2023 Virtual Women's Health Seminar Day 2 Transcript

Please use the raise your raise hand function. And if you would like to function so that way the presenter may call on you. Or you may type your question in the chat box so the presenter can address it. We strongly encourage asking questions and staying engaged during this question. Answer sessions. However, we kindly request that all participants stay muted during the presentation itself and save their questions until the question answer session. Today's seminar will conclude at approximately 1400 Eastern Time. Our first presenter for the day is Lieutenant Commander Eubanks, Lieutenant Commander Eubanks, thank you so much for being with us today. I'll hand it over to you for a brief introduction and to kick off our first session of the day. I see my slide up. I don't know if everybody can hear me or if we're waiting a little bit longer. We can hear you loud and clear. We can hear you like. OK. Everyone to wait a little bit. Or do you want to go ahead and start? You can go ahead and get started. OK. Umm, so I'm gonna tenant Commander Eubanks. I'm a OBGYN. I'm currently stationed at Rota, Spain. And. And I don't know. I'm sorry. Do I have control of the slides or do there we go, OK. And so I have no disclosures and kind of I think this is the same for everybody, no disclosures and this is a activity that has been managed by DA and they abused in this presentation don't reflect the policy or position of the DoD or the government. So today my discussion is just gonna be to discuss the different sub community boards and the ongoing efforts that the Women's Health group are have put together. I think that it's incredibly important to. You know, this conference alone demonstrates that how important this knowledge is and the beautiful thing is that a lot of these discussions have an incredible resources. We just have to know where to find them and what they are. So the Office of Women's Health and it's underneath the medicine. And really the goal is to keep as many of our sailors and marines ready, you know, readiness is the end goal. And and in order to do that, we are focusing primarily in our division on Women's Health and what we can do for our female sailors and marines in order to keep them ready. So we're gonna, we're working to improve health literacy. So really just knowing more about your body as a woman or your sailor and Marines bodies as providers and how do we optimize that in terms of readiness. We also wanna continue to create a culture that's accepting of female sailors and marines. And that Women's Health problems are not taboo. I think, you know, we've done a good job over time to get. Better and better, but we certainly have a lot of work to go where, you know, we can say the word period in front of a coworker and not everybody has to turn bright red. And then a lot of this is also shaping policy. So especially in the recent times where there are some changes to policy, federal policy and state policy, we work to make sure that the policies for our groups aligned with what we think is important and know is important for Women's Health. So one of the things one of the ways we're doing this is the embedded Women's Health provider program. So E WHP basically it's to ensure that there is a Women's Health provider in appropriate billets, which the goal is to be operational billets. So that there is always somebody in that in that division who is a capable of handling Women's Health concerns that sailors and marines have a a person that they can go to that they feel comfortable with. And you know the goals are gonna be this contraceptive care. Well, woman care. Menstrual management, screening for STI's, Pap smears and pointed care. Pregnancy test. So again, you know, while the GMO's and Heidi C should be able to do that, if we really embed a Women's Health provider, a manage, maybe a little bit more of the complex issues and be kind of identify this person as a safe person, you know, comfortable person. So that sailors and marines feel comfortable. And we're trying to expand this, uh, after the very successful pilot, which ran from October of 2020 to May of 2021. And and so the goal is to expand this and really bring that to as many different. And billets as possible. Right. Uh sorry U M1 side back the right now the family medicine physicians will end up filling that position. We had talked briefly about you know

OBGYN's or midwives, but our family medicine physicians right now will primarily fill that position as well as GMOs and Omos. Umm, but if you can see at the bottom, you know we've got actually tangible duty hours based on preventative women's healthcare. I know it's in the next slide. Thank you. Umm, so then the other big change? Umm, that's happened really in the beginning of this year end of 2022. Is that the walk in contraception clinics formally known as Pink Clinics? If you've been in a facility where you've had pain clinics that originally pink is processed improvement, so it's no longer a process improvement project. It is now just a stand in walking contraception clinic and many MTFS did have it but. And we, you know, we had 24 and MTF that we had walking contraception clinics. And by the end of this month, actually 31 January, every MTF is supposed to have a functioning walking contraception clinic. And the benefit of that is that previously that women would have to come in for a pregnancy test and counseling and then come back for their contraceptive care. And you can imagine getting two different appointments at two different times is hard to get approved by your command. Also, that delay in care. And can lead to pregnancies. And so if you can make it as easy as possible and it's a walk in, right. So you don't have to have an appointment if you just happen to have that time off, you can walk right in. And I've been at big facilities in small facilities with it and I really waiting is is not as much of a concern as I think a lot of people have. But these these clinics are for active duty service members and eligible beneficiary. So dependence as well, which I think is a misnomer. And. You know each location has different times, so here in Moto we do Wednesday afternoons. In Okinawa, we just came from. We did Thursdays all day. And so each MTF just make sure that if you're interested in that or you're interested in volunteering for that, that you pay attention to when that is every we're all supposed to have the same website available to advertise what we do. But this isn't just for initial contraceptive care, but each facility should be available for counseling on Plan B, care counseling for tubal ligations. Umm and STI screening is offered at each of these, so you know certainly the long acting reversible contraception are larks are really the biggest result of operational readiness. If you can prevent pregnancy and effective long term manner then that really is the goal. But these clinics are open for any and all even removal of IUD's or removal of an exponents. So look out for wherever MTF you're stationed at. There's a WIC clinic that should be up and running by the end of this month. So the BMN Office of Women's Health. And and then you know the leadership and the operational providers are really focusing on. Uh, certain proficiencies as the requirements. And so the operational providers are capable of caring for under the Comprehensive women's care, so. And that is a long way of saying we wanna make sure that every active duty woman, especially before this embedded Women's Health care provider, is. Is up and running. Has access to comprehensive care. So how do we how do we ensure that? And what competencies do the Office of Women's Health feel that IDC GMO's? Umm, you know, deployed physicians, what competency should they have in order to really support our women in the in the fleet? So the competencies are, you know, provide basic preventative healthcare to female service members. So to be able to talk about self-care, to be able to talk about personal hygiene, preventative practices, you have to be able to recognize Gwynn concerns that are gonna escalate very quickly. So how do you recognize a next topic pregnancy? How do you recognize a hemorrhage, things like that? You have to be able to diagnose pregnancy. And there are emergency pregnancy situations. So I could just said traffic pregnancy. Pilon afridis. In pregnancy, things like that. And how do you get that person out? How do you stabilize them and how do you, where do you go? And and then you have to be able to talk about all the different contraceptive options. You don't have to be able to do a tubal ligation, but you should be able to talk about it. What are the risks? Are the benefits and you know, be able to have these conversations with your sailors and marines. And we have talked, we've gone back and forth a

little bit about next one on credentialing. So that's the implant in the arm. And it is not a requirement, given that next one on the company is a, you know, a little bit of control of who we credential and who we don't, but at least be able to talk about it, benefits, risks, things like that. But ideally we would get people's credentials that. So that's kind of our 4 1/2. Recommended proficiencies. And I mean, you can see from the statistics on the left, you know less than you know about 1/4 of GMO's. And IC's felt really that they weren't adequately trained on Women's Health. And that's not fair to them to put them in that situation. It's also not fair to our female sailors and marines to be putting them out in the field with a providers that can't accurately or even feel comfortable talking to them about things. And so the important point of this is that the operational provider Development Working Group has established a curriculum which really addresses these 4%, four and a half proficiencies and working to create a training similar to this. That's specifically for GMOs and Idcs. They're gonna be operational. And how do we get them ready? And and you know, again, in a quick training, we can get hopefully people comfortable with these proficiencies that we feel are absolutely important to be deployed with female sailors and marines. Next slide. So hot topic right now, I know that there's been a lot of questions at my facility. I'm sure at every facility is you know, what do we do now with Roe V Wade? So you know, they just I think we all kind of understand it. But just in case. So June of last year, Roe V Wade was overturned and that basically said that the federal government was in charge of all the state jurisdiction for abortion care. And since it was overturned, the rights went back to each state. And we're seeing the outcomes. You know, there are different states that are changing their laws about abortion care. And so right now, I mean the bottom line here up front is that Women's Health providers, OBGYN's, are authorized to perform a board of care for what we are calling Tricare covered abortions. So those are abortions that are a result of rape, incest or would endanger the life of the mother. And so at any facility and any MTF, a provider like myself and OBGYN who feels comfortable with this. I'm can perform an abortion in those three situations. And it really comes down to my assessment with the patient to determine those. You know, if if this is a Tricare covered abortion or not any abortion not covered by the by Tricare does have to, does require the service member to go out into the community and which will require the service member to comply with state laws and hail out of pay out of pocket. And certainly if you're stationed somewhere where abortions are not allowed and your state, you may have to pay to travel as well. We are working with Navy leadership and the services as well as the DHA overall to try and limit the amount of barriers that women may face should they want an elective abortion or not. Tricare covered abortion and you know, how can we support our sailors and marines to make this decision for themselves and not have to pay to travel out of state to take time off of it? You know, the limited leave and things like that. You know, uh unplanned pregnancies are very costly to the force to force readiness. And so there is some, you know, military, DHA motivation behind this because women that aren't intending to carry on their pregnancy. And and then, you know, have this unplanned pregnancy is is a hard thing for them, but it's also hard for the military. And so that's the motivation kind of from all the sides. And you know, we wanna make sure that women are are cared for. Umm. And then if there's been some really incredible responses from the leadership, including the one that listed below from the Secretary defense. So I encourage you to look for those things. I they're in several emails. I'm sure from your facilities, but they, they, DoD, DHA leadership has really come out and response to this. So certainly the you know this is a fast changing thing. And so if you have any questions or concerns, you all now have mine. Information as well as the. Leadership hosting this call. And so, you know, look for those emails that with the updates, but also you feel free to reach out and ask you know what new changes are coming through. And next slide, please, and I see a couple of questions in the box. If if it's better for

everybody, I'll kind of wait and see if I answer them and if not, we'll go back and read them at the end. Umm, so the structure of the. Navy Medicine operational clinical community, which is an MOCI think it's important to talk about just you know, how is this? Who, who am I talking about when I'm talking about we are we are right. So it's leaders from the Navy and the Marine Corps and providers that work with the office and Women's Health really. Again with this goal of medical readiness. So the female Force Readiness Advisory Board. So that's what I serve as the vice chair for this is. And the voting body of the. And Navy and Marine Corps or Navy medicine operational clinical community. So these are the providers that are really voting and and making these changes underneath the Office of Women's Health and certainly the bigger changes are coming from higher than our working group and our Advisory Board. And then the. But FRB the fraud overseas 3 subcommunities in two working groups. So the three sub communities that we have are family planning, mental health and neuromusculoskeletal. And those communities are working on their own individual projects and process improvements and handouts and resources for their specific topic. Umm. And then the operational provider Training Development Group and then the Women's Health Seminar Working group. So this presentation is a product of the Women's Health Seminar Working group. And like I just in the last slide, the operational provider Training Development Group is really working to create a. A presentation and A and a teaching resource for GMO's and IDC's to really educate on those proficiencies that we listed. Next slide, please. So just to kind of go in a little bit more detail about each of the step communities, so family planning. Community Board has more than 25 members. You know, they they change as people move and move on with their military careers. We have GYN, we have family medicine, we have midwives, we have pharmacy. And and this community has created 11 treatment algorithms and they have really supported this like a branching of The Walking contraception clinics. And and there are two big resources. I think everybody on this training should be know about is the service member guide for early pregnancy loss recovery from early pregnancy loss. So I think you know that that after a miscarriage you know how do you move forward? What are your resources and what are your next steps? Who should you talk to? And that's an incredible resource there. And then the handout for service members on emergency contraception. So what are your options, everybody you know, always think so, Plan B. But you know, there are many options, including the Marina now. So you can actually have a Marina placed. So you are provided emergency contraception, but also now have long acting contraception. And so really a handout that goes through those things. And so if you you yourself are counseling somebody, you can utilize that but also provide it to the service member to review on their own. And, UM, the future goals for this one is the. Is really that the working on this nurse run protocol to to allow nurses and patients to do a self swab whenever they have concern for abnormal vaginal discharge? So said waiting to get an appointment with a provider and then you know, maybe it's gone, you've already like mistreatment or trying this stuff where you get from the grocery store, how can we again limit the time to treatment and time to care for patients and and get them back into the field? Next slide please. Can I have the next slide please? Alright, the mental health subcommunity. So that's the second one that covers underneath the crab. So this is a sub community that has a psychiatry, social work, psychologist and behavioral health specialists of all kinds, again really focusing on this Women's Health and female readiness. Umm, so there past accomplishments that are pretty incredible as this mental health provider survey and that really was a kind of a broad reaching survey that worked to identify the gaps that we have with current provider capabilities. And in terms of their comfort to treat female specific mental health concerns. So I'm chronic pelvic pain, early pregnancy loss. You know rape incest, right? But from a female perspective. And then using that this subcommunity has really developed their goals and their their

products. So they've developed specifically, again, I think 2 that are really important to know about is the reporting intimate partner violence. So that's a guide to help providers. How do we how do we report this correctly? I think a lot of people want to do the right thing and they you know there there's good intention there but to know you know, who do I even where do I even start? And then certainly the normalizing the military, mental health care. So we've come a long way in the military, even in my time in the military in terms of the taboo of talking about, you know, depression, anxiety and things like that and. But I think that there's still a lot of myths out there. You know, if I tell my doctor that I'm depressed, they're never gonna let me deploy again. And things like that. So again, I think these are both incredible handouts for both providers and patients together. And then there were the SUBCOMMUNITY is working on developing new resources. And so one is really to help support service members after they return from deployment. So if anybody has deployed, you know, that coming back is hard at home, it's hard at work. It's hard. And actually, it's hard physically. So, you know, really focusing on the mental health aspect of that return from deployment. And then also, you know, resiliency I think is is kind of a buzzword right now, but the important Ness of that in terms of overall well, Bailey being and so the other resource they're working on is this kind of self-care and and warfighter resiliency, but kind of in a day-to-day picture. And so look for those to resources here and then it coming months as well. Next slide please. Umm. And this is the links to the. But I'm resources that they also have as well. So and cultural competency so. Again, this is really aimed at operational providers that I think all these resources are are worth looking at, whether you're deploying or not. But kind of that. And understanding of women's readiness issues and what may may arise infertility, I think a lot of people think that the that that's kind of a topic that the military doesn't address. But this resource that they also provide here talks about the options for infertility. And I think one of the things that's often missed is how emotionally challenging and fertility can be. And so this this topic or this resource in particular addresses the options for support during that as well. And then we talked about the other two, but the links are in these these slides here. And the third subcommunity board is the Neuromusculoskeletal, so that's family medicine, nutrition, health, sports medicine, physical therapy, occupational health, occupational medicine. And and this group is really focusing on PT. You know, women's physical health and again, specific to female sailors and marines, so. There's a point paper on pelvic floor physical therapy recommending that we have better support for our sailors and marines with a more access to care of the pelvic floor, physical therapist, and how important that is for females. And you know, again as an OBGYN and it's pretty rare. It's pretty rare to not have a reason to refer somebody to a pelvic floor physical therapist. I think it's one of those. And. Overlooked resources for people, and so this point paper really kind of talked about that. And the UM, this subcommunity has also talked has two more resources, so one is on the relative energy deficiency in sports. So the Reds. And again, this is for providers, but good information on you know, staying physically fit using. Then. Using this resource to really make sure that you're sailors and marines are are, you know, getting the nutrition that they need and the support that they need. And then specific to that, too, the nutrition guidelines and recommendations for service women. So those two resources are attached there as well. And they are developing a self-directed video program to come back from hip injuries which you know, can be very detrimental to your ability to be a, to be ready. And so that will be an incredible resource for. People can do this on their own and providers can can. Provide access to this and sailors and marines can do this on their own and kind of manage their own care, which is incredible. And then kind of this pre enlistment injury prevention training. And is also a point paper that they're working on as well. So how do you optimize fitness for recruit as you're bringing them in because the injuries that are sustained in boot

camp are pre detrimental, sometimes to to physical readiness. And Doctor Maria brought up in that on the last slide with the infertility mental health support. And that I think a lot of people not only do people not realize that infertility is a topic that we can help with often, but there is infertility support for LGBTQ plus couples. And there are they the infertility resource addresses. You know how much care we can provide and and every MTF has different access to care, but you can utilize that last resource on infertility to kind of guide how much we have available. Next slide please. And. So in sum, right, you know where do I find all these resources? Where can I get more information? How do I stay afloat to all of the new products that these subcommunities and the crab and the Navy Women's Health Office and Women's Health they're putting out and that's this website. And we've worked really hard to make this website as user friendly as possible. And you know, basically if you kinda you can use the QR code in this there's a link in this. But if you really type in like Navy Women's Health in Google, this website should come up if not first like second. So this is really the key. This is gonna be you know every time you have a new resource it's updated and we've really broken it down into as many sub talk topics as possible. So that you can easily find things and we've also broken it down into provider handouts and service member handouts. And teachings and things like that. So again, as we're trying to make it as user friendly as absolutely possible. And so really, hold on to this QR code. Save the website you know, sometimes I I will just kind of look through it and make sure that I haven't missed any updates. I think there's incredible handouts, there's incredible posters. So if you're working in an ETF where you're like, gosh, wow, then any other stuff existed. There's actually posters that we've made that have the QR code that have links to things that you can get your command to allow you to put up on all your hallways and bathrooms and. And then, you know, patients themselves can go directly to the resources that you're intending them to find without even having to come in to see you. Next slide please. Uh for leaders? And so we have a we provided a guide which really summarizes the. What we hope that Navy and Marine Corps leaders. I used to really create an environment where women feel comfortable coming to their providers, advocating for their health, advocating for their readiness and providers feel comfortable with. And providing that and if not then they know where to go. So this resource, this guide helps. Address the needs that that women that women should have. And and access to to be ready, and again that keyword readiness. Right. That's what that in the day we want people to be ready, even want them to be immensely ready. We want to be physically ready. We want them to be supported all the way around. And in doing that we need. We need to ensure that leadership is supporting that. So again, another great resource resource that's available especially for those of you on this call that our leaders are going to be leaders. This is where this is where you should be directing your initial attention. Next slide please. So I touched on it really briefly earlier, but the cultural competency guide, another important resource for leaders. But I think too, you know again you everybody on this call is is going to be addressing women's care and that's why you're here, right? So another guy that I would really recommend that you. That you really come through and you really pay attention to the to the smaller details on it. It's got what what has been decided as the 8 high priority needs and details these actions that leaders can take to address those needs. And again it's all in a very simple place. The link is on this page but it's also on the website. Next slide please. And SO4 service members and I've used this one a lot for my patients. So this is the deployment readiness and there's a handbook and there's an app and. The handbook is, you know, printed out. And you can. I've got a copy of it in my office and I show it to people sometimes, but it's a digital resource as well. So you don't have to waste paper and kill a bunch of trees. But you can also just use the app and the app is available and it is very user friendly. And it addresses everything from, you know, financial management before deployment to you know, what do

you should you have a will before you deploy. How would you get one to menstrual suppression? Do you have to suppress your menstrual cycle? How would you do that if you wanted to? If you don't want to, what are your options, things like that. And you know, again, very comprehensive. I think there's a lot of questions, especially for a very junior sailors deploying for the first time. You know, they're not only afraid kind of afraid of all the the regular things to be afraid of what the deployment. But then they have all these questions and. And so this is a way to get all those questions answered, have a resource to look at or spark new questions which I've had more of. I think when you direct people to these resources, people coming and asking questions, I didn't even think of this. You know, how do I how do I get this done? This app showed me that I should be asking these questions. And so again, if you are not familiar with this, then I would go through it yourself so that you can probably talk about it. But on that website, one of the handouts that you can put on the bathroom doors and they are office doors and things. Has a link to the app that end this QR code that takes patients directly to the app. Next slide please. Umm Hennigan, this abortion care that abortion care is a really hot topic right now. I have. I'm patient after patient. Even though this kind of all happened in the middle of last year. And coming into the office asking, you know, what, if questions, what if? What if, you know, what does this mean? How does it affect me? And so again, even though it's very quickly changing, we've put together a handout that talks about. You know what are the? What are the guidelines? What is a Tricare covered abortion? What is a not Tricare covered abortion? Where can providers find resources for the abortion laws and how do we, you know, as providers support our sailors and marines and and. And I think again I think this is a handout that both providers and service members can use to kind of keep their knowledge afloat. And again the only disclaimer I have is it is it quickly changing topic but this handout is pretty general overall. So I think even with quick small changes, it's still gonna be very accurate. And again, this is available on the website as well. Next slide please. So Plan B. So this is specifically for Plan B. The service member guide and that is a type of medication. So we talk about Plan B as kind of this general Emergency Council steps of option. But so the the guide references that, but it actually what's important is that it does talk about the other options for emergency contraception. So it's not just this morning after pill, this Plan B pill, but there are like I said earlier other options what you know how does it matter what? What things to know, like for example, Plan B, the actual medication, if you have already ovulated it will not work as emergency culture section. And I don't think people really realize that. So they say Plan B and they come see me a couple weeks later because now they're pregnant and there like I don't get it. I took Plan B, but if you have already ovulated for that cycle and then you have unprotected sex, Plan B does not. Umm. Impact that pregnancy. So those situations, things like the copper IUD or the hormone IUD may be more effective. And so if we as providers also patients are more educated on things like that, they can make a better decision potentially in that moment when they're trying to find appropriate emergency contraception. So again, this is a handout directed at service members, but always a good thing for providers to be more well educated on this. Next item please. And then the training toolkit so. And we have the toolkit available to everybody. It's got the. The full comprehensive toolkit available, so the training planning guide. So how do we how do we get ready to host a training, the curriculum and the presentation. So the actual link to the. And the PowerPoint slides how you know what it should look like, what the organization of this teaching is. And then I facilitation guide to enhance the training so. And that allows the persons that's conducting the training to go through the questions and and you know what is the important point on this slide to say what is what should I be saying now and this is you know really. At information on the menstrual cycle information on pregnancy, you know the very the very simple, you know things, but you know also very complex and and this is part of our role in in advocating

for Women's Health literacy, teaching women, about their bodies, teaching providers about the menstrual cycle. I think there's a lot of fear. There's a lot of misnomers. There's a lot of unknowns, and that becomes very scary for both providers and patients. And so the more we can talk about it, the more we know about it, the simpler we make it, all the better. And so. There's two, OK, it really allows. Like any platform, you know, if you have a little bit of downtime to conduct this training and that's a really incredible opportunity that we've kind of. And you know, the Office of Women's Health is really kind of handed out on a silver platter. And again, everything is always on the website. So the whole toolkit is on the website. Next slide please. Umm, so this is a big also a big topic. You know. How do you how do you go from having a baby to postpartum care to, you know, returning to duty and coming back to work? And what does that mean and what does that look like? And you know, how do you go through the leaving your baby in daycare or leaving them with it, another care provider and the mental health that how do you run a PT test again after a C-section after vaginal delivery. And so kind of again, it really comprehensive document that. Allows patients and or service members and providers to answer all those questions or even again come up with questions that they didn't even know they had. And and so there is a section on there for, you know, the fitness test. When do I have to run it again? When do I have to get weighed in again? When do I need to be ready? There's links to the applications for birth control, links to the PFA. The application app for your phone, you know to help you get ready, things like that so. Sure. We again on the website a comprehensive care and then look out for some of the things that the neuromusculoskeletal group puts out for postpartum, you know public floor, PT things, postpartum physical readiness and then you know the mental health subcommunity is. I'm in has a input on the mental health aspect of coming back to work and emotional recovery after giving birth and things like that. So incredible resources as well. This is another app I use all the time with patients and I think again people are always shocked because they didn't know it was out and it didn't know was the thing and so it's intended for service members. But there are plenty of times where I help I I advocate for them to to download it and then we go through it together and that way they can show their friends or they can do it again when their lifestyle changes or when they have different opinions, different concerns. So it's called the side and be ready. And it asks, you know, all the all the questions about picking a birth control option. You know, I think a lot of people think that's the pills or the thing that goes inside you. Those are usually what what people come to me with. So this addresses that there are many different types of things. There is different types of pills. Right. And so again, the the QR code here. There's also a really nice poster that you can put up in your office. Umm. Or have access to for patients to have the QR code to even be aware of this app again, I encourage everybody to just download it right now and then play with it yourself. And so that way you can help people kind of walk through it and and show them how easy this is. And that way when they come to the Wix clinic, of course. You're welcome to sit down with the provider and discuss, you know, these questions, but sometimes it's nice to come in and be like already done my homework. Here's what I want based on what I've already learned. So in your free time, download it and and play with it so so I can go ahead and next slide. And all of those things I just talked to about are on the next slide and there's links in every single to every single one of those. If you lose that side or you can't get the links to work. And just go to the website and they're all there. Next slide please. So again, all the all the things so you can see that in the middle of that column, every single thing is on the website too. And alright questions and answers. So I'll start with the ones in the chat and then if anybody wants to jump in with another. And. And another question we can. So I think. This was the first comment here. And. So, doctor, you, thanks for those of us heading to family medicine residency this summer. Are there any opportunities to work in

the Office of Women's Health in any of these projects working in pink clinics, being a part of the operational Women's Health conversation? Absolutely. So again, every MTF should have a WIX clinic. And I know here in Rhoda, I would love to hear somebody wants to come in and and join me. Follow me or, you know, if you are an independent provider and you feel comfortable, you know, credential to do so and then jump right in, I think that's an incredible opportunity, I think here and other people sometimes. Once on birth control and I, you know, I've been in practice for a little bit of time and I love sometimes getting my counterparts Council on things and they just say things in a different way. So especially going into family medicine, residency kind of being out of potentially out of direct Women's Health care for a while to kind of just hear counseling to, you know, get your hands on with next and runs and and ID if your credential to do so, we're just shadow. I'm absolutely. And then there's always openings on these working groups. We're always advertising so. Emailing the the host of this meeting and asking for opportunities. Please please and I think that's a it's a good thing to jump into in residency especially. If you've been operational for while you bring it a different perspective. And if I don't address the question, please refer to jump in and interrupt me or or ask again, or if things, does anyone know if there's opportunities for providers on an operational platform? So again the same thing, right? So jump in. And lots of operational platforms are near in near MTX, so I've got a ton of of ships out in Rhoda here. When I was in Okie there was a bunch of ships with IC's and GMO, so. Please, I know I speak for the all of the providers are working there. Please come by, e-mail your local GYN or family medicine, practice dinners and ask. Because I know people will want to be there. Want you to be there. And. So I see this question from. Uh, Robin White is there a training pipeline for those are interested me coming ones. How train I I guess I don't I I would assume kind of on the. Like IDC platform or I? Or are you looking for marvel like the toolkit we talked about? I mean, that's really kind of basic Women's Health, but certainly impactful. I don't know if I know enough of the specifics to adequately address that question. Feel free to message me independently or ask identify if you can help clarify, so I'll jump ahead and then come back to that. For IDC, who are credentialed to place and move next on, how can we be more efficient if our GMOs aren't credentialed to help streamline the process room and service mode? Yeah, I think that's a hard one. And I, you know, again the goal is to have all of our demos and IDC credentialed. But you know, if you are credentialed, you know that there's, like, this meeting. You have to go to in a dinner and things like that. At least it was, you know, back in my day. But it it it does take a a step over. I would encourage you at this point to see if you can can find a family map practice. Practitioner or a GYN and near your. Near where your station and see if you can work with them to help either train the jammo or. And or, you know, kind of keep your skills up yourself by going kind of, you know, again, volunteering the WIC clinic, things like that. I think ultimately go certainly would be to have all GMO's and IDC's credentialed for our next buttons. So we are working towards that. But we're finding a little bit of a barrier given the. And next we'll on credentialing process. Umm, the next comment? U M1 gap I agree that we need all primary care providers trained in large insertion removal one gap in training is a PA colleagues do not receive vendor training right? So again that that's the problem is East vendor trainings. And the PA aspect, I think is is also hard because we're not going through the MO training, they're going through the LDC training, they're not going through the medical like doctorate training. So it's interesting point and I think I'll, I'll take note of that and take it back and see if we can add that on to the group we're we're aiming for. Question. Can a service Member State it was rape and get an abortion? How would that work? So that is a it's an interesting question so. Umm. When I fill out my paperwork as a GYN for for performing an abortion and MTF. And. I have to ask a certain amount of questions that will. Help me understand the situation better. Trying to trying to. To make sure that that's

what's going on, I will say that. Certainly that's kind of a thought in the people's hands. Well, if you just say it's a rape, then you get an abortion, right? I have not come across that situation. I think there's a lot that goes into this and. I mean, yes, theoretically I think you could do that, but this is not to do with restricted unrestricted. This is a medical facility. I don't have to tell anybody. I don't have to do anything unless I thought, you know, her life was at at risk, but. And she can come to me and say this is what happened. I will inform who the only people that I need to inform and the providers that are involved in this care also have to know that that's the situation and that they can opt in or out. So anesthesia O our nursing scrub text, right, they all have to know that we are performing an abortion for this patient. They don't get to know why or who are in circumstances of that, but they have to. They have to opt in or out of care, so if they don't feel comfortable with that, that is their prerogative and they will will find a replacement. But it's a very closed loop, you know, kind of, you know, must know, need to know. And there are some. There are questions I have to ask to make sure that that the timeline minds up and things like that but. And in the cases that I have seen, I have never been concerned if that was the case. Somebody else's supporting the postpartum return to duty transition guide and then the Marine Corps pregnancy and postpartum physical training guide like absolutely. And they've very nice. Commander Madsen is really nicely linked them in this chat. So please go there. And. Somebody is advertising that. They are holding next on training for incoming GMO's going amphibs that's fabulous. Can you give a link for the Women's Health education for staff? Everything is on the website so that all that stuff is on the website you just go there and then that last page where everything was on. Uh, somebody else is asking for next one training in the Portsmouth area. Uh, would you consider medical abortion or just surgical either? I mean, I, you know, for any of these, like, Tricare covered abortions, you can do either. And most patients, especially in those situations, want the surgical, but you can do either. Man, this person is a Lieutenant Commander is a PA and talks about how they've worked and gotten credentials for everything. So that's fabulous. So again, I think there's work arounds for all this. We just want to make it as absolutely easy as possible. Umm for everybody to get credentialed support. Their failures and marines. Make sure that people are ready, make sure that they got their questions answered. I never want and I never wanna hear somebody say, well, I didn't feel comfortable asking this question and be in pain or uncomfortable or anything like that. So really, that's the goal of this of this office of Women's Health. How do we make sure women already, how do we make sure we got providers that are willing and capable and able to talk to him about their health needs. I mean, again, I think we've come a long way in terms of things being taboo, but certainly there are. You know daily I have a patient that didn't feel comfortable going to the IC. They waited two months to come see me. I I think that that's, you know, that's really what the world trying to overcome. You know how many times I have to pull somebody off a ship because they had to wait to see me and then now I have to intervene with a, you know, a colposcopy or things like that. They didn't want their Pap smear done three months ago and now they've missed their deployment. So. You know that those are the situations that I'm really that I think we're all working to avoid and and it's, you know, not appropriately gotta be able to care for our sailors and Marines and their whole comprehensive care. How do we, you know, get people back from postpartum and make sure they're ready and losing for the team. So the bottom line of this whole talk is that website is everything. And if you have any other questions or concerns. There's links to people. I'm obviously on global. I'm willing to answer any questions you all have, even if it's a clinical question. Certainly if I don't know the answer, I know I could probably get us to who can. And in terms of, you know resources, somebody did link the Women's Health. And Christian Sands linked the Women's Health in the chat, but again, it's on the website. And. I think that's it for me. Any last minute questions,

there's a couple of people talking about next one on training and things like that in the chat. So you have questions about that jump in. And oh, this commander Mari brought up for those credential to manage. Missed. Missed miscarriage. So you know, a loss of pregnancy, but you don't. Your body doesn't get rid of the pregnancy on its own. The mifepristone thing is is working in progress. We are working to get me for Christina covered by all facilities and then. I don't know the answer to the to the credentialing process, but the that is a hot topic again and we're working to make sure that it's available on every facility and of the MTF because you go from like an 80% chance of effectiveness to like a 96% chance simply by adding me for pristine. That's huge. I mean, you know, again talking about readiness, talking about return to the fleet, talking about recovery from the miscarriage. But you know that's huge. OK, I will stop here and I've pretty much run up to my time. Certainly any other questions or concerns, please send me an e-mail or. A message and it was a pleasure talking to you all today and I hope I helped highlight some of our fabulous resources. Anything else I'd let me know. Thank you so much, Lieutenant Commander Eubanks. All right. So moving right along to our next session, Lieutenant Commander, you may thank you so much. That was wonderful. I think we had some great interaction in the chat. So thank you all for your participation. So moving along to session, #5 will have our Women's Health considerations for military health providers and this will be by commander Heather Shipley. So, Commander Shibley, I will pass over to you, ma'am. Thank you. Do you want me to give the two-minute break to start at the top of the hour or do you want me to start now? Ma'am, you can just go right into it if you'd like. And we OK. let participants know if they need a break throughout. They can just step away briefly and come back. So you're all set. OK, perfect. Thank you. Thank you so much. So yeah, so I'm commander Heather Shipley. I'm actually an adult and child psychiatrist. I trained civilians. So I finished up my training at random mass general. And then I joined an approximately 2010 or so. And so I had several different jobs throughout my time in the military. I was stationed at Camp Pendleton and Camp Lejeune, so spent the vast majority in my early career with the Marines deployed to Afghanistan and did a bunch of mental health there. And then from my last six years, I've actually been the Naval special warfare. Command psychiatrist with some worldwide demands there and then just recently 90 days ago or so, I became the psychiatry residency program Director at Naval Medical Readiness Training Command Portsmouth. And so that's where I'm currently located. And before I get going, I do want to just make sure I can be found in the global. I think one of the most important things ever is to make sure that you do have contact with specialties and so and specialists. And so I am fine, just like Lieutenant Commander, you bank said for her is that if you have questions afterwards, if you ever just need a curbside, that's what we want to be able to be able to be reached for. But probably the most important thing you can do is find a local psychiatrist at a local MTF who's embedded with you. Because I know we're embedded. We've done. They just bought 31 more embedded mental health psychiatry billets. Across the fleet and Marine Corps. And so we're pretty much everywhere at this point. OK, next slide please. All right, so I have no relevant financial or non financial relationships to disclose for this activity and the views of this presentation are mine and mine alone and they don't necessarily reflect the official policy or position of the Department of Defense. And of course I know Miss Fitzpatrick has been working with you all on the CME. OK. Next slide, please. OK, learning objectives, we're going to review the key elements of mental health disorder screening and assessing risk. We're going to look at the gender differences in mental health. From work on a highlight, those common mental health diagnosis that women have. We're also gonna discuss the difference a little bit between baby Blues and postpartum depression and just the implications of mental health on pregnancy. I'm going to discuss stigma and medical management and substance abuse. Next slide, please. Alright. And then I'm also just like

Lieutenant Commander Eubanks was mentioning all the resources, I'm also the chair of the female Force readiness Mental Health Subcommittee of all those resources that are put up there. And I took over for some predecessors that did some amazing work, and we're continuing to. And I'll go into a little bit of the current resources that should be populating within the year. So first and foremost, the US Preventative Services Task Force does recommend screening depression for all adults. That's men and women. Including pregnant and postpartum women. OK, so that's when you're seeing a female in your clinic. We should be screening them for depression. We should also be screening them for intimate partner violence, somewhat disheartening. The most recent major study that just was published this past year showed that almost one out of two females experienced intimate partner violence in their life. So to take that, like, think about who you're treating and how many females are coming through, think about right sisters. Houses, kiddos. That that numbers alarming and so prevention is always gonna be the best model and so we encourage prevention talks with everybody about safe relationships, healthy and unhealthy relationships and so on. But so bottom line screen. Every female for depression and intimate partner violence and then the women's preventative service also added on screening anxiety and all women coming in. So that's pretty much all three OK depression anxiety, intimate partner violence and then you may say well that's going to take too much time and so in the next couple slides. We're gonna teach you some of the rating scales that you can use that you know the front desk can hand out. The coreman can hand out to try and maximize your time with further follow up. Of course by the provider. And these validated screening questionnaires can of course identify some service members, but it doesn't mean that if they they click up high on those ratings scales that they actually have a diagnosis. Next slide please. Alright, so the first one you see is called the PHQ 9 Patient Health Questionnaire 9 and it's just the nine questions. And so most of our medical training has taught us about city caps, right. So when we think of depression, we think of sleep and interest. Are they feeling guilt E for energy, right, C for concentration and appetite, right. And then P the psychomotor. Whether it's retardation, which just means the slowing down of movement or the the increase agitation. And then of course, the number 9 question, which is the most important, is going to be about suicide. So if there is one question you look for on that is, please don't let them walk away without further questioning. If they clicked on that number 9. And of course, they they talk about, you know, the different scoring of it. That rating scale makes it very easy, of course, by showing you the grade columns. And of course that's going to be most of the days, right? And pretty much every day now, if I wrote this rating scale, I probably wouldn't have written the second column that says several days, and then the next column that says more than half the time, because that can be confusing, right? So when you're looking at this and the generalized anxiety disorder, I would just when they have that second column that says several days that one more means a few days, right. So the first ones not at all the second one, please consider that as a few days and then of course, more than half the days, right? So that's like several of course. And then in the early everyday, all right. And so if they're scoring, I mean 15 to 19 is already considerately moderately severe depression. And of course, 20 and above is severe depression. So anxiety screening, same thing. They're gonna ask general questions on anxiety. Do you feel nervous? Do you feel tense? Can you quiet your mind? And so you're monitoring that. And so zero to four on the GAD screening is pretty much minimal anxiety. We don't really do much with that. Right then. 5 to 9 is more mild. Moderate anxiety is when you're approaching around 12 to 14 ish and then severe anxiety is the 15 to 21 now some people are going to come in and they're just going to mark threes like as high as it can all the way down. And so that's where it's going to take some clinical. Acute am as far as asking the right questions to determine severity and then the the third screening on this form is so critical, right,

the Annenberg Post Natal Depression scale and we've really have to screen all women that are postpartum for depression and in my opinion anxiety as well. I know OB, GYN does that all the time and family medicine and we'll go into why we want that a little bit further. OK. Next slide please. Alright, alcohol misuse. We have the audit C questionnaire. Very basic, right? How we all know from you know, just basic literature about binge drinking and and the problems that that can have, right the hazardous drinking. We see them all the time on alcohol pops from the DUI or some type of fight related to alcohol involved. And so it's the quickest way to end careers right now. And so please keep making sure that we're talking about the healthy relationship with alcohol for many reasons, right. General Health, but also mental health. So for women, you know, if they're drinking pretty much four and above or so, it's considered binge drinking that can happen really fast, right? They buy A6 pack and they just had a binge drinking episode. If they went through it clearly in the media. Right now, there's lots of lots of emphasis regarding some of several bad outcomes with potential alcohol use involved and so healthy women can become very vulnerable in an intoxicated state. So just for the health of the force. Please meet monitoring for alcohol use and then the middle one is post traumatic stress disorder. This is a PC LM. You will also see PCL 5 and those are post traumatic checklists for the military type screenings. Umm. And so when we're looking at PTSD diagnosis, right. We're thinking about major categories, of course. They had to be exposed to a trauma, and it can be of actual or threatened injury, death, sexual violence. All of that counts. And then underneath that, of course, there's several different clusters of symptoms. One is, you know, somewhat of the reexperiencing right. They are having intrusive symptoms of whether it's thinking about it when they don't want to, whether it's nightmares. Whether they're getting physical symptoms like getting physically sick when they're reminded by the cues, right, their heart is racing, you're sweaty, kind of like panic or psychological reaction cues of just feeling threatened again. A needing to escape the area, right? So that falls into the next cluster of symptoms, which is avoidance. We will see many people avoid things like being in locker rooms right being in showers and public places, if they've had a history of sexual violence in combat right people would avoid things on the road that looked like IED 's they would sometimes avoid places where they used to hang out if they're best friends have died since that so on, so that's the major avoidance. One then there's like negative cognitions where people can't remember things as well, and negative mood states that that could just be anger irritability. Right. There could be blaming themselves or blaming the the world, right? They look at the world differently. And then the last cluster of symptoms and PTSD is often in the arousal category. And that can mean really hard time sleeping, right? Really hard time as far as hypervigilant or startle response. And so, of course they go through all the questions. They are right in front of you. And that's a quick, easy way to get a baseline screening for as far as PTSD. And then the third one on the sheet. Is the intimate partner violence screening and so it's pretty easy with the nemonic hits. So how often does your partner hit you physically insult you right or top down? How often do they threaten you or how often do they scream and curse at you? Right. And so, never rarely, sometimes fairly. And of course, they talk here about 10 or higher would be considered domestic violence. But we know in the military if they are hit ever right one time we need to refer. We talk about the family. That Macy program and so on. And I'm happy to answer some questions with that down the line. OK, next slide please. Alright. And assessing risk, right? So us in the psychiatry world have to assess risk. Every patient, every time, but we've really want you asking the questions about risk to harm to self and others. And I'm going to talk about how to do this. But before I do, I just want to talk about let's talk about rates, right of death. So the CDC always pushes out the rates of death per age group and they have the most recent up to date for 2020. And I just took a quick look right before coming on just to see if anything was updated from

2021 yet. So for each 10 to 14 year olds, and I know many of you may not treat children, but maybe some of you may, some of you may have your own children, right? So it's pretty alarming that between ages 10 and 14. The second leading cause of death is suicide. Second, leading cause of death. And maybe it's because we know how to treat so many other conditions so well. You know, of course, they have a lot of accidents and injuries and so on, but that should be striking, right? So even when we're we're talking about kids, we're screening them for depression and anxiety and then following up with these questions, right, ages 15 to 24. For females, it's the second leading cause of death. Suicide is for all genders. It is the third leading cause of death between 15 and 24, and it's edged out by homicide, right? So both of these risk right for 25 to 34 year olds, right? Large part. Again of what retreat? Suicide is the 2nd leading cause of death. Homicide is the third leading cause of death and then for our more senior and enlisted and officers. It's from 35 to 44, right? It's the 4th leading cause of death. So no matter what you're seeing, a lot of causes of death, right? Being related to mental health conditions. And so this is where we're what we're asking you guys all to screen because so many of the times people that complete suicide never actually make it to mental health treatment. And whether maybe they just don't disclose. Or maybe they're not asked, but bottom line is, is we're losing many people that are not in our clinics. So how do we assess, right? So there are tools, there's you know the GR IST and then there's a Columbia suicide severity rating scale. OK. So the GIS T is pretty much risk and safety technology and you go through this website and you go through all these questions, the Columbia Suicide Severity Rating scale, you'll often hear it referred to. As sea SSRS is used in every single mental health appointment, so we really encourage you to try that again. It doesn't mean anything without the follow up question, so that's the most important for all of these rating scales. But the CSRS can sometimes pick up stuff that you may not have, because sometimes people will write things down on a paper and they just won't talk about it. And so some of this, you know, there's several different questions that you know that people are asked with the CSRS. And then there there is. One version which talks about projects like lifetime risk that you're doing on your intake the first time you're meeting these people and that asks about like, you know, suicidal thoughts in the past three months, it talks about what are your recent losses or changes in your life talks about. Have you had prior history of treatment clinical stressors, right, like substance abuse, depression, severe agitation, risk, you know, thoughts of harming others, aggression. Do you feel a burden on others? Are you isolating? Do you have a history of sexual abuse? Is there a history of family suicide because of course family history of suicide definitely increases the risk. Even a grandparent who killed themselves increases the risk in that grandchild. And then it goes through protective factors, right? So these things just chew you right off the bat to to know what to focus in on. And so there's that version. And then there's, like, the monthly version or since last visit and that see, you know, SSRS since last visit. Have specific questions. Just six questions. Have you wished that you were dead or wished that you went to sleep and never woke up? Have you actually had thoughts right about killing yourself? You know, how would you do it? Have you ever had the intention that you were going to do it? Have you ever started to work on a plan? And so on. And so usually when people are in my clinic, I, you know, you start with the easy questions, right. Like, man, you know, have you ever just wished it was over? You know, like, as if, like, you know, you didn't wake up or you got hit on the way home. From March, they're more likely to answer that question before you jump straight into. Are you thinking about killing yourself today? Right? You have to work up to it. I'll often say, of course I will use the word suicide. Have you had thoughts about suicide? Because I think he can't mince that word. But I'll often say like, how close have you come? You know, once you've formed that relationship that how close have you come? I can't tell you how many people will tell me that they've had a loaded weapon to

their head, but they never told anybody, you know, or I can say, you know, when I treat other people, I know many people with your same symptoms have thought about it or started to act on it or have come really close. But then on the flip side, I'll say, you know, well, what kept you here? What was it that made you not go through with it? Because I think we can align with some of those protective factors and work that right into the safety plan. And we have all kinds of stuff on safety plans. I'm happy to talk to you offline on that or in the Q&A as to like well, what do you do then. So right now in the brief, we're just on the screening forms, OK. The next thing we want to talk about is the violence against others, right? And so they give an example of the bio scan. And so you say, well, where did the bio scan came from? Well, they studied over 1000 military veterans that have been in Iraq and Afghanistan, and they not only did assessments with them, but importantly, they went and asked for collateral. Information for the people around them really about their violence level and then out of that they did regression analysis and evidence based studies and they came up with five factors. Now of course, in the forensic psychiatry world, we're going to come up with more than those factors, right. But these five are from the bioscan. So financial instability was linked with potential violence, combat experience, but especially personally witnessing someone severely injured or died. Alcohol misuse, right? We make poor decisions when there's alcohol in our blood and then it's your history of violence or history of arrests and then PTSD, but particularly PTSD associated with anger. And so those are things that should be curing you in, right? I also know, right, if there's NCIS investigations going on, if they've been inflicted by violence growing up, right, we're just everything that they've been exposed to in their life. What is the history of violence in their family? What have they seen? And so there's so many extra questions to ask, but it's a good start. Of course, you need to say have you had thoughts about killing somebody else? And I usually say outside of comp, right or outside of your direct admission. So have you. Have you ever had, do you have an intent or plan? Because if they're saying yes, I'm going to kill this person now. Then of course, where we have to follow the Terrace Office rule about notifying and and and creating them in a safe environment set of course we would be hospitalizing or getting police involvement. So, alright, so individuals who you determine or high risk right for self harm or violence against others really need to be referred to a mental health provider to be able to do that at the next level. Next slide please. OK, gender differences because This is why we're here. So of course, mental illness says it's no surprise to anyone on this line that they're among the most common health conditions. And per the CDC, about 50% of people will be diagnosed with a mental health condition or disorder at some point during their life. And right now, of course, the overall prevalence in women is about 22%. So one out of five, knowing that 18% of the total force is female, we also need to know that military experiences of women. Just in general are different than than males, and that they're responses to those experiences are difficult, so they may have the same the same direct thing happened to the two of them, and the response will be different. So incidence rates of mental health diagnosis were higher among females than males for things like adjustment disorder for things like anxiety for PTSD and for depression. Next slide, please. Alright, so common diagnosis, right? We know anxiety and depression and women, right? So per CDC one in 10 will have reported symptoms of major depression in this past year, right? In the last year, one out of 10. So if you had ten women in your clinic today, one of them will likely have had depression at least this past year. Adjustment and personality disorders, twice as often diagnosed in active duty women than men eating disorders 20 times higher in females than men. Maybe that's because we're screening them more. Are would definitely because there's a significant amount and then the civilian population as well and results from female veterans showed that there is a predictive relationship between deployment, actually deployment related trauma stressors, whether it was sexual assault on

deployment or other types of combat experience as on deployment than with men. I can tell you from my time on deployments. One of the hardest things to treat ever is when a woman has been sexually assaulted by someone of their own military while deploy trying to fight. You know, for for the country, it's really hard from that sense of betrayal to overcome that next slide, please. Alright. Also what is unique to females? It's gonna be the hormones and how the hormones change throughout a woman's life cycle, right? So and it can impact emotions and moods in different ways, right? And so below are some of the examples, right. Perinatal depression. So both prenatal and in the postpartum period, it could be as high as about, you know, one out of four female service members experiencing this. And so especially in women who had to deploy after childbirth or. And to experience combat right after childbirth, premenstrual dysphoric disorder. Right. Similar to PMS, but much more severe depression, irritability, tension. You really need to diagnose it with them, documenting it because it has to start in certain periods of time before the Menzies begins and usually resolves shortly after. And so this is stuff that we have to take really good history to be able to diagnose that. And then of course, Perry. Menopausal related depression is pretty common. Next slide, please. Alright, postpartum depression, right? So depression that occurs after having a baby and the feelings is much more intense than the baby goods. Baby Blues is just the typical worries of having a new baby being sad, not sleeping, and it typically resolves in a couple days, right? Postpartum depression is real, and it can be incredibly dangerous. So one out of eight experience postpartum depression and things that puts them at a higher risk to experiencing it is having stressful life events, right. Around them, sometimes especially and like you think about military, military couples and husbands downrange or just, you know, not around low social support, right. We are oftentimes delivering babies away from our larger families, like very rare. Do parents are parents able to fly in to be with that female service member who's delivering, unlike in the civilian population, because you're living across the world or across the country from your primary care folks as far as previous history of depression? So if. Any of your female service members have depression already or before. These are people you really wanna check in on and I would recommend giving them phone calls during their their con leave and now we know the con leave right. So it's six weeks, Conley, 12 weeks, additional parental leave. So that could be 18 weeks without too much medical touch point. So you being the OO out there those phone calls can mean everything as far as picking up some of these concerns family history of depression. Difficulty getting pregnant right, which meant there was all kinds of stressors involved, especially if they had to use IVF and the ups and downs of that being a mom to multiples, right? Because if one baby's hard enough to get to your own sleep, two or three babies is much harder because they're all waking up at different times. Preterm labor and delivery was treated. Many of people who had to spend the first couple months of their life in a pickup right and niku and all this stuff that goes on with neonatal intensive care and the bonding that can and cannot happen during that time. And then of course, if there was pregnancy or birth complications, all of those things make the bonding really hard and being a child psychiatrist, I can tell you how important the mother child relationship is in those first. Couple weeks, couple months, couple years not only on the moms house, but actually on the baby and the child's health. And what what they may develop over time because their brain epigenetics, right. Their brain actually changes depending on the stressors that they experience in those first couple weeks in years of their life. Next slide please. OK, so women with eating disorders, of course, may experience relapses during pregnancy, right? They are gaining weight or they are trying not to gain weight and their doctors are all telling them they have to gain weight and it can cause miscarriage and premature births. We take it super serious and of course low birth weight. Bipolar very dangerous during pregnancy, they may experience some relief during it, but right

afterward, there's a skyrocketing of mood disorders and people swinging from mania to depression. Right afterwards, some moms want to come off their medications, and some medications are more safe than others during pregnancy. And if you speak to while it's a, it's a patient and their current doctor decision. There are many experts in maternal fetal mental health that will talk about really the importance of maintaining. On those medications during of course, if someone has depression and anxiety and it's mild but rallying around as much as we can, the psychotherapy to minimize the effect of some types of, you know, psychopharmacology on the baby. But we know many of those medications for depression, anxiety and are safe in the fetus. There's been several studies to show that. And so. But it's a personal decision between the patient and the doctor. But if I would highly recommend you're having those discussions, really. But you're getting them to a psychiatrist to also be discussing it. Alright. And anxiety, of course, and obsessive compulsive disorder, are oftentimes likely to relapse during. And after pregnancy, we we often see even new cases of obsessive compulsive disorder type reactions happening after a mom has a newborn. You know, it's very common for guys and women to come back from combat and to be representing, like, obsessive compulsive symptoms. Sometimes it's related to PTSD, right. But it's like that beer and that wanting to control of all those outcomes and just the way the hormones impacting the brain so important to treat. Next slide, please. Alright, of course they can have a lasting impact, right? Mental health conditions, effects at least 10% of women worldwide, and probably much more. And of this is an extra special population to please pay attention to women with miscarriage, right. They can show PTSD type symptoms, right? Some of them can show a prolonged grief reaction. Right. Complicated bereavement type stuff. And they say 17% will have anxiety even nine months afterwards. So this is not just like a quick. Ohh, you had a miscarriage at two months and like just get back into it and it should all be fine and you didn't really hold the pregnancy for that long, so it shouldn't be that big of a deal like they've already changed and became a mom the moment they found out that they were pregnant and all those hopes and dreams come with it. And so we really encourage sometimes they're not even in mental health treatment. And so that primary care doc is critical to working through this Listen to this. and of course, going to have lasting effects on maternal and What? infant health, right. And reproductive health can be particularly challenging for women in the military. But. Already, right. We know the rates of infertility, we know a lot of women will try and plan their pregnancies. Around. Like deployments and around milestone billets and it's just not that easy because the longer you wait, the harder it is to become pregnant and we know physicians, you know speaking to the crowd and they probably nerf partition like people that are high charging have harder rates for fertility to begin with. Next slide please. Up next slide please. I don't know if we're there we go, OK. One thing I wanna tell everybody on the line and whether it's behavioral health techs or cormant, there were many people who feel much more comfortable talking with another enlisted right then they will with a provider. And so I would always make sure that my core men and behavioral health tax or someone had time actually with the patients and I would queue in and ask them each time like, hey, did you text anything? How's it going, how they checked in? And so on, because sometimes they can bring you that information that you can then ask about, or sometimes they're willing to let on that life isn't that good or they're stressed out about their family or their kids or so on. And so please use that information, implement them right into this care, just like you would for other medical stuff. They're critical in it. And don't shy away from having them touch base with the patient. So mental health, road map. OK, so chaplins 100% confidential. Right. You can tell you're going to kill someone better that they're not. They're not allowed to report. And they take that. So, serious as they should, right. And this was like now I have had you always want to have really good relationships with your chaplains because they can

end up bringing you patients. So maybe they won't be talking about it, but they're like, I think, you know, and they bring the patient right on over and they just kind of give you a head nod. And, you know, if a chaplins walking a patient to you is probably a reason. And so ask those questions real good on that point. But form those relationships so you guys can work together. Then there is a military and family life counseling. They go by M flex. We talk about non medical counseling courses. I oftentimes will utilize them to help with the relationship stuff. The parent child stuff some and blacks are actually willing to work with people that have more severe diagnosis as long as there is another provider working on the more serious diagnosis, they can augment. Or while you're waiting for someone to have their first appointment with a specialist, some impacts are actually willing to see people to just kind of hold them together while you're waiting for that specialty appointment. So I use M flex. All the time. Alright, fleet and family support center, another fantastic resource that we use and they and of course military one source. We prefer them out in town all the time. Right now a majority of the military treatment facilities, including the one that I'm on. We have more referrals than we have staff to take up because, of course, mental health and bedded billets continue to explode in number, right. And so our Manning and the next year for mental health psychiatry is probably going to drop to about 77% or so. So Big Deal is we want to be able to use these extra resources that have been implemented to help with the less severe cases and many times all people need is psychotherapy, right? For me, being a psychiatrist, I probably even do more. They go therapy, then medication management, because that is oftentimes where true change happens. Yes, we will often augment with medication options. You know, psychotherapies not enough, but please do not underestimate that power. You know Frank Pribadi from Harvard always. You know the the secret of the care of the patient is actually caring for the patient. And I can promise you. Patients now service members know when you actually care and don't care, right? They know when you're just rushing through or when you're genuinely listening. Study after study in the psych world show that it's not so much the type of psychotherapy you know, we have many different types called cognitive, behavioral, psychodynamic. All these terms that you guys really don't need to know. But it's not the exact type that you choose that influences it. It's your therapeutic report. And so as a primary care doc, I don't have to tell you how important here. If therapeutic report is and if somebody's gonna actually tell you what they're worried about. Right. Alright. So IDC's right see medical officers. It looks like for the smoke. Anyway, he sees your doc, right? The people that they open up to the one who's P teaming with them and so on. And obviously OO, I mean being operational the last six years walking the grounds right was how I got the O fives and 06 to come in, right. They weren't going to just show up in a mental health clinic or. Even in the medical clinic, right, it's PT with them, it's going to the family nights and the resource nights and it's being present is how they trust you enough to actually let you know when there's a weapon to their head or when their entire life is crashing. All right, so embedded mental health. Of course we have Oscars, Sykes. We have people in surf plant. We have people in the sub community, right. Or it down there in the flight teams, we we have different specialists across many different areas. But you may not. You may be in a place where you're not as lucky to have one right there. If you are, please go meet them and for I would I used to have meetings where I would meet, oftentimes with the diagrammatical and the primary care team, the sports we have. We we did multi ideas, but I would meet with them outside of it just to curbside. Right, because you can't take all the referrals on. But to be able to answer, hey, do you think you should? Zoloft or Prozac? And how do you cross titrate between these two medications or this person said this, would you worry about it or how do you follow up on that? Or I think there's something going on and I'm not quite sure what to ask. All of those questions, we're here to support you and of course the, you know, the

MTF's big and small and then the network, right, Tricare coverage, they cannot make duty determinations. And so here at Portsmouth, we will frequently be asked to determine are they fit for duty. And while we would love to take all of them on and give them, you know, military treatment facility providers, we we can't just because we don't have enough of us. And so it will often do that one time evaluation on limdu or fit and then have to defer to network to try and get them better. OK. And then of course, there's emergency room. There's always the ER for danger to self and others, or inability to take care of self from a psychosis perspective, process disorganization, type things. Next slide please. OK. When does specialty services are needed? Well, when there's a concern of course for duty status like we just mentioned. When there's an acute safety concern to self and others, so it's a little bit tricky for the ones that are chronically suicidal, right, that they're chronically suicidal is very dangerous. Same thing as chronic non suicidal self injury like people that caught or burn or someone because we know both of those are predictive of someone dying from suicide. And so it's tricky as to know when and how and what. And so we know also that people after they've been discharged from the hospital. Are actually at very high rates in the first couple months afterwards. And so just because they're discharged or they made it two months out, I would still be recommending all of you guys still meeting with those people just like if you had someone with a cardiac arrest and they got discharged from them. But like you're going to still want to meet with those folks, they should be on your high risk tracking system for months and months to come. It does not just turn around after a two to five day hospitalization, the hospitalization is for acute stability. It is not for long term treatment. There is very little psychotherapy that happens on an inpatient unit. Alright, other services have been used, you know. Let's say another reason. Why would you consult a specialty if you've already tried a few meds and they're not working? If psychotherapy is not enough and you've tried, let's say search ralin, right? Fluoxetine, escitalopram. If you've tried Wellbutrin, right? Bupropion is the generic term. There's different formulations, but many times the phone calls enough, right? That's that curbside console. And where do I go? How do I augment? But if that's not enough, you definitely would wanna go ahead and refer. And they're saying here, of course, just because of resources that we would encourage Umm flax and military one source. I know that there is the Cohen Center and many different geographic locations in the in Conus. And there are great program with evidence based treatment models. I know that there is people are always saying like where I know that there is other programs that we use. I'm sure you guys are familiar do you do you know they pushed out resources on things like telemedicine. Things like. Just hope you know home front we use home base. There's a couple of different programs that we use at like mass General and Chicago Rush and Emery and UCLA that has been studied for like the TBI slash mental health folks. And so there's tons of resources out there. And I also always encourage and this is hard because it's like the extra step. How do you form relationships with people out in town to know, like who's good and who's not? One of the ways to that is like, do the people out in town contact you? If you given them a release of information to get that information right, you have to have those dialogues, because otherwise these referrals out in town. We have no idea what's happening with them. The other thing is outcomes. When you send someone out in town, you follow up with them and are they getting better? Like how are they doing? You always want to say like, if they're going out in town for treatment, if they're ever started on any medication. You want to be known, told about right within the two to five days, so you can add it to their record and you can ensure there are no medication in Med, Med interactions like Iowa staffing. One of the residents cases and they went out in town and got put on a medication and it was absolutely at risk of seizures for one of the psychiatric medications they were on. So you're wanting to get that information back. Of course, we don't ever make recommendations of one place versus another, but I

want you to have, you know, names in the back of your mind to know like, what is and you're looking for, who's evidence base. Who's on the Tricare list for who they can be referred to because they're supposed to be vetted. If they're on that list and they take the Tricare insurance and so on. Sometimes mental health your mental health Mt app will know who. Who do they refer to like? I know when I was at an operation command, I would call back to Portsmouth and say, who are you getting the best outcomes for? For what we call residential treatment facilities in the region or even nationally. Like, what are you seeing right, because they're gonna always have the most sick patients. So they will always have the best queue as to the bounce backs. Who is, you know, having suicide attempts after they went to these other places and so on. What is the information they're getting back? What is the dialogue they have? So all of that is really important. Next slide please. OK, medication management, it may be in, right, it could be important part could be not primary care, right? 70% of visits are right now driven by psychological problems. That is probably why you guys are all on this line and listening to the speak 70% many primary care physicians, right? You can all like prescribe depression and anxiety and ADHD medications and so on. Now for ADHD, right, there's a lot of people that want to be diagnosed with ADHD. So I encourage you to screen them as a child's like I literally will have guys come to me at 30 years old and I'll be like, OK, I'm gonna go ahead and call your mom or dad because I need to see. Even though you may not have been diagnosed before age 12, I need to see, was there a history of behaviors that you exhibited in childhood that showed that ADHD was was likely right? You'll talk to some parents and they're like, oh, yeah, the teachers told me to get them screened, but I just didn't believe in medications. Right. Or it took Me 2 hours every night for Johnny to sit at the table. To get his homework done when it really should have taken 15 minutes or yeah, they always said he didn't live up to his potential. Right. Or yeah, they had to put him in a cardboard box in school or have him sit in front of the teacher, right. There's certain cues that we should be able to be like, oh, OK, we're not doing neuropsychological testing for everyone with ADHD because across the general population, it's about four to 8%, right, 4 to 8%. So we just don't have the staff to say like, if we're going to do in depth testing for all of this. But the same thing for depression and anxiety. Back to the familiarity, right? With the serotonin selective reuptake inhibitors medications, you know like venlafaxine or duloxetine which are, you know, the SNR eyes. I would just say you know, we always want to be cautious with medications because it could be Downing and I know we may get to this, you know, on a slide or two from here. But I think it's important enough that we speak about it here. So first up, depending on what their rate is, medications can drop them and they can be no longer fit. Right. So when I took a for soft like the special operators on whether it's at marsac, whether it's NSFW, the EOD population, right, divers nukes, submarines like we have to be really smart and looking at that manual of medicine to say, Now I absolutely could get waivers for the vast majority of those medications. But I would be really smart in the timing of those trials. And I time them in between right the inter deployment cycle cause of course all psychiatric medications will down people for 90 days before deployment. Right. And then there's other places that have different rules. For instance, AFRICOM surgeon was not taking people on with Trazodone to Africa just recently, right? There's a UConn surgeon and, you know, there's Moss. And they, they have different roles, right? Of course. If we are going into battle benzos, Z drugs, right, those are not effective because how can they? They're said right on it that they're not allowed to operate heavy machinery. And if they're there to man some, you know, heavy weapons systems. That is not a medication that we want and deployment. Same thing of course with lithium. I remember when I was in Afghanistan, we had some folks being sent forward on, you know, lithium into the Middle East where it was incredibly hot. And so it's some of this stuff just doesn't make sense because of course, it could be

at risk for dehydration and and lithium toxicity and. And so you want to be very mindful when you're talking about mood stabilizers or lithium. The truth is for people on deployment, clearing them for deployment, right, they should not need specialty care. Anymore than every three months or so, and we're saying that quarterly would be enough, right? And that's just check-ins with primary care, right? There is no golden hour and some of our the current concerns across the country. And of course we're on Nipper and not zipper and we won't be discussing any of that. But what I'm saying is we really need to be mindful of what we're doing. I also understand that speaking with some of the fleet commanders that we can't limb do every single person right with a mental health condition, one that would be huge stigma, and I'm here to say that we can get people better, vast majority we can. But I'm also here to say that, like, hey, if they're having recurrent suicidal thinking, that is not the person to be putting down range in a fitness continuum, right? Or if they're having severe treatment resistant, major depression, they need to be near specialists and therefore they can't go on underways and so on. But that becomes a decision. Between you and the specialist. But just please be mindful on that. Alright. Next slide please. Next slide please. Shannon, can you hear me? There we go. Alright. Substance abuse screening process. Right. We in the US and probably across the world, we are having increased right and substance abuse deaths and Fastenal and all the new drugs and of course alcohol is notorious in the military. And so there's different types of referrals, right. There's a self referral with someone comes in and says I'm drinking too much. I really need help. Right there's command referrals. So let's say someone pops. On a urinalysis for drugs or let's say they have an alcohol related incident. And of course, there's medical referrals where there's like the doc that says, hey, I'm gonna refer on over. So how do you want to make sure they're meeting with the dapper or the Sacco? You know, whether it's Navy or Marine Corps to complete the initial screening, I'll often put referrals in, you know, through Alta and now Genesis because we're rolling Genesis this week. And so on. And so they talk about the SMAC, this act at United States Marine Corps, and that one they talk about was being nonmedical. Right. A lot of prevention services, a lot of, you know, just undercut counseling. And then, of course, there's sarp. Which is the substance abuse rehabilitation program, and there's different levels of SAR. Next slide please. Yeah. So you know, some people use the ASAM criteria. You know, the American Society of Addiction Medicine. And that's often what psychiatric psychiatrists will be basing like. What level are we going to refer to right in this acute intoxication? Is there withdrawal like, that's why you'll often times see psychiatrists. There's many reasons why we want the blood alcohol level to come down before we assess because one things change too. Withdrawal starts if withdrawal symptoms start kicking in right while they're still low levels of blood alcohol in their system. That's a it's a big concern that they're gonna need medication managed one right. We look at what is the history and physical health? Have they failed lower levels of treatment? Can they maintain sobriety at home? Do they have any support? What's their relapse potential? And so on. Next slide please. OK, prevention early. Intervention, right. These are just the level 123 and four and there's actually 2.5 and it really depends on what military treatment facility. So one is like outpatient, hey, you're going to go a couple days a week, then there's intensive outpatient and most programs at six days a week, all day. Then there's a residential treatment, which is pretty much many times the 35 day program. Some people run a 28 day program and then there's some of the stuff that we use and they have to be on in acute hospital ward and whether that's on like the medical floor or the psych floor and they're literally undergoing. Umm. Withdrawal. Next slide please. Alright, other considerations. Right side conditions ranked among the top three for reasons for medevacs for the last 10 years. It's a big deal. 10 years we were still on the height of some of the war, so mental health was a reason then and it still is now. Right Chapter 15 is a big deal. It talks about what are the duty status for

the people you are taking care of. Please get to know it. Umm, there is existing mental health problems. Many of them are supposed to come in on waivers before they joined. Many of them did not come in on waivers. There are ways to deploy people that have PTSD. I promise you there are ways that was like to deploy people with major depression. So a diagnosis is not the end all be all. So we don't want patients to be afraid of the diagnosis. We just want to be able to treat it. And so patients must be deemed by their provider to have no conditions interfering with their ability to be fit for operational duty and screening. Right. And I already talked about the meds in 90 days before deployment. Next slide, please. Alright, 2021 sexual assault is a terrible number, right? 35,000 almost 36,000 active duty service members experience some form of unwanted sexual contact, a 13% increase. Now is that a 13% increase because of the me too movement that people are willing to come forward? Or is that because this stuff is still happening at a higher rate than it was in the years before sexual assault victims? Of course. So increased rate of depression and PTSD and sexual dysfunction. They often will have all kinds of stomach disorders pelvic complaints. Many of them I'll watch with chronic pain, neck pain, headaches. I see a lot of there. There's no doubt. And we know through hard science that trauma impacts the physical body and the inflammation. And it is an absolute leading cause of even respiratory symptoms, right. They talk about Ace and the adverse childhood events. And if you've been exposed to trauma or apparent with substance abuse and all these other major areas of, you're more likely to have all of this stuff as an adult. So please screen for childhood abuse. Alright. Patience confiding in medical professions professionals, if they've had an assault, can still pursue right. Restricted reporting. This is really important, and that's where our resources on the mental health part of the website they were talking about. It goes through them. And of course you can always call your victims advocate at your command to talk with them and be guided into which way. And because you want that patient to have the advocate. But it can also help you know what is your next step as a provider. And of course, we have the safe helpline. And then we have the sexual assault helpline. Next slide please. And of course, there's also the 988, right? The phone number that you know has been advertised, right? If someone is suicidal, they can call 988. Of course, they could still call 911. And here are some of the great references and links. And I know I have a lot of questions populating up here. So I want to make sure I have plenty of time to go through them. Umm, alright, next so questions and answers, let me just see if I can go to the top one. Alright, so I see them thinking that, commander, you bank. Umm. And so OK. So the first question I see Doctor Shipley is there essential website resource for the screening questionnaires that is a good question. I have always gone to the individual websites, but I know that there has to be. I know there's a defense health agency one and so misfitz, Patrick, I would love you to put. I love you to put that answer to that question to the group, OK, because that is critical. We have like a behavioral health data portal where like our patients have to come in and fill out those screenings and it automatically shoots to the provider and then we're able to take them and shoot them right into the record. And so that is for a lot of MTF, but I'm not sure, you know, if you're in operational world. So what what I would often do is do the paper ones. If you don't have the electronic ones and and and you can just make, you can make many copies of them. And so you're able to just do do that. And so that's where, that's what I saw at Pendleton, Lejeune, and so on. But Shannon, if they're having a hard time with the links because I know you tried to, to put it through Google Chrome, that they could just link on all the ones. That's why we wanted it on that slide. That would be another thing, just pulling up a PHQ 9 and GAD 7 and the PCL five or the PC LM. And I think that would be an awesome thing to send to these providers because the truth is, the moment they get off this call, they're going to be inundated with the work. And I feel like anything that's easy to their inbox is something that we're likely. Able to, Umm. They'll they'll end up

using. Alright. Next question. OK. West Coast should board GMO. OK, I sometimes have sailors who come to see me and endorse recurrent situational passive without a plan not requiring hospitalization. We have one embedded mental health provider who it can take a couple weeks to see unless they're underway. Then it takes longer. Our therapy resources in San Diego are limited, but we do have 1M black attached to our ship. However, for her contract, she cannot work with sailors once they endorse. Assemblance of ESI. Yeah, and I I've seen different M flex interpret that differently, but I do believe it's in their contract. They're not supposed to be seeing super high risk patients. So based on your recommendations, what can I as a GMO do to keep these sailors safe until they can get to see our FST psychiatrist? Right now I have them come see me for a short interval, follow-ups and spend building report and talking about life. However, I have no formal therapy training. OK, so. So there's several things you can do. One, I'm just happy that you're conscientious enough and recognize that there's actually risk. Umm, there was a recent suicide here that I just, you know, heard about this past week where it was like this chronic suicidality and they had seen providers since, but it was always passive, right until it's not. And unfortunately, in the military, many people will go to completion the first time they actually try, so. So these touch points. So if the M Black will not see them, I would use your chaplain. If you do not, because you're chaplain can absolutely, even they they don't. You can literally talk to the patient and the chaplain and be like nonreligious. I want non religious counseling like you know if the patient you know doesn't a religiously a formality because they can also just counsel they counsel people that consider themselves. Atheists, so they have that ability, right? But what you have is a professional who is trained in that ability to have extra eyes on. I will oftentimes use Corman to, let's say, you can't see him every week, but you have a Corman that's willing to to, to meet and talk to them about it, and then they can bring up, you know, if there's any higher level concern to you. We use a ton of apps. And so if there isn't, if you do not have an app sheet where you have like 10 or 15 different mental health apps, Shannon Shannon, are you on the line? Can you hear me with all these ideas? Hi, ma'am. Yes, I am. I'm taking some notes over here, so I'll be Yes, all right. Perfect. So I am writing myself a sticker right sure to do that. now, a sticky tape. I'm gonna send you a resource that we have of mental health apps. OK. And I'll also send a website for what's called mindfulness based stress reduction, which has absolute evidence of improving mood and anxiety. And they can go on now, of course, if you're underway and they can't get electronics to, you know, if you guys are blacked out and so on. But there's, like, a Palo. Like app and it will go through 8 sections and it's free and these like even in the JAMA side CHIATRA and the past month just produced another evidence based study to show that it rivaled other types of psychotherapy and these are self help tools. So sometimes you know no one has money for any of this right. But sometimes if if command doesn't have money for a rotating library sometimes I buy them on myself and I'll loan them out now could it never come back maybe but some there are self help workbook books that people use so all of those things. Are your resources right? Right. So the meditation, the exercise of physical trainers, all those people have touch points. The nutrition is that can then get back to you on it. And I would be putting referrals out, right? So if you can't, yes, there's an FTP site, I'd be curb siding them and asking them like, hey, who do you recommend? Who's the person out in town? Can we get them to a focus provider? Right. Focus. You know, it wasn't on the slide, but it's one of the best resources I've come across. It's called families overcoming under stress. Where did write? It is infiltrated right into the military. At NSFW, we had two just for our East Coast, but here at Norfolk and region, there is one. There's one at what's called Fort Story 30 minutes away. And they are evidence based. You don't even have to be married. But you can. You have to be in a relationship. Right? So like a couple don't have to be married. Don't have to have kids. And they meet. It's like an 8 week or so. 8 to

12 week program. When they work on relationships and communication and and they are providers which means. They will be screening your folks for suicidal thoughts and so, which means right that they will be referring to higher level care if they're concerned and then they have the spouse there, or girlfriend or boyfriend, and they're able to get that extra history from them and see them in real time. As far as the risk. And sometimes they go phone be like, yeah, yeah. He had a weapon to his head yesterday. And that's information you would have missed if you didn't refer. So I use all of those additional resources. And sometimes we do military one source of while we're waiting for Portsmouth, right or San Diego. Next slide. Ohh, sorry, not next slide. Next question, I'm just scrolling down, OK, I know with the Marines, we now have a pronounced Sierras. Do you have a recommendation for how long after admission for a dual diagnosis or mental health, the service member should be on high? It's a good question. And it's going to be, of course case dependent like no one ever wants to hear. But I promise you that that the risk doesn't go in the first month to three months or so. So I can't imagine anyone coming off a high risk list in my opinion in the 1st 90 days because there's often suicides during that time and so. You know, per many of the man meds and mod, you know 13141516 it was saying that you couldn't deploy someone down range for 12 months. Like if you actually look at the data or even 12 months after a sharp residential, I'm also tracking there's a lot of people on those lists. And so there's pressure to write waivers for them one way or the other. And that's discussions you need to have on whether you guys are right in those waivers with your commanding officers. They cannot make a blanket statement on that. But I can tell you I take fitness for duty seriously because everyone in my really needs to be fit. Before you know whatever kicks off in the world, and so we're doing a disservice by not adjudicating cases and a limb. Do Med board or admin set perspective if they're never going to be worldwide. Right. And so, you know, it depends on is there alcohol involved there? Was there a recent loss or death? Right. Is there a major diagnosis, like anything in the psychosis perspective should be on it for life pretty much unless it was like a postpartum thing that happened immediately. But we're often medically retiring them as well. Because there's a risk to go back to it and any acute stress and so, of course, the military, stressful if you're at bipolar, you should be on the list forever until you get out, right. There's just risk. But work with your embedded folks with the Marine Corps or set up a meeting with the local MTF and and they can kind of go through what their mental health considers because MTF's have their own high risk tracking system. And so you can ask them, like, hey, for this region, what are you considering high risk, right. OK, hopefully that was helpful Next up. What is the quickest way to access mental health resource in a deployed setting with an immediate with immediate response instead of a delay with prompting via telephone? Any recommendations? So you mean like you're trying to get, not an appointment, but you're trying to speak with somebody? I guess that's what my question will be. If you're trying to speak. Right, with a psychiatrist to kind of Co screen, you know, every MTF have like right. Like I should say MTF your major 3 MTFS have psychiatrists that are on call 24/7, right. And so even through a quarter deck, there's someone who's carrying a pager. Now they're not going to be able to just speak exactly to wherever you are. But there are. People that represent the region, right, there's the Pacific region and I know Captain Vance, like, is more like the Atlantic region mental health. And so when you're speaking with your smile, you have to have your chain of command, like your reach block as to who is your person that's covering your region. That can help with that. Clearly, chaplains are gonna be the 24/7 that are often integrated and deployed out there with you all. And so they're often on the 24/7. I can tell you when I was one of one for NSFW for six years, I was 24/7 365 and so they had my cell phone and it was, you know what I mean? It was like I was on. So that's where you're trying to say, like, we have to know your current resources as far as, like, texting that ends up becoming the

prompt. So it's like, yeah. Like, it's like the 988 with people responding. You know the VA suicide help desk is talking to National Alliance of mental illness. There's other resources, but if you're talking military, that's what I would say. Right. What tool are you using to diagnose adult ADHD? There's no great tool. So there's an adult, you know, ADHD rating scale, right? But I mean, like it is highlighted and grayed out in the answers that would get you the diagnosis. So I trust it less. Some people do the corners performance test. There's some MTF that we'll use that electronic tapping test. That will kick up higher levels, but there's many MTF's that won't do that per the APA, it is actually a good clinical history and it is not neuro psych testing. However, if I had operators or certain people where it would be Downing them, I would take it serious and we'd often try and get some of the neuro psych testing for them because it would just push them offline for a period of time. So you'd want to see it. I would also say be incredibly smart and and make sure you're getting sleep studies, if there's any sniff of a sleep disorder because many people it's undiagnosed OSA. That people think is new onset ADHD or it's alcohol use disorder and I can't pay attention, right? Or it's because I'm trying to work 18 hours a day and I don't pay attention as well. In the last three. So it's a battle rhythm thing or it's depression and anxiety period. All these things cause decreased concentration. And so that clinical history is really critical. I I came from a population that had a ton of mild TBI, right. So trying to make sure is this residual from a TBI perspective? And is there something that we should be tweaking? I make them do meditation. First. I make them do heart rate variability training. I teach them how to change their breathing, change their mind, and see if we can get through on all of those other things before consider stimulants. But you know, a spade is a spade, a spade if it's. If it's classic ADHD, I can't talk you through getting better. If they have, you know there's no psychotherapy that's effective really. For ADHD we can do different types of modifications, but like many times from the way the brain forms and you can see it on functional MRI. The ADHD legitimately lights up differently than people that don't have it right? The prefrontal, the cerebellum, and all the stuff in between. So that's a long answer, but it's because I know this is a problem throughout the week. All right. Yeah, OK. What is the time limit is required to be stable? Give me one second. I just gotta stop while my pagers. I'm sorry I have about three of them, so bear with me. Alright. Gonna let that go? OK. What is the time limit? Is state required to be stable on antidepressants and anxiolytics to be allowed underway 90 days. So 90 days. Very big deal on that one. And that could even mean like if you drop sertraline from 100 to 50, you just extended them for 90 more days of not being fit. And so this is the tricky part, right about being an operational provider. Sometimes I would have that discussion where it maybe if they were civilian, I would have taken them off. For any or drop the dose, but if if that's gonna hurt the mission and hurt there like development and their milestones and promotion, I why would you do it? What you would just say like hey, on post deployment leave. Come on back. We'll reevaluate and do it then. OK. Next. Yep, 90 days. You guys answer. Good. Thank you. Thank you. Yep. Is there any way around sarp if all referrals go through them and they are blocking further treatment? That's an interesting question. When you say, are they blocking further treatment? So first things, first, AA and NA are free and anybody can go. Next thing is, I would pick up the phone and get your senior medical officer. Or maybe that's you and have a conversation with the director of the Substance abuse treatment. So sometimes if people are considered treatment failure, which is a terrible word because in the addiction medicine right, there is no doubt. Why can't relaxing in that condition right? But we call it treatment failure here. And so there's things where I will sometimes say, like, hey, I noticed that we're not really getting the dual diagnosis treatment out of that start program. And I'd love to send them out in town. Can we disengage to the network to, you know, a certain type of program? And there are many of them that we use, and I'm happy to talk to you offline about them, but

sometimes we'll get benefit if they're dealing with combat PTSD during that treatment program. Now, there's some sort programs that are amazing and have the best outcomes. Because they have the staff that do that dual stuff. But that's what I typically do. If you don't like the disposition, then you know what I mean. Then you you can go to the department head of a program or the Directorate or so on, though. That's just a professional courtesy that we're curbs, siding that all day. We can't make the right call and everyone but I can also say, you know, there's only so much to go around. And so if you have someone who has not failed treatment yet and you only have, you know you're going to try and give them that. It's like mission readiness, right? It's a triage system. It's just like on the battlefield, right. There has to be calls. And I think sometimes in the mental health world. It's harder to understand it. Uh, is it can be cocom dependent. Yeah, medication dependent also. OK, good. Does that time frame apply if we are using behavioral health Med for a non behavioral condition? Yeah, very tricky. I tried to augment with some of my surgeon, you know, Cocom surgeons to say like, hey, I'm using gabapentin and they're using it for this and not that from there. It depends on the, the the current surgeon that's out there. But I promise you they want 90 days to ability. So ellaville gabapentin, they're serious. And if there's any. Any type of behavioral health Med, they want it stable. So I sometimes choose a non behavioral health Med for a different condition if it could be considered in that lane. So, but I've also had other surgeons that will allow it to go. Also, if you're on a ship and you have doctors there, sometimes they're more likely to allow some of this stuff because they have medical assets right there. Then if you're going and there's no medical resources out there for more land deployments, all right, for our submariners, divers off, they must be stable for some of the free, yeah. Yes, excellent, correct. Alright. Submarines diverse off. Yes, 1000% all I did was waivers over there with our awesome Diet medical docs. OK. Thank you, miss presentation. Mental health is a big issue, especially from marines, United States, Marine Corps, tone of the force. Data was just released with very upsetting numbers. All the following numbers were increased compared to last year. Sexual assault, domestic violence, drug abuse and suicide when compared to 2014, 2015 numbers. The 22 numbers were much worse. Drug testing, increased sexual assault, increase suicides were nearly double. Yeah. So there's, I think they're just acknowledging. Umm, that we're in the fight of our lives, right? It doesn't like it, doesn't stop. You know, whether they're they're on deployments or not deployments. It's almost like every day we come in and we're trying to work through this. And you can take a look at, you know, the civilian population as well and the amount of stressors going on. Right. And it's more than just the COVID. Right. Pandemic. I don't think it helped anything. But I don't think it was the make or break of things. We look at the financial market stressors, we look at relationships falling apart. We look at social media, we look at the destruction of the family of origin. We look at, you know, there's just so many things and we know that baby's brain is impacted since in utero. But this is not hopeless. I am absolutely an internal optimist and I have watched people save themselves and I've just kind of helped them along in it. I think compassion goes a long way. I think. Walking with them, looking at as a team approach. I believe in all of that. So anyway, I know I have more questions. I gotta keep going regarding charting. There are many of these forms embedded. Yes, you got it. Thank you. We're still working through our concern Genesis, but I'm glad to hear that they're embedded right through. This is a great topic. Yeah, 50 to 70% are mental health related. This week alone, we had two sailors brought to the clinic by their command for SI. I'm happy the word is getting out for commands to know where here, but want to ensure we're doing the right by our patients. Any new resources given to command leadership to help with mental health concerns exhibited or expressed by their staff. Yeah. So this is part of that female force readiness. And of course, it applies to both genders. And where we're just trying to get resiliency focused, right? There's a warrior transition. A

warrior toughness apps that are out there that a lot of the military is using right now. There's the human performance programs that a lot of people are using. There's the meditations, but we will have that channeling the warrior within. It's going to be a great podcast resource and ways that we can push to the deck plate how to get them to self reflect. How can they find their grit? How can they rediscover that toughness? They can listen. They can take it on their own. We are constantly pushing resources to them, but sometimes it just doesn't feel like enough. Do you have recommendations for resources? Yeah, resiliency training. So. So we're resiliency training, right? That's that warrior toughness. If you're not tracking it, please take a look at that. There's an app. It's all free. And that channeling the warrior within is going to be another one soon coming. And then. Of course, with the resiliency training, there's eosc, EOSC and a lot of commands are pushing. People to it, there's a formal training programs that are associated with it. They prioritize certain billets to be able to attend it first, but I'd encourage you, you know, there's like the NC cost, right? You know, which is just like. Operational Stress Control Marines have that as well. So OK, any tips for screening for sailors seeking only for secondary gain of leaving a tough, demanding job? Or is that just a bad mindset to have in general? You know, I think there is a diagnosis of malingering because there are some people that are secondary. Gaining the question is secondary gaining for what? And is that something that we can re incentivize, you know, the people to come back and remotivate and maybe if we can get them a good enlisted mentor, Officer, mentor, they can they can push through it. We use some more sophisticated psychological tests that I'm not gonna push on here because you won't be able to run those batteries and the OO, you know, GMO dive, medical officer and and, you know, IDC world. But we do have some evidence based ways to screen people to see if they click on those secondary gains. It's frustrating and unfortunately, it takes away the motivation from all the rest of them that aren't doing it. I'm always like men and people are lying about certain mental health conditions. Their life is probably not that good. Like who has the time? Like if I'm not gonna wake up today and be like, oh, I think I'm gonna do this. Cause my life is so great. I'm usually their life is pretty not great. And so I'm trying to do implementations of how to adjust that. OK, next. Your thoughts appreciated on young sailors already stationed overseas who have entered into treatment via medicated and Council depression and anxiety with regards to their next overseas assessment. Suitability. Right. So they can be suitable like you have them overseas. You treated them right. You recognize it and treated them. Which is exactly what we want. Right. So that 90 day stability they can clear on a regular basis with when I was engaged with our dive, medical and GMO and like and they were asking like hey from a mental health perspective, are we clearing these folks? And the answer is yes. Like if they are stable and treated, it's just like hypertension stable and treated right it should be not considered anything else. There's biological reasons for many of these disorders and so we cannot look at them any different than other types of medical conditions. Now if they are in and out of SI. And you're still on a met. I mean, that's not stable. I would not screen them clear for the next oconus villa or C duty. So I think that needs a hard look at each and every time. OK. Is there a timeline for when Warrior within podcast will be released? Huh. I am so excited about this because we worked on it for months. I can tell you it's in the final. So the female Force Advisory Board approved it. They had asked for us to add one or two extra slides to talk about resiliency and and and a certain diversity population. It is being added. I gave a resource to the Tiger team. They have a meeting next week. They're going to try and generate it as soon as we get it back from that Tiger team. My hope is in the next month. We have to push it to the view Med Public Affairs office, and then we're gonna push it across all medical specialties and listed officer and we're going to try and get it to our contacts at deck. You know line side. OK, Next up. Sorry, I'm talking fast. I know we have a ton of questions. They just keep popping naval Center for

combat and operational stress control used to teach mind body resilience, train the trainer and Balboa. Do they still offer this course? Additionally, Balboa has a mind body medicine course at one time. OK, Dave, Nissan, Nissan, David. Nissan is the psychiatry residency program director and is my direct contact for Naval Medical Center San Diego. And he would be somebody. Who should be able to find that answer on what Balboa offers? David Nissan NIS, SAN Commander type. Alright, regarding sleep, I have heard there are some available resources for various bases for folks struggling with sleeping like insomnia, nightmares that in hold on that. May make both mental health and physical pain worse. I haven't heard that, but what I would say is what is **** **** evidence base is cognitive behavioral therapy for insomnia. There is a CBT I app that anyone can access and it's it's actually great. And so it's really hard to stick with because the truth is on one of the things we have to do is sleep restriction. So if the only sleeping five hours, I'm not going to have to go to bed at 10, stay in bed awake until 1:00 AM and then sleep until six. We actually have to reduce the time they're in the bed because they conditioned their mind. Like Pavlov, that the bed means insomnia, and so there's certain things that we do. So for like a week or two, it's it's a tough go, but that doesn't mean it's always worth as far as nightmare. We use kind of like imagery rehearsal therapy, which is another evidence based treatment therapy to try and target through that. Clearly if they're having PTSD, we want to use cognitive processing therapy, right. Prolonged exposure. Emdr one of those evidence based psychotherapy. Sometimes we use medications as well. I agree there's rebound insomnia off of Lunesta off of Ambien. And and, you know benzos, I try and hardly ever go to those medications. Once they're on it, they don't ever want to come off of it and they can be highly addicting. And so I don't see much use except in acute short term for those medications. We will often use medications like mirtazapine which is Remeron for those that are unfamiliar with the other name we use Doxepin right. Sometimes that is helpful for sleep maintenance. We'll use medications that people can be on for other reasons to try and help with sleep. OK, but of course, meditation, meditation, meditation. Another good website for phone applications. I don't know if they're just telling me or you want one. Yeah. Cbti, maybe they're answering. Any recommendations? Feedback one mind cyberguide.org. Perfect. Thank you for pushing it. What was the acronym? Yeah. EOSC, I think it's Expeditionary operational stress control EOSC I may be butchering that, but you can literally just scoop it up and if not, I have a normal e-mail address now that you can find in the global, it's Heather dot. L.shibley.mil. At health.mil. So we'll be able to find that. And I think I know it's 1213. I think I hit the questions. Please type in or raise your hand or just unmute. So we can have a dialogue or if you have. Any cases, please don't use any HIPAA format, but I I'm all about. I have this case and I don't know what to do with it. I know some people may or not be comfortable with that, but I'm so used to answering on the fly questions. One other resource that people may or may not be aware of. You know there's a lot of self help guides out there. I'm going to turn around and grab one or two books that we recommend to people all the time, so bear with me. Give me one SEC. Alright. We'll start with this one. I don't know if you can see it. All right. This book is great. The anxiety and phobia workbook, right, we also have, there's a dialectic and behavioral therapy workbook, but this anxiety, one the index of this chapter, it goes through like relaxation, physical exercises, coping with panic attacks, self talk, mistaken beliefs. Right. So what is self talk and mistaken beliefs when someone comes in, right? Sometimes they're caught in that negative thing that just goes around and around in their mind. And so we want to catch. What is it that they're saying to themselves and and. And the Cycle World I always want to know, where did they hear that first? Many times they're internalized something apparent, a teacher, somebody else, somebody told them. And so we challenged, like, is that your voice or is that somebody else? I also do a lot of work where I try and find where did they stall

developmentally. Right. There's core wounds. Is it trust? Is it worth? Right is safety. Is that unlovable? Right, not good enough. I wanna understand that because then I can understand where those comments, but I can't catch it until I have them write down. Like, what are you saying? That catch yourself? What are you saying to yourself? Just write it down. Don't challenge you. Just write. And then the next time I come in, I'll say. OK, let's look at this like judge and jury. That's CBT. Like, is this true? Is it true all the time? Is it not right? Is it not true or is it? Is it helpful? Like let's say it is true, right? Is it helpful? So a lot of the work that I do is actually on acceptance, like the letting go. But they're not being able to change the past. They call it the F word, but it's the other F word. It's actually forgiveness. I mean, it's a beast to get someone to forgive or self compassion. So when I'm working. When I'm working, let's say with senior senior folks or senior operators, there is a sense that they have to be perfect, right? There is no room for mistakes ever. I don't care if it's Admiral generals commanding officers, shooters, you know, whatever it is, right. And so how does it? How do we teach them when we taught them always to be invincible, that that's actually not their truth. That's no one's truth. Right, sue. And to how to show themselves some of that break some of that. And so I'll I'll often times. Use some of their own words and it's important too. So when you're in the OO, you know you're embedded, you're out there. What is the language? So you know, an SWF, oftentimes we say work the problem. So when I see someone just coming undone, I make them pause and I'm and I'm like, well, because it automatically snaps them back into what they're taught. Right. We talk about ambush like they come into the situation, right with a spouse and and they get into this argument. They don't even know they were dragged in. Right. But then all of a sudden, they feel ambushed. And So what do you do in an ambush? Right. You shoot yourself out now, please don't think that there shooting themselves out at all times. But what happens is they become louder or they become more or they have to remove themselves altogether. And it's because what they learned their carrying over. Right. So in combat and all of our guys that have done a whole bunch of stuff are they're sitting. There doesn't have to be in combat, but. Their bodies are overdriven right their quarterfinals off. Their insulin growth factors. Everything's off because they're responding like they had to when the decision was on the line, right? And so, So what does that do? Most people, you can be irritable. Or you can be numb. And you can oftentimes be effective right in comma. Is it anger and numbness? Right. Is it because if you fall apart, if you become sad and also the the worst thing is not that you die? The worst thing is that somebody else dies on the left and right, right. And so that's so how do you get them back to the language of just the reset. Right. And so I actually force our guys to do guys and gals. Right. Cuz I know because we have hard charging amazing women that I'm impressed with every 5 minutes meditation after their workout because usually they say I have no time. So when you're stretching. Right, do a body scan. Do all the stuff. The other thing I want to tell you and I just came across this resource last week and it's being pushed out. There's a provider resiliency, so you can literally type in Google in like provider resiliency like military or DHA provided William C and while it's not an app, I wish it wasn't the App Store, it is not you go through it and it has burnout scales for ourselves, right, quality for ourselves, but it actually has right on the first sheet. It's like when's your next vacation, right? Something we all need it has. And things like it has four different free meditations. It has multiple different motivating quotes because sometimes we just need to get out of what we're currently in. And so if I can say anything, it would be to take care of yourself. Because when you don't, there is no way you can extend that healing to the person in front of you. Sorry. So what's the provider resiliency? So I'm going to look away from the screen right now and I'm gonna go give me one second. OK, so I'm going to read this from. Bear with me. I have the I have the e-mail, so this is from Colonel Dizzy. And So what I am tracking is it's called DH a provider resiliency. And I

literally Googled that yesterday. Or you can just say DHA provider resiliency app. But please just Google it, don't put it in the App Store. I know that sounds weird. But anyway it it's it's a you know it's from the DHA physiological Health Center of Excellence and it's totally free of charge. The other thing that there's a resource out there is there's it's called center of deployment psychology. OK. And the center of deployment psychology has free training for military and now sometimes you just have to, you know you have to sign up and you have to sign up in advance and you know. You guys aren't. Don't have to be expert in some of the therapy, but wouldn't it be nice to know a little bit more if 50 to 70% of who you see are coming in with mental health because then you can utilize some of the things like I talk about the £5000 phone like it's the hardest thing in the world to pick up. But once you do right, I talk about how sometimes the enemy has a vote. Right. And so if your body dies like, like when you're out in mission set and you kill somebody, you had a vote, right? Yeah. So probably if you enemy took that away and just said the person just died, right. And so sometimes you have to flip their challenge or like that, you know, but it really depends on the trust that you have with them to sit. So what you need to do right is listen more than talk. I will use words like. I can see that you're in pain. I'll see where it's like. It seems like you're carrying a ton. You know what was the worst of it? Right. What is your greatest challenge? And then just stop. I will never hand a tissue over to somebody because I never want them to stop where they need to emote. I will have it. They can reach for it. It's not that. I'm mean. It's actually a therapeutic technique because the moment I hand them a tissue. I'm shutting it down. Why would I do that? They probably haven't shut down their whole life, right? And so I'll pull. And I'll say, and where did you fill that lap? Right. There's all of these things. And so anyways, that gets into the details. But yes, acceptance. Forgiveness, sitting with walking, with answering the phone. When they call, it's important. I know there's boundaries and stuff, but if they call in and you don't return it, it's the little things. They'll never come to you for the big things. OK, so that was the last question that came as 1221. My God, I hope you're eating while this is going on. I know I have 9 more minutes, but Shannon, I'm going to pass it back to you to see if there's anything else that you wanted me to touch on. And just to remind everybody that all of our resources are on that mental health site. I would shoot it again, Shannon, right into that chat. So the people that weren't. On Lieutenant Commander Eubanks, call can see it once again. And then I'm tracking that you're gonna try and shoot those rating scales on over, but that they are embedded into our electronic medical record. You know, genesis. Alright, I'm muting myself. I hope that was fun for everybody. Hit me if you need me. Commander Shirley, thank you so much for that presentation. So engaging. And I think we had some really, really great questions from the chat as well. So thank you very, very much. I think we should be all set to move right along to our next session. And so we've got session 6, transgender healthcare and military and we're excited to have a presentation by Commander Mara and Lieutenant Commander Bucknam. So I will pass it over to Commander and Lieutenant Commander Bahnam. Thank you so much. Hi, it's commander Mara. I just wanted to check to see if my mic's working OK. Yes, ma'am. We can hear you. Thanks. Thank you. I think Lieutenant Commander Brougham was going to start us off. I'm just working on my camera right now. Hopefully that comes up. Can you hear me OK? Yes, ma'am. We can hear you. OK, OK. I'm working on my camera. Sorry about that. I'm Lieutenant Commander Beckham. I'm an OBGYN at Naval Medical Center, Portsmouth. I've been a staff OBGYN for over 6 years. And I've been involved in transgender healthcare with the military for nonconsecutive 4 years about, and I'm currently on the NFL transgender care team as one of the Co chairs. Next slide. We have no disclosures. For this presentation, we want to approach different types of terminology that you might enter encounter with your patients and the transgender. There. It goes in the transgender community as well as discussing primary care that you might provide

to your patients, talk about policies in the military, in particular in the Navy. Umm that are relevant for your patients and how to access transgender healthcare for these service members. Discuss the transgender care teams. They're set up and how to make a transgender medical treatment plan or MTP. Umm. Address the role of the primary care provider as well as operational providers and how to facilitate transgender healthcare and discuss a medical treatment options that might be provided for transgender members as well as surgical treatment options that could be discussed with these service members. Next slide. So there are a lot of different parts of the patient to consider in discussing the gender spectrum. We think about gender identity versus gender expression, which is separate from sexual orientation. So linking the two together would not generally be appropriate as one equaling the other. So considering that the patient a transgender patient can be anywhere on the spectrum and for the. Sake of this lecture, we're using the term transgender, but this could be anyone on the spectrum of transgender to include nonbinary. Umm or agendered so for, but for the sake of this presentation, we'll just say transgender. But for gender identity, they could be cisgendered or transgendered, or somewhere in the middle, and then they can express their gender and gender fluid fashion or as one expression of these. And then again, this is different from sexual orientation, where they may be attracted to someone of the opposite gender or the same gender. Or both. Next slide. So it's important in the clinical setting to approach transgender patients in all patients in general with no expectations or preconceived notions. And so one way you can do this is to set up your clinic space in a way that makes it more approachable and inclusive. So instead of calling it location, a women's healthcare. Clinic. It can be a sexual and reproductive care clinic. I know this was touched on a little bit yesterday as well as things like the women's well women examination, calling it an annual or well personal examination and there's some different terminologies you can use here. Also setting up an inclusive environment starting from when the patient arrives in the waiting room. And so I'm calling a patient from the waiting room by their last name and a non gendered addressing. Umm uh, which for us in the military is fortunate we can use a non gendered rank. And so calling of rank and then a last name would be appropriate. And this is an important. Thing to consider because in the waiting room this is a person who's very publicly located, and if you're using a non gender, that terminology that they don't associate with, this could cause significant. Umm, uh associated feelings for them of gender dysphoria. And then again, we will discuss this further, but taking sexual histories that are appropriate and menstrual histories and then. Talking about their sex marker in the medical record would be appropriate as well, and listing that down as far as what they're using so that can be looked at by future providers. Next slide. Next slide. Umm, so some statistics here in the military, this is a more recent statistic, but it's most likely increasing from this, but about 1.5 million individuals identifies transgender or somewhere on the spectrum. This is actually more frequent in the in the world at .6% of the population. It is important to note that a large percentage of transgendered individuals do have significant psychological distress. Umm. Or comorbid psychological conditions and up to 40% of these will attempt suicide at some point in their life. Due to either feeling unaccepted or having feelings of depression, anxiety overlapping with their gender dysphoria, they're more prone to increased frequencies of unemployment. Situations of poverty, homelessness and being uninsured with healthcare in the clinical setting. Many of these have been refused care by providers for being unable to be addressed in an appropriate fashion or being treated for the medical condition they're seeking care for. So almost a third of them have been harassed for their being transgender or made fun of or felt uncomfortable in this situation. Umm. And then being in healthcare setting has led to significant delays in care due to concern for experiencing pain with the physical examination or worsening of dysphoric symptoms due to having to discuss their their transgender condition or to be

called by pronouns that they don't identify with. Next slide. This is a little bit more about the gender spectrum as well as different terminology that you might approach, and I think the biggest thing here is that you're not going to know every term that you're supposed to use in every situation, but just having an open frame of mind and talking to the service member or the patient about what terminology they use for themselves and knowing some more offensive terminology and avoiding that is appropriate. Umm. So in general, transgendered man or transgender woman or transman transwoman is appropriate? Non binary. And the things that we don't generally use anymore, transsexual will get to this a little bit later, but that's still is part of our I CD10 coding, but in more coal, local colloquial terminology, it's generally not used. Gender dysphoria is appropriate. But talking to your patient and talking to them and using the terminology they use is most appropriate. Next slide. So setting up a appropriate clinical encounter would be starting out by making no assumptions, asking the person that you're seeing what their pronouns are and how they identify. And then as you continue your patient encounter, supporting those pronouns. So continuing to use those pronouns that they've given you before at the beginning of the encounter and not ignoring them or intentionally using the opposite. Pronounce. If you do use the opposite pronouns and it was accidental. Of course you can. You can make mistakes. It is natural in the clinical setting and just acknowledging that and moving on with your encounter is appropriate. Umm. In the clinical environment using generic terms. For different. Umm, situations in in physical examination and was well as the clinic environment against instead of saying well, woman exam just well exam educating the staff on how to. And a appropriately interact with transgender patients, again calling from the waiting room and maybe doing. Different parts of the vital sign checks and such, such as that and talking to them about menstrual histories or getting that initial intake, would be appropriate if available. Using having some type of more welcoming all gendered restrooms. Umm or. Pictures that are welcoming to the LGBTQ community and then during the encounter, trying not to ask probing questions that aren't relevant to the encounter and that would make someone feel like you're just asking questions because you're curious and not necessarily related to the reason that they're there. And then more importantly, making sure that the reason that they presented for their encounter is addressed. And so there are situations that you might see transgender patient that you don't feel like you can particularly treat them for that. But making sure you can refer them to someone who can so that they can get the care that they need would be appropriate. And then along the lines of relevancy, you would want to make sure that any examination physical exam, especially if the genitals. Would be appropriate to the reason that they're there for and, and considering that it may be something that could worsen gender dysphoria or cause them significant pain. Next line. Next slide. Umm, so a little bit about preventative care for the transgender population. Umm and trans men, it's important to consider what what organs are present essentially. So in a trans man who is not had a hysterectomy, there's still cervix. So you treat the cervix. Essentially, you would want to make sure they have appropriate Pap smear screening. You would perform this as you would perform any other Pap smear on the frequency. That's appropriate. Lesson 30 versus over 30 in particular. For trans men, it is important to be mindful if they're taking testosterone therapy. They're much more likely to have vaginal atrophy, and for this there would be a much more likelihood of increased pain with the exam and then also an inadequate specimen for the Pap smear due to that atrophy and so counseling that then that they might need a repeat pap smear for. This unfortunately could be helpful at the outset. Also, breast tissue screening and so some individuals may have a mastectomy or chest contouring surgery where a lot of the breast tissue is removed. Umm, if this is performed in general, there is still fatty breast tissue there and this can lead to breast cancer in the future. So some type of screening that

is still recommended per guidelines. As for a Natal female who still has normal breast tissue so annual or biannual screening with an ultrasound or MRI could be considered after the age of 40. And then for trans men who have not had a mastectomy. Similarly to. Cisgendered female. For trans women, breast tissue screening is important because exogenous estrogens would likely increase their breast tissue or breast cancer risk, and they will have hypertrophy of the breast tissue. And so starting breast tissue screening 5 to 10 years or after the age of 50 would be appropriate. Regardless of the type of surgery, if they have a reconstructive surgery, the prostate is not removed in general for trans women. So prostate screening is still important. And then depending on types of surgical reconstructive procedures that a trans woman might have, if there is a neovagina that's been constructed from penile tissue, this is a cartoonized epithelium. And so a new vaginal exam may be appropriate if they're. At a higher risk for any type of skin cancer. Excited. And so a little bit more about sexual health, preventative care. It's important to consider distinct language. I know this was discussed in the the lecture yesterday as well, but talking about specifically what type of intercourse. I am a trans individuals having to know what their sexual health risk is and so. Umm obviously if it's in the purview of why you're there for that encounter, making sure you know if they're having penetrative anal intercourse is this from another penis so that you know what the type of? It's uh STI risk is and you can start out by asking very open-ended questions. What type of intercourse do you have? Can you tell me about it so that you don't have to be as. Umm, invasive in your quoted line of questioning, but make no assumptions about when when they say they have sex with a female. This could be a trans female. You don't know what what exactly kind of they're referring to as far as risk based approach goes, it's important to note that HIV is much more prevalent in the trans female population up to 14% and up to 44%. And black trans women. So this is a a large group of. Individuals that HIV screening might be more appropriate, and then for those who are at high risk prep assessment or assessing those for whether or not prep would be appropriate is definitely advised. So in individuals who are having sex essentially with a penis with other individuals, with a penis, high risk screening would be appropriate every three months in addition to annual HIV's every three months, he would do a syphilis as well as a chlamydia and gonorrhea of the urine, ******, and faronics. And then in addition, an HCV our hepatitis, if they were HIV positive. It's important to note that testosterone, although it will most in most cases stop menses, is not considered a contraception and they may still ovulate, and these transmen and in transmen who are taking testosterone and can cause infants with a low birth weight. And if that infant is a female masculinization of the female, and so test contraception counselling or knowing their risk for being. Possibly to to conceive would be appropriate, and then also for these individuals, if they need some type of contraception. Progestin therapy would be you're most likely route or barriers, of course, because this won't impact their estrogen levels and their testosterone therapy. Next slide. Text. OK. Commander Morrow. I don't know. She wants to. Jumping. Maybe not. OK, well, I will keep going then. OK. So switching gears toward naval or DoD in general policy? We have a gone through a lot of changes in the last seven or so years with the military. Originally back in 2015, this was advocated as a area in the military to. Look at for transgender individuals to start serving openly and it was made it into a policy in 2016. Umm, over the next several years there was some dialing back of those policies, for lack of a better word, and then back in 2021. Umm it restore the original 2016 policies with this new DoD I accessions and this has gone undergone a few changes since to make it a little bit more accessible for transgender service members to join the military. Next line. So this is a little bit of a busy pathway, but this is just showing specifically for San Diego, who I don't work with myself, but it's pretty similar across the board for the Navy and and most and most services that. When a transient under service member would like to start the transition process in the military, in general, they start this

by going to see their PCM or bringing this up to a mental health provider who can start to get the ball rolling. And so this starts a process of activating referral to mental health if they haven't seen them yet. To get a diagnosis of gender dysphoria. Umm, making sure that any other comorbid mental health conditions are well controlled then this gets. K referral, usually to a transgender healthcare team to help with care management coordination and then to endocrinology. If the service members desiring gender affirming hormone therapy. After this, if everything's been completed and the service member is appropriate for. Transition, which in most the vast majority of cases they are it care plan is generated which is then goes to the service members CEO for approval and then after that it's up to the CEO to approve it with a timeline that they specify. Either it's a yes or it's a yes with this particular timeline. Next slide. Umm so after the the service member submits their care plan and the CEO decides to approve it or amend the timeline, then the process of the the transition starts. With either hormone therapy. Or if the service member did not desire hormone therapy, this is typically in folks who are nonbinary. Umm, this would be a case where they would just move on to surgery, but generally in this category gender affirming hormone therapy would be started, which gets the timeline started to access surgery and then an ENTP or an exception to policy would be requested to allow the service member. To access. Uniform standards, grooming standards, birthing and then also PFA. Standards for the gender they're transitioning to. The transgender care team. And it can vary depending a little bit for us versus the. West side, but for the most part, there's gonna be a chair or a couple chairs. Case management is a big part of this. Administration. Uh, endocrinology is huge primary care as well as a little bit of involvement from OBGYN. Who helps provide? Generally, hysterectomy services psychiatry is huge. With psychology as a mental health providers, urology, which can generally provide orchiectomy services, plastic surgery, who does provide mastectomy chest contouring services and then some fleet representatives as well. Next. That's all. Moving on to. Service member responsibilities and so the service members going to see a military medical provider, they will get their medical diagnosis of gender dysphoria generally from mental health, and then they will send their treatment plan to their CEO, make sure their CEO is kept in the loop of their care and what their treatment schedule is going to be if they're going to get a deers gender marker change, which can happen after six months starting hormones. Umm. And then if there's any changes to the schedule of treatment. That will need to be assessed and then if there's new care after gender marker change that was not in an approved treatment plan. This wouldn't require an update to the treatment plan. Next. So the CEO is responsible for looking at the military or the medical treatment plan. Approving it, essentially, if there's something that they have questions about, they should contact his transgender care team or the SCC. And if there's something concerned about the timeline, they can review this with the service members as well as the care team or the SEC. If there is a discussion about deployability or whatnot that they would like to alter the timeline for and make sure everything's within regulations, make sure this service members maintaining readiness as well, and that the service members following their SMTP in concert with their medical providers. Next slide. Umm, a military medical provider is important for helping to establish the medical diagnosis in concert with a mental health provider. If they're comfortable with this, recommending any medically necessary care and treatment options to include surgery. Different types of surgeries advise the CEO and provide kind of liaison services as well, with a transgender care team and can help advise the CEO as well when transitions complete for the service member. And if they need to after the gender marker change, they can provide any additional necessary care that the service member is requesting. The primary care provider is essential in this role, and this can be someone from the fleet. Of course, the operational providers, someone in one of the clinics, but they're important to provide a preventative

healthcare discussion of, you know, sexual health risks assessments and for prep. And then of course, contraception. It is important to note that in transgender service members, if they're desiring gender affirming hormone therapy. Some discussion about if they're interested in future fertility is is warranted prior to this, because starting hormones is going to cause a decrease in any sperm or ovarian function, and it may or may not be reversible. Umm. And then if they are able to and feel comfortable with, they can manage gender firm and hormone therapy with or without endocrinology involvement and whoever starting gender affirming hormone therapy is responsible for starting limdu for the individual. It is a requirement that they be on the limb do while they're on gender affirming hormone therapy for up to one year until stability is reached, and then they can place referrals to other. Surgical providers, including OBGYN, urology or plastic surgery, as well as mental health reproductive endocrinology. If there's a trans man desiring ovarian cryopreservation and then assist with completing documents, of course, and helping the. Transgender care team with these documents as well. Next slide. So the service member will need referrals to the various specialists again to establish their diagnosis, including mental health, to obtain the diagnosis of gender dysphoria, which is, as we will talk about a little bit down the road, how this diagnosis invade. Yeah, which must be documented or validated by mental health provider. So a lot of these service members may be in more small commands where there is no mental health provider at that command and they have to be seen by a civilian provider. And so this generally will have notes uploaded to their chart that then end up getting reviewed by one of our military and mental health providers to assess their their clinical diagnosis. Also to some type of endocrinology expert, whether that be endocrinology, we have an adolescent medicine physician here is very comfortable with our. Prescribing of hormones, use of the other Co chair for the team as well as possibly fertility preservation if they're interested in this to that being too possibly urology or gynecology. Looks like. Alright. And I'll jump in here to talk a little bit more about the initial consult from the primary care team to the transgender Cura team and some of the things the console should include. So these are things that will be helpful moving forward and I do want to pay. Uh acknowledgement to their questions that are coming up. Some of this will be covered, but some won't. So especially for resources, we will have some slides at the end that will have some of the instructions et cetera. So stay tuned and or get copies of the slide deck for those for references. But as far as your initial console to the transgender care team, it should include some basics like making sure the phone number or e-mail or in there the service name pronouns and their preferred name. If it has not been legally updated. Their primary care physicians, name or PA's name or IDE's name and their e-mail and phone number because the care team will actually send updates to you both with the initial care plan and every review that they do. The final desired gender marker, because that actually marks the technical end of the transgender care team. But again, there will be continuing to care after that if mental health services ongoing or desired. If they have a comorbid diagnosis, this should be included. They plan for hormone therapy surgery and if they've begun any transition, gender affirming care prior to referral to the team, which happened especially in the early stages. I was involved in the transgender care team on the West Coast pretty much as soon as the policy got rolled out. And again, that mental health diagnosis needs to be either validated or documented by a military mental health provider, and that will be using the DSM criteria. Next slide. So as far as the initial visits and I make sure to document this as a continuum because again, many times it will take more than one initial visit to initiate somebody's care plan. So you're going to be reviewing the history of their gender experience, you're going to be talking in any prior hormone use and any also real life experience. You're gonna discuss patient's goals. Everybody's goals are different in their gender journey. And you're gonna talk about safety concerns it. Depending on where they are or

they in the barracks, or they set to deploy. You know, things along that pathway, addressing their social support system, talking about readiness for gender affirming care and discuss any risks or benefits of hormone therapy. Again, through the benefits are significant. The risks in many of our young healthy people will actually be relatively minor informed consent model is actually what we've moved to with the new standards of care which will be coming up. There will be a photo of this coming up in the in the slide deck and a little bit as OC 8 is what we're on right now that was just published last year by Wpath World Professional Association for Transgender Health and. Primary care or the initial person seeing this patient can talk about worrying screen lab studies, and we'll have some slides that go over this in depth as well as I'll make sure to get you all some references and providing referrals if other people are needed to be involved in this journey. Next slide. So follow up visits, we'll include assessing the response to masculinizing or feminizing hormone therapy if that has been initiated. Reviewing the medication use and making sure they have all the resources that they need at, like sharps containers, things like that. Talking to patients about mood and adjusting the medications as indicated. And oftentimes, again, we'll also talk to patients just about how they're feeling in general as they go through this transition. And because sometimes things crop up that they weren't expecting, discussing some social impacts on transition for patients as they start moving into presenting more as the quote UN quote, passing gender as some people would consider it. So again, things are gonna change as the way they present to the world counseling regarding sexual activity. And there are some great resources out there. I'm happy to share with folks if they have additional questions as folks are transitioning or undergoing gender affirming hormone or surgical therapy. There are some great resources out there for transgender people to continue to have enjoyable sexual activity. One thing that many of my friends and colleagues have come to me that are on the transgender spectrum talk about how sometimes their sexual orientation may change as they undergo their gender affirming hormone therapy, and so sometimes that can be a challenge. For example, one person I worked with was a very out lesbian and that was their identity. And then they began testosterone and their gender journey, and now they're viewed to the world as straight. And so that was a challenge. In in many regards, but definitely something to be aware of for your patients. Discussing and reviewing surgical options, we'll talk about some of the kind of check marks to moving towards surgical options, but you may not cover that all in one visit and things may change. Reviewing any plans to update legal name and gender marker on forms as I tell people your transition is not just medical or surgical, it also includes a legal aspect. So it's important to talk to folks, especially if they're going to be remaining on active duty on where they are and updating passports and things like that. And then assessing safety like we should be doing with all of our patients. Next slide. So this is a photo again at the W pasteurs of Care Eight, which was published late last year, and this is much more expansive than the previous versions that were placed out. And Newpath also runs a conference that you should consider looking into if this is an area that you think you're going to want to become. One of the care providers of somebody that is on the transgender spectrum. Next slide please. So this slide is meant again to focus on folks that are gonna be using DSM 5, TR criteria to diagnose folks with gender dysphoria, and this is adolescence and results and so many folks out there like somebody just shows up in an office and asked for her months, and we give it to them, especially within the military. We try and really go by the guidelines again that are in the DSM, the wpath, the Endocrine Society. So you can see on here again, it's a marked increment. Incongruence between somebody's experience and expressed gender and assigned gender of at least six months duration and manifested by at least two of the following. And again, it goes through the multitude of things that, especially our mental health colleagues, will be documenting in their notes. To say This is why we're giving this diagnosis of gender

dysphoria. Next slide please. And again, you'll want to specify if there is a disorder or difference of sexual development. We've moved more towards discussing differences of sexual development in the intersex population, so somebody with congenital adrenal genital disorder or things like that, again, they still can have gender dysphoria and they can still be transgender. But you want to make sure you're documenting this and your record as you're moving forward. Especially it may have impacts on somebody's surgical transition. And then you wanna specify if somebody as post transition. So again. We are going to be caring for people across their lifespan, especially in primary care, especially in family medicine, internal medicine. So we'll wanna make sure we acknowledge where they are in their gender journey as we move forward. And this is also important as was discussed for what types of preventative health screening will be needed. So for somebody that has undergone a radical mastectomy with or a mastectomy with chest reconstruction. They may not require the same treatment or screening guidelines, and you may have to to change those and. Increased information is continuing to come out to address these screening guidelines in patients that are of a gender minority. Next slide please. So again, this is going to go over some of the ICD 10 criteria that are gender identity is orders and this is something that some other countries have moved towards updating the language. But unfortunately we are lagging behind a little bit, but there are folks working on updating this language to make sure it reflects a respect and acknowledgement of the language that folks that are undergoing this lived experience use. So transsexualism is still in our IDP 10 and again that is falling out of favor. Gender identity disorder, again still in the terminology for ICD 10, falling out of favor. And so again you will see some of these codes in your note. And if you're having to code it, I do feel it's especially with the transparency of the medical record now. It is nice to let your parents, your parents, know that, hey, these are the terms that we use to make sure that we can get your care plan initiated and underway. Next slide please. And so going over the specifics of the transgender carotene care plan, so again. The the CEO is going to be integral and and and critical in certain parts of the the care plan prior to the initiation of any medical or surgical care. They're usually going to be involved prior to the initiation of any medical care. They will actually sign a memo that the patient will have, and usually it's also scanned into the patient record, acknowledged by both the CEO and the patient of the care plan. And certainly as was mentioned, any changes usually will get routed up to this CEO for anything that is in the. Pathway of an electively time surgery, even if it's medically necessary. As far as other portions of it, you'll have your mental health portion again with the military diagnosing provider and the date that that was done. Usually in there, they'll also talk about any comorbid diagnosis or complications that may be anticipated as a patient may move forward. And the plan for follow up care if they're just gonna be on a PRN or an as needed basis or if they're going to need scheduled follow up care. As far as medical treatment, the person that evaluated the patient got the initial lab work and did the counseling with the patient will often be named in this portion of the transgender care team care plan and the clearance for initiation of gender affirming hormone therapy, also called cross sex hormone therapy, will be in that section. As surgical the surgical section, we'll talk about any medically necessary surgeries that the patient currently plans at the time of initiation. And then as we review the care plan that will get updated and then occasionally there will be quote UN quote non medically necessary surgeries desired. And again, there's some significant debate amongst the folks that are occurring for transgender patients on if they're truly non medically necessary. But examples of some of this might be facial feminization surgeries or the. Cricoid cartilage sheep or things along that pathway. Vocal cord surgery is another one exceptions to policy. Again, some patients will pursue an exception to policy to try and be able to follow grooming standards sooner rather than later. And if a patient actually is able to update their dearest gender

marker and a timely manner, sometimes this exception of policy is not necessary though. So I do bring this up with patients as we're kind of going through that. You don't have to have an exception to policy, but many folks do. Want to opt for this, especially if it is around ball season or things like that where they want to be able to be acknowledged in. Along their colleagues, with their desired appearance and an anticipated completion date, will be on there as well. And again, it depends on the types of medical and surgical treatments the patient plans to undergo, and this is obviously a flexible date. Next slide. Next line. So we're going to go into a little bit more about medically, medically appropriate gender affirming care. And so the criteria for hormones are gonna be listed on this slide. Again, it's gonna be very similar to those DSM criteria. So gender incongruence is marked and sustained. They meet the diagnostic criteria. They have a capacity for consent. So again, this does not mean that they don't have any comorbid mental health diagnosis, but they have that capacity for consent, which again the majority of our active duty population, I would. Are you essentially all that are on full duty status will have the ability to consent. And again, these were suggested criteria and W path. When you look at the military specific guidelines that is going to be a little bit different for us and we do really try and go by these standards. Next slide please. So your initial lab work may vary on your patient and there's actually a really good thing. I recommend folks print out. It's from the it's called Trans Line and they actually have a guide and I'll try to include this in the links and I believe it's on our slide deck at the end that has basically little print out with recommended starting doses, initial lab work and then follow on lab work, but some of the baselines that you'll see is a complete blood count and this is to make sure that they're not anemic or have any elevated bug. Not as you're starting it, especially testosterone based hormone therapies. A lipid profile like 10 panel or CMP to look at renal function especially and also LFTS and then hormone levels or plus or minus. Some folks will draw an initial testosterone and prolactin level on anybody that's initiating feminizing hormone therapy and an additional estradiol and anybody that's planning on undergoing masculinizing therapy. I think there's quite a bit of variance in that but it is an option and then hemoglobin A1 see your fasting glucose is. I mean option especially based on the patients history, they're medical, both their personal and family medical history and next slide please. Next slide please. So initiating feminizing hormone therapy so the main component of. Of feminizing hormone therapy is going to be an estrogen and an antiandrogen, and again we have a list of some of the commonly seen medications and dosages on here. I put this up here as a reference for you, but again, there is some clinical art of medicine that will go into this as well. Overall, you will see some people drift towards certain methods of giving estrogens. One thing I would say is if somebody is high risk for a VTE blood clot. E consider the transdermal options, again across the field. There's some significant evidence that the transdermal options have the lowest VTE. Profile. So again, if you have somebody that you're concerned about this going with a method like that may be a good option. And then for anti androgens, there can be oral options like spironolactone and injectable options such as your GNRH agonist loop, prom, et cetera. You will see some evidence out there in the community about progesterone and particularly about breast growth with progesterone. It's pretty controversial and it's not in the clinical practice guidelines for most of the. Pain societies right now, but you will see it come up quite a bit in literature. Next slide please. So talking about your effects and the timeline is very important part of the informed consent because again, some patients may or may not have a great knowledge of how quickly their body is gonna undergo changes. And as you can see on this table, there is a big range in the amount of time it may take for somebody's body to undergo these changes. So some of the common ones I talked to folks about are the redistribution of body fat, talk about changes in muscle mass and strength again softening with skin changes in the. Oil glands at sexual desire may

change, decrease spontaneous erections. Brush growth, decrease in testicular volume, decrease from production and because and again going back to the discussion on if somebody desires genetically related offspring. There is some evidence that the reversibility is very quite variable. So for folks that are thinking they may want to undergo procedures to have a genetic offspring down the road. I do really encourage them to bank sperm and big a decent amount of sperm prior to beginning their feminizing hormone therapies. Uh scalp hair will change and it is important to notice voice changes are non based on the effects of feminizing hormone therapy. There is vocal cord. Vocal coaching that we can send patients to, especially with the military and speech therapy, is definitely a covered benefit. It's important to try and find somebody in your area that is able to and willing to work with folks. There's also actually quite a few good online resources that patients can look into you now. Unfortunately, the cost may not be covered fully, but for some folks that want to be able to do their vocal coaching and the privacy of their own home, this is a great option for some. And as I mentioned, vocal cord surgery is done by some of the ear, nose and throat and physicians. So again and that can be done through some of the military treatment facilities, next slide. So monitoring on feminizing hormone therapy, again, the you'll typically see us talk about ordering labs when there has been a dose change and ordering labs every three to six months. And those are kind of the guidelines you'll see in most and that's for the first year of undergoing gender from informant therapy. Typically after that it's every 6 to 12 months. So basically like your annual lab work, your some of your goals for your patient undergoing feminizing hormone therapy is try and get that testosterone level. With your testosterone, the total testosterone level below 50. And then also looking for the estradiol not to exceed the peak physiologic range for a cisgender female in their age range. They usually say 100 and 200 micrograms per ML. Certainly if you have somebody on spironolactone getting serum electrolytes and making sure they're potassium, particularly is looking appropriate is gonna be something that you're going to consider. And again, as we move forward and talk about some of the surgical treatments, folks that undergo an orchiectomy can actually stop that antiandrogen medication, which again some of the side effects are often related to spironolactone, if that's the one that patient is using. It does talk about considerations for bone mineral density and again. I'm talking to folks about kind of their risk profile. Certainly again in my other, my other role as a sportsman Doc, I talked to people about, hey, if you're getting lots of stress fracture or stress injuries, think about maybe getting that bone mineral density and making sure you're on supplemental calcium, getting good weight, bearing exercise, etc. That drop. For folks that end up going off their hormone therapy, their gender affirming hormone therapy is specially if they've already had removal of the testes. It is important to keep a close eye on their bone density because, again, that can certainly be impacted. Next slide please. So this is a table taken from the Endocrine Society guidelines. And again, this is based on estrogen. So their biggest risk that they always talk to people about that very high risk is thromboembolic disease, which again is lower if you use a transdermal preparations. So it is important to kind of consider that in folks that may have a risk profile, moderate risks again would be things like macro prolactinoma, breast cancer, coronary artery disease, cerebrovascular disease, chlorophyll. Yes. And hypertriglyceridemia. And again for most of the patients I've cared for. And again when I was with the Pacific transgender care team, probably 2 to 300 patients give or take have gone through this and the large majority that we're in, physiological ranges did not have any of these problems arise. Next slide. Next slide. OK. So as far as your masculinizing hormone therapy, really it's gonna involve 1 main component and that is testosterone. So one thing to be aware of for the idcs on the line is that testosterone is a controlled substance. So again, you'll have to be ordering this with your physician supervisor. And refractory bleeding again, you can consider a GNRH agonist. Oftentimes, I encourage

folks to take a look at their testosterone levels though, as typically testosterone, we'll do it pretty good job within the first one to six months of stopping mentees in many patients that are on an adequate dose. And as you can see here, there are multiple routes. The probably most common one I have with my patients is parenteral testosterone. Now as a question came up in the chat. There are some cocoms that do not allow patients to come into their area with an injectable medication of any kind, and so that includes testosterone. And so this is something that again you will have to look into the Cocom specific guidance for folks deploying on if you may have to look at transitioning them from a parenteral testosterone to a transdermal testosterone, which is also available in gel or patch forms, probably more commonly, I see gel used with most of my patients, but again. And then as far as things go, making sure patient has a good supply. If they are gonna go in and deployment is gonna be interval. And again that transline reference resource I discussed actually has a really nice table about transitioning from parenteral to the transdermal testosterone options. Next slide please. Other masculinizing medications I want you to be aware of that you'll see testosterone, cream, and Aquaphor that may be applied topically over the clitoral region for clitoral enlargement, especially as some patients prepared to undergo procedures such as metoidioplasty or things like that. There's some. Questionable again on how effective this is, but it is certainly something that you may see patients request and or you may see them get if they're seeing a specialist or a surgeon moving forward. Estrogen vaginal cream. So for anyone that's engaging in penetrative intercourse, if they have significant atrophy, estrogen, vaginal cream is something that is an option. You may also see this used for folks that have an unsatisfactory pap smear for a period of time to consider using estrogen creams topically for a period of time before they do a repeat pap smear if they want to move forward. And we can certainly answer more questions on that and some of the screening options for patients like that, I'm retainer finasteride. For male pattern, bonus is another thing you may see used cause again as that androgens go up. So maybe male pattern baldness. And then use of pedestrians again to reduce the estrogen levels in aid of cessation immensity. That might be an option for some folks and GNRH agonist like Lupron again to see sementes if it's not set with testosterone alone. Next slide please. So take this table 12 is again from the Endocrine Society guidelines and it's gonna talk primarily about the masculinizing effects in transgender males. And so again, this is that same timeline. And I encourage folks, if you're gonna be doing counseling with patients, which primary care is very able to do printing off this. This information to have available as part of your informed consent is very helpful. Most of my patients been very grateful to have something like this to go back to some of the main changes you may see is skin, oiliness and acne, which again can be in one to six months. Facial or body hair growth is going to be 6 to 12 months. The scalp hair changes 6 to 12 months. Increase muscle mass and strength over 6 to 12 months and fat redistribution, cessation and months are gonna be in that one to six month range. Clitoral enlargement one to six months, vaginal atrophy one to six months and deepening the voice in 6 to 12 months and vocal things to be aware of for your patients is that often they will. Go through what folks talk about that have gone through a cisgender puberty as kind of that squeaky teenager voice. So. Sometimes that can be pretty dysphoria inducing for folks, and so just letting them know, hey, you're going to get to the other side of this. We can also get you vocal coaching or speech therapy to get through this as well. And again, some of those online resources are also available for folks undergoing masculinizing hormone therapy. The masculinizing hormone therapy chart should be available again on the Endocrine society guidelines, and I will make sure again to try and get you all copies. There's a new reference I actually found that I really like, which also talks about the reversibility of many of these changes, because again, some folks may at some point in time want to. Discuss down the road. What would happen if I can't have access to my

hormones? What is gonna stay and what is gonna remain so that's another good reference that I can share with the group afterwards. Next slide please. So again, monitoring of people on gender affirming hormone therapy masculinizing gender affirming hormone therapy is going to include checking some hormone levels as well as folks will usually suggest you check a CBC to make sure that they're in the physiologic range. Now, be aware, especially if they're gender marker, is not changed in Genesis or Alta. You will wanna make sure that you're using the correct guidelines for the cisgender. Equivalent of whatever hormone you're using. So again you wanna make sure you have a mail range of, otherwise you'll be like, gosh, looks like they're off the charts on some of these levels. For other things that you will want to check again, making sure the testosterone is in the range of that, give or take 400 milligram micrograms per milliliter, and again, the transline reference that I keep talking about has an excellent table that actually gives the guidelines from the Endocrine society guideline, which is what this comes from, as well as the WPATH guidelines, and then also use CSF or the University of California, San Francisco also has some excellent guidelines. And they're all a little bit different, but they all span at these cisgender male range for age appropriate levels. Again, we talked about if that organ inventory or if they still have a a service screen, their cervix or talk to them about options for screening their surveys that can be HPV only swabs that can be making sure that they are comfortable with aspect of the museum and anywhere in between. So making sure that this is a available for patients, it's important. And then again based on if they've had chest reduction and chest reconstruction surgery, if they have tissue available to be screened by mastectomy by a mammogram, excuse me, that is something you can discuss with them because again, there's not great. Guidelines out right now for patients that have had top surgery for non cancer regions to figure out what's the best mammogram schedule for them. Next slide please. And so going over the wrists again, this is from the underground society guidelines as well. The biggest concern that they have is that erythrocytosis or hematocrit greater than 50%. And so again, I think in all the patients I've cared for over the years, we had one patient, maybe two that had this significant breakthrough cytosis and it was for folks that were going out in town to a testosterone location with a civilian that didn't check lab values at all. So. It just based on how the patient felt. And so unfortunately if you have a prolonged elevated erythrocytosis, you're at risk for things. And so you definitely do wanna be aware and getting some screening labs on patients as you move forward, moderate risk for adverse outcomes, again less likely to see, but certainly it will be on that informed consent form for many folks, the severe liver dysfunction, so transmission greater than threefold above the upper limit of normal and then. Again, some debate on coronary artery disease through vascular disease, hypertension and then breast and uterine cancer. Next slide please. Next slide. Alright, so the W path criteria for surgery. Again, this is the criteria for surgery, but it's going to look very familiar to the criteria for Harmons. So again Mark sustained congruence. Is something to be aware of and making sure somebody is mean that diagnostic criteria within the military, the criteria for surgery, will talk about two mental health notes to be eligible, and again, this doesn't mean they have to be sustained with mental health, but they just need to basically be have talked to mental health similar to our patients that undergo bariatric surgery, that they're ready and they have social support and they're ready to move forward with a major life changing surgery. And this is for. Any of the surgical procedures that impact fertility, and I understand that this is if a topic fraught for debate as far as why is it only for fertility impacting surgeries or why do we put this restriction in play? Many of this is mirroring the civilian guidelines. So again, if patients ask about it, I typically will tell them unfortunately this is where insurance coverage is across the board right now. And so this is frequently things that if you were out in town, it would also be. It would also be. Something that you would have to kind of jump through, it's not

a military specific loophole per se. Alright, next slide please. So as far as types of surgery, again for feminizing surgical treatment. So if your patient has been. Undergoing greater than two years or 24 months of gender affirming hormone therapy in a stable range, and it still does not have adequate breast growth, they could be actually a criteria for getting a breast augmentation within the plastic surgery department at participating military treatment facilities, depending on if it's deemed medically necessary or not, they may incur costs similar to other plastic surgery procedures that can be done through the military but can incur a cost. For example, I know several of the plastic surgeons in San Diego have done many of these procedures and again, there is some cost that may be incurred by the patient, again for surgeries impacting fertility. So again, for our transfeminine patients working actiony or genital reconstruction, penectomy or vaginal classy, it does require at least 12 months of gender affirming hormone therapy if they are otherwise medically eligible and it requires at least 12 months of full time real life experience. Either buy an exception to policy or a dearest gender marker change, and this is again a requirement from the surgeons again, which are gonna be civilian surgeons through either OHSU up in Oregon on the West Coast or from Cedar Sinai down in Los Angeles. Also on the West Coast. And again the East Coast would have their own local civilians that they were typically referred to. Again, as I mentioned, it does require two mental health evaluations or two mental health letters from a person that is. Familiar enough to be comfortable writing a letter, and again, they know that mental health specialty leaders do have some excellent resources from the leads on each of the transgender care teams to assist folks if they want to be able to help patients in this realm. And then the way that these are routed is through a DHA supplemental healthcare waiver for network care because currently at this stage in the game, the military is not offering any sort of genital gender affirming surgery with the exception of. Removal of testing so orchiectomy, removal of uterus, ovaries, tubes for our patients that have those organs. Again, cosmetic procedures may be covered. Things like a chondroplasty shave, facial feminization and again, that's either plastic surgery or oral maxillofacial surgery that may be moving. Down that pathway, next slide please. So for maximizing surgical treatment, this is going to be primarily chest reconstruction and it will be surge independent somewhat, but they will usually wanna see roughly three to six months of gender affirming hormone therapy with testosterone. There is a suggestion that there should be at least one mental health evaluation and a referral to plastic surgery at the local military treatment facility that's performing these surgeries. The reason for the six months gender affirming hormone therapy is again, the skin will change and there may be some changes that again wanna be stable as well as the muscle will bulk up. And so again you want to try and get the best contours. And so this is the the guidance that I've heard from the plastic surgeons that I've worked with on the transgender care team. As far as fertility surgery and packing fertility, so again, oophorectomy hysterectomy, bilateral self injected Amy and genital reconstruction, which could include metoidioplasty philosophies, apathy and implements for testicles and penile prosthetics. Again, at least 12 months of gender affirming hormone therapy, 12 months of full time, real life experience or role, or through an exception of policy or a deer gender marker change at least two mental health letters and DHA supplemental healthcare waiver for network care. And then. The Lieutenant Commander that asked our surgical treatments provided to transgender patients. Covered by Tricare, yes, they are covered by Tricare. As far as reversible, I'll get back to you on what you're asking about for that. If you're talking about detransition, that might be another tough call to get there. Next slide. So as far as administrative costs or administrative changes go, again some of the things that we're going to be looking for moving forward is and again, this is not in policy change right now, but uniform documentation of counseling on gender specific standards. So like the PRT, PFT or CFT. The so again, some folks for example here where

the Marines are documenting on a certain piece of paperwork, other services documented on a slightly different piece of paperwork and then uniform documentation and routing, hopefully being able to stop at a lower level with those exception to policies. Because right now they have to all the way up to DC, to the end job. So again, it's something that folks have been requesting when they especially within the community, if they ever meet with somebody that has the ability to change these things. On currently as far as the waivers for BCA PRT PFT CFT, it is Co dependence Joel. So again you still need your amdr or your local doc to sign off on why they think you should be waived and that CEO still has the ability to give the thumbs up or the thumbs down on that waiver. Again, other things that are being considered. So currently surgical procedures that are available through our military treatment facilities or things like chest reconstruction, hysterectomies, orchiectomy and there has been discussion on expanding and allowing reconstructive bottom surgeries to occur or reconstructive general surgeries to occur through the military treatment facilities. But that has to go through a pretty high level to be approved and again has a lot of discussion going on at this stage in the game. Next slide please. One other thing I would be remiss to mention is again, there's still not great guidance for folks that are serving on active duty for if they are able to seek treatment, medical and surgical treatment, if they are gender nonbinary. And so that's another thing to be aware of cuz unfortunately, our military system is still very binary in many of its guidance and gendered pathways. So I always like to include this slide as we go through talking with folks about. LGBTQ healthcare and that is, do you ask, do you tell as somebody who's a bisexual female, cisgender physician that served during don't ask, don't tell. It is so good to hear from folks that are able to. Ask their patients and engage their patients with gender neutral language and not assuming the gender of their spouse or things like that. This is actually a campaign that was put on by the national LGBTQ IA. Health consortium out of Fenway in Boston. And so they have these resources available with posters, trifles, et cetera, on their website. I'd make sure. Again, your local PA or Comm Strat gives the thumbs up, but again, these are things that I would love to see in more clinics within military medicine. And next slide please. And this is a slide that was from one of my good colleagues that is in Sparta, which is one of the transgender service organizations to assist in pure support as well as legal support for folks that are undergoing their gender journey well and active duty or in the VA and so this was put out when the guidelines were first changing allowing for open service back in the 2015 time frame. And basically they're telling the world they are. 30 they are already here, and they have already been surveying, so again, many of these folks I've been blessed to call close personal friends and have served with many of these folks. And again, I'm just grateful to be able to hear their stories and share a little bit of their gender journey. Next slide please. And know folks were asking for instructions and guidelines, so we do have the Doti on here, which is a 1600 TACK 5. Again military service have transgender service members. There is the Dodi 1322 Tech 22 which talks about the service academies. There's a duty for 1300 tack 28 on Inservice transition of transgender service members from back in 2021 and then most recently the they did some tweaks. On the sessions and retention standards. So these are your references. Again, if you need these available, next slide. These are gonna be some of your instructions that are coming up. So your milpersman, the secretary of the Navy instruction as well as some guidelines for folks that want to be able to see some of the equal opportunity policies. One question I get asked frequently since I've been over at with the Marines is how to figure out who is supposed to screen them for your analysis. So again, this covers this in many of these guidelines. And again, there are more admins covering some of this as well. Next slide please. So for clinical questions, again there is regional transgender care team, both Atlantic and Pacific. So on each of the coasts, I know the Pacific folks pretty well. So if you have questions and you're in the Pacific region, please feel free to reach out to me. Again, there's this service,

central coordination cells or the ECS. And again there is a Navy specific 1A marine Specific 1A Air Force specific one in an army specific one. So just depending on if you're going to try service or multi service location, make sure you contact the correct or have you. Their CEO contact the correct server central coordinating cell and just so you understand that is for administrative questions that come up. So anything that falls in that kind of admin pathway, a lot of times medical will get questions on it. So just you knowing that it's actually if it's admin, it's the service central coordinating cells that are gonna help the CEO or the leadership on those next slide please. And again, here are some of our references and I'll make sure to get out to you. The transline resource that I think may not have made the cut. Next slide please. And were to our Q&A, so. Lieutenant Commander, do you want to scroll through and start looking at some of the questions, or do you have a Sure. preference? Uh, yeah, we can start. And. Do you have a standardized template or screening form? Did you send that out? I know you sent a few links. Screening form with the questions and the screening questionnaire. I think I. For a Pap smear pelvic exam. Yes. So I included a couple of things in the chat. As we were discussing that trans Care, UCSF guide for physical examination, there's a Canadian medical journal that has some resources and then also a cervical cancer screening for patients on the female to male spectrum, which is a guide for clinician. So if you can't access those, let me know and we'll try and get them out to you in another forum. Great. UM, deployability of their own testosterone, so that's yes, if they're considered unstable on testosterone therapy, meaning still requiring frequent checkups and dosages, changes, dosage changes, that's when they would be non deployable. Umm, so that's when they would require limdu. And I think you addressed the other one. I know resources and training is not robust. It's. And evolving area. A wealthy they're doing a much better job than the residencies, so I'm here at Camp Pendleton and again we've got several passionate residents that are typically in the LGBTQ community, but not always. And they've started making sure that folks are not leaving residency training, especially for family medicine, without a good knowledge base. But again, as one of the Navy subject matter experts, at least in the primary care realm, I'm always happy to answer questions from folks if they feel like they don't have a resource. I think uh, as far as research and training, I think medical medically it's pretty good. But access in the military is a little difficult figuring it out. Sometimes I get that. We hear that a lot. And so first referral for primary care generally to mental health. Umm for the SEC. I know you mentioned this, there's also a Coast Guard SEC. We do treat Coast Guard members as well. Umm. Umm. For homework. I will add a, so I think it's a doctor Moore put in here about instructions for solid recommendations. And again this is going to be cocoms dependent. So as far as things go for certain regions that they're deploying to, that may be a little tricky. And I will say for operational and overseas screenings, I know I just signed one as the MLG surgeon or gave recommendations to somebody else on these, and again, if they're stable and don't have any pending urgent surgical procedures, there is no reason that they can't go on operational or a deployment or overseas. I thank you for that very much and hello. I just wanna make sure that moving forward we have a DHA policy on guiding everyone to standardize this. I know that it's very, very difficult and it's in the making, but that would be. Optimal. Shall we be able to do it? And I think if anybody can do it, come in tomorrow again. I would. I would love to see that myself. And again, standardization is something that makes things much easier. So I I I certainly if anybody on this call has the has the legs to push it up. I know I'll keep talking to folks about standardization. Yeah, there is a DHA policy in the works. It's been ongoing, you know, for several months. So but just hasn't been able to be finalized. Many thanks. Thank you. Umm. CEO approval required prior to starting non psych treatment, so any kind of hormones or surgery, yes. Uh CEO approval of the MTP. And actually, as long as the surgery is in their initial care plan, they don't require a

new procedure or a new CEO memo. They actually can continue with the old CEO memo. I will say again, for things like convalescent leave, especially if they're in an operational command, you'll want to make sure the correct person has signed off on their convalescent leave and things like that. I know there's some discrepancy between the two coasts as far as if transition is always aligned do. And again it. Depends on, I think if they're at a shore operational command and what things are available because again, it is mostly based on the potential for complications or the potential need or the need for continued lab work, which again depending on the location you're going to and for how long you're going for it can be an issue. So I know we've managed many on the West Coast without limdu. I do understand there may be some policies coming out directing that a little bit more certainly for the Air Force and the Army they have profile status that they place people on. It's for a little less than a year but. Those are things that I've heard from my colleagues in the other services. Yeah. So if they don't know the extent of the transition, they could have a more minimal MTP and then have it updated later as well to add additional treatments. It would require new CEO approval. Umm. Then I don't know if this is different on the West Coast, but if a service member PCs they do also require a new SMTP to be approved by their CEO as well. Correct. And the one thing I forgot to bring up also in regards to change over if the CEO changes over, you do not need a new CEO memo signed. I would recommend for somebody to sit down and brief that Theo or make sure they don't have any questions and make sure they have the CEOs handbook which I think is LinkedIn, our references or resources section. Think Commander might white just asked about the therapy chart? We should be able to find that resource. So I think the question about the problem list containing. And and this was brought up a little bit with the DSM criteria post transition being an option. I think it's up to the clinical provider to be honest. I mean if. I think ideally if we have the ability to do organ inventory, that would be the best case scenario. But I know Genesis still has some issues with that. So certainly again, I know it was mentioned later on the chat if somebody is post hysterectomy, making sure that's clearly documented. Or, you know, post for ectomy and things like that. I agree. Unfortunately, there's not always great terminology. Cervical agenesis wouldn't work because they weren't born without a cervix. But certainly hysterectomy would be an appropriate option if they are post hysterectomy. But no standard accepted for sure. Umm. Umm. As far as the question about reversible, if you wanna elaborate on that, feel free. I was going to say I'm not sure if this is addressing detransition or not, so again that would be kind of another topic for another day, but as far as any medically necessary or even again as I mentioned, the critical more cosmetic procedures, many of the times can be partially or fully covered by chart care if they're done in an MTF. If they go out to network, that's when it's a challenge. Or if you're talking about dependence, that's when it can be a challenge. Yeah. So that's when the supplemental healthcare waiver comes in to have it covered by Tricare, which is just a. Very time consuming process for the service member but it will be covered as long as it gets approved. And yeah. Who pays for travel to the MTF? The command. That's it. Same with the non medical attendant. If they're going to be going away from the area, so I recommend folks try and be transferred to the nearest military treatment facility again because that will stay within the network. But that is gonna be a command funding. Yeah. And the referral to civilian surgeon, this is kind of a in the weeds, but if if they require supplemental healthcare waiver generally they'll have to be on hormones for longer than they would if they go to an MTF depending on what type of surgery it is. So that's a little bit of a. Longer discussion but. If it if it can be done at MTF, it's generally better for the patient. And we do currently recognize nonbinary service members. We've had a few MTV's come up for nonbinary service members, requesting simply mastectomy typically. Or. As far as hormone therapy, it's. Not necessarily all or none. It can be. I guess tailored to the patient, but I'm not really exactly sure. I

don't provide all that the specifics of that. I don't know if Commander Mara has come into these across these cases. Yeah. So I'll stay on the West Coast at least the last time I was working directly on a case similar to this with the transmitter care team on the West Coast. And acknowledgement that nonbinary service members exist. Is there medical and surgical treatment? Not so much. And that was because the most recent iterations that had come out talk about transitioning in the end of the the transgender care team being a deer gender marker change. And so if the end goal is not a deer gender marker change many times we've told those folks you can talk to whomever you want to talk to about whatever treatment you want to do it, but it wouldn't actually be through the transmitter pair. I mean, because your end goal is not at your age, gender marker change. As far as things in the pipeline, I definitely do know and I've posted. I've seen posts about there being higher level reviews similar to what happened prior to open transgender binary service. Undergoing for nonbinary service members, and again part of that is when you look at the statistics for the current. Folks that are coming up, that will be a sessioning into the military and near future. There are a lot of folks that identify as non binary that are otherwise very, very qualified to serve. So I think that may factor in again this is me speaking not on policy that is ongoing, but just an awareness of some of the discussions that have been happening. But as far as if you're in a civilian sector, absolutely, transitioning is not all or none outside the military. In the military, it's still very much geared towards a deer gender marker change being the end of again when the transgender care team has to follow you. Now most of the time. Again, we will continue to follow you to help with any issues with the supplemental healthcare waiver and things like that. The other issue unfortunately, a lot of folks have run into you, as I mentioned with many of the hormone therapies. On. There can be weight shifts. There can be muscle shifts. So again, if there is no exception of policy which I I personally haven't seen 1 granted for a nonbinary service member yet. Same with the standards for the BCA, BCP, PFT, PRT, CFT. They're still binary, so if somebody gets into a situation where they lose muscle mass or gain muscle mass, more so lose muscle mass or gain weight and can't make standards anymore, where it's gonna be a big challenge to kind of manage that. So I know that might have been a bit circuitous, but I do know there are multiple groups working forward. To be able to allow nonbinary service members with the medical and surgical treatment, it's somewhat on a case by case and somewhat under the radar right now by my understanding. OK and. Instruction for CEOs in particular. Umm, typically we'll refer them to the SCC for answering questions. If they can't be resolved with the service member or the transgender care team. Umm. The CEO's handbook actually has some really nice cases too, so I do encourage folks to look in the. See who's handbook both for yourself and also be able to give that to your CEO. So I've had two CGS and two CEOs that I've worked with over here that both times when we had a case came up and made sure that they had this reference and guidance and some of them were savvy ones. Had it highlighted and flagged before they ever met with me. So I do find that this is pretty helpful and there is a version too that you want to make sure you get if you're gonna give it to your CEO. Excellent. I don't know if you want to address the next one about. Flight status. Sure. So I can address the fact that again any of the server, any of the special duty statuses, do you require a supplemental approval and that would be from flight dive any of the special operators. Basically they would need approval from a higher level from that community. So I do know there's been some change recently in the civilian. Air community on as far as flight status and gender affirming hormone therapy I. I don't know where we are in the military community right now, but I do know that it does have to go to the service specifically. So in other words, the the lead flight surgeon and things like that. So unfortunately this is the case for many special duty statuses right now and we're slowly seeing folks be able to go through, but it's still one of those areas that needs additional level review. OK. Firing a patient

to the. TGC T who initiates the I'm assuming MTP? Who are they contacting? Umm. So it isn't referral uh. It's usually either through GTP if they're distance from you or in the ER. A transgender care team through case management for the West So there is. Coast. Yeah, ours is through through the GTP. If it's long distance or directly through the ER. I have heard of your oconus. You would need to make sure to. Umm, potentially scan and send something or facts and send something over. So again I would definitely get you in contact with the case manager for the region so that way they can. You can make sure you get the information from them. To savage process where object. I'm not sure about the sea duty screening. Question. So my understanding is the operational screening or the overseas screening would cover the. Like actually getting them into the region and then when they arrive there, the new CEO would sign off on the treatment plan after they actually arrive. So if they'd screens biomedical before they arrive to the area, basically the CEO would never see it. But if they were accepted into that area, then when they arrive, basically that would be part of their in brief is sit down with their CEO and say I have an ongoing gender treatment plan or a transgender care plan. And here's what's. Up and coming again, the hope would it be would be that folks can at least get their dear gender marker changed on one station and then technically they don't have to disclose to their CEO once they're dear gender marker is changed unless they have upcoming surgeries or something like that coming up. So I have many folks that I try and encourage them. Hey, if you can extend and get that deer gender marker changed here, yes, you'll still need an operational oversee screening because you're on potentially an injectable hormone or a chronic medication. But you're you're sharing markers already changed your names, already changed your passports already changed, so it makes it a lot easier for them to just arrive at the new location and then just like anybody else who needs a medical or surgical procedure, they'd sit down with their leadership or their CEO to say, hey, I've got this upcoming procedure that's been my experience and my how I've cancelled folks. But that's my two cents. Great. What other questions aren't there? Shannon, do you wanna take the cause? I actually, I've had this question personally a couple times. As far as the copies of the slides for the last couple days, will there be like a PDF or something that will be posted or sent to any attendees? Hi, ma'am, thank you. Yes, so we because the file is so large, we're likely going to have to send it via DoD safe. I know there are some folks who may not have a military e-mail address, in which case these slides will be approved by viewed PAO and then eventually housed on the Women's Health web page. So that might just take slightly longer than directly distributing them, but they will be available. Thank you so much. And certainly again, if anybody has any questions or questions or references, I know I'm available and I think Lieutenant Commander Buff and very, very similar is available for questions. Absolutely. I don't get the picture. Well, that is a tough one. Uh-huh. It does come up on, fortunately, too frequently. UM. So sometimes there's a they initiate limdu overseas to get the person back stateside to start care. We've got that happen. And due to an accessible care, there's also theme you which does remote services if there's an access to endocrinology. If the command denies care, we try to coordinate and figure out why they've denied the care. UM and talk with them about it and and see what we can do to try and mediate. Umm. As far as unaware that if they're requesting care, they shouldn't be unaware of the, the command needs to be aware the CEO needs to be aware because they're gonna improve the MTP. So the one thing I told CEOs when I sit down with him and talk about it is again, most of the time the command is approval should be based on timing. So like, hey, we're about to go on a major mission. We can't have somebody kind of down for the count. This person down for the count for this amount of time. So it shouldn't be that this person can never transition. There should always be kind of an. I encourage the CEO to actually say like, hey, maybe we can't do it right now if if you do wanna go on this mission, but in six months,

that'll be our our start date and they can actually add that into their CEO memo to say unable to transition at this time plan to transition start at X date and time. And so that is one thing I've encouraged committee officers to do, cause again, that that way everybody's expectations are understood now, can things change certainly. As far as the lack of a credential personnel and they're location, I do encourage folks to make sure. Again, they do their CME and learn more about gender affirming care and even. Some of the initial portions, so like again, the orchiectomy, oophorectomy, hysterectomy, self inject Tommy to again make sure cause each of the major organizations you're giving education ongoing CMD on these things. As a Mac chair, now I can say again nobody is. Credentialed to do gender affirming hormone therapy or gender affirming surgical care, but they are credentialed to provide care to patients. So certainly an IDC may not be able to order testosterone, but I would encourage anybody that's gonna be hands on and patient care or front desk etcetera to at least get knowledgeable and the language and some of these other terminologies. And again making sure your environment open to caring for patients because that's really the most important thing is providing. Somebody that cares about your patients and again that will actually decrease some of those adverse outcomes that we talked about in the beginning of this deck because again if somebody just cares and is willing to take care of their patients, that's really the most important piece. Type. Thank you everyone for listening. Yeah. Thank you very much. Thank you everyone for your attendance and participation in the 2023 Virtual Women's Health Seminar and thank you to our presenters who have taken the time out of the past two days to share their knowledge with us. We hope that you found these topics that have been covered both informative and useful. That concludes our training this year. For next steps, Please ensure that you follow instructions that have been highlighted on this slide as well as communicated via e-mail to receive continuing education credits and certificates. Uh, that requires that you register for this event no later than tomorrow at 1300 Eastern Time. So if you haven't done so already, you do have a little bit of time left along with completing the post test and evaluation by 10 February at 2359 Eastern Time. And for any questions or concerns related to obtaining credit, please contact the e-mail address at the bottom of this slide. Thank you again for your participation and we hope to see you next year.