

***The following questions about caring for LGBTQ people in community health centers were asked and answered during NACHC’s virtual Ask Me Anything held in recognition of Pride Month 2020.***

**Question**

**What is the value for health centers to create Diversity Director/Officer positions to improve the quality of health provided to patients?**

**Response**

I'm definitely passionate about this role. At Howard Brown Health we posted recently for a Director level role and embedded this position with our Vice President of Human Resources. The value that I see is in a couple of things: 1) Putting intentionality around what we have said we want to do. So, if we say that we want to be a health center that looks at diversity, equity, and inclusion, then putting a position in place so that that person can be focused on it and can drive initiatives forward, I found to be really helpful in making strides there. 2) Having that role in and of itself tells the staff that this is important and that it's not just a concept or another thing that we're going to layer on to their work. 3) Diversity, equity, and inclusion work is ever changing and it’s valuable to have someone who can keep tabs on best practices, making sure they're looking at all aspects--everything from care delivery to how we are as an employer to connecting things that are going on in advocacy or in the world that ties to our mission. And so, I'm definitely a big fan of making sure that this is a role that all health centers are either striving towards having or already have and think it can bring a lot of value. The last thing I will say is I think for our health center, it has also brought a diverse workforce. When people see that this is something that's important, if that's important to them, then they may also look at you as an employer of choice. And then to your patients--knowing that your patients know that there is someone thinking about these things, is really important as well.

**Question**

**In our patient population we found a much lower rate of people who identified as LGBTQ compared to the general population within our state. I have many theories as to why that is the case. However, we want to make sure that each of our patient’s care needs are being met. Do you have any suggestions about how to make certain processes, which can include the intake forms or waiting room interactions, more comfortable for people to disclose their sexual orientation and or gender identity?**

**Response**

The first question I'd have for you as a health center is to really ask yourself how many people are filling in those questions versus how many are leaving them blank. If you are having large percentages that are still not answering them, really then figuring out what those reasons could be. I will say for our population base, keep in mind that when you look at LGBTQ health disparities, one of the big things we see still today is a lower engagement in care in general. We know that health centers are passionate about reaching populations, preventative health, and getting out ahead before there's an issue but we also know that this community in particular definitely has a delay in how and when they seek care. There are various reasons for that. So that could be why your numbers are different.

When we think about the forms, people question why these questions are being asked. There's a lot of worry still in the community. Who is collecting this data? Who is it going to be shared with? One thing that we've done that has been helpful is add a few lines to our registration paperwork that says really clearly, *we ask this to all people and here's why we're asking*. The why we're asking is really helpful because people then don't just think we are trying to collect data on them or that it's sort of the big brother mentality. It says we are asking it because we want to be able to care for our community. We want to know what your unique needs are. We are able to then collect the data to know where research needs to happen and where we need to give better care.

Normalizing these questions is also really important. Make sure that your forms have the why, but also say, *we ask these questions of all people*. And that rings true even as a clinician. When I'm talking to patients, I always make sure that my patients know that I'm not just asking them based on something they told me or the way they look. I ask this of all people. Making it very normalized can help.

If the health center’s numbers are a lot lower than what is seen in the state, I would look broader. I would look at your organization and ask what you are doing, if anything, to market or outreach to the community. Depending on the part of the country you're in, whether you're urban or rural, it's really important to know that each community has different ways that they know they're welcome, or not. For some people it takes a lot of intentionality. It's not just if you build it they will come, but you have to actually put out some intentional messaging that you want to care for this community and that you have expertise. For some of the patients in the community, really bad health experiences in the past surrounding gender identity and sexual orientation often not only delay their care but make some question or be weary of coming to health centers where they're just unsure. Community advisory boards can also be really helpful if you have LGBT people that are on those boards and give their ideas about how to get the word out that the health center is having intentionality around this and wants to care for the community. The word travels fast. In my community there is a lot of word of mouth. It's a lot of people getting recommendations about where they can get health care, because nobody wants to enter it and go through trauma or have something asked of them that's uncomfortable or be made to feel like they have to hide who they are.

**Question**

**Are there standard or best practices for how to list the answer options to the SOGI questions?**

**Response**

NACHC’s LGBTQ Health Task Force, which I chair, has done a lot of work to really push UDS SO/GI questions out to health centers so they can see how important they are. I believe that there is [guidance for health centers](https://www.nachc.org/wp-content/uploads/2018/07/LGBT-Toolkit.pdf) on how those questions can be asked. I know some health centers have taken it a step further. For instance, at my health center, we found that the questions were still a little too broad and we wanted people to see their category on the paper rather than it being something a little more high level. So, we broke up even some of the UDS categories. For instance, splitting out lesbian and gay so people have more opportunity to see themselves in those questions and responses.

I don't have suggestions on the order it needs to be in necessarily, but I think it is important to be inclusive. It has been helpful at Howard Brown Health to ask in our patient satisfaction surveys and through our community advisory boards if the way we are asking SO/GI questions is affirming and makes sense. Also, patients have an ability to write in or to say other, and we keep an eye on those responses. If people are writing in a lot of other things, then maybe we need to update our verbiage and make sure that we're staying on top of how people identify.

When you're asking these questions on your registration forms, make sure that your front desk is well versed to answer patient questions and actually explain what those questions and responses mean. There's a lot of patients that maybe come to the health center who don't even understand those terms, don't understand why we're asking, aren't a part of the LGBT community. And so, they may skip, not knowing. So even having a little explanation on the form or making sure that we've done some things in our health center that are visible, like signage at the front desk, that encourage people as to why we're asking. And it really is about inclusivity rather than just having someone answer another question on an already long registration form.

**Question**

**Health care for the rural LGBTQIA population is kind of a challenge. How can we reach out as a rural health care partner when our patients may live in rural communities to provide the best care with minimal resources?**

**Response**

I am not a rural health care provider and so I don't want to say that I know all in that area because the majority of my career has been in an urban health setting. I will say that before I was in Chicago, I did practice in rural medicine for five years and at a National Service Corps health center in rural California. So, I certainly see what you are asking about. I think in rural health areas where you may be further away from a center of excellence or further away from specialists, sometimes those resources are going to be less prevalent than you're going to have in an urban setting. And so, I think that it really goes back to the basics.

I can give advice on a couple of things: 1) Utilize the NACHC LGBTQ Health Task Force. There is a mix of rural and urban health centers represented. I have learned a lot from my rural counterparts to make sure that we're keeping those things in mind. And we've connected a lot of different rural health centers together so that they can actually talk about those challenges and what they've done so that they can help give TA to one another. It’s easy for me as someone from a renowned urban health center to do these things but not as easy in a rural area. For example, one thing at my health center that I really am passionate about is making sure when I make referrals to specialists for patients that the cardiologist or the pulmonologist provides LGBT affirming care like I do. In a city I have 20 or 30 of those to choose from and in a rural area that may not be the case. Reach out to the Task Force and we can connect you with some of those rural health centers. 2) Reach out to those specialists and those other care providers to talk about how important they’re going to be.

Go back to those basics of patient satisfaction surveys, community advisory boards, getting a couple of champions from the community who are really interested in this to actually hear the patient perspective of what the challenges are and how you can be the best health center you can be when it comes to that. Connect with the closest urban area you have where there may be more resources and see if there's ways to sort of bridge the gaps between them getting some of the connections they might need when it comes to some of that care or those resources.

There's also a lot of resources when it comes to online health. There is the TransLine, which is a great resource and we get a lot of rural health questions. I volunteer for that. It is a great way to pose clinical questions that you may have about taking care of patients. NACHC also has different resources available.

**Question**

**What are policies and best practices that Howard Brown Health has put in place for working with transgender diverse populations?**

**Response**

I certainly learned a lot along the way. In the 14 years I have been at Howard Brown things have changed quite a bit in terms of how we have delivered care to the trans and gender non-binary population. It’s multifaceted: 1) We have made a much more concerted effort at hiring from community. So, making sure that we are bringing employees on from community because people definitely want to see a staff reflecting their communities. That has been a huge win for us when it comes to caring for the trans community. 2) Questioning, never stop yourself from asking why. I think back to when I was first a clinician at my health center, and I was really new to doing hormones and trans health. What I've learned in the decade and half since then is that I'm never okay with the status quo. For example, when I first started, we had three visits to get someone on hormones. It was a lot of hoops to jump through and I challenged myself to keep saying, why, why are we putting up these barriers when at the end of the day, the clinical data tells us this is a really safe, affirming thing to do. 3) Make sure to really think about the different systems. For instance, maybe we are doing good with our forms, but then our EMR isn't friendly to the community, or doesn't do a good job with pronouns or names. Then we're really falling short. So, looking at all of the systems and the entire patient experience. 4) Make sure that you think outside of just the meat and potatoes health care to what the other needs of the community are. So, I know with the trans community in Chicago, one of the things that we really recognize is that yes, hormones are important. Yes, surgery and referrals are important. But also because of the different needs that the community has, housing, testing, education, employment, legal resources, and all the wraparound services have been a critical piece for us to be able to care for the community in a way that tells them, *we care about you*. And we don't care about you just as a number, just as I'm needing you to take safe hormones, but we care about your whole life. 5) Outreach. Sometimes we need to go to the community rather than expecting them to come in. Really look at our systems and consider what barriers might be in place that we're not thinking about. Think about basic needs and the patient's hierarchy of needs.

One thing I always say is that I may go into a visit with the things I hope to accomplish, but the first step I take is to ask myself the question, *what is it that the patient wants to achieve*? And when I think about the trans community, and I think about things like depression or HIV or hypertension, all the clinical things that go through my brain, I have been able to develop a relationship with my patients and really say to them, *what are the things that are most pressing to you today*? and prioritizing those. And I think that that has brought about quite a great success.

**Question**

**You mentioned the importance of community advisory boards, and I am wondering if you have a trans or gender diverse community advisory board. If so, could you talk a little bit about that and what went into that process of getting those people to come in?**

**Response**

We have a couple layers of this. We have two separate CDC grants where we actually have specific transgender non-binary community advisory boards that advise us on outreach and testing efforts. When it comes to our FQHC status, we make sure there's representation on the board. We look at our UDS patient population data and then look at how our board of directors, as well as our community advisory board, reflect these numbers. And we've done a variety of things. One has been to do very clear marketing and advertising about what the community advisory board is, what the board of directors is, what the difference is between them, and specifically say, *this is who we are looking for because this voice is important.* And that has been helpful to do more of a targeted marketing. We also talk to our staff and ask if there are patients they think would be interested.

What's been important is making sure that it is layered. We want to make sure that we're really doing a good job of intentionality versus tokenizing. And the reason I mention this is that if you have just the bare minimum of representation on an advisory board, the voice doesn't necessarily come to where it needs to or to the front. And so I think that making sure those meetings are being facilitated well by someone who is encouraging all voices, making sure that you're constantly evaluating those boards and those processes and that you're getting feedback from the people who are on the boards on how to improve them are all ways that have been helpful.

**Question**

**The LGBT community is aging within our health care system. What sort of nuances of care do providers and staff need to be aware of when working with this population?**

**Response**

I've learned a couple of different things along the way. Even within the LGBTQ community there are differences of opinion, there's differences of approach, there's different needs when it comes to health care or how people look at the world. So, I think that that is something to keep in mind--that intersectionality is so complicated and that when we lump words together like LGBTQ, knowing that within the LGBTQ community, there are layers and layers and layers of intersection where there is not always agreement, there's not always alignment. And that rings true especially right now with what we are seeing in the world, right? When we think about racism and we think about the ways that intersectionality plays into how we deliver care, how we approach the work.

When I think about the aging community, there are a couple of things to keep in mind: 1) We do know from data and research that there is absolutely more isolation and more loneliness in aging LGBTQ people. As we're seeing younger LGBTQ people have higher rates of having families currently right now, that may not be true in decades to come. So, when I think about the aging community, I'm thinking about social events. We do a lot of work at our health center to have different community events. For instance, we have one event once a month called an intergenerational dinner, and it's just a casual dinner with people of all ages. It's really an opportunity for people who are younger to learn from older people and for older people to hear younger people and to really just bridge those things that we don't often see in society as much as we'd like.

I think also perspective is important. When I think about things like PrEP and HIV, I'm understanding that when I have a patient in front of me, who's 70, that I've been caring for since they're 55, their reality of what they've seen when it comes to LGBT liberation, equal rights, and HIV is very different than the person who's 20 or 24, where they may have just heard about those things. So really honoring that and making sure that that voice is there. And then the last thing I'll say is with all things I say, and being an LGBTQ person myself, is remembering that our sexuality and our gender identity is just one aspect of who we are. What we see in health care sometimes is this hyper-focus on sexual orientation/gender identity when what the person's really asking for is, *treat me as a human being*. I have a family and I have family risk factors. I have different demographics of my makeup. And so, just thinking about that also is really important so that we don't only focus on that part or only focus on STIs or sexual activity. And then on the flip side of that also really it all comes down to individualizing, right? As people get older, whether they're in the LGBT community, or they're not, they are less likely to have conversations around relationships and sexual activity and those are things that they actually want to talk about it. It's not all about aging or how many meds they're taking. So, I think just continuing to learn, ask questions, and individualize care are really important as we think about older patients.

**Question**

**There's a lot of stigma in our community, which is keeping our LGBTQ community quite hidden. Do you think providing more education for the community would help us engage more with our LGBTQ members or patients?**

**Response**

Yes, I definitely think so. I would encourage also for it to be really affirming positive messages. I think that what happens as an LGBTQ person is that often what we see in the media or what we see in advertising is around disease or health disparity or how we drink more, or we have more HIV, or we have more STIs. And so instead, what if we thought of the community in the view and lens of health, in doing the same things that other people do and normalizing it a little bit? So, thinking about your imaging and your marketing, how do you show people doing everyday things rather than just the things that they've already been kind of stigmatized for, of being known for, can go a long way. And then just really positive messaging I think is going to be really important as well.

**Question**

**Can you walk me through a typical PrEP patient visit? Who do they work with on staff? And in your opinion, what role do you think is the most crucial in a PrEP delivery model and why?**

**Response**

I'm a big proponent that PrEP is a primary care issue. I think that we need to continue to push the bar on getting more and more people who are in the primary care setting on PrEP. I think in the very beginning, it sort of fell on the shoulders of people who treat HIV and although there is a place for it there, I think really at the end of the day, if we're thinking about getting to people, we really need to think of it as a primary care issue. At our health center we do same day PrEP, and we have a multitude of roles.

The first is a PrEP navigator, which I think has been a pretty critical role. It's someone who walks the patient through the access issues. So, whether they're using a patient assistance program or their insurance, really understanding how to get PrEP is going to be a big part of it. They also can help answer questions around different things like adherence, what their lab costs might be, how long you may want to be on it, about partners, or just other things there.

I think one of the most critical aspects of PrEP is if someone wants PrEP and is interested, is to do everything in your power to make sure that they get it in their hands. I think that we have an incredible opportunity for people to be on something that really right now is the most promising way that we can eliminate HIV in this country, in this world. And it's a multifaceted thing. I think that we look at it sometimes as sort of a lot of questions around, *well, do they fit the criteria, what should I think about here*. I think rather we should back up and just say, *this person has identified that they are interested in it. They want it, there must be a reason why*. And even if I think I'm really good at taking a sexual history or understanding why, knowing that the data tells us that most people are not going to want to take something every day if they couldn't benefit from it. So those PrEP navigators have been probably our most critical role. And then I think just someone who can talk to patients about what PrEP can do for them and what it can't do for them, so that we can make sure we're still keeping them healthy in terms of other health care needs, sexual health needs, et cetera. And then just encouraging them to keep lines of communication open. If they decide to stop it, to chat with us about why. To know that it doesn't need to be a forever, but it is a tool that can be extremely helpful for them. And just thinking about it as kind of that new approach.

Last thing I'll say with PrEP is we've approached PrEP from a perspective of, if someone mentioned PrEP to someone at our health center -- a case manager or a navigator or front desk person--and doesn't even have an appointment that day, our staff have been trained to say, *"Great, you're here today. Let's get you in and let's talk about it."* That’s been a critical way to get people engaged.

**Question**

**What do you think is the biggest barrier when starting or maintaining a PrEP program within a health center?**

**Response**

Often the medicine is actually pretty readily accessible between assistance programs and the one from the Bureau, as well as through the manufacturer. That's been pretty good. In my opinion, the barriers have been twofold: 1) The lab costs and the office visit cost. So, as a health center, that is something that sometimes for the patient can be overwhelming, but also for the health center thinking about it. And so, I think we need to do more in terms of assistance when it comes to lab and office visit reimbursement as well as cost to the patient. 2) Awareness of community, the community knowing when they could benefit from it and knowing who those patients are and really thinking of creative ways to reach out to those patients before they come in and they do have that test that is positive for HIV.

It's the first time that we've had this kind of medicine and it's not intuitive to us. We're overall a western medicine culture, we're a treatment culture and so to think about prevention, it is a different ball of wax in terms of talking to patients. You're already thinking about patients who may have not otherwise had a reason to come in for care. Think about how to get in front of them. They may not be people you're seeing already. They may be people in community that don't have that primary care provider yet. Think about that as well as the patients who are already coming to see you.

**NACHC Resource**[Transforming Primary Care for LGBT People Toolkit](https://www.nachc.org/wp-content/uploads/2018/07/LGBT-Toolkit.pdf)