Clinical Education Initiative
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CREATING AN LGBTQ-AFFIRMING PRACTICE

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3/16/2022

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[video transcript]

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Today's speaker is Dr. Noelle Marie Javier. Dr. Javier is a hospitalist geriatrician and palliative care specialist with the Brookdale department of geriatrics and palliative medicine. Her areas of interest are intelligent palliative rehabilitation, pain management, wound care and geriatric slash palliative care for the LGBTQ plus community. Dr. Javier is also a new CI faculty, and helped create today's training in collaboration with sci fi. And there's one fun fact about her that she likes to sing. So like to welcome you, Dr. Javier. Thanks for collaborating with us here at sci fi and presenting on your expertise. And I'll let you take it from here.

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Thanks so much, Tara for that wonderful introduction. And I really want to give a shout out to see AI and also Mount Sinai Institute for Advanced medicine for inviting me and giving me the opportunity to present. And the title of my presentation is creating an LGBTQ affirming practice. So I do not have any financial disclosures. So there are really two main learning objectives that I wanted to tackle in today's session. The first one is to describe key concepts, constructs and guiding principles in the cultural understanding of the LGBTQ population. And the second one is to provide some practical, inclusive and affirmative communication and clinical care strategies for this population. And I really wanted to go back to the basics and just put, you know, a landscape on how we can care for our patients who identify as LGBTQ plus. So I would like to start out with some epidemiologic data. I think everyone is probably familiar with a Gallup poll, but if not, this is, you know, a think tank poll that really collects information, really a lot about various identifiers. And in particular, what we're really interested in is the LGBTQ plus population. And it really has to do with a two questions, what is your gender identity and also your sexual orientation. And the Gallup poll has been instrumental in collecting data around identities of the LGBTQ plus people. And as you can see, there has been an upswing in terms of the proportion of individuals identifying as LGBTQ from 2012 at 3.5%, all the way to 2017 at 4.5%. And then there was a lapse between the years 2018 and 19, and then a reset in 2020. Again, there was a notable uptrend in terms of the portion at 5.6%. Of note, the most recent one, with the 2020 data is really looking at respondents of about 15,000 individuals, and majority of them identifying as women and also identifying their sexual orientation as bisexuals. Now, I wanted to focus a little bit more on the one in 2017, where the proportion was 4.5%, because we definitely have a more robust data as far as the number of respondents to the poll. At that time, they were able to collect responses from close to 350,000 individuals. And at that point, they were able to estimate that the LGBTQ community comprised about 4.5% of the population. And that's about 11 point 3 million out of the 323 million back in 2016 2017. About 40% belong to the, you know, racial and ethnic minority groups. And I also have to highlight that one of the marginalized within the marginalized is as our older adults. So in the data that we have, it was at the age range of 50, and above about 2.7 million individuals who are in that age group. But if we're really really looking at the geriatric population, which is defined as 65 and above, close to a million comprised LGBTQ plus population. Of note the transgender community was estimated at about 1.4 million. We don't really have data on the gender non binary or gender nonconforming cohort, and that's something that we will have to look forward to in the

upcoming surveys. So we can also identify that one in every 200 Americans identify as transgender.

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So I wanted to be able to highlight a friend of mine who died a few years ago because I think that he was one of the pioneers as far as advocating for inclusive and affirmative healthcare. His name was Jay callow. And he was a great advocate. He was such an extraordinary man. And he really, he and I talk a lot about some of the barriers that lead or that leads to disproportionate care affecting the LGBTQ plus community. And as you can see in this schema, you know, it has to do with the fact that there is still increased invisibility and also the practice of implicit and explicit biases. There are also structural barriers, financial constraints, lack of provider education and training, a long history of stigma and oppression towards the LGBTQ plus community. There's also gaps in research and gaps in policies and regulations. And that and these domains are not mutually exclusive. They they overlap, and they intersect in many ways. In 2016, the National Institute on Minority Health and Health Disparities designate that the sexual and gender minority population or the LGBTQ plus community as a health disparity population, so and we know that because first of all, they're you know, marginalized. And as you can see in the in this map a geographically, it's unfortunate that in the year 2022, up to 29, states are still without LGBTQ non discrimination protections. A lot of the protections are centered around the Northeast, the West Coast, a few in the Midwest. And in really, the South is not really having a lot of representation. And this is there's still a lot more work to be done as far as regulatory considerations are concerned. There is robust evidence that there are significant health care disparities within the LGBTQ plus community. In fact, this the next two slides will highlight the evidence based approach and data around health care disparities that you know, the LGBTQ plus community experience harassment and refusal of care by staff. There's definitely fear of persecution and discrimination on the basis of sexual orientation or gender identity known as Sochi. Only a third felt that they could be opened with staff about their Sochi, there are significant gaps in knowledge and training for all clinicians and staff. transgender and gender non binary individuals are openly made fun off with over disapproval from staff and other long term residents. And there's also changes around LGBT inclusive questions a national survey, such as the national census and the Older Americans Act, which you know really impacts more of the visibility and representation and hence the equitable allocation of resources. There's also known increased financial instability and lower earnings across lifetime compared to the cisgender heterosexual cohort. There is also a reliance of informal caregivers for social support, because these are actually called extended families, chosen families or lavender families, because their nuclear families have either ostracize them shun them or really discriminated against them. It's also known that bisexual older adults have lower levels of social and community support. And with respect to our transgender and gender non binary Optimation 1/3 of them on the MetLife survey survey were uncertain if they even have future caregivers to take care of them when they get older. There's definitely greater risk of physical disability, psychological distress, mental health, obesity and cardiovascular disease. And there is also robust data to show that there is lower utilization of health maintenance and preventive screenings. In this slide, I wanted to highlight just to focus on transgender adults at large because we I wanted to be able to compare and contrast the data that we have on hand with certain risk factors compared to the general population. As you can see under right it is an

overwhelming difference in terms of the data that we have as far as HIV infection rate, incarceration, the rates of homelessness, whether it's they've ever been homeless or current homelessness, alcohol or other substance use. And so we signed a tab which is really significant at 41%. And across the board, you can see a exponential or really a linear relationship with that, and the numbers are quite staggering.

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So this healthcare disparities are important for us to call out this elephant in the room because there are significant math effects in the personnel and health care of these individuals. A lot of them read returned back to the closet and for transgender and gender non binary individuals, they end up the transitioning which further leads to more invisibility and lack of representation. There's also ongoing unmet healthcare needs. And these will have some consequential effects on the physical and mental health of individuals such as isolation and depression. There's definitely low rates and delayed utilization of preventive and, and other health related services. And also, what is more important, but it's also very significant is the fact that there couldn't be complicity of health systems to ignore the needs and concerns of this vulnerable population when in fact, healthcare as a system, the primordial, you know, area of interest is really to provide inclusive and all encompassing care. But if there is complicity of healthcare systems around the disparities that exist leading to this matter of facts, we can just imagine that the cycle of oppression and victimization can will continue to commence and progress. There's also unfortunately a lack of investment and commitment to training and other resources. And there's also a lack of standardization of policies protecting against discrimination and prejudice, as evidenced in the previous lines. So why are we here today, you're all here today, because you are taking the first step in answering the call to action. In 2011, the Institute of Medicine, delivered its first report of the Institute of Medicine has now been renamed the National Academy of Medicine. And what they figure out is that there is significant or significant gaps in research towards LGBT people's needs, concerns and priorities. And you know, as a provider, as a physician, myself, I am supposed to provide care that is inclusive and affirming and affirmative, and independent of anyone's race, color, religion, national origin, sexual orientation, gender identity, or any other identifiers that define an individual or to describe an individual. The good news is that you don't have to be identified as LGBTQ to provide this best practice and care well. And also, I think that it's a stereotype that just because somebody is identified as LGBTQ, that they are, in fact experts in their care. I think that it takes a village and for as long as you have a progressive and open mind and heart, to be able to practice cultural humility and engage in cultural competency and sensitivity training sessions, then I think you're on your way to success. So as evidence in the multiple, you know, different disciplines from geriatricians, to internist, to the nurses, to the physician assistants to the chaplains, to the psychiatrists, everyone is really now on the bandwagon, and putting out a lot of executive summaries, some best practices, some stance on minimizing healthcare disparities, and we've definitely come a long way compared to 4050 years ago. However, you know, as we know, this is not a stagnant event, and we need to continue to be dynamic and fluid and progress in the right direction.

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I also really wanted to highlight the area of how to care, you know, because that's also one of my expertise, but also the fact that we cannot deny that LGBTQ individuals will experience a

serious illness at some point in their lives. And I think that, you know, focusing on the provision of high quality, hospice and palliative care is definitely integral to any type of medical care that's provided. I was fortunate enough to partner with a lot of these experts, researchers and clinicians around LGBTQ plus care. And we were able to do a cross sectional study using an online survey measuring discriminatory behavior targeted towards the LGBTQ population based on their Soji data. And we've actually included 865, hospice and health care providers. And the net results are again, quite, quite staggering. Sorry about that. So 64% reported a transgender patients are more likely to be discriminated against. About a third of them reported actual observation of discrimination towards transgender patients. 14% observed that sexual and gender minority partners were disrespected. And more than half of the respondents thought that LGBT patients were more likely to be discriminated against. One might think that the data that we've provided is not necessarily rocket science and that this is something that already exists. However, in this day and age when everything happens when it's in writing. I think that this will definitely contribute to the evidence to the literature that we have on hand. Now looking at some of the Important anecdotal comments, there were a lot of really heartbreaking stories many jokes made targeting transgender patients giggling about the use of pronouns. During a code situation, staff were making jokes about what pronoun to use, a woman of trans experience in the ICU was critically ill and dying. And the primary nurse refused to use her pronouns. The case manager referred to transgender and a partner as it instead of, you know, the proper pronoun, and was really accommodating a lot of mistakes overtly using different types of pronouns, you know, when in conversation. And you can see a lot of, you know, really appalling types of behavior in the form of Job's microaggressions. And really overt discrimination, as seen in this particular slide set. And really, the takeaway here is that disrespectful and discriminatory behaviors observed towards transgender patients are quite again, staggering. And, and really heartbreaking. And to know, and especially now, in the 21st century, this was a study that was done initially in 2019 2020. So you can just imagine that in this day and age, there's still a lot of discrimination and oppression that's going on in our in a different in long term care settings. Now, I just don't want to focus on sort of like the Grim side of the reality that LGBTQ Population fees, I think that, you know, because of the long standing oppression that has happened, I think that the community has definitely, also recently location to make sure that they are prepared when it comes to end of life care. So you, as you can see a lot of our LGBTQ plus community and patients, and really discussing end of life care preferences with their primary care provider, they've also ended up really complete completing living wills and advanced care directives, such as self care proxies, and living wills. And there's definitely much more of that, that we see compared to the national sample, you know, again, comprising of cisgender heterosexual individuals, now, we can see that the trend is definitely higher. As far as the completion rate. However, we definitely want to target more of this. And I think this also has to just have to do with the fact that healthcare providers in the primary care setting and those in the inpatient setting may or may not necessarily discuss advanced care directives with their patients, regardless if they're LGBTQ or not. So that's another topic of its own. But I just wanted to highlight that in this talk,

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along with, you know, some of the good points in resiliency is that we can see, there's definitely hope, in the present and also in the future, you know, for for now, at least with the national

survey for older adults, American, you know, project, we are able to really collect data now in terms of Soji information, Well, initially, so g and then during the previous administration, they took up so G and then they put back the so but not the G but it's better to have something than nothing. And I'm pretty sure that right now, with the current administration, they're gonna, you know, make sure that this is not reflected in the surveys. And this is critical, because the Older Americans Act, provide services in the form of transportation meals, and also homemaker services. So just imagine if you have an LGBTQ older adults 65 And above, and they are not visibly seen and represented in national surveys, you can just imagine that resources will not be allocated for them, and they will continue to be victims of oppression within a disjointed healthcare system that is not acknowledging, you know, the presence and existence of LGBTQ plus community. There's also a lot of lobbying around LGBT data inclusion Act, which is really something that the Congress that the the people in Congress are trying to lobby for. So that again, all the national and federally funded surveys will include Soji information. Now, in terms of the transgender and gender non binary community, there's also great news because the current administration did his President Biden first did address the joint session back in April of 2021. And he really shed light on the fact that he was all for and his administration was offer advocating for transgender Americans. And we and then the month before that, in March of 2021, the house was able to pass the LGBTQ rights bill. Now I could not overemphasize the success of this LGBTQ rights bill, if it gets passed into law and signed by the President, because this will really be an overarching encompassing policy that regulates services without discrimination around Soji. So you can just imagine that in areas of public accommodation, housing, employment Education, credit, federal housing and other benefits, you know, from a federal and also a state level, these are all going to be encompassed in that. And that's going to be a huge landmark policy change that for the LGBTQ progress. And we also know that Rachel Levine is the first openly female secretary of transgender experience, who is the assistant secretary of health. In the nursing home setting, there's also good news that, you know, there is the there was the creation of the Federal Nursing Home Reform Act of 1987, which if all, and anyone in the room who is affiliated with a nursing home or an Institute, an institution of the same caliber, effective enactment of this can significantly increase knowledge gaps as far as cultural sensitivity training, and definitely be helpful and instrumental in shifting culture around negative attitudes. And also, I think it's really, really critical that open and visible LGBTQ staff will be hired because I think that, you know, that definitely says a lot about the organization. But more over, there's also going to be expanded research on just the the needs and the care needs of LGBT others and long term care settings. And there will also be stronger collaboration with other institutions for systemic and structural changes. I included the LGBTQ healthcare bill of rights, which actually in my institution at Mount Sinai Hospital, if you go into the main lobby, this is literally like plastered on the wall as you enter on the left hand side and the main lobby, so you cannot really ignore this. And it's such an empowering signage that really tells the, you know, people walking through the doors that this is an institution that is diverse, inclusive, and provides affirmative care to everyone, including LGBTQ individuals.

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I also wanted to point out that in long term care services or long term services, such as nursing homes, adult daycare centers, assisted living facilities, residential care facilities, and even in home environments that we have now at least in our state have created what we call aging in

place, or aging in places for this matter, because we actually have one that's already open now. It's called the Stonewall house in Fort Greene, Brooklyn. And it is a very inclusive and affirmative housing for individuals within the LGBTQ community to feel safe, to have space that they can call home and have access to services. So the units are all all taken up. And it is important to note that this was in partnership with ch, which is the service services for an advocacy for elder GLBT individuals. And the partnership created the Stonewall house, which again really targets you know, providing affordable, affordable housing for individuals and LGBTQ plus community. Of note, this house is not exclusive to the LGBTQ community, people who do not identify can also take advantage if they wanted to live in this environment. So that's just another plus that again, it's all about inclusivity. Now, the partner housing it's called Katana senior residences and microtonal park up in the Bronx, this is still a work in progress. And if you actually go to the website, you can see more information and how you can also help raise funds in order to to create an established senior housing. So I wanted to dive into the first main objective after that introduction, because I think with the introduction, I'm able to lay the groundwork as far as why we're even having this conversation to begin with. But I think now that we're segwaying into the first objective, I wanted to provide some context as to how you as providers, whether your nurses, your psychologists, social workers, chaplains, students, physicians, administrative staff, rehab, whichever discipline you're in, I think understanding some guiding principles and some constructs around the LGBTQ plus communicator community, LGBTQ plus community will hopefully provide you with some guidance and in terms of how you're going to move forward with the care and really show that empathy because there's a lot to unpack here. So, I think that if we can develop a cultural lens of understanding in the set in this in the sense so that all of these important domains are going to be tackled, I think that we can definitely fortify and strengthen our knowledge, our knowledge base and also our competency. So I'm talking about so gene, which again, stands for sexual orientation, gender identity, I'm also going to touch on a little bit about the minority stress model. A little bit on unconscious bias, we'll definitely talk about intersectionality lived experiences of the especially for the LGBTQ plus community. We're also going to talk about resilience and robustness, because not everything is sad about how we have about how the community has thrived. In fact, if our anything the resilience and robustness really overshadows that of the long history of oppression, because people have definitely risen up to the occasion and have tapped into resources, both internal and external, in terms of navigating and mitigating some of these stressors. And I think that by the end of the first objective, that we would then develop a sense of cultural humility, so that when we go back to our respective institutions, we can really take this with with us and also help spread the word and and teach other people. So sexual orientation and gender identity I like the the gender unicorn and also the Sochi Venn diagram, because it really highlights a distinction between all of these different constructs. So, gender identity is that internal sense of the individual or the core sense of the individual, identifying as either a woman or female men or male and or non binary, or a little bit of both, or none at all.

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So, which is also called the gender so you know, gender identity is different from the sex assigned at birth, where we distinguish them as two distinctive constructs, because this will then shed light into the transgender identity. So the sex assigned at birth has to do with your chromosomes, your anatomy, your physical, you know, your physiology, genetics, obviously,

you know, falls into that. And then there's also the gender expression, which is really the external manifestation of how you you would want to present and which may concur with your gender identity or not. So, gender expression is really the expression that you have independent of how you will identify as and you know, sexual orientation, on the other hand, is really it has to do with your relational affectional sexual attraction, behaviors, relationships, to a member of, you know, different types of identities and orientations. Now, the opposite of transgender is cisgender, or non transgender. And that essentially means that your sex assigned at birth, typically based on anatomy, and genetics is concordant with your gender identity and who you identify yourself as. So an individual who is assigned male at birth with penile and scrotum parts, and identifies as male, is considered cisgender. Whereas an individual who is assigned male at birth, again with female and Scotto parts, and do not identify as male, and rather, let's say, identify as female, are considered transgender and transgender female. Now, the Venn diagram on the right hand side really looks at the intersection of all of these constructs, because they are all interrelated, and they're not, again, mutually exclusive. They all overlap in one way, shape, or form. And they actually make up kind of the, you know, a good description of just the totality of the person. So in 2017, the equality study was created in the Greater Baltimore area, and this was featured in The New York Times looking at clinicians, particularly in the emergency room setting or trying to elicit information around Soji. So this was an exploratory sequential mixed method design in the Baltimore area, there were 53 patients, for the live interviews matched with 26 health care professionals. But then when it came to the online, part of the study, there were more than 1500 patients and for close to 450, IDI providers and they did online surveys, they collected demographic information, so chi and so forth, and across the board, the mean age was about, you know, close to the same. And what's really important that I wanted to highlight here was that only 10% of patient reported refusal to disclose their Sochi information, but The more staggering thing about this is that more than two thirds of the providers thought that patient would review Soji information, it did not really go into sort of the explanation why that might be the case. But we, you know, we can only imagine that perhaps the the providers might not have felt that that was a relevant piece of information, or maybe within the provider, himself or herself or themselves, that they are not comfortable asking these types of questions, because it might seem intrusive, so or maybe just the fact that they're just not really trained. And that's just not something that really crossed their mind. So there's a myriad of reasons to explain this. But this is really important to highlight because this means that we have an opportunity to do education and to be and to be impassioned about really advocating so that this is now going to be standard and practice. So if we standardized patient centered approach, and so data collection, then, then that's a great feat. Now, in a parallel study, they also just looked at the transgender community. And again, they looked at different, you know, respondents and got them their demographic information, majority identifying as male, Caucasian, and the sexual orientation, about a third of them was other than LGB s, with s being straight. Again, the overwhelming majority 89% felt that gender identity was more important to disclose. However, when asked for both respondents felt that they're able to disclose votes for as long as you know, the clinicians are interested in knowing about Sochi, and in fact, really getting to know that person and putting it on, and putting it into context. So that, you know, that's a way for them to personalize the encounter.

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So how do you operationalize that? So if you have electronic medical record, you can just include that in your demographic information. So when a person walks in, you could have your administrators put in the right answer, or you could give a link to the patient's and they can access the link they can put in their information themselves. Or you getting if you're not using electronic yet, you can still use paper charts. And then I think being intentional about putting questions such as What is your gender identity, putting a lot of options in what is your sex assigned at birth, and also what are your pronouns, I think is a way to provide and give that visibility and representation. So here at Mount Sinai, if you guys use epic in your respective institutions, you know, you might want to check and see if you enter demographic information, you can actually look at Sochi as part of it. Thankfully, at Sinai, this was years in the making, and we were able to put in the electronic on the electronic medical record Soji information as is depicted in this slide. And this has been really helpful for providers to you know, name and identify and really call out individuals for who they truly are and, and to be seen as who they truly are. In the palliative care realm, six national palliative care organizations joined together to form this Palliative Care Quality Collaborative. And really, it was aimed at promoting a unified data registry at both programmatic inpatient and outpatient levels. And I was fortunate to be part of this, you know, to this advocacy, because when we looked at sort of the template for what was going to be the next steps in, you know, in terms of visibility, there was not really a lot of mentioned about Soji. And so thankfully, we were able to pick to pick this up earlier on, and to make our boat make a bold claim that you should now be part of care, because, again, we would be hypocritical to say that this type of subspecialty care is inclusive, but then it does on Sochi and pans will just put the LGBTQ community in the dark. I'm gonna segue into the second construct, which is minority stress model. This was created or devised by Dr. Ilan Meyer, who is an American Psycho epidemiologist, and he's also a scholar for research and policy. And he created this minority stress model. So what this essentially means from left to right is that as a human being in society, we are all exposed to circumstances in the environment and those circumstances could be rough or they could be supportive circumstances. However, if you are a minority belong to the LGBTQ plus community. And again, notwithstanding your other identifiers, whether you're also Latin x, or you're African American and so forth, just imagine that there is an aggregate effect on your minority status as regards to all of these identifiers. And those cause significant stressors. And those stressors then pile up to the general stressors, where you just want to thrive in society, you just want to live, you want to just go to school, find work, make ends meet. And then you still have to deal with some of the oppressive, that you know, patterns of behavior, that society at large displays towards, you know, the LGBTQ plus community. And what I also really love about this is that although the the piling up and the stacking up of all of these stressors on top of the other, could lead to negative mental health outcomes, it could also do the reverse. And it could, in fact, also do lead to positive health outcomes, physical and mental. And the way that I say that is the fact that, you know, over time, when you are in an oppressed situation, you then develop a sense of resiliency and robustness, you know, in terms of valence and prominence and integration, and also coping and social support, and people, you know, people but in general, and by and large, are survivors, and they will find a way to be able to thrive in society, and live as they should be. Now, we cannot deny that over time, a long history of oppression has been really imprinted. You know, in, you know, since time immemorial, from all the way even before the 1950s, quite honestly, when homosexuals were classified as perverts to the Stonewall riots, which really started up the, you

know, the modern Gay Rights Movement. And thankfully, in 1973, the American Psychiatric Association,

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you know, remove homosexuality as a mental illness. We've also seen significant strides in some of our advocates from Harvey Milk, to the repeal of Don't Ask, Don't Tell, and also DOMA. And in 2015, we were able to recognize on a federal level, that same sex marriage is valid, and that partners can enjoy the benefits, the same way that cisgender heterosexual heteronormative cohorts do. And this is a great stride in the right direction, and really quite a feat, you know, in the LGBTQ plus community. I'm gonna segue now into the third construct, which is unconscious bias, I think that all of us are guilty of this, we all have our biases, whether or not it's, you know, towards LGBTQ plus population could be other, you know, other minorities and other cohorts, we have to acknowledge that. But I think what is probably more important is how we tap into these unconscious biases, especially if they're negative, and try to rectify the situation by creating a positive change and opening, opening up our minds even more. And I think that if we're able to engage in unconscious bias training, and that's one way for us to really mitigate unconscious bias that exists, because unconscious bias leads to more progressive stereotypes microaggressions, and even overt is leading up to discrimination, hate crimes, hostility towards others. The fourth concept is intersectionality. Why do so I'm going to spend a couple of minutes here because I think that this is really important for us to identify intersectionality is you probably heard me say over and over again, identifiers domain, some of the buzzwords and you know, I think that the reason being is that an individual if you look at it from a holistic standpoint, it's not only defined by a certain identifier, or domain, we all know that, you know, we're, you know, we're more than our physical bodies, there's a psychological a spiritual element to us, there's a social interpersonal component to us, there's a sexual component to us, all of these things, you know, all join together can fluently to really create the person that we are, unfortunately, because of the complexities and the layers of identifiers that we have, we end up also being the recipients of certain forms of stigmas, which can then lead to further stressors leads to further oppression and healthcare disparities, which is really the, the gist of, of this, of this talk. So I think that being able to know our intersectional selves and who we define and describe ourselves as is really, really important for us to have a good understanding of ourselves and also of the patients that we care for. I'm going to put myself as a case study here So I am a woman, first and foremost, who is a straight woman, heterosexual woman, and also identify as transgender. And I was born transgender, I'm also an immigrant. And in 2015, became a naturalized American citizen, I'm originally from the Philippines, I did all my medical school training abroad of Asian descent Filipina. And in this card, in this cartoon, you can see all of the different intersectional identities by hold from challenges and strengths. And that really make me the authentic and unapologetic and apologetic woman that I am. That, really, that I really wanted to highlight, and thereby cementing my place at the table. And the reality is that, you know, my life is that it's fascinating, maybe to a few, but in close, in another microscopic level, I'm dealing with the same type of stressors as everyone in this room, have, I'll be it, I probably have a little bit more, because I'm also in a more nuanced space. However, I also take pride in the fact that I've built resiliency over time, that really allowed me to thrive and exist in society and, and make a name for myself, from family supports to being an inclusive environment. But and I also had

my fair share of challenges being victimized, you know, microaggressions, and, and sometimes overt discrimination.

41:40
Which brings me to the lived experiences of individuals, such as myself, and really everyone else, whether you're LGBTQ or not, I think that our lived experiences, really has a lot of bearing in terms of defining who we are. And so lifecourse theory posits that there are multiple transitional points that are impacted by society history and gender roles, and that as LGBTQ adults age over time with the goal oriented theory, that their experiences are shaped by challenges and triumphs while striving for life's goals and developing their core sense of being. So an affirmative tip here is just listen to the story of your of your client or your patients. And keep that open mind, keep that open door going. And I think that you will be able to establish rapport and really engage with that individual and provide that person with the best care possible. talk a lot about resilience and robustness. And I could not overemphasize the fact that this is one of the highlights of, you know, just the journey going being part of the LGBTQ plus community. And the community as a whole that we've developed individual and community based resiliency is in the form of spirituality, volunteerism, advocacy, hearing relationships, engaging in exercise. And that really allowed us to develop what we call crisis competence, so much so that when we are subjected to significant stressors, nothing really will faze us anymore. And I think that we're now able to tap into our internal and external resources, so that we can really rise up to the occasion, and, and live the lives that we're supposed to live. Which brings me to the last construct that I wanted you all to have a sense of understanding as well as we're trying to develop cultural humility. I think that the principles and tenets of cultural humility is something that that says a lot. Wonder is a lifelong commitment to learning and critical self reflection. There is a desire to fix power imbalances within the provider client dynamic. And there's also institutional accountability and mutual respectful partnership based on trust. And if we put in the, you know, the traits or the attributes of openness, egolessness, self awareness, supportive interactions and self reflection, then that is a major milestone, as far as really providing compassionate, culturally humble, culturally sensitive care to the LGBTQ plus community. And again, I salute each and every single one of you who attended who attended the session, not just today, but for all the sessions and sessions in the past, because this really says a lot about your commitment to providing the highest quality of care to patients who belong to the LGBTQ plus community. So now, where do we go from here? So I think that it's great that I was able to share with you some epidemic, epidemiological data, and also highlight some constructs that is certainly helpful for for all of you to kind of anchor your your assessments regarding your your patients, but at the same time, I think That would I would be remiss if I did not operationalize this and put this into like a tangible, affirmative and inclusive practice strategies. So, I think that creating a welcoming environment is truly essential, right? In the title of this talk is creating a safe space for affirming care? And how do you how are you able to do that. So you have to make sure that the in the physical space is really conducive and inclusive of the LGBTQ plus community. You can put some signage, you can train your, your, your your staff on how to interact with individuals, you can put a friendly symbols and stickers and magazines and other paraphernalia that will be helpful to let the individual know that this place is, you know, LGBT inclusive, and affirmative. Again, just in the Sinai setting, we do have the signage regarding the LGBTQ healthcare bill of rights plastered on the wall. But we also have a

lot of others, you know, visible indicators, like we have pins that say we don't discriminate, we have bands, showing the rainbow flag, the equality sign from the Human Rights Campaign, the pink triangle, are familiar in some of the offices. And again, electronic medical record goes a long way, if you have those Soji on there, that is really, really important. So and I think that this also goes to the fact that we, apart from the physical environment, we also need to start changing the mindset of the staff and really developing the skill set as far as communication is concerned.

46:40
So in terms of the patient encounter, I think that we need to understand the rich history of the LGBTQ plus population, we need to be intentional in changing negative attitudes. And we also have to be kind of patient ourselves. This takes time. And you know, again, showing openness and and being patient with the change, I think is really crucial as well. normalizing the collection of Soji information is definitely helpful. Listen to the story of the patient, that's always a plus. And that's integral I think that too, to everything that we do, and also practicing the dignity question, Harvey Max Jojen knob is a palliative care specialist out of Manitoba, University of Manitoba in Canada. And he created this one simple straight to the point and yet very compassionate question, what do I need to know about you as a person to give you the best care possible and if the person is you know, comfortable enough to share their LTE ears, they're so Gee, then that will start the conversation. And then the next thing you know, you'll they'll be sharing their lived experiences. And then you will have a more compassion, compassionate plans as far as providing care for these patients. Also, engaging in advanced care planning conversations is really, really important involving the interprofessional team, rely, you know, making sure that you have tapping into resources, both internal and external, with sage in the safe zone project support groups. standardizing the policies I think is really important. And last, but not the least expanding research and now we're in the cap. So some more case study for the next three minutes or so. So this is a case vignette, you are the clinician taking care of a 57 year old person with a medical history pertinent for osteoarthritis, hypertension, diabetes, HIV, coronary artery disease, this patient was transferred from a nursing facility after a fall resulting in a left arm of fractured brain surgery. You had just attended this session, Dr. Javier gave and you would want to practice your skill set as far as cultural humility training that you have obtained, how do you go about taking your history and physical examination and just starting the process of interaction? So you can start with reading the patient by saying hello my name is Dr. Heavier My pronouns are she her hers? You are so in. So how would you like to be called? What are your pronouns? Moreover, you can again, just use again if, if, if for anything, if you just had one question to choose from just use the Demeter question. What do I need to know about you as a person to provide you with the best care possible? You can always preface your conversations to say that this part of elicited can affirmative care, I asked my patients, you know all of these questions, and provided this has not been already elicited in the electronic medical record. And you can go ahead and ask this OG information. If you're doing a psychosocial history, you can ask about the important people in the person's life, current living situation relationship status. You can also ask about advanced care directives. When you segue into the physical exam. It's very important to ask permission is it okay if I do a physical exam for our transgender and gender non binary patients? You might want to ask them how would you like me to proceed with a physical exam? How would you like me to do able bodied parts? Is it okay if to have this exam

by yourself? Or would you prefer it if your partner friend or caregiver is in the room? You know, and doing a full anatomical inventories is critical, because you're also providing, you know, Oregon based medical care. Sexual Health Information is one of those very, very sensitive topics. And if you're not comfortable with eliciting sexual health information, then that becomes a challenge because then patients will not be comfortable divulging that information as well. Again, you can do some priming statements that preface it to say regarding your sexual practices, is it okay if I asked you that this is part of, you know, sexual health history taking, and I really want to be inclusive of that, please feel free to share information that is that you're comfortable with sharing. But I think you know, the other thing that you can also do in the beginning is giving them an opt out, you can tell them if this is you know, too intrusive, or you feel like this is too personal, we can always put that in the back burner. And we can kind of get into it at a later time. When misgendering, a transgender and non conforming patient, you can apologize for the mistake, you immediately call the patient with the right name and pronouns, and then you move on, don't dwell on it. And if you make the mistake, you know, another time, apologize, move on, and also do your own internal reflection. Because what will happen is that, you know, it's always good for us to learn from our mistakes, and really being intentional about it so that we don't make the same mistake again.

51:41
If you're doing a goals of care conversation, when somebody has serious illness, you can definitely again use the dignity, dignity question. In palliative care, we use a lot of communication tools, such as these acronyms that you are seeing on the on the screen, we want to be able to contextualize the goals in the setting of the constructs that I've just described to you all, you want to include chosen families in decision making, and you want to rely on other members of the team as well.

Tara 52:09
So

52:11
as I come to a close in my presentation, I would just like to leave you a few take home points. The first one is to recognize and appreciate that the adult and older adult LGBTQ plus population is a marginalized community with unique healthcare needs impacted by significant disparities in a provision and access to essential health health care. And this includes primary care, HIV care, palliative care, end of life care, you name it, any type of medical care, I think that it's really really important to develop a sense of Lancer cultural humility, and that constitutes, you know, doing training sessions around competency and sensitivity training, and really incorporating some of the constructs and the guiding principles that were shared with you earlier. Because again, that will anchor your knowledge and your approach in terms of providing high quality care for your patients. I think that we need to be deliberate in changing attitudes, beliefs, and practices, so that we will provide whole person and caregiver centered care. And finally, there continues to be gaps in research in federal and state policies. Hopefully, they will catch up soon. Again, I don't want to be in the picture that we have not come a long way because we have. However, I think that there's still a lot more to do. And I am hopeful that the future will be bright for the LGBTQ plus community. I just included a couple of selected readings

and resources. I do want you to take a look at the YouTube videos Jen silent and also Vanessa goes to the doctor as part of your homework. If you're able to take a peek at that it's a really helpful way to understand, you know, some basic tips in terms of just offering culturally sensitive and humble, inclusive and affirmative care to the LGBTQ plus community. Finally, one of my favorite authors and an advocate for LGBTQ rights, James Baldwin, wrote this very important quote, not everything that is faced can be changed, but nothing can be changed until it is faced. And And with that, I hope that I was able to open those minds and and also change some of the lens in terms of providing high quality care for our patients who are in the LGBTQ plus community.

Tara 54:43
Thank you. Thank you so much. Dr. Javier. Just going to quickly describe this this slide here. I'll see you guys offerings. We have our C eyeline. We have a podcast out with new episodes and we have clinical tools that I include cards on HIV testing PrEP, PEP, and we also have gender pronoun buttons. So like to order those, you can go ahead and click the links when I also have the PDF, and you'll have direct links to those. But in the meantime, Dr. Javier, if you can go to the last slide, so everyone can see your email, just so they can connect with you if they have any questions. And we have time for maybe a few questions. We have one here in the chat. So in the meantime, if anyone else would like to write in feel free. So Charlie noted that, can we select more than one pronoun epic? I think it only allows you to select one. A lot of folks use more than one pronoun. It might be something to modify in the future iteration.

55:46
Yeah. So the answer to that? What was the name of the person again with the question, Charlie, Charlie, Charlie, thanks so much for the question. You can definitely do that. I think that it's a little bit of pulling hair with with epic, because you really need to work with them around that it's not impossible. But it requires a lot of patience. As far as, as I've said, this took us years, because there's just a lot of steps and a lot of hoops to shoot in order to just like a committee with epic would have to work with them. But in all intents and purposes, yes, I mean, people should be able to choose however many options they want to, they want to click on that describes them.

Tara 56:29
Thanks, everyone, for writing and thanks and everything. We appreciate you coming today to our training. And thank you Dr. Javier for presenting today. Really appreciate it.

[End Transcript]