WEBINAR: Providing Equitable Care Across New England: Understanding the Unique Experiences and Needs of LGBT Patients

January 24 @ 11:00 am - 12:00 pm

>> Good morning, everyone. This is Stephanie Baker, Senior Program Coordinator from Massachusetts. I am involved in the Care Transitions work with the New England QIN-QIO. I'd like to thank you for joining us today for our webinar titled, "Providing Equitable Care Across New England – Understanding Unique Needs of LGBT Patients." Before we get started I'm going to quickly review a few housekeeping items. This webinar will be recorded in the presentation will be available within a few business days on the QIN-QIO website. The phone lines have been muted for the presentation but we do ask that you please not put your line on hold. Also, if you have just joined us these announcements being made, please manually mute your line by pressing *6 or using your manual mute button. If you have a question at any point throughout in the presentation, please enter it into the chat panel on the right of your screen, and make sure you send your comments to "all participants." My colleague Lorraine will be monitoring the chat window and will be responding to your comments in real time. Please don't be shy. We would love to hear your thoughts about what our speakers are saying and how you are addressing the needs of your LGBT patients. You will also have the opportunity to ask questions over the phone at the end of your presentation.

>> Our learning objective for the program are to recognize disparities that LGBT people experience in urban, suburban and rural parts of New England, to describe the distribution of the LGBT population across the 6 New England states and nationally, adapt current tools and resources to better capture sexual orientation and gender identity data and apply best practices to provide equitable care for LGBT patients.

>> As I shared during this call, we want you to use the chat feature so we can hear from you. Please chime in with chats and comments, your experience and what you might need assistance with. Let's start by seeing who is on the call. Please type in your name and role, and the organization and state you are calling in from. I would like to introduce our speakers. Today I am thrilled to have with us, Sean Cahill. He is the Director of Health Policy Research at the Fenway Institute and Timothy Wang who is the Policy Analyst at the Fenway Health Institute. It is important to note that today's speakers have no conflicts of interest to disclose, and this webinar has been granted ACPE credits by the Connecticut Pharmacists' Association for one contact hour. Pharmacists who would like to receive credit need to compete and online evaluation and enter the code that will be presented at the end of the webinar. Please remember that this code will only be available at the end of the presentation and cannot be emailed after. And now, I would like to hand it over to Sean and Timothy to get started.

>> Thank you, Stephanie, and thank you to everyone for joining us this morning. This is Tim. Sean and I are going to be talking to you today about providing equitable care across New England and understanding the unique experiences and needs of LGBT patients. So again, thank you for joining us this morning. Sean and I both work at Fenway Health. We're a federally qualified health center right next to Fenway Park, if you're familiar with the area. We serve about 32,000 patients each year, half of which identify as LGBT, 4000 transgender patients and 2200 living with HIV. We are a Ryan White Part C clinic and we participate in a lot of HIV prevention and HIV vaccine research. We also have our behavioral health integrated within our primary care. We also offer dentistry and optometry. Sean and I both work in the Fenway Institute which is the research, education and policy arm of the federally qualified health center.

>>> Today, this is the outline for the webinar. I'm going to go over some terminology, LGBT 101 and then I will talk about the demographics and distribution of LGBT people across New England with some deeper dives into Massachusetts data. Sean will take over to talk about LGBT health disparities, both general and those relating to elders, and also strategies to improve LGBT cultural competencies.

>>> We're going to start off with some terminology and a lot of you are probably familiar with this already. Sexual orientation is how people identify their physical and emotional attraction to others. It can be helpful to think about it in these different dimensions of sexual orientation. We have identity, which is how you consider self and what terms you use to describe your sexual orientation such as gay, lesbian, bisexual, straight. Then there is behavior – so who are you having sex with and attraction or desire, so what genders are you attracted to physically and emotionally? And these don't always align, so for example, a woman might be attracted to a man and have sex with men and identify straight but that is not always the case. You can have, for example, men who identify straight but also have sex with men. Here is a quick list of terms people use to describe sexual orientation. This is not an exhaustive list but is some of the most common terms that we see. Heterosexual or straight describe someone who is attracted to people of a different gender, so for example, a woman who is attracted to a man. Gay is usually used to describe men but it can be used to describe someone who is generally attracted to people of the same gender. Lesbian describes women who are attracted to other women. Bisexuals are individuals are who are attracted to both men and women. Queer is a term that has been more popular in recent times. A lot of folks use it as an inclusive term to describe a bunch of different sexual minority or gender minority identities. So a lot of people will use queer instead of saying lesbian, gay or bisexual. But this is just a note that language changes over time. Context is important. For a lot of older folks, "queer" was used as a derogatory term so they have a lot of negative connotations with it.

>> Gender identity is a person's internal sense of gender, so, do I consider myself a man, a woman, maybe both or neither, so its important to distinguish that all people have a gender identity and have a sexual orientation and they are separate from each other. When we are talking about gender identity we are specifically talking about the T in LGBT which stands for transgender. That means that the person's gender identity does not align with the sex that they were assigned at birth. Assigned sex at birth is determined by the doctor or nurse when you are born and is based on physical attributes and sex chromosomes in reproductive anatomy. So for example, if you are male assigned sex at birth but you do not identify as male you can be described as transgender. Some alternate terminology includes Trans

woman or transgender woman, and that is someone who was male assigned at birth and identifies as a woman. Transgender man or transman is someone who is assigned at birth but identifies as male. There other terms like Trans feminine and trans masculine as well as non-binary and genderqueer which are terms people use when they do not want to identify themselves on a binary gender, based on male and female, so kind of outside of that binary and existing more on a spectrum.

>> Now we're going to talk about the demographics and the distribution of LGBT people in New England. We have some deeper data dives for Massachusetts. We actually just published a report on the demographic of the LGBT community in Massachusetts. So this is a graph from that report. It shows the percent of the adult population by each state that identifies as LGBT. You can see here that the six New England states are identified with little arrows. Vermont is the most LGBT state out of all of them, so congratulations VT. They are followed by Massachusetts then Maine, New Hampshire, Connecticut and Rhode Island. It is important to note that this data is from Gallup Daily Tracking Poll, which is a phone survey that is conducted almost every day. This is from about a year ago. We went back and looked at the Gallup Daily Tracking data just a week ago. So, the numbers are a little bit different but the order of the states is still the same. We also went and found some BRFSS data if it was available online from the state. So for Massachusetts we actually see from our 2016 BRFSS that of the adult population, 7.2% identify as LGBT compared to 5% from the Gallup Daily Tracking Poll. That is a trend that we've noticed. The Gallup poll kind of underestimates the LGBT population in comparison with the BRFSS. We also see that for Vermont – 7% according to their BRFSS and 5.8% according to the Gallup. Those are likely all underestimates.

>> Just looking more closely at the Massachusetts data, that 7.2% that you saw earlier is actually broken down to 6.8% of adults identifying as lesbian, gay or bisexual and .4% identifying as transgender, so adding those together, that's where the 7.2 comes from. Also, we had some data analysis relating to folks that are aged 50 to 75 in Massachusetts. So LGBT people actually make up 4.2% of that population. And 9% of that population lives in greater Boston with 3% living in other parts of the state. LGBT people tend to concentrate in the more urban/metropolitan areas. Even though the percentage is concentrated in these urban areas we wanted to make the point that the LGBT population lives all across the state in every county – rural, suburban and urban areas. You can see that in nine of the 14 counties in Massachusetts you can see that the LGBT population is greater than 6% of the adult population. Across the state and where Boston is. This is also a trend that we saw in Massachusetts but likely exists in other New England states and nationally: younger people are more likely to identify as gay, lesbian, bisexual or something else. This is BRFSS data for Massachusetts by age cohort. For those age 18 to 24, 15.5% identify as LGBT or something else. You can see that number steadily drops as you get older in age, with 2.7% identifying as LGBT or something else for those aged 65-74. That could be for a lot of reasons. Mostly we attribute that to times now being more accepting for LGB folks. It is lot easier for people to come out earlier. I think that also speaks to the fact that we will see those numbers, the 7.2% increase over time as the environment becomes more friendly to LGBT folks.

>> So now we also wanted to make sure that we made this point for New England as a whole. There is a great interactive map that was developed by the Williams Institute at UCLA that is using census and ACS data that we're going to share with you now. This map, you can see, if you hover over a specific county,

you can actually see the number of same-sex couples per thousand households as well as the percentage that are raising children. As you can see for the entire New England area, every county has same-sex couples. I think this county has probably the least number of couples and it still has .94 per every thousand. That goes to show you that same-sex couples and LGBT folks are living everywhere in New England, including the rural areas. It is also important to note that this is same-sex couple data, same-sex household data. The census does not ask about sexual orientation so this is the only way we can get that data from the census. Usually that is an underestimate of the actual number of LGBT individuals in the area. So for example, in Massachusetts it says there about 20,000 same-sex couples which means that there are about 40,000 LGB individuals and according to the BRFSS we have about 400,000 LGBT individuals. So the same-sex couple data is about 10% of the actual community. This is an underestimate of the number of LGBT folks living in the community. Now we are going to move on to talking about LGBT health disparities. My colleague Sean Cahill will take over from here.

>> Thank you Tim. Hi everybody. It is great to be with you today. I'm going to talk about disparities. What we see with the LGBT population is disparities in disease burden, chronic condition burden and risk behaviors and in access to care. We know that LGBT populations have high rates of tobacco, alcohol, and substance use. Men who have sex with men who identify as or bisexual or gay are at higher risk of HIV and other STI's. Lesbians and bisexual women are less likely to get preventative screenings for cancer. There is some emerging research that indicates there may be higher rates of breast and ovarian cancer among sexual minority women. This is not related to same-sex behavior but related to higher rates of nulliparity, which means not having children. Many lesbian and bisexual women do give birth to children but on average, compared to heterosexual women, they are less likely and that is a risk factor for ovarian and breast cancer. Sexual minority women are definitely experiencing the same rates of breast and cervical cancer but we know from the BRFSS survey in most states and other data sets that sexual minority women are less likely to have mammograms and pap tests. So if they do get diagnosed they may have a poor treatment outcome because they're getting diagnosed later on average. We see higher rates of obesity and overweight among lesbian and bisexual men. Transgender people, particularly transgender women have higher rates of HIV and STI's. We also see higher rates of behavioral health issues like depression, social anxiety and higher rates of suicide. Transgender people are less likely to have health insurance than heterosexual or LGB individuals. In those disparities that I just described, we also see the sexuality and gender disparities intersect with race and ethnicity disparities. So for example, higher rates of obesity among sexual minority women intersect with higher rates of obesity among black women who are mostly heterosexual. Lower rates of cancer screenings – we also see that among black and Latino women. Those intersectional populations would be priorities in terms of public health outreach and promoting cancer screenings, diabetes and obesity screenings.

>> Among older adults who are LGBT we have a study from the University of Washington that is a national study. Boston was one of 10 sites, and actually, our colleagues at the LGBT Aging Project helped recruit people for the study. About half of the 2500 people surveyed aged 50 or older across the US had a physical disability, about a third reported depression, we saw higher rates of cardiovascular disease and obesity among sexual minority women, and poor physical health among sexual minority men. Close

to two-thirds reported being victimized at least three times in the lives because of sexual orientation and/or sexual identity and about one in four were veterans.

>> Just some important context to understand in terms of healthcare. It is important to understand the context of the lives of LGBT older adults. Many came of age during a period of intense homophobia in our culture. If you look at the early 1960s, homosexuality was criminalized in all 50 states. It was considered a mental illness by the psychiatric profession until 1973. Many healthcare providers encourage their gay and bisexual patients to seek therapy to try to stop being gay or bisexual. I have a friend who celebrated his 50th anniversary graduating from Harvard and he had a classmate who in 1964 when they were freshmen, went to the infirmary on campus and disclosed is same-sex attraction to a healthcare provider and was referred for electroconvulsive shock therapy. This person is now in his 70s that was his experience with the medical profession. That is important in terms of understanding medical mistrust with this population. Gender identity disorder was only removed from the diagnostic manual in 2012 and replaced with gender dysphoria but there is still a pathologization of transgender identities. Homosexuality was a legitimate cause for being fired or denied employment, losing custody of your children until well into the 70s and 80s and is still a factor in people losing their jobs today in certain parts of the country. For many LGBT people nondisclosure was a survival strategy. That is another important thing. Particularly in rural areas and in terms of getting people to disclose that they are gay or bisexual or transgender. Many continue to fear discrimination in healthcare and in senior settings like senior living centers and meal programs.

>> This is the front page of the New York Times in 1963 ("Growth of Overt Homosexuality in City Provokes Wide Concern"). It is a very interesting article that I have taught in classes. It gives you a sense of how different the world was when the LGBT older adults were young and coming-of-age. These were the kinds of messages they were getting. In this article there is a very clear social consensus that homosexuality is a crime, a moral failing or a sin – all major religions considered homosexuality a sin and a mental illness. The goal was to reduce or eliminate it as opposed to acknowledging it is a variation in the human experience and accepting it and supporting it. This is an image from the American Psychiatric Association Conference in 1972. On the left are a couple of early gay-rights activists. They were advocating for the APA to de-list homosexuality as a mental illness on the right is Dr. John Fryer, who was known as Dr. Anonymous. He was worried about losing his license to practice but he wanted to speak out in support of removing homosexuality from the list of mental illnesses. This campaign was effective. A year later they did de-list homosexuality. Another thing to know in terms of the demographics of older LGBT adults is that many are single and live alone. On average they are less likely to have children and grandchildren. Some who have children are estranged from them. This is especially true now with transgender older adults. This may mean that LGBT older adults are more in need of formal caregiving support so they can stay in their homes and age in place. Another concern we have with older LGBT adults is higher rates of social isolation. One approach to reducing that and helping them develop and strengthen social support networks is using Older Americans Act funding to support congruent meal programs for LGBT older adults. This is a picture from a senior meal program in the Boston area for lesbians and their friends. This provides nutritional support, but more importantly helps people get together with friends and develop and sustain friendship networks that could be helpful with

caregiving and other assistance. If you need to get a colonoscopy, you know, you have a friend that can bring you and help you get home.

>> We now have 23 meal sites in Massachusetts. One is not on this map from a year ago, in Greenfield, the Northwest of Massachusetts. These are really great. There are other states in the country doing this. This is something that we encourage people in other New England states to take up. We are using existing funding streams to do this and it does not cost a lot of money. Some of them, like the one on Cape Cod in Orleans, they have a once a month dinner and movie night. So they have a meal plus a movie and people discuss the movie. The life experiences of LGBT older adults shape how they engage healthcare and support networks. Many LGBT people are veterans despite all of the anti-gay and anti-transgender policies that we have had over the years and still to this day in terms of transgender service members. They often associate military service with prejudice, many of them were dishonorably discharged and some might not access VA healthcare, they think they are not eligible to access healthcare at the VA and other services like housing assistance, suicide provision, employment assistance. So it important to encourage LGBT veterans to access the VA. There's a lot of good stuff happening there, I will talk about that in a bit. For many older gay men AIDS decimated their social networks, and that's a factor in higher rates of social isolation. Social isolation is an important health issue because it can correlate with depression, with higher rates of substance use, with poor medication adherence including HIV medication adherence. Another thing to know is that many older Americans, older American as a group are more likely to hold anti-gay views to morally disapprove of homosexuality or to believe that HIV can be casually transmitted by a person living with HIV, eating in the same dining room or eating at the same restaurant. That is not true. You cannot transmit HIV that way. Older Americans are more likely to believe that. It is important to understand that and ensure that elder services are accessible to LGBT older adults and that LGBT clients are not experiencing prejudice in treatment by their heterosexual age peers.

>>> Another health issue affecting this population is HIV. HIV is not a gay disease but it disproportionately affects gay and bisexual men and transgender women in the United States and around the world. More than half of people living with HIV in the U.S., about 1.2 million people overall, about 60% are gay and bisexual men or transgender women. They are disproportionately black. In Massachusetts, about two thirds are 50 or older. We see higher rates of substance use, including tobacco use and behavioral health burden among people living with HIV in general. Many of these people are now engaging senior service systems and entering nursing homes. That is an important population to understand. We have some resources on our website that I will mention at the end of the presentation – to learn more about things you can do to improve the health of your patients or clients who are HIV-positive. Here is some data from the Massachusetts BRFSS showing higher rates of depression among middle-aged and older adults who are LGBT, compared to heterosexual adults in that age cohort. And even some other differences that we found. We worked with our state health department in here in Massachusetts and they did analyses of the data from our BRFSS and actually pulled a couple of years of data to actually look at differences and found that there were similar rates of poor mental health and regular cigarette smoking but higher rates of e-cig use and higher rates of marijuana use among the LGBT folks who are middle-aged and older vs heterosexuals. So these are

some important health issues to know about. When you are screening for tobacco don't just say, “do you smoke?” Make sure to say, “do you vape?” because a patient might say they do not smoke but they vape. It is important for you to know that and to talk to them about the risks of vaping as well as traditional smoking.

>> Some of the correlates of higher substance use is family rejection, lack of social support, stigma and minority stress which often involves anxiety related to disclosure. Tim and I are both out as gay men but we navigate disclosure all the time, on the subway, when we meet new people and that can create stress in your life. Abuse, harassment, violence victimization are correlates, also pro-and anti-LGBT policies and policy debates. Whether it is an anti-transgender ballot campaign that we had here in Massachusetts, which thankfully, was defeated by about a 2 to 1 margin, or the debates over whether transgender people should serve in the military, even just the fact that there is a debate can create stress and make people feel unsafe and make them question their sense of belonging in society.

>> So here is a little bit more data on veterans. We found that among middle-aged and older adults – I think this is really compelling – despite the anti-LGBT policies in place, including the anti-transgender one today, and the anti-gay one that was in place until about 8 years ago, LGBT people are serving in the military at about the same rate as heterosexual people. That is important to helping them access the VA for healthcare. 9 million Americans get their healthcare through the VA system. So it is important that LGBT veterans access that system at a similar rates and get the benefits that they have earned by serving our country. Most veterans are men but lesbian and bisexual women are more likely to be veterans than heterosexual women. It is really important that you talk to your older sexual minority women patients about this in particular. Like I said, about a quarter of LGBT elders in the survey are veterans, the VHA is a large provider of healthcare. There is a lot of good work happening within the VA. A lot of staff training, directives to ensure that LGBT veterans and intersex veterans, which is a related population, another population, people whose physical genitalia or chromosomes don't fall completely on the male end or the female end of the spectrum. Maybe 1 to 2% of the population is intersex. The VA is also trying to ensure that intersex patients access healthcare. There is a need for affirmative outreach to LGBT vets. Veterans as a group have high rates of suicidality, and within that veteran population, LGBT veterans have even higher rates of suicidal ideation and attempt, so that is an important health issue. This is an image of some older lesbian or bisexual women from the Boston area.

>> Another issue is discrimination in healthcare. This is a national survey that Lambda Legal did. It found that more than half of the LGB patients and almost 3/4 of transgender patients experienced discrimination in healthcare settings. We did a survey, which I will mention in a minute, but the National Center for Transgender Equality did a national survey with about 28,000 transgender people and found high rates of verbal harassment, being physically attacked, so this is important context. We treat a transgender patient it is quite possible that they have PTSD related to being harassed in a public space or in their neighborhood. There are high rates of poverty, homelessness, psychological distress and about 10 times the rate of suicide attempts. We did a study here in Massachusetts and found that about two thirds of transgender people (we surveyed about 450 respondents) experienced discrimination in a public accommodation in the last year. Those who experienced discrimination had about twice the rate of physical and mental health symptoms like pounding heart, headaches, feeling sad or depressed and

those who experience discrimination in a healthcare setting were less likely to seek subsequent care. That is something about the context, so what can healthcare providers do to improve cultural competency in the experience of care? One thing is that they can train all staff on how to provide affirming, culturally competent care. They can put up posters and pamphlets in the waiting room that depict LGBT people or same-sex couples, they can post a rainbow flag. It seems really simple but this can send a message that LGBT people are welcome and that the staff are competent to serve them. Adopting a nondiscrimination policy and training staff on how to uphold it is important. It is a great teaching opportunity for staff, and then hiring from the LGBT community, especially the transgender community. We see high rates of unemployment and if someone walks in and there is a person at the front desk or a physician's assistant or medical provider who is a transgender person or openly gay person that can send a message as welcoming and inclusion as well. Thankfully, the joint commission has required that healthcare organizations have a nondiscrimination policy as an accreditation of criteria since 2011. CMS has also required since 2010 or 2011 that same-sex partners be allowed to visit their spouse or partner in a nursing home or hospital that is participating in Medicare/Medicaid. Marriage equality also protect visitation rights for same-sex spouses. Thankfully we live in a part of the country where all New England states have sexual orientation and gender identity nondiscrimination laws that cover employment, housing and public accommodations, but is still good for institutions to have these policies to use them to teach staff and to publicly display them so patients can see that. It sends an important message to the majority, heterosexual, non-transgender patients as well.

>> There is limited research on the experience of LGB people in rural areas. Because these communities are less visible than say, the gay community in Boston, or the gay community in Burlington, VT, LGBT people may feel less safe disclosing their sexual orientation and gender identity to a healthcare provider in rural areas. In spite of this it is important to remember that LGBT people live everywhere. Like Tim pointed out, even in small towns or rural areas. It may be a smaller percentage of the population in rural areas than say, urban areas, but in some rural areas there are definitely big LGBT populations. One of the studies that we found out of New Mexico, in rural areas in New Mexico, they found that LGBT clients experienced widespread discrimination when trying to access mental health care and substance use treatment, at the hands of both providers and heterosexual clients. So it is important to ensure that there is training available and on a regular basis is given to staff and volunteers, to ensure that LGBT patients can access these services. We had a man who reached out to us seeking an LGBT friendly bereavement group because he lost his spouse recently, his husband, and he reached out to a mainstream group and was told that he was welcome to come but he should not disclose that he had a same-sex spouse. Well, that will not help him work through his loss, to have to be worried about people finding out that he is gay and responding in a hostile way. So it is important to make changes in behavioral healthcare as well as medical care.

>> This is a map for the Williams Institute showing the percentage of all households that are same-sex households by city and town in Massachusetts. So again showing that its not only in Boston and Worcester or Springfield but it is all over the state where we see high proportions of same-sex couples among all couples. There are a couple of issues relating to caring for transgender patients in particular. Frontline staff should follow a set protocol for noting preferred names and pronouns for communicating

with transgender patients. Something as simple as, instead of saying hello sir hello ma'am when a patient walks in the waiting room and instead saying hello, how can I help you – that can ensure that accidentally misgender a transgender patient, which can set off a negative experience for that patient. Having an appointed staff person who is responsible providing guidance and assistance with procedures can be helpful, and ongoing training and retraining for staff on transgender competency is important. Identification wristbands for patients should show the preferred names, pronouns and gender identities. Even if a transgender patient has different information on their insurance card, that is important for billing purposes, but there is no reason why you cannot use the preferred name and pronoun when you're interacting with that patient. We also think it's important to collect sexual orientation and gender identity data. I will mention some resources we have online to assist with this. This allows healthcare providers to better understand health disparities and inform interventions to address them; it is especially important for a healthcare provider to know if they're treating a transgender patient so they can ensure they are offering the right preventative screenings, like prostate screenings to a transgender female patient, breast and cervical cancer screenings to a male transgender patient. Perhaps the best way to collect this data is through patient portal or a patient reported outcome tablet because that is seen as the most confidential way to collect this data.

>> These are some questions we developed and that are encouraged by CMS. This is the sexual orientation question; we also encourage you to ask what is your current gender identity and what is your sex assigned at birth. That way you'll definitely identify transgender patients. All of these things are important for a healthcare provider to know, so we have our client registration form which collects all of these things. Its important to ask open-ended questions to allow patients to feel comfortable and to let them know that you are asking everybody these questions. Sometimes people make defensive and if you say we ask all of our patients about their sexual orientation and gender identity just like we ask age, race and income, that usually tends to reassure people.

>> The final thing is to mention some resources. We have a training available at the CMS learning network, the Medicare Learning Network, on how to collect sexual orientation and gender identity data and use it to improve quality of care. The National LGBT Health Education Center has a myriad of resources that can be helpful for you in training your staff. They're all free; you should try to access them. This is their website. This is a project of the Fenway Institute. A lot of the contact content there, Tim and I actually developed. That includes this issue brief on strategies improve the health of older adults living with HIV. It also includes a webinar on this topic. And actually, we have some materials in Spanish, Chinese and in other languages. How to collect SOGI data in Spanish in Chinese, but also, how to provide the healthcare in Spanish and so on. I think we are trying to move through the other languages like Haitian Creole and Portuguese that we see a lot of here in Massachusetts. This is a general brief understanding the needs of LGBT people. We also have some specialized topics like, how to provide affirming care to LGBT farmworkers, migrant workers. This is website we have called DoAskDoTell.org, which is a toolkit for how to collect SOGI data and use it to improve quality of care. We did this with support from the Johnson foundation. We also have an aging commission here in Massachusetts that I serve on and we put out a list of recommendations for how to improve elder services for LGBT older adults and I would encourage you to take a look at that and feel free to share it

with your elder services department in your state and encourage them to reach out to us and we would be happy to talk to them about some of the issues we raised. So, thank you, and I'm going to hand it back over to my colleagues, and we look forward to your questions.

>> Thank you so much Sean and Tim. That was a wonderful presentation. We would like to now open this up for some discussion and questions. As a reminder, if you like to ask a question over the phone you need to unmute your line and you would press #6 to make that happen. While we are waiting, Lorraine, I think I saw a couple questions in chat.

>> Yes, thanks Stephanie. We got a question from Petra: "Can you tell me if there are specific ways to help veterans who identify as gay or bisexual to improve their access to care. I know you touched a little bit on it but I was wondering if you could elaborate further."

>> Absolutely. I would encourage – first of all, we offer veteran support groups here at Fenway Health. And I know that the Boston Veteran's Hospital and the Bedford, MA facility also offer LGBT support groups and I think there is a transgender veteran support group. Those allow people to come together and talk about their experiences as service members. Also about them trying to access services now. You can see if that exists in your area. Another thing I want to mention is that there are two individuals who are national ombudspersons or liaisons for LGBT veterans. One of them is Michael Kauth, who is out of the Houston VA. The other person is Jillian Shipperd out of Boston Veteran's Hospital on Mission Hill. She is the other liaison. If anyone has any trouble accessing VA services, they can reach out to Jillian Shipperd or Michael Kauth and they should be able to refer them to someone who can help them locally or go to bat for them within the VA system. I hope that is helpful. There may be other things but those are two that I can think of.

>> Great, thank you. We also have another question from Elizabeth: "For institutions of higher education that are preparing future healthcare professionals, what should graduates entering practice or residency ideally have an understanding in terms of caring for LGBTQ population?"

>> That is a great question. I would refer you to a couple of resources. One is at the American Academy of Medical Colleges, or the Academy of American Medical Colleges. They have put out a curricular guide, maybe three years ago. It is basically a guide for what medical students and other healthcare professionals should be learning in graduate school related to LGBT health disparities, etc. but also how those schools can improve their teaching of the LGBT health concerns. I think the LGBT health issues should just be integrated into the curriculum along with racial and ethnic disparities and issues related to serving patients who have limited English capacity. That is one resource. The other resource is, Fenway Health has put out a medical reference guide, called "The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health." We published that guide with the American College of Physicians. That is available on our website and the ACP website. I think it is $50. It is the only thing we charge money for, everything else is free. That may also be beneficial. It has chapters on transgender healthcare, LGBT older adults, sexual minority women and men sexual health for gay and bisexual men,

it goes into a lot of details. I just want to correct one thing I said about the VA. I want to give you Jillian's correct name, her last name is Shipherd. She is the person you should reach out to at the Boston VA.

>> Thank you so much. I have two similar questions that came into the chat about your written materials and their availability in multiple languages. Can you talk a little bit more about your resources, are they all available in multiple languages and how would people access those resources?

>> Yeah, they're not. The vast majority are only in English. Some are available in Spanish and I think there is one document about collecting sexual orientation and gender identity data in Chinese. I think our goal is to make more things available in other languages but we do not have a plan to translate everything into Spanish and Portuguese and Chinese. That is not our plan. But I think going forward we will try to do more in languages besides English.

>> I think a lot of it is – the ones that we do offer in different languages are how to ask the questions. A Spanish translation how to ask the Spanish speaking patient, and collect the data.

>> I know there is one document on how to provide affirming, culturally competent care to transgender patients and that is in Spanish too. It is mostly about how to collect and use the data, and use the language that people understand. For instance, in Spanish, there wasn't initially a word for heterosexual. People would just say "normal," that normal was heterosexual. So we tried to figure out ways to ask the question in ways that did not confuse people. There is some research that indicates that Spanish-speaking immigrants and Asian immigrants were higher nonresponse rates when you ask those questions of them. That is one reason we have been translating to those languages and testing the questions.

>> Thank you. I just want to check, is there anyone on the line that would like to ask a question? If you do want to ask a question you can hit #6.

>>Okay. I do have another question for you in the chat. It is a specific question that asks, "do you refer to someone who does not want to identify with a specific sexuality, 'queer'?"

>> I think that is a way that a lot of people use the term now, as an umbrella term that is more inclusive. So they do not have to necessarily label themselves. A lot of people just say queer. I would not necessarily recommend calling someone queer if they don't identify with another sexuality. Language changes over time and queer still has negative connotations with some people. You do not want to offend someone by just calling them queer. I think for a lot of younger folks that is how they are using the term. But I would probably advise against calling someone that unless they already referred to themselves as that.

>> Someone who's not sure of their sexuality would probably be "questioning." When you see the Q, especially with youth, it stands for questioning. They are still trying to figure out their sexual identity and who they are attracted to. But queer tends to be something more that young people use rather than older people. If your patient population is middle-aged and older people, I would only use that word if

somebody else already identified themselves that way. Some people get offended with it. I don't have a problem with it. I don't have a problem with homosexual. A lot of people think that is stigmatizing so they prefer gay.

>> This question rolls into where you were going a moment ago. Can you speak to healthcare disparities and concerns specific to the LGBT youth population?

>> I will and then I will let Tim talk because he is on the Massachusetts LGBT Youth Commission. The issues that we see, it is important to understand that this is a huge population. In Massachusetts on our behavioral risk factor survey among 18 to 24-year-olds 15.5% identify as LGBT. That is like one in six are identifying as LGBT. And then on our youth risk behavior survey 15% are LGBT. Altogether that is 13% of the youth population. This is a big population. I would say, that a lot of the issues that they face are the same as other adolescents experience but with gay and bisexual male and transgender female youth, HIV and STIs are still a big concern. Sexual health and educating them about how to protect themselves is very important. Also just helping them get information about sexual health. We have another project that we are doing with the CDC and a lot of young people do not know where to get information and they are not getting it from healthcare professionals or sex education class in school. They're getting it online and it is not always from the greatest places. That is important. Behavioral health issues like anxiety, depression, high rates of suicidality, we see five times the rate of suicidality in LGBT youth vs heterosexual youth nationally and in Massachusetts. About 5% of all youth are thinking about suicide or attempting it whereas 25% of LGBT youth are. Even in a liberal state like Massachusetts where we have a lot of resources for LGBT youth, we continue to see that disproportionate burden.

>>Another issue we see is eating disorders. Higher rates of dieting, taking diet pills, bulimia, anorexia, particularly among gay and bisexual male youth and transgender youth. With the transgender youth sometimes it will involve dieting, we've heard of gender-variant youth who are approaching puberty and will diet to stave off puberty because they don't want to develop secondary sex characteristics. Or youth who have gone through puberty, to over eat to cover up those characteristics. Those are important issues for pediatricians and adolescent providers to know about. If you are seeing that with a lot of your sexual and gender variant patients it is not an accident. A lot of those topics are covered on the LGBT education website. Do you want to add anything, Tim?

>> As Sean said, I am on the Youth Commission, and we have three main areas that we are looking at to tackle with LGBT youth. One of them is sexual health and behavior health. The other two areas are bullying in schools and homelessness. There is data that comes out every two years about bullying of LGBT students. We see higher rates of verbal harassment, as well as physical, sexual harassment with LGBT students. Again, that is definitely an issue we are looking into. We are also looking for strategies to combat that. There needs to be more inclusive curriculum. This is important for LGBT students to feel like their identities matter. For homelessness you see an increase with LGBT people in general, but an increase with LGBT youth because it has to do with being kicked out of their home, by families who aren't accepting. The intersection of that is something that we see a lot too.

>> great. Thank you so much Sean and Tim. I'm turning this over to Stephanie to wrap up this amazing webinar. For those of you that had questions still left over in the chat we will make sure to try to get those answered for you. Stephanie…

>> Thank you. What a great discussion. Sorry we had a few questions left. We will make sure to touch base via email afterwards and as Lorraine said, try to make sure we get those answered for you. For those pharmacists who are claiming continuing ed credits the code is LGBT and as a reminder you will not be emailed this code after the presentation, so please write it down now. You must also fill out the online evaluation. I would like to thank the New England Rural Health Association for cosponsoring this webinar with us and remind everyone that we are on social media so check us out on Facebook, YouTube and LinkedIn. And finally, if you would like to reach out to our contacts in the individual states here is everyone in the states and their email addresses, so please reach out to us and ask any additional questions. I hope everyone has a wonderful Thursday and enjoys the nice weather we are getting. Thank you.

>> Thank you Sean and Tim.

[Event concluded]