 'this is our patient population, thirty-some-odd percent of our patients identify as trans, genderqueer or gender variant'. We cannot have the system not work for us. And they told us, 'we can definitely do that'. But then once we actually went live with the EPM portion (the billing and scheduling portion). We created some work arounds; It's still not competent. We ran into issues after the fact. It actually genderizes…It puts blue male symbols and pink female symbols next

to a name based on the gender markers from the insurance. So I had to create a policy in house that said, 'I'm sorry, my employees are not allowed to use half of the screens you provide because they are offensive to our patients'. So we have to create workarounds within the scheduling system even just to make it work for us….which there is an element of '[this is so] typical' right? [sigh] That it is always the case around queer community in general, having to make it safe for us.

0:16:45

LW: I was just going to say, in the last year or so the NIH has been soliciting input on health research and lgbt populations.

ES: Recently I was talking with someone at a big conference in dc and there was discussion of how federally there is a big push around appropriately getting data on the trans community. And that conversation is amazing. When I talk to people, it is still very limited in terms of the scope of what they are thinking about. Again, it's about …The thing is that it requires so much flexibility in the system, which IT is not about flexibility in the system.