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BEGIN TRANSCRIPT:

ADAM SWANSON, MODERATOR: Hello, everyone, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions and CDC-funded National Behavioral Health Network for Tobacco and Cancer Control's webcast "Resources for Culturally Appropriate Integrated Services for LGBT Individuals."

My name is Adam Swanson, and I'm a policy associate with the National Council, and will serve as your Moderator today.

Before we get started, a couple of housekeeping items –

To download the presentation slides, please click the drop-down menu labeled "Event Resources" on the bottom of your screen. During today's presentations, your slides will be automatically synchronized with the audio, so you will not need to flip any slides to follow along. You will listen to the audio through your computer speakers, so please ensure they're on and the volume is turned up. [00:01:01]

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Today's webinar will focus on ways to evaluation organizational barriers to assessing care, strategies for reducing these barriers, and actionable steps for implementing culturally appropriate services for LGBT individuals. [00:01:58]

We will hear remarks from Dr. Scout at LGBT Health Equity, a program of CenterLink; Dr. Harvey Makadon with the National LGBT Health Education Center at the Fenway Institute, and Andrea Washington with the Montrose Center in Houston, Texas.

I would now like to introduce our first speaker – Dr. Scout. Dr. Scout has been training in state health departments and cultural competency for more than eight years. He is the Director of the National Network of LGBT Health Equity at CenterLink and is an adjunct assistant clinical professor at Boston University's School of Public Health. He specializes in tobacco, wellness, transgender health, social determinants, health disparities, and surveillance.

And, now, I'll turn things over to our first speaker. Scout, please go ahead.

SCOUT, Ph.D., PRESENTER: Thanks very much, Adam. I appreciate it. And the Network for LGBT Health Equity is one of the sister networks with the National Behavioral Health Network for Tobacco and Cancer Control, so we really appreciate this partnership between two of the disparity networks with CEC [ph] funds to get our message out more broadly and give the audience access to resources that I'm looking forward to you being able to use and implement in your own environments. [00:03:18]

So, with that, let me jump in.

I am actually going to talk to you about a lot of the "why we're here." Why is it the lesbian, gay, bisexual, and transgender communities have – why they need special consideration in the medical care environment, and why you should have particular issues in mind as you think about LGBT client populations and how welcoming your own agency might be to LGBT people. So we can kind of jump right in.

I'm going to talk a little bit about what we see here - and we're going to start to paint a bigger picture as this goes on – is that there is a constellation of lesbian, gay, bisexual, transgender health disparities that start to be – create a profile of, basically, this is an outcome of stigma and discrimination. [00:04:08]

But we're going to jump right in and look a little bit at what those exact kinds of outcomes that we see are. And I want to tell you it is not important for you to remember the details on this. What I really want people to remember is the takeaway that, hopefully, at the end of this, you're going to understand that you have to put out a flag of welcoming to the LGBT communities because, often, we come to a clinical interaction with fears that other people may not have about not being accepted. And if you haven't done something on *your* end to try and *overcome* those fears, then we would have no reason to think that you're a safe environment. So the details of these stats aren't as important; it is the picture and what you need to *do* with that information that is the real message.

So, with that, we're going to jump right in to access to healthcare and health insurance information. A lot of this is from Center for American Progress, evidence they compiled together. [00:05:01]

We're going to run through some health disparities. As you see, health disparity number one – heterosexual adults are more likely to have health insurance coverage. The blue bar on the top there – 82 percent – is for heterosexual gender-conforming people, and then the red bar is for lesbian, gay, bisexual people, And, *if* there is evidence on transgender – because it is not always collected – it is the gray bar. So, as you can see there, obviously, the blue bar is highest for health insurance, drops with LGB, and even farther down to 57 percent if it is for trans folks. LGB people are also – when I say "LGB," it just means that, in that study, "T" was not collected, so it is not trying to say that "T" is not the case; it just was not collected. They are more likely to delay or not seek medical care. Again, it is another study here: 17 percent of straight gender-conforming adults were delaying healthcare, but 29 percent of LGB adults were.

Still on access to healthcare and health insurance – LGB adults are more likely to delay or not get needed prescription medicine. The number is 22 percent for LGB adults versus 13 for straight gender-conforming adults; that would be non-LGB. [00:06:11]

We also see that LGB adults are more likely to receive healthcare services in emergency rooms – 24 percent of them versus 18 percent of non-LGB.

We know that the societal biases, discrimination, and stigma take a direct toll on our physical health, and we see this in a lot of different ways. Non-LGB adults are more likely to report having excellent or very good health overall. Again, you can see the top bar is for non-LGB, and then people reporting excellent physical or good health starts to drop once you go down to LGB, and drops *further* once you get into the trans population. Lesbian and bisexual women are less likely to receive mammograms here. Again, what we're trying – what I'm trying to do here is, really, to show you that there is a *pattern* here. The pattern even doesn't have to do with one, specific health issue; it has to do with anything that could be a result of stigma or discrimination. [00:07:08]

LGB adults are more likely to have cancer. Six percent of non-LGB adults report having cancer, and nine percent of LGB do. And that is like a good example of something that we would often think has to do with *biology*, but, in a lot of these cases, we really understand now that biology is *less* a determinant in our health than we might think at first glance. And by the time you get to the end of your life, a *predominant* portion of your health is actually social determinants that have affected you throughout your lifespan. So *that* is why we see even things like cancer having a very quantifiable difference.

LBG youth are more likely to be threatened or injured with a weapon in school. Five percent of non-LGB youth report while *19* percent of LGB youth report that. [00:08:00]

Again, going through physical health outcome LGB youth are more likely to be in physical fights that require medical treatment; only four percent of non-LGB youth report this, and 13 percent LGB youth report it. They're also more likely to be overweight, as well – *double* the average for non-LGB youth.

And I want to note, also, on this that, for a lot of these studies, we have to find information because, unfortunately, many of the large surveillance systems don't collect LGBT data.

Oftentimes, as might be the case in your own institution, the electronic health records don't, either. So it is one of the things that we're encouraging people to do at *all* levels, because it only hamstrings *all* of us in trying to identify and overcome these problems if we can never see them. And so if we're not asking the question on surveillance systems and no electronic health records, then we're never able to see the differences in the first place. [00:09:00]

Moving on the mental health outcomes – impact of societal biases –

LGB adults are more likely to experience psychological distress. Nine percent of non-LGB adults reported in the last year versus 20 percent of LGB adults. They are also more likely to need medication for emotional health issues, over twice as likely as the general population. There, you see ten percent for the general population, 22 percent for LGB adults.

And transgender adults, in almost *every* health measure you can find, are even *more extremely* stigmatized, discriminated against, and, as a result, have more unstable health outcomes and health measures on practically every indice. Trans adults are much more likely to have suicidal ideation; it is up to 50 percent. There was another study that showed that, in the general population, it is two percent. There is another study that showed that one-third of trans adults have *attempted* suicide. So if you can imagine "I am transgender," can you imagine if every time you got together with someone else who was like you – two other people – that one of you would have tried to *kill* yourself for who you were? That is an incredible *burden* that the populations living with. [00:10:11]

LGB youth are also much more likely to attempt suicide – 35 versus ten percent.

We know, overall – I think some of the findings on this slide are interesting because it talks about how policies – we all may be familiar with, maybe, the battle for gay marriage, things like that, [but] these policies don't exist in a vacuum; they play a role on our health, they take a toll on our health very directly. In that first study there, you see that LGB respondents, in states that didn't have protective policies - like non-discrimination or marriage equality, things like that – were *five* times more likely than those in other states to have two or more mental disorders. And *actually*, another point from that same study was that, if a negative policy passed in that state, the number of mental disorders would spike for the LGBT population in that state *and* in the surrounding states, as a matter of fact. [00:11:07]

So you see this associative trauma effect, as well. We understand that we're a stigmatized and excluded population and that plays a direct role into our mental health status.

LGB people who experience prejudice-related major life events are three times more likely to have suffered serious physical health problems in the next year, versus others. And lesbians or gays who were in physical fights or physically assaulted had higher odds of being current smokers than their counterparts who didn't experience those stressors. Again, we start to see that more and more lines get connected in this web of how discrimination turns into adverse health outcomes for the population.

Here, you see that there is actually some newer information coming out about this in the National Health Interview Study, but it was just released yesterday, so we're still analyzing it.

Whoops – did someone else move that? OK, it is back. That is fine.

Prevalence to psychiatric diversion [ph] – the last 12 months – [00:12:01]

LBG, in this case, is the blue line, higher on every single indice you see here. Again, this is all related to stress. And this actually is an excerpt of the newer information that just came out. According to the – literally, released yesterday – 2013 National Health Interview Survey data for LBG adults: 35 percent of lesbians and gays had had binge drinking – five or more drinks – one day in the last year, versus 41 percent of bisexuals, compared to only 26 percent of the non-LGB respondents.

And then this is my *personal* favorite, because we do a lot of work in tobacco and cancer, that one of the issues with the LGBT population doesn't even *understand* we have a disparity related to is the level at which we smoke. This is an infographic we put out with the Surgeon General's Report that came out in January of this year. On it, we show - first of all, if you see those white dots along there and then the rainbow dots around the end – that there has been that many Surgeon General reports but, in them, only three of them have even *mentioned* LGBT. [00:13:09]

So one of the reasons why we don't understand that we have this health disparity is because the policymakers and the health decision-makers haven't actually reflected in their funding and in their policy decision-making as much as would be warranted, oftentimes, as these data were not collected. But we calculated, according to our current smoking rates, how much we spend on tobacco cigarettes each year, and it is, as you can see down there on the bottom-left, $7.9 billion. That is actually 65 times more than funders spend on *all* other LGBT health issues combined. So this – smoking, for us, is a *huge* challenge. Our smoking rate is 33 percent compared to the general population rate of 20 percent, according to the most recent adult tobacco survey. [00:13:58]

And we are also seeing – there is actually a new CDC initiative around this, with a Tips campaign ad for an HIV-positive smoker - we're seeing that smoking and HIV have a *synergistic* effect with each other, too, each *accelerating* the number of years lost if you have the two – if you are an HIV-positive smoker. So I will actually try and make sure there is a follow-up resource and that you can see the link of these new ads that CDC has put out, to try and bring awareness to how the two of them together are particularly toxic.

Across all the studies, basically, we consistently show higher smoking rates and, according to the largest full-population study, our rates are 68 percent higher – rates of smoking cigarettes – than others. We also see elevated rates of *menthol* smoking. We also see elevated rates of dual use – cigar, cigarillos, everything like that. In all, according to the CDC, 2.3 million people – LGBT people are currently smoking, and it is estimated that over a million of them will die early from smoking. [00:15:00]

Yet, despite this being our largest health burden, most of us don't even understand that we smoke more than other people. Actually, if you talk with LGBT people, many of them will not even understand how or why, or that we have health disparities because, oftentimes, not being public health professionals, they come to it and they think about biology instead of like we do, thinking about social determinants.

There was a long study – the Family Acceptance Project – on LGBT youth, and it really had some profound findings, that LGBT youth were eight times more likely to have accepted suicide if they were in a rejecting home environment. Though, with members of the LGBT populations, it is different than many other stigmatized communities because you usually do not have your *parents* as members of the same community like you would if you were a racial/ethnic minority. Those parents can often teach you how to navigate safety and deal with the depression in the world, but, for LGBT youth, they are not – they do not have that. [00:15:59]

So three – LGBT youth are also at three times' greater risk for HIV and STDs if they were in a highly rejecting family. So this is something, especially with behavioral health professionals, that you're going to be seeing it *all* throughout their life course but, especially if you're dealing with younger people, it is a *huge* impact on their stability. I just want to note down that, at the bottom of this slide, you see – and I know these can be downloaded – that SAMHSA has, actually, two great resources on this. They have a resource guide they did with Family Acceptance, then they also have a definition of family, in ensuring that *you all* make sure that you're defining "family" as people's chosen and not necessarily simply by the legal definitions.

And, of course, all of these health outcomes are a result of discrimination. That some kind of discrimination, unfortunately, exists in the medical care environment. According to National Transgender Discrimination Survey, one in five trans people report being turned away from a medical provider for being trans, many were harassed, and many had to teach their medical providers *how* to do care. [00:17:00]

We also find in surveys that people routinely report avoiding medical care. In the 2013, NHIS data, we see that bisexuals, in particular, had less frequently a usual place to go for medical care. We have a National Cancer Network Survey that has a *lot* of experiences from people on how they *left* providers because of a chilly or hostile environment. And just to remind you that, while it may be more accepting now, everybody you see is bringing *their* lifetime's worth of experiences, so they're bringing things that could be 20 or 30 years old to the table with them as they approach you. So, hopefully, by now, you might get a sense that people are not necessarily thinking that you are a safe person to go to. And it is really – it is going to be – and the ball is in *your* court to *demonstrate* that to people.

But let me just do a couple of more things first. First of all, how many people are affected? According to the best current estimates, there is a minimum of nine million LGBT people in the U.S., which is roughly equivalent to the population of the State of New Jersey. [00:18:05]

And just FYI – LGBT folks are found across all racial/ethnic groups, socioeconomic classes, everything like that; it is not clustered in any one section of the population.

So now, this is one of the things I really love doing the most when I'm directly in person with people, and that is - "Is it legal to fire someone for being LGBT?" (Since I hear that there are about 900 people on the phone, we won't ask you to answer, but answer in your head if you can) - because, oftentimes, I realize that people *don't* know that the truth is – if you can look in the last column - in 28 states in the Country, it is legal to fire people for being LGBT; it is also legal to kick the out of an apartment, not rent an apartment, not sell a house to them, kick them out of a restaurant, anything like that. And the reason why this is important is because this is the knowledge that these people are coming to the table with *you* on, and if you don't *realize* that that is what *they* are concerned about, then you're not understanding what *their* issues are. [00:19:00]

People in the U.S. can still be fired, kicked out of an apartment, anything like that in 22 states. It also creates a barrier in getting coverage and accessing care, absolutely to getting health insurance. There is a resource to find out more there. So the question I really have for you is, "Are you familiar with what your patients and clients are bringing to the table as far as their concerns as to whether they can trust you?" and "Have you given them any reason to trust you?" Even if you have non-discrimination in your state, there is a huge history of discrimination in the medical arena. Have you done anything at your agency or in your practice, or with your clientele to show them that you are *not* one of the bigots, that you're actually a welcoming and accepting place? And, with that, I just have a couple of resources here for us, and then I'm going to turn it over to our next presenter. We have a blog that covers a lot of the stuff we do, a lot of policy work, things like that. We also – this talk thing [ph] is actually pretty helpful. If you want a weekly news update of just five or six stories of what is going on in LGBT health, follow – I happen [ph] to post "LGBT Wellness Roundup" that we create each week. [00:20:06]

And here are some of the other things that we offer as well as one of the National Disparity Networks. Feel free to contact us. And, with that, I think I'm going to turn it over to our next presenter - Harvey Makadon.

ADAM SWANSON, MODERATOR: Yes, thank you, Scout. This is Adam. I'll introduce Dr. Makadon really quick.

Dr. Harvey Makadon is the LGBT Advisor at Harvard Medical School's Office for Recruitment in Multicultural Affairs. Dr. Makadon is also a member of the Division of General Medicine at Beth Israel Deaconess Medical Center in Boston, where he had a primary care practice for over 25 years, and served as Vice President of Medical Affairs. He developed the first practice in the *Country* that integrated HIV care into academic primary care practice. And, now, I'll turn things over to Dr. Makadon. Harvey, when you're ready… [00:20:57]

HARVEY MAKADON, M.D., PRESENTER: Oh, thanks, Adam, and thanks, Scout. It is really a pleasure to be here because I think that we're talking about a very important topic. And providing accessible quality care for LGBT people is particularly important as we are also integrating behavioral health and primary healthcare across the Country, in many different configurations. So it is also a way that I learned to practice when I was first an intern at Beth Israel Hospital many years ago, but I'll talk a little bit about that towards the end of the session.

I wanted to start off by talking about where I work. I work at the National LGBT Health Education Center that is based at the Fenway Institute at Fenway Health. Fenway Health is an FQHC in Boston, that serves the LGBT community but also the greater Fenway community. [00:22:00]

About 40 percent of our patients identify as LGBT and the rest are a mixture of people, students, elders, people of all ages, sizes, and shapes. We have a large HIV practice and a large transgender practice integrated into our primary care practice. So it is a very interesting place to work.

The Fenway Institute, where the Education Center is housed, really focuses on doing research, education, and policy advocacy, but the Education Center offers educational programs and resources to organizations like all of yours, with the goal of providing affirmative, high-quality care. Part of our work is funded by a HRSA national cooperative agreement that allows us to do training and technical assistance in health centers. We do grand rounds in academic centers. We do focus workshops on critical issues. [00:23:02]

We also work with individual programs to help them to assess what they need to do to create change to be more welcoming to LGBT people, and we do this both through a written assessment, some online and live educational programs, and a number of resources and publications which I'll highlight towards the end of the session.

This is a photograph of Fenway Health, which I have already described so I won't go on and say much more about it, but we are located in the Fenway neighborhood of Boston, right across from Fenway Park, for those who are familiar with it.

In terms of our educational activities, they began around 2008 with the publication of the *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health,* which I co-edited with a number of colleagues here. [00:23:58]

We're about to come out with a new edition of that book at the end of this year - I'm actually sitting here with a photograph of the new cover on my desk - so we're very excited that that is coming out, because there has been a lot of interest, and a lot of students across the Country use this as part of their – to supplement what *isn't* being taught to them, necessarily, in medical school or nursing school, so we hope that you might find it helpful in your practices.

In terms of the Education Center, we do our work – we try and do our work as much as possible in cost-effective ways and not necessarily traveling all over the Country. But we do do live workshops, largely at meetings of groups like the National Council or Healthcare for the Homeless, Farmworker Justice, other groups that represent large networks of health centers. [00:25:00]

We do work for some state health departments. But we also do many webinars, which we provide free CME and CEU credits for, and these are available online, and I'll show you that information later on. We do grand rounds. We have a number of publications. And all of these things are kind of highlighted on our website, the address of which is right here, where we make

all of our webinars available on demand. So if you get – if you can't sleep one night and you want to get some CME credits or CEU credits, you can also look at some of our webinars. These are done by a national advisory board and faculty, who come from across the Country and really represent a large spectrum of LGBT people coming from very different places. Some - I'm not going to go and mention everybody's name, but you can find them listed on our website. [00:26:04]

In terms of our reach, we've kind of worked almost all across the Country at this point. The blue states are where we've been, and we'll be – and the stars represent states where we will be going back in the next four to six months. So we're very pleased that we've been able to do that much over the last two and a half years, and are looking forward to working on this project, at least for three more years, with our newly renewed HRSA grant.

As I said, aside from the HRSA grant, we also do workshops and grand rounds at other organizations, so here is a list of organizations where we've done grand rounds on general LGBT health, with a focus on ending LGBT invisibility in healthcare and what we can do to overcome barriers, to provide better health. [00:27:05]

And I'd say those are the two main themes that we've talked about in addition to getting more specifically into more specialized areas like transgender health or cancer prevention, and things like that.

We do a lot of our work, as I mentioned, in collaboration with other organizations – primary care associations, our associations of health centers in different states - and we've done a lot of our programs in conjunction with them as well as, as I've said before, in conjunction with other HRSA National Centers of Excellence that have collaborations with health centers sponsored by HRSA, so: the National Council Healthcare for the Homeless Council; Farmworker Justice; the Center for Excellence for Transgender Health at UCSF; North American Management, which runs a public housing program; and the National Association of Community Health Centers, that we've done a lot of work on sexual health and teaching about sexual health with. [00:28:15]

So those are just a sample of where we've done things. We've tried to focus our work in the last year, particularly, on regional programs in parts of the Country that have not traditionally been bastions of LGBT communities or cohesive communities, in trying to work with communities to do more. So these four photographs represent programs we did in – on the upper left-hand corner – Salt Lake City. This is the Salt Lake City Library, where we did a two-day program sponsored by Utah Pride and the Primary Care Association. [00:29:02]

On the upper-right is a health center that just opened in Jackson, Mississippi, called the Open Arms Healthcare Center, which serves the LGBT community and was started by some colleagues at the University of Mississippi. We've actually done four programs in Mississippi over the past year, recognizing that that is a place where there is a very high incidence of HIV and, obviously, a lot of stigma and discrimination, with a lot of LGBT people not really very open about their identity; although, they certainly live there and want to have a better experience. In the lower-left is a program we did in San Juan, at the San Juan Primary Care Association. And

on the right is a photograph of the University of Arkansas Medical Center, which is, again, a place where we've been doing ongoing work. [00:30:06]

I've been there about four times in the past year, and we're looking forward to continuing our work there, because these *are* places where, despite the fact that we may not *think* of them as necessarily places where there are lots of LGBT people, I think there is a lot of recognition among healthcare providers that, despite a history of discrimination, people do want to do a good job at taking care of diverse populations including LGBT people, and want to learn how to provide equitable care, so we've found these programs have been very satisfying for us and engaging for a lot of clinicians. This is, again, some photographs – some more photographs from Mississippi, a photograph from our first program in Little Rock, Arkansas, which we did both at the Medical Center as well as the Arkansas Department of Health and, since then, have done programs for the Department of Family Practice at the University as well as a primary care conference which we organized at the Primary Care Association. [00:31:16]

And, again, we just had a conversation today about going back to do work in San Juan, where we've been doing some work assessing community health centers and their LGBT readiness, and going back and doing trainings with specific health centers on how they can improve the care because, again, there is a great deal of interest in these efforts. So we've been working in collaboration with some faculty at the University of Puerto Rico with these health centers, and doing work with both urban and rural health centers in Puerto Rico. [00:32:00]

In the United States, we've been doing a lot more work with – and I think this is very relevant to today's conversation – but mainstream health centers, which are trying to do more work with their LGBT communities, so we've done a kind of long series of programs at Piedmont Health. It is a network of six health centers in and around Raleigh, North Carolina. And we're going to be doing a presentation at the next meeting of the National Association of Community Health Centers, on providing LGBT-affirmative care in mainstream health centers, which I'm going to do with the CEO and the Board Chair of Piedmont Health, to talk about why they did what they did and also the challenges they face, and what are their plans for the future. [00:32:59]

I think a lot of people in health centers like this sort of question. "Why should we be doing something special for LGBT care?" And I think the answer that I usually give is that we're not doing something special but I think that, as Dr. Scout pointed out, we're making people aware of some of the unique issues that LGBT people face so that clinicians are more prepared to take care of them. I think that it is less an issue of overt discrimination on the part of most physicians. I think that most clinicians of *all* types – physicians, nurses, social workers, psychologists, psychiatrists – want to do the best they can, but we haven't been taught much about this in professional education, and I think we're trying to make up for some of those gaps, and I do think that this kind of education makes a difference. [00:33:53]

I mentioned our webinar series. I think our number is now up to 29 webinars. We just did one earlier today on cancer prevention, and we'll be doing a number over the summer. But we've had over 2,000 participants over the past year and, as I mentioned, these are available online. Here are some of the topics from the webinars. Some of them are very basic like "The Introduction to LGBT Health," then we deal with some specific populations as well as some specific content

areas such as: HIV, transgender care, sexual health, anal HPV and cancer, substance use, mental health issues in primary care, and also some more issues around how to provide an appropriate atmosphere for the LGBT workforce, because that is very important if we're going to keep our workers satisfied. [00:35:01]

In terms of our publications, these are all available for free on our website; they can be downloaded. The first one at the top – "Do Ask, Do Tell" – is both a poster and a brochure. The poster is to show people who come to your facility that you're interested in talking to LGBT people and encourage LGBT people to talk to their providers about their concerns. And the brochure, which we have in English and Spanish, is something that really kind of helps consumers learn about what kinds of things they *should* be talking to their providers about, getting into some of the issues that were discussed previously. [00:35:56]

Next is a brochure, a toolkit that we put together with the National Association of Community Health Centers, both "Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers," which really goes through what we need to do to learn, really, about all aspects of individuals, not just focusing, as sometimes people do, on sexual risk but really getting into sexual behavior, sexual identity, gender identity, and really learning how to talk to people about these issues.

On the right-hand side, there is a study we've done, which reflects some work we've been doing advocating, collecting data routinely on sexual orientation and gender identity in clinical settings, and these are all available for free. On the bottom, there is one on transgender health for frontline staff best practices and HIV prevention, hepatitis C- and HIV-infected men who have sex with men. And so I think that you'll find these very valuable. [00:37:04]

Just in conclusion, I wanted to say that I think that the integrated care model that you're pursuing is something that is very familiar to *me* but is something that a lot of people are trying to work at, so we have to think about how to kind of really help our colleagues, both doing behavioral health and primary care, think about how much better it is to work in an integrated care model where different providers work together. I sort of just drew this for the fun of it, but this was an example of an exam room module, where I used to work, in which the different professionals – nurses, doctors, nurse practitioners, psychiatrists, social workers – all worked together in a little kind of module, and we could – we would meet together at least once a week to talk about our common patients. [00:38:01]

Clearly, for the future, we need to think about expanding that group of the traditional focus on that group in looking at what we can do to do outreach. The slide now shows that we really need to think more about how we do outreach so we learn about the population we're taking care of and help to do outreach to them, get them signed up for healthcare and into care through peer navigation, and include prevention in care as well as ongoing engagement in care.

I'll just go through this quickly, but, clearly, the key to effective integrated programs is that we do comprehensive care focusing on the needs of patients, and make sure that care is coordinated using case management as much as possible, and that we also focus on quality and safety so that we collect information on sexual orientation and gender identity so that we can ensure that we

track that people are getting the same level of care and have the same level of patient satisfaction as do *non*-LGBT individuals who come for care. An electronic decision support can be very helpful in ensuring that this happens. [00:39:23]

So, again, the National LGBT Health Education Center is here to help you. At the bottom of this slide, you'll see our information, and you can get in touch with us when you get these slides. And I look forward to talking more at the end of the program. And, now, we're onto our next speaker. Thank you very much.

ADAM SWANSON, MODERATOR: Thank you, Dr. Makadon. Our *final* speaker – before we go to a panel discussion between all of the speakers on this webinar – is Andrea Washington with the Montrose Center in Houston. Ms. Washington is a licensed clinical social worker who has worked with the LGBT community for more than 13 years, starting as a medical social worker at an HIV clinic. She has worked more specifically with the LGBT community in mental health and substance use disorder treatment settings in recent years. Until recently, Ms. Washington served as the PBHCI Project Director for the Montrose Center and the Program Coordinator for the Organization Substance Use Disorder Treatment Services. [00:40:27]

And now, I'll turn things over to Ms. Washington. Andrea, please go ahead.

ANDREA WASHINGTON, LCSW-S, PRESENTER: Thank you. To give you a little bit more background about the Montrose Center, it has been around for about 36 years, serving the LGBT and HIV-positive community, and providing those services as far as mental health and case management services and then broadening out in different capacities for outreach, getting people tested for HIV, getting them connected to other services. [00:40:58]

The integrated care model that we actually *worked* with initially started from the HIV community in which, using case managers to keep clients interconnected with the doctors and other services that they're providing, it is the model that we use with the PBHIC grant.

So far forward – there is a lot of terminology but the most appropriate are these that are listed:

"Heterosexual" is very common, also known as someone who is straight, that their attraction is toward someone of the opposite sex or gender.

"Gender" and "gender identity" – "gender," in particular, refers to attitudes and feelings, and behaviors that a given culture associates with a person's biological sex. And then "gender identity" is the person's *internal* sense of either being male or female, or even something else. And since "gender identity" is *internal*, one's gender identity isn't necessarily visible to others, so "gender" and "gender identity" go very close together. [00:42:05]

And then "gender expression," or how someone may *present* is the manner in which the person represents or expresses their gender identity to others. And it may or may not conform with socially defined behaviors and external characteristics that are commonly referred to as either masculine or feminine.

And "sexuality" is a person's overall experience of sex. It includes their beliefs and their attitudes, and their behaviors, their attraction.

And "sexual orientation" alludes to a person's *emotional* and sexual as well as relational attraction to others. So "sexual orientation" is typically classified as heterosexual, bisexual, or homosexual. The "homosexual" is a rather outdated term that isn't used and is more specific to either lesbian or gay. [00:42:58]

Other terminology – "gay" – that we've all referred to and that we've all been using on the webinar at "LGBT" – is the lesbian and gay, bisexual, and transgender. "Gay" typically refers to men who are attracted to other men, but there are women who also use that term towards themselves. Lesbians refer to women who have same-sex attraction and sexual behavior towards other women. People who are bisexual have romantic attractions to both sexes or both genders. And then the people who are transgender – it is more about the person's gender identity and/or expression being different from that which is typically associated with their sex assigned at birth. Within those categories, it leaves the two *main* categories. Understand that "transgender" is an umbrella term for anyone who is not presenting in a gender-conforming way. So you have FTM, which is a person who is transitioning from female to male and may or may not include sex reassignment, or it may include hormone replacement therapy, the same for male to female (MTF), who is a male person transitioning to a female gender. [00:44:13]

And then the term "bigender" goes with someone whose gender identity or their gender *expression* encompasses both male *and* female, and maybe one is stronger but not necessarily. This is also a term that could be replaced with "gender-fluid," in which someone's gender expression is fluid. It also could encompass the term "two-spirited," if you've heard that, which is used in the Native American community.

Now, "cultural competency," which, I am assuming, is one of the main reasons why many people are also on this webinar, because Scout has talked a lot about the health disparities which are *extremely* important to know and are the main reason why the LGBT community is not accessing healthcare. [00:45:05]

And then Dr. Makadon really expressed a lot of how much education he and his organization have done. The Fenway Institute is an awesome institute in which they do provide *very* relevant, *very timely* health information and education. I actually utilized their website back in January, at the Regional Conference for the PBHCI Grantee Meeting when I was speaking about health disparities, so it is a very good resource.

So starting with cultural competency, we have the role of leadership, because it starts at leadership. Leadership is about the people who create policy. So in cultural competency, the leaders must be able to clearly articulate their commitment to meeting the unique needs of this population, which means that they are committed to doing whatever it takes to be an inclusive organization. [00:46:00]

Steps toward cultural competency leadership, at least from the leadership's standpoint, is adopting a non-discrimination policy which protects patients from discrimination based on

personal characteristics including sexual orientation and gender identity. This is also *very* important in how you also develop a complaint and grievance policy around whether or not someone has experience in ending discrimination, and they can actually let you *know* of that. So, oftentimes, people will experience things but they never say anything out of fear that nothing will be done or that they themselves may be kicked out because they're causing problems. So adopting a non-discrimination policy, developing a policy that – in the patient's rights and letting them know that they are supported and that their choice of family and how they identify and support it. [00:46:58]

Incorporate a broad definition of "family" into new and existing policies that is consistent with the law. SAMHSA recently released a Post-Windsor Guidance for Federal Grantees related to the definition of "family" and, as a result of the Supreme Court's decision, SAMHSA is no longer prohibited from recognizing same-sex marriages and, now, SAMHSA programs recognize same-sex spouses.

The fourth thing is monitoring organizational efforts to provide culturally competent care; that is, making sure that it is family-centered and patient-centered, and that patients can – know that they are free to bring the people that *they* consider family along with them, in to be part of their care.

Identifying an individual leader who will be accountable – so having, maybe, one particular person who is in administration as the one who is going to make sure the policies and everything are carried out and that people are abiding by them, that patient care is being reported as excellent, or that problems are being reported to them and taken care of, as well - so one person who is able to kind of oversee the implementation of this as well as whatever problems may come up. [00:48:21]

And then support champions with special expertise and experience – you might hire a doctor or a nurse, or there may be a social worker in your agency who has worked with the LGBT community before but, because that may not have been the focus of your population *currently,* there knowledge and expertise has gone untapped. So if you *have* someone who is a part of your organization right now, who has this expertise, promote them and encourage them, and let them know that their knowledge is needed for the betterment of the clients that you want to serve as well as for the edification of your colleagues. [00:49:00]

So steps towards welcoming and inclusive environment – prominently post your non-discrimination policy and/or patient bill of rights, making sure that even clients who are *not* LGBT recognize that you are an organization that is promoting non-discrimination, and that it is something that they'll have to get used to if it is not something they've *previously* been used to. So being inclusive in all standpoints, which means that it is informing them that you are inclusive in all standpoints.

Your waiting rooms and common areas should reflect and be inclusive of LGBT individuals. So images that you may have on the walls, magazines that you carry, health topic pamphlets that are also inclusive of or targeted towards the LGBT community.

Create designated sex-neutral or single-stall restrooms, which are *very* important, particularly for the transgender community. People who are in the early part of their transition may not always look the way someone expects them to look as either someone presenting as male or someone presenting as female, and then they get questioned or they may get harassed, or even something possibly dangerous could happen to them in a public bathroom because they are intending to use a bathroom that is associated with *their* identification but other people are not necessarily recognizing that. [00:50:25]

Refrain from making assumptions based on appearance. So I stated that someone who may be transitioning - say, someone who is female transitioning to male – well, you could say that this person could be what is considered a butch lesbian, or this person could be a female-to-male; you don't know, so if it is safer to not make assumptions than it is to *make* assumptions and then be wrong, and then potentially offend someone. So make sure that you don't make assumptions. And it is very appropriate to ask someone how they wish to be referred to, what gender they wish to be referred to when spoken to. [00:51:06]

The same thing even with their partners or their spouses now that same-sex marriage is legal in many states - though, unfortunately, still not legal in Texas - but if the spouse is there, being able to ask them how they want them to be referred to as.

And then facilitate disclosure of sexual orientation and gender – realizing that both of these are very sensitive topics, and people are not always very eager to out themselves, and so it is better if they can do it on their own and in their own time. But if the environment is safe and the environment seems very inclusive, then it may happen even on the first visit; you never know. Which goes to [pauses] the next slide, which is talking about documentation of forms. [00:51:55]

So on your admission/intake paperwork, if you only have "male" and "female," or if you only have "married," "single," and "divorced," then that is not inclusive of someone who may be gay or lesbian and in a long-term relationship that they are not legally married to, or is not inclusive of someone who identifies as transgender and it has only two genders down; they may not completely identify as either male or female, as I mentioned with someone who is considered bigender or gender-fluid. So changing your paperwork so that it is more inclusive in self-identification. The same thing even with sex and sexual orientation, asking whether or not someone is gay, lesbian, or bisexual is very important information that is going to be needed to you in working with that client, but if you never put it on there, then they may never decide, "Well, OK, it is not important for my doctor to know this." So it is really important to make it a welcoming environment so that you are welcoming them to disclose to you. [00:52:59]

Using neutral and inclusive language when you're interviewing and talking with your patients – neutral language in that you are not making assumptions about type of people that they have been involved with or neutral language about who they are and how they identify.

Listen to and reflect a patient's choice of language when describing their *own* sexual orientation, and have the individual refer to [ph] their part of the relationship; I mentioned that earlier. But it is really important to understand the CDC uses a term which is called "men who have sex with men," and there are men who identify as a sexual orientation as heterosexual or straight but their

sexual *behavior* may be that they often has sex with men. So if you never really ask that question and you only stop at someone's sexual orientation, then you're missing a whole lot of data that goes along with their sexual behavior which also impacts their health. [00:54:00]

Become familiar with online and local resources available to the LGBT community. There is a plethora of information out there, not nearly as much as there for everyone else but there are good websites like Health Equity Network that was on earlier with Dr. Scout, who gave an excellent presentation about health disparities; the Fenway Institute and, from them, I know – since I've been on both of their websites – they give links to other websites that can provide other information. So become more familiar with the resources that are out there. Even publications, even just *social* publications that are out there, or the political publications so that you know or at least have a better idea of the things that are going on within the LGBT community, that mainstream America may not know.

Seek information and stay up to date to LGBT health topics, and be prepared with appropriate information and referrals. [00:54:55]

Lesbians are women – yes, they are – but they have health issues than someone who is a straight woman. They even have different health issues than someone who is a *bisexual* woman, and they have different health issues than someone who is a transgender woman, as each of them have different health issues from the other people. So understanding the specific health issues related to each person or type of person within that population is really important. You can't treat all women the same. All women have different issues and different needs based on their life and also based on the type of people who are part of their lives.

So workforce culture and competence – earlier, I mentioned the importance of having someone who could be a designated person, who is implementing this policy change in your organization. I also mentioned people who have expertise in working with this community. But it is also just as important for people who are *part* of this community to feel that they are open and welcoming to be "out" in their work environments. [00:56:06]

So treating your employees equitably and with non-discrimination, and making it safe for them to be "out" as themselves demonstrates a commitment to the community through recruitment and hiring. So if you need someone who could *be* that spokesperson, and no one at your organization either has the knowledge or has the expertise, or even has the willingness, then *hire* someone who is *part* of the community. About eight years ago, the Montrose Counseling Center – and this is an example – got a SAMHSA grant to work with elder LGBT persons, and so they hired outreach people, who themselves were LGBT and elders, to go and do outreach with this community. So having someone who is part of the community interface with the clients that you're working with is often a very key and important situation or a key and important thing to have as part of your organization. [00:57:07]

We talked about incorpor – as Dr. Makadon talked about with *education*, so you're incorporating patient care and information into the employee and staff training, so you're providing staff training on LGBT health topics; you're providing staff training on cultural competency and the appropriate ways to provide better and more inclusive and affirming care to this population. And

then it is also important that, as Dr. Scout talked about, if you want them to trust you, me seeing you as part of something that is important to me as a lesbian or as an LGBT person, being part of the Pride events, National Coming Out Day, AIDS awareness, and National AIDS Day – so knowing that those things are things that you *know* of as well as things that you are willing to *participate* in would go a long way in engendering my beliefs that you have my best interests at heart, that I can be "out" and safe with you. [00:58:10]

Uh-oh, something is happening. [Pauses] OK.

So substance use disorder treatment, which is my specialty, is extremely interesting, extremely [pauses] – did I miss it? OK, I'm sorry. So in working with people who have substance use disorders, realizing the degree of "outness" is very important. Now, Scout mentioned earlier that – I'm not sure what is going on with my slides; they keep moving around. OK, I think I'm there.

Substance use in the LGBT community is *extremely* high considering how small of a population it is in respect to the greater community. [00:59:01]

So when you're providing treatment to this population, being very sensitive to the degree of "outness," which is how "out" are they in their lives. Are they "out" to their family? Are they out to their employers, or is it only in their personal life? It is also the fear of *being* "outed" when they come and share this information in a group setting, and so many will *not* share. One of the things that I've told other providers in the *Houston* community is that one of the reasons why the Montrose Center has been in business so long and has done such a good *job* of it is because they *have* done a good job of being inclusive and affirming when LGBT have come to their doors and sought treatment with them.

Realizing that family considerations are extremely important and whether or not someone's partner is welcome in a family group, whether or not their family or their partnership and their family is recognized as a *family* and not just as a "friend" that some people often say about… [01:00:14]

[Pauses] I'm getting to wind-up time, so – provide a safe and non-judgmental environment, which is extremely important in both individual and group therapy - group therapy, in particular. Sometimes, providers will have a very affirming environment and are very welcoming to the LGBT clients who come in and access their services, but they may encounter problems in the group setting from other clients. So be very sensitive to that, in making sure that discrimination is not acceptable when dealing with other members within the group.

Sensitively managing experiences of tolerance, which are huge issues, regarding trauma within this community – that can be either – anything from their family, from something – a hate crime that happened to them on the street, be it fired from a job, experiencing religious intolerance and being kicked out of their church, things like that. [01:01:05]

And become, also, very aware of internalized homophobia and shame, which is also just as big of an issue within the addiction population, because many people in this day and time still struggle with their own sexuality and orientation and, because of the experiences that they've

had, the trauma that they have lived through, they have not integrated that, so be able to be aware of that and be sensitive in working with the client through that.

So the last few things are connecting with the greater community, and this is *extremely* important in working with substance use and in helping clients space over. So connecting with the community, sponsor/sponsoree relationships, realizing that, when you're talking about the 12-step community, particularly since it is the most prevalent community, male sponsors work with male sponsorees. Well, that can also be a problem if you're talking about two men who are gay. [01:02:03]

So a sexual component becomes a rather sticky issue, so making sure that clients are at least picking sponsors that are safe with them, to help to work through their recovery. Finding alternative recreational and leisure activities is extremely important because, in many communities, the gay bars are the place that people socialize, and if that is where most of the socialization was in their addiction, then they need to find different places now that they're clean and sober, which includes having new friends, going to new places to have leisure activities, and doing new things.

So I think that wraps things up. I know I kind of went through things rather fast, and I'm sorry, but I hope that other resources that we're providing will give you further information. So I'm turning it back over to you, Adam. [01:02:56]

ADAM SWANSON, MODERATOR: Thank you, Andrea. Now that we have a better understanding of some of the background issues and struggles facing LGBT individuals seeking care, we're going to facilitate a discussion between our panelists around tactics and approaches that organizations can take to improve their services they provide to LGBT individuals. A lot of the questions we've developed here complement a lot of the questions we've been getting throughout the webinar. Following the panel discussion, we will highlight some SAMHSA resources as well as answer some questions from the audience, that will not be covered in this panel discussion.

So, first up, to all of our speakers on today's webinar, given the research available on the health consequences of institutional sexual orientation and gender discrimination, what steps should providers take to ensure their services do not re-trigger traumatic experiences?

[Pauses]

[Crosstalk]

SCOUT, Ph.D., PRESENTER: Well, Adam, I…

HARVEY MAKADON, M.D., PRESENTER: [inaudible at 01:03:53] [Pauses]

SCOUT, Ph.D., PRESENTER: Go ahead.

ADAM SWANSON, MODERATOR: Go ahead, Scout. [01:03:56]

SCOUT, Ph.D., PRESENTER: OK, I think that, depending on how big your agency is, one of the – if you're in a larger agency, one of the things that I really recommend is using your own internal LGBT staff as experts to try and help look at your own programming and make sure it is welcoming and inclusive; if not, look to see if you have a community advisory board and make sure there are LGBT leaders on that, who can also help you look. Because we can give you steps, but the truth is that, unless you have people who are most steeped in the communities, taking a fine-grained look at what you're doing, they're just – you're not going to be able to see some holes that are there.

If you are a smaller or individual provider, then the other thing I would say is to make sure that the first time an LGBT person sees or interactions with your organization that they have some kind of a flag of welcoming. If you're doing any kind of promotion, are you programming with LGBT groups in your area? As was just covered wonderfully, once they get to your door, do they see any LGBT imagery? Do they see a non-discrimination statement? Are they being referred to by the right pronoun by your front-desk staff? Just make sure that – we have a tendency to think that we want to train the center of an organization, but we will need to train all of the outer layers of it because *that* is what people see first. [01:05:07]

ANDREA WASHINGTON, LCSW-S, PRESENTER: I completely agree with Scout.

[Crosstalk]

ANDREA WASHINGTON, LCSW-S, PRESENTER: If you can't use any staff within your organization who are LGBT, you can also do a focus group, which means to ask people from the community who may never have accessed your services to come and see, "How are we – what kind of changes do we need to make, or how well are we doing at being inclusive and being affirming, and not being re-triggering or traumatic?"

ADAM SWANSON, MODERATOR: And, Dr. Makadon, did you have a comment to add?

[Pauses] [Silence for seven seconds]

Dr. Makadon, if you're trying to speak, I think your phone might still be muted.

HARVEY MAKADON, M.D., PRESENTER: Ah, can you hear me now?

ADAM SWANSON, MODERATOR: Yes, sir.

HARVEY MAKADON, M.D., PRESENTER: Can you hear me?

SCOUT, Ph.D., PRESENTER: Yes. [01:05:58]

HARVEY MAKADON, M.D., PRESENTER: OK. Yeah, so I think, a lot of times, when we see clinicians, I think they – the negative experience isn't so much kind of active discrimination or overt discrimination as it is, really, that people just haven't thought about what they need to do to

learn more and also create an inclusive environment. And so, since a lot of my work *is* with clinicians, I try to frame things not so much in terms of discrimination and – or talking about re-triggering traumatic experiences, but I think about my *own* experience; it wasn't so much that I was traumatized when I told the doctor that I was gay, and he didn't ever bring it up again the rest of that visit, but it is more that I just never went back to the doctor for a while. [01:06:55]

So I think that we have to create – we have to sort of *help* clinicians understand why LGBT people *do* have the kinds of issues that have been described on this webinar and, I think, do it in a really positive way so that they kind of feel *good* about providing equitable care and making sure that people *are* going to want to come back to see them.

And so I just – I think that the – at times, we have a tendency to *over*state the issue of disparities, because we also have to recognize that a lot of LGBT people are very resilient. And, aside from disparities, I also want to talk about things like relationships and having children and families. And those are things that clinicians also need to learn about but which have unique aspects when talking to someone who is lesbian, gay, bisexual, or transgender, and we have to learn first how to end the invisibility, learn who our patients are, and make them feel comfortable. [01:08:04]

ANDREA WASHINGTON, LCSW-S, PRESENTER: I just wanted to add to that, Dr. Makadon knows very truly it *is* just about being just a little bit more sensitive and being a little bit more educated. But I also wanted to mention that the trauma-informed care model that SAMHSA is very sensitive about us using in dealing with our clients is a perfect model of working with this community and ensuring that you're not re-triggering and not re-traumatizing someone.

ADAM SWANSON, MODERATOR: Great. I want to get to this next question, which is, "What factors should providers consider when working with LGBT *sub*populations such as transition-aged youth, minorities, adults over the age of 65, and other specific populations?"

SCOUT, Ph.D., PRESENTER: If I can jump in, because this also brings up one of the questions that was down there, around health disparity information to subpopulations. [01:09:04]

We definitely struggle because of the lack of data, but when we *do* find evidence for subpopulations – racial, ethnic, and minorities – and, actually, bisexuals as well as transgender, we often find really elevated levels of both risk and poor health outcomes. So one of the things that you should *definitely* consider when working with these subpopulations is that, when you add – when stigma is lowered upon [ph] stigma, you get, sometimes, even *more* than an additive effect between them, and that means that the person there could be *that* much more vulnerable coming to your door. So, in that way, especially if it is any kind of a part of your general population base, you should be doing some more education with yourself around what kind of issues people would be dealing with, locally, and you just really have to understand that you have to put down the red carpet of, "It is safe to be who you are here," and make sure that you've done a good job of examining all your own systems to make sure that they are all uniform in conveying that same message to the people who walk in your door. [01:10:09]

ANDREA WASHINGTON, LCSW-S, PRESENTER: I completely agree with you, Scout. When you get into the subpopulations, it is even *more* repressed as far as the willingness to be "out."

The senior population – there was a movie that came out, I think, about two years ago, a documentary called "Gen Silent," that talked about that, when LGBT individuals grow older, their degree of "outness" diminishes, so they are less "out," less willing to be "out," because, as they *age*, they are more vulnerable, and so they no longer believe that it is safe for them to be "out." So you may *have* elders that are coming to you and not know that they are LGBT elders. But, again, as Scout said, making sure that it is absolutely clear that you are affirming and welcoming, and that it is *safe* for them is the best way of dealing with those types of populations. [01:11:00]

[Silence for eight seconds]

ADAM SWANSON, MODERATOR: Fantastic. And, Dr. Makadon, did you have any comments to add?

HARVEY MAKADON, M.D., PRESENTER: No, I think that there is a lot to learn about many – we tend to think about all the different kinds of diversity there is in the LGBT community, and an individual can really reflect many different identities or intersectionality. And they each present their own issues, but, in some ways, it is probably a bit more exaggerated because of the vulnerabilities. And yet, when you're taking care of younger people or adolescents who are straight, it is also very different than taking care of adults or older people. And I think we just have to learn that there are different approaches that work for different kinds of people, and recognize that we can actually – or that we *need* to talk about some things with *everybody*. [01:12:07]

So one of the things that I am always concerned about is that people tend to not talk about sex with elderly people, and yet, when we look at sexuality, we see that both LGBT and non-LGBT elder adults are very sexual people, and so we have to continue to ask those kinds of questions. And so, in some ways, the analogy also applies to LGBT youth and elder people. They have certain unique issues. We have to learn a lot more about the development of sexual orientation and gender identity in the youth because there is really – there are a lot of implications of that in terms of how people should be cared for, supported, whether they need any treatment and when. [01:13:03]

And there is a lot – and, actually, there is a lot of confusion in the literature as well as in the medical community about that. So I think that we have to recognize that there are both a lot to do and a lot we have to still learn in order to really do a good job. But the most important thing is that we share the information that we *do* know and that we try and keep abreast of the information and the evidence that is available, so that we can help every patient to make an informed judgment about what is best for them.

ADAM SWANSON, MODERATOR: Great. Thank you, Dr. Makadon, for adding that. Before we go on to some of the audience questions, I'd like to highlight a couple of resources. First, I'd like to take a moment to highlight the SAMHSA resource "A Practitioner's Guide: Helping Families to Support Their LGBT Children." This resource is available on SAMHSA's website and specifically gets at specific considerations for organizations when dealing with LGBT individuals *and* their families. [01:14:08]

In addition, I would also highlight visited the Fenway Institute's website as well as the Network for LGBT Health Equity at CenterLink. In *addition*, SAMHSA has an entire LGBT training curricula available for providers, which offers CEU credits to providers interested in reviewing these materials. There are different resources on their website, located at the bottom of your screen right now. And listed in *front* of you are just a few of those resources that are available.

So now we're going to take some questions from the audience. Our first question comes from Bill. Bill wants to know, "How do you make people comfortable to share their gender identity/sexual orientation – *or* sexual orientation when they may not understand the importance of their healthcare provider *knowing* that information?" [01:15:02]

I'll repeat that one more time…

HARVEY MAKADON, M.D., PRESENTER: The – the…

ADAM SWANSON, MODERATOR: "How do you make people feel comfortable to share their gender or sexual orientation identification when they may not understand the importance of their healthcare provider *knowing* that information?"

SCOUT, Ph.D., PRESENTER: I'm going to say that, really – I'm sorry, Harvey. Do you want to go?

HARVEY MAKADON, M.D., PRESENTER: No, you go on.

SCOUT, Ph.D., PRESENTER: All right. You, of course, can't *force* someone to feel *safe*, but, usually, it takes more effort to *hide* it than it does to just – it is in the fabric of our lives. Right? so the question, first, is, "Is that an open thing that has already been stated and put up in the environment, in your organization?" If they're not already seeing *something* that has to do with sexual orientation/gender identity, whether it is in promotional materials, whether it is non-discrimination or something like that, again, they have no *reason* to feel safe, and you're *certainly* not going to get there. But if have already put all that out there to try and help them feel safe, then, at that point, all you can do is be educated about the types of differences that might happen. [01:16:02]

You can watch for scanning for people, because people sometimes avoid talking about their partners because they don't know it is *safe;* and, if so, there is a great trick of saying back to them, "Will your partner – he or she –?" – and then go on with whatever your sentence was, which is a great way to just throw another slide of welcoming out there. So you can't force them to feel safe, but if you have done a *lot* of work to put a lot of things up there – showing that LGBT is out and open in your environment – then it is more likely that they will feel comfortable disclosing.

HARVEY MAKADON, M.D., PRESENTER: And I – I can't really add much to that. But I *do* think that one of the publications that I highlighted, that I think is important is that, as we train clinicians, we also have to educate consumers as to why it is important to talk to your clinician

about certain issues. And the more we can kind of communicate to clinicians and consumers in a parallel fashion about the same issues, I think, the better communication will ultimately be. [01:17:09]

But there is no question that an organization has to have the right environment to be conducive for people to bring these things up. Having said that, I know that just having the questions out there and having things asked may not lead to somebody disclosing their sexual orientation or gender identity on their first visit, but at least it gives them a sense that you're concerned about it. People ultimately bring things like that up, but it may take a little time.

ANDREA WASHINGTON, LCSW-S, PRESENTER: Adam, I don't have anything to add. Both Scout and Harvey are saying all the right things. You can only create an atmosphere of welcoming and opportunity in making sure that the clients at least know that they have the opportunity and that they are welcome to do. [01:18:04]

I mean, Montrose has worked in the HIV population for 35 years, and we still have clients who – it may take them two or three visits before they finally talk about being HIV-positive. So you can only do what you can do, and as long as you're doing everything that you can do then that is all that you *can* do.

ADAM SWANSON, MODERATOR: Fantastic. Our next question is, "As a straight provider, would putting a rainbow flag sticker next to me name or in my office be helpful in sending a message of safety, or some *other* symbol? I'm looking for a visual cue that immediately *sends* a message of safety. What do you suggest would be best?"

SCOUT, Ph.D., PRESENTER: My answer is, "Yes, please *do* it." I was actually at one training for school-based health centers where, literally, by the end of the training, they were buying *hundreds* of rainbow flags on Amazon to put through *all* of their different offices. And it is a quick and easy way to convey welcoming, and I would love to see them all over the place.

ANDREA WASHINGTON, LCSW-S, PRESENTER: There is also another sign that uses the pink triangle that says "Safe Space," as well as the rainbow triangle that says "Safe Space." They can also be purchased and that gives the same information or at least the same message. [01:19:13]

HARVEY MAKADON, M.D., PRESENTER: I agree. I would agree with that.

ADAM SWANSON, MODERATOR: "Are there any studies that any of you could cite, that correlate adverse childhood experiences in the LGBT population as a distinction from the rest of the adult population or general population?"

SCOUT, Ph.D., PRESENTER: I don't have any off the top of my head. Although, I have – I know there have been some; I just don't have them in front of my head. I'd have to look and get back to you on them.

ADAM SWANSON, MODERATOR: OK.

ANDREA WASHINGTON, LCSW-S, PRESENTER: I don't know of any studies. I have tons of anecdotal information about it but I don't have – I'm not aware of any formalized research.

ADAM SWANSON, MODERATOR: OK. [01:20:00]

This question specifically comes from Scout's presentation – "Do we know why lesbian and bisexual women are less likely to have mammograms? And, for example, other health disparities that are specific to this population, is it due to fewer visits with the primary care, or what does that result from?"

SCOUT, Ph.D., PRESENTER: There is a constellation of research that would be in the same area, which talks about avoiding the healthcare providers because of fear of coming out or not finding one that you think is welcoming, or not having the health insurance where you can choose one that you know is welcoming. Some of the lesbians are probably gender-non-conforming, in which case it is actually – they probably have to be *nudged* by their healthcare provider to take care of body parts they may not identify with as much. So, for all of those reasons, we think that the answer has everything to do with a history of adverse experiences in the communities with healthcare providers. [01:21:00]

ANDREA WASHINGTON, LCSW-S, PRESENTER: Can I answer that, Adam?

HARVEY MAKADON, M.D., PRESENTER: I think it is another…

[Crosstalk]

HARVEY MAKADON, M.D., PRESENTER: Oh, go on, Andrea.

ANDREA WASHINGTON, LCSW-S, PRESENTER: Well, one of the other reasons is that lesbians and bisexual women are also less likely to have health insurance up until the Affordable Care Act. So prior to the Affordable Care Act, lesbians and bisexual women were not in a lot of jobs that provided health insurance and, therefore, health insurances generally wouldn't pay for mammograms. Mammograms are not something that just can be done in the doctor's office, so that is also one of the contributing factors.

HARVEY MAKADON, M.D., PRESENTER: I think…

ADAM SWANSON, MODERATOR: Yeah.

HARVEY MAKADON, M.D., PRESENTER: I also – I think that both of those are sort of structural things that are really important, but another one really goes to kind of clinical education so that a number of clinicians assume that, if someone is a lesbian, then they may not be having sex with men and, therefore, may not be – kind of being exposed to human papillomavirus that causes cervical cancer. [01:22:01]

That is – that is *not* true, and so, therefore, it is important that lesbians and bisexual women have pap smears and mammograms according to the same recommendations as for *all* women. And I think it is *also* important that we begin to think that all transgender people are not the same, and that some are going to have a cervix and some aren't going to have a cervix, depending on what kind of course they've pursued, so that some transgender women - some transgender men are still going to need to have a pap smear. And so we need to learn to understand those things and ask people about things; although, it is a – it *can* be a very sensitive issue to discuss. [01:23:02]

ADAM SWANSON, MODERATOR: Great. So I'm going to ask our last question. This question has been asked *multiple* times. It says – or some version of this, "How does an organization address stigma and/or negative attitudes and beliefs about LGBT individuals among staff? And how could an *employee* in a non-leadership or non-decision-making role help to implement more compassionate attitudes within the organization?"

SCOUT, Ph.D., PRESENTER: I have a good example. Recently, at Veteran's Hospital, a nurse in the Veteran's Hospital decided that she wanted to do a better job with LGBT patients. And, of course, she was *not* in a leadership role whatsoever; she is not LGBT, so she didn't even have her own, personal experience to pull from. But, in some ways, it almost *freed* her to be more of an advocate. And, of course, there were hostile people in the hospital but there were welcoming people, as well, and she just kind of went on a one-woman mission to go up to the leadership to find the doors that were welcoming, find the doors that she could open up; connect with *outside* resources – in this case, it was the local SAGE Organization doing more training – that is the LGBT elder group. [01:24:11]

And so she brought them into to advise. She kept banging on those leader doors until the leaders said, "Yes, we agree." And it ends up, it is about a year later now, and the hospital is one of *the* leading institutions in the area with LGBT work. They have an LGBT ombudsman. So while she had some barriers, she just kept going until she found open doors and decided the change needed to *happen*. Even though she had no *authority* herself, she [chuckles] *just* made it *happen*.

ANDREA WASHINGTON, LCSW-S, PRESENTER: That is actually [inaudible at 01:24:44]. It is – it does take that one person who is willing to be an ally. It takes that person who is willing to be the one who may be identified as the LGBT person at this organization, and they're knocking on doors as well as in talking with the consumers, and even possibly getting *them* involved by saying, "Hey, we need this care. Hey, we want this type of care. Hey, we need to know that this is a safe place." [01:25:12]

And *then* the people who are part of the powers that be start looking at what – the policy that needs to be enacted and put in place in order to say, "Hey, we *are* that safe place. And, yes, you *can* receive quality care from us." So that one person can change a lot. They can change the world.

[Silence for seven seconds]

ADAM SWANSON, MODERATOR: OK, great. And I think, with that, we're going to move to the end of this presentation. You'll see displayed on your screen now the contact information for

everyone that spoke on this webinar. If you want to contact *any*one, please feel free, for additional resources and/or information. [01:26:00]

Before we move on, I want to thank our panelists for speaking on today's webinar. Please note their contact information, and contact *any* of us if you have additional questions or requests for information. If you have *other* questions in regard to this webinar or other Center for Integrated Health Solutions' resources, please e-mail the Center for Integrated Health Solutions at integration@thenationalcouncil.org.

And, as a final reminder, a recording of this presentation and the webinar slides will be available at www.integration.samhsa.gov, within 48 hours.

Thanks again for tuning in today and have a great day.

HARVEY MAKADON, M.D., PRESENTER: Thank you very much.

SCOUT, Ph.D., PRESENTER: Thank you.

ADAM SWANSON, MODERATOR: Thanks a lot, everybody. Go make some change!

END TRANSCRIPT