

NWX-BPHC

Moderator: Tracey Orloff
October 24, 2011
12:30 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in listen-only mode until the question and answer session of the call. If you would like to ask a question at that time, please press star then 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn over the meeting to Angela Powell. You may begin.

Angela Powell: Thank you. Good day and welcome to the Bureau of Primary Health Care Grantee Enrichment Series. Today, the topic of our call is Public Health Concerns of the Lesbian, Gay, Bisexual and Transgender Population. I'm Angela Powell and I will serve as moderator for today's call.

The plan for today's call is to one, provide an overview of relevant activities, two, discuss relevant data and terminology, three, identify some of the unique health experiences and needs for these populations, and four, recognize the importance of cultural competency training for providers and organizations.

Lesbian, gay, bisexual and transgendered individuals are often referred to under the umbrella acronym, LGBT. Though these groups are often combined

as a single entity for research and advocacy purposes, each is a distinct population group with its own specific health needs.

The experiences of LGBT individuals are diverse and are shaped by complex factors that can have an effect on health-related concerns and needs. These factors include race, ethnicity, socioeconomic status, geographical location, and age. Researchers still have a great deal to learn and face a number of challenges in understanding the health needs of LGBT populations.

Today, we will talk with a number of HRSA staff and grantees as we discuss public health and primary healthcare concerns, access and discrimination issues, and identify appropriate resources for health centers to enhance their competency. We are especially pleased today to have our HRSA administrator, Dr. Mary Wakefield, join us on the call to provide opening remarks, Dr. Wakefield?

Mary Wakefield: Thank you so much, Angela. And thanks to each of you that have taken the time to join us on this very important call today. And let me just begin by saying at the outset that I'm really, really quite proud to be part of an administration that is working very hard to advance the rights and interests of lesbian, gay, bisexual and transgender individuals.

Over the last two and a half years the Obama administration has worked to use all of the tools available to us to ensure that LGBT Americans have a chance to reach their full potential. Last year, by way of example, the President signed the repeal of the Don't Ask, Don't Tell Policy for the U.S. Military.

And about the same time HHS issued rules that, as the HRSA administrator, but also as a nurse who happened to spend a lot of time practicing in hospitals, were rules that I strongly value. And those rules that were issued gave all

hospital patients, including those with same-sex partners, the right to choose who can visit them in the hospital.

These rules apply to all hospitals that participate in Medicare and Medicaid. And since announcing them, HHS has reached out to the state agencies in charge of enforcing the rules to make sure that they are fully prepared to do so. We see this as good health policy, but perhaps even more importantly, it's a matter of simple justice.

Under the President's leadership, all HHS operating divisions are moving aggressively to protect every American's right to access our programs. HHS employees are explicitly directed to serve everyone eligible for our programs without considering factors such as race or national origin, color, religion, sex, disability, age, status as a parent, genetic information, or, of course, sexual orientation or gender identity.

And Secretary Sebelius has formed an HHS-wide LGBT coordinating committee to ensure that LGBT issues are front and center in this department's work. All of us at HHS want to improve our service to LGBT communities. And to do that, we need to understand the health challenges they face, and we can't do that without good data.

So this summer, HHS released an LGBT data progression plan to begin the work of integrating sexual orientation and gender identity variables into HHS national surveys.

The one thing that we already know is that access to providers who are knowledgeable and competent is important for every community. And we want to make sure that cultural competence on LGBT health issues extends

into every health center that HRSA supports. Pushing that agenda forward is why we are all gathered for this virtual meeting today.

HRSA's mission as an agency goes to the heart of struggles faced by many LGBT Americans. At HRSA, we seek to improve health and achieve health equity through access to quality services, through a skilled health workforce, and we aim to do that through innovative programs.

In communities across the country, HRSA's health programs are leveling the playing field for people who are underserved, who are geographically isolated, or who are medically vulnerable, and that includes LGBT people.

I'm really proud to say that HRSA has long been working on issues important to the LGBT community. For example, for many years, HRSA has led federal efforts to fight bullying, an effort that Secretary Sebelius has expanded to include all of HHS.

A new HHS Web site, stopbullying.gov, contains a specific section directed to LGBT use. At HRSA, we'll continue our work and partnership with LGBT organizations and stakeholders to fight bullying.

On the health center front, two grantees that began as LGBT centers, the Aids Foundation Chicago and the Mazzone Center, were among 129 organizations that recently won health center planning grants.

And you'll hear more in this call from Angela, Seiji, and Judy about an exciting new grant that HRSA made to Fenway Health to create a national LGBT technical assistance and training center for all health centers and also, for state primary care associations.

It's the first time that HRSA has entered into a national cooperative agreement focusing on LGBT health. And it's the largest grant that HRSA has ever awarded to target the health care needs of LGBT people.

Well that's one of our newer points of engagement. HRSA's longest involvement, though, with the LGBT community, of course, has been as a home of federal efforts to fight HIV and Aids. Through the Ryan White HIV Aids program, HRSA has partnered with LGBT organizations across the nation to deliver services to HIV positive patients.

Since 2000, HRSA has routinely collected and published data on transgender people in its annual Ryan White Program report. And after a consultation with transgender Americans in 2005, we began collecting transgender client data broken down into male to female and female to male categories, and that information is updated annually. And it's available at the state level on our Web site at hrsa.gov.

These efforts in health centers, and HIV/Aids care, and in our anti-bullying work, represent the foundation of HRSA's work with LGBT communities. And under President Obama's leadership, we're building on that foundation to extend our support of LGBT Americans even further.

Earlier this year, for example, my senior staff and I met with the National Coalition for LGBT Health to focus on ways to improve care to LGBT patients at health centers, to enroll LGBT providers in the National Health Service Corps, and to encourage cultural competency across HRSA's programs, and I was really happy to address the coalition's annual meeting last week.

In April of this year, our National Health Service Corps staff attended the second annual LGBT Health Student Symposium in Philadelphia where they explained the benefits of serving in the corps and fielded questions. And earlier this month, the National Health Service Corps offered a webinar to its clinicians titled, Providing Care to the LGBT Community, Cultural Competency Strategies.

We've also made sure, for the first time, that LGBT populations are included in health center applications as a population served. Organizations applying for funding are asked about their community characteristics and LGBT populations are now included on HRSA's standard form.

And in another first, this year's annual Women's Health USA Chartbook will include data on lesbian and bisexual women's health as well as on same-sex couples. This is the first time in the publication's ten-year history that data points on lesbians and bisexual women will be included. And we should be releasing that Chartbook soon so keep an eye out on our Facebook page, on our Twitter feed, and our HRSA newsroom.

And just this past June, in yet another first, we were really pleased to be able to join with our sister HHS agency, the Substance Abuse and Mental Health Services Administration, to sponsor an LGBT pride month event.

SAMHSA administrator, Pam Hyde, and I spoke as did Office of Personnel Management Director, John Berry, and LGBT movement pioneer, Frank Kamany. You can find John and Frank's inspirational speeches on our HRSA Web site at hrsa.gov/ourstories/lgbt.

So we're reaching out and that's great, but we're also reaching in, inside HRSA, to make sure that the culture of our organization, and the people that work within it, reflect all of America.

To support Secretary Sebelius' HHS-wide coordinating committee, I established an LGBT workgroup at HRSA. The workgroup has organized into subgroups on cultural competence, on data and research, and on grants and administrative issues. I'll share a word with you about each of these.

The cultural competence subgroup has developed a list of cultural competence resources on serving LGBT people and they've also offered recommendations to me on a listening session with LGBT health providers and students.

The second group, the data and research subgroup, is preparing a paper documenting HRSA's LGBT data collection, our research and reporting activities, which they'll be presenting at the 2012 National Health Promotion Summit.

And the third group, the grants and administrative issues subgroup, is compiling a list of HRSA programs that may benefit LGBT people, and this group is also developing a plan to make the community aware of upcoming funding opportunities.

Well, with all of that, what else are we going to be doing going forward? Well, to begin with, we'll continue to sponsor meetings and webinars just like this one. And we'll continue our work with SAMHSA and other HHS agencies on recommendations around cultural competence. And we'll complete our review of a new grants policy statement that broadens the definition of cultural competence to include LGBT populations.

The drive for full equality for LGBT individuals is really gathering strength across America. And since its goal of equal rights is supported by President Obama, by Secretary Sebelius, by me, by Pam Hyde, and by other members of the administration, I think that the future looks brighter than ever for members of the LGBT community.

With that, by way of background, let me turn the program to Angela, one of HRSA's terrific leaders. And I also want to let folks on the line know that my senior advisor, Tina Cheatham, another terrific leader, will stay on for the entire call, and they'll both be happy to answer questions that you may have about any of this important work.

Again, thanks to each of you for joining us today. Thank you, Angela, for your great work and I'm going to turn it back to you now.

Angela Powell: Thank you, Dr. Wakefield. We really appreciate you joining us for the call. This conference call has been organized to draw attention to all of the BPHC-supported programs to HRSA's commitment to serving LGBT populations, the health disparities faced by LGBT people in our communities, and to provide concrete steps that the network of BPHC-supported grantees can take to ensure access to a healthcare system that understands the unique needs of LGBT adults and youth, and treats them with dignity and respect.

Before we go further into our discussion, let's take a few minutes to understand some of the relevant data and terminology for these populations. To plan and provide necessary and appropriate healthcare services, it is necessary to have good information about the health needs of the people served as well as overall health status.

The Affordable Care Act funding has enabled the Institute of Medicine, as Dr. Wakefield mentioned, to identify research gaps and opportunities related to LGBT health and to outline a research agenda.

As part of this effort, the IOM published a report in March entitled, the Health of Lesbian, Gay, Bisexual and Transgendered People, Building a Foundation for Better Understanding. This report will serve as a significant stride in improving our understanding of LGBT healthcare disparities.

With regard to terminology, LGBT populations are defined with reference to two distinct and complex characteristics, sexual orientation and gender identity. There is an increasing awareness that all population groups neither share the same health status nor have equal access to quality healthcare and relevant related services, and that there are vulnerable and underserved populations that face many barriers to healthcare.

Some of these barriers include having no health insurance or having inadequate health insurance coverage, having a low income, living in isolated areas, or in overcrowded inner cities, where there may be a shortage of needed healthcare providers.

Our panelists for today's call will help us explore some of these issues, with a particular focus on LGBT populations. Again, the goal is to provide information that supports our healthcare home model, that it's health centers that are open and welcoming to all.

Just a reminder that we'll open up the phone lines for your questions after the panel presentations and discussion. Again, joining us today are Miss Tina Cheatham, Senior Advisor to Dr. Wakefield, Dr. Judy Bradford from Fenway Institute, Dr. Seiji Hayashi, our Chief Medical Officer here at BPHC, Dr. Eva

Hersh, the Chief Medical Officer at Chase Brexton Health Services in Baltimore, and Mr. Rodney VanDerwarker, Administrative Director of the Fenway Institute.

With regard to sexual orientation, it's generally defined as having at least three dimensions, sexual self-identification, sexual behavior, and sexual attraction.

Researchers have usually defined sexual orientation by one of these three dimensions, most often using either self-identification as gay or lesbian, bisexual or heterosexual, or using the gender of one's sexual partners, either same gender, both same and opposite gender partners, or opposite gender partners, as the defining criterion.

Gender identity refers to a person's internal sense of being masculine, feminine, or androgynous. Rather than a binary either/or concept, gender identity includes gradations of masculinity to femininity as well as identification as neither essentially male or female. Transgender is an umbrella term that is broadly used to describe people with gender identities, expressions, or behaviors, which differ from their biological gender at birth.

Judy, you were one of the researcher's for the IOM study and are one of the authors for this report. Would you share with us the challenges associated with health planning for the LGBT population and, in particular, the need for collecting information on gender identity and sexual orientation on federally supported surveys, and the significance and key findings from the IOM report.

Judy Bradford: Thank you, Dr. Powell, you've covered the most, I think, the most important idea and concept that people need to have in responding to and starting to think about LGBT people. And that is the diversity within this population.

LGBT people are different from each other according to their sexual orientations, their behaviors, but also all of the other characteristics that distinguish people who live throughout this country.

For instance, the age cohort, when a person was born, in this case when the person came out, and the tenor of society at that time and the openness that organizations have to people at different ages, so that it may be easier for young people in LGBT communities, now, to come out than it was for individuals who are in their 60s, or 70s, or older.

Race ethnicity distinguishes us within our populations as we are, in essence, a slice of the American population and just as likely to find, within LGBT populations, people from each of the different races, ethnicities, and cultural backgrounds, as in the population as a whole.

We're also distinguished within ourselves, like the rest of the population, in the ranges of education that we have had, and our socioeconomic status, and where we live, our geographic location. So we are a very diverse population and one could ask, why do a study that looks at LGBT people as a population group? And so this was a major idea to clarify for us on the IOM report.

So, in essence, then, the phrase LGBT community, or lesbian, gay, bisexual, and transgender community, really refers to a broad coalition of groups that are diverse in the ways that we have both talked about with respect to gender, sexual orientation, race, ethnicity, socioeconomic status, and so on.

And in the IOM report, we highlighted the importance of recognizing that these subpopulations are distinct and each has its own special health-related concerns and needs. So it's important to highlight these differences as well as

thinking about LGBT populations more broadly. So these groups do, though, have many experiences in common, such as the experience of stigmatization.

With that, sort of, overview of what it is that LGBT people are like, or at least how we're defined and how you think of us as one larger group, even though we're very diverse, the committee was charged with the responsibility to review all of the literature that there was around the health status of the populations.

And as Dr. Powell pointed out, to identify research gaps and opportunities, outline a research agenda, and consider the training needs to foster advancement of knowledge around LGBT health.

It's very complicated. There's a lot that's known and a great deal that's not known, and perhaps even more that we think we know, but that we don't. And so we, in order to make sense of this, and after some discussion, we adopted four frameworks through which to look at this body of literature and this very diverse and complex population.

And these are conceptual frames like this, the life course, what was going on in society in your family and your community at the time you came out. So the events at each stage of your life influence what happens to you in subsequent stages of your life, your experiences are shaped by age and historical context.

So the life course was a critical conceptual frame to look at this information that we were to organize. Minority stress, LGBT people experience chronic stress from social discrimination and stigma.

And this is a variation, thanks to (Elan Meyer), who was able to show, through a very rigorous study, that the stress that many people in our country face because of their racial and ethnic backgrounds, their low income, also is more complicated when it come to LGBT people.

There's some unique chronic stress that come along with that as well as all the multiple identities that every one of us has and understanding the concept intersectionality now.

That it's not just that you add a number of these characteristics and you get above 100% all of a sudden, but, in fact, that each of us has multiple identities and they all come together in mix to make us who we are.

And then lastly, social ecology, the fourth framework, in which we know that health is not just an individual matter, it's affected by how your family thinks and lives, what your communities think about LGBT people, and how societal attitudes influence the health of LGBT people.

This is true for everybody, but it's specifically difficult for LGBT people because of the discrimination and lack of understanding. So here was our critical findings. Our principle finding was that most areas related to LGBT health are lacking research all together, or need additional research. Most of the research has been conducted with gay men and lesbians, less with bisexual and transgender individuals.

Most has been conducted with adults, less on adolescence, very few studies on LGBT elders, and research has not adequately examined subpopulations, particularly racial and ethnic groups.

So just to conclude this part of our conversation for now, the outcome of the IOM report was that lesbian, gay, bisexual, and transgender individuals have unique health experiences and needs. But as a nation, United States doesn't know what these experiences are and what their needs are, so a lack of understanding and knowledge.

Researchers face a number of challenges and understanding these health needs, including a lack of data, as was referred to earlier, and more detail on that later on. And that in order to address that issue of lack of data, we need a more solid database, without that, we can't build a field.

Angela Powell: Thank you, Judy. I wanted to pick up on a part of that conversation around minority stress. This is developing stress, including the experience of having prejudicial events and expectations of rejection, either hiding and concealing internalized homophobia, and the continued need for coping strategies can lead to a higher prevalence of mental health concerns, more so than in other populations.

Specifically looking at individual discrimination, I think LGBT people commonly experience discrimination in the form of personal rejection, hostility, harassment, bullying, physical violence, and some of those other areas that you mentioned.

And one especially powerful stressor for LGBT youth is rejection by parents and other family members. A study of White and Latino LGB young adults from age 21 to 25, found that those who experience frequent rejecting behaviors from their parents, or from other caregivers, during adolescence, were over eight times more likely to report making a suicide attempt than those with accepting parents.

As you mentioned, LGBT adolescences and young adults who are homeless are estimated to constitute about 20% to 40% of the almost 2 million homeless youth in the United States.

And then we talk about institutionalized discrimination, and this results from laws and public policies that create inequities, or fail to provide protections, against sexual orientation-based discrimination.

These adults who lived in 1 of 19 states that lacks specific protection against sexual orientation-based hate crimes, or employment discrimination, have significantly higher prevalence of mood, anxiety, and substance use issues compared to heterosexuals living in those states and LGB adults living in states that extended protection in at least one of these areas.

Given these societal attitudes towards this population, how is this minority stress different from the stress that people face every day? And how can we address this type of discrimination in the healthcare setting or begin to address this type of minority stress in the healthcare setting?

Judy Bradford: That's an excellent question and a good way to frame the differences that do happen at a population level as well as an individual level, sort of, take the importance of the people who matter to you in your life as an example of this, and the recent research that's been around families with LGBT children, helps us understand this a bit better.

I think we all know that when your growing up, if your family is accepting of you, and then other challenges that you may face in your life, your parents can come to your support and can help you get through a period of time when you may be mistreated somewhere else and misunderstood.

One of the very difficult things in our communities is that, still, many parents and families reject their children when there's a sign or a statement by the child of sexual difference.

And when that happens, it can be because the parents don't know any better. Don't understand what this means, or afraid for themselves, for other people in the family, or become ashamed because they think that this is a bad thing.

And in a situation like that the child is left without the protection of the parent to face what can be, otherwise, a very hostile area at school, in the community, with friends, and friend's houses.

This is one example of how minority stress, which many people already face, and it's not just unique to LGBT people, but in other minorities, if a child were to have a difficult time at school, for instance, or to be beaten up, I think you may find that it's more typical, perhaps, for families to come to the rescue of the person and support the child.

Whereas, we get many stories about how it is that when things of that kind, negative things, happen to LGBT people, that the family moves away and doesn't protect the child. And I think this, kind of, comes back to what you were saying, Dr. Powell, that, there is something going on here that makes life more hazardous.

That the stress that comes with feeling is if you're not going to be supported and you don't know where to turn is probably a lot of what underlies the greater rates of homelessness and suicide attempts that we believe take place in our children's populations.

Angela Powell: In October, 2010, the National Center for Transgendered Equality and the National Gay and Lesbian taskforce, published the National Transgender Discrimination Survey Report on Health and Healthcare.

This study was conducted over a period of eight months and included an original 70-question survey instrument and over 7000 people responded to the survey.

Some of the key findings included that 28% of survey participants postponed seeking avoiding seeking medical care when sick or injured due to discrimination. Forty-eight percent of the survey participants postponed seeking medical when sick or injured due to the inability to afford care.

Fifty percent of the sample reporting having to teach their medical providers about transgender care, documenting the lack of provider knowledge, and sometimes when medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination served to increase.

And, finally, over a quarter of the respondents reported misusing drugs or alcohol to cope with the discrimination they faced due to their gender identity or expression.

In addition, these survey data show that racial bias presents a significant additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their healthcare access, and outcomes, dramatically worse.

Dr. Hersh, can you briefly tell is about what Chase Brexton is doing with regard to this organizational culture, and with their staff, in working LGBT

populations, and in particular, what you're doing with your transgendered population to increase their access to care? Dr. Hersh?

Eva Hersh: Yes, I'm here. I'm just thinking because it's a multi-faceted question.

Angela Powell: Thanks, I'm happy to repeat that if you need me to.

Eva Hersh: No, it's fine. What we started out as an organization with roots in the LGBT community assuming that, of course, we're all sensitive. But, over time, we came to realize that we've grown too big to assume that and all staff, especially new staff, needed specific training.

The goal is to develop staff who are oriented, first, to the existence of GLBT people, the need to welcome them, and who will react appropriately when given the name of a same-sex spouse, or when a child has two parents of the same gender.

It's necessary to go beyond being tolerant and be GBLT, and excuse me if I say GBLT apposed as opposed to LGBT, the idea is to go beyond being tolerant to be affirming. People come into the office having already experienced so much discrimination, especially transgender people as you were outlining, that they may come in with a chip on their shoulder, an angry attitude, being prepared to experience hostility and discrimination.

And we have to take the extra step to be welcoming it always will diffuse those attitudes and behaviors. At the very begging of this effort, we hired a diversity trainer to present, first, and overall cultural orientation to GLBT people and their medical needs, and then second, in a whole separate presentation, an orientation to transgender people.

This was a required training and this fact of making it required showed us some of the problems in our staff because there were some who didn't want to attend and had to be counseled.

We now tell all staff, as part of a new hire interviewing process, that caring for LGBT people is an essential part of our mission. To follow up on that initial training, the monthly new staff orientation includes a half-hour talk on GLBT issues.

In addition, we place materials in the waiting room that include separate pamphlets that include information for lesbians, gay people, bisexual, and transgender. We added artwork in the waiting room and halls that include images of same sex couples, same sex parents, and transgender people.

An alternative that some offices use has been to display meaningful symbols such as the equality symbol or rainbow decals. And importantly, for transgender patients, it's necessary to have at least one bathroom that is gender neutral.

Perhaps most important we've changed our demographic forms to be inclusive of GLBT people. Changes are needed in two areas in most offices, marital status and gender.

When a form in a medical office includes partner or in a committed relationship as well as the usual single, married, divorced, or widowed, that lets gay, lesbian, and bisexual people know that organization recognizes their existence and welcomes them.

For gender, including more than two options for gender, for example, by adding transgendered with either additional boxes for male to female and

female to male, or a blank to write in details, lets transgender people and their allies know that the organization recognizes and welcomes them.

These changes to forms send a positive message not only the LGBT patients, but to patients who have friends and family who are LGBT and will result in referrals to the center from those allies.

In addition to the front desk staff, it's necessary to make sure all the medical providers are onboard. Medical providers should be trained to take complete sexual history, which if done well and without any embarrassment on the provider's part, will go a long way to identify medically important risk factors.

The sexual history should be a routine part of the social history. Just the fact of making it a routine part breaks down barriers for the provider to be able to truthfully say to patient, we ask everybody these questions, goes a long way towards making the questions acceptable.

Bringing GLBT patients into the practice is a twofold effort. One part is bringing in new patients that you don't already have. The other part is letting your existing patients who are LGBT know it is safe to come out in your office and to your staff.

It's remarkable how many providers I meet who are certain they have no LGBT patients in their population and I'm equally certain that those patients are there, but have not felt comfortable to identify themselves.

We had to make special efforts to bring in transgender patients because many transgender people are marginalized and completely outside the standard medical system, and assume they will not be welcome.

It's important to go where patients are and this applies to gay, lesbian, and bisexual patients as well. Where the patients are means emails list serves, in-person support groups, the local gay and lesbian community's center can often provide sources for where you can network with local LGBT people.

Send a clinician to give talks on your services. We also advertise in our local gay publication in every issue. And this is for an organization that already was known as the GLBT health center, but that fact is, many of those patients still are not in care and need out reach.

Angela Powell: Thank you very much. I wanted to touch upon a couple of areas, one, being teen suicide. Over the last two decades an increasing body of research in the U.S. has pointed to significantly elevated suicide risk among LGBT populations compared to the heterosexual population.

Gay, lesbian, bisexual, or not sure youth reported significantly increased frequency of suicide attempts. And for you researchers out there, sexual orientation has an independent association with suicide attempts for males.

GLB youths who self-identify during high school report disproportionate risk for a variety of health risk and problem behaviors including suicide, victimization, sexual risk behaviors, and multiple substance use. These findings suggest that educational efforts, prevention programs, and health services, must be designed to address the unique needs of GLB youths.

Even though there are many unanswered questions, there appears to be little doubt that a broad national effort will be needed to encourage and fund the needed research, raise awareness of the problems among LGBT and suicide prevention leaders, and develop the interventions, prevention strategies, and

policy changes through which suicidal behavior and suicidal risk and LGBT populations can be reduced.

And with consideration to HIV infection, among some urban man who have sex with men, elevated risk of HIV/AIDS has been found to be associated with depression, substance abuse, and elevated risk, also, of suicidal behavior.

Risk of suicidal behavior in HIV positive individuals appears to have decreased as more effective anti-retro viral treatments have offered a better prognosis.

Could we get a little bit more from our expert panel about the extent of these additional challenges and what can be done to carve a pathway for improving outcomes in this area? For example, once LGBT patients are in the health center, Dr. Hersh, can you talk a little bit more about some of those specific health needs that should be addressed?

Eva Hersh: The first thing I want to reiterate is that LGBT people need the opportunity to identify themselves. And this matter is not only because of indentifying health risks, but for the same reason that knowing a patient's family setting, what one the previous speakers referred to as their personal ecology, matters for every patient.

If the patient feels they cannot disclose information about their family and the related supports and stressors, medical staff will not have an accurate picture of the patient's overall health status. In the most recent studies we have, over half of LGBT patients say they have not disclosed their status to their physicians.

One of the best ways of getting this information is the complete sexual history and I want to emphasize that this is appropriate for teenagers as well. Most of our teenagers are sexually active starting at age 15 or 16, yet we rarely take a serious sexual history.

Asking both, do you have sex with men, women, or both, and also, are you attracted to men, women, or both, may not elicit a completely honest answer the first time the question is heard, but it lets the adolescent, especially, know that you think it's acceptable that they might be having same sex attractions, and that you may be someone they can talk to. And that may be exactly what's needed when the pressure starts to build for that adolescent.

A good sexual history should include the number of sexual partners in the last month, and in the last year, and in a lifetime, and, specifically, what sexual practices the person engages in, whether oral, vaginal, or anal intercourse, and whether as the insertive or the receptive partner. If you don't ask these questions, it's impossible to really know the risk the person is putting themselves under.

Just asking do you have safe sex is not sufficient because most people will discount oral sex when answering that question. Getting this information will allow the provider to screen for gonorrhea and chlamydia at all appropriate sites.

We also ask patients, directly, if they consider themselves lesbian, gay, bisexual, or straight. This is relevant not only to get a better understanding of the client's identity, but also because we know that men who have sex with men but do not consider themselves gay are much more likely to have risky sexual behaviors, and more likely to acquire sexually transmitted infections than men who have sex with men and do consider themselves gay. It's also

useful to know whether a female patient who reports sexual activity with men, might regard herself, for example, as bisexual or as a lesbian who sometimes has sex with men.

When asking about contraception, if you ask any woman who says she's sexually active what kind of birth control she uses, it negates the possibility that she could be sexually active with another woman. It's more appropriate to ask, do you have a need for contraception?

The sexual history should be redone annually. People's lives change and as they become more comfortable with the provider, they may be able to get a more complete and accurate history.

People of all sexual orientations, but particularly LGBT people, can suffer from feelings of shame about sex, which may make it difficult for them to give an accurate history, especially the first time around. The interviewer demonstrating that she or he is comfortable with the questions and these issues goes a long way towards making the patient comfortable.

Angela Powell: Thank you Dr. Hersh. The lack of culturally relevant education among health professionals has been found to be a significant contributing factor with regard to LGBT health disparities. Homophobia, transphobia, and other forms of heterosexism on the part of healthcare providers can sometimes contribute to the inadequate assessment, treatment, and prevention of LGBT health problems as we've discussed.

This drives home the need and importance of cultural competency and cultural sensitivity training for healthcare professionals. We should also note that many of the cultural competency issues that we have discussed will also apply to other distinct groups and populations.

Dr. Bradford, in addition to the research conducted at the Fenway Institute, the Fenway Community Health Center has been a leader in its commitment to enhance the wellbeing of the LGBT community. Fenway Health is a BPHC-supported health center that provides access to high-quality healthcare.

Based on Fenway's longstanding experience with the LGBT populations, what practical advice do you have for HRSA-supported health centers to improve health outcomes for the LGBT populations and their community?

Judy Bradford: Thank you for the opportunity to comment on this, what I think is a very, very important issue right now, and an opportunity to think about how the translation from research and review, as the IOM report handled, into the real daily life of providing adequate care and best care for LGBT people.

So I think that I have four steps here and then I'd like to say a little more in detail about them. And this is, kind of, to sum up what Dr. Hersh has said in a very - my simplistic way, it's important to maintain a non-homophobic attitude throughout the entire organization. To distinguish sexual behavior from sexual identity as has been noted several times in our conversation so far.

To have a sexual identity means that you actually put a name on yourself, but to have sexual behavior doesn't tie you into that so much, it relates to whom you have sexual activity with, and these two are not necessarily one in the same. Also, to communicate clearly and sensitively using general neutral terms, which Dr. Hersh laid out a very specific way that they do this at Chase Brexton.

And I think this is, maybe, one of the most difficult ones of all and, therefore last, for providers to be aware of how their own attitudes affect clinical judgments. It's not the easiest thing for human beings to be, really, always aware of his or her own thoughts and feelings.

And, particularly, in the provision of healthcare, it's critical that providers be able to separate their own attitudes and their own experiences from what their patient is presenting them with.

So here is some practical advice of mine for community health centers that's consistent with the IOM recommendations and, I think, implementation of the Affordable Care Act as it's currently emerging. It is important to incorporate measures of sexual orientation, and gender identity, in electronic medical records, as Dr. Hersh was describing at Chase Brexton.

And this is important and critical now, and very timely, because the National Center of Health Statistics has said 2012, you know, for the inclusion of sexual orientation measures in the National Health Interview Survey, and it's possible that gender identity may also be included in 2012, perhaps more likely in 2013, but this commitment has been made and it opens the door.

As this happens, and it works, we're going to see these measures added more and more across other federal surveys and used for monitoring federal programs. This is really critical because the importance that community health centers understand these things about their own populations, the more they're going to link with federal initiatives.

So other suggested advice, when you decide to do this, select standardized measures that have been developed, or approved, by federal agencies so that you can maximize comparability of data. Now it's also critical to be

responsive to your own patient population, so doing what (Anne Hiss), for instance, does, doesn't necessarily finish it for you.

You can add other things that reflect with - and you can add other things in conjunction with your patients and their advice, and your providers and their advice, to, sort of, tailor the way you collect these data. To also, you know, to match what's happening at the federal level for reporting, but also to make it clear to your patients that you are sensitive to their needs and their ability to express themselves in their own way.

Another piece of advice is, that it's critical to provide all staff training and discussion about cultural competency with LGBT people, don't assume that just because your organization serves this population it's necessarily completely culturally competent, and so some of these discussions and learnings are easier for some people than others.

It's important, then, I think, to have all staff training, but also have this discussion happen at the department level where smaller groups of people may know more about what each other is doing and may feel more safe to talk about the specifics in their area of practice.

So in other words, establish an environment of acceptability and respect for all sexual orientation gender identity patients, and the staff in your organization, through making this a part of the regular discourse of what's happening. Monitor the environment, don't just talk about it, but monitor how things are happening, and develop practices for responding to anti-gay behaviors, such as verbal discrimination.

Because your organization may have served this population for a long time and be very highly culturally competent, doesn't mean that slurs are not going

to be made. And when these things happen, have some sort of plan in place to respond to them so the organization communicates to everyone, this is just not okay here.

And I suggest that you keep track of inappropriate events when they're reported. Not to, you know, to antagonize people, or to blame people, but just to say keeping the pulse of how the organization is growing.

You can make an analogy to what's happened in this country, it seems like not so very long ago when the Civil Rights Act was so powerful in this country, and when we all became aware of how racial and ethnic discrimination happens all the time even though we may not experience it ourselves, it's like that now with LGBT health, I think.

And then just to, sort of, wrap up, I think that there are - it's critical, my last advice, establish organizational standards for interacting with patients in the exam room, as Dr. Hersh was pointing out, using existing protocols from other practices, not just your own, and materials that have been published.

We have the Fenway guide out, which is a clinical guide for people who provide care to LGBT people. It's not the most recent thing, but it's very comprehensive. The Transgender Equality Center, which was mentioned earlier, has done some excellent work in this way, as has the Gay and Lesbian Medical Association, and so forth.

So I hope that these, sort of, practical advice pieces will tie into the development of the new center that HRSA's funding.

Angela Powell: Thank you. And speaking of the new center, Rodney, as we've mentioned, the Bureau of Primary Healthcare recently awarded funds to the Fenway Institute

for this national training center. Can you give us an overview of that effort and where you all are?

Rodney VanDerwarker: Sure, thanks, Dr. Powell, so I did want to introduce everybody to our National LGBT Health Education Center here at the Fenway Institute. And the center's being led by Dr. Harvey Makadon who, unfortunately, couldn't be here with us today due to a scheduling conflict, but he does send his best to everyone.

So the center's focus is on training clinical and administrative health professionals. And, over the years, we've developed the book that Judy just mentioned, the Fenway Guide to LGBT Health, which was done in collaboration with American College of Physicians.

We've developed free downloadable training materials, which are on our Web site, which is www.thefenwayinstitute.org, and we've also developed, and implemented, a grand round series that we've done in collaboration with American Medical Association.

And so this recent award from HRSA is a three-year national cooperative agreement and will be offering training and technical assistance to HRSA-funded organizations throughout the country.

So our focus is on training providers and staff at community health centers, and in the first year, we're going to focus on reaching broad audiences through live presentations at conferences and meetings, and by hosting webinars, many in collaboration with our other NCA partners, and state and regional PCAs.

We'll further develop resources that are available through our Web site and we also hope to complete a needs assessment in the first year, which is going to help us identify priority topic areas in LGBT health for a community health center staff and clinicians.

So we just started up, I guess we were funded about two months ago, and we're already looking like we're going to be presenting at the National Association of Community Health Centers Policy and Issues Forum, which is in Washington, D.C. March 21st through the 24th, and we plan on being, also, at the National Healthcare for the Homeless Conference and policy symposium, which is in Kansas City this year, May 15th through the 18th.

And we expect we'll be at many other conferences and PCAs over the coming months, so please look out for more information for us, or if you have any questions, feel free to contact our project manager, whose name is Hilary Goldhammer, she's the easiest person to spell on the team, I guess, so it's hgoldhammer@fenwayhealth.org.

Angela Powell: Thank you, Rodney. HRSA has over 1100 health center grantees that operate more than 8000 community clinics in every state and territory, giving geographically isolated, or economically distressed people, access to preventive and primary healthcare.

Dr. Hayashi, from your perspective as the Bureau's Chief Medical Officer, and consistent with the goals of the Affordable Care Act, what other opportunities do we have that community health centers can take to integrate LGBT services into routine primary care?

Seiji Hayashi: Great, thank you very much, Angela. And what are the opportunities? There are many, many opportunities and opportunities are everywhere. But before I begin about specific, sort of, programs that I think everybody should know about, I wanted to, sort of, tell a story about my personal experiences around these issues.

And ten years ago I came to Washington, D.C., and I started working in a community health center here in D.C., which was right around the corner from a neighborhood where there were a lot of homeless transgender sex workers.

And when I realized this, you know, I asked the clinic staff, why aren't we seeing people, you know, from this community in our health centers? And people just shrugged it off, I don't know, maybe they go somewhere else, you know, whatnot.

And then, about a year after that, I found out, at a function, from an advocate for the community, that we had a reputation for being unfriendly to this community, and I was just really floored. And that's me, who grew up in San Francisco, who trained in San Francisco at UCSF, and had a lot of, actually, direct training on caring for LGBT community.

And so I was, you know, ten years fast forward, now in my role as Chief Medical Officer here, I'm always thinking to myself, you know, how do we do this better, but at the same time, how do we incorporate everything so that we're not sacrificing, you know, care for Latinos and Asian-Pacific Islanders for, you know, if we focus on LGBT community?

And how do we do it all together? How do we actually add primary care providers and try to do it all? And it's always a challenge, so what we do well in the federal government is try to create a system and infrastructure. And

sometimes, you know, if you, sort of, try to do everything, you don't do anything well.

But at the same time, you know, you need to do everything, but with a focus, and you need help. And that's where, I think, the Fenway Institute and the National GA Center, really is going to help us quite a bit.

But many of you have already heard me talk about, certainly, the quality improvement strategy. What are we about? We're about providing high-quality, culturally competent care, no matter who you are, what your background is, and how do we do that?

Number one, we talked about access, but specifically, what does it mean to have access, you know, to provide access for members of the LGBT community? And we know that if we start looking at where people come from to access care, the service area is not the same as, sort of, a traditional primary care practice.

And I hear this from, you know, I'm sure it's true for Fenway, for Chase Brexton, and many other health centers that do great work for the community, that people come from all over, that the traditional primary care service area isn't there, so what do we do? We have the UDS mapper that, kind of, shows the traditional service area, but then look at your community, you know, where are your patients, who are LGBT, coming from?

Do you need to think about your service area differently? So tools like that, you know, beginning to look at how we can do that. So once you have access, what's the next thing you can do? It's comprehensive integrated care. And we already heard about mental health issues, substance abuse issues,

discrimination issues, so how do we, sort of, create a health center environment that's comprehensive and integrated?

And we think that patient-centered medical homes is one way of doing it. And certainly not, you know, the end all be all, but, you know, a great start. And I think that, in line with patient-centered medical homes, the meaningful use standards, data collection, as was already mentioned, those things are going to be crucial.

If we don't know who we're treating, we're not going to be doing a good job doing it. So I hope that, as people think about becoming a medical home, adopting electronic health records, and achieving meaningful use, that the data is being captured for specific sub-populations.

And along the lines of HIT, and Fenway is part of this initiative, the Community Health Applied Research Network. This is a program out of HRSA to establish a community-based, practice-based, research network. And there are health center controlled networks that are participating and Fenway is one of them.

One of the things that I encourage all of you, all health centers in the United States, to do is ask your research partners to, you know, not only, you know, answer the questions that you may have about this community, but, really, coming up with solutions.

And I think that, you know, we're just getting started on the Community Health Applied Research Network's infrastructure, but, you know, building this in, from the get-go, asking the questions that need to be answered so that you have the evidence and the information necessary to provide the highest quality of care for the LGBT community.

And then, finally, you know, even Fenway, and Chase Brexton, and some of these health centers that are the best practices, they can't do it alone. It needs a partnership and collaborative effort throughout the community, whether it's the health centers with mental health and substance abuse treatment centers, whether it's social service organizations and other community partners, we have to do it all together and not alone.

And in order to do that, one of the things that we're trying to do in the federal government at HRSA is aligning with our partners. If the National Health Interview Survey is going to incorporate LGBT data issues, then we need to go step-by-step with them to make sure that what we're measuring, or what we're asking, is in line, or the same.

Meaningful use measures, you know, when, you know, more and more specific measures come out in the future, we want to make sure we're there. Research questions by the Agency of Healthcare Research and Quality, or the CDC, or NIH, we want to be with our federal partners to make sure that we're doing this.

And, finally, you know, these things don't work unless, you know, the best practices, the good ideas, the innovative practices, are shared with the others. And I think that the TA Center, led by Fenway and others, is really going to be essential as we begin to, sort of, try to disseminate and infuse the best practice across the country.

So those are some of our, you know, our strategy as well as specific programs that we have going that I think will be helpful for health centers.

Angela Powell: Thank you, Seiji. Your comments reminded me of a quote I heard a while back, and that was it is just as important to know about the person who has a disease as it is to know about the disease that the person has, so it's really important for us to know the population that we're dealing with.

And so at this point we want to open it up to questions and, (Angela), if you will let us know about the dial-in, call-in process for questions.

Coordinator: Thank you. We will now begin a question and answer session. If you would like to ask a question, please press star 1 and record your name.

Angela Powell: In the interim, I wanted to remind people that on the BPHC technical assistance Web site, we'll have a list of resources that we've pulled together for health centers, both providers and administrative staff, that will be useful to you, hopefully useful to you, as you do more in your centers around enhancing your cultural competency wherever you are in the spectrum of providing services to LGBT populations. Operator, do we have any questions?

Coordinator: Yes, our first question comes from (Carol).

(Carol): Hi, I just had a question for the folks from Fenway, we've been, sort of, an LGBT-friendly site for many years and I was just curious whether you all are using the DNA probe in the throat and in the rectum? I know that's not FDA approved.

Eva Hersh: I can take that one if you'd like.

(Carol): That'd be great.

Eva Hersh: We are using it at Chase Brexton only because we now have a lab that has, for that lab, independently validated those tests.

(Carol): Okay.

Eva Hersh: That's what's required. It happens that, in Baltimore, our city lab that works with the city STD clinics, has also independently validated the tests, but if that isn't true for the lab, they generally will not process the specimen and that's the problem.

(Carol): Okay.

Eva Hersh: So you have to speak with the lab that you're using about whether they can accept the specimen.

(Carol): Fair enough.

Angela Powell: Rodney, did you have any comments on that from a Fenway perspective?

Rodney VanDerwarker: No, I would, not being a clinician, I trust Eva's recommendation on that. I'm sure they're very similar to Fenway's.

(Carol): Great, thank you.

Coordinator: Thank you, next question comes from (Charles).

(Charles Schroeder): Good afternoon, (Charles Schroeder) from the Lion Center, New York City. Besides being an affirming organization, what other work, and I've heard some really good ideas working with our other, not necessarily staff, but our

other patient populations, specifically seniors and the religious community, as you move forward to really embracing the LGBT community?

Judy Bradford: Hi, this is Judy Bradford. I think one of the things that we find very useful, and it's just, sort of, a way that we generally operate in the Fenway Institute and I'll speak, specifically, about the population research center.

There are, as you're pointing out, within our overall LGBT populations, some subgroups that have particular burden, or particular challenges, to overcome in order to get their needs met, and certainly LGBT elders is a good example of that. Our general approach to this is to form relationships with partner organizations and members of the community to develop what you could describe as a community-based (unintelligible) research approach.

We have two such things underway, right now, that are actually going very, very well. One, with a network of LGBT elder serving programs, health programs, and other social service programs, to develop research that would help us understand, better, the needs of LGBT elders in our geographics area, so that the organizations could have some shared information that they could use, and, you know, build out a full network of services that people could access, and could access through any of those organizations.

In a similar fashion, we work with the Massachusetts GLBT youth commission and scientists from our area, but also from across the country, who have a particular area of interest in the effectiveness of programs directed at youth, and how useful these programs are to assists LGBT youth to get their needs met.

So this is a way of responding to some of the mistreatment that young people are getting. This approach of working with populations that are at particular

need with other individuals who are service providers and scientists who are affiliated with them, gives us a way to build research programs and to tailor and then evaluate programs that are developed in conjunction with the people who are going to use them.

(Charles Schroeder): Great, thank you.

Judy Bradford: Sure.

Coordinator: Our next question comes from (Frannie).

(Frannie): Hi, can you hear me?

Angela Powell: Yes.

(Frannie): This is just a really simple question. I work at Chase Brexton with Dr. Hersh and I was trying to find the literature that you referenced on the SAMHSA site, and I was wondering if someone could repeat that because I wasn't - I may have gone to the wrong area?

Eva Hersh: I'm sorry. The reference list that I was talking about is going to be on the HRSA BPHC technical assistance site.

(Frannie): Okay. In the near future?

Eva Hersh: The resource list is on there now and we'll also upload an archive of this call, and probably some addendums to that resource list, subsequent to the call.

(Frannie): Okay, great, thanks. I appreciate it. I'm all about getting free resources from the feds. It's always helpful.

Tina Cheatham: Well that's good to hear. This is Tina Cheatham and I'll just say that we're also, in addition to the great resources that the Bureau of Primary Healthcare has put together, we're also in the process of updating a page that Dr. Wakefield referred to earlier that's at hrsa.gov/ourstories/lgbt.

We're working with our sister agencies like SAMHSA, like the Administration on Aging, we're going to be putting up more tools and resources linking to this call, linking, of course, to the call that Dr. Wakefield referred to, the National Service Corps just recently had a really excellent webinar presentation, we'll be linking to that, also, linking to some other tools that are happening in other places of the federal government.

Elders were mentioned earlier, in addition to the really great technical assistance project that we're funding here in HRSA, our sister agency, the Administration on Aging, has an LGBT elders technical assistance center.

Their primary audience are some of your community partners, the area agencies on aging, but there are also some really cool tools. They're about a year ahead of us in terms of their project.

(Frannie): Good, good, excellent, thanks. I mean, I've taken advantage of the SAMSHA, CSET, and CSEP stuff for years, so it's good to hear that they're updating some stuff. Great, thank you, thanks.

Coordinator: Once again, if you'd like to ask a question, please press star 1. One moment, please, for the next question. Our next question comes from (Linda). Your line is open.

(Linda Frank): Hello, this is (Linda Frank) from the University of Pittsburgh Graduate School of Public Health and I run the Pennsylvania Mid-Atlantic AIDS Training Center. I just wanted to complement all of you on this great presentation, very informative and very timely. And I wanted to make mention that the AIDS training centers has made LGBT healthcare and primary care a priority.

In our ATC we're doing a lot of work with community groups and other healthcare providers as well as community-based organizations that are working in the community, and have developed a number of products for primary care providers about doing assessment of the LGBT population.

And so I was wondering, anybody on the panel, if you could talk about how such resources, or training, is being coordinated, if in any way.

Tina Cheatham: This is Tina again, on some of the part about how training is being coordinated. Dr. Wakefield referred to, at the HRSA level, us having a cross-HRSA group really trying to get a handle on all of these fabulous activities going on through the AIDS education training centers, through area health education centers, you know, even through some of our conversations we found out that one of our geriatrics grants that went to another health center, Howard Brown, is funding a cultural competency curriculum for nursing.

And so what we're trying to do, right now, within the agency, is harness some of that. Our workgroup has a report that is near (unintelligible), we should be having that report up soon, and it'll talk about some of the other activities within the agency. But, kind of more importantly, there is a real effort to look at some of the training programs we have, not just within HRSA, but also within SAMHSA, we're working very collaboratively with them.

One of the things that we'll be doing in the very near future, next month, is having a conversation with about 40 different folks from across the country, just about cultural competency, and training of providers, and, you know, if there are any levers, policy levers, that the federal government could use to advance cultural competency, and health professions training programs, you know, what strategies do community folks think that the federal government should be engaged in, both for HRSA and SAMHSA, as well as the Agency for Health Research and Quality, I think, is going to be able to join us.

Space is kind of limited for that room, but if any of you all on the phone want to send your ideas in, we're inviting people to send any written input to Dr. Wakefield's email address, which is administrator@hrsa.gov, that's administrator@hrsa.gov, and already we're hearing from folks, you know, across the country, and I certainly welcome anybody on this call to send in their comments around what more we can do, and how we can better coordinate.

Angela Powell: Thanks, Tina.

(Linda Frank): Okay. Thank you very much.

Coordinator: Our next question comes from (Tess).

(Tess Kenning): Yes, hello. This is (Tess Kenning), I'm the director of the Primary Care Association in Vermont and New Hampshire and I wanted to thank you very much for HHS and HRSA's commitment to this population, and thanks to the faculty today.

I went on the Web and looked at all of the resources that you have and it's a really rich compendium, I think it'll be, really, quite helpful. I wanted to ask a

question if you could speak a little bit more to the support to the Primary Care Associations with regard to training and technical assistance you had mentioned on the call.

Rodney VanDerwarker: I think what you're asking is, this is Rodney from Fenway, about the types of support we'll be offering to the Primary Care Associations on behalf of the education center here at Fenway, and part of it is we want to seek input from the Primary Care Associations on the specific areas where people's interests, where they're seeing the most need.

We know it's broad, but that's a piece of doing a needs assessment in the beginning is to identify those priority areas.

(Tess Kenning): Great, I'd love to work with you on that. So I'll connect up with you with regard to, sort of, a follow through on that.

Rodney VanDerwarker: That'd be great, thank you.

Coordinator: Our next question comes from (Mary).

(Mary Wichita): Hi, this is (Mary Wichita), I'm on the board of a healthcare center in rural Wisconsin and this has been fabulous and extremely helpful. We're in a community, like a rural community, so we touch a lot of towns, a lot of people, very few gay, lesbian, or transgender folks even come out in our community.

And I think where we have a very sensitive staff who pride themselves on being inclusive, you know, I think we're, sort of, starting, almost, from scratch in terms of ramping up for specific training and specific changes in policy.

So I guess I'm looking for a, I mean, you've given a lot of resources, but if there's anything you can say, specifically, to resources of training, you know, where we're both trying to, you know, get people comfortable with using the words and helping people feel comfortable coming out, that would be great.

Judy Bradford: (Mary), I think it's really important to be raising these questions now in the early stages and it reminds me of when we first starting doing lesbian research in this country. It seems like it's been forever, it was in 1984, I think, at the national level, and how it was that people didn't even understand what we were talking about.

And then when you tried to explain it, people would get nervous because they weren't sure what it meant. I think that maybe you could consider finding someone to come and talk to your organization, to do, just like a training on what these terms are about, in a very simple way, to, kind of, make it seem more acceptable to people.

So that, even starting off with, like, word games and having people move around the room and lineup, so that it's some way to, sort of, loosen up the situation for people so that you could, then, include a discussion around what the healthcare needs are and what some of the disparities are that the population is facing.

So it's, kind of, a basic 101 in a way, but it's not just people sitting around hearing someone talk to them about it, it's some way to get people in touch with their own lives, with the lives of people that they know, some of the values that they may not have really questioned before.

And I think that, I don't know that there is - that I can just tell you, now, what a list of trainers are to do that, but I know that I can get something like that

together and give it to Angela Powell and the people here who've put this conference call together. Do you think something like that might be helpful?

(Mary Wichita): Yes, I do. And, actually, I mean, we do have a wonderful, relatively new, PFLAG chapter, so we've actually done that among ourselves for chapter members, you know, so, I mean, I think we have resources here, and that's a great idea, which, you know, worked in our monthly meetings, so I think we can branch out. That's a really good idea. It's very basic, but very important.

Judy Bradford: Right, sometimes starting with the basics is much more relevant than you might think, that's been my experience, right.

(Mary Wichita): Yes, yes, right, thank you. Okay, great. Thank you.

Tina Cheatham: This is Tina, if I may add one other thing, because rural populations are an area that is, especially, very much on the mind of Dr. Wakefield and very much on my mind as well, as you can hear from my accent, I'm from rural Central Texas, and we were recently having this conversation that the census came out with same-sex household composition.

And some folks in California did some further work on it, and my little rural county in Texas, actually, has many more same-sex households reporting to the Census Bureau than anybody ever thought. And so I was just flagging for the team here, we may want to make a link to those reports coming out of California so you can look at your own county because that might even be another place to start.

(Mary Wichita): Yes, that would be very helpful.

Tina Cheatham: To tell folks, well people are discreetly reporting to the census, but they're not telling us.

(Mary Wichita): That would be great.

Judy Bradford: That raises, in my mind, the possibility of data being collected at your state level that you may not be aware of. For instance, the Behavior Risk Factor Surveillance System, states can add these measures to them, and many of them do.

The Youth Risk Behavior Survey, again, they are measures that have been created for this and states can decide whether or not to put them in, and your state may have data that you're not using yet. Have you looked at those? Do you know if your state...

(Mary Wichita): No, I don't, personally, but maybe the staff do, but we can find out.

Judy Bradford: And, (Mary), what's your state again?

(Mary Wichita): Wisconsin.

Judy Bradford: Wisconsin does have data.

(Mary Wichita): Okay.

Judy Bradford: Some population-based data on lesbian, gay, bisexual people, maybe not trans, and so I think we could follow up and give you contacts on that as well, or you can just ask folks that you know, you probably know them already.

(Mary Wichita): Okay, good.

Judy Bradford: Sure.

(Mary Wichita): Thank you.

Judy Bradford: You bet.

Angela Powell: Operator, do we have any additional questions?

Coordinator: No further questions.

Tina Cheatham: Well, actually, while we're seeing if anybody else has any other question, on the rural point, there was one other item that I'd like to mention is that there is, currently, within HRSA's Office of Rural Health Policy, the Rural Outreach Grant Competition, I believe, has not closed yet.

As of last week it had not closed, so if any of you are looking at - know that LGBT populations are inclusive, we're inclusive in HRSA, and LGBT populations are certainly a population that could be served by that grant. We took a look backwards at our grants and found out that in our rural outreach and network grants, there have been a couple of successful grantees serving LGBT populations. So I just wanted mention that in case that's helpful as well.

Angela Powell: Thank you very much, Tina, and thank you to all of our panelists and to our listening audience. This call was recorded and will be archived on the Bureau of Primary Healthcare Web page. And as I mentioned, in addition, there will be a resource list and other relevant materials that will be added, subsequently, after this call.

The Bureau appreciates your time and your commitment to improving the health of the nation's underserved communities and vulnerable populations by sharing access to comprehensive, culturally competent, quality primary healthcare services. I hope everyone has a good afternoon and thank you for joining us.

Coordinator: This concludes today's conference. Please disconnect at this time.

END