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### Purpose

The purpose of this chapter is to review access to health care for LGBT persons, specifically the barriers to care faced by LGBT patients, as well as how providers can establish a medical home with LGBT patients and assess their identity as part of patient-centered care.

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### Learning Objectives

- List the barriers that could cause difficulties in communication between LGBT patients and providers and identify facilitators to overcome these barriers (*ICS2, ICS3, PPD1*).
- Describe how social and medical institutions contribute to health care access disparities for LGBT patients (*KP4, ICS3*).
- Discuss the role of training of health care providers in health care access issues for LGBT patients (*Pr3, Pr4*).
- Identify at least three opportunities to support a patient-centered medical home or patient-centered practice to facilitate access for LGBT patients (*Pr3, PPD1*).

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### Barriers to Care

Many LGBT patients may avoid or delay accessing healthcare. Though historically few studies on health care access have included questions on sexual identity, sexual behavior, or gender identity, studies mainly on cervical cancer screening offer some evidence. In one large, national survey conducted in the mid 1990s, lesbian women were less likely to report routine Pap tests despite having higher risk sexual practices [1]. In a similar sample of adolescents and young adults, women who identified in a sexual orientation category

other than completely heterosexual were significantly less likely to have had a Pap test in their lifetimes and in the last year [2]. A smaller study examined reasons for lack of screening and found that fear of discrimination, low knowledge about screening, and lower likelihood to have disclosed sexual orientation were significantly related to not receiving routine Pap tests [3].

The reasons behind delay in or avoidance of care are not completely understood but are likely multifactorial. Studies consistently demonstrate lower proportions of health insurance coverage among sexual minority women (SMW), likely related to the fact that women in general earn less than men and have a higher tendency to be covered under a male partner's insurance [4]. As insurance coverage for domestic partners grows in popularity and the Affordable Care Act takes effect (also see Chap. 24), SMW may make gains in insurance coverage; however, current trends in income have not relieved the gender gap [5], leaving households without men at a disadvantage in terms of health care access. It is widely accepted that transgender people have even less access to health insurance. Several studies support this disparity, including one conducted in San Francisco (N=515) in which 52 % of male-to-female (MTF) and 41 % of female-to-male (FTM) persons lacked insurance [6]. The National Transgender Discrimination Survey in Health Care found that 19 % of respondents were uninsured, higher than the national rate of 15 % at the time. Rates were even higher in ethnic minorities and MTFs [7]. Although the ACA eliminates the barrier of coverage denial for transgender patients based on a "pre-existing condition," the degree to which medical care for transgender-related diagnoses are covered by insurance is variable, leaving trans patients personally responsible for a significant proportion of their medical bills.

#### Helpful Hint

Sexual minority women and transgender patients are at higher risk of not having health insurance. Transgender-related care such as hormone therapy and surgery is not covered under many plans.

Stigma and discrimination also play a role. There is substantial evidence that LGBT patients perceive discrimination in the health care environment [8, 9]. In the National Transgender Discrimination survey, 28 % of transgender and gender nonconforming respondents reported postponing or avoiding acute care and 33 % did the same for preventive care, with discrimination and disrespect most commonly cited as causes [7]. Kitts et al. [10] surveyed 464 resident and attending physicians and found that the majority of physicians did not routinely discuss sexual orientation, attractions, or gender identity with sexually active adolescents, even in the setting of depression or suicidal ideation. Nearly half did not know the association between LGBT identity, those questioning their identity, and suicide [10].

Lack of health care provider training correlates with patient experiences. Providers may knowingly create an unwelcoming environment on the basis of upholding religious or cultural beliefs. Perhaps more commonly, they can unknowingly express stigma or discriminate even with the best of intentions. They may lack awareness of sexual minority health issues or lack training in terminology and patient communication. Even recent studies have found that providers feel unprepared to give quality care for LGBT patients. In the Kitts [10] study, only 44 % of physicians agreed that they had the skills needed to address sexual orientation with patients and 75 % agreed that sexual orientation should be covered more often during training. The results of a 2010 GLMA–American Medical Association Collaborative Survey on Physician Experiences Caring for LGBT Patients (Survey on Physician Experiences) reveal the lack of current physician training on LGBT issues and LGBT discrimination in health care settings. Almost 40 % of physicians participating in the survey reported they had no formal training in medical school, residency or from continuing medical education on LGBT health issues, while 50 % reported receiving fewer than 5 hours of training on LGBT health. Of those who received some training in LGBT health, most found that the training was "not very" or "not at all" useful in preparing them to care for LGBT patients. Fifteen percent had witnessed discriminatory care for LGBT patients and nearly 20 % had witnessed disrespect toward

the partner of an LGBT patient. 5 % of physicians in this survey said they referred an LGBT patient to another provider because they felt uncomfortable treating them [11].

#### Helpful Hint

Discomfort discussing sexuality and gender exists for both providers and patients. Providers may not receive training and are often not prepared to ask about and respond to these issues. Learning and practicing communication regarding sexuality facilitates these encounters and then builds trust that can help patients be more open in their communication as well.

Research on the extent and quality of LGBT health training for medical trainees has focused primarily on undergraduate medical education [12–15]. In a large recent survey assessing LGBT curriculum in undergraduate medical education, Deans from a majority of existing medical schools reported a median of 5 hours of time devoted to LGBT training overall, and a median of 2 hours during clinical years. When asked about the content, 26 % said the content was “poor” or “very poor” [13]. The only recent study of LGBT health inclusion in residency found similar results among Family Medicine residency directors. 16 % had no content and the majority had 1–5 hours, but only a minority of directors rated the curriculum as “adequate.” In addition, 11 % had major concerns or would not rank a transgender applicant, revealing a residency climate that might not promote diversity [16].

Some medical schools have begun to integrate LGBT health in their curriculum with associated increases in knowledge and more positive attitudes. Sanchez et al. [17], for example, found that students having more interactions with LGBT patients were more likely to ask about sexual orientation, hold more positive attitudes toward LGBT issues, and demonstrate objective LGBT health knowledge. In this cross-sectional study, students with more positive attitudes might have been more likely to ask about orientation and

therefore report more experiences with LGBT patients [17]. Nonetheless, additional small studies evaluating specific LGBT health training curricula have demonstrated some positive outcomes [18–20]. Only a few curricular innovations in LGBT health during residency exist in the literature (e.g. [21, 22]) Anecdotally, many more medical schools, residency programs, and other health professional training programs have added LGBT health curricular content in recent years. These programs, however, have rarely been evaluated or published, so little is known about the quantity and quality of training needed to improve knowledge and skills, much less about specific topics or modalities that are effective in achieving learning and practice outcomes.

#### Helpful Hint

Having a reputation for respect and open communication with all patients will help LGBT patients find and trust you as a provider.

## Finding a Medical Home

Despite the importance put on having a personal medical home, in most health systems it is up to the patient to find one. Many patients stay with a primary care provider or practice that they already feel is their medical home, but those who need a new primary care provider (PCP) or want to switch doctors or practices face obstacles. Due to primary care physician/provider shortages in many regions of the country [23], the number of providers not accepting public insurance, and limitations on practice choice as a cost control imposed by insurance companies, many PCP's no longer accept new patients or have very long waits for a new patient appointment [24].

Finding a PCP who is knowledgeable about LGBT issues and welcoming to this diverse clientele can be even more challenging. *GLMA: Healthcare Professionals Advancing LGBT Equality*, a national LGBT advocacy organization

for health professionals, suggests a number of strategies employed by practices successful at providing LGBT patients with competent care in a patient-centered environment. These strategies include featuring LGBT persons and families in the materials available in the waiting room or exam rooms and posting non-discrimination policies including sexual orientation and gender identity prominently in public areas. GLMA also recommends actions compatible with the welcoming displays, including having gender-neutral restrooms and registration forms inclusive of diverse genders and relationships [25, 26]. These types of practices are perceived as important to patients in choosing and staying in a practice [9, 27]. The GLMA guidelines are available through a URL in the helpful hints [26]. GLMA also operates a national list of providers who have identified themselves as LGBT-affirming [28]. Providers can designate themselves as allies (non-LGBT persons who are supportive of the community) if desired and are only asked for name, specialty, and some form of office contact information. The GLMA provider directory is free—both for providers to list themselves and for patients to access. Most non-LGBT patients are unaware of this resource, so it provides a particularly helpful and powerful method for providers in more conservative communities to let LGBT patients know of them without overt advertising or symbols. The listing can be accessed by interested patients through the privacy of their own computers and thus avoid any sense of being “outed” by actively asking about welcoming providers, while providers can use this list in cases where more overt signs of LGBT solidarity might not be as well received by the community at large. Nevertheless, most LGBT patients who have a trusted PCP find that person through word-of-mouth and through scanning the safety and competency of the practice environment, as well as implicitly or explicitly assessing the attitudes and competency of the individual provider [29–31]. The best thing that a provider can do to become a medical home for LGBT patients is to be respectful, patient-centered, and competent with regard to the care of all patients.

#### Helpful Hint

Health professional schools are beginning to teach LGBT Health. One repository of peer-reviewed LGBT health education resources for students is shared through the Association of American Medical Colleges LGBT/DSD Affected Patient Care Project of MedEdPORTAL: <https://www.mededportal.org/>

To add yourself to the GLMA Provider Directory or access the GLMA Guidelines for Care of LGBT patients, go to: <http://www.glma.org/>

### Assessing Identity (Table 2.1)

One of the challenges for the PCP attempting to be welcoming to LGBT patients is that of identifying who they are. Historically, sexual orientation and gender identity were almost universally guarded due to high levels of societal stigma and discrimination. Health care providers often adopted the practice of specifically not documenting patient identification as a confidentiality issue [32]. Unfortunately, that stigma and discrimination also translated into providers not assessing sexual or gender identity at all. As noted in the section on provider training above (under “Barriers to Care”), health professionals generally are not trained to assess identity. Often training consists of learning to ask in a sexual history, “Have you had sex with women, men or both?,” a question which is helpful in assessing behavior but incomplete. It also reveals little about a person’s identification, can lead to erroneous assumptions when used to ascertain identity, and is not always appropriate for the clinical situation.

A fundamental principle of assessing sexual identity is the recognition that attraction, behavior and identity are not the same. (See Chap. 1 for more details on the definitions and differences. See Chaps. 5 and 7 on intake for details and electronic health records). Behavior can be assessed

**Table 2.1** Model questions for a primary care interview

Note that the following questions are not meant to be exhaustive. Some would be used in different situations than others. They are examples that you could use or adapt for the appropriate time in the clinical interview. You would often consider prefacing many of these questions with a normalizing remark, such as, “In order to better understand all the things that affect my patients health, I ask about ...” (identity, sexual history, exposure to violence, etc.). Reminders about confidentiality are also helpful. Remember that the most important elements of the clinical interview with all patients are to avoid assumptions, ask open ended questions first, and always demonstrate respect for the patient and the truth of the patient’s own experience

*Directly assessing identity*

- How do you define your gender?
- What pronouns do you use for yourself, for example she/her, he/him, or something different?
- How do you define your sexual orientation?
- Do you feel attracted to men, women, both, or neither?

*Taking a social history*

- Who have you brought with you to the visit?
- Do you have a significant other?
- Are you in a relationship?
- Can you tell me a little about your partner or significant other?
- What do you call your partner?
- Tell me about who makes up the people you consider your family?
- Who are the people that you turn to for support?
- Are there people in your life who are not supportive?

*Taking a sexual history*

- Do you have any concerns or questions about your sexuality, sexual orientation, or sexual desires?
- Can you describe the sexual aspect of your life with your partner(s)?
- Have you had any sexual contact with others in the last year, (meaning, have you had any contact that involves the mouth, vagina, penis or anus)?
- When was the last time you were sexually active?
- Have you had any sexual contact in your lifetime?
- Can you tell whom you are attracted to?
- How many partners do you have now? (how many partners have you had in your lifetime?)
- Have your sexual partners been men, women, or both?
- What kind of sexual activities are a part of your relationship?
- What kind of sexual activities are a part of your sex life with partners that you are not involved with romantically?
- Do you use sex toys or other items as part of your sex life?
- In what ways do you practice safer sex?

in a fairly straightforward manner as part of a sexual history when such a history is appropriate. Sexual identity, while clearly related to inherent attractions and behavior, is a more complex social construct that can change over time and with a change in environment. In a patient-centered approach, the patient’s self-identification as straight, gay, lesbian, bisexual, queer, questioning, asexual, something else, or no identification at all, should be respected regardless of whether that identification seems to the provider to match attractions or behaviors of the patient. Open-ended questions are the most patient-centered way to ascertain patient sexual orientation while deriving accurate information [26, 33]. Because identity can be a sensitive issue for some patients, it is common that patients might need several visits with a provider in order to feel comfortable discussing identity [34, 35]. Nevertheless, we agree with the finding of the Institute of Medicine Board of Select Populations that best practice for holistic, patient-centered care dictates that the provider know enough about the patient to understand how the patient identifies, and that communication to that effect should occur within a few preventive or chronic care visits or as needed during acute visits when it might relate directly to behavioral risks or mental health concerns [32]. A number of sample questions for ascertaining identity in an open-ended manner appear in the box above. It is recommended that health professionals and students practice these questions in simulated patient visits or professional trainings in order to become more comfortable using them. Curriculum guidelines for medical student education and residency education from the Association of American Medical Colleges (AAMC) and the American Academy of Family Physicians (AAFP), respectively, detail these and other recommendations [36, 37].

Assessing gender identity can be just as challenging. As noted in Chap. 1, people may identify as transgender as an umbrella concept of not identifying as a single, clear gender all of the time. Patients may use the term transgender to mean that their sense of gender does not exactly match the sex of their birth, or that they have



already taken steps to live in a gender different than the sex assigned at birth. Others identify as bigender, transsexual, genderqueer, or even reject the notion of gender entirely [38, 39]. The word used academically for the majority of people whose gender identity matches their sex assigned at birth, “cisgender,” is not generally used by the people it describes (in contrast to the words “heterosexual” or “straight,” which are widely understood and used in casual language). Given the variety of gender identities, the changing landscape of gender identity terms, and a particular lack of provider training in this area, it is especially crucial to approach gender identity in an open-ended manner. Cisgender people might be confused about being asked for a gender identity that they perceive as evident, so asking for gender identification requires practice and finesse. Using multiple options for gender on registration forms (as noted in Chaps. X and Y on intake and EHR), is a particularly good way to have some transgender-spectrum patients identify in a more comfortable way while simultaneously training other patients and staff to be comfortable with such questions. In addition to identity terminology, transgender persons may also have particular preferences in terms of referring to body composition that providers should be aware of. Questions to use during a primary care interview are listed above and body specific terminology is covered in Chap. 18 [26, 32].

It is also important to emphasize again that sexual orientation does not indicate or predict gender identity, and vice-versa. Several studies on the sexual identity of transgender persons find a large diversity of identifications spanning straight, gay, lesbian, bisexual, and other identities [38, 39]. A gender transition for someone already in a relationship may also complicate sexual identity identification terms and how to communicate those to others. Ultimately, it is important for patients to be able to identify both sexual and gender identities for themselves, even when that includes nontraditional labels or no labels at all. It is also to be expected that these identity labels could change over time and does not indicate instability in mental health [39–42].

Similarly, it is important to remember that LGBT persons may have multiple other identities that influence their feelings about gender or orientation, as well as the labels they use for themselves. It is vital that the PCP and the medical home as a whole view patients in the multiple cultural contexts in which they exist, where culture ranges from race/ethnicity to age to occupation to neighborhood.

#### Helpful Hint

A patient-centered approach is key. Not every visit is appropriate for discussions of sexual and gender identity, but practice in ascertaining identity and responding to disclosures is important for trust-building that allow patients to receive tailored care and work in collaboration to improve their own health.

#### Helpful Hint

Terms to avoid

- Sexual preference (use the term *sexual orientation* or *sexual identity* instead)
- Homosexual (use the words *gay* or *lesbian* instead; use the words the patients use to describe themselves)
- Transvestite (use *transgender* or the words the patients use for themselves)

Portions adapted from: 1. Policy Brief: How to Gather Data on Sexual Identity and Gender Identity in Clinical Settings. The Fenway Institute. 2012. Available via: [http://thefenwayinstitute.org/documents/Policy\\_Brief\\_HowtoGather...\\_v3\\_01.09.12.pdf](http://thefenwayinstitute.org/documents/Policy_Brief_HowtoGather..._v3_01.09.12.pdf) AND 2. Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients. GLMA. 2006. Available via: [http://glma.org/\\_data/n\\_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf](http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf)

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Lesbian, Gay, Bisexual, and Transgender Healthcare  
A Clinical Guide to Preventive, Primary, and Specialist  
Care

Eckstrand, K.L.; Ehrenfeld, J.M. (Eds.)

2016, XVII, 483 p. 62 illus., 11 illus. in color., Hardcover

ISBN: 978-3-319-19751-7