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Contact Hours: **2**

LGBTQ Cultural Competence Training for Washington, DC

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LEARNING OUTCOME AND OBJECTIVES: Upon successful completion of this continuing education course, you will be prepared to provide effective and respectful care for patients identifying as LGBTQ+. Specific learning objectives to address potential learning gaps include:

- Distinguish between respectful and marginalizing terminology helpful in establishing clinical relationships with members of the LGBTQ+ community.
- Describe health disparities, health risk factors, and clinical implications specific to members of the LGBTQ+ community.
- Discuss legal issues associated with quality care for LGBTQ+ patients.
- Identify best practices regarding collecting and protecting patient information for LGBTQ+ patients.
- Discuss elements of culturally competent care for LGBTQ+ patients, including physical space, informational materials, patient communication, and staff training.
- Examine the intersection of oppression, discrimination, and cultural biases in order to provide nondiscriminatory care.

INTRODUCTION

It is not uncommon for a person who identifies as lesbian, gay, bisexual, transgender, or questioning/queer (LGBTQ) to have had negative experiences in the healthcare environment due to discrimination and/or stigmatization based on their sexual orientation or gender identity. Such encounters may occur due to cultural bias or a lack of awareness and understanding by the provider on how to appropriately interact with a patient who has a gender identity and sexual

orientation that does not follow what they might consider a “traditional” gender role or sexual orientation.

For example:

- A gay man might be screened for HIV before being assessed for his actual risk.
- A transgender man may be denied a mammogram because he transitioned from female to male.
- A lesbian visiting a new primary care provider for the first time might be asked if she would like a mental health referral to explore her “abnormal” sexual feelings.

These sorts of negative encounters immediately affect the patient’s trust of the healthcare system and marginalize their needs. Continuing stigma makes many patients reluctant to reveal their sexual orientation or gender identity to healthcare providers even though this information is important to receiving individualized care.

From a historical perspective, it was not until 1973 that the American Psychological Association declared that homosexuality (now considered a marginalizing term) was not a mental illness (Lyons, 1973). This was a major milestone in the movement toward cultural awareness and in the fight for equal rights for people who identify as lesbian, gay, or bisexual. Similarly, being transgender was listed as “gender identity disorder” until a recent change to “gender dysphoria” made it a more patient-centric term (National LGBT Health Education Center, 2016).

Over the past 20 years, the medical community has started to recognize and research the unique needs of these groups. One of the most significant reports includes the 2011 Institute of Medicine report titled “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.” This document outlined a research agenda for the future. The report also placed a focus on the needs of LGBT patients and described the uniqueness for each of the LGBT groups (IOM, 2011). Similarly, Healthy People 2020 created a goal to improve the well-being, safety, and health of the LGBT patient population (ODPHP, 2016).

Even though social acceptance has been increasing since that time and laws and policies are changing, LGBTQ+ individuals continue to face barriers, stigma, bias, and discrimination. Access to healthcare that is unbiased and culturally affirming remains a challenge in most parts of the United States.

People within the LGBTQ+ population are extraordinarily diverse, representing every social class and ethnicity in every geographical area and every profession (HRC, 2019). Healthcare professionals who show and practice cultural sensitivity in working with LGBTQ+ patients can have a positive impact and increase trust as they continue to understand the individual needs of their patients.



TERMINOLOGY

LGBTQ+ ACRONYM

The acronym *LGBTQ+* used in this course refers to the lesbian, gay, bisexual, transgender, and queer/questioning populations. The “+” designation is included to encompass additional populations (e.g., intersex [I], asexual [A], genderfluid, and others) that are not explicitly referred to by the acronym *LGBTQ* alone.

In order to better understand the LGBTQ+ population and their unique health concerns, it is important to define and clarify some basic concepts of gender identity and sexual orientation. Terms and definitions are ever-evolving, and clinicians must update their knowledge regularly in order to provide effective and respectful care for all patients. It is also important that clinicians have the comfort and sensitivity to ask their patients how they would like to be addressed in terms of identifiers of gender identity and sexual orientation in a respectful, honest, and open-minded manner.

Terminology described in this course is taken from recognized sources at the time the course was written. These terms may not reflect an individual’s personal preference, may become outdated (even as they are mentioned in current clinical references), and may not reflect all local and regional variations.

Terms and Definitions

- **Anatomical sex:** The presence of certain female or male biologic anatomy (including genitals, chromosomes, hormones, etc.); also referred to as *assigned sex at birth (ASAB)*
- **Asexual (A):** People with no or little sexual attraction to other people
- **Bisexual (B):** Men or women who are sexually attracted to people on the basis of characteristics other than their sex/gender
- **Cisgender:** People whose gender identity aligns with the sex they were assigned at birth, i.e., the opposite of *transgender*
- **Gay (G):** Men who are primarily attracted to men
- **Gender identity:** A person’s internal sense of being a male/man, female/woman, both, neither, or another gender
- **Gender expression:** The way a person presents their gender in society, through social roles, clothing, make-up, mannerisms, etc.
- **Genderfluid or genderqueer (also called *nonbinary*):** People who identify as transgender but not as strictly male or female; a mix of male and female (genderqueer/genderfluid); neither male nor female (nonbinary); or no gender at all



- **Intersex (I):** People with an indeterminate mix of primary and secondary sex characters (e.g., a person born appearing to be female “outside” who has mostly male anatomy “inside,” a person born with genitals that are a mix of male and female types (a female born with a large clitoris or without a vaginal opening, or a male born with a small penis or a divided scrotum that has formed like labia))
- **Lesbian (L):** Women who are primarily attracted to women
- **MSM:** Men who have sex with men
- **Queer/genderqueer or questioning (Q):** An umbrella term for all who are not heterosexual or who are not 100% clear of their sexual orientation and/or gender identity
- **Sexual orientation:** How a person identifies their sexuality, including who they are physically and emotionally attracted to and with whom they choose to have sex
- **Transgender (T):** People with gender identities that do not align with their assigned sex at birth; some transgender individuals may alter their physical appearance and often undergo hormonal therapy or surgeries in order to affirm their gender identity. However, many do not undergo the medical transition process for a variety of reasons, including cost or other health concerns.
 - Transgender female/woman, trans woman: A transgender person who was assigned male at birth (AMAB) but who identifies as female; formerly referred to as *male-to-female (MTF)*
 - Transgender male/man, trans man: A transgender person who was assigned female at birth (AFAB) but who identifies as male; formerly referred to as *female-to-male (FTM)*
- **WSW:** Women who have sex with women
(National LGBT Health Education Center, 2016; HRC, 2019)

Terms and Concepts That May Be Marginalizing

Terms that marginalize and stigmatize people who are LGBTQ+ are still common. Also, some words previously used and accepted in the medical community may no longer be in common usage or considered acceptable/respectful today. Examples include:

- Homosexual
- Sexual preference
- Transvestite
- Male-to-female (MTF) transgender
- Female-to-male (FTM) transgender



Examples of concepts that may contribute to societal stigmas for LGBTQ+ patients include:

- **Heterosexism:** The general presumption that everyone is straight or the belief that heterosexuality is a superior expression of sexuality
- **Homophobia:** Negative attitudes and feelings toward people with nonheterosexual sexualities; may include discomfort with expressions of sexuality that do not conform to heterosexual norms
- **Internalized oppression:** The belief that straight and cisgender people are “normal” or better than LGBTQ+ people, as well as the often-unconscious belief that negative stereotypes about LGBTQ+ people are true
- **Transphobia:** Negative attitudes and feelings toward transgender people or discomfort with people whose gender identity and/or gender expression do not align with traditionally accepted gender roles
(HRC, 2019; Lambda Legal, 2019)

Sexual Orientation Versus Gender Identity

The terms *lesbian*, *gay*, and *bisexual* describe an individual’s sexual orientation, attraction, or behavior. They reflect the fact that sexuality is not exclusively heterosexual, or what many in society consider “normal.” In contrast, transgender people are defined according to their gender identity and presentation. This group is composed of individuals whose gender identity differs from the sex originally assigned to them at birth or whose gender expression varies significantly from what is traditional for that sex (i.e., people identified as male at birth who subsequently identify as female, and people identified as female at birth who later identify as male).

Transgender individuals (and many others) may also reject traditional concepts of gender as being strictly binary in terms of the male–female dichotomy. The population is diverse in gender identity, expression, and sexual orientation. Transgender people can be any sexual orientation. Some lesbians, gay men, and bisexuals are transgender, although most are not (IOM, 2011).

The gender-binary system is also important to understand in the context of the LGBTQ+ population. This system is based on the fact that society in general categorizes people as falling into one of two categories (man/woman, male/female, masculine/feminine). Individuals who identify as nonbinary or genderfluid may use gender-neutral pronouns such as they/them/theirs. It is imperative to address the question of pronouns with patients in each healthcare encounter.

LGBTQ+ POPULATION

It is difficult to accurately describe the demographics and statistics of the LGBTQ+ population. This may be due to the lack of appropriate survey questions on demographic questionnaires as well as a reluctance of individuals to respond for fear of stigma or discrimination. However, researchers have estimated that approximately 3.5% of adults in



the United States identify as lesbian, gay, or bisexual and that at least 0.3% identify as transgender (National LGBT Health Education Center, 2016; Hafeez et al., 2017).

Of those who identify as transgender, it is estimated that around 35% or more identify as genderfluid or nonbinary. While difficult to obtain exact numbers, some experts estimate that about 1 in every 1,500 people is born with genitals that cannot easily be classified as male or female (intersex) (APA, 2015).

HEALTH DISPARITIES AND HEALTH RISK FACTORS

Ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location are all factors that contribute to an individual's ability to achieve good health. A disparity refers to a health outcome that is seen to a greater or lesser extent in one population relative to another population. A risk factor is a behavior or condition that increases a person's chance of developing a disease or health condition. This may include social and environmental factors (ODPHP, 2016). The LGBTQ+ population is diverse in terms of race, ethnicity, disability, and socioeconomic status. Therefore, risk factors and disparities in each patient will vary depending on these individual factors. (See discussion below on specific population groups.)

Research has uncovered that LGBTQ+ individuals often face health disparities related to societal stigma, discrimination, and denial of civil and human rights in some manner. Discrimination has been linked to higher rates of psychiatric disorders, substance abuse disorders, and suicide. Violence and victimization are also more common and have life-long consequences to the individual and the community as a whole. Personal, family, and social acceptance of an individual's sexual orientation and gender identity often affects these individuals' mental health and personal safety (ODPHP, 2016).

Individuals who identify as LGBTQ+ may also experience minority stress. Minority stress theory connects health disparities among individuals to stressors induced by a hostile, homophobic culture in society as a whole. This often results in experiences of prejudice, internal expectations of rejection, and internalized homophobia. Aspects of minority stress, including the perception of prejudice, stigma, or rejection, are associated with higher rates of depression and dysfunctional coping strategies (Dentato et al., 2013).

LGBTQ+ populations experience a greater prevalence of mental disorders, such as:

- Anxiety and depression
- Suicidal ideation and attempts
- Other forms of emotional, physical, and sexual trauma (such as intimate partner violence) (Butler et al., 2016; National LGBT HEC, 2016)



Gay, lesbian, and bisexual adolescents and young adults have higher rates of tobacco and alcohol and substance abuse, unhealthy weight control, and risky sexual behaviors. This may be due to a higher level of psychological distress (National LGBT HEC, 2016).

SOCIAL AND ENVIRONMENTAL FACTORS

Social determinants of health that contribute to marginalization, health disparities, and health risk factors among LGBTQ+ patients include:

- Legal discrimination in accessing health insurance, employment, housing, marriage, adoption, and partner retirement benefits
- Lack of laws protecting against bullying in schools
- Lack of social programs to support youth, adults, and elders
- Lack of healthcare provider training on the unique needs and culture of the population

Environmental factors that contribute to positive effects on health and wellness of the LGBTQ+ population include:

- Safe schools, housing, and neighborhoods
- Access to facilities and activities where individuals feel safe and accepted
- Access to health and wellness services provided by culturally competent providers

(ODPHP, 2016)

Men Who Have Sex with Men (MSM)

The most researched health disparity among MSM is HIV/AIDS incidence and prevalence. Gay men or men who have sex with men are 44 times more likely than heterosexual men to be diagnosed with HIV (Butler et al., 2016). Gay, bisexual, and men who have sex with men have also been found to be at increased risk of other sexually transmitted infections (STIs), including:

- Syphilis
- Gonorrhea
- Chlamydia
- Human papillomavirus (HVP)
- Hepatitis A and B

(National LGBT HEC, 2016)

Gay men are also at an increased risk of cancers, including prostate, testicular, anal, and colon, which may be related to limited cancer screening and prevention services for this population (Hafeez et al., 2017).



CLINICAL IMPLICATIONS

Understanding the risk factors and health disparities for MSM, it is important to address the unique clinical concerns for this population through:

- Regular assessment and screening for STIs and HIV
- Routine vaccination for hepatitis A, hepatitis B, and HPV
- Prevention and screening for prostate cancer, testicular cancer, anal cancer, oral (head and neck) cancer, and colon cancer (ODPHP, 2016)

Women Who Have Sex with Women (WSW)

Lesbian and bisexual women are more likely to be obese and to use tobacco and alcohol than heterosexual women. Stress may be a contributing factor to the increased substance use or abuse in this population (National LGBT HEC, 2016). WSW are also at increased risk for depression and anxiety disorders and are less likely to receive routine reproductive care. Lesbian women are also less likely to access cancer screening and prevention services (ODPHP, 2016).

Lesbian women may be at a higher risk for uterine, breast, cervical, endometrial, and ovarian cancers for some of the factors listed above. Also, lesbians have traditionally been less likely to bear children, and hormones released during pregnancy and breastfeeding are believed to protect women against breast, endometrial, and ovarian cancers (WebMD, 2020).

CLINICAL IMPLICATIONS

Clinicians working with WSW should carefully assess and address the multiple risks that this population faces by providing:

- Preventive and wellness care to prevent or treat tobacco use/abuse and alcohol use/abuse
- Screening and early identification of behavioral health concerns such as depression or anxiety
- Regular preventive care and screening for uterine, breast, cervical, endometrial, and ovarian cancers
- Programs for healthy weight and exercise (ODPHP, 2016)

Transgender

Transgender individuals often face victimization, violence, and minority stress, and they are less likely to have access to health insurance for a variety of reasons. Transgender individuals have a higher prevalence of:



- HIV
- Sexually transmitted infections (STIs)
- Behavioral health disorders
- Suicide
(ODPHP, 2016)

CLINICAL IMPLICATIONS

Caring for transgender patients therefore includes screening for the following risks, as appropriate:

- Access to appropriate health insurance
- Violence
- Minority stress
- HIV
- STIs
- Suicide
- Behavioral health disorders
(ODPHP, 2016)

GENDER-AFFIRMING MEDICAL INTERVENTIONS

Some transgender individuals desire to undergo medical interventions to alter their outward appearance and secondary sex characteristics in order to feel aligned in their body with their gender, while others do not desire this intervention. It is important to recognize the unique needs of these patients as they make decisions about transition-related care and treatment.

Some surgical treatments can take years, with multiple procedures needed to complete a gender-affirming transition. Education on preparation, treatment, supportive care, and follow-up care are essential to support transgender patients in this process. In many cases, gender-affirming surgeries are done at specialty centers, so it is important to understand where this care can be obtained and how to refer patients to these services while also tending to their healthcare needs before, during, and after treatment for transition (National LGBT HEC, 2016; Gay & Lesbian Medical Association, n.d.).

Adolescents and Young Adults

Many concerns may impact the health and well-being of an LGBTQ+ individual. This is especially true for adolescents, who are in the process of navigating developmental milestones along with sexual or gender identity. Young adults who “come out” may be faced with bullying from their peers or family rejection. LGBTQ+ youth have a high rate of substance abuse, STIs,



and homelessness (ODPHP, 2019). They are more prone to have an increased risk of depression, suicidal ideation, and substance use, including tobacco, alcohol, cannabis, cocaine, ecstasy, methadone, and heroin (Hafeez et al., 2017).

Research has shown that LGBTQ+ adolescents and young adults with family acceptance have greater self-esteem, more social support, and better health outcomes. This acceptance also reduces the risk of substance abuse, depression, and suicide (National LGBT HEC, 2016).

CLINICAL IMPLICATIONS

Clinicians and providers working with this population should pay careful attention to subtle clues and risk factors of each individual, as adolescents and young adults may be especially reticent to discuss their concerns. Careful assessment focuses on:

- Evidence or risk of bullying
- Dysfunctional family dynamics
- Substance abuse risks
- Depression screening
- Suicide risks
- STIs screening
- HPV vaccination
- Home living conditions
(ODPHP, 2019)

CASE

Mark is a 38-year-old presenting to the urgent care clinic with UTI symptoms. Mark describes to the nurse practitioner, Jocelyn, his concern about this being his third UTI in the past three months. According to Mark's medical record, he is male and currently taking testosterone and Wellbutrin.

It could be easy to assume that Mark's genitals and organs match his outward male appearance and gender identity. But due to his medication history and in order to clarify, Jocelyn asks Mark which organs he has. She explains that she is asking Mark about his organs to explore whether there may be another medical reason Mark is having repeated UTIs. Mark tells Jocelyn that he has ovaries, a uterus, and a vagina. Jocelyn then explains to Mark that UTIs are common in people with frontal genital openings or vaginas.

Aware that using public restrooms can be uncomfortable or unsafe for some transgender people, Jocelyn asks Mark if he is always able to empty his bladder when it is full or if there are times or situations where he is not able to do this. Mark responds that he is able to empty his bladder now but that prior to his top surgery (6 months ago), he did not feel comfortable or safe using either female or male public restrooms due to his large chest.



Ruling this out as an issue that might be contributing to his UTIs, Jocelyn explains to Mark how testosterone can lead to vaginal atrophy and that the urethra is estrogen responsive. Since Mark is having repeated UTIs, it may be helpful to treat him with a course of vaginal estrogen.

By normalizing the discussion of his UTIs and gender identity, Mark leaves the office not only feeling very affirmed in his gender, but also relieved to understand that there is a medical reason for his continued infections.

LAWS RELATED TO LGBTQ+ HEALTHCARE

LGBTQ+ individuals continue to face unique legal challenges due to the inability to be recognized as their identified gender and/or to formalize their relationships. (Not all state legislatures are abiding by the Supreme Court ruling supporting the right to same-sex marriage.) This can leave many individuals and families feeling invisible in healthcare settings. In order to provide effective care, healthcare professionals should educate themselves and their patients about such laws, policies, and requirements needed to protect and ensure quality care for LGBTQ+ patients.

Expanded Health Insurance Laws

The federal Affordable Care Act (ACA), passed in 2015, includes certain provisions important for LGBTQ+ patients and their families:

- Health insurance plans may not exclude transition-related care for transgender patients.
- Coverage may not be denied based on pre-existing conditions (important, for instance, for patients with a pre-existing HIV/AIDS diagnosis).
- Insurance coverage must be made available regardless of employment status (important since protection from employment discrimination is not guaranteed for LGBTQ+ individuals).
- Expanded coverage is available (in most states) for LGBTQ+ partners and children (depending on the state's definition of "family members").
- Certain coverages are mandated for preventive services and screening, mental health, and substance abuse treatment.
- Protection is provided against discrimination based on sexual orientation and gender identity.

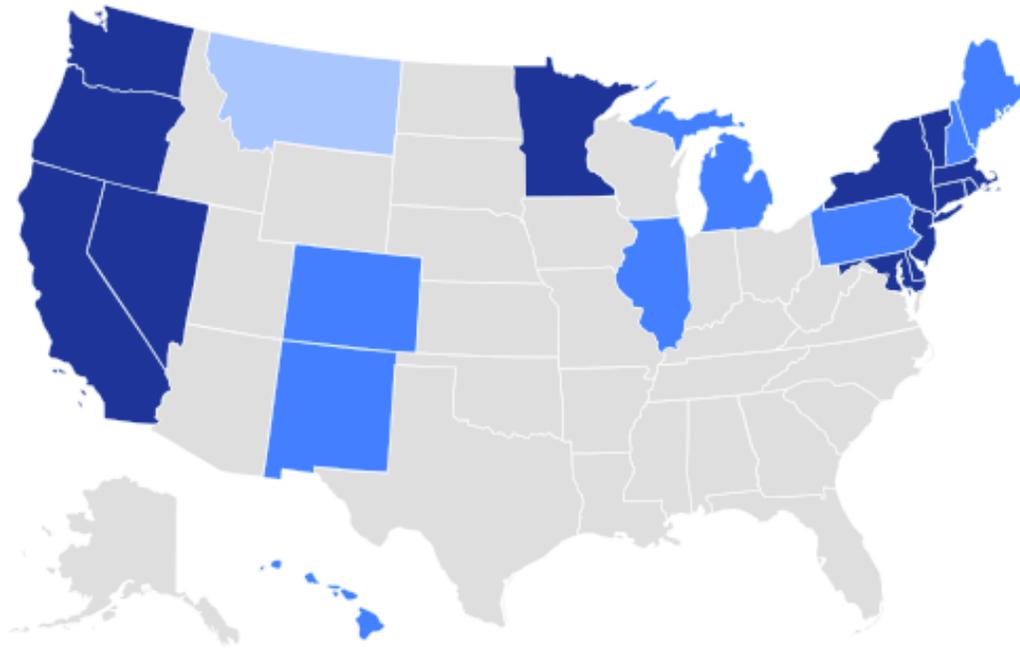
(Eliason & Chinn, 2015)

Some states have also passed laws regarding access to healthcare for transgender individuals (see map). **Washington, DC**, has both a ban on insurance exclusions for transgender healthcare and



provides transgender-inclusive health benefits to state employees. (See also “Resources” at the end of this course for more on state laws and policies.)

Healthcare providers working with LGBTQ+ patients can assist in advocating for quality care by supporting the above policies and referring patients who have questions about care or health insurance coverage to a social worker or case manager.



TRANSGENDER HEALTHCARE

Dark blue = Bans insurance exclusions for transgender healthcare and provides transgender-inclusive health benefits for state employees: California, Connecticut, Delaware, **District of Columbia**, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Oregon, Rhode Island, Vermont, Washington

Medium blue = Bans insurance exclusions for transgender healthcare: Colorado, Hawaii, Illinois, Michigan, New Mexico, Pennsylvania

Light blue = Provides transgender-inclusive health benefits for state employees: Montana

Gray = No ban on insurance exclusions for transgender healthcare nor transgender-inclusive health benefits to state employees

(HRC, 2020)



CHANGING RULES AND LAWS

Changing rules and laws related to healthcare coverage specific to sexual orientation and gender identity is a reality in today's political climate and can lead to potential discrimination against transgender patients.

For example, under the Obama administration, guidance on the implementation of the Affordable Care Act included rules to ban healthcare discrimination on the basis of gender identity (as described above). In early 2019, however, the Trump administration proposed a new rule, still pending when this course was published in January 2020, that would remove those requirements under the Affordable Care Act for transition-related care for transgender people in the United States. Similarly, the Supreme Court is expected to rule in 2020 on a case involving whether sex discrimination includes discrimination based on gender identity (Supreme Court, 2020).

LGBTQ+ Cultural Competency

In 2015, the D.C. Council Committee on Health and Human Services voted unanimously to approve the LGBTQ Cultural Competency Continuing Education Amendment Act of 2015. This act requires all healthcare providers to complete cultural competency training on the unique culture and healthcare needs of LGBTQ+ patients. Some U.S. states are considering similar measures.

Professional Association Policies and Position Statements

In order to protect the rights of LGBTQ+ patients, various professional and oversight organizations have also adopted policies, position statements, and/or requirements. Some of these are included below.

AMERICAN NURSES ASSOCIATION (ANA)

The ANA (2018) published the following position statement:

The ANA condemns discrimination based on sexual orientation, gender identity, and/or expression in healthcare and recognizes that it continues to be an issue despite the increasing recognition and acceptance of LGBTQ+ populations. Many LGBTQ+ individuals have reported experiencing some form of discrimination or bias when accessing healthcare services. Persistent societal stigma, ongoing discrimination, and denial of civil and human rights impede individuals' self-determination and access to needed healthcare services, leading to negative health outcomes including increased morbidity and mortality. Nurses must deliver culturally congruent, safe care and advocate for LGBTQ+ populations.



AMERICAN PHYSICAL THERAPY ASSOCIATION (APTA)

The APTA (2019) published the following nondiscrimination statement:

The American Physical Therapy Association opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA)

The AOTA has established the Network for Lesbian, Gay, Bisexual & Transgender Concerns in Occupational Therapy with a mission and purpose as follows:

The mission of the Network is to create the means for members of the occupational therapy professional community who are committed to advancing the understanding of sexual orientation issues to identify, support, and mentor one another and to promote research in occupational therapy.

The purpose of the Network is to:

- Provide a consistent voice to AOTA and state and local professional organizations regarding the needs and concerns of LGBT practitioners, students, and consumers
- Support and mentor one another and promote LGBT representation and leadership in local, state, and national decision-making bodies
- Promote the exploration of careers in occupational therapy by LGBT individuals
- Promote scholarship and research by and related to LGBT individuals within the profession of occupational therapy
(AOTA, 2019)

THE JOINT COMMISSION (TJC)

The Joint Commission ambulatory care standards address discrimination and a patient's right to have an advocate: "As a patient, you have the right to be informed about and make decisions regarding your care. You also have the right to care that is free from discrimination as well as the right to have a patient advocate" (TJC, 2019).

In addition, **The Joint Commission** (2011) earlier published an extensive field guide for hospitals to meet the needs of LGBT patients. This field guide points out potential barriers to care that LGBT individuals might face in the hospital setting, such as:



- Refusal of care
- Delayed or substandard care
- Mistreatment
- Inequitable policies and practices
- Little or no inclusion in health outreach or education
- Inappropriate restrictions or limits on visitation

These guidelines have created awareness to the needs of LGBTQ+ patients and outlined a roadmap for healthcare organizations to follow as they create and implement new policies and make change for a more inclusive healthcare environment for all patients.

THE JOINT COMMISSION FIELD GUIDE RECOMMENDATIONS

- Hospitals must prohibit discrimination based on sexual orientation and gender identity or expression, and this requirement applies regardless of local law.
- Hospitals may not refuse care because of sexual orientation or gender identity or expression.
- Hospitals should recognize same-sex partners as the patient's family, including recognizing same-sex marriages, even if not recognized by the law of the state in which the hospital is located.
- Patients may designate same-sex partners as surrogate decision-makers, including in advance directives.
- Hospitals should involve same-sex parents in their children's care, even those parents who lack legal custody.
- Hospitals should not permit a patient's parents who disapprove of the patient's same-sex relationship from excluding the patient's partner against the patient's wishes.
- A patient may designate a same-sex partner as family for visitation and other purposes.
- Healthcare providers should use neutral language when taking sexual histories.
- Hospitals should use a transgender patient's preferred name even if not the legal name.
- Hospitals should refer LGBT patients to welcoming healthcare providers for follow-up.
- Hospitals should maintain the confidentiality of information about sexual orientation and gender identity or expression.



- Hospitals should use available research data to understand LGBT community needs.
- Hospitals should consider modifying data systems to permit the capture of sexual orientation and gender identity or expression information in electronic medical records.
- Intake forms should be inclusive of LGBT patients.
- Hospitals should create a welcoming environment for LGBT staff and patients.
- LGBT hospital staff should be protected from discrimination.
- Key terms, such as *family*, *gender expression*, *gender identity*, and *sexual orientation* are defined in ways affirming to LGBT people, and the LGBT community's preferred and expansive phraseology important for transgender people—"gender identity or expression," is adopted throughout.
(TJC, 2011)

Other Legal Concerns of LGBTQ+ Patients

While not all jurisdictions provide specific legal protections for LGBTQ+ individuals, healthcare professionals and institutions can discuss and address various legal issues with patients.

LIVING WILL AND MEDICAL DIRECTIVES

LGBTQ+ individuals, as with all patients, should file documents outlining their wishes concerning life-sustaining medical care, funeral arrangements, and organ donation. This is especially important as they grow older. Each state may have different document names or requirements. Documents may be called:

- Living will
- Medical directive
- Healthcare directive
- Directive to physicians
- Declaration regarding healthcare
(Eliason & Chinn, 2015)

The "**District of Columbia Declaration**" is the District of Columbia's living will. It allows individuals to state their wishes about medical care in the event that they develop a terminal condition and can no longer make their own medical decisions. The declaration goes into effect when a patient's physician and one other physician certify that the patient has an incurable condition that will lead to their death, with or without the use of life sustaining medical care, and that life-sustaining procedures would serve only to postpone their death.



DURABLE POWER OF ATTORNEY FOR HEALTHCARE

A durable power of attorney for healthcare (or healthcare proxy) is a legal document that allows a designated person to make medical decisions for another person in the event they are unable to do so themselves. For an LGBTQ+ patient, this is a very important document that can protect their wishes at a time when they may not be able to speak for themselves. Same-sex partners should file these documents and make their wishes known to their family members as well. This is a legal document that should be kept on file with the healthcare facility and with the person who is named as the healthcare proxy.

In the **District of Columbia**, specific forms are available to create and notarize a durable power of attorney to keep on file as a legal document. (See “Resources” at the end of this course.)

HOSPITAL VISITATION AUTHORIZATION

A hospital visitation authorization allows a patient to name specific individuals they wish to visit them in the event that they are no longer able to communicate their wishes. For participating hospitals, a Centers for Medicare and Medicaid Services rule ensures visitation rights for family members, partners, and spouses of all patients, including LGBTQ+ individuals. Hospitals are required to inform each patient (or support person, where appropriate) that they may receive the visitors they designate, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend (CMS, 2010).

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

Medical treatment of a minor requires authorization from the legal parents. In states that do not recognize both parents in a same-sex couple as legal parents, it is critical to file the appropriate state form to address this issue. Such a form may be helpful in times when emergency care for a child of a same-sex couple is needed. For couples who are planning to have children, this document should be completed before the birth mother goes into the hospital. Most hospitals honor this authorization.

In the **District of Columbia**, the law reads:

A parent, legal guardian, or legal custodian may authorize an adult person, in whose care a minor has been entrusted, to consent to any medical, surgical, dental, developmental screening, and/or mental health examination or treatment, including immunization, to be rendered to the minor under the supervision or upon the advice of a physician, nurse, dentist or mental health professional licensed to practice in the District of Columbia, provided there is no prior order of any court in any jurisdiction currently in effect which would prohibit the parent, legal guardian, or legal custodian from exercising the power that they seek to convey to another person. Medical, surgical, and dental treatment or examination may include any X-ray or anesthetic required for diagnosis or treatment (Code of District of Columbia, 2019).



DURABLE POWER OF ATTORNEY FOR FINANCES

A durable power of attorney for finances designates a person (agent) to take care of finances when a person is not able to do so. This may include paying medical bills, cashing checks, and receiving benefits.

WILL

A will is a legal document that allows a person to designate who will receive any property when they die. If a person dies without a will, their property is automatically distributed to their legal heirs. A will is important for anyone to have, but especially important for same-sex partners, since they may not be recognized as a legal heir in all states.

“KNOW YOUR RIGHTS” IN WASHINGTON, DC

In the District of Columbia, specific laws and regulations may apply to the LGBTQ+ community, including these sections of the DC Code:

- 1-529, Spouse equity
- 1-612.31 and 32(b), Voluntary leave transfer program
- 1-621-07, 623.10 and 33, Health benefit coverage
- 1-2512, 2515, 2519 and 2520, Unlawful discriminatory practices in employment, real estate transactions, public accommodations, and educational institutions
- 2-1401, Human rights definitions
- 4-201.01, 205.22, 213.01, 218.01, 1301.02, Public assistance support actions
- 7-205, 215 and 219, Vital records - Birth and marriage registration
- 7-1601, AIDS health care definitions
- 16-1001, Intrafamily proceedings definitions
- 16-2345, Changes to new birth record upon marriage or determination of natural parents
- 16-2501, Change of name
- 21-2113, Uniform general power of attorney, related to personal and family maintenance
- 21-2202, Health-care decisions
- 22-201 and 501, Criminal offenses and penalties concerning adultery and bigamy
- 22-3700, Bias-related crime definitions
- 31-3303.07, Health insurance portability and accountability
- 32-501, Family and medical leave



- 32-701, 702(i), 704, 705(a), 705(b), 705(c), 705(d), 706, Health care benefits expansion
- 32-1201, Parental leave definitions
- 32-1501, Worker's compensation definitions
- 42-1102, 3404.02(b)(c), and 3651.05(c)(3)
- 46-301.01, Interstate family support definitions
- 46-405, Illegal marriages entered into in another jurisdiction
- 47-601, Property rights enumerated
- 50-1501.02(e)(4), Adding joint ownership to registration of motor vehicles

Specific acts and amendments to acts include:

- Bias-Related Crime Act of 1989
- Omnibus Domestic Partnership Equality Amendment Act of 2008 (Law 17-231)
- Jury and Marriage Amendment Act of 2009, B18-0010, A18-0070B18-0010, A18-0070
- Religious Freedom and Civil Marriage Equality Amendment Act of 2009

(DC.gov, 2019)

BEST PRACTICES REGARDING PATIENT INFORMATION

The process of collecting, storing, using, and keeping confidential information regarding sexual orientation and gender identity is evolving at most healthcare institutions. In 2011, the Institute of Medicine recommended that all healthcare institutions integrate data related to sexual orientation and gender identity into medical records. Appropriate data collection and privacy policies can lead to improved access, quality of care, and outcomes (Cahill & Makadon, 2014; GLMA, n.d.).

Inclusive Data Collection

Data collection on intake and other forms should allow for appropriate responses that are inclusive of LGBTQ+ patients. Best practices when collecting data include asking questions about gender first, then sexual orientation, followed by relationship status. Examples of inclusive data collection are indicated below.

Name

- Legal name: _____
- Chosen (preferred) name: _____



Gender Identity

- What was your assigned sex at birth (ASAB)?
 - Male
 - Female
 - Another
 - Do not wish to disclose
- What is your gender identity? (check all that apply)
 - Male
 - Female
 - Transgender Male
 - Transgender Female
 - Genderqueer
 - Other _____
 - Do not wish to disclose
- What are your pronouns?
 - He/him
 - She/her
 - They/them
 - Other _____

Sexual Identity

- Straight
- Gay
- Lesbian
- Bisexual
- Queer
- Questioning
- Don't know
- Something else _____
- Do not wish to disclose

Relationship Status

- Single
- Married
- Partnered/long-term or domestic partnership
- Divorced/separated
- Widowed
- Do not wish to disclose

(Kofie, 2017; National LGBT HEC, 2016; GLMA, n.d.)



Privacy Policies

It is important to assure all patients that any information collected is considered confidential. Confidential information may include patient-provider conversations and any data collected and stored in the medical record. Assurance of patient privacy may help LGBTQ+ patients feel more comfortable disclosing information within a healthcare setting knowing that it is protected. A confidentiality and privacy policy should be available in written format and readily available for patients to read and understand.

Elements to include in a privacy policy include:

- What information is covered by the policy
- Who has access to the medical record
- How test results remain confidential
- How information is shared with their insurance provider
- Any instances when maintaining confidentiality is not possible (GLMA, n.d.)

BEST PRACTICES FOR CULTURALLY COMPETENT CARE

LGBTQ+ patients, particularly those who identify as transgender or nonbinary, often face barriers to accessing healthcare services due to the lack of provider understanding of their gender identities. Providing high-quality, culturally competent, patient-centered care is a complex process that requires ongoing learning and awareness of the various factors that affect the LGBTQ population.

Even healthcare organizations that have taken positive steps toward improving cultural competency for LGBTQ+ patients will find new ways to address barriers to care and engage staff in improvement initiatives. Improving skills and knowledge among healthcare leaders, providers, and staff should be looked at as opportunities rather than as organizational or individual weaknesses.

Physical Space

Best practices start at the front door and extend into the provider's office and treatment areas. Everything from the hospital website to the front desk and waiting areas should reflect a healthcare setting that is welcoming, open, and inclusive.

- Include gender-neutral restrooms and signage.
- Post signage to affirm nondiscrimination policies that include sexual orientation, gender identity, and gender expression.



- Evaluate environmental factors of potential concerns for LGBTQ+ patients and families, such as bathroom designations, artwork, posters, educational brochures, etc. (DC.gov, 2010; Eliason & Chinn, 2015; GLMA, n.d.)

Internet and Website

Informational, educational, and support materials should be designed to help LGBTQ+ patients feel comfortable and supported in the healthcare setting.

- Include inclusive language on any websites and marketing materials that describes a commitment to high-quality, culturally competent, patient-centered care.
- Ensure that marketing, advertising, and informational materials reflect diverse populations, including same-sex couples and families.
- Create a separate webpage or portal for information and resources related to LGBTQ+ care. (DC.gov, 2010; Eliason & Chinn, 2015; GLMA, n.d.)

Supportive Communication

An individual may delay or avoid accessing care due to the fear that their provider may not take their gender identity and pronouns seriously or be entirely dismissive of them, causing them to feel “invisible.” There are many ways that a healthcare provider and support staff can communicate with patients to help them feel respected and comfortable.

- Avoid the use of gendered titles such as “Sir” or “Ma’am.” Instead of Mr. or Ms., patients may also wish to be addressed as Mx. (pronounced with a “ks” or “x” sound at the end).
- Ask patients for information such as pronouns, preferred name, and gender identity. Pronouns may include: he/his/him, she/hers/her, or a range of options for nonbinary transgender patients, such as they/their/them, ze, sie, hir, co, and ey. Always respect the patient’s pronouns and apologize if the wrong pronouns are used by mistake.
- Always ask for clarification when not clear what a patient would like to be called or how the patient would like to be addressed. Apologize if you refer to a patient in a way that seemed offensive.
- Ask patients what terms they use to refer to their anatomy and mirror those terms during the patient interaction. Transgender patients may experience gender dysphoria and/or may not be comfortable with traditional terms for body parts.
- Ask the patient to clarify any terms or behaviors that are unfamiliar, or repeat a patient’s term with your own understanding of its meaning, to make sure you have a good understanding of what this means for them.



- Do not make assumptions about patients' sexual orientations, gender identities, beliefs, or concerns based on physical characteristics such as clothing, tone of voice, perceived femininity/masculinity, etc.
- Do not be afraid to tell a patient about one's own inexperience working with LGBTQ+ patients. Honesty and openness will often stand out to a patient from their previous healthcare experiences.
- Do not ask patients questions about sexual orientation or gender identity that are not material to their care or treatment.
- Do not disclose patients' sexual orientations or gender identities to individuals who do not explicitly need the information as part of the patients' care.
- Keep in mind that sexual orientation and gender identity are only two factors that contribute to a patient's overall identity and experience. Other factors—including race, ethnicity, religion, socioeconomic status, education level, and income—also contribute to the patient's experiences, perceptions, and potential barriers to healthcare.
(AHIMA, 2017; TJC, 2011; DC.gov, 2010; Eliason & Chinn, 2015; Transgender Law Center, 2011; GLMA, n.d.)

CASE

James is a 23-year-old patient brought to the emergency department by a close friend who is concerned about James's symptoms of depression and a statement he made about "wishing I were dead." James has no significant medical or mental health history according to his medical record.

When the clinician greets James, she asks him which name and which pronouns he would like her to use with him. James notices that she is wearing a pin indicating her own pronouns and also sees a rainbow flag hanging on the wall of the exam room. James breaks down in tears and says that he sometimes just wants to die because he feels like he is supposed to be a woman. He is afraid this will never be a reality or possibility for him. If he shares his feelings with others, he worries about how his family will react and whether he'll lose his job or healthcare coverage.

The clinician responds with understanding and stresses that the most important thing now is to make sure he is safe and has the support he needs. She brings in the social worker to complete a behavioral health assessment clearing James of imminent risk of self-harm. The social worker also asks James his name and pronouns, and for the first time, James tells the medical team that he would like them to call him Jenna and use "she/her" pronouns. The social worker adds this information to the medical record and then provides Jenna with a national suicide hotline number for transgender people, a list of local support groups, the name of a psychologist who specializes in gender issues, and an insurance contact to review her benefits related to gender care.



Jenna states that she was previously unaware of all these support resources. She adds that she feels more hopeful than she has in a long time and that she had never been able to express her feelings so freely before.

Institutional Policies and Practices

In order to provide culturally competent care, institutions must assess current organizational practices and identify gaps in policies and services related to care and services for LGBTQ+ patients. This also includes ensuring that policies comply with all federal and state regulations (see “The Joint Commission Field Guide” earlier in this course).

Recommendations to build awareness within an organization about the LGBTQ+ community include:

- Hold an open discussion with healthcare professionals and staff about the difference between sexual orientation (lesbian, gay, bisexual, etc.) and gender identity (transgender, nonbinary, intersex, etc.), since this can be confusing to those who are not familiar with such concepts
- If not already in place, establish a point person, office, or advisory group to oversee LGBTQ-related policies and concerns, ideally including members representing the LGBTQ+ community
- For inpatient facilities, review visitation policies to empower patients to decide who can visit them and act on their behalf (see also “Legal Issues” earlier in this course)
- Review codes of conduct and ethics to ensure they include expectations for respectful communication with all patients, visitors, and staff members and that they specify consequences for code violations
- Provide training and orientation on a regular basis to professionals and staff on culturally competent care and organizational policies related to conduct, ethics, privacy, nondiscrimination, and antiharassment policies
(DC.gov, 2010; Eliason & Chinn, 2015; GLMA, n.d.)

ELEMENTS OF CULTURAL COMPETENCE TRAINING

Cultural competence training should occur at all levels within a healthcare institution and utilize a variety of approaches for all types of learners and providers. Elements to include in staff training should include:

- LGBT terminology and demographics
- LGBT history and background



- State and local laws affecting LGBT people in healthcare settings
- Stories of LGBT-related bias and substandard care
- Systemic barriers to care for LGBT patients
- LGBT health disparities and inequities
- LGBT subpopulations
- LGBT clinical concerns
- LGBT health promotion and disease prevention strategies
- LGBT mental and behavioral health concerns
- Best practices for communication and other interactions with LGBT patients
- Resources for follow-up learning
(TJC, 2011)

OPPRESSION, DISCRIMINATION, AND CULTURAL BIAS IN HEALTHCARE

While a person may define themselves largely by their sexual orientation and/or gender identity, one's experience is also influenced by the intersection of sex, race, ethnicity, socioeconomic status, ability, and other social determinants. All these factors have an impact on a patient's access to healthcare, health risks, and health outcomes. And any past and present discrimination, oppression, or fear related to these factors can greatly influence an individual's actions to actively seek care when needed or, conversely, to defer their healthcare needs until a crisis occurs (Ng, 2016).

An Intersectionality Perspective

Providing whole-person, patient-centered care requires proactively considering how the intersection of each person's diverse identities and broader cultural factors can affect their health risks, healthcare experiences, and health outcomes. Such an "intersectionality" perspective should not lead to assumptions about an individual based on the minority groups with which they identify but should inform the clinical experience in a positive manner in order to respect and address each person's unique needs (Ng, 2016).

Cultural Bias and the Provision of Care

When working with LGBTQ+ patients, it is especially important for clinicians to build a positive rapport as a way to counteract the exclusion, discrimination, and stigma they may have experienced previously in the healthcare environment. However, despite their best intentions, healthcare professionals may hold internalized cultural biases that affect their interaction with patients. For example, a clinician or other staff member may say something



or use body language that communicates a stereotype or negative message about LGBTQ+ people.

These biases can lead to unequal care and affect a patient's decision to follow medical advice or return for follow-up care. Negative messages can also become internalized in the patient, adding to an LGBTQ+ person's stress and contributing to negative mental and physical health outcomes (National LGBT HEC, 2018).

Studies have shown that no matter how individuals may feel about prejudiced behavior, everyone is susceptible to biases based on cultural values and stereotypes that were embedded in their belief systems from a young age. To increase one's own awareness of internal bias, it is helpful to notice times when biased attitudes and beliefs may arise. Such internal awareness is the first step in making changes. Internal questions to ask may include:

- How do my current beliefs help me?
- What might I lose if I change my beliefs?
- How might my current beliefs harm others?
- How might it benefit me and others to change my beliefs?

(National LGBT HEC, 2018)

It is important for clinicians to focus on remaining open and compassionate by consciously intending to set aside assumptions and get to know a patient as an individual. For example, when first meeting a new patient who is a transgender man, the clinician can imagine what it might be like for this person to see a new provider for the first time. Instead of focusing on the patient's gender identity and when or if he has transitioned, the clinician can focus on getting to know him as a person, such as understanding where he lives and works and more about his family support.

CONCLUSION

Providing high-quality, culturally competent care to all patients involves understanding the cultural contexts of each individual. In the case of LGBTQ+ patients, it is important to educate oneself on issues related to sexual orientation and gender identity in order to address and understand the spectrum of these patients' health concerns. This may include addressing any health risks or disparities, with careful attention to any behavioral health needs and transgender care.

When considering best practices for providing culturally competent care, healthcare professionals should carefully evaluate their practice environment; examine, advocate for, and modify practice policies when needed; take detailed and nonjudgmental histories; educate themselves and/or update their knowledge on the health issues of LGBTQ patients; and reflect on any personal attitudes or bias that may prevent them from providing the highest level of



care to their patients. By taking these positive steps, healthcare providers can ensure that all patients they care for achieve the best possible health outcomes.



RESOURCES

Gay and Lesbian Medical Association
<http://www.glma.org/>

National Center for Cultural Competence (Georgetown University)
<https://nccc.georgetown.edu/>

Human Rights Campaign
<https://www.hrc.org/>

The Joint Commission
www.jointcommission.org/lgbt/

Mayor's Office of Lesbian, Gay, Bisexual, Transgender and Questioning Affairs
(Washington, DC)
<https://lgbtq.dc.gov/page/glb-t-know-your-rights>

National Center for Transgender Equality
<https://transequality.org/know-your-rights/health-care>

National LGBT Health Education Center (Fenway Institute)
<https://www.lgbthealtheducation.org/>

State maps of laws and policies (Human Rights Campaign)
<https://www.hrc.org/state-maps/transgender-healthcare#>

Washington, DC, advance directive form (National Hospice and Palliative Care Organization)
<https://www.nhpc.org/wp-content/uploads/DistrictofColumbia.pdf>

WPATH (World Professional Association for Transgender Health)
<https://wpath.org/>

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TEST

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1. Gender identity is best described as:
 - a. The presence of certain female or male biologic anatomic traits.
 - b. How a person identifies their sexuality, including who they are physically and emotionally attracted to and with whom they choose to have sex.
 - c. The way a person presents their gender in society, through social roles, clothing, make-up, mannerisms, etc.
 - d. A person's internal sense of being a male/man, female/woman, both, neither, or another gender.

2. A transgender person is defined as:
 - a. A man who is primarily attracted to men.
 - b. A person who has a gender identity that does not match their assigned sex at birth.
 - c. A woman who is primarily attracted to women.
 - d. A person who is attracted to someone on the basis of their characteristics rather than their gender.

3. Which term is **no longer** considered acceptable?
 - a. Transgender
 - b. Queer
 - c. Homosexual
 - d. Gay

4. Which is an example of a pronoun that may be used by a patient whose gender identity is nonbinary?
 - a. They
 - b. Her
 - c. Him
 - d. It

5. When meeting with a 19-year-old woman who identifies as lesbian, the healthcare professional is aware that she may be at increased risk for:
 - a. Gonorrhea infection.
 - b. Hepatitis infection.
 - c. Depression.
 - d. Colon cancer.



- 6.** A teenage student mentions to the school nurse that he is really stressed out because his parents are not accepting of him after he recently “came out to them as being gay.” The nurse recommends support resources and assesses the student for signs and symptoms of:
- Obsessive compulsive disorder (OCD).
 - Attention deficit disorder (ADD).
 - Post-traumatic stress disorder (PTSD).
 - Suicide ideation.
- 7.** Which institutional policy does **not** meet The Joint Commission standards for appropriate care of LGBT patients?
- LGBT hospital staff may not be discriminated against in the workplace due to their sexual orientation.
 - Information related to sexual orientation and gender expression is protected as confidential.
 - Same-sex partners are not considered “family” for visitation purposes unless required by state law.
 - The hospital’s intake form shall include questions to capture a person’s sexual orientation, gender identity, and relationships.
- 8.** When admitting a patient who has a same-sex partner, as with all patients, it is particularly important to ask the patient about which document?
- Durable power of attorney for healthcare
 - Marriage certificate
 - Health insurance policy
 - Life insurance policy
- 9.** When asking a patient to indicate their gender identity, which would be considered an appropriate option to include on a healthcare facility intake form?
- Transitioned male
 - Transgender female
 - Female-to-male (FTM)
 - Hermaphrodite
- 10.** Which element is part of a culturally appropriate physical environment for LGBTQ+ patients?
- Locating male and female restrooms in separate areas of the building
 - Avoiding images of same-sex couples on posters
 - Posting nondiscrimination policies discretely in private areas
 - Providing gender-neutral restrooms for all patients



- 11.** When first interacting with a patient whose admitting documentation lists the legal name “Karl,” the clinician employs which best practice?
- Shows the patient the men’s restroom to help orient him to the clinic facilities
 - Refers to the patient as “sir” until a more relaxed relationship has been established
 - Asks the patient their preferred name and pronouns
 - Inquires if the patient is married in the event he will need help at home during recovery
- 12.** According to The Joint Commission, which is **not** a recommended component of cultural competence training for those who provide care to LGBT patients?
- Information on current LGBT terminology
 - Examples of bias and substandard care and recommended alternatives
 - Best practices for communicating with LGBT patients
 - How to recognize LGBT patients based on physical characteristics and behaviors
- 13.** What exercise is recommended in this course to assess one’s own cultural bias?
- Asking oneself the question, “Is my current belief wrong or right?”
 - Taking a survey that tests one’s knowledge of LGBTQ+ terminology
 - Asking oneself the question, “How might my current beliefs harm others?”
 - Debating one’s beliefs on LGBTQ+ issues with other clinicians

