



MINNESOTA LGBTQ

# Standards OF Inclusion

FOR HEALTH AND HUMAN SERVICES



## MINNESOTA LGBTQ STANDARDS OF INCLUSION FOR HEALTH AND HUMAN SERVICES

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### Why do we call this a working draft?

A third component of this project, a user guide, is forthcoming in early 2017; the user guide will be an interactive tool to assist organizations to implement these standards. Additionally, as new LGBTQ health data will be imminently released, we will update this document accordingly to reflect the most up-to-date research.

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# EXECUTIVE SUMMARY

**The Minnesota LGBTQ Standards of Inclusion for Health and Human Services represent a vision of health equity for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) communities in Minnesota.** This vision is necessary as LGBTQ communities throughout Minnesota continue to experience systemic health disparities. These Standards of Inclusion are best practices and policy recommendations for all types of clinics, hospitals, and organizations within the Health and Human Services sector. The standards provide a comprehensive framework to improve systems, policies, and professional development to advance equitable and inclusive health care for LGBTQ Minnesotans.

This document is designed for use in multiple capacities by different sectors within the Health and Human Services field including administration, human resources, patient experiences, and compliance teams to improve the quality of care their systems provide to LGBTQ patients, clients, and employees. These standards should function as the foundation for providers in their care delivery. It will be important for all providers to incorporate local, as well as sector specific standards depending on their capacities, as well as community needs.

## **The LGBTQ Standards of Inclusion:**

- Create and sustain an inclusive physical environment for LGBTQ communities.
- Recruit and retain LGBTQ employees.
- Require LGBTQ culturally responsive education for all care providers and support staff.
- Develop policies, procedures and care provisions that are intersectional.
- Implement an equitable and inclusive LGBTQ patient experience from in-take through completion of care.

LGBTQ healthcare disparities are not inherent to LGBTQ communities. They result from a healthcare system that systematically and historically ignored and undervalued both LGBTQ communities and their unique health needs. These standards provide a vision of systemic change where LGBTQ communities are no longer ignored, untreated, or discriminated against because of their sexual orientation and gender identity.

# BACKGROUND

Rainbow Health Initiative (RHI) was founded in 2001 by a group of community activists, health care providers, and health advocates who noted the significant health disparities facing members of Minnesota's LGBTQ communities. Seeking to address the need for comprehensive, culturally responsive, quality healthcare for LGBTQ Minnesotans, RHI applied for and was awarded a Bush Foundation Community Innovation Grant in May 2015 to develop the Minnesota Health and Human Services LGBTQ Standards of Inclusion. RHI's first step in this process was to convene an advisory board of health and human services professionals from urban and rural Minnesota to guide the development of the standards.

The advisory board met quarterly over the course of 2015-2016. RHI also convened a community review process involving stakeholders from throughout Minnesota to provide input on the standards. RHI facilitated this process as the primary grant recipient.

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# A NOTE ON TERMINOLOGY

The term SOGI (Sexual Orientation and Gender Identity) refers to all sexual orientation and gender identity expressions (including heterosexuality and cisgender), whereas LGBTQ specifically refers to Lesbian, Gay, Bisexual, Transgender, and Queer individuals. SOGI and LGBTQ are not interchangeable terms. Additionally, since medical and social science research on LGBTQ communities is not collected in a standardized or comprehensive way, there are several instances where the acronym LGBTQ is shortened to reflect the research of a particular study (e.g. LGB for Lesbian, Gay, and Bisexual).

We acknowledge that LGBTQ does not explicitly cover all sexual orientation or gender identities. While there are shared cultural experiences within each identity and community, it is important to understand that there is no single LGBTQ community, but rather multiple smaller communities. Just as with any other demographic group, LGBTQ individuals occupy many cultural spaces reflecting intersecting identities which impacts their health and well-being.

All other terms are defined in the glossary.

## LGBTQ HEALTH DISPARITIES

**While Minnesota consistently is regarded as one of the best healthcare systems in the country, many of its famous health outcomes are not shared by all<sup>1</sup>.**

Overall, there is a gap both in knowledge of and service for LGBTQ Minnesotans compared to heterosexual and cisgender populations. This section is not an exhaustive review of all medical literature related to conditions affecting LGBTQ populations. The aim of this section is to outline themes and trends of LGBTQ health disparities both in Minnesota and nationally. This section reviews data challenges, as well as health disparities for specific LGBTQ populations as well as those occurring at the intersections of sexual orientation and gender with age, race, and ability. All other terms are defined in the glossary.

<sup>1</sup>Minnesota Department of Health. (2016). Advancing health equity in Minnesota: Report to the legislature. Retrieved from [http://www.health.state.mn.us/divs/chs/healthequity/ahe\\_leg\\_report\\_020414.pdf](http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf)

## THE DATA CHALLENGE

Because individual SOGI data is not collected nationally via the U.S. Census, one of the biggest challenges to understanding the patterns of health disparities for LGBTQ communities is the systemic lack of data collection. Most health and human service systems ignore LGBTQ communities and simply do not collect SOGI data for clients, patients, or employees. This lack of data collection results in fewer high-quality studies detailing LGBTQ health.

This trend is endemic across several fields. Because SOGI data is not collected nationally via the decadal U.S. Census, there is no baseline measure for the population across the country. Additionally, attempts to estimate the population size varies as each survey uses different measures on who to include, as well as different survey methodologies. For example, in 2016, the Williams Institute reported that approximately 3.8% of the population identify as being LGBT<sup>2</sup>. The Williams Institute also reported in 2016 that 1.4 million people in the United States identifies as Transgender<sup>3</sup>.

In the absence of consistent federal or national healthcare baseline data what emerges is a collection of studies and reports from academics, peer-reviewed journals, think-tanks, and non-profits. This research tends to focus on a particular sexual orientation or gender identity. As a result, current research on LGBTQ health disparities tends to be specialized on a particular identity or intersection of identities – with fewer meta-analyses across LGBTQ communities.

## NATIONAL STUDIES OF LGBTQ HEALTH

### Physical health

Lesbian, Gay, and Bisexual persons exhibit higher rates of asthma, allergies, osteoarthritis, and gastrointestinal disorders than heterosexuals and have a higher prevalence of debilitating disabilities<sup>4,5</sup>. These populations also have a heightened risk and diagnosis of cardiovascular disease than straight persons<sup>6</sup>. Lesbian and Bisexual women are at an increased risk of developing several cancers particularly breast and cervical cancer due to a lack of preventative screenings<sup>7</sup>.

<sup>2</sup>The Williams Institute. (2016). Same-sex couples and LGBT demographic data Interactive. Retrieved from <http://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&compare=percentage#comparison>

<sup>3</sup>Flores, A.R., Herman, J.L., Gates, G.L., & Brown, T.N.T. (2016). "How many adults identify as transgender in the United States?" The Williams Institute.

<sup>4</sup>Durso, L.E., Johnson, K.L., & Lick, D.J. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science*. Retrieved from <http://pps.sagepub.com/content/8/5/521>.

<sup>5</sup>Buchmueller, T., & Carpenter, C.S. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health*, 100(3), 489-95.

<sup>6</sup>Beamesderfer, A., Dawson, L., Kates, J., Ranji, U., & Salganicoff, A. (2015). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. The Henry J. Kaiser Family Foundation. Retrieved from <http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-health-challenges/>

<sup>7</sup>Bassford, T., Bowen, D. J., Carter, R. A., Charney, P., Valanis, B. G., & Whitlock, E. (2000). Sexual orientation and health: comparisons in the women's health initiative sample. *Archives of Family Medicine*, 9(9), 843.

### THE PROBLEM WITH THE TERM "MSM"

MSM stands for "men who have sex with men." We do not condone this term. It classifies people by biological sex and sexual behavior instead of by gender identity. In doing so, transgender women are classified as MSM and remain invisible. This term is problematic and an example of how healthcare systems are not inclusive. We include this term because it is used by the Center for Disease Control (CDC) in data collection. Please note this limiting category skews our data.

### Research also indicates the following:

- 63% of estimated new HIV infections were among Gay and Bisexual men<sup>8</sup>
- 86% of estimated HIV diagnoses were amongst Gay and Bisexual men<sup>9</sup>
- African-American Gay and Bisexual males accounted for 39% of HIV infection diagnoses in 2013<sup>9</sup>
- Rates of sexually transmitted infections (STI) are also higher among men who have sex with men (MSM)<sup>10</sup>
- Rates of human-papilloma virus-associated anal cancers are seventeen times higher in MSM than heterosexual men<sup>11</sup>

According to the National Health Interview Survey (NHIS), Lesbian and Bisexual women were less likely to report excellent or very good health than heterosexual women. While obesity remains an epidemic for all populations, we see that Lesbian women are twice as likely as heterosexual women to be overweight or obese<sup>12</sup>. Conversely we see that Gay and Bisexual men are less likely to be overweight than heterosexual men. However, this result may be connected to data which states that Gay and Bisexual men are far more likely to have eating disorders such as anorexia than heterosexual men<sup>13</sup>.

Women in same-gender relationships were less likely to have received a mammogram, pap test, or their annual physical<sup>14</sup>.

LGBTQ persons of color continue to be disproportionately affected by HIV incidence and prevalence with rates consistently higher than white LGBTQ persons<sup>14</sup>. Transgender women have a high risk of HIV infection with African-American Transgender women having the highest percentage of HIV positive-test results<sup>14</sup>. Many different surveys show that the rates of HIV infection amongst Transgender women across the country range from 14% - 68%<sup>15</sup>.

<sup>8</sup> Centers for Disease Control and Prevention. (2010). HIV among gay, bisexual and other men who have sex with men (MSM).

<sup>9</sup> Centers for Disease Control and Prevention (2016). Gay and bisexual men: HIV by group. Retrieved from <http://www.cdc.gov/hiv/group/msm/>

<sup>10</sup> Bauer, H. M., Klausner, J. D., Mark, K. E., Moore, D., Samuel, M., Wang, S. A., & Weismuller, P. (2005). Prevalence of and associated risk factors for fluoroquinolone-resistant *Neisseria gonorrhoeae* in California, 2000–2003. *Clinical infectious diseases*, 41(6), 795-803.

<sup>11</sup> Centers for Disease Control and Prevention. (2016). STD facts - HPV and men. Retrieved from <http://www.cdc.gov/std/hpv/stdfact-hpv-and-men.htm>

<sup>12</sup> Bauer, G.R., Boehmer, U., Bowen, D.J. (2007). Overweight and obesity in sexual-minority women: Evidence from population-based data. *American Journal of Public Health*, 97(6), 1134-40.

<sup>13</sup> Forstein M., & Ruble, M.W. (2008). Mental health: Epidemiology, assessment, and treatment. In H.J. Makadon, K.H. Mayer, J. Potter, H. Goldhammer (Eds.), *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health (187-208)*. Philadelphia, PA: American College of Physicians.

<sup>14</sup> Buchmueller, T., & Carpenter, C.S. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health*, 100(3), 489-95.

<sup>15</sup> Rodriguez-Madera, S., & Toro-Alfonso, J. (2005). Gender as an obstacle in HIV/AIDS prevention: Considerations for the development of HIV/AIDS prevention efforts for male-to-female transgenders. *International Journal of Transgenderism*, 8, 113-122.



LGBTQ youth are more likely to experience homelessness increasing their poor health outcomes. According to the Williams Institute, nationally we see that approximately 40% of youth clients served by homeless service centers identify as LGBT<sup>16</sup>. LGBTQ youth disproportionately represent the populations served by drop-in centers, street outreach programs, and housing programs, representing 30% to 40% of clients<sup>16</sup>. According to the Centers for Disease Control and Prevention (CDC), rates of alcohol and drug abuse are higher among LGB communities than amongst heterosexuals<sup>17</sup>. Tobacco usage is also more prevalent for the Lesbian, Gay, and Bisexual population<sup>18,19</sup>. Nationally, nearly one in four LGB adults smokes cigarettes, compared to one in six heterosexual adults.<sup>20</sup>

When LGBTQ persons find themselves in need of supportive services they often face barriers to access due to the facilities provider of the service. Many food shelves and shelters are primarily operated by religious organizations, which may not support LGBTQ persons. Even if the facility may not actively discriminate against LGBTQ individuals, the religious association may dissuade people from seeking help from these organizations due to prior experiences of discrimination.

### Mental health

LGBTQ people report higher rates of depression, anxiety, and suicidal ideation<sup>21</sup>. A survey conducted in San Francisco showed that of the over 500 respondents, rates of depression were 55% for Transgender men and 66% for Transgender women<sup>22</sup>. Many studies and meta-analyses consistently show that the Transgender community has significantly higher rates of suicide and suicidal ideation<sup>23</sup>. LGB youth are twice as likely to attempt suicide as heterosexual youth<sup>24</sup>. For LGBTQ adults, homophobia and minority stress are often cited as reasons for the higher rates of substance abuse<sup>25</sup>.

<sup>16</sup> Durso, L.E., & Gates, G.J. (2012). Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless. The Williams Institute with True Colors Fund and The Palette Fund.

<sup>17</sup> Birkett, M., Espelage, D.L., & Koenig, B. (2009). LGB and questioning students in schools: The moderating effects of homophobic bullying and school climate on negative outcomes. *Journal of Youth and Adolescence*, 38, 989–1000.

<sup>18</sup> Lee, J.G.L., Griffin, G.K., & Melvin, C.L. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: A systematic review. *Tobacco Control*, 18, 275-282.

<sup>19</sup> Colfax, G., Guzman, R., Sevelius, J.M., & Song, Y.S. (2008). Substance use and abuse. In H.J. Makadon, K.H. Mayer, J. Potter, H. Goldhammer (Eds.), *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* (209-247). Philadelphia, PA: American College of Physicians.

<sup>20</sup> Centers for Disease Control and Prevention (CDC). (2015, Nov 13). Current Cigarette Smoking Among Adults—United States, 2005-2014. *MMWR. Morbidity and Mortality Weekly Reports*. Retrieved from [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm?s\\_cid=mmb6444a2\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm?s_cid=mmb6444a2_w)

<sup>21</sup> Meyer, I.H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin* 129 (5), 674–97. Retrieved from <http://psycnet.apa.org/?fa=main.doiLanding&doi=10.1037/0033-2909.129.5.674>

<sup>22</sup> Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, 91(6), 915.

<sup>23</sup> Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

<sup>24</sup> Grossman, A. H., & D’Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior*, 37(5), 527-537.

<sup>25</sup> Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better*

## Transgender health

According to the 2011 National Transgender Discrimination Survey<sup>26</sup>:

- 28% of respondents experienced discrimination resulting in delaying or cancelling care.
- 48% of respondents had to postpone treatment due to an inability to cover the cost.
- Over half of the respondents reported having to inform their providers of Trans-related care needs.
- Of the Minnesota respondents, 43% reported attempting suicide at some point in their lives, which is twenty-seven times the rate of the general public.
- 15% of Minnesota respondents to the survey reported that they were denied service based on their Transgender or gender-nonconforming status.
- One of the most alarming facts of this survey is that 28% reported being verbally harassed in a medical facility and 2% of respondents reported actually being physically attacked in a provider's office.

The results of the 2015 National Transgender survey will be released late in 2016.

## DISPARITIES IN MINNESOTA

Seeking to fill the data gap in Minnesota, RHI conducts an annual health survey called Voices of Health (VOH).

The 2015 VOH survey reported high rates of depression and anxiety compared to heterosexual and cisgender Minnesotans<sup>27</sup>. 8% reported being homeless at the time of the survey, compared to the estimated 3% homelessness rate of all Minnesotans. One-fifth were not out to their doctor about their LGBTQ identity. 12.3% of trans respondents delayed getting care because of previous discrimination, compared to 5.4% of cisgender LGBQ respondents. The 2014 survey found that 1 in 5 LGBTQ Minnesotans (18%) experienced some type of discrimination by a healthcare provider due to their sexual orientation or gender identity, and 1 in 11 (9%) had experienced discrimination by a healthcare provider in the past year. The 2014 VOH report also found that 7% of respondents did not feel their doctor was competent in LGBTQ care and 27% did not know or were unsure<sup>28</sup>.

<sup>26</sup> Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). Injustice at every turn: A report of the national transgender discrimination survey. National Center for Transgender Equality.

<sup>27</sup> Rainbow Health Initiative. (2016). Voices of health: A survey of LGBTQ health in Minnesota. Minneapolis, MN. Retrieved from [http://www.rainbowhealth.org/files/3314/5874/9353/web\\_version\\_voicesofhealth2015report\\_FINAL.pdf](http://www.rainbowhealth.org/files/3314/5874/9353/web_version_voicesofhealth2015report_FINAL.pdf)

<sup>28</sup> Rainbow Health Initiative. (2015). Voices of Health

In 2014, Hennepin County Human Services and Public Health Department conducted the Survey of Health of All the Population and Environment (SHAPE) and found that LGBT respondents had much worse mental health indicators than heterosexuals with more reports of anxiety, depression, and psychological distress<sup>29</sup>. The SHAPE results also found that LGBT respondents had higher rates of prescription insecurity due to costs compared to non-LGBT respondents. Prescription insecurity being defined as skipping doses, taking smaller doses than prescribed, and not filling prescriptions due to costs.

The survey also found that LGBT respondents experienced the following at higher rates than non-LGBT respondents:

- Housing insecurity (missed rent/mortgage payment in past 12 months)
- Residential instability (moved two or more times in past two years)
- Lived below 200% Federal Poverty Level

In 2015, RHI released Invisible Youth: The Health of Lesbian, Gay, Bisexual, and Questioning Adolescents in Minnesota. This report was based on data collected in the 2013 Minnesota Student Survey (MSS). Invisible Youth found significant mental and physical health disparities for LGBQ youth in Minnesota. Compared to straight peers, LGBQ youth reported high levels of internal distress, particularly young females<sup>30</sup>. Over half of the LGB youth stated that they were significantly depressed in the past year.

Other mental health issues found in the survey were:

- Over half of LGB youth reported feeling trapped, lonely, or hopeless about their future
- 50% of Bisexual and Gay males reported problems with anxiety
- 14-17% of GBO males reported high levels of external distress
- 16% of Bisexual and Lesbian females reported high levels of external distress

## INTERSECTIONALITY

LGBTQ persons come from every demographic sector possible. These multiple identities intersect to influence their experiences. These intersecting identities shape their healthcare and can compound disparities. Equitable and inclusive services for a transgender Latina woman are different from the needs of an African-American gay male. Equitable and inclusive care for LGBTQ persons must incorporate anti-racism practice. It is important that care organizations incorporate this knowledge in their practice.

<sup>29</sup> Hennepin County Public Health. (2016). The health and well-being of LGBT residents in Hennepin county: Data from Metro SHAPE 2014 [PowerPoint slides]. Retrieved from [http://www.rainbowhealth.org/files/5214/5988/9538/MetroSHAPE2014adult\\_LGBHealth\\_RHI\\_DataForum\\_FINALv2.pdf](http://www.rainbowhealth.org/files/5214/5988/9538/MetroSHAPE2014adult_LGBHealth_RHI_DataForum_FINALv2.pdf)

<sup>30</sup> Rainbow Health Initiative. (2015). Invisible youth: The health of lesbian, gay, bisexual, and questioning adolescents in Minnesota. Minneapolis, MN. Retrieved from [http://www.rainbowhealth.org/files/1714/4561/9488/Oct\\_23\\_MSS\\_Report.pdf](http://www.rainbowhealth.org/files/1714/4561/9488/Oct_23_MSS_Report.pdf)

## LGBTQ persons of color

There is substantial evidence of increased health disparities for racial, ethnic, and linguistic minorities within Minnesota and across the country<sup>31</sup>. Across the board, communities of color are experiencing poorer health outcomes for most of the metrics of the 2014 National Healthcare Quality and Disparities Report (NHQDR). Persons of color are more likely to develop cardiovascular disease, diabetes and receive a cancer diagnosis<sup>32</sup>. People of color also often do not receive mental health treatment for depression and substance abuse issues due to the high percentage of uninsured individuals and social stigmas regarding mental health.

In Minnesota, people of color who identify as LGBTQ have higher rates of discrimination, poorer quality care, and lower rates of insurance compared to white LGBTQ people<sup>33</sup>. The intersection of race, sexual orientation, and gender identity can create clinical situations where LGBTQ persons of color experience multiple stressors compounding negative health outcomes.

Examples of this include the following studies. Nationally, LGBT Asian and Pacific Islander Americans have higher rates of mental health disparities and lower health care access compared to white LGBT Americans<sup>34</sup>. According to the CDC, 56% of black transgender women tested positive for HIV, compared to 16% of Hispanic/Latina transgender women, and 17% of white transgender women<sup>35</sup>. These individuals not only deal with homophobia and racism health care systems and institutions, but also face prejudice and racism within the LGBTQ community.

Care professionals should be aware of the intersecting identities of LGBTQ persons of color when assessing their care needs. Providing a range of supportive services is necessary as there are cultural barriers which many LGBTQ persons of color face. African-Americans and Latinos are less likely to seek mental health services due to cultural stigma around mental health disorders. Linguistic services are necessary to ensure access for non-English speaking LGBTQ persons of color. Many of the same tools which are recommended for improving care for racial and linguistic minorities are beneficial to LGBTQ persons of color. Creating inclusive care environments means addressing the complex barriers for individuals with intersecting identities.

<sup>29</sup> Hennepin County Public Health. (2016). The health and well-being of LGBT residents in Hennepin county: Data from Metro SHAPE 2014 [PowerPoint slides]. Retrieved from [http://www.rainbowhealth.org/files/5214/5988/9538/MetroSHAPE2014adult\\_LGBTHealth\\_RHI\\_DataForum\\_FINALv2.pdf](http://www.rainbowhealth.org/files/5214/5988/9538/MetroSHAPE2014adult_LGBTHealth_RHI_DataForum_FINALv2.pdf)

<sup>30</sup> Rainbow Health Initiative. (2015). Invisible youth: The health of lesbian, gay, bisexual, and questioning adolescents in Minnesota. Minneapolis, MN. Retrieved from [http://www.rainbowhealth.org/files/1714/4561/9488/Oct\\_23\\_MSS\\_Report.pdf](http://www.rainbowhealth.org/files/1714/4561/9488/Oct_23_MSS_Report.pdf)

<sup>31</sup> Brennan Ramirez, L. K., Baker, E. A., & Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. Atlanta, GA: U.S. Department of Health and Human Services Centers for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf>

<sup>32</sup> Agency for Healthcare Research and Quality. (2015). 2014 National Healthcare Quality & Disparities Report. Retrieved from <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html>

<sup>33</sup> Rainbow Health Initiative. (2015). Voices of health: A survey of LGBTQ health in Minnesota. Minneapolis, MN.

<sup>34</sup> Jose-Rey, M., Shilpi Islam, N., & Trinh-Shevrin, C. (Eds.). (2009). Asian American communities and health: Context, research, policy, and action. San Francisco, CA: Jossey-Bass.

<sup>35</sup> Centers for Disease Control and Prevention. (2016). HIV among transgender people. Retrieved from <http://www.cdc.gov/hiv/group/gender/transgender/>

In short, achieving health equity for LGBTQ communities of color requires racial equity and substantive anti-racism practices.

### LGBTQ persons with disabilities

The 1990 Americans with Disabilities Act (ADA) defines a person with a disability as someone who has a physical or mental impairment which substantially limits one or more major life activities. According to the 2010 U.S. Census, 1 in 5 Americans is living with a disability<sup>36</sup>. Recent studies find that rates of persons living with a disability are higher in the LGBTQ community<sup>37</sup>.

Because of many factors such as social isolation, poverty, and environmental barriers, many persons with disabilities have multiple comorbidities. These individuals must not only cope with their primary disability but also additional chronic conditions such as obesity, depression, and arthritis. These co-occurring conditions decreases the quality of life for many LGBTQ individuals. Persons with disabilities are often marginalized because of their disability by both the Heterosexual and LGBTQ communities<sup>38,39</sup>. Both communities stigmatize persons with disabilities as asexual or not being able to control their own sexual health. This has resulted in higher rates of risky sex practices amongst LGBTQ persons with disabilities putting them at risk of HIV/AIDS.

Many providers are not knowledgeable about LGBTQ persons with disabilities and are not trained to understand their unique risk factors. Care providers may also be uncomfortable with the idea of loved ones with disabilities being sexually active or building sexual relationships and may try to prevent or limit LGBTQ persons with disabilities from living complete lives<sup>40</sup>. These care providers may also harbor homophobic, or transphobic biases forcing the LGBTQ persons with a disability, who relies on them for care, to stay in the closet and engage in risky sex practices.

It is important for health providers throughout the state to be cognizant of the intersecting identities of LGBTQ persons with disabilities because of the diversity of this group. Not only are LGBTQ persons with disabilities part of many racial, socio-economic, and faith communities there is also a great deal of diversity within the community because of the varying types of disabilities experienced by each individual. The needs of someone who is Blind are not the same as someone who is wheelchair bound despite both being part of the disability community. Health providers must incorporate all the identities of LGBTQ persons with disabilities into their plan of care.

<sup>36</sup> United States Census Bureau. (2012). Nearly 1 in 5 people have a disability in the U.S., census bureau reports. Retrieved from <https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html>

<sup>37</sup> Barkan, S.E., Fredriksen-Goldsen, K.I., & Hyun-Jun, K. (2012). Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk. *American Journal of Public Health*, 102(1), e16-e21. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/>

<sup>38</sup> Clare, E. *Exile & pride: Disability, queerness, and liberation*. Cambridge, MA: South End Press.

<sup>39</sup> Rothenberg, P.S. (Ed.). (2010). *Race, class, and gender in the United States* (8th ed.). New York, NY: Worth Publishers.

<sup>40</sup> Gruchow, P. (2012). *Letters to a young madman: A memoir*. Minneapolis, MN: Levins Publishing.

## Elder LGBTQ

Census data from 2010 shows that the American population is aging. The median age of Americans has steadily increased with many states having median ages above 40<sup>41</sup>. This trend is placing greater stress on care systems throughout the U.S. Elder individuals tend to have greater mental and medical health needs as well as specialized housing considerations. These needs are rising healthcare costs which is a concern for many older individuals living on fixed incomes.

In the 2011 Aging and Health Report, nearly half of the LGBTQ participants reported a disability<sup>42</sup>. This same report found that 30% of the participants were diagnosed with depression. Persons living with HIV are experiencing greater life expectancies due to advancements in antiretroviral medications. The physical toll of managing a chronic condition, such as HIV, over their lifetime means these individuals have specialized care needs. Medical care providers are encountering elder LGBTQ individuals and are finding themselves unaware of many care concerns resulting in poorer quality care. Elder LGBTQ persons are presenting with more comorbidities and high rates of depression and anxiety<sup>43</sup>.

Unfortunately, elder LGBTQ persons are not considered to have “greatest social need” under the Older American Act (OAA) meaning that they are not receiving needed services through the OAA. The OAA provides funding for nutritional, housing, and social services for older Americans and is the largest such entity in the country. Individuals receive support based on their need and since elder LGBTQ persons are not considered, their needs are neglected. This is troubling since 1 in 3 elder LGBTQ adults lives alone and thus require additional supports.

It is important to note that as LGBTQ individuals age their housing needs will change. This places greater stress on aged LGBTQ persons as many individuals go back into the “closet” to enter assisted living facilities or nursing homes. The lack of other LGBTQ individuals within these facilities, creates a sense of danger and a potential for discrimination resulting in the need to shield oneself. This exacerbates existing mental health issues such as depression and anxiety resulting in a reduced quality of life.

## LGBTQ youth

LGBTQ youth experience high rates of physical and emotional violence in school as well as their homes<sup>44</sup>. They often do not receive adequate support from schools

<sup>41</sup> United States Census Bureau. (2011). Age and sex composition: 2010 Census Briefs. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf>

<sup>42</sup> Emlet, C.A., Erosheva, E.A., Fredriksen-Goldsen, K.I., Goldsen, J., Hoy-Ellis, C.P., Kim, H., Muraco, A., & Petry, H. (2011). The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults. Retrieved from <http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf>

<sup>43</sup> Emlet, C.A., Erosheva, E.A., Fredriksen-Goldsen, K.I., Goldsen, J., Hoy-Ellis, C.P., Kim, H., Muraco, A., & Petry, H. (2011). The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults. Retrieved from <http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf>

<sup>44</sup> Rainbow Health Initiative. (2015). Invisible youth: The health of lesbian, gay, bisexual, and questioning adolescents in Minnesota. Minneapolis, MN. Retrieved from [http://www.rainbowhealth.org/files/1714/4561/9488/Oct\\_23\\_MSS\\_Report.pdf](http://www.rainbowhealth.org/files/1714/4561/9488/Oct_23_MSS_Report.pdf)

to ensure their welfare and may even face rejection from their families. Rates of homelessness are significantly higher amongst LGBTQ youth. This lack of housing security has severe impacts on the health of these individuals. Results from 2001 show that in the U.S. 1.6 million (approximately 1 in 7) youth aged 12- 17 ran away from home and experienced a night of homelessness<sup>45</sup>. Some estimates put the proportion of LGBT homeless youth at 20 to 40 percent<sup>46</sup>.

Attempted suicides are also highly prevalent for LGBTQ youth as is drug and alcohol abuse<sup>47</sup>. Suicide is the second leading cause of death for youth aged 10 to 24. Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose requiring treatment from a doctor or nurse, compared to straight youth<sup>48</sup>. LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection<sup>49</sup>. Rates of substance abuse amongst LGBTQ youth is significantly higher with some studies showing that a quarter of young Gay men report repeated binge drinking<sup>50</sup>. Similar studies found that Lesbian and Bisexual girls were 9.7 times more likely to smoke than heterosexual peers<sup>51</sup>.

The status of many LGBTQ youth as minors presents its own challenges, as most youth are required to share medical decisions with a guardian. While there are methods of exempting minors from this burden, the act of requesting these exemptions is itself a burden for LGBTQ youth. This places many youth in a tenuous situation especially in the case of Transgender and Queer youth. Many of these individuals do not receive the care necessary for their mental and physical well-being due to discrimination and bias. Homeless youth are least likely to receive necessary medical care due to a lack of insurance and competing priorities such as housing and employment. Creating equitable and inclusive spaces for LGBTQ youth is necessary to improve their health outcomes.

## PHYSICAL VIOLENCE

Physical violence represents a significant health threat to LGBTQ communities. According to data analysis by the Federal Bureau of Investigation (FBI), LGBT persons are the most likely victims of a hate crime in the United States<sup>52</sup>.

<sup>45</sup> Krehely, J. (2009). How to close the LGBT health disparities gap. Center for American Progress, 1-9.

<sup>46</sup> Durso, L. E., & Gates, G. J. (2012). Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless. Retrieved from <http://william-sinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf>

<sup>47</sup> Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., & Russell, S. T. (2010). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *Journal of Homosexuality*, 58(1), 10-51.

<sup>48</sup> Russell S.T., Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91, 1276-1281.

<sup>49</sup> Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346-352.

<sup>50</sup> Wong, C. F., Kipke, M. D., & Weiss, G. (2008). Risk factors for alcohol use, frequent use, and binge drinking among young men who have sex with men. *Addictive Behaviors*, 33(8), 1012-1020.

<sup>51</sup> Austin, S. B., Ziyadeh, N., Fisher, L. B., Kahn, J. A., Colditz, G. A., & Frazier, A. L. (2004). Sexual orientation and tobacco use in a cohort study of US adolescent girls and boys. *Archives of Pediatrics & Adolescent Medicine*, 158(4), 317-322.

<sup>52</sup> Park, H., Mykhyalshyn, I. June 16, 2016. "L.G.B.T. People Are More Likely to Be Targets of Hate Crimes Than Any Other Minority Group." *New York Times*. <http://www.nytimes.com/interactive/2016/06/16/us/hate-crimes-against-lgbt.html>

The Youth Risk Behavior Surveys found that in 2001-2009, 12% - 28% of LGB students were threatened or injured with a weapon at school. Upwards of a third of LGB students experienced dating violence. Between 14%-32% of LGB students disclosed they were forced to have sex at least once<sup>53</sup>.

The Victimization by Sexual Orientation Report states that 26% of gay men, and 37% of bisexual men, report intimate partner violence at some point in their life<sup>54</sup>. The same report found that 61% of bisexual women and 44% of lesbian women experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

## SOURCE OF DISPARITIES

Understanding the sources of health disparities for LGBTQ populations requires a discussion of the social determinants of health. These are the factors which exist within the lived environments of everyone which impact our health.

Several such factors include:

- Access to resources for daily needs such as housing, healthy foods, and clean water
- Access to employment, educational, and economic opportunities
- Availability of community-based supports such as shelters and food shelves,
- Access to health care facilities
- Social support

## Minority Stress Theory

The higher incidence rates of several health disorders and illnesses is partly explained by Minority Stress Theory. This theory explains that repeated instances of discrimination and hardships faced by many minority groups depresses the body's immune response and increases the deleterious effects of stress on the body<sup>55,56</sup>. Minority Stress Theory has also been applied to the high rates of disparities found within racial, ethnic, and linguistic minority groups. This is particularly important in the context of LGBTQ persons who come from many different demographic groups resulting in the intersection of multiple stress factors affecting health. Minority stress theory can also be used to explain low rates of preventative health services and adherence rates among the LGBTQ population because historical trauma and the fear of future discrimination prevents many individuals from seeking care.

<sup>53</sup> Kann, L., O'Malley Olsen, E., McManus, T., Kinchen, S., Cheyn D., Harris, W.A., Wechsler, H. (2011). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12—Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009. United States Centers for Disease Control and Prevention. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6007a1.htm>

<sup>54</sup> United States Centers for Disease Control and Prevention. (2011). NISVS: An Overview of 2010 Findings on Victimization by Sexual Orientation. Retrieved from [http://www.cdc.gov/violenceprevention/pdf/cdc\\_nisvs\\_victimization\\_final-a.pdf](http://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_victimization_final-a.pdf)

<sup>55</sup> Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. Retrieved from <http://psycnet.apa.org/?&fa=main.doiLanding&-doi=10.1037/0033-2909.129.5.674>

<sup>56</sup> Lick, D.J., Durso, L.E., & Johnson, K.L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Perspectives on Psychological Science* 8 (5): 521–48. Retrieved from <http://pps.sagepub.com/content/8/5/521>



LGBTQ persons face discrimination on a spectrum from microaggressions to physical assault on a daily basis resulting in more anxiety and higher levels of stress. Despite protections under the Minnesota Human Rights Act, many LGBTQ persons risk unemployment and loss of health coverage if they are open about their sexuality or gender identity in the workplace. According to the Williams Institute, rates of LGBTQ public employment discrimination in Minnesota are similar to those of discrimination based on race and sex<sup>57</sup>. Rampant homelessness and workplace discrimination has resulted in depressed wages for LGBTQ persons. The relationship between low wages and poor health has been established by the literature which points to this being a factor in the poor health outcomes of LGBTQ persons.

Many of the reasons for poorer health outcomes are structural and stem from a neglect of incorporating inclusivity into the delivery of care. For many LGBTQ persons, interactions with care providers are rife with incidents of microaggressions and discrimination due to structural failings. This lack of inclusivity in the delivery of care, often results in disillusionment with care providers and a reticence to address health issues. Without addressing the factors which lead to health disparities, health and human service systems will continue to harm the populations they are trying to serve and harm themselves in the process. This holds particularly for any care provider receiving federal funding as continued funding is tied to improving LGBTQ care.

<sup>57</sup> Williams Institute. (2015). Evidence of Employment Discrimination Based on Sexual Orientation and Gender Identity: An Analysis of Complaints Filed with State Enforcement Agencies, 2008-2014. Retrieved from <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Employment-Discrimination-Complaints-2008-2014.pdf>

# LEGAL PROTECTIONS

## **The Minnesota Human Rights Act (Minnesota statute 363A)**

States that it is illegal for any health and human service facility to discriminate against a patient or employee based on their sexual orientation or gender identity. This statute also covers employment based discrimination within health and human service facilities. Additionally, no insurer can deny coverage or benefits to a person based on their sexual orientation or gender identity. Exemptions to this law include religious organizations, employment where the sex or the gender of the person is a determining factor of employment, and nonpublic service organizations targeting youth.

## **Administrative Bulletin 2015-5 – Minnesota Departments of Health and Commerce**

Directed to insurers within Minnesota, this bulletin explicitly mandates that insurers must provide transgender health coverage for all clients or they will be prohibited from providing insurance within Minnesota. All medically necessary treatments for gender dysphoria and related health conditions, including gender confirmation surgery, must be covered by insurers providing coverage to Minnesotans. This is an important protection for Transgender Minnesotans because it ensures that they are able to access needed medical treatment.

## **The Patient Protection and Affordable Care Act (PPACA)**

The PPACA requires insurers to provide insurance regardless of pre-existing conditions such as HIV, mental illness, or transgender medical history. Private insurance plans must also include screenings for HIV, STIs, depression and substance use. The PPACA requires implementation of data collection strategies for healthcare organizations to collect patient data on sexual orientation and gender identity. This mandate also applies to any insurance company which offers a plan as part of the national exchange or a state-based exchange. The PPACA also provides funding for healthcare systems to update medical records to collect this data. This will improve data collection for organizations which receive insurance reimbursements but other human service organizations do not fall under these provisions.

The PPACA requires implementation of data collection strategies for healthcare organizations to collect patient data on sexual orientation and gender identity. This mandate also applies to any insurance company which offers a plan as part of the national exchange or a state-based exchange. The ACA also provides funding for healthcare systems to update medical records to collect this data. This will improve data collection for organizations which receive insurance reimbursements but other human service organizations do not fall under these provisions.

**Section 1557 – Nondiscrimination Provision (Gender Identity Protections)**

This section of the PPACA prohibits discrimination based on gender identity for any entity receiving federal funding through the PPACA. This includes receiving funds from Medicare and insurance plans purchased through the federal marketplace. This provision also applies to all insurance agencies which are part of the national and state-based exchanges. The PPACA also establishes provisions for the enforcement of these new laws through legal action as well as enforcement through reporting discrimination, refusal to care, or coverage exclusions to Department of Health and Human Services (HHS). While this section does not specifically protect individuals from discrimination based on sexual orientation, it does provide some support. For example, a Lesbian or Gay individual could claim they were discriminated against because they were not conforming to a particular gender identity (i.e. that women and men must be heterosexual).

The Patient Protection and Affordable Care Act is increasing the number of insured LGBTQ Americans. This is also an increase in the number of LGBTQ patients who are encountering health care providers who have not created equitable and inclusive environments for LGBTQ communities. This increases providers' risk of discrimination lawsuits.

**Code of Federal Regulations 42 CFR Parts 482 and 485**

This is a presidential memorandum issued by President Obama in 2010. Medical care facilities (including Critical Access Hospitals) participating in Medicaid and Medicare may not restrict or limit visitation rights based on sexual orientation or gender identity. Patients have the right to designate visitors and hospitals must ensure all visitors have full and equal visitation consistent with patient wishes. Medical facilities must create written policies and procedures regarding patient visitation rights. These must be shared with patients. Failure to comply could result in termination from Medicare program.

**U.S. DHHS Health Resources and Services Administration (HRSA) PAL 2016-02**

This Program Assistance Letter (PAL) issued March 22, 2016 from HRSA approved changes for Uniform Data System reporting. Requires participating care providers to collect SOGI data.

**The Civil Rights Act - Title VI**

Prohibits discrimination based on race, color, or national origin in programs or activities that receive any type of federal financial assistance. Hospitals or medical facilities receiving federal financial assistance may not deny services, segregate individuals, deny opportunities to serve on advisory/planning boards, or select a location for a facility that excludes individuals based on race, color or national origin. This includes ensuring that policies and procedures are accessible for LGBT individuals who are limited in English proficiency.

**The Civil Rights Act - Title VII**

Prohibits discrimination by employers, including employment agencies, labor organizations, joint labor-management committees, to discriminate against an individual based on sex or gender identity. Does not prohibit sexual orientation or gender identity discrimination. However, case law demonstrates that individuals can file complaints if they are discriminated against for nonconformity with sex stereotypes; for examples, see *Oncale v. Sundowner Offshore Services, Inc.* and *Price Waterhouse v. Hopkins*.

**Title IX of the Education Amendments of 1972**

Prohibits gender discrimination against students enrolled in, or planning to enroll in, hospital based education or training programs, clinical rotations for nurses and health professionals, and any educational program receiving Health and Human Services (HHS) funding. Does not prohibit sexual orientation or gender identity discrimination. However, case law demonstrates that courts use the same legal analysis used for Title VII Civil Rights cases (see *The Civil Rights Act – Title VII*).

**Emergency Medical Treatment and Labor Act (EMTALA)**

All hospitals with emergency departments, who participate in Medicare, must provide medical screening examination to any LGBT individual who requests such a screening. The emergency department must provide further examination and treatment to stabilize the individual – within their capacity and capability – or provide an appropriate transfer to a medical facility that can treat the individual.

**Americans with Disabilities Act of 1990 and Rehabilitation Act of 1973 – Section 504**

Titles I and II of the Americans with Disabilities Act applies to employers with 15 or more employees. Requires that individuals with disabilities benefit from all employment opportunities as well as equal opportunity to benefit from health care programs, services and activities. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination, exclusion, and/or denial of benefits, for any individual with a disability from any program that receives federal financial assistance.

**Health Insurance Portability and Accountability Act of 1996**

Concerns protection of patient information and privacy, and guarantees rights that hospitals, or any other covered entity, may not disclose demographic information or any other protected information about their LGBTQ patients (except as permitted by the Privacy Rule).

**Obergefell v. Hodges**

Supreme Court decision issued in June 2015 requiring all states to license same-sex marriages and to recognize such marriages performed out of state. Allows for expanded access to dependent health coverage, as well as family and medical leave.

**Assembly Bill No. 496 – Chapter 630 (State of California)<sup>58</sup>**

This statute updated California’s Medical Practice Act and requires accrediting associations of physicians and surgeons to develop continuing education cultural competency requirements to include information, appropriate treatment and competent provision of care for LGBTQ communities.

**The LGBTQ Cultural Competency Continuing Education Amendment Act – B21-168 (District of Columbia)<sup>59</sup>**

Statute requires all health care providers to receive a minimum of two continuing education credits of LGBTQ related clinical or cultural competency training for any license, registration, or certification.

<sup>58</sup>State of California. (2014). Medicine: continuing medical education: sexual orientation, gender identity, and gender expression. [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB496](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB496)

<sup>59</sup>District of Columbia (2016). The LGBTQ Cultural Competency Continuing Education Amendment Act. <http://lims.dccouncil.us/Download/33671/B21-0168-Introduction.pdf>

# STANDARDS OF INCLUSION

**The following standards outline necessary policies and provisions to provide equitable and inclusive care for LGBTQ individuals.** These should function as minimum standards for providers in their care delivery. It will be important for all providers to incorporate local, as well as sector specific standards depending on their capacities, as well as community needs. The goal is to enable all health and human service providers to deliver the best quality care for all Minnesotans. The language of each section is meant to be instructive and not prescriptive for providers.

## The LGBTQ Standards of Inclusion:

- Create and sustain an inclusive physical environment for LGBTQ communities.
- Recruit and retain LGBTQ employees.
- Require LGBTQ culturally responsive education for all care providers and support staff.
- Develop policies, procedures and care provisions that are Intersectional.
- Implement an equitable and inclusive LGBTQ patient experience from in-take through completion of care.

## CREATE AND SUSTAIN AN INCLUSIVE PHYSICAL ENVIRONMENT FOR LGBTQ COMMUNITIES

Health care providers should develop knowledge and comprehension of how a medical facility or care provider's physical environment contributes to LGBTQ inclusion. Providers should develop the ability to use knowledge to create inclusive medical facilities, hospitals, and clinics.

### Supporting explanation

Creating inclusive environments is critical for improving care delivery for LGBTQ individuals. The environment is the first chance health and human services facilities have to make a solid impression upon LGBTQ persons and encourage their adherence to care. Persons seeking care will be alert for signs of inclusive and supportive environments because of previous discriminatory experiences with care facilities or staff (LGBTQ individuals are especially cognizant of safe spaces). If an area is not perceived as inclusive, they will vacate, limit the information they share with the care provider, and/or not return for follow up care due to fear of discrimination.

If LGBTQ individuals are not able to locate safe inclusive care facilities then they are not able to attend to their basic care needs increasing the likelihood that they will have adverse health events. An inclusive environment is necessary through all points of a person's care continuum: from the need for housing, receiving an annual check-up, to the need for emergency services. It is important that they experience an inclusive environment or they are likely to abandon care.

### **Recommended actions**

#### **LGBTQ advisory board**

Community inclusion is a necessary part of developing a safe and inclusive environment. Health and human service facilities should develop an LGBTQ Advisory Board. This Board should develop a procedure to conduct listening sessions and focus groups with their LGBTQ communities to craft strategies for creating inclusive environments. This Board can provide input and guidance on planned renovations, and/or building acquisitions, and/or expansion plans, but also care provision, employment policies, etc. An LGBTQ Advisory Board ensures that the management of the care facility reflects local realities and specific cultural needs of these communities. A strategy developed for a substance abuse treatment facility in a rural northern Minnesota county can be dramatically different than a similar facility in an urban southern county.

It is highly important that persons from LGBTQ and intersecting communities be represented on these boards. This increases the visibility of LGBTQ inclusion within these agencies and encourages LGBTQ persons to have input in improvement measure recommendations.

#### **Signage**

When individuals enter a care facility they are looking for visible signs of inclusion. Images, posters, and materials which reflect the diverse populations served by the health or human service facility should be part of the design and decor of the areas in which an LGBTQ person is receiving care. Displays of the facility's mission statement and non-discrimination policies should be prominently displayed. These policies should be written with inclusive language, and clearly highlight LGBTQ communities – to indicate care for all patients. These policies should alert a person to their rights as a client, patient, and employee. Other visible signage can include ally training or safe-space stickers displayed at entrances, offices, examining rooms, or in any area where clients or patients will spend a majority of their care experience. Posters featuring LGBTQ individuals or couples also create an inclusive environment as well as information materials which are targeted to LGBTQ issues or health.

All media representations of LGBTQ should reflect the diversity of the community, which includes ability, gender, race, ethnicity, social class, national origin, immigration status, and faith tradition. Media collateral should be highly visible to in-coming care recipients. Health and human service providers should also ensure

that their websites and external communication include inclusive imagery and language. Websites should indicate providers who specialize in care to the LGBTQ communities as well as those individuals, and/or departments, who have completed specialized training to provide care to LGBTQ communities.

### **Gender inclusive restrooms and locker facilities**

In addition to existing restroom facilities, health and human service settings should label any single stall bathrooms “all gender restroom” for patients/clients and staff ensuring that they are accessible to all without barriers. This allows for a safe space for non-binary gendered individuals. Gender inclusive bathrooms are great for creating safe spaces for all people, families, and abilities. Patients/clients and employees should be informed of bathroom policy changes while also always notifying others that these bathrooms exist without making assumptions. These bathrooms should be ADA compliant, with the ability to lock the door, and labeled “All Gender.” Signage should include a toilet and a wheelchair, however no gendered symbols. If possible, care facilities should also have all gender locker rooms and single stall showers made available to staff and clients. These should be identified with gender neutral symbols and their location should be communicated with clearly visible signage.

## **RECRUIT AND RETAIN LGBTQ EMPLOYEES**

Health and human service care providers must develop inclusive recruitment and retention practices for LGBTQ individuals.

### **Supporting explanation**

Research shows that the quality of care is improved when the care provider and the recipient share a common cultural background. The evidence demonstrates that when this occurs, providers are able to leverage their existing knowledge of the individual’s culture to accurately assess their condition and provide unbiased care. Increasing proportions of LGBTQ employees also ensures LGBTQ voices in the creation and implementation of policies and programming. Additionally, this requires continuous commitment on the part of the organization to be thinking about LGBTQ equity and inclusion.

### **Recommended actions**

#### **Recruitment**

Advertise positions and highlight a preferred qualification as being a member of the LGBTQ communities. Utilize alternative methods of recruitment that reach LGBTQ communities. Human Resource departments should attend LGBTQ job fairs, recruit employees at PRIDE festivals, and post positions on LGBTQ listservs.

#### **Employment policies**

Employee non-discrimination policies should follow national and state guidelines and specifically highlight the care provider’s commitment to LGBTQ employees.



The contents of these policies should be explicitly communicated to staff and incorporated during new hire trainings. Employee rights, avenues for complaints free of reprisals, should be outlined within the non-discrimination policies.

Health and human service agencies should conduct a review of employee benefits to ensure that LGBTQ employees are covered equally. This includes leaves of absences, disability-related benefits, healthcare coverage, and same-gender spouse and domestic partnership benefits. Agencies should also develop transitioning guidelines for Transgender employees. Information regarding health benefits for Transgender employees should be made clear to all staff as well as information regarding gender inclusive spaces.

It is further recommended that all facilities develop a framework for implementing an equitable workspace at their locations. This should be guided by national and state frameworks with processes for evaluation and audit. Included in this framework should be multiple methods for employees to report discrimination and misconduct anonymously and without fear of retaliation. Trained professionals should handle investigating these reports and ensure the privacy and safety of the individuals. Agencies should have policies in place for remediation for employees in the event of discrimination or misconduct.

### **REQUIRE LGBTQ CULTURALLY RESPONSIVE EDUCATION FOR ALL CARE PROVIDERS AND SUPPORT STAFF**

LGBTQ culturally responsive education should start in post-secondary programs and extend through a care professional's working career via continuing education licensure requirements.

**General outcomes of education should include:**

- Knowledge and comprehension of LGBTQ communities' characteristics and needs.
- Knowledge of and comprehension of national and Minnesotan LGBTQ health disparities, including contributing factors and influences.
- Systematic knowledge, comprehension and positive engagement with one's own cultural background such that one is able to understand the conscious and unconscious ways that their culture influences their behavior.
- Knowledge, comprehension and assessment of cultural competency skills as they relate to LGBTQ communities.
- Ability to utilize knowledge to create equitable and inclusive environments for LGBTQ communities within care facilities.

#### **Supporting Explanation**

One of the key components of any care professional's development is education. How, where, and what comprises a care professional's education can directly impact their approach and behavior to LGBTQ persons. Most care professionals within

Minnesota do not receive specific LGBTQ training regarding health or cultural responsiveness. When this information is included, it is often embedded in the context of wider cultural competence and responsiveness, and insufficient time is spent discussing the complexities of LGBTQ communities. This leaves care providers and support staff ill-equipped to deal with the unique challenges faced by LGBTQ individuals – thus resulting in lower quality care.

As noted above, LGBTQ persons come from all cultures, backgrounds, and experiences and cannot be easily defined or contained within the simple narratives of existing educational programs. The needs and risk factors for a white, transgender, straight woman could be the same or entirely different than the needs and risk factors of a Latina, cisgender, lesbian woman. Care providers must be knowledgeable about medical and cultural differences and have the capacity to coordinate responsive care for all LGBTQ persons.

Currently, a large number of care professionals are required to secure licensure to practice within the state of Minnesota. These professions cover a variety of points of contacts LGBTQ persons may encounter in seeking care. The professional licensure processes outline qualifications all applicants must obtain in order to be certified to practice within Minnesota. Part of these qualifications are educational requirements which applicants must obtain before licensure as well as afterwards to maintain certification. While many of the licensing boards include a cultural competence component to their educational requirements, LGBTQ education is not required. This leaves it up to the care professional to decide which cultural groups to give priority in their education.

In both California and Washington D.C., governing bodies enacted requirements for providers to attend LGBTQ competency training as part of their annual continuing education requirements. These laws ensure that care providers are at least introduced to LGBTQ health issues and are able to incorporate this knowledge into their practice. While the law covers all providers along the continuum of care in D.C., the California regulation does not address competency gaps within mental health providers or non-medical care providers such as social workers and homeless shelters.

### **Recommended Actions**

Health and human service systems should use the educational guidelines outlined below to establish competency requirements for providers within their facilities. These should form the minimum standard of educational attainment that providers should have to maintain working within the facility. Health and human service systems should establish systems which monitor the educational certification of their providers to ensure compliance with the above educational standards. Outlined here are examples of a core curriculum, including profession specific and continuing education guidelines.

### Core curriculum

This would constitute the required minimum SOGI inclusion and cultural responsiveness knowledge that all health and human services providers, staff, and consultants must have in order to operate within Minnesota. This would cut across disciplines and represent a basic level of understanding amongst all HHS professionals.

- **Cultural awareness and bias** — Care providers should be knowledgeable about basic aspects of LGBTQ culture and history. This is a difficult process given that the cultural experiences of each of the sub-communities is complex and deserving of its own educational module. Two important sub components of this training would be awareness of privilege, intercultural competency, and implicit bias training. Care providers should be trained to be aware of how their own biases and privilege impact the care they deliver to LGBTQ persons. Often this is unconscious or implicit behavior on the part of the care provider. Additionally, care providers should be trained to understand their own culture and how it affects their behavior towards other cultures.
- **LGBTQ health** — This training should focus on expanding the knowledge of care providers regarding health concerns specific to LGBTQ persons. There is an existing body of literature regarding this topic, thus developing training is not difficult. However, this training can be modified to suit the needs of the care professional depending on the level of care being provided, e.g. the health knowledge required for a physician would be different than for a social worker.
  - Practitioners working in addiction/recovery will need to understand minority stress theory, discrimination, microaggressions, and how these factors create the symptoms of smoking, drug and alcohol abuse.
  - Medical providers treating transgender patients for trans related care need a different base of knowledge than providers treating patients with diabetes or broken bones who happen to be transgender. One provider needs clinical and inclusion best practices and the other would only require inclusion best practices. Though it can be argued that all medical providers should be able to responsively treat trans patients with any medical needs, including trans related care.
  - Social workers and case managers should receive LGBTQ inclusion with an extra emphasis on locating and confirming culturally responsive referrals before recommending employment, housing, or other services. For example, many human services organizations are founded by religious institutions which allow discrimination against gay and trans people-- some even refuse service.
  - Communication strategies - Many LGBTQ individuals harbor mistrust and skepticism when communicating with care providers due to previous discrimination. Every layer of staff from the call center to

the front desk to the patient centered care should be trained to use inclusive language and communication techniques to gather sensitive but necessary health information about sexual orientation and gender identity. For example; medical providers could be required to use patient centered care techniques and human services providers could be required to use motivational interviewing techniques to follow the lead of the patient/client.

- **Profession specific curriculum** — Each profession must develop LGBTQ-specific curriculum which outlines the unique challenges faced by LGBTQ persons receiving care from these professionals. This should be developed with LGBTQ persons and be more comprehensive than the core curriculum given that it is targeted to the needs of each profession.
- **Continuing education units** — In addition to the knowledge gained through pre-professional training, all care providers should be expected to receive ongoing training to ensure their competence. Further research will continue to expand our understanding of LGBTQ-specific health needs and challenges and care providers must stay cognizant of new knowledge. Depending on the professional needs of the care provider, the number of continuing educational units would be tailored to the time limitations of these providers.

### **Evaluation and assessment**

The education and training obtained by care providers should be regularly evaluated and the data of these evaluations should be incorporated into future courses. This ongoing process improvement strategy should ensure that care providers are receiving the best quality of care which improves care provision for LGBTQ communities.

### **Licensure requirements**

Licensing boards should develop a requirement for care professionals seeking licensure within the state of Minnesota to attend continuing education training courses specifically regarding LGBTQ health. The Minnesota Department of Health and Department of Human Services should play a primary role in this process since they are the central licensing bodies for most care professionals within Minnesota. As a baseline, the licensing certification standard should be two contact hours of LGBTQ health training for all MDH and DHS regulated licenses annually.

## **DEVELOP POLICIES, PROCEDURES AND CARE PROVISIONS THAT ARE INTERSECTIONAL**

Care providers should have knowledge and comprehension of Intersectionality as theory, methodology and practice. This includes knowledge and comprehension of LGBTQ identities as intersectional and how identities based on race, ethnicity, age, ability, social class, national origin, and religion can intersect with a patient's LGBTQ

identity to influence their care needs and treatment plans. Care providers should have the ability to use knowledge to create policies and procedures that can support multiple identities and communities simultaneously.

### Supporting explanation

LGBTQ identities are complex and intersect with other markers of difference such as age, ability, race, ethnicity, national origin, social class and religion. There is significant demonstrated evidence of how age and LGBTQ identity intersect to compound health disparities for both LGBTQ youth and elder LGBTQ patients. We see similar evidence when LGBTQ identities intersect with low-income households (social class) and/or ability (persons living with physical or emotional disabilities).

Studies also demonstrate that LGBTQ people of color face different health disparities than white LGBTQ patients; moreover, too often with the disparities that they share, LGBTQ communities of color demonstrate worse health outcomes than their white LGBTQ counterparts. When creating policies and procedures, a medical facility or care provider needs to spend the time to develop knowledge of individual identities and communities (i.e. LGBTQ, race, age, social class, ability, etc.)<sup>62</sup>. However, policy and procedure development must also consider the intra-category differences within these identities and communities, otherwise outcomes from policies and procedures can be incomplete or lead to negative unintended outcomes.

### Recommended actions

#### Intersectionality-Based Policy Analysis

Care providers conducting Health Impact Assessments (HIAs) should conduct Intersectionality-Based Policy Analysis (IBPA) to strengthen their HIAs<sup>63</sup>. This framework will provide care providers with a comprehensive view of the impact their policies, procedures and care have on LGBTQ communities. This will also allow for data collection and analysis to have an Intersectional component to understand intra-category differences and to develop comprehensive data sets for LGBTQ communities.

### IMPLEMENT AN EQUITABLE AND INCLUSIVE LGBTQ PATIENT EXPERIENCE FROM IN-TAKE THROUGH COMPLETION OF CARE

Care providers should have knowledge and comprehension of how to conduct an intake and assessment in a culturally responsive manner with LGBTQ communities. This should include knowledge and comprehension of how Electronic Health Records (EHR) and Client Management Systems (CMS) do and do not contribute to equitable and inclusive patient experiences. There should be the ability to collect evaluation and feedback data from LGBTQ communities to improve patient care.

<sup>62</sup> Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13(1), 1-16.

<sup>63</sup> Hankivsky, O. (2012). An intersectionality-based policy analysis framework. Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University. Retrieved from <http://www.sfu.ca/iirp/ibpa.html>

### Supporting explanation

Many LGBTQ individuals avoid visiting care providers due to fears of discrimination. These experiences of discrimination often take the shape of subtle microaggressions which form the basic processes of care delivery. Carefully designed protocols for providing care to patients and clients can be imbued with insidious questions or behaviors which unknowingly discriminate against sexual orientation and gender identity minorities.

This is why modifying the systems of care delivery can drastically improve the experiences of patients and clients. These guidelines encourage participation and reduce avoidance of care systems. These standards should be viewed as building upon the previous sections because they amplify the existing inclusive practices of the education and environment sections.

### Recommended actions

#### Intake and assessment process

An individual's first experience of discrimination at health and human services facilities may be during the intake or assessment process, as it is often the first point of contact. Existing forms, in most cases, are not designed with a focus on inclusion. This can result in too many individuals forced to lie or withhold important information during this process. Often front-line staff, performing the assessment or intake, have not received training on LGBTQ care or usage of inclusive language. As part of creating a safe and inclusive environment, intake, and assessment forms should be updated to include several key features:

- Preferred name
- Personal gender pronouns
- Name and gender identity recorded with insurance company
- Gender identity
- Sex assigned at birth
- Sexual orientation
- Partner/marital/relationship status

Please refer to the companion user guide on best practices for collecting this type of SOGI data.

Forms should also be written with inclusive language which does not impose heteronormative behavior onto patients or clients. For example, individuals should not be assumed to be monogamous if they are married or in another committed relationship. If it is necessary to patient care, detailed sexual histories should be collected which collect pertinent information in an inclusive manner. Front-line staff

should also be trained to review forms with an eye to sensitivity towards individuals during the process.

LGBTQ persons can be mistrustful of care providers due to prior experiences of discrimination. All staff should be trained to explain the reasons for gathering personal information and how it will be used in their care. It should be clear that patients and clients are not required to share any information and that this will not negatively impact their care. These intake forms may also be made available electronically prior to their visit. This allows the person to fill out the form without fear of sharing sensitive information with someone they do not trust. Once this information is collected during the intake and assessment process, care providers should create systems within their workplaces for staff to use preferred names and pronouns. This ensures that the information is incorporated into the person's care during their visit.

### **Electronic Health Records and Client Management Systems**

More and more health systems are moving towards transparent, open records which share information with patients and clients. This transition requires that systems reflect accurate information about the care of an LGBTQ individual. Electronic Health Records (EHR) and Client Management Systems (CMS) should be designed similarly to the inclusive intake and assessment forms to feature inclusive language. The records should highlight to staff many of the pieces of information collected during the intake process such as chosen name, gender, sex at birth, preferred pronoun, sexuality, and family structure. Identifying family structure is particularly important when treating minors because they may be part of a family with same-gender parents or have more than two caregivers. Incorporating this knowledge into the care of the person is key to offering competent care. This will reduce apprehension and improve the quality of care for the LGBTQ individual.

During a patient visit, the EHR should prompt providers to ask specific LGBTQ health related questions. There should be overrides within the system for gendered services. This ensures that the patient is receiving the highest level of care because providers are alerted to the unique health needs of LGBTQ persons. Most EHR systems do offer these options as well as provide training to ensure that staff utilize these options effectively.

### **Patient Satisfaction Surveys**

These can be an excellent source of evaluation and feedback for care providers to improve the quality of care delivered to LGBTQ persons. Surveys should be designed with inclusive language and to ask pointed questions about experiences of discrimination and bias during their care experience. Mailing these surveys, either electronically or via post, allows individuals the privacy to complete the survey

without fear of reprisal. These surveys should explain how this information will be used and provide respondents with information regarding its function within an evaluative process. It is important to use chosen name on all mailings and to address patients with such via email or web portal.

### **Community Outreach and Engagement**

Health and human service facilities should also make efforts to connect with LGBTQ communities through outreach programs and community events. Agencies should develop community engagement strategies that outline methods to increase the visibility of LGBTQ health issues. These strategies should also make clear to LGBTQ persons how this agency is creating safe inclusive spaces and highlight that LGBTQ care is a priority for the agency. The community engagement plans should be developed in collaboration with community members to ensure successful implementation.



# CASE STUDY — FAMILY TREE CLINIC (ST. PAUL, MN)

**What does the implementation process for the Standards of Inclusion look like at an actual clinic?** Family Tree Clinic in St. Paul, Minnesota conducted the following case study to guide you through the process and illustrate what it takes to implement the standards. The full case study is available on the Rainbow Health Initiative website, as well as upon request.

Contributing authors to the case study: Alissa Light, Executive Director; EJ Olson, Clinical Operations Director; Erin Wilkins, Clinical Programs Director; Clive North, Billing & Front Desk Manager; Liesl Wolf, RN Care Coordinator; Jennifer Demma, APRN, CNM; Damion Mendez, Trans Health Advocate.

Since 1971, Family Tree Clinic has been an integral part of the Twin Cities community, offering essential community-based reproductive and sexual health care and education. The mission of Family Tree Clinic is to cultivate a healthy community through comprehensive sexual health care and education. Starting in 2009, Family Tree Clinic began an initiative to increase the organization's cultural responsiveness to LGBTQ communities.

In the following section, we list each Standard of Inclusion and how Family Tree Clinic interpreted and implemented it at their clinic.

## ADMINISTERING AN INCLUSIVE PHYSICAL ENVIRONMENT FOR LGBTQ COMMUNITIES

### **Board governance**

As a community clinic, Family Tree long sought to have broad community representation on its board of directors. Articulating goals around board recruitment was a deeply held practice. The more work Family Tree undertook to become a culturally responsive resource for LGBTQ communities, the more word of mouth and organic interest there was from LGBTQ identified people to contribute to Family Tree's work through employment opportunities, board service, volunteerism and philanthropy. In addition to this, in 2014 the board determined it needed to form a specific committee for board recruitment.

### **LGBTQ advisory board**

While Family Tree Clinic has not convened a formal LGBTQ Advisory Board, they do employ smaller advisory groups as needed for different projects and purposes. For example, before embarking on an expansion to deliver Transgender hormone care, Family Tree convened a Transgender health work group, which included staff from all departments of the organization, two community member liaisons, and the executive director. On an on-going basis, they actively seek input from LGBTQ communities through paper and digital surveys, community listening sessions, and individual communications. LGBTQ folks work in every clinic department, hold leadership/management roles, and sit on the Board of Directors.

### **Signage**

Family Tree Clinic enhanced its signage and physical environment to be more welcoming and reflective of the LGBTQ communities it seeks to serve. At the entrance of our clinic, the main door is decorated with several LGBTQ identifiers, including a rainbow flag and upside down pink triangle. Waiting areas feature many queer and trans-affirming posters as well as LGBTQ-focused magazines and publications. They seek out and display informational posters and handouts about various health issues (such as intimate partner violence, cervical cancer, and sexually transmitted infections) that are gender neutral and have images of people with a broad spectrum of gender presentations and races.

Additionally, Family Tree creates their own handouts about a variety of sexual health topics. In 2014, they updated all handouts and materials using gender neutral language. One example of this language change involved their breast exam materials. They renamed them “breast and chest exams” so that all people can see themselves in the terms they use. They use “breast and chest exams” on all postcards, visit types, as well as written materials. This way it is used by all employees and volunteers regardless of where they work in the clinic.

### **Gender-inclusive restrooms**

Single-stall, gender-inclusive bathrooms are an important component of an inclusive LGBTQ physical environment. Accessible through the waiting room, Family Tree has two single bathrooms with all-gender signs on them. The signage was donated to the clinic by a company that specializes in gender inclusive bathroom signs. We did not face resistance to this signage change, but received questions from other clinics looking to make similar changes. Anticipating all types of questions and comments, Family Tree prepared talking points to describe the value of all-gender signage and restrooms. Specifically that all gender restrooms help create a safe space for all patients, including transgender and gender non-conforming folks, parents with children, and patients who need assistance in the restroom.

## RECRUIT AND RETAIN LGBTQ EMPLOYEES

### Staff recruitment

LGBTQ individuals are highly encouraged to apply for positions at Family Tree, and they seek to employ a staff that is reflective of the clients and patients we serve. The majority of their current staff are LGBTQ-identified and many of the people that apply for positions at the clinic are drawn to the organization because of their work with the LGBTQ community. Their Racial Justice and Anti-Oppression Committee also has a board and staff recruitment work group that meets regularly to develop policies and procedures that ensures they are reaching communities of color and LGBTQ communities in the employee recruitment process. Positions are posted locally on non-profit job boards, as well as on their website, and are also distributed widely among LGBTQ networks on social media. Interview questions are constructed so that during the interview process hiring managers and committees can assess an applicant's current knowledge of LGBTQ health equity, trans-cultural responsiveness, and/or a candidate's willingness and readiness to learn. This has been essential when hiring at all levels and in all departments.

Confronted with significant provider turnover in 2014, Family Tree took advantage of the vacancies to recruit providers specifically enthusiastic about delivering trans hormone care and LGBTQ culturally responsive health care. This coincided with the launch of their strategic plan. Family Tree specifically recruited a team of engaged providers who joined the clinic at the hormone care planning stage so they could lead and drive the protocol development, participate in listening sessions, and co-create the program design and implementation plan.

### Employment policies

Family Tree Clinic's employment policy states that they will not unlawfully discriminate against or harass any employee or applicant for employment because of race, color, creed, religion, gender identity or expression, national origin, sex, sexual orientation, disability, age, marital status, familial status, membership or activity in a local human rights commission, genetic information, veteran status, status with regard to public assistance, or any other status or relationship protected by applicable law.

They also have a recruitment and interview process in place that helps to ensure that the candidates they hire strongly share the values and goals of the clinic. This includes panel interviews with staff representing multiple clinic areas and departments, as well as interview questions that facilitate a conversation specific to the values that inform our work towards LGBTQ health equity.

All new staff members participate in an onboarding process that includes training on the basics of LGBTQ health care and cultural responsiveness, as well as training about intersectional approaches to health care and harm reduction.

## **REQUIRE LGBTQ CULTURALLY RESPONSIVE EDUCATION FOR ALL CARE PROVIDERS AND SUPPORT STAFF**

Family Tree Clinic recognizes that most nursing and medical education degree programs do not include adequate, if any, curriculum regarding sexual orientation, gender identity, or LGBTQ health equity. To supplement their providers' education, Family Tree developed ongoing training and professional development opportunities for all staff members, including providers and medical staff. All new staff members participate in an onboarding process that includes training on the basics of LGBTQ health care and cultural responsiveness, as well as training about intersectional approaches to health care and harm reduction. Their providers and clinical staff participate in quarterly trainings on LGBTQ health issues as well as targeted education and training on LGBTQ-specific clinical topics. Additionally, staff are encouraged to attend queer and trans health conferences. Family Tree Clinic provides financial and logistical support to do so.

## **DEVELOP POLICIES, PROCEDURES AND CARE PROVISIONS THAT ARE INTERSECTIONAL**

The philosophy of care at Family Tree Clinic includes an intersectional vision of health care and patients' experiences. Their organizational mission and vision reflects this intersectionality and their medical providers carry out this approach in their delivery of care. Family Tree has not yet participated in a formal intersectionality-based policy analysis but is interested in doing so.

Family Tree Clinic has a racial justice and anti-oppression committee and it is the intention moving forward to have this committee review all recruitment and inclusion policies to provide recommendations for improvement toward intersectionality.

## **AN EQUITABLE AND INCLUSIVE LGBTQ PATIENT EXPERIENCE FROM IN-TAKE THROUGH COMPLETION OF CARE**

### **Intake & assessment process**

Family Tree Clinic's intake and health history paperwork is continually updated to be optimally inclusive and reflective of a current and broad spectrum of gender identities and sexual orientations.

Currently, their intake demographic forms list options for gender identity:

- Male
- Female
- Transgender
- Gender non-conforming
- Genderqueer
- Write-in option

Options for sexual orientation include:

- Straight
- Lesbian
- Gay
- Bisexual
- Queer
- Asexual
- Write-in option

Additionally, Family Tree asks every patient what their preferred name and personal gender pronouns are, which they record in their electronic health record system and communicate to all clinic staff via labels and written forms.

### **Electronic health records & client management systems**

Family Tree Clinic has invested a great amount of time and financial resources into modifying their electronic health record (EHR) system to be more inclusive of their trans, gender non-conforming and queer patients' lived experiences. On the practice management side of the application, they created "user defined fields" that allow staff to capture information about the gender identities and sexual orientations of patients and link that information to their health outcomes. They also found creative ways to record and recognize the patient's preferred name, if it does not match their legal name or the name listed on their insurance.

On the health record side of the application, Family Tree modified the exam templates so that they are not gender-specific. Typical EHR systems assume certain body parts based on the gender that is selected for the patient. For example, if a patient is marked "female" then a vaginal and cervical exam template will automatically be attached to the patient's chart, even if the patient does not have a vagina or cervix. The modifications Family Tree initiated allow exam templates for every body part to be pulled through for every patient, regardless of gender.

### **Patient satisfaction surveys**

Family Tree Clinic distributes a paper LGBTQ-specific patient survey to patients in the clinic throughout the year, which can be filled out during or after a visit. The results of the survey are recorded and reported to the full staff on a quarterly basis. Feedback is presented to individuals and teams as needed. Additionally, an evaluative survey is distributed yearly to all participants in the trans hormone program, the results of which are shared with patients, staff, board of directors, and wider community.

### **Community outreach and engagement**

Community outreach and engagement are central to the work of Family Tree Clinic. They participate in as many LGBTQ-focused events as possible, and sponsor events. Since they work collaboratively with many LGBTQ organizations in the region, community outreach happens organically.

Importantly, Family Tree Clinic created a new position, Community Engagement Director. A staff member who was their long time educator, and spent years in the field providing education and outreach in schools and prisons, was appointed to this new role.

While Family Tree is active in their work toward outreach and engagement, it is a process like any other. They continue to strive to commit the resources and energy toward best utilizing the skillset of their team, the commitment of stakeholders, and enacting their organizational mission and vision.

# CONCLUSIONS

**These recommendations and guidelines were developed to create safe inclusive care settings across Minnesota for LGBTQ persons.** However, although the provisions outlined above were designed to support LGBTQ individuals the enactment of these standards will improve the quality of care for all Minnesotans. Many of the health challenges faced by LGBTQ individuals are faced by members of other minority groups. By establishing these inclusive environments, health is improved for all Minnesotans leading to reductions in health disparities and improvements in health outcomes. An inclusive continuum of care covering Minnesotans across health and human service settings will improve the quality of life of all Minnesotans and truly make our state the best in the nation.

# RESOURCES

**We have developed a user guide specifically geared to assist clinics, hospitals, and organizations implement these standards.** Please refer to the Rainbow Health Initiative website for the user guide and other available resources. Please also refer to the case study conducted by Family Tree Clinic. The case study details how Family Tree Clinic interpreted these standards and implemented them at their clinic. Please refer to the Rainbow Health Initiative website for the case study and additional resources.

# GLOSSARY OF TERMS

**Editor's note: Creating a glossary is an act of privilege. The idea that the lived experiences of people can be reduced to one, two, or three sentences is deeply problematic.** This glossary should not be read as definitive. Rather, what is outlined here should be understood as general themes of a particular term, but not a universal definition applicable to all. The power to name and define one's experience of their own sexuality and gender should rest with the individual. Moreover, every year new revelations into gender and sexual orientation are explored. There is constant discovery of new concepts, as well as new insights into previously established concepts and theories. As such, the idea of a definitive glossary of terms is not feasible.

## **Agender**

An individual who, to varying degrees, does not identify with a gender and/or does not feel a sense of gender identity.

## **Asexual**

An individual who, to varying degrees, does not experience sexual attraction to persons of any gender. Some may experience other types of attraction, including romantic, emotional, intellectual, or sensual, or they may not. Asexuality is not a choice (i.e. celibacy) and does not determine sexual behavior.

## **Bisexual**

An individual who has the potential to be attracted – romantically and/or sexually – to people of more than one sex and/or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree.

## **Care provider**

A professional who provides health-related supportive services to the public. This includes behavioral, medical, and mental health practitioners as well as providers of supportive human services such as case managers and counselors.

## **Cisgender or cis**

An individual who identifies with the gender they were assigned at birth.



**Cultural responsiveness (see also intercultural competence)**

The development of a set of values, behaviors, attitudes, and practices (by an individual and/or organization) which enables them to work effectively across cultural difference by incorporating the cultural characteristics, experiences, and perspectives of patients and clients into their care. Cultural difference can be defined by race, national origin, gender, sexual orientation, ability, social class, faith tradition, age, and/or ethnicity.

**Gay**

An individual who identifies as a man and is romantically and/or sexually attracted to people who identify as men. This term is also used as an umbrella term to refer to a non-heterosexual person and/or to the entire LGBTQ community (e.g., gay rights, the gay community).

**Genderqueer**

An identity commonly used by people who do not identify within the gender binary. Those who identify as genderqueer may identify as neither male nor female, may see themselves as outside of or in between gender binary identities, or may feel restricted by gender labels. Some people who identify as genderqueer also identify as transgender.

**Gender identity**

An individual's sense of maleness, femaleness, or other place along the gender spectrum, which is separate from the sex and gender roles assigned at birth.

**Heteronormativity**

Assumption and/or expectation, either implicitly or explicitly, that all people are heterosexual. The design of policies and programs with the implicit, or explicit, assumption that the people affected by the policy, or using the program, will be heterosexual.

**Heterosexual**

An individual who experiences sexual and/or romantic attraction to a sex and/or gender other than their own. In some contexts, this term refers to a person who self-identifies as a cisgender woman who is sexually and/or romantically attracted to a cisgender man, or vice-versa.

**Intercultural Competence (see also cultural responsiveness)**

Variably defined and is generally understood as a set of skills that allows an individual, and an organization, to adapt their own cultural behaviors and perspectives to bridge cultural differences and work effectively with a culture that is not their own. Various definitions will focus on skills related to communication, conflict resolution, and cultural self-awareness. Cultural difference can be defined by race, national origin, gender, sexual orientation, ability, social class, faith tradition, age, and/or ethnicity.

**Intersectionality**

First coined by legal scholar Kimberlé Crenshaw, Intersectionality refers to the study of how social identities (sexual orientation, gender, race, ethnicity, social class, national origin, faith tradition, ability, etc.) overlap and intersect to create multiply oppressed and multiply privileged groups of people. Additionally, it explores how groups and individuals can simultaneously experience oppression and privilege based on their intersecting social identities. For example, a person who identifies as gay, white, and male can experience discrimination due to his gay identity, but simultaneously experience white and male privilege. The experience of privilege does not diminish or ameliorate his discrimination, but demonstrates that people live complex lives of intersecting identities, and therefore laws, policies, and programs should reflect those lived experiences.

**Lesbian**

An individual who identifies as a woman, who is romantically and/or sexually attracted to people who identify as women.

**LGBTQ**

An acronym designating Lesbian, Gay, Bisexual, Transgender, and Queer persons.

**Microaggression**

A brief and commonplace daily verbal, behavioral, or environmental indignity, whether intentional or unintentional, that communicates hostile, derogatory, or negative slights and insults towards marginalized groups.

**Nonbinary/Non-Binary**

A preferred umbrella term for any person with a gender identity between, around, or outside of the gender binary.

**Provider**

See care provider.

**RHI**

Rainbow Health Initiative

**Sex assigned at birth**

The assignment of an individual's gender at birth, as female, intersex, or male by the care provider based on biological criteria. This assignment is reported on the birth certificate.

**Sexual orientation**

A culturally defined set of meanings through which people describe their romantic and/or sexual attraction to people of certain sex, sexes, gender, or genders.

**SOGI**

An acronym which stands for Sexual Orientation and Gender Identity. It is inclusive of all sexual orientations and gender identities.

**Transphobia**

The irrational fear, distrust, or discomfort, dislike, judgment directed towards trans people or trans concepts.

**Transgender or Trans**

An individual who identifies with a gender that is different from their gender assigned at birth.

**Transition**

A person's process of developing and assuming a gender expression to match their gender identity. Transition methods can include any of the following, but is not limited to: coming out to one's family, friends, and/or co-workers; changing one's name and/or gender on legal documents; changing one's pronouns; changing one's wardrobe; hormone therapy; and possibly some form of gender confirmation surgery. Every transition is unique and there is no set standard or expectations to transition.

**Queer**

An umbrella term that can refer to anyone who transgresses society's view of gender or sexuality. A queer person may be attracted to people of multiple genders and/or identify with any gender along the gender spectrum. Queer may also be used as a political identity that refers to a disruption of social norms.



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