

Health Resources and Services Administration
Bureau of Primary Health Care
Health Centers Serving Lesbian, Gay, Bisexual and Transgender Populations
Special/Vulnerable Populations Enrichment Webinar
Tuesday, June 24, 2014, 1:30 p.m. – 2:30 p.m. ET

Coordinator: Welcome everyone and thank you for standing by. At this time, all participant lines are in listen-only mode. Following today's presentation, we will have time for a question and answer session. At that time, press Star 1 on your phone to ask a question. I would also like to remind participants that the call is being recorded. If you have any objections, you may disconnect. Now I'll turn the call over to our host and our moderator for today, Ms. (Tonya Bowers). Ms. (Bowers), you may begin.

(Tonya Bowers): Thank you very much and good afternoon and good morning to everyone on the West Coast. I am (Tonya Bowers), the Deputy Associate Administrator for the Bureau of Primary Healthcare. I want to welcome everyone to today's Bureau of Primary Healthcare Special and Vulnerable Populations Enrichment Webinar, One Successful Strategy as an Available Resources for Health Centers Serving Lesbian, Gay, Bisexual and Transgender Populations.

As you know, the Bureau of Primary Healthcare funds health centers to provide high quality primary healthcare services to medically underserved communities and vulnerable populations which includes the lesbian, gay, bisexual and transgender community. The LGBT community represents all races and ethnicities, age groups and socioeconomic status. Culturally appropriate primary healthcare and preventive services tailored to the needs of LGBT populations are critical to advancing health equity and reducing health disparities.

In recognizing the unique needs of LGBT populations, in September of 2011, BPHC awarded a national cooperative agreement to the National LGBT Health Education Center which provides specialized training and technical assistance to health centers across the country to improve clinical performance and HIV prevention, sexual health, transgender health and other LGBT health issues. We are very pleased to have Dr. (Harvey Makadon), Director of the National LGBT Health Education Center, a division of the Fenway Institute, one of the largest LGBT focused health centers as part of today's panel of experts.

The overall goal of today's enrichment webinar is to learn more about culturally appropriate care of LGBT populations and technical assistance resources available through the National LGBT Health Education Center. We hope you will have an opportunity to engage with today's presenters and to share your own experiences. I will now turn it over to Commander (Jacqueline Rodrigue), Chief of the BPHC's National Partnerships Branch in our Office of National Assistance and Special Populations who will introduce today's panel of experts. Commander (Rodrique).

(Jacqueline Rodrigue): Thank you (Tonya). Before we get started, I have a few reminders to point out. Please use the chat function in the webinar users panel to submit questions to the panel members. At the end of the panel discussion, we will have a Q&A session. Also, please remember to complete the evaluation survey at the end of this session. Your feedback will help us to improve our online training session.

It is truly an honor to introduce our panels of experts who will be sharing their knowledge and expertise in the LGBT health. Our first speaker is Dr. (Harvey Makadon). His presentation entitled: "Meeting the Healthcare Needs of

Lesbian, Gay, Bisexual and Transgender People” will provide an overview of the challenges and opportunities faced by the LGBT community in the healthcare setting.

Dr. (Makadon) is a professor of medicine at Harvard Medical School and the Director of the National LGBT Health Education Center at the Fenway Institute in Boston. He has a long history of teaching how to improve access to quality care for the LGBT population. He has written numerous peer review articles and chapters related to LGBT health. Dr. (Makadon) developed the first practice that integrated HIV AIDS care into primary care practice.

Our second and third speakers are Mr. (Jonathan Chapman) and Mr. (Aaron Price). They will provide an overview on the work that the Louisiana Primary Care Association has engaged in around LGBT health. Since 2011, (Jonathan Chapman) has served as the executive director of the Louisiana Primary Care Association. The LPCA represents 30 health centers operating and more than 140 service sites across the state of Louisiana. Prior to this, Mr. (Chapman) worked directly with a number of community health centers and primary care associations to strengthen their infrastructure and capacity to improve the quality of care for their patients. He is a lifelong resident of Louisiana.

(Aaron Price) is a Community Development Coordinator with the Louisiana Primary Care Association. In this capacity, Mr. (Price) provides guidance and technical assistance to medically underserved communities in establishing and expanding health centers. Prior to joining the Louisiana Primary Care Association, Mr. (Price) worked as a policy analyst in the Washington, DC area on the provisions of the Affordable Care Act that expanded behavior health treatment.

Our final speaker is Ms. (Avein Saaty-Tafoya). She will provide the perspective from a migrant health center in recognizing the unique needs of the LGBT community. Ms. (Saaty-Tafoya) has served as the CEO Officer for (Adelante) Healthcare Center since 2006. As the CEO, she provides oversight and management for more than 250 employees at seven comprehensive primary care sites and six WIC sites throughout the country and the surrounding rural area. Ms. (Saaty-Tafoya) has worked with community health centers, primary care associations and health plans in various capacities since 1996. She is currently serving as Arizona Alliance of Community Health Centers Board of Directors. She is also the co-chair of the National Association of Community Health Centers Farmworker Health Committee. Please welcome Dr. (Harvey Makadon) as our first presenter. Thank you.

(Harvey Makadon): Thank you very much (Tonya) and (Jacqueline). It's really a pleasure to be here today and along with my colleagues be able to talk about meeting the healthcare needs of the LGBT community. This comes at a particularly appropriate time from our perspective as the National LGBT Health Education Center, we're hearing from more and more health centers across the country that recognize that as they get more involved in doing population health as part of the Affordable Care Act, they're learning more about the needs of LGBT people in their communities and are seeking support in developing culturally appropriate programs. So it's a pleasure that we can do this today.

The - just by word of introduction, the National LGBT Health Education Center does offer educational programs and resources to healthcare organizations. They are based at the Fenway Institute which is in Fenway Health, a federally qualified health center located in Boston, Massachusetts and that's a picture of the health center in the lower right hand corner of the slide. We're supported for our work with health centers by a HRSA National Cooperative Agreement to provide training and technical assistance. We have

a number of resources and publications and webinars which are featured on our website which will be noted on the last slide of my talk. We also do other specific programs for healthcare organizations.

At this end of this session, our hope is that we will have described how health disparities affect LGBT people, enable you to discuss more about LGBT definitions and dimensions and describe how to overcome barriers to providing better care for LGBT people through collecting data and improving the environment of care.

When I think about what we've learned about LGBT health disparities, two documents are extremely important in guiding our work. Those were both published by the federal government in the last several years. One is Healthy People 2020 which as many of you know is a guide to what our goals are for improving public health over the next decade.

The other, on the right, is a publication of the Institute of Medicine called the Health of Lesbian, Gay, Bisexual and Transgender People. That was published with support from the National Institutes of Health to do an overview of what we know about healthcare disparities among LGBT people and also recommend a research agenda for the future and I recommend both of these publications to anyone who is beginning to think about what they need to do to focus on both systems of care but also creating a better environment of care for LGBT people in your health centers.

As we look to what health disparities are, they really do occur throughout the life course from childhood and adolescents through later adulthood. On the summary from Healthy People 2020, just suggests that in youth, LGBT youth are two to three times more likely to attempt suicide, are more likely to be homeless and this is a major problem among homeless youth but up to 40% of

homeless youth are LGBT and they certainly are at higher risk of HIV and STD's.

Men who have sex with men are at higher risk of HIV and STD's especially among communities of color particularly young black men who have sex with men and transgender women. LGBT populations have the highest rates of tobacco, alcohol and other drug use. Lesbians are less likely to get preventive services for cancer. Transgender individuals experience a high prevalence of HIV, STI's, victimization, mental health issues and suicide and elderly individuals face additional barriers to healthcare because of their isolation, having grown up with fewer family supports and a lack of social and support services. Something that with a number of changes in federal policy and laws will probably change but nevertheless, it continues to be an important problem for us to address in taking care of elderly LGBT individuals and finding out who they are.

I wanted to spend a few minutes going through some basic LGBT concepts so that we all have a common understanding. First is that it's important to recognize that all people have both a sexual orientation and a gender identity. How people can identify can change over time and terminology can vary geographically and within an individual and just as time changes but it's important to remember that gender identity is separate from sexual orientation and there's no correlation between what someone's sexual orientation and gender identity are.

In terms of dimensions of sexual orientation, sexual orientation relates to how a person identifies their physical and emotional attraction to others and the dimension are identity behavior and attraction and desires. Generally, identity is expressed in terms of being straight, gay, lesbian, bisexual or queer and some people may not identify as such but still may behave in a way that's

consistent with that. So it's important to inquire of people whether they have sex with men, women or both and then again, some people have same sex attraction or desire but have yet not acted on it. So it's important that we understand all three dimensions in getting to know our patients.

In terms of transgender, I like to think of what we need to know to understand the basics of the T in LGBT. Transgender is an umbrella term. It really relates to gender identity which is what ones internal sense of their gender is when it's not congruent with their assigned sex at birth. Alternate terminologies are used as I mentioned. People use the term transgender woman or trans woman and sometimes use the abbreviation MTF, similarly transgender men or FTM meaning that someone was assigned a female sex at birth but transitioned to being a man.

Gender queer is a term that's used by some. It blurs the gender binary and people don't identify as either male or female but it is being used by particularly younger people and clinicians should be aware of that terminology.

Now, gender dysphoria is a relatively - it's not a new term but it's newly identified as a diagnosis in the DSM-5 in that it describes individuals who have a strong and persistent cross gender identification and a discomfort with his or her sex or a sense of inappropriateness in the gender role of that sex. So that is to say that ones gender identity is not congruent with their assigned sex at birth and it's causing them distress which is really the basis for engaging in behavioral, medical and surgical interventions.

Gender affirmation is the process by which individuals are affirmed in their gender identity and as I just said, this can take behavioral, social, medical change but also involves legal changes in terms of people changing their

names on legal documents. Transgender people, as I said, can be of any sexual orientation and then another terminology is the term cisgender which is basically the equivalent term for people who are not transgender.

I did want to highlight what (Tonya) mentioned briefly in her introduction which is that LGBT people have a great vulnerability to poverty and despite the overall acceptance of the LGBT people that we hear about and read about and the LGBT people who we may see on TV and in the movies, it's important that we recognize that while children generally have higher rates of poverty than adults, children of lesbian, gay and bisexual parents are especially vulnerable to poverty.

African American children in gay male households have the highest poverty rate. About 52.3% of children of any children in any household type and the rate for children living with lesbian couples is 37.7%. So these are extremely high poverty rates and then with respect to transgender people, respondents to the National Transgender Discrimination Survey which was done in 2011 were four times more likely than the general population to have a household income of less than \$10,000.

So as you can see, people have a difficult time socioeconomically and if it weren't for some of the extension in the context of the Affordable Care Act would be large - way more uninsured than the general population and still do struggle in states that should not extended Medicaid.

Now, one of the issues that a lot of health centers ask about is how do we overcome the barriers to really feeling like we're providing an equal level of care to all of our patients including LGBT people and I want to spend the next few minutes talking about this topic.

In terms of overcoming barriers, I'd like to start at the top with overall just focusing on the fact that we do have to end invisibility and learn who is lesbian, gay, bisexual and transgender in our practice and we do that through taking a history of sexual health and increasing interest in collecting data in electronic health records. We also need to education clinicians and staff and make resources available so that people can learn more about what they need to do.

So as I said, we don't know when people come for care to our health centers who are new patients and who might be new lesbian, gay, bisexual or transgender patients and the questions is, what do we do about finding out? Well, getting back to basics, I'd say we need to get to know patients in clinical settings through taking a good history which is what we're all taught in nursing school and medical school and social work school but sometimes, people don't do it as well as they might.

So here, for example, is a slide of a study about physicians talking to HIV positive patients and as you can see from this slide, 84% talked with them about use of antiretroviral therapy but only 14% talked with them about the more intimate issue of HIV transmission and/or what they did about risk reduction like using condoms or other alternative methods of reducing risks so that we clearly have an issue that needs to be addressed and partly in response to this, the education center working together with the National Association of Community Health Centers has developed this toolkit called Taking Routine Histories of Sexual Health, A System Wide Approach for Health Centers which really goes through a number of issues suggesting questions that clinicians can ask patients to learn about their partners, their practices, their past history of sexually transmitted diseases, what they do to protect themselves from STD's as well as plans for pregnancy and desires for pregnancy.

So these are things that I think it's important to cover. This monograph toolkit is available on the websites of both of our organizations and downloadable for free and for your use and your health center. We also have a webinar on this topic online but in terms of the history, just a brief summary, is that core history for LGBT people is really the same as for all patients keeping in mind that LGBT people, once they've identified, do have unique health issues.

We all want to get to know our patients as people and get to know about their partners, their children, their jobs and their living circumstances. In order to do this and really engage people in discussion, we recommend that a clinician use inclusive and neutral language and this is really true for all people we see in the office. So we recommend that instead of terms like do you have a wife or husband or boyfriend or girlfriend, you ask people do you have a partner or are you in a relationship in a more open ended way which doesn't suggest that you may have a preconceived idea about what the relationship is and then you can say, what do you call your partner and probably end up finding a fair amount about what you need to know in a lot of cases but for all patients, it's important that we make these questions routine, make no assumptions and really before getting into the meat of the sexual history, put it in context about why you're taking and getting this information and assure people about confidentiality of what you're asking. So as I just said, it's important to make people comfortable and set the context, give them an opportunity to ask any questions before you begin to talk with them.

In taking a history of sexual health, traditionally, people ask about behavior and risk. So people may ask questions like, have you had sex with anyone in the last year? Do you have sex with men, women or both and how many partners did you have? So you have some sense of what people's behavior is like and also how risky their behavior may be. You also want to talk to them

though about their sexual health in general as well as their sexual and gender identity.

So questions like, do you have concerns about your sexual function? How satisfied are you sexually? Do you want to talk about your sexuality, sexual identity, gender identity or sexual desires and have you had any change in your sexual desires? So you get to know if people are feeling like they need some help in this regard and then finally, ask about both reproductive health and desires.

Traditionally, as I mentioned, there's been a tendency to only talk about contraception but in same sex couples, frequently they're struggling to figure out how to have children and do it legally within the states rules -- the state where they live rules -- and so it's important to really be able to talk to them about opportunities for using a surrogate or by adoption in the state where you're seeing patients. So these are the kinds of questions that we think are important in addition to others such as talking about issues about sexual violence or trauma which come up frequently.

I wanted to turn now from what we do in office settings traditionally to a new concept of gathering data in electronic health records. Both the Institute of Medicine reports that I referred to earlier that's pictured on the left and a newer report of an Institute of Medicine Workshop from 2012 suggests that we collect data on sexual orientation and gender identity in electronic health records because it's a direct benefit to individual patients, ensuring quality and helps evaluate disparities in healthcare at the practice level so that we can learn about educational needs for both clinicians and staff.

In order to do this, we have to come up with appropriate questions. At Fenway Health on our demographic form, we use a question such as this highlighted in

blue -- question seven -- which asks do you think of yourself as lesbian, gay or homosexual, straight or heterosexual, bisexual, something else or don't know and then with respect to gender identity, we recommend asking two major series of questions. One is what is your current gender identity and you can check all that apply and the second -- as I explained earlier -- is what sex were you assigned at birth and if there's a disparity between these two or a lack of congruity, it certainly suggests that someone is transgender.

In addition, for support staff, it's also helpful to know what someone's preferred name and pronouns are and so that if that's asked up front and put on the front of the chart, it can help receptionists and medical assistants who may not be involved in patients care still make them feel more comfortable by using appropriate pronouns, although if they do make mistakes, they can always apologize.

I'm not going to go into the details of this study but as part of the process of trying to get sexual orientation and gender identity questions included as part of meaningful use, we have done a preliminary study of asking these questions in four health centers across the country -- one in a rural area, three in urban areas -- in which we asked people what they thought of the questions that I just went over and overwhelmingly, over three quarters of the patients felt that we should definitely be communicating about sexual orientation and over 80% thought we should be communicating about our gender identity when we're seeing our clinicians.

So I think people generally feel comfortable with this, this needs more study and there is a process underway through the Office of the National Coordinator for Health Information Technology to look at how to include these or when these could be included as part of meaningful use.

The second area that I talked about was aside from ending invisibility and getting to know our patients is educating people about culturally appropriate care and I wanted to talk about just three examples although there are really many. One is cancer prevention and promoting cancer prevention among lesbians and bisexual women but also among transgender people. If we look at rates of cervical cancer screening among lesbians and bisexual women compared to heterosexual women, studies have found that lesbians and bisexual women have significantly lower cervical cancer screening rates. Up to four times lower than the general population of women.

Similarly, a recent study from New York City indicates that lesbian and bisexual women over 40 were less likely to have a mammogram than heterosexual women based on this study published in 2013 by the Empire State Pride Agenda Foundation. So it's important that educational programs emphasize the need for women who exclusively have sex with women and bisexual women to be screened according to the usual guidelines for all women in order to ensure appropriate cancer prevention.

I did want to bring up though that transgender men are also at risk in many cases for cervical cancer screening or at risk for cervical cancer and requires screening. The majority of transgender men do not undergo complete sex affirmation or reassignment surgery and retain a cervix if a total hysterectomy has not been performed. Cancers of natal female reproductive organs are still possible in these individuals. So it's recommended that transgender men with a cervix should follow the same screening guidelines as natal females even though it's important to point out that pap tests can be a bit more difficult to do on transgender men for a number of reasons and there is a lot of sensitivity to having a genital examinations in transgender people. So it's probably not something that you would do on an initial visit but only after you'd get to know somebody and develop a degree of trust with the patient and vice versa.

I wanted to turn from cancer prevention to HIV prevention for men who have sex with men and transgender women specifically focusing on what we need to be doing to begin to create effective programs in our health centers. As we all know, there is a high rate of HIV among both young black men who have sex with men where the rate of HIV infection has continued to increase. It's increased by 15% between 2008 and 2011 and also in transgender women where the prevalence of HIV is over 28% for transgender women in general and over 50% for transgender women of color.

So this makes us look at what are the opportunities to improve HIV prevention in community health centers and we really should be looking at three areas. One is implementing programs for universal HIV screening as recommended by the CDC since 2006 to ensure that all individuals between the ages of 15 and 65 be screened at least once and individuals at high risk based on the sexual health history that you've taken be screened more frequently. Both for HIV and other sexually transmitted infections.

For people who are HIV infected, it's important that we begin treatment as soon as possible both to benefit individuals and also a very important study has been done which shows that early treatment and effective treatment so that viral load is suppressed prevents transmission of HIV to others so that treatment can be a very important prevention technique and finally, for people who test negative, it's important that we continue to talk with them about protection using safer sex approaches and also addressing sexually transmitted infections which makes the risk of transmission of HIV easier but also get to talk to them about bio medical approaches to HIV prevention such as post exposure prophylaxis after someone has had an episode of sex which they consider to be unsafe or a newer approach, pre exposure prophylaxis where someone can take a pill a day that has very high rates of success in preventing

HIV infection assuming that individuals are adherent to their medication and also engage in continued counseling about behavior as well as adherence to their medication and if we do this, I think it's highly likely that we'll begin reducing the incidence of HIV in the general population which has been very, very stable for many years and we now have the tools such as we just discussed to really make a difference but it requires that we develop systems of care that deal with these issues in all care settings but particularly health centers which see people who are at very high risk for HIV.

I did want to mention that hepatitis C is something that I know health centers are very concerned with because 3.2 million Americans are infected with HIV but we've seen a growing incidence of sexual spread of hepatitis C among HIV infected men who have sex with men. Until recently, it wasn't felt that hepatitis C was spread sexually which makes it important that we emphasize the use of condoms to prevent the spread of hepatitis C virus because other medications and other antiretroviral medications at this point are not shown to prevent transmission of hepatitis C. So, again, this is something that's relatively new but something for people to be aware of and there's lots of systems issues that are relevant to this which we don't have time to get into today.

Finally, my last example -- my last clinical example -- is to point out why clinical care of transgender people requires that we know about their gender identity as well as sex assigned at birth by going over two case examples with you. The first is (Jake R's) story. (Jake R) is a 45 year old man who came in with pain and on x-ray what appeared to be metastases from an unknown primary cancer. His evaluation ultimately showed he'd developed cancer in residual breast tissue after surgery to remove his breast and unfortunately no one had ever told him that he needed routine breast cancer screening even

though his mother and sister also had breast cancer putting him at high risk for developing it.

The second is the case of (Louis M), a 59 year old woman who developed high fever and chills after head and neck surgery. The source of her infection was her prostate gland. She had inflammation of the prostate or acute prostatitis but no one knew that she had this anatomy because no one had ever asked her about her gender identity or knew that she was transgender highlighting, again, the importance of our gathering this information if we're going to make appropriate and rapid diagnoses when individuals have problems.

Finally, I wanted to turn to the topic of creating a welcoming and inclusive environment which can make a huge difference for individuals seeking care. This is a photograph of the waiting area at Fenway Health where all of our primary care patients are seen. In doing this, I think some of these points follow from what I've already said but it's important that we teach clinicians and all staff about the health of LGBT people, that employees feel respected and safe at work and that forms reflect the full range of sexual and gender identity and expression.

There's a number of transgender standards of care which are available on the internet such as that from the Center of Excellence for Transgender Health as well as those from the Endocrine Society and the World Professional Association for Transgender Health on the right. At the Education Center, we've developed this resource that we recommend that goes over creating affirmative care environment for transgender and gender non conforming people. It helps teach front line and healthcare staff about things to do and gives them very practical tips on how to deal with people who've had name

changes or where they're uncertain what pronoun to use and ways to approach patients. This, again, is available for free on our website.

We recommend adding affirmative end imagery with pictures of same sex couples or transgender individuals in our educational and marketing materials so that people feel welcome at health centers. It really makes a big difference to see pictures of people who remind you of yourself on the brochures you see in the waiting areas and partly as a reason, as a way of helping health centers do this, the Education Center has designed this poster and brochure called Do Ask, Do Tell.

The poster is to suggest to people that they talk with their provider about the fact that their LGBT and the brochure really suggests topics that are important to talk about which summarizes a lot of the issues that I've discussed today but we've already had many requests for these from health centers and again, these are available on our website and can be printed out and printed with the logo of your health center in case you want to post these in waiting areas, exam rooms and leave the brochures for patients as education materials but also as a sign that your health center is welcoming LGBT people.

Finally, I just want to say that the LGBT Health Education Center is really here to help you. We're located in Boston. Our phone number, email address and website are located at the bottom of this slide and we hope that we hear from many of you in the weeks, months and years ahead. We look forward to helping you as you begin to develop programs for LGBT individuals who live in your community. So I think we'll save questions for the very end of this program and I think and I'd like to turn this over now to our next speaker, (Jonathan Chapman).

(Jonathan Chapman): Thank you Dr. (Makadon). I really appreciate that introduction and the comprehensive information that can serve as context. So my name is (Jonathan Chapman) and I serve as an Executive Director of the Louisiana Primary Care Association. I have joining me today Mr. (Aaron Price) who serves as our Community Development Coordinator. We were asked to briefly address the Louisiana Primary Care Association, I guess, involvement over the last couple of years and LGBT efforts.

When I came on board about three years ago, I was aware of the high rate of AIDS prevalent in both New Orleans and Baton Rouge but really didn't have the clinical background to know about how to go about addressing that. Not long after I started this endeavor, I attended the National Minority AIDS Counsel Meeting that was having a national conference in New Orleans and that lead to a real awareness of the LGBT needs and the gaps and services and so, beyond that, we were then introduced to Dr. (Makadon) and the Fenway Institute who was working with a group of providers in New Orleans in trying to put together some specific LGBT training.

That training was over multiple days allowing many of our New Orleans health centers to participate and that really lead to, I guess, a further awareness of not only the LGBT community but some of the specific providers and our more urban areas that were reaching out. Some of those efforts include The Tulane Community Health Center which is now under management in New Orleans and through that transition, its continued to provide those services to the LGBT communities.

So with that awareness and now armed with some information and just being, again, a realization of the community, we began to offer LBGT topics at our annual conference. We participated in a National Healthcare for the Homeless

Conference not long ago in Baton Rouge and as well as the HIV and AIDS Stigma Summit also produced lately in Baton Rouge.

So we continue not only to provide that support to larger organizations but certainly want to reach out and make this information available to our individual providers health centers. Along that line, we've included specifically the LGBT and our special (pops) work and that's what (Aaron) is going to briefly discuss now.

(Aaron Price): Thank you (Jonathan). Again, this is (Aaron Price). I'm the Community Development Coordinator for the LPCA and just wanted to talk briefly about some of the successes, challenges and lessons learned as well as best practices that we've encountered along the way. So we consider just having the discussion here a success and providing information a success. We're working to create an awareness and understanding of the unique health needs of those key individuals by providing this information.

Though we have encountered some challenges, including a lack of awareness as well as cultural barriers, as you might know Louisiana is a conservative rural southern state and as a result, some might feel that there are social and health needs that may not be relevant to the population here and as well as we've encountered some of these challenges on a statewide level as far as legislation is concerned.

This year at the legislative session, a few bills were introduced to protect LGBT rights but were voted down including one to prohibit housing discrimination based on sexual orientation though it should be mentioned that many in the LGBT community actually considered just having these bills introduced as a success. So just moving onto lessons learned and best practices, we've learned -- through hosting and trainings and sponsoring

trainings -- that certainly the time and place where trainings occur affect their attendance. It depends on where in the state they're held or what time during the day and whether it should be meant for the health centers and we've also learned that just establishing LGBT health as a top priority requires consistently providing relative information. So we've done so through continuing to put out updates about the webinars in our hones of interest as well as in our bimonthly newsletter. So just want to wrap up and hand it back over to (Jonathan) to talk about our future plans.

(Jonathan Chapman): Thanks (Aaron). So as you can see, we're in a process of trying to, again, determine what those needs might be. Certainly we want to reach out to those communities outside of Baton Rouge and New Orleans to understand that the LGBT needs and community is not geographically bound and as well as we've really tried to make a conscious effort to further develop our social media and that's really geared around a number of topics but certainly want those LGBT topics and interest included in that work and so, as you can see, it's become a priority within the PCA as well as our members and we'll certainly include this going forward in our strategic planning efforts. So, again, as Dr. (Makadon) mentioned, we will have any questions or comments for the end and I'd like to turn it over now to Ms. (Avein Saaty-Tafoya).

(Avein Saaty-Tafoya): Hello everyone. This is (Avein Saaty-Tafoya). I think I've had every pronunciation of my name possible during this session. I am really proud and pleased to be included in this group of presenters. I think they've covered such a wide array of considerations that all of us as leaders and members in the community health center as well as the LGBT movement need to think about and to employ and how we participate in delivering care and how we engage our employees as well.

I've been Health Center Leader at (Adelante) Healthcare since 2006 but the organization goes back to the time of Cesar Chavez. We were granted our federal grant in 1979 and we're a community health center as well as a migrant health center. In that time, the community of Phoenix and the metro area were mostly rural and agricultural. Over the last 35 years, we've become much more urban and suburban although our \$30 million organization with 250 employees serving about 40,000 patients covers eight sites that include a frontier site in (Gila Bend), rural sites in Buckeye and (Wickenburg), suburban sites in Peoria, Avondale and Buckeye and urban sites in (Surprise), Mesa and Phoenix.

I want to start by sharing with you a personal story and some leadership lessons that I learned a few years ago. As a community health center, I think we pride ourselves on being culturally effective, being confident in serving any number of special populations and I think my organization certainly fit into that frame of mind. A few years ago, we had a provider who was quite beloved and had started our OBGYN and women's health program almost 12 years prior suddenly passed away from a cardiac condition.

He was 43 years old, probably one of the most vocal and successful of our providers, had a following of patients that was unparalleled. In the aftermath of his passing what I realized was myself and his OB practice partner were really the only people in the organization that knew he was gay or that had a relationship with him and his partner of more than a decade. In the aftermath of his passing, I started to participate more actively as an ally in a number of LGBT organizations including physician groups.

I thought about what we were doing as an organization. We had a culture that certainly provided care from the heart and did that with the best of intentions. We got involved in the human rights commission equality index survey to

really answer the question of how are we doing? Can we answer that objectively? What would it take for us to demonstrate competence and effectiveness with this special population? As an employer, were we aware of our own providers, staff, even board members who belong in that community? Were we inclusive and were we investing in training for our folks? Did we have an understanding of our patients and were we considering their lives whether they were caring for family members from the LGBT community or they themselves identified?

We became the first community health center in Arizona to pass the HRC Healthcare Equality Index and what I can tell you is, it was short lived because a lot of what we uncovered were the things that we weren't doing or that we had lacked awareness around especially when it came to training for our staff and providers.

I think that the lesson in that for all of us as community health centers is our hiring, our diversity practices, our inclusion and representation from a leadership, governance, staffing and service delivery engagement with the populations that we serve is the next frontier of advocating as a community health center and so for us, it's become a real labor of love to learn the kinds of things that Dr. (Makadon) outlined to become involved in a much more participatory manor.

The other aspect of this that I'll share is that as a Migrant and Farmworker health community health center, it was important that we develop an individual who could really coordinate and liaison with the migrant and farmworker community. To have that authenticity in that front line connection was really important because it's difficult enough to engage with the migrant community and farm worker community but even more so with the stigma associated with being LGBT in that community, the youth -- especially this

next generation -- may of the children in the farm worker community have really very few outlets.

When you consider the health disparities -- as Dr. (Makadon) outlined -- higher than average rates for just about everything. It's a very communal environment that farm workers live in and so, individuals can be ostracized, they can live in hiding, they will often mistrust and fear accessing healthcare or even sharing some of their practices or activity, transportation, lack of coverage. I'll raise Louisiana with Arizona politics and it's a state that has not been particularly friendly to that population and certainly to immigrant populations from a number of countries.

So I think what this illustrates is we've got work to do as a community health center movement but there is hope in sight. I've listed there some of the support groups that are involved with migrant and farm worker health that create a safe and inclusive environment for LBGT migrant farm workers. We need to advocate, we need to improve our own awareness and I think at this point, that's what I'll share and leave the discussion to the Q&A portion. Thank you for your time.

(Jacqueline Rodrigue): Thank you very much and thank you so much to all of our esteemed panelists today for your extremely informative and thoughtful remarks. We're just going to go a couple of minutes over -- I'm sorry about that -- and operator, I'd now like to open up the session for Q&A.

Coordinator: Thank you. If you have a question, press Star 1 on our phone. Just remember to unmute your phone before asking your question. Record your name clearly when prompted to. Thank you and stand by for the first question.

(Jacqueline Rodrigue): Okay and while we're waiting for the questions to queue up, I think we have a question here in the room.

Woman: Hi there. I've heard the term MSM or men who have sex with men. Can you elaborate on the difference between MSM and gay?

(Harvey Makadon): This is (Harvey) so I guess I'll answer that. Men who have sex with men is a term which really describes behavior and there are people who or men who behave in a way that's consistent with being gay but don't identify as gay. Some of them are only have sex with men but still don't identify as gay and some of them are bisexual but a man who has sex with men or MSM is someone who -- for a variety of reasons -- may not identify or choose to identify as gay but want to be engaged in sex and is attracted to having sex with other men.

(Jacqueline Rodrigue): All right. Thank you very much Dr. (Makadon). Operator, do we have any questions on the line?

Coordinator: No ma'am. There are no questions at this time.

(Jacqueline Rodrigue): Okay. I think we have another question in the room here.

Woman: Yes. Hi. Do you know if any resources that specifically address culturally appropriate healthcare for (activity) migrant or cultural workers or any other resource that is developed in other languages?

(Jacqueline Rodrigue): Dr. (Makadon), any thoughts on that?

(Harvey Makadon): Yes. There are - we have been developing - we have done two webinars with farm worker (Justice) about LGBT issues. One on MSM actually and one

on transgender migrant workers. Those have not been translated into Spanish. We are in the process of translating the guide on Taking A History Of Sexual Health into Spanish now and we have some other materials that are in the process of being translated such as the Guide for Front Line Staff and Dealing with Transgender and Gender Affirmative People.

There is a general webinar that was done about a year ago that's archived on our website on ending invisibility that is in Spanish. It was done by two of our faculty members from Puerto Rico, (Carlos Rodríguez-Díaz) and (Carmen Vélez Vega) and so those are what we have available now and will be interested in hearing from you what resources you would find useful and considering what we can do in the course of the next year or so, so that if you write us any specifics in terms of what kinds of resources you would find helpful, we can consider putting those into our considerations for our work plan for this year and next year. Thank you for asking.

(Jacqueline Rodrigue): Thanks. Operator, any questions on the line?

Coordinator: No miss. We have no questions at this time on the phone.

(Jacqueline Rodrigue): Okay. Well, in closing today, I would just like to thank all of our presenters today and all of you for joining us on this Enrichment Webinar. Again, I'd like to thank our presenters for their remarks and all of the great work that they're engaged in. As a final reminder, please fill out the evaluation survey that's on your screen so we can get feedback from you on this session. Thanks very much and I hope you have a great day.

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

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