

NIHCM Foundation Webinar: Addressing Health Disparities in the LGBTQ+ Community

- Cait Ellis: [00:00:01](#) Good afternoon. I'm Cait Ellis, senior research and policy analyst at the National Institute for Healthcare Management Foundation and on behalf of NIHCM, welcome to our webinar today. LGBTQ plus individuals face health disparities linked to stigma and discrimination. These disparities are exacerbated when people are unable to access care or are uncomfortable communicating with their providers about their treatment needs, and these disparities impact the LGBTQ community at all ages with higher rates of suicide for youth, higher rates of substance use in adults, and increase social isolation and loneliness in elderly individuals.
- Cait Ellis: [00:00:42](#) We know that culturally competent healthcare can make a difference with the right tools and training, providers and community partners can build more inclusive environments for LGBTQ plus individuals inside and outside the doctor's office. We have assembled a group of speakers today that are leading efforts to address the barrier to high-quality healthcare for this community. Before we hear from our speakers, I want to thank NIHCM's president and CEO, Nancy Chockley and the NIHCM team who helped to convene this event today including Kathryn Santoro, Julie Schoenman, Kaitlin Swanner, Harpur Schwartz, and Kirsten Wade.
- Cait Ellis: [00:01:20](#) You can find biographical information for all of our speakers along with today's agenda, copies of the slides on our website. We also invite you to live tweet during the webinar using the hashtag LGBTQ health. I am now pleased to introduce our first speaker, Dr. Alex Keuroghlian, director of education and training program at the Fenway Institute, an assistant professor of psychiatry at Harvard Medical School. Alex has been recognized for his leadership in improving high care services and reducing disparities for LGBTQ communities. He has widely published and has spoken extensively on topics that include HIV medication adherence, sexual orientation, and gender identity [discussion 00:02:04] and homelessness among LGBTQ youth.
- Cait Ellis: [00:02:08](#) In addition to his research role at the Fenway Institute, Alex is a clinical psychiatry within the behavioral health department. We are so pleased to have him with us today. Alex.
- A Keuroghlian: [00:02:22](#) Thank you Cait. Hi everybody. Nice to be speaking with you today. We have a lot of exciting material to cover and hopefully, we'll all learn from each other. I'm going to spend about 15 minutes talking about LGBTQ health and gaps in medical care, and then pass it on to our next speakers. A quick word about Fenway Health and the Fenway Institute, we're a federally qualified health center in Boston, founded in 1971. From the

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beginning, Fenway's mission has been focused on the well-being of the LGBTQ community and people in our neighborhoods through high quality care.

A Keuroghlian: [00:03:05](#) We're unusual as a health center and that we have an institute within Fenway Health, the Fenway Institute that focuses on research, education, training advocacy, and policy for gender and sexual minority people and people living with HIV. Within the institute is our division of education and training that includes the national LGBT health education center funded by the US Bureau of Primary Health Care. We provide on-site training and technical assistance in all 50 states DC and Puerto Rico. Live webinars are then archived and available for free on our website for continuing education credits and health equality index credits.

A Keuroghlian: [00:03:46](#) We have a national transgender ECHO program that's trained up over 125 health centers at this point and a number of publications and other resources available for free download from our website on gender and sexual minority health. Feel free to check us out at LGBThealtheducation.org. In many ways, we've made a lot of progress societally toward inclusion in the mainstream fabric of US society of gender of sexual minority people. We've also noticed in recent years some setbacks and rollbacks with regard to rights that were previously enjoyed by the community.

A Keuroghlian: [00:04:32](#) Most recently, there've been limitations on inclusion of transgender and gender diverse people in the military efforts to reduce collection of gender identity data, which is important for the health and well-being of gender diverse people. About a year ago in Massachusetts, we had a ballot measure to rescind public accommodations protections for transgender and gender diverse people, and recently the results of Supreme Court decision to support service providers who selectively discriminate against same-sex couples. It's a complicated time we live in and certainly a focus on health equity for LGBTQ plus people is one that needs to take into account the societal context in which we operate.

A Keuroghlian: [00:05:25](#) Why is it important to have health programs and medical education specifically for LGBTQ plus people? Healthy People 2020 and the Institute of Medicine, two large federal initiatives convening national experts, reviewed the existing literature and concluded that there really are unique health disparities faced by LGBTQ plus communities, and that the way to address these health disparities is to tailor and develop health systems that are patient centered and responsive to the sexual orientation

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and gender identity of all patients. We've used the term LGBTQ plus a few times as if it's one homogeneous population where everybody has the same experiences and the same health needs.

A Keuroghlian: [00:06:13](#) The reality is each of these subpopulations and I've used comments here intentionally to distinguish them as unique experiences and need help. Let's talk through some of these concepts and terminology a little bit together to make sure we're all on the same page. There are lot of words, terms that get used when we first start focusing on improving care for gender and sexual minority people that can be overwhelming and confusing initially. Let's go through it slowly to make sure we all understand the terms being used. The first point to make is regarding the concept of sex assigned at birth.

A Keuroghlian: [00:06:58](#) When babies are born in most countries and cultures around the world, they're typically assigned a sex at birth based on biological factors, whether it's external anatomy or chromosomes or some combination. Most often assigned to either female or male sex at birth, and some cases, intersex status based on having anatomy that doesn't traditionally fit into notions that we've had historically of being either female or male. Sex assigned at birth is really a biological construct. What is gender identity? This is a person's inner sense of being a girl, woman, boy, man, something else in terms of gender or having no gender at all.

A Keuroghlian: [00:07:45](#) We appreciate that these babies assigned at sex at birth grow up become children, adolescents, and adults who may have a gender identity and inner sense of their gender that doesn't allow in a conventional sense that the sex they were assigned when they were born. We also appreciate that many people have a gender identity that doesn't fit one of the two traditional options of either being a girl or a boy, either being a woman or a man. We appreciate that many people have non-binary gender identities, and here we see the gender identity continuum. In summary, there are many other terms that people will use to describe their gender identity.

A Keuroghlian: [00:08:23](#) We see a continuum that includes more traditionally binary identifications like identifying as a woman or as a transgender woman, identifying as a man or a transgender man, and then a range of non-binary or gender diverse or gender expansive identifications that also exist. That's gender identity. In contrast, sexual orientation is how a person identifies their physical, emotional, and romantic attachments to other people, and we think of this typically in three categories. The first is attraction.

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This is whom someone is attracted to when they desire in an intimate context. When I was in medical school, I was trying to ask are you attracted to women, men or both. We moved beyond that.

A Keuroghlian: [00:09:12](#) Now we ask who you attracted to generally or what are the genders of the people you're attracted to, to acknowledge the fact that there are more than two possible genders. The second component is behavior, and this refers to whom someone is or isn't engaging in sexual activity with and what kind of sexual activity they may or may not be engaging in. Something we're very focused on in my field of psychiatry or behavioral health and also in the field of infectious disease, for example where we're focused on transmission of sexually transmitted infections. The third component of sexual orientation is identity.

A Keuroghlian: [00:09:45](#) They're suppose to the range of labels and communities that exist in society that a person may or may not affiliate with regarding their sexual orientation. Some of the more common terms that we may know are gay, lesbian, bisexual, straight, queer. There are many other terms as well. We have a glossary of terms on our website at LGBThealtheducation.org that we revised last year, and now in the process of revising it substantially again just because the way people are conceptualizing their identities and defining them, referring to them is evolving so quickly.

A Keuroghlian: [00:10:23](#) What does the Q stand for? Can stand for a couple of things. It can stand for questioning, someone who's exploring their sexual orientation or gender identity that hasn't yet settled on a particular one. It can also stand for queer, which historically was a derogatory term a slur for gay and lesbian people, which has been taken back by the community, reclaimed and is used by many people with great pride. It indicates generally that someone doesn't identify as straight, but also doesn't necessarily identify with gay, lesbian, or bisexual identities. With all these terms, an important point is one of self-identification. We can't assume someone is comfortable identifying in a particular way because of their sexual behavior, for example.

A Keuroghlian: [00:11:05](#) You have to ask them in healthcare and document sexual orientation and gender identity based on what they tell us. Not based on how they look, how they sound, or what their behavior is. A critical point to make is that sexual orientation and gender identity are not the same thing. Those are two different experiences, two different concepts. Everyone has both a sexual orientation and gender identity. Each of us on this webinar has one of each, and the terms people use to define

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their sexual orientation or gender identity will evolve throughout their life. Someone may initially identify as a man and later identifies a woman. Someone may initially identify as straight and later identify as queer, for example.

- A Keuroghlian: [00:11:47](#) The terms we've used throughout history have also evolved. The terminologies now is different than what we were working with 20 years ago, 10 years ago, five years ago, even a year or two ago. I'm hearing new terms particularly from my younger gender and sexual minority patients in the last four to six months that I hadn't heard even a year ago. As Cait mentioned earlier there, unfortunately a range of health disparities either uniquely or disproportionately experienced by gender and sexual minority people that start young in childhood and evolved and persist in many cases into older adulthood.
- A Keuroghlian: [00:12:38](#) The way we understand these health disparities among gender and sexual minority people in clinical care, in research and policy increasingly is related to the minority stress framework. In this framework, we understand that gender and sexual minority people developmentally experience everyday discrimination, victimization, microaggressions, frank violence unfortunately at a higher prevalence in the general population. We think of all this as external stigma related stress.
- A Keuroghlian: [00:13:09](#) All these stress over time can take a toll for any people lead to disruptions in general or psychological prostitutes, like coping skills, emotional regulation, interpersonal functioning, having beliefs or cognitive structures as we say that aren't necessarily super adapted like leaving, it's never going to get better, nobody can be trusted, no one will ever love me. All this external stigma-related stress can contribute to internal stigma-related stress, internalized homophobia, internalized transphobia leaving all the negative things society has to say about your identity, expecting rejection because you're so used to it and in many cases, identity concealment to prevent being mistreated or abused.
- A Keuroghlian: [00:13:48](#) All these stress we think is related to what we see in the research, which is a much higher prevalence of various behavioral health problems, like higher prevalence of depressive disorders, anxiety disorders, post-traumatic stress disorder, substance use disorders as a way to cope with all this stress, decreased self-care, decreased engagement in healthcare including primary care and down the road, a higher prevalence of various physical health problems among gender and sexual minority people as well. We're really interested in healthcare in thinking about how we can turn the crisis of

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product minority stress into an opportunity for people to develop adaptive coping skills.

A Keuroghlian: [00:14:30](#) Instead of developing responses that may include identity concealment, social disengagement, lack of participation in routine healthcare, how is this an opportunity to foster effective identity management, adaptive learned coping skills, more connection to community, and participation in routine healthcare as a way to solve certain problems, and we consider it a responsibility and duty of ours as clinicians to ensure that we're proactively trying to turn this expense in minority stress into an opportunity to foster health promoting behaviors and improve physical and mental health outcomes.

A Keuroghlian: [00:15:11](#) Just to briefly review some of the disparities that we have alluded to, unfortunately abuse and violence are much more common among gender and sexual minority people and in the general population. Schools are often still unwelcoming environments for gender and sexual minorities students with much higher rates of physical, verbal and sexual abuse than experienced by other peers. Intimate partner violence among gender and sexual minority people is often under-reported. It's something that police often don't know how to handle. Perpetrators are often not charged and services for intimate partner violence are often not inclusive and welcoming of gender and sexual minority people.

A Keuroghlian: [00:15:56](#) Hate crimes are much more prevalent towards gender and sexual minority people than many other populations, and the FBI has consistently reported in recent years that the population in the United States with the highest prevalence of hate crimes is African-American transgender women. This is unfortunately the danger and horrific reality that many people continue to live with. As we've mentioned, substance use disorders are much more prevalent among gender and sexual minority people. We have data here from SAMHSA on the right side showing that every type of drug use disorder is significantly more common among sexual minority people than among sexual majority people.

A Keuroghlian: [00:16:38](#) Sexual minority youth initiate alcohol and illicit drug use earlier than their peers. Sexual minority women have higher risk of alcohol and drug use disorders. Sexual minority men have higher risk for drug use disorders, and bisexual people have higher risk for all substance use disorders than even gay and lesbian populations. That's often in the context of increased stigma even within sexual minority communities toward bisexual people. Tobacco use is unfortunately much more

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prevalent among transgender adults and sexual minority adults than among straight and cisgender adults. It's also more common among queer and trans youth delegates among straight and cisgender youth.

- A Keuroghlian: [00:17:24](#) There is a lot of interest in understanding differences in prevalence and use patterns of vaping among gender and sexual minority communities compared with other folks. Psychiatric disorders unfortunately are more common among sexual minority people as well. Sexual minority men are more likely to have major depressive disorder, panic disorder, and at least two co-occurring disorders than their straight counterparts, and sexual minority women are more likely to experience generalized anxiety disorder and at least two co-occurring disorders than their sexual majority counterparts.
- A Keuroghlian: [00:18:05](#) Suicidal ideation and attempts are much more common among queer and trans youth than in their counterparts, and suicide attempts unfortunately are much more common among gender minority people, trans youth and adults than in the general population, and higher than in any other sub-population in the United States that we're aware. It's important to note that HIV incidence is highest in the US among black men who have sex with men and transgender women of color black, African-American transgender women and Hispanic, Latinx transgender women. This is really where the epidemic is concentrated and focused now in terms of new infections.
- A Keuroghlian: [00:18:52](#) Gay and bisexual men often do not receive the care needed with regard to HIV. Eighty-three percent are diagnosed, but those only 62% received care. Only 48% of those are retained in care, and only 52% of those achieve viral suppression. We have a lot more work to do in terms of HIV treatment and viral suppression particularly in communities of color. There are disparities in access to HIV pre-exposure prophylaxis or prep to prevent HIV in populations at high risk, use of antiretroviral medication to do so, while 44% of people who could benefit from prep are African-American, only about 1% of prescribed prep. While 25% of people who could benefit from prep are Latinx, only 3% of those were prescribed prep.
- A Keuroghlian: [00:19:51](#) An important note about sexually transmitted infections on sexual minority women, practices will vary with a lot of diversity among sexual minority women. Many sexual minority women may have had sex in a house or be having sex with men. Their limited data on STIs that risks clearly exist with regard to herpes simplex virus and human papilloma virus and bacterial vaginosis. It's important to note that providers will often not do

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appropriate screening based on report of same-sex behavior among women. It's important to continue to consider and perform screening for STIs based on guidelines that exist for women regardless of the presence of same-sex sexual behavior.

- A Keuroghlian: [00:20:37](#) Sexually transmitted infections among transgender and gender diverse people should be assessed screen for treated based on current anatomy and sexual behavior, not based on identity. We may need to look into behavior, the anatomy that's present, and make clinical decisions accordingly. Cancer screening is an area with many disparities and a lot of room for improvements. Sexual minority women experience disparities with regard to screening for breast cancer and cervical cancer when the guidelines really call for the same cancer screening and vaccination for all women. Sexual minority men are at increased risk of anal cancer, particularly when living with HIV and access to preventive care in this regard.
- A Keuroghlian: [00:21:26](#) High-resolution anoscopy or eve Pap test is something that is limited nationally and often only available in certain centers of excellence. Transgender women can experience breast cancer. There are case reports of this and transgender men who retain the cervix require screening for HPV and cervical Pap tests. This is something that we need to be much more training and implementation around. Transgender communities often report denial of insurance coverage for hormones, even others is considered medically necessary by the American Medical Association since 2008. Also, considered medically necessary by the AMA is gender affirming surgery, despite that folks report 55% denial of insurance coverage, even when they are able to access competent confident providers.
- A Keuroghlian: [00:22:17](#) Transgender communities often report being refused treatment, verbally harassed, physically or sexually assaulted within the context of interacting with healthcare providers, and having to teach providers about care related to their gender identity. Twenty-two percent also reported not seeking needed to educate fear of being mistreated related to their gender identity. This is a paper we published a couple of months ago in the American Journal of Public Health looking nationally at the prevalence of gender identity conversion effort, efforts to convert the gender identity of transgender people to cisgender so trying to make people no longer identify as transgender.
- A Keuroghlian: [00:22:57](#) This is a very condemned practice that has been found to be unethical and recently we also published a paper showing that this is associated with significant increased risk of suicide attempts. As you can see, unfortunately it still occurs in every

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state nationally in DC and Puerto Rico. We found it's occurred in every state as recently as 2015, with a lifetime prevalence of exposure among transgender people nationally of 13.5%. We have a lot of work to do in terms of adopting a gender affirming framework, not a gender identity conversion framework that's still highly prevalent.

A Keuroghlian: [00:23:38](#)

Finally, I just like to end on a note about the ways in which our field as healthcare professionals, we can really move things forward and creating a more inclusive and affirming society for gender and sexual minority people. Historically, there's been a failure within the medical field to accept naturally-occurring gender diversity and biological diversity with operations on intersex babies to make their bodies fit a gender binary. There's a move away from this now. Perceptions of gender diversity as deviant, which are shifting in 2013. There was a shift in the DSM-5 of psychiatric disorders from gender identity disorder to gender dysphoria, which is still evolving as a diagnosis. Perceptions of same-sex sexual behaviors deviant have evolved significantly.

A Keuroghlian: [00:24:24](#)

A huge moment for this was removing homosexuality from the DSM in 1973. There's movement to move away from conversion efforts, which we were mentioning earlier or reparative therapies as they're often referred to. The American Medical Association started opposing this in 1994. California banned conversion efforts as the first state to do so in 2012. This year, Massachusetts became the 16th state to do so. Colorado, the 18th to do so, but most states still don't have bans on this damaging practice, and finally sex orientation and gender identity data collection and healthcare, a strong recommendation by the Institute of Medicine and Healthy People 2020.

A Keuroghlian: [00:25:05](#)

This started in national surveys for sex orientation in 2012 and the US Bureau of Primary Healthcare mandated in 2016 that all 1400 health centers nationally had to report on sex orientation and gender identity for all patients, so things are really moving forward. With that, I'll turn it over to my colleagues to talk about how we can overcome these barriers through medical education

Cait Ellis: [00:25:31](#)

Great. Thank you Alex for providing such a thoughtful and informative background on inclusive terminology and on the health disparities faced by the LGBTQ community and all of the unique subgroups. Next, we will hear from Dr. Jennifer Potter, professor of medicine at Harvard Medical School and Susan Sawning, research director at the University of Louisville School

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of Medicine. Jennifer has extensive clinical medical education and research experience who's advancing LGBT health through a commitment to quality improvement. Her work includes enhancing how providers communicate with their patients around topics like sexuality. You'll then hear from Susan Sawning.

- Cait Ellis: [00:26:12](#) At NIHCM, we have had the pleasure of working with Susan and her team through a NIHCM funded research grant to produce the eQuality Toolkit. This toolkit is designed to train medical students on clinical skills for patients of diverse sexual orientations and gender identities. For her work on the toolkit, Susan and her team were awarded the 2016 and 2017 AAMC Southern Group on Education Affairs Innovation Award for outstanding innovation in medical education, and the Organizational/Institutional Leadership Award at the 2019 LGBT Health Workforce Conference. We are so pleased that both of these leaders could be with us today to share their efforts to advance LGBT health through medical school education. I'll start by turning it over to Jennifer.
- J Potter: [00:27:05](#) Thank you very much and good afternoon and good morning to everyone. It's a pleasure to be able to join this webinar with all of you today. As Alex and our introducers explained, we are going to be focusing on the role of the medical education community in addressing sexual and gender minority health disparities. First before I start the slide set, I want to make you aware of the link for the eQuality Toolkit since you might potentially want to take a look at it during the presentation. You've had an opportunity to hear from Dr. Keuroghlian about health inequities that are faced by sexual and gender minority people.
- J Potter: [00:27:52](#) Definitely changing this state of affairs is going to require collaborative implementation efforts at individual, interpersonal organizational, community policy, and cultural levels, which is why we're so very excited to have such a diverse audience in attendance today. You comprised people from federal programs, state health departments, health plans, universities, medical centers community clinics, schools, health professionals caring for sexual and gender minority individuals in all regions of the country and across the lifespan, as well as providers and staff who are focused on improving physical, mental, and behavioral health. Together, we can collectively move the needle.
- J Potter: [00:28:38](#) Why should we focus on medical education as a key driver of change? Positive experiences in the healthcare system and in

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particular building a trusting relationship with a provider play an incredibly important role in helping sexual and gender minority people heal from previous traumatic experiences and adversity, and in supporting their overall health and well-being. However, research shows that we're not yet doing as good a job as we can.

J Potter: [00:29:07](#) One reason why is that despite changing societal attitudes, the majority of physicians who teach our students and the students themselves still manifest implicit bias towards sexual and gender minority people and in addition, significant gaps remain in their knowledge and skills about sexual and gender minority people's healthcare needs. This shouldn't surprise us considering findings of a study published in 2010, which showed that the average amount of time dedicated to teaching LGBTQ plus related content in North American medical schools was only five hours across all four years of undergraduate training. This situation maybe somewhat improved now, but no new study has yet been undertaken to gauge our progress.

J Potter: [00:29:54](#) Besides time spent on these topics in the curriculum, another important factor is that faculty are not uniformly knowledgeable or comfortable delivering key content about sexual and gender minority health. In recognition of these facts, the American Association of Medical Colleges published a roadmap for medical educators in 2014, and this cover is pictured on the right. This roadmap outlines the competencies that medical students should achieve by the time of graduation along with suggestions for how to integrate curricular content to close knowledge and skills gaps. Through trial and error, we have learned that there are some key things we need to consider when developing and implementing sexual and gender minority health curricula.

J Potter: [00:30:43](#) For a long time, the research community has known that it's crucial to involve community members in all phases of population health research. Without doing that, we can't be sure that we will address the right issues in the right way and draw the right conclusions. The same is true when we're teaching medical students about sexual and gender minority health. We have to involve community members in the development and rollout of the curriculum. Involvement of community members has another important benefit. It turns out that greater familiarity with sexual and gender minority people breeds compassion and caring, rather than contempt as was incorrectly suggested by the old saying.

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- J Potter: [00:31:23](#) Therefore, successful education programs need to provide ongoing opportunities for students to interact with sexual and gender minority people. Unfortunately, educational gains we make in a classroom in the preclinical years sometimes unravel a bit when our students go out onto the wards and into the clinics, and they witness uninformed faculty and residents role modeling discriminatory behavior towards sexual and gender minority patients. This is the so-called hidden curriculum. This makes it all the more important to educate our faculty via faculty development efforts and to make sure that we help our students retain and build on their skills over time by layering educational opportunities repeatedly across all four years of training.
- J Potter: [00:32:08](#) We also need to assess our student's competency to make sure that they attain the knowledge and skills that they're going to need to take good care of sexual and gender minority people in the next phase of their training. The University of Louisville School of Medicine is the first US medical school to comprehensively integrate key sexual and gender minority health content across the curriculum. Susan will now describe the approach and highlight a practical toolkit that you can use to boost your own student's knowledge and skills.
- S Sawning: [00:32:38](#) Thank you Jenny. As Jenny said, we fought to integrate key sexual and gender minority health content across the curriculum, and we refer to this effort as eQuality leading medical education to deliver equitable quality care for all people inclusive of identity development for expression of gender sex and sexuality. We made some decisions early on that helps informed how we built eQuality. We knew that we wanted to take an integrated educational model approach instead of separate elective. We want a representation in clinical skills instructions, case-based discussions, exam questions, and it was important to us that we did not zero type the content.
- S Sawning: [00:33:28](#) We knew that we wanted to teach and affect and research in order to publish our findings so that other schools could build on what we were doing. We implemented content beginning in the 2015-16 academic year and in the end, this involved 50.5 hours of eQuality curriculum. We knew early on that this would require targeted faculty development since it would involve 23 teaching faculty and from day one, we discussed the importance of multiple threads purposeful content and engagement with our SEM people focus in and beyond our school. It was very important to us from the beginning to include our local community in the creation, implementation,

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and refinement of the curriculum. We developed an eQuality community advisory panel that met on a regular basis.

- S Sawning: [00:34:24](#) We knew that from the beginning that we wanted to speak to improve system, specifically organizational climate and we decided that we would start with the resources that were available to us. For us, it's about starting our curriculum first and then planning to build an essential pieces that we needed for role modeling and reinforcement. Then lastly, we develop experience in the very early that was made up of various departments, offices, and stakeholders. This committee made decisions about directions, continent and that very frequently to keep project moving forward. We get lots of questions about how did you do this, and again I'd like to refer everyone back to the medical science educator publication that Jenny discussed.
- S Sawning: [00:35:18](#) This is really a how we built it type of publication. It's really worth downloading if you're listening and you're in the medical education community, and if you're interested in building this content because it really has very minute details that we will not be able to get you today, but I would like to discuss very briefly how we went about this. Our first step was bringing together our key advocates, so really starting with our champions. We wanted to establish program vision, one that was an inclusive of our community and our institution's needs.
- S Sawning: [00:35:44](#) We were able to demonstrate a need for this content because we were offering an optional certificate program and we saw that we had a large number of medical students that were attending, and they were very vocal about the need to integrate the content into the required curriculum. We knew that we needed to identify and engage with content experts and in our case, this was Dr. Jenny Potter, John Davis, and [Christian Extern 00:36:06]. They really helped us to build upon best practices, developed content, and we really wanted to build upon the tremendous amount of work that they had already done related to the WMC publication that was mentioned previously.
- S Sawning: [00:36:21](#) As I mentioned before, we established a steering committee, which helped us to define goals, roles, and action plans and helped us to move things along. We engage our local, sexual, and gender minority champions, stakeholders and faculty, and this was a must because we knew that we wanted to respond to our direct community's healthcare needs in order to do what we wanted to do. We needed to make sure that we were rippling out beyond our steering committee. Faculty development was a must, not only because we need the faculty

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buy-in, but also because we really needed them to champion the project and to provide role modeling.

- S Sawning: [00:36:58](#) As I mentioned previously from day one, we knew that we needed to not only develop curriculum, but also assess and research these efforts in order to affect medical education nationally. We knew from the very getting that we wanted all of our content to ripple out on a national level, and we planned our research aims accordingly. Then last but not least, we knew that we would need to keep faculty learners and our local sexual and gender minority community and a quality improvement process that included reviewing and improving content. I'm not going to go over and behold this table, but I did want to include it for those of you who are listening from the medical education community. This is from the publication that was referenced earlier.
- S Sawning: [00:37:49](#) We often get a lot of questions about exactly what we taught, what we taught it, where we taught it, how many hours of content accounted for, how it was assessed. If you are in a medical education, you will be interested in this table and definitely downloading this publication. After our students participated in two years of integrated at quality content, our data show that students were still demonstrating gaps in clinical skills. We sought funding from NIHCM to develop the eQuality Toolkit, which is a concise clinical skills manual that was written with medical students in mind, but it's really for all physicians to improve their skillsets.
- S Sawning: [00:38:34](#) We sought not only to teach the eQuality Toolkit to our students, but also to evaluate its outcome. This is a snapshot overview of what the toolkit includes. There's a section on inclusive communications, gender affirming care, preventive care, social determinants of health, and sensitive physical exams, and now Jenny is going to talk about some of the detailed clinical skills content that is included in the toolkit.
- J Potter: [00:39:01](#) Thank you Susan. As we've heard inclusive communication is crucial in medicine, and here you see a table from the toolkit showing introductory questions students can easily learn to ask to affirm their sexual and gender minority patients identities. These include simple questions about the name a patient goes by, which for trans and gender diverse patients may differ from the legal name that is entered in their chart. Also, pictured here are questions about sex assigned at birth, gender identity, and gender pronouns. Learning this information is crucial to understand a person's gender and using the right name and

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pronouns indicates recognition, respect, and affirms the person's gender.

- J Potter: [00:39:44](#) Overall, this affirmation helps to engage sexual and gender minority patients in care and gets the provider-patient relationship off to a good start. Continuing on, this table shows questions students can easily learn to ask in order to take an inclusive sexual history. These questions are important to ascertain risk for sexually transmitted infections and unintended pregnancy and set the stage for specific types of counseling and screening that patients may need. As you can see, the questions include specific ones about sex partners, sexual activities and parts of the body a patient uses when they have sex. You'll also notice the question if your sexual activities change, you may need additional screenings.
- J Potter: [00:40:31](#) This indicates recognition of the fact that sexual behavior is fluid over time, and it lets the patient know that the student is open to having more discussions in the future. As another example of material included in the toolkit, this table provides students with clear guidance on cancer screenings that are appropriate for patients of different genders. The major take-home message at this table and the one I'll show you in a moment on the next slide is that students should screen patients at the appropriate age who have the relevant anatomy present. This means, for example, that a transgender man who still has a cervix needs to have cervical cancer screening.
- J Potter: [00:41:15](#) A second take-home message of these tables is that as for all patients, some cancer screenings are appropriate only for people with increased risk factors. For example, anal Pap testing maybe appropriate for patients having receptive anal intercourse if follow-up after an abnormal anal Pap test is available at the provider's institution or in their community. Similarly, low-dose chest CT scanning should be discussed with sexual and gender minority patients of the appropriate age group who have a 30-pack year tobacco smoking history who currently smoke or have quit in the past 15 years. This slide as you can see shows information for anal, breast, cervical, and colorectal cancer screening.
- J Potter: [00:42:00](#) Here you can see information for lung, oral, ovarian, prostate, skin, testicular and endometrial or uterine cancer screening. All of these recommendations are evidence based, which is an important feature of the toolkit in general. In recognition of the enormous contribution of structural factors such as you see featured here on a person's health, the toolkit also teaches students the importance of patient assessment that goes

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beyond clinical and physical issues. In order to be able to address these root causes of health inequities, the toolkit also emphasizes to students the importance of interdisciplinary collaboration with people in the community networks such as patient navigators, social workers, insurance companies, community resources, and ultimately policymakers, and now I'll pass the baton back to Susan.

- S Sawning: [00:42:59](#) In many medical schools, they want to know how we taught the eQuality Toolkit with our students, so I thought it would be helpful to briefly discuss our methods at U of L. In spring of 2018, our second year students who had already completed the eQuality curriculum content are required to engage in an online learning activity via SoftChalk, and the goal for this activity was to really have students engage with the toolkit prior to an in-class session. Our second year students were then required to participate in an in-class session that involved facilitated small groups of 12. We decided to use facilitators because this was really our first launch of the toolkit, and we wanted to be sure that the group stayed on task.
- S Sawning: [00:43:42](#) In these small groups, there were four unique varying cases that required application of the clinical skills that they had previously learned in the toolkit. Students were asked to role play as a physician, patient, and observer and they switch roles for each case. The goal for this activity was actual clinical skills practice and application. Then lastly, we had expert clinicians who debrief the class as a whole to highlight important points of clinical care to answer any questions. We did gather pre-tests and post-tests feedback and paired pretest post-test results showed significant improvement in clinical knowledge and 93% of our students reported that the session changed their confidence caring for sexual and gender minority individuals.
- S Sawning: [00:44:37](#) We assess student's clinical skills using standardized patients, and this is what we call SPs in medical education, and these are people who are paid to train to act as patients in clinical encounters in a simulated clinic. We recruited gender minority SPs from our local community, and these SPS were paid to portray a case related to establishing primary care. All SPs reported same health history and students were blinded to the case prior to entering the room. The SP case varied only by gender identity and sex assigned at birth. You can see here the breakdown of the SPs that we were able to recruit. Our students were assessed using these assessment tools.
- S Sawning: [00:45:27](#) One important thing to note, we conducted this SP assessment the year prior in 2017 with our second year students who had

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not received the eQuality Toolkit session, but they had received two years of equality content, and this gave us a comparison group to help us understand the effects of the eQuality Toolkit teaching session. We then conducted this SP assessment again with students who had received the eQuality Toolkit teaching sessions. SP used a checklist to assess students on their clinical skills after each encounter. Students completed a subjective, objective, assessment and plan or what we refer to as a SOAP note or post encounter note.

- S Sawning: [00:46:08](#) We also developed a code of checklist for trained observers to rate student's clinical skills. Lastly, we asked students to provide feedback, perceptions, and treatment recommendations. Here are some of our preliminary results. Note that some of our comparison numbers are probably higher than other medical students nationally because remember that these students had completed two years of eQuality content. As you can see, asking about sexual orientation and having medical relevant hormone therapy discussions increased somewhat. However, we were able to increase asking about gender identity, asking about specific sexual behaviors, and being willing to prescribe hormones quite substantially.
- S Sawning: [00:47:00](#) In our intervention cohort, SPs indicated that they felt some skills related to inclusive communication and gender affirming care improved, and I do think it's important to remember that the community is also within the walls of your institution. We knew that we wanted to take a systems-based approach to change, and we felt we could only change at the organization level by being honest about where we were as a school, so we decided to conduct an organizational climate survey. We wanted to understand our climate better and to address any weaknesses, and we had support from our leadership to do. We were very transparent about what we found and we made sure others at the school knew what our results were, and we were explicit about our actions for improvements.
- S Sawning: [00:47:52](#) These are examples of how we shared our results with others and our plans for improvement. The first one has to do is developing and implementing bystander and upstander training to give individuals tools to interrupt in instances of comments, and then the second one that has to do with conducting focus groups to better understand the needs of our faculty and staff and how to support someone. Here are some examples of ways that we decided to respond to our own data. First, we wanted people to feel comfortable disclosing, so we launched an allied campaign. We wanted to intervene in learning and clinical

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learning environment situations when micro-aggressions occur, so we conducted bystander/upstander training.

- S Sawning: [00:48:35](#) Students reported that they felt supported, but some of our faculty and staff reported less support, so we conducted focus groups and created interventions based on those results. Then finally, I can't emphasize the massive importance of faculty development. We had multiple targeted training to bring faculty together, not only to improve skills, but really to create a community of people who were really all in related to this project and could really help us increase interest and to move it forward, and now I will pass it back to Jenny for the final wrap-up.
- S Sawning: [00:49:15](#) Oh actually, I do want to note that it's really important to think about ways in your physical environment that can be and show inclusivity, and so these are an example from our background of science. We thought this is very important. There were other ways that we can help our physical environment as well, and I just want to make sure that people pay attention to that.
- J Potter: [00:49:41](#) In summary, we've given you a snapshot of learning gains that medical students at the University of Louisville have been able to achieve by using the toolkit and having the opportunity to participate in other parts of the curriculum. What we found in summary is that students apply inclusive clinical skills after comprehensive participation in a curriculum like this that directly having the opportunity to practice the clinical skills can address gaps and make broad improvements. Our hope is that addressing training gaps will down the line decrease health inequities that are experienced by sexual and gender minority patients, and we do know that students need more opportunities to practice their skills over time in order for us to realize clinical impact.
- J Potter: [00:50:32](#) Here is a final slide of the resources that I mentioned at the beginning. First is a free open access resource showing the toolkit and print copies are available as well. All of the proceeds importantly go to the U of L LGBT Center. There also is a free CME available incorporating this tool for medicine and nursing, and the University of Louisville is currently developing teaching materials, which should be available soon.
- J Potter: [00:51:01](#) We would like to thank the entire eQuality specifically, Dr. Weingartner, Noonan, Holthouser, and Kingery for their many hours of expertise that went into writing and assessing the toolkit as well as Dr. Shah who supported us with additional resources, the U of L LGBT Center, the local LGBTQ plus

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community members whose partnership was crucial in making all of this happen, and NIHCM for funding the project, and now we'll turn back to the moderator so we can hear the next presentation. Thank you so much.

- Cait Ellis: [00:51:34](#) Great. Thank you both so much for sharing your process when creating the toolkit and your use of assessment and evaluation to measure the program's impact. Your efforts to improve medical education will have a substantial and lasting impact. We have now heard from several experts on efforts to improve LGBTQ health and healthcare within the traditional medical community. Our last speaker, Dr. Alexis Chávez, medical director at The Trevor Project will speak about the care needs for LGBTQ youth and share examples of initiatives outside the doctor's office that have lasting impacts on youth and communities. The Trevor Project is the nation's leading organization serving LGBTQ plus youth in the areas of suicide prevention and crisis intervention.
- Cait Ellis: [00:52:16](#) At Trevor, Alexis works to improve care for this youth and to ensure that all of Trevor services and programs are evidence based and to date with the latest research. We are pleased to have Alexis with us today to share her work. Alexis.
- A Chavez: [00:52:32](#) Hi and thank you for that introduction. It's a pleasure to be here talking with all of you. The first thing that I would like to address is the need for data on LGBTQ youth, and especially their mental health because if we don't have data that helps us understand what is the current state and what are the factors that are affecting youth mental health, then we can't work to understand how we can improve that mental health. We know that overall when barriers are put in place that prevent data collection, that is a form of discrimination against youth. An introduction to our first national survey on LGBTQ youth mental health that we conducted last year and published the results of this year.
- A Chavez: [00:53:34](#) I would encourage all of you to check out the results from the national survey in full. It has its own micro site, but this survey has helped us understand what are some of the unique needs of LGBTQ youth. To help understand how the survey was conducted, it was 34,000 youth that we contacted, none of which we contacted directly through the Trevor Project in order to best prevent any bias on our part. The data that currently exists on trans youth especially is fairly lacking. There's not much nationwide data on any of the risk factors and outcomes. The CDC YRBS does have some questions on gender identity,

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but I think that there are certainly a move in which we can make it even more inclusive and even more comprehensive.

A Chavez: [00:54:50](#) It's still lacking a bit geographically in terms of how much we can capture. Some of the key results from our survey have found a number of the ways the mental health of LGBTQ youth is significantly impaired by the discrimination that they're facing every day. We know from the research that the discrimination that they face directly results in these numbers that we see with the increased risk of suicide, of depression, and of any of these conditions. There are ways in which it's been tied to the constant stress to the lack of affirmation of the basic aspects of themselves as a person, especially with regards to their sexual orientation or their gender identity.

A Chavez: [00:55:47](#) We know that LGBTQ youth experience all the same struggles that non-LGBTQ youth do, and they additionally face struggles related to their sexual orientation and their gender identity. With regard to suicide, 39% of youth have seriously considered attempting suicide in the past 12 months, and that number is even higher when we're talking about transgender and non-binary youth. There are also particularly high numbers of youth that have reported feeling sad or hopeless for at least two weeks. Over the past year, we understand that there are impacts of the current political climate. Not only do a number of you feel that it impacts their mental health, we have seen real-time results.

A Chavez: [00:56:49](#) Immediately following the most recent presidential election, we saw a large spike in our call volume. It very quickly doubled after tweets about the transgender military ban. We again saw an enormous spike in our call volume, and really we see that over time, there are measurable impacts of all of this political environment that if their basic rights are being debated, whether they can use the bathroom that corresponds to their gender identity, we know that about half of all youth have reported that they have had struggles in their schools using the bathroom that corresponds to their gender identity.

A Chavez: [00:57:47](#) With regards to the bathroom, there's also been case studies reported of recurrent urinary tract infections, of hospitalization due to these long-term chronic urinary problems because people were not allowed to use any bathroom at school that corresponds their gender identity. We know that not only is their mental health affected, we have measurable impacts in how their physical health is as well. We also know that that conversion efforts, so-called conversion therapy is still happening to youth even today. We have found direct

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correlations between those youth who have experienced conversion therapy and their reports of suicidal ideation or even suicide attempts.

A Chavez: [00:58:54](#) We know that this happens across the nation in every state, at least as recently the data that we've last looked at was from 2015. When we hear lawmakers arguing that these don't happen that it's not important, we really have to push back on that and look at how it is currently an ongoing affecting our LGBTQ youth. The link between suicide attempts and conversion therapy as I mentioned is starting to be elucidated. There have been two reports that have come out over the past couple months that have correlated the links both between conversion efforts for sexual orientation and also those for gender identity, understanding that both of these are harmful, and it's not just conversion therapy as... Let me rephrase that.

A Chavez: [01:00:10](#) Conversion therapy is not only in its most extreme forms. We know that in its most extreme forms where it is akin to torture, I think that it's very easy for people to understand how that's harmful, but we also know that any attempts to change a youth sexual orientation or gender identity can have lasting harmful effects. We know that many youth have experienced discrimination due to their sexual orientation or gender identity. I think that although there's a lot more discussion that's being had overall about movement toward the quality for LGBTQ youth, I think that it's very clear that we're really not at this point yet. As I mentioned earlier, over half of trans and non-binary youth have been discouraged from using a bathroom that corresponds to their gender identity.

A Chavez: [01:01:19](#) Youth when they're experiencing this discrimination every day, they've made it very clear that it's important for them to have someone they can reach out to that understands what they're going through. There are many youth who feel it's especially important for an organization to have clear focus LGBTQ youth, such as we have here at The Trevor Project. I think that there are ways in which other organizations incorporate LGBTQ competence as we've heard about.

A Chavez: [01:01:51](#) There are ways that providers are being trained, and we think that this is so helpful and so important because youth need to know when they're reaching out to somebody that they're not going to be subjected to conversion efforts, that their provider is going to have a holistic understanding about development of gender identity, of development of sexual orientation, and how that might change throughout the lifespan. Another thing that we've noticed is that youth more today are identifying with so

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many different terms for sexual orientation and gender identity, that there's such a diversity and expression that we really are hearing so much more, and realizing all the ways that people can exist.

A Chavez: [01:02:49](#) With regard to some of the future directions of data collection, the first is to further exploring other interactions of health factors. Some of this is how LGBTQ youth are particularly by homelessness. We know that about 40% of all homeless youth identify as LGBTQ. When we're talking about trans youth, when we're talking about youth of color, then the numbers are even higher. There are particular challenges that they're going to face because of this in terms of how can they be placed into the appropriate foster care system or other supports. We also want to look at the effect that substance use is having on LGBTQ youth.

A Chavez: [01:03:39](#) Part of the problem with identifying exactly how let's say the opioid crisis affects our population is that we don't have clear data collection on what happens for the deceased. If someone is the victim of a hate crime or if someone has died to an opioid overdose, currently there are no widespread efforts to collect sexual orientation and gender identity data from those deceased. We're making an effort and we're happy to say that LA County has been the first to sign on to start collecting this data, so that we can better characterize how so many different things are affecting our young people.

A Chavez: [01:04:27](#) Outside of research and data collection, I think it's important to think about what are the ways that we can support the mental health of all young people outside of the healthcare system. Ideally, every young person would be connected with a primary care provider, with a mental health provider whether that's a psychiatrist, a psychologist, a therapist, whatever that means to them. However, we know that that can be a problem for many people for a number of different reasons, whether it's access to transportation, whether it's financial difficulties, whether it's where they're living in the country, whether it's they have access to providers, but maybe not to LGBTQ competent providers.

A Chavez: [01:05:13](#) For any number of different reasons, people are not able to get complete access to everything that would be helpful. However, we can think about ways that we can support them regardless. One of the ways that we can support them is in the schools. In Trevor here, we've worked with various national organizations including the American Foundation for Suicide Prevention, the National Association for School Counselors to come up with

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what we've called a model school policy. This gives examples of what every school could implement for best suicide prevention practices. This also includes how to be aware of those with unique needs such as the LGBTQ population.

A Chavez: [01:06:03](#) I'll talk a bit more on the model school policy in a second. Also, we have the lifeguard workshop, which is a way for us to help youth identify their own emotions and feelings, when to reach out, when to recognize both in themselves and their peers when someone is struggling. We often know that youth are so much more tuned in to the well-being of each other oftentimes much before adults, teachers, their parents might know. If we can get youth to help be lifeguards for each other and to help support each other, to encourage reaching out to a trusted adult, that's another way that we can have a significant impact. With regards to school policies, we recently did an assessment on New York State policies and keep in mind, this is just an example of one state.

A Chavez: [01:06:58](#) This is by no means unique to New York, but over a third of New York school districts currently don't have any suicide prevention policy. In fact, if we think about how many New York state policies incorporate anything about LGBTQ youth, it's a much, much, much smaller number. Only 2% of the policies we looked at specifically talked about that, and that leaves this gap of how LGBTQ youth can get the best care that they need to be supported with their sexual orientation and their gender identity. As an example of another state from last November, we had looked at how the implementation of suicide prevention policies in school particularly in California had affected this. Before there was a policy statewide, bill or law for that, only about 3% of policies included LGBTQ youth.

A Chavez: [01:08:14](#) After there was a bill that said that school should implement suicide prevention policies that incorporate the needs of special groups, 90% of those written afterwards included LGBTQ youth. We can see the impact that various policy changes might have. In addition in the schools, we understand that youth are looking for more ways to connect with each other. One of the ways that we are addressing this is with TrevorSpace. It's a social network that's moderated by individuals here at The Trevor Project. In a way, we are acting as trusted adults that are creating this space where you can connect with each other to find their communities that they may not have great support for at their own schools if they don't have a GSA, if there's no one else at their school that they know is out in any particular way.

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- A Chavez: [01:09:12](#) Then also in addition to social connectedness, we understand that while we would like everyone to have a direct link to a mental health provider all times, there is a lot of space between those who have nothing and those who have that access, and that's where some things like crisis lines can help fill the space. We run a 24/7 crisis line that's specifically for LGBTQ youth. Youth can call in. They can chat or they can text at any time, and the way that we imagine this is that if we continue to incorporate more ways that youth can get access to any support that they need, if we can add this to mental health, if we can add this into the various apps that are being created, CBT apps or mindfulness apps, there are many, many ways that we can all work together to better improve health.
- A Chavez: [01:10:12](#) Here's my contact info, and I'm not sure that we have questions in this, but I think that we're about to move into that in the webinar maybe.
- Cait Ellis: [01:10:23](#) Yes, we are. Thank you Alexis for sharing the important role of the non-traditional medical community and for highlighting the importance of data and evidence in reducing health disparities for LGBTQ youth and identifying solutions to move things forward. Now we want to hear from our audience what questions do you have on these efforts and what information would be helpful based on what you heard from our speakers today. I would like to start by asking all of our speakers to come off mute. We just came off of a presentation learning about LGBTQ youth, and so I want to transition. We've had a few questions come in on older adults.
- Cait Ellis: [01:11:01](#) What are some of the health issues that we should be concerned about for the aging LGBTQ population, and I open it up to any of our speakers.
- J Potter: [01:11:11](#) Sure, this is Jenny. I'd be happy to speak to that, and Alex can add to it. What we find for our elderly LGBTQ plus patients is that they often are more isolated than same aged individuals who are not LGBTQ plus. They're less likely to have had children, which is one reason they are more likely to live in poverty or with a lower income as well, and they are fearful particularly when they have to go back into care, into a nursing home, for example, or an assisted living type of an arrangement to be out. They frequently go back into the closet, which enhances the isolation, so that in turn can lead to issues with loneliness, depression, anxiety, and things of this nature.

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- J Potter: [01:12:04](#) We also find that LGBTQ plus elders suffer from higher rates of disability in general, and then some of the health disparities that we spoke of before.
- A Keuroghlian: [01:12:18](#) Thanks Jenny. This is Alex. I agree with everything Jenny said and just to add to it, we do have confirmed in a research a much higher prevalence of depressive disorders, anxiety disorders, and substance use disorders among older LGBTQ plus adults than among their non-LGBTQ plus counterparts. There's also an increased risk of STIs both incidents of sexually transmitted infections, and these not being screened for and treated by clinicians because there are assumptions about sexual activity decreasing with age that are often incorrect. These are some of the considerations. At the part of all of this is the stigma and social isolation that occurs that generationally has improved in many regards for younger LGBTQ plus people.
- A Keuroghlian: [01:13:17](#) However, this plays out in assisted living facilities, services for older adults. We have within our institute at Fenway and within the division of education and training and LGBT aging project that focuses specifically on care for older adults, technical assistance, and after nine years of lobbying, they succeeded in having signed into law by our governor in Massachusetts, a law that says all services for older adults in the state have to train every staff member in LGBTQ plus competence, both clinical and non-clinical staff. Our LGBT aging project developed a module for the state government to do that, so we're hoping that similar laws will be of help around the country over time.
- Cait Ellis: [01:14:02](#) Great, thank you. Anyone else would like to comment on that? Great. Well, we've also had a few questions come in around rural communities. Is there a difference in the health disparities you're seeing among the LGBTQ populations in rural areas, and what are some of the evidence-based programs that can be implemented to better serve this population?
- A Keuroghlian: [01:14:37](#) This is Alex...
- A Chavez: [01:14:38](#) This is Alexis.
- A Keuroghlian: [01:14:38](#) Oh, go ahead Alexis. You start please.
- A Chavez: [01:14:39](#) Well, I was going to say that I think that one of the things that we noticed is that there's certainly tends to be a higher concentration of LGBTQ competent providers and healthcare systems in the more urban areas, and so rural individuals often do have difficulty accessing those and how do they know which

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providers are going to be a good fit for them, so that can be particularly difficult. I think that there are certainly things that can be implemented, it depends on whether you're talking about physical health or mental health. I know that in terms of mental health, there is a LGBTQ affirming CBT program that John Pachankis has been championing, and Alex if you want to speak to some of the other issues.

A Keuroghlian: [01:15:43](#) That's great. Thanks Alexis. There are very real challenges in terms of rural access to care for LGBTQ plus people. We did a study that looked at sexual orientation, gender identity data collection at health centers nationally that we published this summer in the American Journal Public Health and did an analysis working across these 26 million people who access care at health centers, study data collection in urban versus rural settings, and found that while in rural settings people were more likely to report something related to sexual orientation or gender identity, they were less likely to report an LGBTQ plus identity, so there is some work to be done in that regard.

A Keuroghlian: [01:16:24](#) One of our programs through the USB Obama healthcare is transgender ECHO where we have cohorts of 25 health centers at a time commit their medical and behavioral health teams to train up in transgender health, and we've trained 130 health centers now nationally in that regard. We have a mix intentionally of urban and rural health centers to increase access in that regard, and we're now doing a planning study in rural New England of what trans and gender diverse community members would like their health services to look like with an electronic survey of community members as well as trans and gender diverse kids, providers in these rural areas, and we're learning a lot about transportation issues and how far people are really willing to travel in order to get affirming care.

A Keuroghlian: [01:17:11](#) It's a vital part of what people need. Finally, there's a lot around TelePrEP, so HIV pre-exposure prophylaxis. There's innovation happening here in SOGI, Emory and Atlanta that is developing a lot in this regard, and we're doing a primary care forum in the southeast of US with their primary healthcare next week in Atlanta, specifically on how to implement prep where people don't have to travel as far for regular visits and the like. There's a lot of innovation happening in this regard. We also did telepsychiatry for surgical evaluations for trans and gender diverse people, but ideally people would have services locally, not just have to rely on telehealth resources, which that said are underutilized.

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- Cait Ellis: [01:17:57](#) Great. Thank you. Stemming off of that question, several of our speakers have also touched on the increased rates of substance use disorder among LGBTQ individuals since we had a question come in asking what types of barriers do folks from the LGBTQ community experience when trying to access substance use disorder treatment, and how can we address these barriers.
- A Chavez: [01:18:25](#) This is Alexis. There are a number of different barriers. One of them is whether the... Let's start from a residential substance abuse treatment facility. How is the facility segregated into sex assigned at birth let's say, does it incorporate gender identity, are the programming sex specific, and then let's talk about some of the ways in which the understanding is of cutting down the amount that they're using, is there the understanding of where the individual is finding their community because historically, especially for the middle-aged and older LGBTQ individuals, much of where the community lied was in bars.
- A Chavez: [01:19:26](#) The bar culture in the LGBT community has certainly contributed to the exposure of people to substances including alcohol and in an extra layer of difficulty in eliminating that because if someone's let's say not going to go to some of these spaces, that then they have to find out where are they going to interact with their community, that for them it's not just losing the bar, it might be losing some of these friends, and in these contexts that they've had for a particularly long time. The last thing I would add is in what way is substance use being tied into their mood or how they're coping with some of the struggles related to the discrimination faced because of their sexual orientation or gender identity.
- Cait Ellis: [01:20:22](#) Great. Thank you. We did have a clarification question to come in for Susan and Jennifer. What was in your campus climate survey? Did you use a standardized measure or did you make your own?
- S Sawning: [01:20:38](#) We made our own, and so it was unique to our school. It covered... Yeah, I don't know how much detail they wanted, but yes it was developed in-house and it addressed various things related to inclusiveness and among different groups of people, faculty staff, students.
- Cait Ellis: [01:21:04](#) Great. Thank you. All of our speakers have really touched upon the importance of data and evidence, and we've had a lot of questions come in around that topic. To just pose to the whole panel, the first is, is anyone aware of a brief questionnaire to measure unconscious bias among healthcare professionals or professionals in general towards sexual and gender minority

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people, and what can we do when a state or local county or city health forum does not ask about sexual orientation or gender identity information?

- J Potter: [01:21:43](#) I can answer the question about the implicit bias measurement instruments. There are actually several of these that have been validated. Some of them are a little bit older, and so may not always have the types of questions or use the type of terminology that are modern today. It is beyond the scope for me to be able to cite the different citations right now, but if you want to be in touch with me, I'm happy to send them to you.
- A Keuroghlian: [01:22:17](#) Hi, this is Alex. I can comment on the SOGI data collection piece. We have a lot of resources for this available for free on our website, again LGBThealtheducation.org where a test by your primary healthcare with implementing SOGI data collection across the health center program nationally. We have already [inaudible 01:22:36] toolkit that is approved and disseminated by the bureau specifically on SOGI data collection. We have demonstration videos that we made with scripts and professional actors and a filmmaking company, 2- to 3-minute videos showing best practice at the front desk, in the clinician's office, when a parent comes in with a gender diverse child, with gender or sexual minority adult, various scenarios.
- A Keuroghlian: [01:23:01](#) We published earlier this year in the Journal of the American Medical Informatics Association an implementation guideline for SOGI data collection. We also work with public health departments and large hospital systems to do this. I'm going to Duke Medical Center next week where we have a grant with them to conduct implementation over three days. People are welcome to be in touch with me directly, and we'd love to work with your public health department or help your organization to help you implement it, or even work with your leadership to understand why this is an important practice to help achieve health equity for patients.
- S Sawning: [01:23:36](#) I'll just add that we did do an implicit attitude test as part of the equality project, and we do have a publication about how we went about that that's in medical teacher in 2018, and I would just want to reiterate the importance of doing really robust debriefing sessions with the implicit attitude test because it really can open up some feelings and conversations. It's really important when we're working with medical students to make sure we provide the time for that debriefing after that implicit attitude test.

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- Cait Ellis: [01:24:13](#) Great. Thank you. We've had several questions come in around pregnancy and family planning. What are the biggest issues facing LGBTQ plus people today as they navigate pregnancy and family planning? What are some ways to address these issues and specifically, are there any resources available for transgender individuals that have chosen to be able to give birth?
- J Potter: [01:24:35](#) This is Jenny. The biggest barrier that remains is ongoing stigma and discrimination, and that would apply across the board in terms of ability to foster adopt, become a parent in every possible way, and also through biological conception with a partner or partners. In terms of centralized resources for trans folks who were interested in family building, Alex I don't know if there's anything currently that you all have in that regard.
- A Keuroghlian: [01:25:22](#) Yeah, we have a number of resources related to family planning on our website for LGBTQ plus people. We're doing more this year in that regard, but we have webinars recorded and available for free. We have a couple of publications on the topic and at our two national conferences we do through Fenway Institute and Harvard Medical School, one of which is our Advancing Excellence in Transgender Health Conferences, November 1st to the third, and the other in March, which is sexual and gender minority health. We routinely have presentations on family planning and reproductive health that actually these are already filmed in on our website under trans talk, so you're welcome to check that out.
- Cait Ellis: [01:26:08](#) Great. Thank you. I know we've talked a little bit about social determinants of health and in relation to homelessness. We've had some questions come in around the topic asking specifically when we're talking about some of the subgroups in LGBTQ population. What are some of the social determinants of health and health needs, and how can we better understand what unmet needs or support services are needed by some of these specific subgroups?
- S Sawning: [01:26:43](#) There is a section in the eQuality Toolkit on social determinants of health, and I think that's a good resource for people to take a closer look at in relation to what other system level, institution level, or community level relationship, and individual level types determinants of health, and I think one thing that we need to really think about and probably move away from is we really have to take a collaborative approach to treating the whole patient and not physician specific, but pulling in other disciplines, pulling in social workers, pulling in mental health professionals, pulling in community organizations that can help

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with housing and so on. I just think that we have to really get into a holistic approach.

S Sawning: [01:27:37](#) I think there's a whole lot of social determinants of health that we could spend a lot of time talking about and probably have a webinar just on that, but I think it's most important that we collaborate with each other and make sure that as healthcare professionals, we are talking to each other, and we're pulling each other in o the care team.

Cait Ellis: [01:28:01](#) Great. Thank you. Well, we are running out of time, so I would like to take a moment to thank our excellent panel of speakers who took time from their busy schedules to be with us today to share their inspiring work, and a thank you to our audience for joining us to learn directly from these experts. We hope you've learned more about improving health in the LGBTQ community and that you leave with ideas to take back to your work in your own communities. Your feedback is very important to us, so please take a moment to complete a brief survey, which can be found at the bottom of your screen, and a save the date announcement for our upcoming webinar on rural health. Thank you again for being with us.