

## **WEBINAR VIDEO TRANSCRIPT**

Partnership for Care HIV TAC

### **Ten Things: Creating Inclusive Health Care Environments for LGBT People**

19 August 2015

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CHELSEA WHITE: Without further ado at this time I would like to turn the webinar over to Dr Makadon.

HARVEY J MAKADON: Thank you very much, Chelsea. And good afternoon, everybody. I'm pleased to be here again. And I just want to say, as I prefaced it for some of you, part of the introductory section of the talk will be very similar to the talk I gave on overall achieving health equity for LGBT people, because I want to make sure that everybody is thinking about things along similar lines. So I apologize if you've heard this before, but please feel free to ask questions to advance what we discuss or to clarify things that you may not have asked about on the first time. And then we're going to get into the 10 things that we usually talk about when we work with community health centers to create inclusive health care environments for LGBT people. And we'll have time to talk about that with respect to your specific circumstances.

I do not have anything to disclose with respect to any conflicts or financial relationships. And the learning objectives for today are, as I said-- to talk about 10 things that contribute to providing affirmative and inclusive care. But we're also going to define the basic LGBT terms and concepts. And at the end you should be able to describe at least three strategies that you can use to implement a more LGBT-inclusive environment for your patients.

So again, we're working out of Fenway Health that in Boston. Fenway Health is a 501(c)(3) Federally Qualified Health Center that was founded in 1991. We have a mission of serving the well-being of the LGBT community but also people in our neighborhood. And we have an integrated primary care model here, which includes HIV services as well as transgender health. And today I am going to just briefly talk about HIV services as part of what we do, but also begin to describe the framework of a transgender health program. As many of the groups like yourselves who are now doing outreach for people at risk for HIV or with HIV to begin to engage them in care are also finding that many of these people are transgender and are questioning how to develop these programs.

The Fenway Institute where the education center sits is an arm of Fenway Health that focuses on research, education, and policy. The education center does training and technical assistance-

- this is one of the kinds of programs we do. We do these live and online. We do grand rounds at academic medical centers and at health centers. We also hold a lot of online learning programs, webinars, are learning modules for which we give continuing education, as well as health equality index credits for groups that are applying for the Health Equality Index through the human rights campaign. And we have many resources and publications which I invite you to look at on our website. This photograph here is a photograph of a training we did for the Mississippi State Department of Health in which they wanted us to do a training for their staff on providing affirmative and inclusive care for LGBT people because they realize the importance of doing so to engage people and keep them engaged in care that was necessary for people with HIV and other chronic issues.

So just to begin-- and remind those of you who were on last time-- why do we have programs for LGBT people? It's really because we've learned that LGBT people experience a number of health disparities. And these are described in either more or less detail-- less detail in Healthy People 2020. But this is the first edition of the Healthy People series that included the LGBT population as a distinct population with unique health disparities that were targeted as issues for us to overcome by 2020. And the other is the Institute of Medicine report that was mentioned in the introduction, which has a much longer description of health disparities. And both of these are available on the websites of the Department of Health and Human Services and the Institute of Medicine if people want to download these and read more detail.

I think the bottom line is that the health disparities that exist are largely the impact of stigma and discrimination. And one of the reasons it's important for us to be on this call today is that a lot of the stigma and discrimination this is experienced does occur in the context of people getting health care and in health care environments. Because clinicians are often not trained-- or frontline staff are often not trained-- in understanding the needs of LGBT people.

And that's not to say that people don't have difficult experiences elsewhere-- the photograph in the center on this slide shows a young boy who's just been bullied in school, and the photograph on the right is of a transgender woman who sadly committed suicide about a year ago and left a suicide note. And what she said-- she had felt rejected by her family and her church, and as a result was depressed and committed suicide. But left a note saying that she hoped that people would learn and change from this act that she unfortunately committed. And so I think that these are the kinds of things we have to be thinking about.

Stigma clearly does relate to health on many levels. People personalize things that they experience and develop internalized homophobia or transphobia. And we call this intrapersonal stigma. There's interpersonal stigma that comes from interactions such as being bullied at school or interactions with a health professional who's not understanding. And then there are structural barriers, such as things ranging from access to health insurance to unemployment, poor nutrition, lack of housing, which all are experienced by LGBT people and which contribute to the stigma and to the development of health disparities. So these are all important things for us to be considering as we think through these issues.

There have been a number of studies of the effects of stigma on health. LGBT people who experienced a stressful life event-- such as an assault or being fired from a job-- we're more likely to suffer from a serious physical health problem over a one-year period following this. People who have internalized homophobia or experience discrimination and expectations of rejection, this has been shown to be associated with increase in HIV risk behavior. And recently a study came out showing that enacted and anticipated stigma in health care settings resulted in approximately a 40% increase in delaying urgent and preventive care in a sample of over 2,500 female-to-male transmasculine people or transgender people. And again, you can see that the stigma that people may experience in our own practices can lead to not receiving the kind of care that people need over the long term.

Some of the health issues that are highlighted as noteworthy of disparities are the fact that LGBT youth are two to three times more likely to attempt suicide and more likely to be homeless, that men who have sex with men-- regardless of whether they identify as gay-- are at higher risk of HIV and STDs, particularly among young black MSM in communities of color. The LGBT populations have higher rates of tobacco, alcohol, and drug use than the general population. Lesbians and bisexual women are less likely to get preventive services for cancer, which is attributable to a number reasons. But one is that people are stigmatized and don't return for the kind of services that they need.

Again, transgender individuals have a high prevalence of HIV and STDs, victimization, mental health issues, and suicide. We talked a little bit more about this on the last webinar. But this group is also less likely to have health insurance than heterosexual or other LGBT individuals. And obviously this is particularly true now in state which have not expanded Medicaid to cover all people. And finally, elderly LGBT individuals face additional barriers to help because of their isolation, fewer family supports, and a lack of social and support services.

Now I just wanted to go through some basic concepts around LGBT and what it means. I think the first is that LGBT is not a homogeneous group of people but is a number of groups of people who are very diverse who share certain common experiences and therefore have been presented together, although I think some people could make a case for talking about each group individually because there's such a rich diversity in each one. And I think that's important for us to keep in mind.

But I think that one important issue-- which, just the other day I was talking to somebody who conflated these two issues-- but that sexual orientation and gender identity are not the same, that all people-- everybody listening to this call-- has both a sexual orientation and a gender identity, but that how individuals identify can change over time. And terminology also can vary. And so it's very important to keep this in mind as we think about both sexual orientation and gender identity.

In terms of sexual orientation, this is probably a term that people are more familiar with. But it's really how a person identifies their physical and emotional attraction to others. And there's felt to be three components. One is desire, something that sometimes clinicians don't inquire

much about and don't give people much time to talk about. But it's very critical that we allow people who may never have acted on their unstated desires to be given a chance to talk about how they feel towards different people and what interests they may be interested in learning more about. Behavior is-- as we say, it's an issue of who people are attracted to or have sex with. But men who have sex with men or men who have sex with men and women. And similarly, for women who have sex with women or women or have sex with women and men.

And then both desire and behavior do contribute to how people identify. People might identify as straight, gay, lesbian, bisexual. And then sometimes people use a term like queer, which may seem discordant to some but nevertheless is increasingly commonly used by individuals who are trying to reject some of the traditional boundaries of terminology that we've used for many years. And so these are important concepts to be thinking about. And now I just wanted to explain a little bit about gender identity and gender expression.

Gender identity is a person's internal sense of their gender. Do I consider myself male, female, both, or neither? All people have a gender identity. Gender expression is different, and it's not directly related to gender identity. So someone's gender expression is how one presents themselves through their behavior, mannerisms, speech pattern, dress, and hairstyles. And it can be on a spectrum of more traditionally masculine to more traditionally feminine and anywhere in between, and doesn't really correlate with someone's gender identity or their sexual orientation. People can be gay, straight, lesbian, bisexual and still have very fluid gender expression. And so I think it's important to understand these terms, again, as distinct from one another.

Getting to understand transgender. Some people use it as an umbrella term to describe a number of different populations. But generally speaking, the main focus is on people whose gender identity is not congruent with their assigned sex at birth. Alternate terminology for transgender can be transgender woman or trans woman, and sometimes male or female, or transgender man, trans man, and female to male. Some people choose to use terminology which doesn't describe them in terms of male or female, but again, more along a spectrum that's non-binary. And people use terms like non-binary or genderqueer. But gender identity is increasingly described as being on a spectrum as opposed to purely male or purely female. And again, this is probably more common in younger patients. But nevertheless, something that is important to be aware of so that we can all be understanding and empathic clinicians when we hear someone talking about this in our offices.

Just to review this terminology-- gender identity is what your internal sense tells you your gender is. Sex refers to a presence of specific anatomy-- and not just genital anatomy, but really all the anatomy goes into leading us to describe someone as male or female. Gender expression is the presentation to society through clothing or mannerisms, et cetera. And then sexual orientation has to do with attraction, who you have sex with, how you identify your sexuality. So if anyone has any questions about this, we're about to go into the next part of the talk. So feel free to write in a question or raise your hand. But I'm just going to go ahead, and then I'll stop if I hear somebody or see somebody's asking something.

Oh, I did want to mention before I get to the next part that LGBT people tend to be from lower socioeconomic status. The children of lesbian, gay, bisexual parents are especially vulnerable to poverty. And that this is particularly true among African American children in gay male households as well as households of lesbian couples. And that transgender people tend to be four times more likely than the general population to have a household income of less than \$10,000.

So we have a question that just came in. It said, what would you say is the most common mistake clinical and non-clinical staff make when attempting to create an inclusive health care environment for LGBT people? I think that's a really good question. And it's actually going to be the topic that we're going to focus on in the next part of the talk, which is called 10 things-- creating inclusive health care environments for LGBT people. So to those who asked this question, if I don't get to the most common, I think they will be one of the 10 things I talk about. And I'll try and highlight what I think are some of the major issues as I go through these. So bear with me and I'm not trying to avoid this question.

But we do a polling question which is also relevant to this issue. It says my health center or organization offers a welcoming and inclusive environment for LGBT patients and clients and their families. And asks you to identify whether you strongly agree, agree, disagree, or strongly disagree.

Maybe just commenting a bit about the question while you're answering this one-- I say that probably one of the most common things that happens in health care settings is something that happens in the waiting area, not necessarily in the exam room. And has to do with our way of communicating and our use of language with people who may have identified themselves in ways that are different from perhaps the way they appear or the way their names have appeared in previous charts. And that we have to pay close attention to that and learn about those things. And I'm going to offer some suggestions as to how to do that in the slides ahead.

And so here we're waiting for the results of this poll, and here they are. So in terms of my health center offers a welcoming and inclusive environment, most of you seem to feel like you do pretty well, with 11% strongly agreeing, 61% agreeing, 22% disagreeing, and 6% strongly disagreeing. And so we have a range of opinion, but clearly people are feeling more positive about this. And we're going to try and help the people who feel like their environments are not as supportive make them better.

So I tell you one of the first things that every organization needs to think of-- although it's something that sometimes as someone who works in a health care center but is not on the senior management we tend not to think about-- but it's the importance of board and senior management being actively involved in efforts to build an LGBT-inclusive environment. Engaged leadership from both the board and senior management is critical even if there are a large group of stakeholders in the organization. Because leadership can set a tone and build LGBT inclusiveness as part of an overall commitment to equitable care for all.

I do want to point out that while this talk is on LGBT health, we recognize that this is one element of inclusiveness that really has to respond to many different population needs. And so it's very important that we see this in the right perspective. LGBT staff champions though need to be involved in designing and implementing change, and it can be very helpful for managers or leaders within a health center to do that.

Here's an example of an organizational chart so that the board members really have to support change. The CEO or senior management group have to be responsible for leading the way, creating the vision, and implementing change. And then throughout the organization stakeholders can make a very big difference in all departments, particularly if they work together and share the practices that are making a difference for patient care. And so I think this is clearly one of the most important things, and one of the first things to be thinking about.

Now we have another polling question. It says my health center includes the following in its nondiscrimination policy. One is sexual orientation, two is gender identity, three is gender expression, four none of the above, and five-- or E-- is not sure. So while I'm going to say this I'm going to speak ahead to the next slide or two and say that a nondiscrimination policy-- including sexual orientation, gender identity, and gender expression-- is required of hospitals by the Joint Commission as part of the Joint Commission survey. And when I last checked, it wasn't yet a requirement for the ambulatory care survey that they do in health centers.

But that I'd say that probably more important than the policy itself is knowing what to do when someone actually feels discriminated against, whether they're a patient, whether they're a staff member, or whether they might be a student from a nearby institute who's there to learn. And so this is a very critical issue because it's the backbone of change. And I'd say any organization that's beginning this initiative should make sure that its policy is in place and that people know how to affect change based on this policy.

So here we see that of the health centers that are participating in today's session 59% have nondiscrimination policy regarding sexual orientation, 29% regarding gender identity, 29% regarding gender expression, 12% none of the above, and 29% are not sure. So I'd say this is pretty interesting, because it shows that if you really are concerned about creating an environment that is supportive of LGBT people that we have to deal with implementing a nondiscrimination policy. And that, as I was saying before, people have to be clear not just that the policy exists but how to help somebody who has a complaint. And so clearly this slide suggests the need for change in a number of health centers. And this is something that we could discuss more later on.

The second, number two-- as I said, which relates to this question-- is that patient and employee nondiscrimination policies should include sexual orientation, gender identity, and gender expression. And as I said, these policies should be known, and the recourse that needs to be taken also needs to be known.

Sample nondiscrimination policies from different organizations are very simple. There are things like the health center prohibits discrimination based on age, race, ethnicity. And then also in addition to other things include sexual orientation and gender identity or expression. And then every patient has the right to receive medical care that meets the highest standards of our health center. And then it's regardless of a number of things, including sexual orientation, gender identity or expression. As I already explained, the Joint Commission require this of hospitals and probably will soon in its ambulatory studies, if they haven't done that already.

The third thing that we usually talk about is doing outreach efforts to engage LGBT people in your community. It's difficult to find people in an organized way so that you can engage them and survey them. So effective outreach requires understanding of the diversity of the community and how to reach them. There's a variety of ways to learn this information through community assessment and focus groups. But again, you have to know how to tap into the right organizations to do these assessments and then to find people who would be on focus groups. But the goals of outreach can range from helping people sign up for the Affordable Care Act, to engage them in care, or to enroll them in research studies to improve care for LGBT people. And outreach is not only important for the health of the community, but also brings a new segment of the community to your organization to receive care. So you can do well by doing good.

LGBT people, as I've pointed out before, are largely invisible to the health care providers until we learn about them and ask about them. And we're going to get to this a little bit. But what we wanted to do was show you a little bit about what we've been doing to get to know your community in different conferences that we've been doing by having patient panels. And what we have here is a panel that we recorded a video of so you can hear people's explanations of some of their concerns regarding access to care. And so we're going to show you a short video-- I think it's eight minutes. But it should raise some questions. And these are presented by the LGBT people who volunteered to be filmed.

[VIDEO PLAYBACK]

[MUSIC PLAYING]

-When I was growing up in rural Delaware, Ohio my doctor never once talked about sexual health, never once asked me if I was a part of the LGBT community. And I always because of that felt a little weird about asking him about that. But I just said specifically remember when I came back from college I told my doctor, yeah, I need to get HIV tests, I need to start getting STD tests. And he was confused-- why do you need to start doing that, why, why do you need those tests. I don't see any symptoms that you have any of this stuff. And I was like well, I am a gay male and I understand that these things are things that I need to start talking about, thinking about, looking at. It brought up all those different things you think about when you tell a doctor you need something and they feel like they don't think that you need it as well. So feeling invisible and those kind of things.

-In my later '20s my partner and I decided we wanted to try to have a baby. And we tried, and we tried, and we tried to no avail. We went to a specialist hoping that we could just begin to understand our options, recognizing that options for two women trying to have babies insurance-wise are a little bit more constricted than they are for heterosexual couples. And he began talking with me-- completely and totally just focusing on me-- and my partner was sitting right next to me. And he acted like she wasn't even there. So I continued to refer to her, and us, and we, and our family that we're trying to create together. And he just couldn't even look to acknowledge her presence, which was disturbing. Because we were together, trying to do this together.

-And he got more and more agitated as I was asking questions, and at the height of it just finally said, you know what, I can't give you any special treatment. And that was when we said thank you very much and left. It made me and us feel invisible. Even if he was looking at me, it made me feel like he's not seeing me at all, he's not understanding what we're here to talk about.

-So I got the name of a physician that I thought would be a good fit for me. And I went in to my first office visit with him to establish care. And I shared with him that I was gay right up-front and that I had a partner that I'd been with for, at that time, maybe 10 years, and kind of went through the list. And I got the impression he was uncomfortable. When it came time to take in a sexual history, one of the things that he said to me was well, of course you're monogamous and really shut the conversation down. Not that I was necessarily going to disclose everything about-- but that judgment, that assumption of who I was and what I did in terms of behavior.

-And it really kind of made the rest of that interview difficult. Because I felt like I couldn't really be honest with him now because of these assumptions that he had implied and made. And what I wanted to find was a provider that understood the needs of a gay male and was comfortable around gay men. We probably could have arrived at an earlier intervention had he just understood the needs of a gay man, understood culture and the different cultures and lifestyles that gay men might lead, and asked questions in an open and inquisitive way, rather than one in which I felt it wasn't safe to disclose personal information about myself for fear I was going to be judged.

-So really my first health care experience as a trans person was when I actually came out to my first PCP and really initiated that process of transition. And it was obviously terrifying. I had been with this PCP for four or five years at that point. And this was really the first step. From the get-go when I first said I'm interested in starting hormone treatment. And she said, well why, you don't have any hormone imbalances or anything. And I said well I'm transgender and I'd like to transition from female to male. And I'd like to use hormones for that. And she was like oh-- well I've never done this before. I've never had a patient that I initiated hormones with and took them through the transition process. But I'm more than willing to work with you. And we can really do this together.

-And that's what I really appreciated, was the fact that she acknowledged that she'd never done this before but she wasn't scared to really educate herself, and listen to what I wanted as well,



and move this forward. It was very affirming in a lot of ways, because there was never a question of are you sure this is how you identify. And she was very good about when they were relevant she asked the questions that she needed to ask. But I don't feel like she was being overly invasive or just asking questions to satisfy her own curiosity. It was very much like very patient-focused care that she gave me, and just really wanting to make sure that I achieved the goals that I wanted to achieve, but helping me get there safely.

-I have had providers in the past who have made some assumptions. And it's like, well, that's not really correct. And that can affect health care. People think that if you're going to go through the process of transitioning to male obviously it's because you're attracted to females. And that's not necessarily the case. And then also recognizing that my journey is my own and not attributing all these other health concerns that may be endemic to the trans population but may not apply to myself.

-So I grew up in the Midwest. And I came out to my family in high school. And I remember having a physical with my primary care provider and not being out to my parents at the time. And being really nervous about being the first adult I might come out to, and not feeling super close to her because I saw her probably once a year. And her asking me if I'm sexually active. And I said yes because at the time I had started dating someone. And then her bringing up a conversation about birth control and understanding that that didn't apply to me and was this going to be the moment where I outed myself. Or was I just going to answer the questions and say no, knowing that if I had done that she would have probably kept pushing me for the answers.

-And so I did come out to her. And I was really nervous. I think I probably stuttered over my words and didn't feel very confident about it. And when I kept coming back to her each year she kept bringing that birth control question back up, which I remember feeling kind of angry about or misunderstood. So I almost felt pushed backwards a little bit I think, in thinking about have I not really figured this out about myself. Or is this something I should just start on, and is this what good health care looks like if you're a young woman. And so having to just reassert myself and be really authoritative with her was uncomfortable as a young person to a much older provider who had known me for a long time.

-I think she could have just asked, Julian I know you're dating women exclusively at this point in your life, I think that's wonderful, I'm so happy that you're in a home that has been accepting of that. If your situation changes, if your identity changes or how you're feeling changes, if your behaviors change let's talk about birth control. Or you know that you could always bring that back up with me, but I'm not going to bring it back up because I understand what you've told me about yourself.

-Now that we are a family of four we often will go to appointments all together. When my children were in preschool, and at that point we had explained to them how they were created, the donor concept and what that all meant, and what it meant to be kids from a two-mom family, and how to explain that to their friends as they started school. And we had noticed

some signs that my son might have had a genetic illness that might get more challenging as he grew older. So we were referred to a genetic specialist. And this person immediately starting saying, and the father, and the father, and the dad, and the dad, and the father, and the father. And I kept saying donor, donor, back. And they kept saying father, father. And our kids are getting more and more bewildered, wondering what are these people talking about. I thought we had this conversation about how our family came to be. And we understand this donor thing. But why is this person saying that we have a dad? And it was just really, really overwhelming and confusing.

-So it makes us invisible. And it's also very confusing and upsetting to the kids when they're not acknowledged. And they don't understand it in the way that we do. So I think that that's a big thing, just making us know that you see us and acknowledge us. And ask questions if you need to. The question we started with, what are your pronouns, that's a really important question. How do you identify? Those are important questions so that a provider can then get the language that the people sitting in front of them use, so that they can then use that moving forward.

[END PLAYBACK]

HARVEY J MAKADON: So I hope you can see now why we think it's important to include the patients' voices as part of our presentations. And we created this so that we could demonstrate this better. I think a lot of the issues that people cover are things that we've discussed either today or on our last session. But if anyone has any questions that they want to bring up regarding the conversations, please feel free to do that now or at the end of the session.

Personally, I was very moved by what everybody had to say. And we tried to choose people and choose parts of what they said, because this was not the whole tape, that really reflected different issues that LGBT people face in the context of going and receiving health care. And so I think these are the kinds of important things that can help us all learn from our communities. And it's probably even more compelling when they're people from your own community who are sitting and telling you these things, which is why I think this is an important element of what we can do to learn from our community.

I think another thing though that I wanted to highlight is not just learning from our community, but helping our community learn to accept, particularly LGBT youth in their families. Because again, that keeps our community together. So LGBT youth rejected by their parents are more likely to attempt suicide, report depression, use illegal drugs, and have unprotected sex. And parents have a number of ways of rejecting behaviors with their children. They can forbid interactions with other LGBT peers. They can blame children for being the victim of bullies, as opposed to bullying. They can hide their children's sexual identity from other family members and friends, which makes kids feel really bad. And they can actually go to the point where they actually kick their children out of the house, which explains the high rate of homelessness. So the family acceptance strategies are important for clinicians to learn about. People should be asking patients how their families have reacted to their coming out.

But there are resources, such as the Family Acceptance Project in San Francisco, that has a number of materials that clinicians can use. And I think one of the key things that I like to emphasize is that we really should be working to explain to parents the negative impact of rejecting words and behaviors. But also suggesting that parents, even if they don't feel totally comfortable, that they support their children's sexual orientation or gender identity as much as possible. Because the general consensus is that a little support goes a long way. And again, the Family Acceptance Project resources are available online for you to use and for you to learn from. And so I think that these are the kinds of things that help us both get to know our community in ways that we probably are not accustomed to as either administrators or clinicians and I think can make a big difference for people.

This poster I think sums up my feelings. This man 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. And I think that's the spirit with which we have to engage parents in really working with their children and staying with their children through what could be a very difficult period of their life.

This leads us to the next point. Four Is all staff receive training on culturally-affirming care for LGBT people. So we started this on the last session. But respectful communication and quality care depend on all staff receiving . Training we have to learn how to avoid assumptions and stereotypes, and to communicate in an inclusive way. And I said before, this really needs to include and begin with frontline staff. Because when patients receive nonjudgmental and welcoming responses to discussions about their sexual orientation and gender identity, they're much more likely to remain engaged in care.

And again, part of avoiding assumptions are things like using gender-neutral language. So we want to avoid assuming gender or sexual orientation with new patients. So training staff to say things like instead of how may I help you, sir, just how may I help you. Or he's here for an appointment-- you could say the patient is here in the waiting room. Instead of do you have a wife, are you in a relationship. Instead of what are your mother's names and father's names, what are your parents' names. Those are all things that can make a big difference to people and make them feel like you actually do understand who they are and how to communicate with them. So communications is really critical.

You have to listen to how people describe their own identities and their partner's and use the same terms if they're comfortable for you. And certainly each individual is unique. And you can't assume that all LGBT people are the same. If you know one, you really only know one.

It's important to use patients' preferred names and pronouns when talking about somebody. For example, most transgender women want you to say she or her when talking about them. And trans men prefer he or his. But some people may prefer words or pronouns that are unfamiliar to you. Pronouns such as z or they are sometimes used by people who don't want to identify with the gender binary of he or she. And some of the pronouns, just again to display these-- here's a list of pronouns that are commonly used, the more traditional. So a transgender woman might use this, but then they might prefer not to identify as male or female

and use one of those groups of pronouns on the bottom of the slide. And people can be very different. And so again, we have to learn about these things and expect to hear about them so that we can put what we learn into practice.

And remember that if you're unsure about a patient's preferred name or pronoun you can always say I'd like to be respectful. What name and pronoun would you like me to use? Or if you accidentally use the wrong term or pronoun, just say I'm sorry, I didn't mean to be respectful. And sometimes when the patient's name may have changed and doesn't match their insurance or medical records, you can say something like could your chart or insurance be under a different name, or what is the name on your insurance. So again, these things can become matter-of-fact, but they do require some practice. And we have some tools on our website that can be helpful. I'm cognizant of some questions that have come in. But I'm going to deal with a couple of those later on in the talk.

Again, not just in our conversation, but as I've already alluded, processes and forms also need to reflect the diversity of LGBT people and their relationships. So forms, again, should avoid gender-specific terms-- like husband, wife, mother, father-- and reflect the reality of LGBT families by asking about relationships, partners, and parents. Forms should include a question about gender identity as well as sex assigned at birth and ask about patients' preferred name and pronouns. And there should be a process for ensuring that all staff use preferred names and pronouns, and that all staff know how to respond if names and gender markers have changed from earlier records or insurance documents.

We usually recommend-- and this is consistent with recommendations of the Institute of Medicine and the Joint Commission-- that information about sexual orientation and gender identity should be routinely collected as part of the electronic health record. An increasing number of organizations are in fact doing this. I was quite surprised-- pleasantly surprised-- when I was speaking with a group of health centers where over 50% said they were asking routinely about sexual orientation and gender identity among their patients recently. And this information can be collected at a variety of points, but is recommended-- as I said-- by the Institute of Medicine in these reports. So you can collect information at home through a patient portal, you can collect information through registration on-site, and finally sometimes people still prefer to have providers ask for this information. But the important part is that it do be asked and that people have an opportunity to talk about it.

The questions that we ask at Fenway are do you think of yourself in terms of sexual orientation or do you think of yourself as lesbian, gay, or homosexual, straight or heterosexual, bisexual, something else, or don't know. And in terms of gender identity we ask a 2-step question. One is what is your current gender identity and give people a variety of options. And then also combine that with what sex they were assigned at birth. And you can generally tell by these answers whether or not someone is transgender. And again, as I said, we also suggest that you routinely ask preferred name and pronouns so that that can be recorded and people can address people appropriately.

Seven is that all patients should receive routine sexual health histories. This isn't done nearly as much as it should be, as we discussed during the last webinar. But the discussions of sexual health should be broader than just to focus on behavior and associated risks, but allow people to talk about a range of issues including sexual satisfaction, desires, questions about abuse past or present, and reproductive options.

This is some data that shows how clinicians act. About 84% of clinicians asked a group of people who are HIV positive about adherence to antiretroviral therapy. But only 14% asked about HIV transmission or risk reduction. So clinicians tend to be much more comfortable talking about medical issues than about behavioral issues. And I think that it's important that we do both. This led the Institute of Medicine to write in one of its reports, "Ironically it may require greater intimacy to discuss sex than to engage in it."

And as a result of these kind of issues the education center worked together with the National Association of Community Health Centers to develop this brochure on taking routine histories of sexual health, which goes into a variety of issues that I've already described. But talking about partners, practices, past history of STDs, protection from STDs, and not just pregnancy protection but pregnancy plans.

So again, taking a history of sexual health should be routine. You really want to get to know your patient as a person. As we've already indicated, use inclusive and neutral language. And make this routine. And ask questions about behavior and risk, such as have you had sex with anyone in the last year. Do you have sex with men, women, or both? And how many partners did you have? Ask about sexual health and sexual and gender identity. And then also ask about reproductive health and desires. Because traditionally people have discussed only contraception, but a lot of people-- and not just same sex couples-- want to discuss desires to have children and the methods they can use when they can't have a gestational pregnancy, such as learning about surrogacy, adoption, or in-vitro fertilization.

So we have a polling question now-- does your organization offer any programs or services designed for LGBT patients and clients, such as support groups, educational programs, family planning for same sex couples? And the responses are yes, no, and not sure.

I will say the while I've been talking a couple of questions have come in. One is how do you deal with religious concerns with parents or friends may have? People believe it's an act against God. I think that partly there's obviously a lot of faith-based concern about same sex couples. Clearly the Supreme Court decision to allow same sex marriage throughout the country has not led that to go away. On the other hand, my experience has been that when people understand the impact of not understanding same sex individuals in their families and that it can actually lead the family to break up, they're willing to not put aside their faith, but understand that the importance of family and the importance of keeping their family together can often override concerns about faith.

Another similar question that's often brought up is what about health care providers who have religious concerns and feel that they can't really care for people who are LGBT. And I've been involved in discussions of that among health care providers. And I'd say that generally the consensus is that if you go into health care our commitment is really to take care of all people, and that not all people are going to be necessarily people who you want to have as your best friend, but that you have to put aside some of your personal concerns in order to be a professional and take appropriate care of people. And I've heard many people say that they feel like if you can't do that, then being a health professional may not be the thing for you to do. So we can talk more about that.

We do have the answers to the polling questions. Of the organizations represented here on the call, 24% do have some specific programs, 65% don't, and 12% don't know. So again, I think in terms of becoming an inclusive environment, I think you need to think about what you can do. And I'm going to be speaking a little bit more about this in just a minute or two. Because I think that we have to think about incorporating both clinical care and services that meet LGBT health needs into our health centers to overcome disparities and to welcome people into our facilities.

For example, men who have sex with men and transgender women experience high rates of HIV, and we need to focus outreach to engage them in affirmative care programs. And then when they are engaged they need to feel comfortable coming and getting care. But transgender people often have difficulty accessing care, and there are few providers experienced and willing to provide basic services such as cross-gender hormone therapy in addition to meeting routine health needs. So we have to be thinking about when caring for this population what we can do.

In the last talk I talked about basic steps to improve HIV prevention in clinical settings. And I know that's a project that you're all working on. But I'm just going to highlight that I think there's three basic things for HIV that can be done in all clinical settings. One is developing a universal HIV screening and making sure that that's implemented appropriately. The second is to develop systems so that once someone tests positive they immediately get begun on antiretroviral therapy. And then in terms of what we do around HIV prevention, we have to be thinking about adding new information about pre-exposure prophylaxis. And I think later on in this series we'll be talking more about that. But these are the kinds of things that are necessary if we're going to reduce the incidence of HIV. And these are also the kinds of things that are going to make a difference if you want to engage the LGBT population in care.

But I also think we need to think about new program development. And transgender health is one that a number of health centers have been asking about fairly regularly in the last year or so. Transgender health programs provide comprehensive medical and mental health care with understanding the special needs and challenges of transgender and gender nonconforming persons that reflect current research and evidence-based care. At Fenway we have a trans health program that's led by a coordinator who's the medical director and a patient advocate along with the associate director of behavioral health. This group meets regularly as a transgender health clinical team to provide consultation on cases that are been referred by

medical and behavioral health providers. And again, it's an integrated program that involves people from both the medical and behavioral health departments.

I think our approach-- and I think increasingly trans health care-- is individualized and not always linear. But it should include cross-gender hormone therapy as part of primary care. Some health centers have asked whether they need to expand their scope of work in order to add transgender health care. But if this is done as part of primary care, which is the way I think it should be done, that's not necessary. Clearly before beginning cross-gender hormone therapy one needs to have an initial complete history and physical and using an informed consent model that is patient-centered. Behavioral health care support is helpful but not a requirement for hormone therapy. And then we need to be thinking about follow-up care and monitoring, particularly including health care maintenance such as routine preventive health-specific care based on someone's anatomy and age, which would include STD and HIV screening, mental health care, and cancer screening.

For example, as-- again, as I think I talked about in the last session-- transgender men may need breast cancer screening. Because even if they've had breast reduction surgery they still may have residual breast tissue. And transgender women all still have a prostate gland, and so prostate screening is necessary for them. And then finally, obviously health centers aren't going to be performing surgery. But certainly basic counseling around surgical options and referrals are something that can be really important to make people feel engaged in care at your health center as part of your transgender health program.

Just as reminders, transgender men may need cervical cancer screening, as most transgender men do not undergo complete sex reassignment surgery. And so that's important. And then this is the case of a transgender men who developed breast cancer. And this was a transgender woman who developed prostatitis.

So at this point, one more polling question-- does your health center distribute patient/client education materials that address specific health care needs of LGBT people? I think the answers are pretty straightforward.

OK so one of the things we're going to get to in a minute is talking about the environment of care. And there are many issues to consider. One that comes up frequently for transgender people has to do with the availability of gender neutral bath facilities or restrooms. And the question is how this should be done. I think generally speaking in the best of all worlds there would be just single stall bathrooms, just like we have at home. In the case that restrooms are grouped, it's good to build stalls where the walls go down to the floor so people feel there's privacy.

Obviously this takes time. But if health centers feel they need to keep the facility segregated it's fine to still have a men's room and a women's room. It's just nice to be able to have some facility this is designated as unisex and that people know they can go to and feel comfortable and that they have privacy. And often people use what are often labeled family restrooms

where you might go and change a child and use those-- which are often single stall facilities-- and use those also for transgender people as gender neutral bathrooms.

The polling question here is does your health center distribute the education materials. And the answer again is yes 31%, no 56%, and don't know 13%. So clearly there's work that can be done to develop materials. And I'm now going to show you some examples of things that we've helped with.

But the question that we were just addressing has to do with the physical environment and what message your health facility gives to LGBT people when they enter. Are there images or brochures specific to LGBT people anywhere? So just think about what it would mean if you have a geriatrics program or an obstetrics program and you have photographs of same sex couples or individuals that might reflect someone who might be transgender. And that can make a big difference to people who are making decisions about where to go to care, and also make people more comfortable coming and getting care.

We developed this campaign called Do Ask, Do Tell for a health center in North Carolina that we work with. Because they wanted to put a poster up in every exam room to let people know that they should be talking to their doctors about being LGBT-- or their nurses, or their social workers. And then we also have a brochure which suggests questions for people to ask. We're in the process now of developing this for adolescent population. And I was pleased just last night to go to a local medical school where they said they've ordered these posters from us and they're using them in all of the exam rooms at a large medical center in Western Massachusetts. So again, I think these can be used all over. We make them available to people for free. They can be downloaded and you can put your logo on them. And we made them to make this process easier for people.

The next question is my organization offers a welcoming and inclusive environment for LGBT employees-- let's see what you think. So we're just going to wait-- should be there in another minute, few seconds I think. Oh here we go. So only 24% of you strongly agreed and 59% agreed. But there were still a number of dissenters and feel like you could do more. So I'd say that in general there's been I think a lot of work done, but it seems like there's still some more work that can be done. And these are not complicated issues-- they're things that a group of people just have to be empowered to work on.

I think the last point I want to make is the importance of recruiting LGBT staff and also retaining them. So having openly LGBT people on staff can really build a foundation for a respectful, inclusive health care environment. You have to consider benefits to treat LGBT people equitably in areas such as insurance and retirement. This has been made a little bit easier now that same sex individuals usually fall under the same requirements-- same sex couples who are married are usually covered by the same benefits that cover married couples in an organization. But think about whether your health policy covers transition-related expenses for transgender employees. That's a very important topic for a lot of organizations, and a place where there's been a lot of change recently. And then finally, mention LGBT nondiscrimination policies in your



recruitment ad, because there's a lot of really great health care workers who are LGBT, and they have a choice of where to work. And so your organization should be one of them.

So I think-- just to summarise-- I think we've talked about the importance of collecting data so we know who we're talking about and doing it in a variety of ways. I think listening to the voices of patients has been something that we've learned a lot from. Educating our clinicians as well as consumers in order to provide patient-centered care.

And with that, we have about 15 minutes for questions. So if people have more questions, feel free. And I've certainly enjoyed talking with you today and hope that you've found this helpful.

So we just got a question-- do you think there's an increased trend toward training future medical professionals on this subject? I think that that's actually a really good question. I'd say there's a lot of medical schools I'm aware of that are having elective curriculum that are often designed by students. But I'd have to say that I don't think there's been a great deal of movement in terms of what's incorporated into the basic curriculum. And I think one of the challenges is not just training future medical professionals, but in order to do that we also have to train the people who teach them. And so faculty development has to go along with whatever curricular changes we make for students. And that's also very important. I think there's a lot of talk about change, but it's been slow. And there's progress in the sense that students are often asking for more and more. And hopefully that will continue.

ADRIANNA SICARI: So if there are no other questions I'll invite Chelsea White from the HIV TAC back to the mic to close out today's webinar.

CHELSEA WHITE: Thank you so much, Adrianna. I'd just like to thank everyone for attending today's webinar on 10 things-- providing an inclusive and affirming health care environment for LGBT people. We hope that you have enjoyed our presentation and find the information presented to be useful. I want to thank our strategic partner, the National LGBT Health Education Center, Doctor Harvey Makadon for facilitating this collaborative training, along with Adrianna and Hilary for working with me on putting this all together. Thank you again for attending. And we look forward to you all completing the survey.

ADRIANNA SICARI: Yes, and to complete the survey all you need to do is close out today's webinar. It'll appear right when you end the session. So thanks everybody. And hopefully we see you on the next P4C collaborative webinar.

HARVEY J MAKADON: Thank you.

ADRIANNA SICARI: Thank you.