

## **WEBINAR VIDEO TRANSCRIPT**

Partnership for Care HIV TAC

### **Achieving Health Equity for Lesbian, Gay, Bisexual, and Transgender People**

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ADRIANNA SICARI: Good afternoon, everyone. This is Adrianna Sicari from the National LGBT Health Education Center, a program of the Fenway Institute in Boston, Massachusetts. We're pleased to have you with us today for the webinar "Achieving Health Equity, meeting the health care needs of lesbian, gay, bisexual, and transgender people," which we're presenting in partnership with the HIV TAC. I'm going to go ahead and turn it over to Chelsea White from the HIV TAC.

CHELSEA WHITE: Hi everyone, and welcome again to the "Achieving Health Equity, meeting the health care needs of lesbian, gay, bisexual, and transgender people" webinar, co-hosted by the HIV TAC and the National LGBT Health Education Center. This webinar will be facilitated by Dr. Harvey J. Makadon, director of education and training at the Fenway Institute, a division of Fenway Health Boston and professor of Medicine at Harvard Medical School. Dr. Makadon teaches about how to improve access to quality care for lesbian, gay, bisexual, and transgender people in health care settings around the country.

He directs the National LGBT Health Education Center, a HRSA-funded cooperative agreement to improve cultural competence in LGBT health and community health centers, and the National Center for Innovation in AIDS Care, also funded by HRSA.

Dr. Makadon is the lead editor of the Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, published by the American College of Physicians. A second edition was published in 2015. In addition to writing numerous articles and chapters related to LGBT health, he served on the advisory committee to the Institute of Medicine of the US National Academy of Sciences in the preparation of the The Health of Lesbian, Gay, Bisexual, and Transgender People-- Building a Foundation for Better Understanding, published in March, 2011. At this time I would like to turn the webinar over to Doctor Harvey Makadon.

HARVEY J MAKADON: Thank you very much for the very nice introduction. And it's good to be working with this important program that is working with health centers to try and improve HIV care. I do think that as a long-time HIV provider myself that understanding the needs of different populations at risk for HIV are very important. And in that vein, the work of the National LGBT Health Education Center-- that HRSA has so generously funded for our work with the community health centers-- is extremely important. Because while not all people are at

high risk for HIV, there are certainly numbers of people in the LGBT community who are and continue to be at high risk for HIV and who desperately need community-based care.

And so I welcome your participation and also your active participation in asking questions throughout the session by raising your hands. And we'll try and get to your questions as promptly as possible. I'm going to go over a number of issues. I'll go through them relatively slowly so that you'll have a chance to think about them. I'm going to ask you a few questions.

And I do want you to realize that this is a first in a series of webinars that we're doing on this related topic. We're going to have one that's more focused on, for example, young men who have sex with men-- which is clearly a big issue in HIV risk-- and another one on issues related to transgender health, as transgender women in particular are the group in the country that has the highest prevalence of HIV. And I'll say a bit more about that later on in the session. So again, thanks a lot. And here we go.

First of all, I have nothing-- no financial relationships-- to disclose. So we can dispense with that. I did want to mention a couple words about where we work. The Education Center is based in a Federally Qualified Health center in Boston, Massachusetts. This is a photograph of our main site, Fenway Health, based in the Fenway neighborhood of Boston. We're right across the street-- or I guess I should say, from the top of the building you can see down into Fenway Park. But the Education Center is located on one of the floors of this building.

Fenway Health was founded in 1971 with a mission to enhance the well-being of the LGBT community. But we also serve all people in our neighborhood and actually beyond. Because many people come here from throughout New England seeking access for quality health care. And we also do work related to developing of education research and advocacy programs.

Fenway employs an integrated primary care model, which I know many of you are trying to develop, which includes both HIV services as well as transgender health. And I think we've been very successful at doing that. Fenway has about 2,200 HIV patients now and about 1,600 transgender patients in its primary care practices. The Fenway Institute is where we focus our academic work, such as the Education Center work that develops education programs. But we also do a great deal of work on advancing prevention and care for people with HIV as well as policies to enhance the lives of LGBT people.

The Education Center, as I said, offers a number of educational programs. One of the things that's been very helpful-- and this is really just a small taste of that, is that we've been working with a number of organizations-- health centers and other organizations-- throughout the country to provide training and technical assistance with a specific focus of improving LGBT readiness or proficiency in how to create an affirmative and inclusive environment-- It really applies to all people.

But then we also do grand rounds at the hospitals. We have many online learning programs-- and you might want to familiarize yourself with those on our website, because they all relate to

various aspects of LGBT health. And all of the webinars and learning modules that we have online are available for continuing education, as well as-- for those of you who participate in the Health Equity Index for the Human Rights Campaign-- credits for the Health Equity Index.

We also have a number of resources and publications which you might find helpful. One in particular that a number of health centers have commented on is our publication on how front-line staff can learn more about dealing with transgender and gender nonconforming people. And another one is a poster and a brochure called Do Ask, Do Tell, which I'll say more about later in the program.

And now I want to get started. So I guess the real question that I often ask is why we have specific programs for LGBT people, as a way of background. Because I think there's a lot of places where we've gone and we've done surveys and people will say well we provide the same care for all people. Why should we need special education about LGBT health? And I think the reason is that both in terms of understanding language and creation of forms, but also understanding unique health issues that LGBT people experience. It's important that we familiarize ourselves with disparities experienced by the LGBT population.

These were highlighted in Healthy People 2020, which was put out in 2010 by the Department of Health and Human Services, that for the first time really had a section that highlighted LGBT health disparities. And it's relatively brief. And I'm going to use their summary in a minute to give you some indication of what the issues are. And then the somewhat longer Health of Lesbian, Gay, Bisexual, and Transgender People that was produced by the Institute of Medicine and has a much more comprehensive review of literature on this topic. But again, those of you who are interested in this might find looking at these two publications interesting. They're both available on the web. They're available for free. You can download them. So I recommend that someone in your health center have this available as a resource.

When we get to wanting to understand disparities in LGBT people, really the bottom line is that most of them relate to the impact of stigma and discrimination. And sadly, often as depicted on the left-hand side there in the photograph, a lot of the stigma occurs in the context of health care. As people enter health care organizations-- including health centers-- whether it's in the waiting area, in the exam room, in the process of checking out, they hear people making negative comments or not getting their names right. And it's upsetting to people. But I think more importantly, studies have shown that people don't come back for care, they don't engage in care, they leave care. And as a result, health disparities develop and continue.

Some stigma and discrimination obviously occurs throughout society. In the middle we see a picture of a young boy who seems very sad at school. And he's been the victim of bullying in his school. And again, that's something that we don't have direct control over. But we do have to realize it's something that's happening in our communities and is something that as health care providers we can speak out about. And we can try and work with schools do things about it. We do work with a number of school-based clinics that do work on these issues very actively.

And finally on the right-hand side there's a photograph of a young transgender woman who sadly committed suicide over the past year. And when she did so, she left a note in which she talked about the fact that she had been rejected by both her family and her church. So acceptance, even partial acceptance, can be very important for LGBT youth. And it's something that, again, we'll talk more about, but I think is important for us to highlight as part of this presentation.

So again, as a way of summarizing that slide, stigma can come in many places. But I think there's three ways to think about stigma. One is the structural stigma that comes about because of barriers that society has put up. So for example, lack of health insurance for single people or people who don't qualify for Medicaid in states that have an extended Medicaid have very difficult times accessing care. People who are homeless can have difficult times accessing care unless there's a homeless health center in their neighborhood. And so there are structural causes of lack of access to health care.

There's interpersonal causes, such as the bullying that I've described. And then some people really have internalized a lot of things and create their own internalized-- some people might call it internalized homophobia or internalized transphobia-- where they feel bad about themselves, not necessarily because of anything they've done, but because of the way they've grown up in a society that hasn't been accepting. And all of these lead to health care inequities or health care disparities and are important for us to recognize.

In going through the literature we can read about the impact of stigma on health. People who experience prejudice-related stressful life events are more likely to suffer serious physical problems. Exposure to discrimination is related to an increased number of sick days. And internalized homophobia, discrimination, and expectations of rejection are associated with increase in HIV risk behavior. So all of these things are examples of research studies that have been done on this issue. And as these things have been put together, we've learned that health care disparities really occur throughout the life course, beginning with childhood and adolescence through early and middle adulthood, and into later adulthood. And so I think it's important that we briefly go through this.

LGBT youth are more likely to attempt suicide. And I'm sure you've all read about cases of this. They're more likely to be homeless. So when we look at homeless populations, we see that up to 40% are often L, G, B, or T. And LGBT youth are at higher risk for HIV and STDs, particularly men who have sex with men in communities of color. LGBT populations also have higher rates of tobacco, alcohol, and other drug use. And these things are interrelated. And so it's important that we not just look at them as individual things, but things that may occur in the same individual.

Lesbians, for reasons that I've already mentioned, lesbians and bisexual women studies have shown are less likely to get preventive services for cancer. And some of that maybe because they drop out of care because of bad experiences.

Transgender individuals have a high prevalence of HIV and STDs, victimizations, mental health issues, and suicide. But they're also a population that is both very poor-- as I'll show you in a few moments-- but they're also less likely to have health insurance than heterosexual or other lesbian, gay, and bisexual individuals.

And finally, elderly LGBT individuals are often invisible. They often [INAUDIBLE] face barriers to health because of their isolation. They grew up at times when acceptance of LGBT people wasn't as great as it is now, and they haven't ever really changed their ways. They have fewer family supports as well as a lack of social and support services.

So some of these things have changed because of some of the changes in regulations in the current administration in Washington. And the Department of Health and Human Services has really made many changes, which has helped people. But nevertheless, I think we still have to be attentive to elderly people who may appear to be single, but to really talk with them about whether there are significant people in their lives, and if so how to incorporate them into their care, and if not how to provide greater support for them.

I wanted to briefly go through some concepts related to LGBT and how to think about it. But the first is that LGBT is probably, not as it sometimes appears, as a homogeneous group. But really L, G, B, and T are different populations. In fact, each of them can be very diverse populations in and of themselves. And it's important that we recognize that, because all of our communities may have many different LGBT sub-communities. And we need to understand those if we're going to provide appropriate care and do appropriate work in terms of outreach for our HIV programs to get people in for HIV screening or testing. And so these, again, are important things for us to understand.

I think there's just a few things that I wanted to particularly highlight. One is that sexual orientation and gender identity are not the same. All people have a sexual orientation and a gender identity. Everyone listening today has one. But how people can identify their sexual orientation and gender identity can change over time. And terminology also varies and is pretty fluid in terms of changing. People use different terminology over different time, and I'll say a bit more about that in a minute. But I just, again, want to emphasize that gender identity and sexual orientation are two different concepts. And we'll go through each of these.

So sexual orientation is how a person identifies their physical and emotional attraction to others. And really it has three dimensions. The first is desire-- what genders are you attracted to physically and emotionally, despite the fact that you may never have acted on that desire. Do you think about things like that? And that's something that many clinicians don't ask about. And someone can come and leave their clinical appointment without ever really talking about that, which is a lost opportunity to help someone feel fulfilled and complete their psychosexual development.

The second is behavior, which is probably the one that we ask patients about most, which is are you a man who has sex with men, women, or both. But more specifically, are people men who

have sex with men or men or have sex with men and women are. And the same thing for women-- do they have sex with women or do they have sex with women and men.

And then finally, how do people identify? Do they identify as straight, gay, lesbian, bisexual, and sometimes using a word like queer, which we may feel comfortable with, but is a way of saying I don't really want to identify in a traditional manner, and doesn't specify whether anyone is gay, straight, bisexual, or lesbian. It allows people the flexibility to live their lives the way they want to. And it's a term that people are using increasingly often. And so you may well hear people use that term. And so it's important that you not get uncomfortable by it, but listen to it, and accept it, and talk to somebody about well what does that mean to you, or why do you feel that way. And these, again, are things that are going to appear in your practices-- and I'm sure they already have-- but that people should be familiar with.

Then I wanted to get to talking about gender identity, but also distinguishing it from gender expression, although there is some overlap. Gender identity is a person's sense of their gender, and whether one considers themselves male, female, and in some cases may consider themselves both or neither. And again, that may sound unusual, but it's something that happens fairly often. And all people do have a gender identity.

Gender expression is how one expresses themselves through behavior, mannerisms, speech patterns, dress, hairstyles. And this may be on a spectrum where people are either more masculine or more feminine, but doesn't necessarily identify somebody as either being gay, straight, or transgender. And so I think we can't make too much of gender expression. It's something that we may just note. And that's really the extent of it. And recognize that there is going to be a diversity of gender expression in any population that we're caring for.

Finally, we get to what's the T in LGBT, which stands for transgender. And I'm going to focus on the core of what I think transgender is. Some people use it as an umbrella term that includes all kinds of people, including people whose gender expression is a little bit different from their assigned sex at birth or what you might expect very typically from somebody with a certain assigned sex at birth. But it really identifies people whose gender identity is not congruent with their assigned sex at birth, that fundamentally they see themselves not as the sex they were assigned at birth but as a gender that's different from that.

Terminology for transgender people can vary. Examples that we've given are people use the terms transgender woman, or trans woman, or male to female, transgender men, trans man, female or male. Some people like to use the term female to male, or male or female, because they like to know that their clinicians understand that they were born a man and have transitioned to female. Some people don't like the emphasis on the transition because they feel that they were born the way they are, it's just that their body wasn't consistent with their identity.

Some people might use a term as I suggested that blurs the boundary between male and female and see themselves as non-binary and use a term such as gender queer or just the term

non-binary. But gender identity, it's important to recognize, is increasingly described as being on a spectrum. And people can change where they are on the spectrum over time. And again, that's something that's important for us as clinicians or as health care administrators to anticipate and to teach our staff about these kinds of things.

In reviewing the terminology, sexual orientation has to do with our attraction, gender identity is what your internal sense tells you your gender is. Sex is the presence of specific anatomy and maybe referred to as a assigned sex at birth. And then gender expression is how you present yourself to society through clothing, mannerisms, and other ways of behaving. And so this is a review of the basic terminology. And again I'll ask if anyone has any questions, don't hesitate to raise your hand.

So someone just raised a question and said does the term transsexual have a place in this dialogue. And I guess the answer to that is that transsexual is a term that historically was used to describe people who now we would consider transgender but who have actually undergone hormonal therapy and surgery. And I think increasingly transgender people feel that the term should not-- people feel less comfortable with the term. Although if you look at the last addition of the WPATH Standards of Care, they use that term on the cover. It's increasingly not being used. And people tend to use the term transgender to describe that population.

And so while in the past I might have said transsexual would be a subset of transgender people or certainly under the transgender umbrella, it's probably not as commonly used, in many ways similar to the term transvestite, which is no longer felt to be a very appropriate term to use. So I think that is a short way of answering that question. I'm sure some people-- this is not an area where there's complete agreement on all these things. And some people may disagree with that. So thank you very much for asking that question, Renee, and asking for that clarification. Because I think it's important that we understand that.

So now we're going to move forward. And I said before that LGBT people tended to be a very poor population. And I added this slide because first of all, you're all folks who work in health centers. And we're basically responsible for making sure that individuals who are underserved get access to care. And that includes people from lower socioeconomic backgrounds. And yet on television we often see LGBT depicted as a more privileged group. And so I think it's important that we understand that LGBT people generally are in the lower socioeconomic strata. And for example, African American children in gay male households have the highest poverty rate of any children in any household type-- 52.3%. And the rate for children living with lesbian couples is 37.7%. So those are very high numbers.

It's also important that we recognize that transgender people also lived in dire economic situations often because they have a hard time getting employment. But a survey done a few years back of 6,500 transgendered people showed they were four times more likely than the general population to have a household income of less than \$10,000. So again, that's a very low income level for a family to live on. And I think we have to recognize that, and one of the reasons why health centers need to serve this populations.

So having gone through understanding some of the disparities that LGBT people face, as well as concepts around LGBT issues, I wanted to talk now about what we can do to overcome barriers to care. Because all health centers can play an important role of this. And this involves understanding population health, doing clinical education, creating an environment that's inclusive and affirmative, and then looking for resources that you can provide for both your staff as well as your patients and students in order to ensure a better future for LGBT people in terms of their health care.

But first, I just wanted to stop and ask a question and see what you thought. I just wanted to ask you all-- because I think that we think it's important to learn about sexual orientation or gender identity-- have you as individuals ever been asked about your history of sexual health, your sexual orientation, or your gender identity when you've seen your primary care clinician or when you've seen any clinician? So I'll give you a minute to answer this and then we can talk about that.

OK so pretty soon we'll see the results of this. But I think that in general-- I always ask groups whether they've ever been asked this question. And since many of you work in health care settings-- or all of you do-- might also say how often do you talk with your patients about their sexual history, sexual orientation, or gender identity.

And we just got the results, which shows that of the people on this webinar only 14% have ever been asked this question when they've gone for care and 86% have not. And we're a group of health professionals. So we're tuned-in to these issues. But think about not learning about someone's history of sexual health, think about not learning about sexual orientation and gender identity. And I hope that you'll realize, now that we've gone through some of these issues on disparities, how limiting it can be to take care of somebody without learning more about this.

So I think what I wanted to do now is turn to what we can do to learn more about sexual health, sexual orientation, and gender identity. And the first is really in the clinical interaction, which is getting to know your patients in clinical settings. Clinicians-- particularly physicians-- have not the greatest track record in talking about these issues, as evidenced by both this slide and your results. So in a study that was published in the American Journal of Public Health on adherence to antiretroviral therapy, 84% of people said that they talked with their patients about antiretroviral therapy, but only 14% talked about risk reduction issues. And so you can see that issues that deal with behavior and risk are less often dealt with, and therefore we're not doing an effective job at making sure that we're helping some people prevent HIV infection. But we are doing probably a better job with effectiveness of treatment.

This led the Institute of Medicine in another report that they wrote say, "Ironically, it may require greater intimacy to discuss sex than to engage in it." And so the question is what can we do about this?



The Education Center worked with the National Association of Community Health Centers to develop this toolkit called Taking Routine Histories of Sexual Health-- a System-wide Approach to Health Centers. And we really focused on not just sexual risk-- which people frequently focus on when they're teaching about this in, let's say, nursing school or medical school, and you'll be learned to ask a question do you have sex with men, women, or both-- but we really want to delve down and get into more detail about people's sexual partners, sexual practices, their past history of sexually transmitted diseases, their protection from sexually transmitted diseases.

And the CDC general has recommended that we talk about pregnancy protection, but we've tried to talk more about pregnancy plans and pregnancy planning or family planning. Because for LGBT couples particularly-- but for many couples-- the issue isn't preventing pregnancy but really wanting to have a family and having difficulty doing so. And then learning about what are the rules, and what can they do to go about adoption, or use of in-vitro fertilization or surrogacy to have a family. And so these are important issues for us as clinicians to talk with our patients about.

When we get to taking a history of sexual health, the core comprehensive history for LGBT people is the same as it is for others. You really want to get to know your patient as a person. I think critically we want to use inclusive and neutral language. So instead of asking do you have a wife, or husband, or boyfriend, or girlfriend, for all of our patients we should say things like do you have a partner, or are you in a relationship, and what do you call your partner. And as I'll say later on, this is important that we think about this in the forms that we use also. And for all our patients we need to make these kinds of questions routine and make no assumptions, for reasons that I suggested earlier. And again, reassure people about the confidentiality of their answers.

Things that I think are important are asking about behavior and risk, as we've mentioned. But also, as we've suggested, talking about sexual health, sexual identity, and gender identity. So do you have concerns about your sexual function? Have you had any changes in your sexual desire? How satisfied are you sexually? And you want to talk about your sexuality, sexual identity, or gender identity? And then again, asking about reproductive health and desires.

There's other things that you can talk about, like have you been a victim of abuse, whether it's physical or emotional. All those things are relevant to the history of sexual health. I think sometimes people feel like they can only ask so many of these questions in the limited time they have with patients. But if you're doing primary care, there's always time to go back to these things and ask more at a future session.

We feel that the electronic health record can help us a lot in terms of gaining some basic information on these issues. And so I wanted to ask you another polling question, whether your organization currently collects any data regarding sexual orientation and gender identity in your electronic health record. And you can answer yes, no, or I don't know.

So someone asked a question that I hadn't seen about pregnancy plans as well as whether it's important to ask males as well as females. Can an HIV-positive male father a child safely? I think that yes it's important to ask everybody about that. And an HIV-positive male can father a child safely if people take appropriate precautions and things are appropriately evaluated. But that's not to say that that's true for everybody.

But it's certainly important that we inquire about this. And the details of how you would go about evaluating people is beyond the scope of this talk. I think that certainly HIV-positive women can prevent HIV infection from passing to their child by taking appropriate medication. And this is a very important question that's probably something that we could probably spend a session just on this and what we need to do about this. So thank you for asking that.

So now back to this polling question. While we're waiting for the answers I'm just going to say that we do believe, as the Institute of Medicine does, that LGBT people should have data on sexual orientation and gender identity collected in electronic health records. It's interesting that of the organization polled, 65% say they do collect sexual orientation and gender identity data routinely and only 12% say no, with 24% of people not sure. This is something that increasingly organizations are doing. I think this is a large number, and it's good to hear that this many of you are collecting this kind of information.

But I'll say that there's a number of ways this can be done for people who are considering how to implement these systems. One is people can provide data from home through a patient portal. They can do it at registration on-site directly into a kiosk or a laptop, that they're handed, to register personal information. Or they can be asked the information by their clinician while they're having their history taken. And then once it gets entered into the electronic health record, the nice thing is that this information doesn't have to be asked again over and over again. So it can make a difference.

The questions that we recommend asking-- at Fenway we ask question seven, do you think of yourself as lesbian, gay, or homosexual, straight or heterosexual, bisexual, something else, or don't know. And I'd say that we've had very good acceptance here. Plus we've studied acceptance in a group of four health centers, and it's been extremely high about asking about both sexual orientation and gender identity.

Regarding asking about gender identity, we really recommend using the 2-step methodology-- what is your current gender identity and then check off all that apply, and then what sex were you assigned at birth, giving people the option of checking male or female or declining to answer.

We also think it's important that we give people an opportunity to say what their preferred name and pronouns are, if they vary from their old records or from their administrative gender, so that front-line staff can actually refer to people appropriately. And this has been very helpful in a number of circumstances. So again, this is something that has to be considered in terms of

both designing your forms, design your electronic health record, and making sure that this is displayed to the people who need to use it.

I wanted to turn now to some issues around just some core topics around education, around culturally-appropriate care that I think are important. I wanted to focus on some of the core issues around HIV prevention and then get into issues around other related topics like LGBT youth, transgender health, primary care, smoking and tobacco use, cancer prevention, and resilience.

In terms of clinical practices to improve HIV prevention and care, many have already implemented some of these programs. But I just wanted to highlight why they're important. Programs for MSM are important-- men who have sex with men-- because 2013 the CDC showed that 68% of new cases of HIV occurred among men who have sex with men and that 51% of these cases occurred in the South. So we do a lot of work in the South with communities that serve black MSM. We're actually now doing a project in Mississippi with five community health centers to help them work with their local populations. And this is obviously a very important issue for us to focus on.

When we look at HIV incidence in the United States between 2008 and 2013, there was an increase of 15% of cases of HIV among men who have sex with men between 2008 and 2011, despite the fact that the overall number of HIV cases has remained stable. It's recalcitrantly stable, despite the fact that we're trying to do so much about it. And hopefully soon we'll see a downturn in this number, as our goal is really to get the number of new cases each year to zero.

But I do want to highlight-- because we've talked a lot about HIV incidence being high in black man who have sex with men-- that this is not attributable to sexual risk behavior or substance use, but more likely has to deal with barriers to care-- as I said before-- the structural stigma that people face because they don't have access to Medicaid or they're too poor to afford health care except in limited numbers of safety net sites that have a low frequency of HIV testing.

I think we have a question that just came up. Yeah, it says-- oh, I see, OK. So I'm sorry, this question goes back and I'm sorry I missed it. It seems that some data collection sets do not include bisexual as an option. What are the rationale for including versus not including? I think that in general when we're asking about sexual orientation we do include bisexual as an option and should be included as an option. But when we're talking about-- so I'm not sure what data collection set is being referred to. But if we're just asking about sex assigned at birth, obviously it would just be male or female. But bisexual should definitely be included when people are asking about sexual orientation. And that has been overlooked a lot in the past. I think we need to learn a lot more about this population. But that's a really great point, so thank you for bringing it up.

Now getting back to the issue that we were talking about-- as I was saying, the most likely causes of high infection rates among young black men who have sex with men have to do with

structural issues, such as barriers to accessing care, low frequency of HIV testing, delayed treatment of sexually transmitted infections. And it's also true that there's a high prevalence of infection in black MSM social networks, especially among people who identify as gay. But again, a lot of that may have to do with the fact that they're not getting appropriate messages and appropriate access to the kind of screening services that are necessary. Because knowledge of HIV status is certainly an important determinant of people's behavior.

Transgender women, as I mentioned earlier, are also at high risk for HIV. They have the highest prevalence of HIV of any population group in the world. 28% of transgender women in the United States are infected with HIV. Among African American transgender women the number goes to 56%. And they're 49 times more likely to have HIV than other adults of reproductive age. Risk factors include social and economic marginalization-- as I mentioned-- high unemployment, and then as a result doing things like engaging in sex work, limited health care access, and obviously also a lack of familial support.

Transgender men are at higher risk for HIV than the general population but less so than transgender women. But they do have high rates of STDs.

Now someone has just asked a question about has there been a study on the impact of transactional sex and HIV transmission. Oh, so there's no question that sex work does relate to higher rates of HIV transmission. And I think that's one of the explanations for high rates of HIV among transgender women. So again, I don't have slides on that today. And I don't have more data on that. But that's clearly an issue that's important for us to be thinking about. And if people wanted, we'd be happy to develop a presentation on that at some future time. So thanks again for asking these actually very interesting and important questions.

Just as a summary I wanted to go through the basic steps to improve HIV prevention in clinical settings. Obviously health centers are one of these very critical clinical settings. But in order to reduce HIV incidence, we have to implement programs for universal HIV screening. The US Preventive Services Task Force recommends that everybody between the ages of 15 and 65 have one HIV test. And yet that's not being done in many centers across the country. There's a lot of reasons for that. And you know that as well as I do.

But I think we need to be thinking about making sure that everybody has one test and then determine whether or not to do additional testing based on risk. As soon as someone tests positive, there's a huge amount of data now which supports early treatment or treatment as soon as possible. And treatment both helps the individual and also can prevent transmission to others.

And then finally, when we talk about seeing negative, it's important that we continue to address safer sex and use of condoms and addressing STIs. But also we have PrEP available-- pre-exposure prophylaxis-- which means taking a pill a day but it's very effective at preventing HIV for people who have high-risk behavior or engage with multiple sexual partners. So I think that, again, we have lots of modalities to prevent HIV infection. And if we use them all

effectively and in conjunction with each other for the appropriate patients, there's no question that we can reduce HIV incidence and hopefully bring the incidence of HIV in this country to zero in a very short period of time.

I did want to highlight that hepatitis C is sexually transmitted by men who have sex with men who have HIV. This is something that isn't well known, but there's growing evidence of sexual spread of hepatitis C among HIV-infected men who have sex with men. And we have to emphasize the use of condoms to prevent this spread, because antiretroviral therapy in and of itself doesn't do that. And I'm not going to give a talk about hepatitis C, although we are scheduling one for the Education Center later on this year. So that's an important topic for everybody to be familiar with.

In terms of LGBT youth, there's a number of issues that we could go over. But I really wanted to focus on one main one, which is the role that clinicians can play at helping work with families to prevent rejection and acceptance. It can mean so much to LGBT youth. We've talked about the disparities that people face. But parental acceptance can make a big difference. And so we recommend that people look at the materials produced by the Family Acceptance Project out in San Francisco and suggest that parents support their children's sexual orientation or gender identity as much as possible.

It's OK to be uncomfortable, but a little support can go a long way. And I think that regardless of what your background is, family is often more important to people than other things. And I think that we need to stress that issue and help people see that maintaining their family intact and keeping their children healthy-- as healthy as possible-- can really make a big difference. So again, I think that this is an important issue for us to think about.

This is a poster that I think expresses this issue. This father and son are talking. The father is saying my son is my life. I know he's gay and I don't always understand, but that doesn't change my love for him. So again, expressing the kind of parental lack of complete understanding and maybe ambivalence, but again embracing him and loving him.

I wanted to turn now to talk about why it's important to learn about gender identity and sex assigned at birth. Two quick examples, clinical cases. First the case of Jake R, a 45-year-old man who came in with pain and on x-ray what appeared to be metastases from an unknown primary cancer. His evaluation showed that he'd developed cancer in his residual breast tissue after surgery to remove his breast. But no one told Jake he needed routine breast cancer screening even though his mother and sister had breast cancer. Now a lot of people are kind of shocked when I show this slide, because they've never thought about it. But I'm showing it because I think we all need to think about learning more about this. That's one.

The second is similar. A 59-year-old woman developed high fever and chills after head and neck surgery. The source of infection turned out to be her prostate gland, but no one knew she had his anatomy. All transgender women have a prostate gland. But in this case no one asked her about her gender identity or knew she was transgender. So no one knew to really think about

that. And again, I think this is a basic issue, something that-- as we keep better track of transgendered people in our records by a more straightforward way of identifying gender identity and the organs that are necessary for us to assess-- I think that we can probably do a much better job with these kinds of things.

Quickly, I wanted to just highlight that smoking continues to be a big issue among the LGBT population and that we have to focus on decreasing tobacco use, however attractive it's been made to appear in the media or in our past. But that studies consistently show LGBT smoking prevalence is way higher than the general population. It's even higher in LGBT people of color. And LGBT people are less likely to use traditional quitlines.

Motivations for smoking are numerous. It may be that it's a way of coping with stress. Smoking can be a way of dealing with social situations. But significantly, tobacco companies do market heavily to LGBT communities. The next slide shows some examples of targeted marketing. I think that this kind of thing does create an attractive situation. But I think we need to do some [? counter-detailing ?] in our offices when we see people who are smoking.

The clinician's role can be critical and we have to be prepared. Just as a basic thing we need to keep in mind ways like the five A's. To ask about tobacco use. To advise to quit. To assess the willingness to attempt to quit. To assist in quit attempting-- one is setting a date for trying to quit, using medication, and counseling, and interventions to increase the likelihood to motivate this in the future. And certainly following up with people.

There are some LGBT-specific helplines. And they're depicted here on the slide. These vary from community to community. And I recommend that this is something that various health centers should look into so they can make recommendations for their patients.

I mentioned earlier that lesbians and bisexual women have less frequent cancer preventive services. Studies have been shown showing that lesbians have lower cervical cancer screening rates. And a recent study of lesbians and bisexual women in New York showed that they were less likely to have had a mammogram. So we have to think about how we educate clinicians to do these things, but also to make sure that we keep people engaged in care. And also to educate our patients about what kind of screening is appropriate for people of different ages.

It's also, again, we need to recognize that transgender men often don't undergo complete sex reassignment surgery and retain a cervix. And if that's the case and they have a cervix, they should follow the same screening guidelines as natal females. So Pap tests can be more difficult for transgender men, and sensitivity to this is important. So it's not something that you just necessarily want to do as routine as a Pap smear on someone who's accustomed to getting them. But it does require that you talk this through and do this kind of screening so that people can, again, maintain their health.

Despite the fact that we focused this so much on health care disparities, I also want highlight the fact that there's a great deal of resilience in the LGBT community. It's a community that

works well together. I think that the response to the HIV epidemic was certainly one amazing example where lesbians and gay men really worked together to mobilize and took to develop organizations in many different ways to fight against AIDS.

A question just came up-- cervical exams can be challenging with patients who have been victim of or experienced sexual abuse. Is there anything on diagnostic testing horizon that's less invasive? You know I'm not a gynecologist, and I'm not aware of anything at this point that can really take the place of a straightforward Pap smear. So I'd say that while it's important that we be sensitive and not necessarily rush into this, that people still need to have a Pap smear. There are situations now where there are home Pap smear tests. I'm not aware of the data on the effectiveness of those tests. And so I guess until I learn more about this, I'd still feel like our routine practice should be doing this in a health care setting, in a more traditional way. So again, thank you for asking these questions.

Finally, I just wanted to end with the fact that I think for all of us-- particularly in the context of setting up HIV programs-- we have to create a welcoming and inclusive environment to make sure that people feel comfortable overcoming the barriers to care and feeling comfortable like they want to come and get attention for both prevention and treatment. And the environment is important for both care, but also for working, for people who work in the health care environment and for people who learn in the health care environment.

I guess I have a polling question related to this now, which is does your organization have a nondiscrimination policy that prohibits discrimination based on sexual orientation, gender identity, or gender expression. And I'll give us a minute.

OK while we wait for the results, I'm just going to go on and talk about some of the things that we can do in health care organizations. I think that one of them is that we need to have nondiscrimination policies that include sexual orientation, gender identity, gender expression, and which apply not just for patients but also for staff. Because I think that we often leave out staff. And we have to make sure that everybody feels protected.

But in addition to having a policy, we need to know that- first of all everybody knows about the policy, and secondly that if there's something that comes up people know what to do about it. So I'm glad to see that of the group that's on this call, 83% say they have a policy in place for both patients and staff and 17% don't know. And no one is saying that they don't have a policy in place. So that's really good news. But I think this is really the keystone of a lot of the things that we need to do.

In addition, we need to make sure that clinicians and staff are taught about the health needs of LGBT people, as I've tried to focus on today and summarise some of the critical ones. That LGBT employees feel respected and safe at work. That's something that we need to survey. We need to make sure that our colleagues feel comfortable. There's a lot of LGBT people who work in health care. But I think we have to question do they feel comfortable expressing that with their colleagues, do they feel comfortable being out. Because ultimately I think you're going to have

a more satisfied workforce and a more productive workforce if people feel that they can be themselves.

And then, as I said earlier, we have to look also not just at the questions we ask verbally but also at our forms and whether those reflect the full range of sexual and gender identity and expression, and do so in a neutral way so that people can feel comfortable throughout their health care experience.

We think that it's helpful to add affirmative imagery and content to education and marketing materials. And we have some examples here. So for example, if you have a geriatrics program it would be nice to feature two men together in one of your brochures. This is something that has like zero cost attached to it as long as you're already doing marketing but can make a difference in terms of your attracting the LGBT community to come and get care.

And we've work together with Piedmont Health Services in North Carolina to develop this brochure and this poster, which we've done in Spanish and English, called Do Ask, Do Tell. The poster is meant to go up in the exam room so people have a clear indication that their provider is expecting them to talk about whether or not they're LGBT. And the brochure is a bit of a way of helping people understand what are some of the questions they should talk about, as I've tried to highlight throughout this talk.

So in closing, I'd just like to say that we really have a range of things to do. We have to think about collecting data. We need to focus on clinical education. We need to educate our consumers about how to be educated consumers-- or activated consumers-- and ask questions and feel comfortable asking questions, if we're really going to provide patient-centered care and high quality care that achieves the satisfaction levels that we want to in the populations that we serve.

So thank you very much for attending. We have time now for some questions. And someone's already just written in. The question is-- for health centers who may have pockets of stigma among providers, staff, board members, or even union reps, what action might you recommend to address the challenge? Thanks again for this important question.

So I'd say there's a number of approaches to this. First, I think that general education about why this population needs specific attention is important. Second, one of the things that I've done in one of the health centers-- in a group of health centers-- in the South where I've worked is ask everybody when I've done the sessions whether people know or have family members who are L, G, B, or T and have them talk about that with their colleagues. And it's actually remarkable what an amazing experience it was for people to hear from their colleagues that they may have grown up with-- a brother's gay, or in one case I recall a mother who is lesbian-- and talk about that with their colleagues. And often these are things that they've never talked about before.



But ultimately I think there are going to be people who are resistant. And I feel like health care is one of those areas where we all commit to providing health care for all when we get our degrees and when we go out into practice. And I think that that's the message that I like to give when I speak. But more importantly, I was once in a session where this question came up. It was a session on transgender health, but it was a session for front-line workers. And someone said well what if my professional values and my personal values are in conflict?

And I invited everybody in the group to speak. And I didn't really give an answer to this question. But the consensus of the group after talking about it for 10 or 15 minutes was that exactly what I just said, which was this is a health care center, and that we are here to serve all, and that we really can't discriminate against people, and have to provide the best and care for people.

So I think that that's the message that I think is important for health care providers or people who work in health care settings to hear. And I know that people may disagree with that. But I've found that even working in the deepest South that there's generally a lot of understanding about the need to take care of people who others can identify as family members, regardless of their sexual orientation or their gender identity, that their health is important because they see them as members of their larger family. And that's, I think, a powerful message, and one that I hope works for you who are faced with this issue.

ADRIANNA SICARI: So if there aren't any other questions I will go ahead and turn it over to Chelsea and the HIV TAC.

CHELSEA WHITE: OK. Hi, this is Chelsea. So I just wanted to thank everyone again for attending today's webinar. We hope that you enjoyed the presentation and found the information presented to be very useful. I also want to thank our strategic partner, the National LGBT Help Education center and Doctor Harvey Makadon for facilitating the collaborative training and for working with HIV TAC. And with that I'll pass it back over to you, Adrianna.

ADRIANNA SICARI: Thanks. Yeah, I think that we just want to say thank you to all the attendees and to the HIV TAC and thanks everybody.

HARVEY J MAKADON: Thank you very much.

CHELSEA WHITE: Thank you, bye bye.

ADRIANNA SICARI: Bye bye.