CULTURAL COMPETENCY FOR CLINICIANS WORKING WITH LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PATIENTS

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Cultural Competency for Clinicians Working with Lesbian, Gay, Bisexual, and Transgender Patients
[video transcript]

This presentation, Cultural Competency for Clinicians Working with Lesbian, Gay, Bisexual, and Transgender Patients about Conducting a Sexual History and Behavioral Risk Assessment, is sponsored by the Clinical Education Initiative of the New York State Department of Health. The AIDS Institute. I am Maureen Scahill. I am a nurse practitioner and public health specialist with the Center for Health and Behavioral Training with the University of Rochester Infectious Diseases Division.

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The learning objectives for this talk are described. The rationale for developing cultural competency for LGBT individuals in clinical care settings, define common sexual orientation and gender identity terms, list three elements of conducting a sexual history and behavioral risk assessment for LGBT patients.

List three open-ended questions to ask about sexual, substance use, and health promotion behaviors, identify ways to enhance the cultural competency of colleagues and work place settings, and finally to identify resources for more information about health standards, continuing education, and patient materials.

The image here is in black and white and intentionally kind of blurred and the citation is below the image. The idea is you can look at this image and draw conclusions about what you're seeing but things are often not how they look.

What that image actually is is a bell pepper with a brussels sprout sitting atop it but it's in black and white and a little bit fuzzy. The point is is that what we see may not represent entirely what's underneath. As I said, the reference citation is here. And also, please notice at the bottom of the slide the little page icon. That's to remind you that there is a handout with this reference and others cited.

Let's talk about some demographics and disparities. The Williams Institute, often cited by, is with the UCLA law school, often cited by government references as a good source. They conduct reviews every so often to look at the prevalence of adult LGBT individuals in the United States. What they do essentially is a meta-analysis of several national surveys or polls and you can see they're listed on the graph. What they found in 2011 report they found that nearly 2 percent to 5.6 percent of adults in the United States,
based on these survey and their analyses, are LGBT with an average across all of them of 3.5 percent. This review shows a range of 2 to 4 percent. Basically, what I'm getting at is that they estimated, based on all that information and the data analyses, that there are between 5 and 9.5 million adults in the United States that identify as LGBT.

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We'll talk about disparities and part of the reason there are disparities is because of stigma. And this paper by Hatzenbuehler looked at the role of structural determinants. What structural determinants are are influences that are bigger than the individuals or even the clinic such that they affect everybody's, in terms of healthcare, access and so on. So, in this case Hatzenbuehler was looking at the role of the protective policies implemented in some states versus others. This is in the United States. So, those states that have so-called protective policies, it refers to hate crime statutes or employment non-discrimination policies that include sexual orientation as a protected class. The non-protective policies are those that don’t have those. So, you can see that there is the non-protective policy states are represented in red on the graph and those with them are represented in blue. And what was looked at was the psychiatric morbidity in those states. So, could you identify that there would be a difference of psychiatric disorders based on-- not based on but in association with these structural determinants. So, you see that on the graph, which the graph and the notation here are taken right from the paper. The graph shows you some psychiatric disorders, dysrhythmia, generalized anxiety disorder, and PTSD, and then finally a comorbidity graph. What they identified is that in the states where there are protective policies, the incidence or prevalence of those psychiatric disorders including comorbidity, which refers to two or more co-occurring psychiatric disorders, was quite a bit lower than those states that don't have protective policies. So, even just visually looking at the graph, you can see big differences. But they also include the odds ratios. It's an interesting paper. I would suggest you might want to look at it.

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Disparities and stigma for LGBT persons has been discussed somewhat and disparities and stigma for persons of color is well known. What about LGBT persons of color? So, since we know health disparities are already a significant issue in the United States for persons of color. For example, certain chronic diseases are more prevalent disparately in some racial and ethnic groups. Could be related to genetics often related to lifestyle, socioeconomic status etc. Mental health problems can be an issue for everyone but in some communities of color, this is associated with stigma and discrimination. Moreover, seeking mental health care is even a greater stigma. Lack of access to health care and prevention services, again, related to structural influences or socioeconomic status and so on. Discrimination then, of course, is also still prevalent for many populations of color throughout the United States and as we've discussed already, there can be disparities and discrimination and stigma for LGBT persons. But this synergy of racism and ethnic discrimination with LGBT stigma and discrimination is significant. So, for persons of color, internalized racism can occur. LGBT persons can internalize homophobia and transphobia. For many LGBT persons of color, this can lead to serious self-identity problems.
Although in communities of color, disparities and discrimination might be considered greater than for LGBT persons in general, looking at LGBT persons of color has been shown to be, like I said, lead to a synergistic effect of poor self-image. There have been many studies, more so for men who have sex with other men but also especially among Black or African Americans, and what these in general find is that combined racism and homophobia, those experiences can lead to feelings of shame, loneliness, and low self-esteem because of the external social forces that they turn inward. A sense of connectedness to the dominant white American society is often low for persons of color. Furthermore, a sense of connectedness to one’s own community of origin is often even lower for LGBT persons of color. For example, same sex orientation is not considered appropriate for cultural, religious reasons and so on among certain communities of color, including for example African-American or Latino. And I have heard some black men who are MSM who identify as gay consider themselves as an abomination, according to their church. So, if that becomes internalized, imagine the sense of self-worth that a person might have. All of this for LGBT persons, and LGBT persons of color in particular, can lead to unhealthy and unsafe behaviors, including substance use, high risk sex, and any sequelae. For example, in the context of this talk, HIV/STD infections, liver disease related to infection or substance use, and, as noted, mental illness.

Back to some general information here. Common terms and definitions. The following were adapted from Fenway Institute Learning Guide for Health Care Staff, published earlier this year. The image is there. The Fenway Institute is just a wealth of information and cited by the New York State Department of Health, the CDC, and so on. So, the term definitions. Some of them are self-evident such as the one for heterosexual and for lesbian. Gay describes someone who is attracted to people of the same sex, usually used for men who are attracted to other men but women who are same sex attracted often use the term gay as well. Bisexual describes someone who is attracted to both men and women no matter the sex or sexual identity of that bisexual person. Transgender describes someone who feels that his or her gender identity is not the same as the birth sex. There are specific terms used for this which will be reviewed on the next slide. Gender identity is the person's internal sense of being a male, female, both, or something else altogether. There are lots of different terms for that but two of them are listed here; gender binary or genderqueer are terms for another gender. And then gender expression is a person's way of demonstrating his or her gender identity to others. So, that could include the name the person uses, speech patterns, mannerisms, clothing, and so on. So, keep in mind that gender in this context is using it from the sociological perspective. It's the identity or the image, it's not the sex in terms of the reproductive differences between males and females.

Specifically for transgender, there are few things to be aware of. Transgender terms are used to describe the gender identity a person feels, not the sex at birth. So, a transgender man is someone who was assigned female sex at birth but identifies as a male. Some use the term female to male or the abbreviation here. Sometimes you'll hear trans man. Transgender woman is someone who was assigned a male sex at birth but identifies as a woman. And so, some use the male to female or the abbreviation. Trans woman is a term you'll hear more and more these days. Transgender persons, however, can have
any sexual orientation and this is a common misconception among a lot of people. A trans person might identify him or herself as heterosexual, that is attracted to the opposite sex based on the trans person's identity. So for example, a trans woman who is attracted to men is considered heterosexual. And then lesbian or gay, a transgender person who is attracted to the same sex as the gender trans identity. So, a trans woman attracted to other women. Something to consider is that the whole idea of transgender is this idea of transforming or transitioning and for persons who are transgender, they might see themselves as being clear about who they are. It's just that something got mixed up at birth and they came with the wrong body parts. So, they don't necessarily consider themselves as transforming. They consider some things that need to be altered. So, using terms like transitioning might be insensitive or even disrespectful for some transgender persons because they're not really changing themselves, they're just changing their outer appearance and affirming might be a better way to approach that. That's discussed in very clear and succinct terms in this same health care.

What about health disparities for LGBT individuals? Compared to those who are not identifying as LGBT, those who do are more likely to lack health insurance coverage, nearly 18 percent versus 13 percent. There have been changes since the implementation of the ACA or Affordable Care Act. Uninsured LGBT fell by nearly 4.5 percent while for non-LGBT, it dropped by 3.5 percent. Lack of having a primary care provider is also higher. So 29 percent of LGBT report no primary care provider compared to 21 percent of non-LGBT. And then finally, over 25 percent of LGBT adults reported a time when they did not have adequate funds to pay for health care or medicines for themselves and/or their families, compared to only 17 percent for non-LGBT. And 17 percent is lower but it's also unacceptable. This, again, comes from that Gallup poll identified earlier.

This is a little more information from that poll placed into a table and a graph that's been excerpted. So, you can review that but generally you see that there are disparities such that LGBT persons' access to care, availability, options to be able to pay for care, or having a primary care provider is all disparately affected in LGBT.

In New York State we have a strong commitment to LGBT health. And this prideagenda.org is a link on the New York State Department of Health website. And it is a-- provides a lot of information but they do this annual review of the LGBT Health and Human Services Network. And so here's a quote from it. Collectively the network now reaches more than 1.5 million people compared to only a half a million in 2004. And provides safe and accessible services for the LGBT community. So, you can see the pie graph here has a lot of information looking at such things as referral services that are so-called gay-friendly and appropriate for LGBT persons. Or community education, general health programming, mental health services, and so on. Unfortunately, anti-violence training is low at only 17 percent and crime victim programs are also very low at 5 percent. But otherwise there are good percentages here for the availability of these services that are LGBT appropriate. And that is an annual report, so this is the one
that has been published thus far this year. I expect a new one out very soon because they do produce them annually.

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That report lists actual health care settings and providers that you can use to refer patients and so on. So it's a very useful guide. I would recommend you have it available. What about guidelines, standards, or health education? One study by McNair and Hegarty conducted a review to study the-- a review to assess whether existing health guidelines for LGB no T persons exist. So, in their review they found that most of the papers that-- they were doing a meta-analysis-- most of the papers had limitations in either methodology or their literature sources, there were limitations in evidence, independent expert reviews and/or procedures for updating any of the guidelines that were developed. Also, only two of them included information about dissemination and diffusion plans of guidelines that had been developed. The conclusion and recommendations include that there is a need for rigorous and specific LGB guidelines and that they need to be developed in primary care and that should be based on sound research and evidence. And needless to say, more research is needed. And once guidelines are developed they should be widely disseminated, which please note that they said that only two studies showed that there was any kind of plan for dissemination at all. And then finally, evaluation and review processes must be integral in the whole process for continued relevance to improve quality assurance and for any necessary updates. And very many other studies show consistent findings to this one.

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Another survey by Khalili et al of medical education liaison committees. These are committees for accredited faculty practices to assess the appropriateness of their education and to make them become accredited. So looking at it for policies and procedures for identification of LGBT competent physicians-- this was only for physicians-- as well as training programs that enhance their competency. They found this. Few of them had existing procedures, only 9 percent, and only 4 percent had policies to identify LGBT competent physicians. 16 percent reported having comprehensive LGBT training and 52 percent reported having none at all. However, encouragingly, 80 percent indicated interest in addressing these LGBT concerns, so perhaps that has been undertaken. Studies of baccalaureate and graduate nursing programs as well as physician assistant educational programs have essentially mirrored much of what Khalili identified. So, education, preparation for nurses, nurse practitioners, and physician assistants have been wanting as well. And I personally contacted the National League of Nursing and found that they have no position currently on the inclusion of LGBT.

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A little bit more about standards and guidelines. This is a lot of information. I just want to point out that the Joint Commission has developed a specific set of guidelines relevant and relative to LGBT health disparities and how they can be addressed. So, I'll just read the quote from that document. "One of the major factors complicating the understanding of LGBT health disparities is a lack of data on sexual orientation and gender identity. Data collection regarding sexual orientation and gender identity have been limited by a number of challenges. However, initiatives are underway to improve data collection on LGBT populations at the national and state levels." And among the reports cited were one from the
Institute of Medicine, which is a division of the National Institutes of Health, and one from the U.S. Department of Health and Human Services and the web links for each of these is identified here. I'd encourage you to consider looking at them. The Joint Commission one is probably the most brief.

In addition to those, there were several professional organizations that have in the past few years established LGBT-specific policy statements. Some are more inclusive than others. So, you can see listed here is the American Academy of Pediatrics, the American Geriatric Society, American Congress of Obstetricians and Gynecologists, and the American College of Physicians. And those are the ones I found. There may be others but those are what I found and the years that these statements have been published are listed here. Please note for the obstetricians and gynecologists congress there are two dates because they did one and then they did an enhancement of it in 2013. The human rights campaign, which is an advocacy organization, is often cited in many of these websites I've shown you so far, including the New York State Department of Health. And they have developed a health care equality index and their website has this information updated relatively frequently so I urge you to consider looking at the website. But what this so-called core four criteria are, these criteria are, is summarized on this graphic which is from their website. So, they want-- one and two are about the patients; patient non-discrimination and equal visitation or equal access for those who would be LGBT identified. But numbers three and four at the bottom half of the graphic shows that they also are looking for the institutional culture and education. So, are there employment non-discrimination policies in place for that institution or clinic? And is there training for LGBT patient-centered care?

Data collection for medical records. This has been addressed a lot recently. And so, the need to collect appropriate data has been addressed. These are some guidelines that I think are really useful. The Williams Institute, which I mentioned earlier, published best practices for asking questions to identify transgender and other gender minority respondents on population-based surveys. While you may not be doing an extensive survey, there is information in there that can be helpful in terms of wording or terminology or specific techniques that might be useful. The Fenway Institute, also mentioned earlier, has two published policy focus papers and one is called Why Gather Data on Sexual Orientation and Gender Identity in Clinical Settings and the other one is How to Gather Data etc. These are brief, not very long, under 20 pages, but they also include a literature review, rationale evidence but also some very basic nuts and bolts, how to kinds of advice.

Proper collection and management helps with understanding the patient population needs, particularly in light of the health disparities previously mentioned. Improved identification of health problems that disproportionately affect LGBT persons and thus how to prevent and screen for these. And though this talk does not focus a lot on specific health problems, among these are certainly mental health problems, frequent disparate prevalence of suicide and suicide attempts among LGBT persons including youth, and also some cancers and obesity. Many other issues have been identified as being disproportionately represented in LGBT individuals. So, many of these references get into that in more detail. I'm not going
to focus a lot on each of those individually. So again, data for medical records will help, if you get the right information, will help with your policy and procedure development, quality assurance, identifying quality indicators, program improvement, and will also meet the Healthy People 2020, the NIH’s Institute of Medicine report and the JCAHO guidelines that I just mentioned as well as some other--

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The use of electronic medical or electronic health records has become pretty common these days and perhaps most if not all of you are using EMRs. This, as you will see in the next slide, provides an opportunity with respect to LGBT care. But of note, the Affordable Care Act provided incentives for the Centers for Medicare and Medicaid Services Meaningful Use, that's CNS Meaningful Use. They require electronic medical records for some of the provisions of the Affordable Care Act and there are incentives associated with that. In a study by Deutsch and others in 2015, a review of gender identity data in EMRs, showed that documentation of them such as gender identity, birth sex, preferred pronouns, was inconsistent, difficult to find within records, and without standardization and often even absent. And the citation is there.

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Many of these documents suggest that the use of EMRs provides us with a timely opportunity to improve some of these health care issues for LGBT persons, not only as individuals which is how we often think of our patient population, but also the population in general. It provides education of faculty and staff. Just having a drop down window in your EMR that says gender identity will help raise the awareness and perhaps affect the practice of your faculty and staff. It can lead to program quality improvement and it can also be useful for billing purposes as I identified on the previous slide.

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About creating a welcoming environment. These are images of two different guides that are really useful. One from the Gay and Lesbian Medical Association or GLMA, which was published in 2009 and it may be hard for you to read but the title is Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients. It's really a handbook. It's got a lot of good information, a lot of references to seek and also evidence. And it also just sometimes gives you the words to say. As does the document published earlier this year by the Fenway Institute called Providing Welcoming Services and Care for LGBT People: A Learning Guide for Healthcare Staff. Both are excellent and have a lot of good information and like a handbook, it's brief but gives you the background and references.

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Both of those resources and others are excellent for providing very basic, simple, and direct ways to enhance the health care setting to become more culturally competent. There are other tools as I mentioned as well. These provide tips for the following. What about the facility environment? Is it physically and attitudinally welcoming for LGBT persons? How are you collecting the data and what are you collecting regarding LGBT as in sexual orientation and gender identity? And then what and how you gather can help to improve the knowledge, attitudes, beliefs and behaviors of the faculty and staff as well as the services in general. What is the language used on the forms? That is are you including LGBT
terms that are relevant? That's coming up in the next couple of slides. What also is the language that the clinicians and other service providers use? And also they recommend of course training for all staff so that just having a rainbow flag or a welcoming rainbow appearance like the one on the slide is not enough.

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Again, although it's not just about appearances, it is recommended that the following could help a person feel more comfortable. Brochures and educational materials that are relevant to the population. For example, I mentioned some issues about cancer among LGBT persons. There are pamphlets published by the various organizations I've already mentioned as well as the New York State Department of Health website for LGBT has some specific links about this. So, you could have some of those pamphlets in your waiting room, in your exam rooms, and so on. Or, you know, possibly posters. Decorate with LGBT-friendly items such as the rainbow welcome sign, flags, pink triangle, unisex bathroom signs. Structurally, your bathrooms may not be able to be identified as unisex but if you have those bathrooms that are just an individual stall with a toilet and a sink etc., you could change the signs to unisex. Just have male and female on there or just say unisex bathroom. And that is particularly helpful for people who are transgender because they often don't know which bathroom to go into. They don't want others to feel uncomfortable and they don't want to feel uncomfortable. Posters with racially, ethnically and gender diverse images. Something we've recognized for some time that you can't just show the classic white nuclear family in a family practice, for example. Display LGBT-specific media. For example, there could be a local publication. There's one in Rochester called the empty closet. You can have that. And there are national publications. Many of these are available at little to no cost. Post and/or distribute complete non-discrimination statements. That is what are patient rights. And as you know, that is mandated in New York State and New York State's language includes sexual orientation and identity. As providers, you want to have a list of "gay-friendly" programs and providers to whom you can refer your patients and you may have these available as a hand out material or certainly you want to have a list available for faculty and staff so that if referrals are being recommended that they are so-called gay friendly.

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There is this multicenter study actually called Do Ask Do Tell on sexual orientation and identity by Cahill and others. They study the acceptability of collecting sexual orientation and identity data in routine health care services for LGBT. So, they studied a diverse group of people in four community health centers in different cities and states in the U.S. and what they were doing is not just surveying people who identified as LGBT. They were surveying this group of people in these different health centers. A lot of data here. Let me just kind of run through some of the more relevant. 25 percent stated they were gay, lesbian or homosexual. Those are the words used on the survey. And 7 percent is bisexual. 47 percent of the 301 respondents were transgender. And that breaks down as 5 percent of the whole number were male to female and 10 percent of the whole number were female to male. Over half identified as straight or heterosexual. And the racial breakdown you can review here yourself. There were a good representation of black, 41 percent, white, 44 percent. However, I see the one number for Latino or Hispanic is only 8 percent, which seems like an underrepresentation which could be a
limitation of the study. And the age ranges they looked at our grouped here, you can see that. But over 50 percent were people in the age ranges from 18 to 49. So, they grouped them and broke down the data according to those age ranges. 74 percent of the people surveyed indicated that asking about sexual orientation on registration forms is important. 25 percent totally disagreed but 74 percent said yeah, it's a good idea. And 82 percent indicated that asking about gender identity was also important, although 17 percent disagreed. So a lot of information on this slide. I encourage you to consider looking at the study. It's interesting. And the citation is below.

Besides the environment, let's look at, think about some things that we ask either in forms or verbally. So, the terminology we use should be inclusive for LGBT and straight or heterosexual populations. And the use of some of these terms has become more common among straight as well as LGBT folk. So, it could work for everyone and not make others feel uncomfortable. So, if you use relationship status rather than marital status. Terms such as partner, significant other rather than just having the word spouse or having the specific words husband and wife could also be more inclusive. Given the fact that many states, including New York state of course, have changed laws about so-called gay marriage, having a husband and wife option could still be useful because some married LGBT persons use those terms husband or wife. Something to consider. Add transgender options to your sex questions. So, you have, you know, you ask your patients are you male, female. You can also then add are you transgender? And if so, are you male to female or female to male? I put the abbreviations there but you might want to spell that out. And then other. Remember I said earlier that some people don't identify as either male or female but they identify as something different like genderqueer was the example in the earlier slide. Avoid using pronouns when you're speaking until you hear the patient use them and verify nevertheless that you are using the correct pronouns.

There is a lot of information on LGBT but when you break it out there’s not so much specifically on bisexual. So, I just want to point out the study by Dodge and others looked at such issues for behaviorally bisexual men, meaning the men have sex with both men and women but their identity might not be quote bisexual. So, they asked about getting this kind of information and how to reach out to bisexual men in a way that will be appropriate and relevant. Sexual orientation or identification is not as clear as it is for gay or straight men. So, when asked about what would be the quote right words to use to recruit bisexual men? The responses varied but here are some of them. Gay or bisexual led many to actually avoid the services. Heterosexual is easier to manage for the men, particularly for those who are closeted around their MSM status. Targeting men without any sexual orientation terminology was the most acceptable. And then with respect to providing mental health services or support, definitely one on one counseling was considered favorable as opposed to group type services.

Fenway has a toolkit for gathering sexual health history information. And this will get us to the the parts of the presentation that are about sexual history taking and behavior risk assessment. The citation is below the images to the left. This guide provides information, as I said. It includes questions about
sexual orientation and or gender identification that might be helpful in giving you actually the words to say. Moreover, it provides sample documentation including EMR.

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This is a busy slide. On the upper half of the slide is an algorithm that Fenway Institute uses in their health settings and I'm just going to kind of walk you through it. If you start over at the left, what you want to do is gather information about sexual orientation and gender identification either by providing a survey that the patient may complete at home perhaps online or upon arrival at the clinic itself. Either way, in that self report of information, do they give sexual orientation and gender identity information? If they do, moving on to the right side of the algorithm. If they do provide the information in one of those surveys, then document it in the record and it's there. If they don't, then when the patient is brought into the room by the intake nurse or maybe the medical technician or the medical provider, that that information is gathered, if possible, by that person doing the intake or during the history and exam. And so, if the patient then does provide that information about sexual orientation and gender identity then enter it into the record. If they don't, you have nothing to enter so don't. You might choose to say not discussed or declined discussion, something like that. So, then the table below or the grid below shows a series of questions that are common in our health intake forms. One of them is highlighted in light blue and it's to show you that you can add this question to get at gender identity and sexual orientation. So, do you think of yourself as lesbian, gay, or homosexual-- that's their word-- straight or heterosexual, bisexual, something else, don't know. So, you can see you could just put that in your intake form.

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How about initiating the conversation? Make sexual health a routine part of your patient care for all of them, included in your history and review of systems for example. Before initiating this part of the history, however, tell the patient something like this. "I talk with all my patients about sexual health so I can provide appropriate care and address your concerns. I'd like to talk with you about that. Is that all right with you? Everything we discuss is confidential." So, if the patient agrees, you proceed and if not say, "Well, maybe we can talk about this at another time."

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If the patient has completed some survey either at home or in the waiting room, you can use that to initiate the conversation. For example, "So, I see you completed the survey. Thank you. I noticed that you identified your sexual orientation as gay and you also indicated that you had some questions about sexual health. I'd be happy to discuss this with you. Tell me more about your concerns."

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The patient might have concerns that-- any number of concerns about his or her sexual health but these may only be expressed if you ask it. So, a survey is one way to get at that as well as directly asking the patient, "Do you have concerns about your sexual health?" And if the patient does express any concerns, it may be something that you don't feel you can or should address given the situation or the
setting but you can make referrals. Either way, if the patient expresses concerns because you asked, you better address them.

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How can you address them? I kind of said this already. For some they're comfortable with addressing it directly. Others may feel that they need someone else's expertise so referrals are fine. Be sure you have a good list as suggested earlier. Establish relationships with providers who are able to discuss such concerns. And again, have that on a list and have that available. Ask your LGBT patients who might be expressing concerns. Have you seen anyone before about this and how did that go? And if you do refer a patient, when your patient returns to you, like anytime you make a referral and ask for consultation, you want to follow up as to how it went not just from the consultant but also from the patient. That's another way you can kind of keep tabs on the appropriateness of your referral list. Not only is this important for the well-being of your patient but for some it could be critical for safety because, as I mentioned briefly, LGBT persons suffer a disproportionate amount of mental health problems, including depression and isolation, which has been shown to lead to suicidal ideation, intention, and actual attempts.

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What about if they do express that they have concerns? How do you get at that? So, you might just start out with what concerns do you have about your sexual health? We could discuss that now or we could arrange another visit. Et cetera. Do you have any concerns about your sexual function? For example, a person might have some issues with maintaining an erection or achieving orgasm. Do you have any concerns or questions about your sexual orientation, identity, or desires? However you want to ask that. Do you feel you are getting enough support and acceptance from those that are important in your life about your orientation and identity? Would you like to speak with anyone further or perhaps join a support group about some of these concerns?

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You've already seen this. I'm just getting us back to initiating the conversation. So you say I see you've completed the survey or I talk with all my patients and when you.

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The purpose of this presentation is obviously to get at the idea of screening for STDs, HIV, and viral hepatitis concerns. Definitely avoid assumptions about behaviors based on how the patient appears or how he or she identifies. Heterosexuals might have same sex partners or persons who are gay or lesbian might have same sex partners or vice versa. So, you want to be sure you clarify that. Simply with a direct question, "Are your partners males, females or both?" If a person is transgender, be sure to ask about any medications, in particular hormones, and how they are obtained and used. Many transgender persons because of lack of health care insurance and/or access to care might often will obtain their hormone therapy on the street rather than through a provider in a pharmacy. Not only that but they may share syringes and other drug paraphernalia to give themselves the hormones so it's important to know about that for general safety but also thinking about blood borne infections. You certainly want to
ask about any surgical history, if there has been any. Be aware that trans persons might feel particularly uncomfortable discussing genitals that don't fit their sexual identity or behaviors that maybe don't fit their sexual identity because this is related to that disassociation of their birth sex with their current identity. So, something to keep in mind. Ask patients to clarify any terms with which you might be unfamiliar. Use the terms that are relevant to him or her. And if you just don't know what it means, just ask. Some terms are population specific. Others are regional. It's okay to ask. We don't always like to show that we're lacking in any knowledge or information but it's actually very helpful to both you and the patient. Just ask. And in general, you want to start with open-ended questions and then follow up with close-ended for clarification and specifics. Some examples of that have already been given.

When you want to open the doors for STD, HIV and viral hepatitis prevention, you have to look at sex, drugs, health care, not rock and roll. But you could ask about music.

Opening the doors. Make this a routine part of your patient care. We've discussed this already. This is an opening statement already seen.

So then again, start with those open-ended and follow with close-ended. So, what about partner situation? What is your current partner or relationship situation? Is that person male or female? How long have you been seeing him or her? What is that relationship like for you? When is the last time you had sex with that person? And how about the last time you had sex with someone other than him or her, when was that? And then you might want to gather information over three to six or 12 month period, specifically asking about the number of partners in the last three months can give me an idea of sort of a snapshot of current situation. But asking additionally about the last six or 12 months gives you an idea of perhaps trends or patterns. You could say how many different partners would you say you've had in the past three months? How about the last six months? Or how about the last year? And you can ask about if the person has a regular partner or relationship, you want to ask what about your partner? Is she or he seeing other sexual partners? And what might be happening there? Because when you're talking about sexual relationship status, it always involves at least two people. And with respect to infection, having more than one partner puts you in a multiple partner situation. Or if a person has only one partner but the partner has others, that's a multiple partner situation which is, of course, a risk for infection transmission and acquisition.

Let's move on. Asking about the types of sex because you're going to want to know what are the actual physical activities that might open the person to risk of infection, transmission or acquisition. So, you want to know about what they actually do when they have what they call sex. "Since you can get STDs in your penis or your vagina, your rectum or your mouth or throat, knowing the types of sex you have helps us know what kind of tests to do. So, what can you tell me about the kinds of sex you have?" I've had patients answer with "Oh, really good sex," and, you know, you want to give them, "Good for you
but I'm interested in knowing if you have penile rectal sex, for example, are you an inserter or a receiver or both?" And likewise for all the rest because in general for infection transmission, being the receiving end of the equation is higher risk for infection acquisition than being the inserter. And being the inserter provides a greater risk of transmission to the receiver. So, you want to know exactly what is--

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When you want to ask about protection, for example, condoms. "What's been your experience with using condoms, or other barriers like dental dams, with your partner? How about with others? Tell me about a situation in which you might have used a condom or something else versus a time when you might not have used one." That's a good way to get at how often do you use condoms? Because if you say do you use them all the time or do you use them some of the time, you're likely to kind of get a yes/no answer and that it's not necessarily helping you. Often it's the partner situation, regular versus outside, that makes a difference about choosing to use protection or not. So saying, "Tell me about a time when you might have used them versus when you have not," can give you a really good idea of risk related perhaps to substance use or related to partner status. "Do you think it would be a good idea for you to use condoms in your current relationship?" And then always, "What do you think your partner would think about that? " Always want to understand what the partner situation involves.

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What about substance use? "What's been your experience with alcohol and/or other drug use?" If some, then "Tell me what types you have used," or "how much do you drink?" or "how often do you drink or use? And what about for your partner?" Again, always got to consider the partner's behaviors. "Have there been times when you have had sex which you might not have planned because you were drunk or high? And does being drunk or high influence whether or not you use some protection?" However you want to frame that. "Have you ever had sex in order to get high, get money, other things?" Transactional sex isn't just about commercial sex work.

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What about healthcare promotion? Asking about STD/HIV/viral hepatitis. "What's been your experience with getting tested for STDs? Have you ever been told you have one? What about HIV, ever tested? When was your last HIV test? Did you get the results? What were they? What about your partners' STD/HIV status?" Last tested and whether or not the partner got results and whether or not the results were shared with your patient. And then you want to ask about STD-related vaccines such as HPV, Hepatitis A or B. And in 2012, there was a brief period in which meningococcemia was being spread among MSM sexual partners. The press release about that is cited here so you can go to the link. They have information subsequent to that the incidence of that has declined. But during that time, New York City Health Department and others around the state were offering meningococcemia vaccine.

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Don't forget to ask about violence including intimate partner violence or harassment and bullying that can happen from various other people. As noted, LGBT persons are often unconnected to family and community. So, mental health and substance use can be common. In addition to these factors and to
low socioeconomic status, LGBT persons could have unstable housing and food access and this could lead them into some violent situations. Violence screening is important whether caused by intimate or domestic partners, other family members, or through social discrimination, harassment on the street, etc. Assess safety issues, in terms of safety from their partners or others, but also safety for the individual that's in front of you. What about self harm or suicide? Especially if the patient is exhibiting evidence of anxiety or depression. The CDC has a nice online tool here called VetoViolence and the web link is there.

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Information should then be used to guide counseling and education. You want to address the person's personal situation based on history and assessment. You want to offer possible solutions. Ask the patient what he or she believes might work in a way to reduce risk that is reasonable and attainable. For example, if the patient says, "Well, I'm never having sex again." Well, there would be a good way to avoid a lot of infections, however it's not necessarily attainable or reasonable. So, you might say, "You know, that's a good way to avoid infection but a lot of people find that impossible to do. It's not necessarily reasonable or natural to that person. So, what if at this point you're not planning any sexual encounters but next month or next week you meet Mr. or Ms. Right? What then? So, you do a little anticipatory guidance and probe and challenge a sweeping statement like "I am never having sex again." Help the patient set a goal such as a simple one, carrying condoms when you go out. Especially if the patient told you that when he or she goes out and wasn't planning to have sex, might have unprotected sex and that perhaps having a condom available would have changed that situation. And be sure, of course, to document what you identify and the items listed here. What solutions might have been discussed and a plan. Plans to start carrying condoms when going out, for example. The ACA provides billing for preventive services which now includes STD, HIV, and viral hepatitis screening and behavioral counseling. There are other aspects, for example, discussing tobacco cessation or vaccines and so on, but relative to STD/HIV/viral hepatitis, there are now some billing provisions and there is a specific provision within that for so-called high intensity behavioral counseling for HIV prevention. And I encourage you to look at various sources for that. In addition, on the CEI website and the CHBT website, we have information about billing and some presentations and documents.

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Sources for LGBT information. Above-noted citations are listed on the next slides. We have a reference list I told you that's a separate handout. Check the websites that offer training, also listed on your reference list.

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Any questions that you might have, since this is a recorded presentation, you can email them to us at CHBT. This is our email address: info@chbt.org.

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Also, the Clinical Education Initiative has a so-called warm line for HIV, Hepatitis C, STD, post-exposure and pre-exposure prophylaxis. And what you do is you call or you can email. You call and you will speak
with the clinician who in general will be directly available by the call or will return a call to you within 24 hours during the weekday and this is a resource for medical and other health care providers. It's not for patients, although some patients in our experience have found it on websites, web searches and have called with questions. It's for you. Providers.

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Just to remind you, there's more training of all sorts of things relative to these topics on the CEI website, the AI training website, that is different from the CEI, and our website. So, please, I invite you to check those out.

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