RAINBOW HEALTH

LGBTQ+ Standards of Inclusion 2021

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2 Executive Summary

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

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

The LGBTQ+ Standards of Inclusion:

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

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

3 Terminology

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

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

All other terms are defined in the glossary (page 37).

4 LGBTQ+ Disparities

While Minnesota is consistently regarded as one of the best healthcare systems in the country, many of its famous health outcomes are not shared by all (Minnesota Department of Health, 2019). Overall, there is a gap both in knowledge of and service for LGBTQ+ Minnesotans compared to heterosexual and cisgender populations. To fully describe disparities that LGBTQ+ people face, this section outlines the importance of intersectionality, identifies the sources of LGBTQ+ disparities, provides data on LGBTQ+ health outcomes, and details LGBTQ+ experiences in healthcare and the workplace. Understanding disparities that impact the LGBTQ+ community is essential to provide exceptional care for LGBTQ+ community.

4.1 Intersectionality

LGBTQ+ people come from every demographic sector possible. Rainbow Health aims to use an intersectional lens when identifying and analyzing data on health disparities, discussing and addressing systemic issues, and caring for all LGBTQ+ individuals. It is necessary to recognize the multiple identities that intersect to influence someone's experiences. These intersecting identities shape their health and can compound disparities. For example, equitable and inclusive services for a transgender Latinx woman are different from the needs of a Black, disabled, gay man. Equitable and inclusive care for LGBTQ+ people must incorporate anti-racism, anti-ableism, and anti-ageism. It is necessary that care organizations incorporate this knowledge in their practice.

4.2 Sources of Disparities

Disparities for LGBTQ+ populations stem from both the structural and the day-to-day oppression that LGBTQ+ people face. Heteronormativity (the expectation that everyone is heterosexual) and cisnormativity (the expectation that everyone is heterosexual) creates systems and individual attitudes that devalue, under-serve, and oppress people who are LGBTQ+.

Intersecting identities multiply the forms of systemic oppression that disadvantage some LGBTQ+ people. Structures in our society—including healthcare, employment, education, and culture—are all impacted by sources of oppression, including white supremacy, patriarchy, classism, ageism, and ableism. Structures of oppression directly impact one's social determinants of health. These are the factors which exist within the lived environments of everyone which influence our health. Several such factors include:

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

4 LGBTQ+ Disparities

Interpersonal experiences of discrimination also affect the health of LGBTQ+ people. Minority1 Stress Theory explains that repeated instances of discrimination and hardships faced by many oppressed groups depresses the body's immune response, increases the deleterious effects of stress on the body, and negatively impact mental health (Durso et al., 2013; Meyer, 2003). Minority Stress Theory has also been applied to the high rates of disparities found within marginalized racial, ethnic, and linguistic groups. This is particularly important in the context of intersectionality — LGBTQ+ people that hold multiple oppressed identities have more potential stress factors affecting their health. This theory can also be used to explain low rates of preventative health services and adherence rates among the LGBTQ+ population because historical trauma and the fear of future discrimination prevents many individuals from seeking care.

Without addressing the factors which lead to health disparities, health and human service systems will continue to harm the populations they are trying to serve and harm themselves in the process.

4.3 LGBTQ+ Health

PHYSICAL AND MENTAL HEALTH

Lesbian, Gay, and Bisexual people exhibit higher rates of asthma, allergies, osteoarthritis, and gastrointestinal disorders, have a higher prevalence of debilitating disabilities, and a heightened risk and diagnosis of cardiovascular disease compared to straight people (Beamesderfer et al., 2015; Buchmueller & Carpenter, 2010; Durso et al., 2013). Lesbian and Bisexual women are at an increased risk of developing several cancers, particularly breast and cervical cancer, due to a lack of preventative screenings (Bassford et al., 2000). LGBTQ+ people report higher rates of depression, anxiety, and suicidal ideation (Meyer, 2003). LGB youth are twice as likely to attempt suicide as heterosexual youth (D'Augelli & Grossman, 2007). Nationally, LGBT Asian and Pacific Islander Americans have higher rates of mental health disparities and lower health care access compared to white LGBT Americans (Jose-Ray et al, 2009). Cultural stigma, systemic mistreatment in the healthcare system, and lack of BIPOC mental health providers makes Black folks less likely to seek mental health services (NAMI, n.d.)

HIV

LGBTQ+ people, and particularly LGBTQ+ people of color, are disproportionately affected by HIV (CDC, 2021b). Gay and Bisexual men account for over two-thirds of new HIV infections with Black/African American Gay and Bisexual men accounting for a third of new HIV infection diagnoses (CDC, 2021a; CDC, 2021b). Transgender women have a high risk of HIV infection with Black Transgender women having the highest percentage of HIV positive-test results (CDC, 2021b). According to the CDC, 44% of black transgender women tested positive for HIV, compared to 26% of Hispanic/Latina transgender women, and 7% of white transgender women (2021b).

HOUSING AND FOOD INSECURITY

When LGBTQ+ people find themselves in need of supportive services, they often face barriers to access due to the facilities providing the services. Many food shelves and shelters are primarily operated by religious organizations, who may not support LGBTQ+ people, or may dissuade LGBTQ+ people due to prior experiences of discrimination (Russomanno & Jabson, 2020). LGBTQ+ youth are more likely to be unhoused, increasing poor health outcomes. According to the Williams Institute, approximately 27% of youth clients served by homeless service centers identify as LGB and 4% identify as trans (Choi et al., 2015).

4 LGBTQ+ Disparities

PHYSICAL VIOLENCE

According to a data analysis by the Federal Bureau of Investigation (FBI), LGBT people are the most likely victims of a hate crime in the United States (Mykhyalyshyn & Park, 2016). The Victimization by Sexual Orientation Report shows that 26% of gay men, and 37% of bisexual men, report intimate partner violence at some point in their life (CDC, 2011). The same report found that 61% of bisexual women and 44% of lesbian women experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime. Transgender people are 3.3x more likely to experience intimate partner violence (Waters, 2017). LGBTQ+ youth experience high rates of physical and emotional violence in school as well as their homes (Rainbow Health Initiative, 2015). LGB students are more likely to be threatened or injured with a weapon at school, experienced dating violence, or be forced to have sex at least once.

CHEMICAL HEALTH

LGBTQ+ individuals have higher rates of Substance Use Disorders (SUDs). In treatment, LGBTQ+ individuals have been found to have more severe substance use issues and higher incidences of mental illness (SAMHSA, 2012). Many LGBTQ+ individuals not in treatment would feel more comfortable getting care from a treatment center that specializes in LGBTQ+ services (Williams & Fish, 2020). One study found that 58.8% of Trans and 28.8% of LGB people believe that there is not enough SUD treatment for people who hold their same identities (Lambda Legal, 2010). Support groups exclusively for LGBTQ+ individuals can create a safe place to share and relate to others who may have similar struggles (SAMHSA, 2012)

QUEER AND TRANS BLACK, INDIGENOUS, AND PEOPLE OF COLOR (QTBIPOC)

Across the board, communities of color are experiencing poorer health outcomes for most of the metrics of the 2019 National Healthcare Quality and Disparities Report (NHQDR). People of color are more likely to develop cardiovascular disease, diabetes and receive a cancer diagnosis (Agency for Healthcare Research and Quality, 2020). BIPOC LGBTQ+ individuals not only deal with homophobia and racism in health care systems and institutions, but also face racism within the LGBTQ+ community.

LGBTQ+ PEOPLE WITH DISABILITIES

Rates of people living with a disability are higher in the LGBTQ+ community (Barkan, 2012). The 2015 US Transgender Survey found that Trans people are six times more likely to have trouble concentrating, remembering, or making decisions as the result of a physical, mental, or emotional condition (30% vs 5% of the US population). People with disabilities are often marginalized because of their disability by both the heterosexual and LGBTQ+ communities (Clare, 1999: Rothenberg, 2010).

Care providers may also be uncomfortable with the idea of people with disabilities being sexually active or building sexual relationships and may try to prevent or limit LGBTQ+ people with disabilities from living complete lives (Gruchow, 2012).

4 LGBTQ+ Disparities

LGBTQ+ OLDER ADULTS

Aging LGBTQ+ people present many comorbidities and high rates of depression and anxiety (Emlet et al., 2011). Aging LGBTQ+ people often keep their sexual orientation and/or gender identity private in order to enter assisted living facilities or nursing homes due to fear of discrimination. This exacerbates existing mental health issues such as depression and anxiety resulting in a reduced quality of life. In addition, people living with HIV are experiencing greater life expectancies due to advancements in antiretroviral medications, which has led to an increased population of older adults living with HIV (MDH, 2019). The physical toll of managing a chronic condition, such as HIV, over their lifetime means these individuals have specialized care needs.

LGBTQ+ YOUTH

In addition to the physical and mental health disparities already discussed, the status of many LGBTQ+ youth as minors presents its own challenges. Most youth are required to share medical decisions with a guardian. While there are methods of exempting minors from this burden, the act of requesting these exemptions is itself a difficulty for LGBTQ+ youth. Compared to straight peers, LGBQ youth have reported high levels of internal distress, particularly young females (CDC, 2019). In 2015, RHI released Invisible Youth: The Health of Lesbian, Gay, Bisexual, and Questioning Adolescents in Minnesota, based on data collected in the 2013 Minnesota Student Survey (MSS).

Some mental health issues found in the Invisible Youth survey were:

- Over half of the LGB youth have stated that they were significantly depressed in the past year.
- Over half of LGB youth reported feeling trapped, lonely, or hopeless about their future.
- 50% of Bisexual and Gay males reported problems with anxiety.
- 14-17% of GBQ males reported high levels of external distress.
- 16% of Bisexual and Lesbian females reported high levels of external distress.

HEALTH DISPARITIES IN MINNESOTA

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

The 2018 VOH survey reported high rates of depression and anxiety compared to heterosexual and cisgender Minnesotans. At the time of the survey, 2% reported being homeless, and 29% of LGBTQ+ respondents had experienced homelessness at least once in their life.

4 LGBTQ+ Disparities

In 2018, Hennepin County Human Services and Public Health Department conducted the Survey of Health of All the Population and Environment (SHAPE) and found that LGBT respondents had much worse mental health indicators than heterosexuals with more reports of anxiety, depression, and psychological distress. The SHAPE results also stated that LGBT respondents had higher rates of prescription insecurity due to costs compared to non-LGBT respondents. Prescription insecurity being defined as skipping doses, taking smaller doses than prescribed, and not filling prescriptions due to costs.

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

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

4.4 LGBTQ+ Experiences in Healthcare

The disparities in LGBTQ+ health continue to intensify if/when an LGBTQ+ person seeks medical care. Discriminatory attitudes, practices, and policies all compound to make accessing and receiving healthcare difficult for many in the LGBTQ+ community. In a study conducted by Lambda Legal (2010), 27% of trans and 33% of low-income trans people have faced refusal of needed care. The same study found that 10% of LGB and 15% of trans patients have and experienced healthcare providers refuse to touch them. Another study found that 23% of trans people have avoided seeking health care they needed due to fears of mistreatment (James et al., 2016).

According to the 2015 US Transgender Survey, one-third of Trans respondents reported a negative experience with a doctor or other healthcare provider (James et al., 2016). This included:

- Having to teach the provider about transgender people to receive appropriate care (24%)
- Being asked invasive or unnecessary questions about being transgender not related to the reason of the visit (15%)
- Experiencing verbal harassment in a health care setting (6%)
- A health care provider being physically rough or abusive when treating them (2%)

Negative experiences with doctors vary by race, ethnicity, and ability. In the same study, 50% of American Indian, 40% of Middle Eastern, and 38% of multiracial trans individuals have experienced one or more negative experiences with a health care provider (compared to 33% overall). 42% of respondents with disabilities reported one of more negative experiences with a healthcare provider. Lambda Legal (2010) found that LGB People of Color were at least twice as likely as white people to report physically rough or abusive treatment form a medical professional.

4 LGBTQ+ Disparities

LGBTQ+ HEALTHCARE EXPERIENCES IN MINNESOTA

The 2018 VOH survey found that, of survey participants, 18% were not out to their doctor about their LGBTQ+ identity and 10% reported having to teach their healthcare providers about LGBTQ+ people to get appropriate care. The survey also found that 11% of respondents had experienced harsh or abusive language from a provider. The 2015 VOH survey found that 12.3% of trans respondents delayed getting care because of previous discrimination, compared to 5.4% of cisgender LGBQ respondents.

The VOH survey results demonstrate that in Minnesota, people of color who identify as LGBTQ+ have higher rates of discrimination, poorer quality care, and lower rates of insurance compared to white LGBTQ+ people. The intersection of race, sexual orientation, and gender identity can create clinical situations where LGBTQ+ people of color experience multiple stressors compounding negative health outcomes.

4.5 LGBTQ+ Experiences in the Workplace

Creating a safe and welcoming environment for staff is foundational to sustaining a safe and welcoming place for LGBTQ+ clients. For many LGBTQ+ people, the workplace can be another sphere of injustice, mistreatment, and harassment. A landmark supreme court ruling in 2020 prohibits discrimination towards gay and trans workers under Title VII (U.S. EEOC, n.d). While LGBTQ+ workers have federal legal protections, workplace policies and culture that negatively impact the day-to-day experiences of LGBTQ+ workers still present a challenge. According to the Human Rights Campaign (HRC) (2018), almost half of LGBTQ+ individuals do not share or express their sexual orientation or gender identity at work. Therefore, creating a safe culture around LGBTQ+ identities is relevant and important even without prior knowledge of LGBTQ+ employees. Workplace standards around gender identity and sexual orientation must be universal.

HARASSMENT

Offensive jokes targeting the LGBTQ+ community are prevalent at work: 53% of LGBTQ+ workers have heard jokes about gay people, 41% have heard transgender-specific jokes, and 37% have heard bisexual-specific jokes (HRC, 2018). LGBTQ+ women are more likely to face sexual harassment, hear sexist jokes, and feel pressured to “play along” with sexual discussions than straight women (Ellsworth et al., 2020). In the United States Transgender Survey, 15% of trans workers reported being verbally harassed, physically attacked, and/or sexually assaulted at work (USTS, 2018 p.153). In the same survey, 16% of trans respondents reported that their employer or coworkers shared personal information about them that they should not have (USTS, 2018 p.154).

4 LGBTQ+ Disparities

MICROAGGRESSIONS

More than half of all LGBTQ+ people have been the target of a microaggression based on their LGBTQ+ identity (Casey et al., 2019). Microaggressions are everyday verbal, behavioral, or environmental forms of discrimination that are indirect or subtle (Galup & Resnik, 2016). Microaggressions can be intentional or unintentional. Some examples include: misgendering someone, not acknowledging relationships or families of LGBTQ+ people, assuming the gender of someone's spouse, or excluding LGBTQ+ workers from social events (Galup & Resnik, 2016). While LGBTQ+ people can experience microaggressions in any setting, workplace microaggressions are distinct because so much time and energy is spent in the same space with the same people. Every workplace microaggression adds up to shape someone's everyday experience and expectations at work. LGBTQ+ workers have reported that microaggressions negatively impact their mood, wellbeing, productivity, and relationships with coworkers, in addition to decreasing job satisfaction, leading to thoughts of leaving the job (Galup & Resnik, 2016).

STEPS TO AVOID DISCRIMINATION

LGBTQ+ workers often take measures to avoid mistreatment. The USTS (2018) found that 77% of trans workers took active steps to avoid discrimination. One option LGBTQ+ workers may take is to conceal their sexual orientation or gender identity. 46% of all LGBTQ+ workers, and 54% of trans workers, do not come out at work (HRC, 2018; USTS, 2018). 26% of trans workers delayed their transition to avoid discrimination (USTS, 2018). LGBTQ+ individuals that are out at work often take steps to downplay their identities, known as covering (Catalyst, 2014). Covering may play out as avoiding discussion, photographs, or introduction of partners, even if your coworkers are aware that you identify as LGBTQ+ (Brower, 2016). One study found that 83% of LGB people have used covering at work (Catalyst, 2014).

While these steps may shield someone from LGBTQ+-based discrimination, they often lead to other consequences. If an LGBTQ+ employee chooses not to come out, they must hide major parts of their life, making it difficult to partake in workplace culture or have genuine connections with peers (Brower, 2016). If someone is out but covering, they may appear standoffish, harming or stunting relationships with other coworkers, and creating barriers to team cohesion (Brower, 2016). 28% of LGBTQ+ workers lie about their personal lives to avoid negative reactions from peers (HRC, 2018). Performing extra steps to avoid discrimination takes a toll on the wellbeing of LGBTQ+ individuals. One study found that 17% of LGBTQ+ workers report being exhausted from spending time and energy hiding their sexual orientation, and 13% felt the same about hiding their gender identity (HRC, 2018). The energy that one must put in to appear as cisgender and heterosexual (known as passing) can increase stress, harm productivity, and ultimately cause someone to leave an agency (Brower, 2016).

ANTI-DISCRIMINATION POLICIES

General anti-discrimination policies such as "We do not discriminate on the basis of race, age, gender, sexual orientation..." leave a lot up to interpretation, which could lead to reinforcing unconscious (or conscious) bias (Galupo & Resnik, 2016). 45% of LGBTQ+ workers believe that enforcement of anti-discrimination policies is dependent on the supervisor's personal feelings towards LGBTQ+ people (HRC, 2018). There is also a fear that reporting mistreatment from a supervisor could result in retaliation, a concern heightened for workers of color (Gates, 2016). Microaggressions thrive in grey areas of workplace policies (Galupo & Resnick, 2016). When there is no direct policy violation, individuals who experience everyday mistreatment have no protections against these types of discrimination.

4 LGBTQ+ Disparities

DRESS CODE

Gendered dress codes enforce the expectation that someone must identify as a man or a woman. When dress codes are not explicitly gendered, cultural expectations around phrases like “business casual” leave room for individuals to place their gendered expectations on the attire of others. 1 in 5 LGBTQ+ workers have been told to dress more masculine or feminine (HRC, 2018). Policies that outline specific acceptable articles of clothing without assigning gender have been shown to help transgender employees feel comfortable and supported and allow gender non-conforming employees to confidently wear what they choose (Sawyer et al., 2016).

HIRING DISCRIMINATION

Being LGBTQ+ may get in the way of attaining a job. One fifth of LGBTQ+ workers felt that they were denied a job opportunity because they are LGBTQ+ (HRC, 2018; Casey et al., 2019). LGBTQ+ people of color are at least twice as likely to experience hiring discrimination (Harvard, 2017). One study found that 13% of white LGBTQ+ respondents had experienced discrimination while applying for jobs, while 32% of non-white LGBTQ+ respondents experienced this discrimination. (Casey, et al., 2016). Overall, 27% of trans workers reported that within the past year, they had been fired, denied a promotion, or not hired for a job because of their gender identity or expression (USTS, 2018). Nearly half (47%) of Black, trans women have experienced this type of discrimination (USTS, 2018). Not passing as one’s gender during job interviews has been identified as a major reason why transgender applicants were passed up for a position (McFadden & Crowley-Henry, 2016).

LGBTQ+ WORKPLACE EXPERIENCES IN MN

According to the 2015 US Transgender Survey Minnesota State Report, almost 25% of trans workers in Minnesota reported some form of mistreatment within the past year, such as being forced to use a bathroom that didn’t align with their gender identity, having to present as the wrong gender at work, or having a boss or coworker share private information about them without their permission.

The 2018 Voices of Health Survey found that 67% of all respondents stated that they are employed full time. Voices of Health also displays the disparities at the intersection of employment, race, gender identity, and sexual orientation in MN. Although 20% of white respondents were unemployed, 38% of Black respondents reported being unemployed. One third of Hispanic/Latinx respondents were employed part time, compared to only 18% in white respondents. Over half (54%) of white respondents were employed full time.

5 Legal Protections

THE MINNESOTA HUMAN RIGHTS ACT (MINNESOTA STATUTE 363A)

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

Administrative Bulletin 2015-5 – Minnesota Departments of Health and Commerce
Directed to insurers regulated by the State of Minnesota, this bulletin explicitly mandates that insurers must provide transgender health coverage for all clients or they will be prohibited from providing insurance within Minnesota. All medically necessary treatments for gender dysphoria and related health conditions, including gender confirmation surgery, must be covered by insurers providing coverage to Minnesotans. This is an important protection for Transgender Minnesotans because it ensures that they are able to access needed medical treatment.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

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

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5 Legal Protections

SECTION 1557 – NONDISCRIMINATION PROVISION (SEXUAL ORIENTATION/GENDER IDENTITY PROTECTIONS)

This section of the ACA prohibits discrimination based on sex by any entity receiving federal funding through the ACA; in June 2020, the US Supreme Court ruled that employment discrimination based on sex includes discrimination based on sexual orientation and gender identity, and it is expected this interpretation will apply to the ACA as well. This includes receiving funds from Medicare and insurance plans purchased through the federal marketplace. This provision also applies to all insurance agencies which are part of the national and state-based exchanges. The ACA also establishes provisions for the enforcement of these new laws through legal action as well as enforcement through reporting discrimination, refusal to care, or coverage exclusions to Department of Health and Human Services (HHS).

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

CODE OF FEDERAL REGULATIONS 42 CFR PARTS 482 AND 485

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

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

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

THE CIVIL RIGHTS ACT - TITLE VI

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

5 Legal Protections

THE CIVIL RIGHTS ACT - TITLE VII

Prohibits discrimination by employers, including employment agencies, labor organizations, joint labor-management committees, from discriminating against an individual based on sex, including sexual orientation or gender identity.

TITLE IX OF THE EDUCATION AMENDMENTS OF 1972

Prohibits sex discrimination against students enrolled in, or planning to enroll in, hospital based education or training programs, clinical rotations for nurses and health professionals, and any educational program receiving Health and Human Services (HHS) funding. It is expected that sex discrimination in Title IX also includes sexual orientation and gender identity, as with Title VII.
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EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

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

AMERICANS WITH DISABILITIES ACT OF 1990 AND REHABILITATION ACT OF 1973 – SECTION 504

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

OBERGEFELL V. HODGES

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

BOSTOCK V. CLAYTON COUNTY

US Supreme Court decision interpreting “sex discrimination” to include discrimination based on characteristics such as sexual orientation and gender identity.

6 Standards of Inclusion

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

The LGBTQ+ Standards of Inclusion:

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

6.1 Create and Sustain an Inclusive Physical Environment for LGBTQ+ Communities

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

6.1.1. SUPPORTING EXPLANATION

Creating inclusive environments is critical for improving care delivery for LGBTQ+ individuals. The environment is the first chance health and human services facilities have to make a solid impression upon LGBTQ+ people and encourage their adherence to care. People seeking care will be alert for signs of inclusive and supportive environments because of previous discriminatory experiences with care facilities or staff (LGBTQ+ individuals are especially cognizant of safe spaces).

If an area is not perceived as inclusive, they will vacate, limit the information they share with the care provider, and/or not return for follow-up care due to fear of discrimination.

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

6 Standards of Inclusion

6.1.2. RECOMMENDED ACTIONS

LGBTQ+ Advisory Board

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

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

Signage

When individuals enter a care facility, they are looking for visible signs of inclusion. Images, posters, and materials which reflect the diverse populations served by the health or human service facility should be part of the design and decor of the areas in which an LGBTQ+ person is receiving care. Displays of the facility's mission statement and non-discrimination policies should be prominently displayed. These policies should be written with inclusive language, and clearly highlight LGBTQ+ communities to indicate care for all patients. These policies should alert a person to their rights as a client, patient, and employee. These spaces should also have information about SOGI health issues in the form of pamphlets and brochures.

Other visible signage can include ally training or safe-space stickers displayed at entrances, offices, examining rooms, or in any area where clients or patients will spend a majority of their care experience. Name tags and name displays that share people's pronouns can make everyone feel safe and welcome to use and share their own pronouns openly. Posters featuring LGBTQ+ individuals or couples also create an inclusive environment as well as information materials which are targeted to LGBTQ+ issues or health.

Advertisements and media for your organization should feature LGBTQ+ individuals to highlight the inclusiveness of your organization. All media representations of LGBTQ+ people should reflect the diversity of the community, which includes ability, gender, race, ethnicity, social class, national origin, immigration status, and faith tradition. Media collateral should be highly visible to incoming care recipients. Health and human service providers should also ensure that their websites and external communication include inclusive imagery and language. Websites should indicate providers who specialize in care to the LGBTQ+ communities as well as those individuals, and/or departments, who have completed specialized training to provide care to LGBTQ+ communities.

6 Standards of Inclusion

Gender Inclusive Restrooms and Locker Facilities

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

Environment Checklist:

- Assess facilities for inclusive environment using Standards of Inclusion guidelines
- Communicate facilities gaps to your leadership team
- Implement environmental improvements identified from assessment
- Ongoing monitoring of facilities for compliance with Standards of Inclusion, state, and federal policies, as well as professional standards

Gay & Lesbian Medical Association Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients

Created by the GLMA, this guide outlines many policies and recommendations for creating inclusive environments.

Click to View PDF

Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities

Fenway Institute guide which provides justification and tools for creating inclusive spaces for LGBTQ+ clients and patients.

Click to View PDF

6 Standards of Inclusion

6.2 Recruit and Retain LGBTQ+ Employees

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

6.2.1. SUPPORTING EXPLANATION

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

6.2.2. RECOMMENDED ACTIONS

Recruitment

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

Employment Policies

Employee non-discrimination policies should follow national and state guidelines and specifically highlight the care provider's commitment to LGBTQ+ employees. The contents of these policies should be explicitly communicated to staff and incorporated during new hire trainings. Employee rights, avenues for complaints free of reprisals, should be outlined within the non-discrimination policies.

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

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

Recruitment and Retainment Checklist

- Recruit from LGBTQ+ communities
- Review employee handbook for potential policy improvements
- Review employee benefits to ensure LGBTQ+ employees covered equally
- Include how welcome and supported LGBTQ+ employees feel in organization culture assessments

6 Standards of Inclusion

6.3 Require LGBTQ+ Culturally Responsive Education for All Care Providers and Support Staff

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

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

6.3.1. SUPPORTING EXPLANATION

One of the key components of any care professional's development is education. How, where, and what comprises a care professional's education can directly impact their approach and behavior to LGBTQ+ people. Most care professionals within Minnesota do not receive specific LGBTQ+ training regarding health or cultural responsiveness. When this information is included, it is often embedded in the context of wider cultural competence and responsiveness, and insufficient time is spent discussing the complexities of LGBTQ+ communities. This leaves care providers and support staff ill-equipped to deal with the unique challenges faced by LGBTQ+ individuals—thus resulting in lower quality care.

Training staff on inclusive care, specifically LGBTQ+ health, reduces the occurrence of discrimination experienced by LGBTQ+ clients. Many times the discrimination occurs because employees are not aware of the policies around discrimination or are unsure how to provide care for LGBTQ+ clients. Trainings can help to give employees confidence in their ability to help LGBTQ+ clients get the best care.

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

6 Standards of Inclusion

6.3.2. RECOMMENDED ACTIONS

Health and human service systems should use the educational guidelines outlined below to establish competency requirements for providers within their facilities. These should form the minimum standard of educational attainment that providers should have to maintain working within the facility. Health and human service systems should establish systems which monitor the educational certification of their providers to ensure compliance with the above educational standards.

The goal of these trainings is to provide all employees with a solid understanding of the needs of LGBTQ+ clients and how to be culturally responsive to these clients. It is important that every employee within your organization receives relevant training for their position. Often, direct service providers, such as nurses, case workers, and doctors, are the ones taking these trainings but front line staff such as receptionists, maintenance workers, schedulers, etc., are excluded from these conversations. As a result of this misjudgment, when moments of discrimination do occur it is sometimes with these front line staff members who are not aware of inclusive policies or communication strategies. This is why every employee should receive some level of SOGI education to ensure adequate knowledge across your organization about the rights of LGBTQ+ individuals and avoid discrimination.

It is important to work with a local knowledgeable SOGI organization to design your training. These organizations typically will have a series of courses to educate employees on inclusive practices which can be tailored to the needs of your organization. If you are unable to find a local organization, there are many resources online regarding SOGI health and equitable care.

Outlined here are examples of a core curriculum, including profession specific and continuing education guidelines.

Core Curriculum

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

Cultural awareness and bias

Care providers should be knowledgeable about basic aspects of LGBTQ+ culture and history. This is a difficult process given that the cultural experiences of each of the sub-communities is complex and deserving of its own educational module. Two important sub components of this training would be awareness of privilege, intercultural competency, and implicit bias training. Care providers should be trained to be aware of how their own biases and privilege impact the care they deliver to LGBTQ+ people. Often this is unconscious or implicit behavior on the part of the care provider (Chapman et al., 2013; Nosek, 2015). Additionally, care providers should be trained to understand their own culture and how it affects their behavior towards other cultures.

6 Standards of Inclusion

LGBTQ+ health
This training should focus on expanding the knowledge of care providers regarding health concerns specific to LGBTQ+ people. There is an existing body of literature regarding this topic, thus developing training is not difficult. However, this training can be modified to suit the needs of the care professional depending on the level of care being provided, e.g. the health knowledge required for a physician would be different than for a social worker.

- Practitioners working in addiction/recovery will need to understand minority stress theory, discrimination, microaggressions, and how these factors create the symptoms of smoking, drug and alcohol abuse
- Medical providers treating transgender patients for trans related care need a different base of knowledge than providers treating patients with diabetes or broken bones that happen to be transgender. One provider needs clinical and inclusion best practices and the other would only require inclusion best practices. Though it can be argued that all medical providers should be able to responsively treat trans patients with any medical needs, including trans related care.
- Social workers and case managers should receive LGBTQ+ inclusion with an extra emphasis on locating and confirming culturally responsive referrals before recommending employment, housing, or other services. For example, many human services organizations are founded by religious institutions which allow discrimination against gay and trans people—some even refuse service.

Communication strategies
Many LGBTQ+ individuals harbor mistrust and skepticism when communicating with care providers due to previous discrimination. Every layer of staff from the call center to the front desk to the patient centered care should be trained to use inclusive language and communication techniques to gather sensitive but necessary health information about sexual orientation and gender identity. For example; medical providers could be required to use patient centered care techniques and human services providers could be required to use motivational interviewing techniques to follow the lead of the patient/client.

Profession specific curriculum
Each profession must develop LGBTQ+-specific curriculum which outlines the unique challenges faced by LGBTQ+ people receiving care from these professionals. This should be developed with LGBTQ+ people and be more comprehensive than the core curriculum given that it is targeted to the needs of each profession.

6 Standards of Inclusion

Continuing education units
In addition to the knowledge gained through pre-professional training, all care providers should be expected to receive ongoing training to ensure their competence. Further research will continue to expand our understanding of LGBTQ+-specific health needs and challenges and care providers must stay cognizant of new knowledge. Depending on the professional needs of the care provider, the number of continuing educational units would be tailored to the time limitations of these providers.

It is also important that all staff, not just clinical staff, receive ongoing training on SOGI-inclusive care through continuing education units (CEU) and trainings through Human Resources. This of course will depend on the type of work of the employee and their level of interaction with community members. CEUs should be reported to human resources for the purposes of tracking staff trainings and ensuring that all staff are trained should be part of strategic plans for every department.

Existing recommendations for the types of training employees should receive are:

- History of LGBTQ+ community
- Sexual Orientation
- Gender Identity
- Overviews of SOGI health (needs and risk factors)
- Rights of LGBTQ+ clients and patients
- Guidelines for providing inclusive care
- Cultural awareness and bias
- Communication strategies
- Profession-specific SOGI components

Evaluation and assessment

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

6 Standards of Inclusion

Licensure requirements

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

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

Licensing boards should develop a requirement for care professionals seeking licensure within the state of Minnesota to attend continuing education training courses specifically regarding LGBTQ+ health.

The Minnesota Department of Health and Department of Human Services should play a primary role in this process since they are the central licensing body for most care professionals within Minnesota. As a baseline, the licensing certification standard should be two contact hours of LGBTQ+ health training for all MDH and DHS regulated licenses annually.

Education Checklist

- Connect with local SOGI organization to develop or modify existing staff training regarding inclusive care
- Incorporate training guidelines of the Standards of Inclusion into staff training curriculum
- Communicate training improvements to leadership team
- Train all staff, at all levels of the organization, on inclusive care regularly throughout the year
- Require SOGI inclusive care continuing education units (CEU) for staff which have CEU professional requirements
- Ongoing monitoring of staff responsiveness and competence through assessment and incorporate results into staff training for quality improvement

The National LGBT Health Education Center

This organization provides many educational materials, guides, and tool kits as well as CMEs/CEUs for care providers.

Click to Visit Website

6 Standards of Inclusion

6.4. Develop Policies, Procedures and Care Provisions that are Intersectional

Care providers should have knowledge and comprehension of Intersectionality as theory, methodology and practice. This includes knowledge and comprehension of LGBTQ+ identities as intersectional and how identities based on race, ethnicity, age, ability, social class, national origin, and religion can intersect with a patient's LGBTQ+ identity to influence their care needs and treatment plans. Care providers should have the ability to use knowledge to create policies and procedures that can support multiple identities and communities simultaneously.

6.4.1. SUPPORTING EXPLANATION

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

Studies also demonstrate that LGBTQ+ people of color face different health disparities than white LGBTQ+ patients; moreover, too often with the disparities that they share, LGBTQ+ communities of color demonstrate worse health outcomes than their white LGBTQ+ counterparts. When creating policies and procedures, a medical facility or care provider needs to spend the time to develop knowledge of individual identities and communities (i.e. LGBTQ+, race, age, social class, ability, etc.) (Hankivsky, 2014).

However, policy and procedure development must also consider the intra-category differences within these identities and communities, otherwise outcomes from policies and procedures can be incomplete or lead to negative unintended outcomes.

Care professionals should be aware of the intersecting identities of LGBTQ+ people of color when assessing their care needs. Providing a range of supportive services is necessary as there are cultural barriers which many LGBTQ+ people of color face. Linguistic services are necessary to ensure access for non-English speaking LGBTQ+ people of color. Many of the same tools which are recommended for improving care for racial and linguistic minorities are beneficial to LGBTQ+ people of color. Creating inclusive care environments means addressing the complex barriers for individuals with intersecting identities. In short, achieving health equity for LGBTQ+ communities of color requires racial equity and substantive anti-racism practices.

6 Standards of Inclusion

6.4.2. RECOMMENDED ACTIONS

Intersectionality-Based Policy Analysis

Care providers conducting Health Impact Assessments (HIAs) should conduct Intersectionality-Based Policy Analysis (IBPA) to strengthen their HIAs (Hankivsky, O., 2012). This framework will provide care providers with a comprehensive view of the impact their policies, procedures and care has on LGBTQ+ communities. This will also allow for data collection and analysis to have an Intersectional component to understand intra-category differences and to develop comprehensive data sets for LGBTQ+ communities.

Leaders as Champions

Using leaders within your organization to promote intersectionality-based policies is important because it helps to give employees the support they need to address discrimination. By recruiting leaders this can help to assuage the fears of employees regarding reporting discrimination and help to motivate employees to learn about inclusive work behavior. Department heads within your organization should have strategic plans for the implementation of intersectionality-based policies. Each department should have performance indicators attached to the implementation of these policies to increase accountability.

When the provisions of intersectionality-based policies are fully integrated into your organization, then ongoing strategic plans should include focus on reach to the intersecting needs of clients and improving quality of care.

Policy Checklist

- Ongoing monitoring of facilities to ensure continued compliance with Standards of Inclusion, state, and federal policies as well as professional standards
- Use data generated from HIAs and IBPAs to review policies for equity and inclusiveness according to Standards of Inclusion
- Identify gaps in existing policies
- Develop inclusive policies to fill gaps in care
- Identify champions, such as leadership, within organization to push work internally
- Incorporation of inclusive care into strategic plans
- Ongoing monitoring of policies for compliance with Standards of Inclusion, state, and federal policies as well as professional standards

The Fenway Guide to LGBT Health

2nd edition. American College of Physicians, 2015. Comprehensive guide for healthcare providers on the needs of the LGBT community and resources for providing care. Available on Amazon.com and at **acponline.org/fenway**.

Human Rights Campaign

Sample patient non-discrimination policies.

Click to Visit Website

Self-Assessment Checklist for Personnel Providing Services and Supports to LGBTQ+ Youth and Their Families

Toolkit developed by the National Center for Cultural Competence to assist providers in assessing their readiness for providing care to LGBTQ+ youth.

Click to View PDF

6 Standards of Inclusion

6.5 Implement An Equitable and Inclusive LGBTQ+ Patient Experience from In-Take Through Completion of Care

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

6.5.1. SUPPORTING EXPLANATION

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

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

6.5.2. RECOMMENDED ACTIONS

Intake and Assessment process

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

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

6 Standards of Inclusion

First, the client should be asked for their **chosen name** and their legal name. The client's chosen name is often the name they prefer to use with others. Their chosen name may not be the same as their legal name. Both names should be documented and it should be noted within the client's chart which name the client prefers.

When asking a client about their **gender** it is important to provide multiple options for clients such as: transgender man, transgender woman, man, woman, non-binary, genderqueer, agender, none, and also a write in option. Providing these different options allows for clients to self-identify their gender without being forced to fit into a particular category.

Along with gender, clients should also be asked their **sex assigned at birth**. This is important because even though they may not identify with this sex, it is necessary for health providers to be aware of this to ensure appropriate health screenings for clients. Additionally, the client should be asked which **pronouns** they use.

Questions regarding the **sexual orientation** of clients should include multiple options such as lesbian, gay, straight, bisexual, asexual, queer, while also offering a write-in option. Along with sexual orientation, the client's **partner status** should also be documented with preference given to a write-in status. This allows the client to define their relationships. This is important because many clients may have a long term partner but may not be married and prefer not to be, so having a write-in option gives them the ability to use the appropriate label. If the client is a minor it is important to identify their family structure with labels for their parents given by the minor or their parents.

The **chosen name, gender, sex assigned at birth, pronouns, sexual orientation, and partner status** of clients should be documented within their chart with labels to draw the attention of care providers. How to ask these questions in a respectful manner should be part of employee training on communication methods. When necessary, it may be important for organizations to collect detailed sexual histories of clients. When documenting sexual histories you should not assume sexual behavior based on the sexual orientation or partner status of the client. Methods for collecting this information should also be included in employee trainings.

If possible, it is beneficial to allow clients to enter this information online prior to their appointment. This gives them the ability to share sensitive information without fear of discrimination. They may also feel less pressure to provide false information.

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

6 Standards of Inclusion

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

Electronic Health Records and Client Management Systems

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

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

Patient Satisfaction Surveys

These can be an excellent source of evaluation and feedback for care providers to improve the quality of care delivered to LGBTQ+ people. Surveys should be designed with inclusive language and to ask pointed questions about experiences of discrimination and bias during their care experience. Mailing these surveys, either electronically or via post, allows individuals the privacy to complete the survey without fear of reprisal. These surveys should explain how this information will be used and provide respondents with information regarding its function within an evaluative process. It is important to use chosen name on all mailings and to address patients with such via email or web portal.

Community Outreach and Engagement

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

6 Standards of Inclusion

Experience Checklist:

- Identify necessary upgrades to records systems to comply with Standards of Inclusion
- Modify intake and assessment procedures based on Standards of Inclusion guidelines
- Mail experience surveys to clients after their visit to provide quality improvement data for provider practice
- Ongoing monitoring of the records systems, intake procedures, and quality improvement measures for compliance with Standards of Inclusion, state, and federal policies, as well as professional standards
- Engage in community outreach with LGBTQ+ communities and organizations

Center of Excellence for Transgender Health

Primary care protocols for Transgender patients: **transhealth.ucsf.edu**

World Professional Association for Transgender Health: Standards of Care

Standards of care for Transgender patients: **wpath.org**

Do Ask, Do Tell: A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings

Guide for developing intake and assessment forms for inclusivity: **doaskdotell.org**

7 Case Study: Family Tree Clinic

What does the implementation process for the Standards of Inclusion look like at an actual clinic? Family Tree Clinic in St. Paul, Minnesota conducted the following case study to guide you through the process and illustrate what it takes to implement the standards.

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

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

Administering an Inclusive Physical Environment for LGBTQ+ Communities

BOARD GOVERNANCE

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

LGBTQ+ ADVISORY BOARD

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

SIGNAGE

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

7 Case Study: Family Tree Clinic

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

GENDER-INCLUSIVE RESTROOMS

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

Recruit and Retain LGBTQ+ Employees

STAFF RECRUITMENT

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

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

7 Case Study: Family Tree Clinic

EMPLOYMENT POLICIES

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

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

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

Require LGBTQ+ Culturally Responsive Education for all Care Providers and Support Staff

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

Develop Policies, Procedures and Care Provisions that are Intersectional

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

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

7 Case Study: Family Tree Clinic

An Equitable and Inclusive LGBTQ+ Patient Experience From In-Take Through Completion of Care

INTAKE & ASSESSMENT PROCESS

Family Tree Clinic's intake and health history paperwork is continually updated to be optimally inclusive and reflective of a current and broad spectrum of gender identities and sexual orientations. Currently, their intake demographic forms list options for gender identity:

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

Options for sexual orientation include:

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

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

ELECTRONIC HEALTH RECORDS & CLIENT MANAGEMENT SYSTEMS

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

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

7 Case Study: Family Tree Clinic

PATIENT SATISFACTION SURVEYS

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

COMMUNITY OUTREACH AND ENGAGEMENT

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

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

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

8 Conclusions

These recommendations and guidelines were developed to create safe, inclusive care settings across Minnesota for LGBTQ+ people. However, although the provisions outlined above were designed to support LGBTQ+ individuals, the enactment of these standards will improve the quality of care for all Minnesotans. Many of the health challenges faced by LGBTQ+ individuals are faced by members of other marginalized communities. By establishing these inclusive environments, health will be improved for all Minnesotans leading to reductions in health disparities and improvements in health outcomes. An inclusive continuum of care covering Minnesotans across health and human service settings will improve the quality of life of all Minnesotans.

9 Glossary of Terms

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

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

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

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

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

Cisgender or cis: An individual who identifies with the sex they were assigned at birth.

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

Gay: An individual who is romantically and/or sexually attracted to people who share their same gender identity. This term is also used as an umbrella term to refer to a non-heterosexual person and/or to the entire LGBTQ+ community (e.g., gay rights, the gay community).

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

Gender Affirmation: A person's process of making changes to affirm and express their gender identity. Gender affirmation can include any of the following but is not limited to: coming out to one's family, friends, and/or co-workers; changing one's name and/or gender on legal documents; changing one's pronouns; changing one's wardrobe; hormone therapy; or gender affirmation surgery. There is no set standard on how someone affirms their gender. Sometimes this process is referred to as Transitioning, however, Gender Affirmation is recommended.

Gender Identity: One's innermost concept of self as masculine, feminine, both, or neither, which is separate from the sex assigned at birth.

Heteronormativity: The assumption and/or expectation, either implicitly or explicitly, that all people are heterosexual. The design of policies

9 Glossary of Terms

and programs with the implicit, or explicit, assumption that the people affected by the policy, or using the program, will be heterosexual.

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

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

Intersectionality: First coined by legal scholar Kimberlé Crenshaw, Intersectionality refers to the study of how social identities (sexual orientation, gender, race, ethnicity, social class, national origin, faith tradition, ability, etc.) overlap and intersect to create multiply oppressed and multiply privileged groups of people. Additionally, it explores how groups and individuals can simultaneously experience oppression and privilege based on their intersecting social identities.

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

LGBTQ+: An acronym designating Lesbian, Gay, Bisexual, Transgender, Queer, questioning, and other sexual and gender minorities.

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

Nonbinary/Non-Binary: An umbrella term for any person with a gender identity between, around, or outside of the gender binary.

Provider: See care provider.

Sex assigned at birth: The assignment of an individual at birth as either male or female by the care provider based on biological criteria. This assignment is reported on the birth certificate. This assignment does not recognize people born with ambiguous biological characteristics (known as intersex).

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

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

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

Transgender or Trans: An individual who identifies with a gender that is different from their sex assigned at birth.

Queer: An umbrella term that can refer to anyone who transgresses society's view of gender or sexuality. Some view the term queer to include sexual orientation and gender identity outside of the traditional categories. May be used to refer to the LGBTQ+ community (I.e., the queer community). Historically used as a slur, queer has been reclaimed as a word of empowerment, though some still find it offensive.

10 Acknowledgment

In 2021, a team of Rainbow Health MN staff updated and refined the LGBTQ+ Standards of Inclusion. The five Standards themselves and the bulk of the document remain consistent with the original publication.

In 2015, this trailblazing project brought LGBTQ+ inclusion to health and human services in the state of Minnesota, creating the “Minnesota Health and Human Services LGBTQ+ Standards of Inclusion” (SOI) together with the guidance of an advisory board, a community review board, and a government review board.

SOI Advisory Board members: Alex Jackson Nelson, Dr. Angela Kade Goepferd, Barbara Satin, Dr. Dionne Hart, Dr. Eli Coleman, Erin Wilkins, Dr. John Knudsen, Khalid Adam, Nathalie Isis Crowley, Peek Ehlinger,Sandra Laski, Dr. Eric Meininger, Dr. Mauricio Cifuentes

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11 Works Cited

Agency for Healthcare Research and Quality. (2020). 2019 National Healthcare Quality & Disparities Report. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf

Barkan, S. E., Fredriksen-Goldsen, K. I. & Kim, H. J. (2012). Disability among lesbian, gay, and bisexual adults: disparities in prevalence and risk. American journal of public health, 102(1), e16–e21. https://doi.org/10.2105/AJPH.2011.300379

Bassford, T., Bowen, D. J., Carter, R. A., Charney, P., Valanis, B. G., & Whitlock, E. (2000). Sexual orientation and health: comparisons in the women's health initiative sample. Archives of Family Medicine, 9(9), 843. https://doi.org/10.1001/archfami.9.9.843

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

Brower, T. (2016). Visibility and the workplace experiences of trans persons in the United States. T. Köllen (Ed.). Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity. (149-166). Vienna: Springer. https:doi.org/10.1007/978-3-319-29623-4

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

Casey, L. S., Reisner, S. L., Findling, M. G., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans. Health Services Research, 54 Suppl 2(Suppl 2), 1454–1466. https://doi.org/10.1111/1475-6773.13229

Catalyst. (2014, December 11). What is covering? https://www.catalyst.org/research/infographic-what-is-covering/

Cauce, A. & Cochran, B. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. Journal of Substance Abuse Treatment. 30. 135-46. https://doi: 10.1016/j.jsat.2005.11.009.

Centers for Disease Control and Prevention. (2021a). HIV and gay and bisexual men. https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf

Center for Disease Control and Prevention. (2021b) HIV and transgender people. https://www.cdc.gov/hiv/group/gender/transgender/index.html.

Centers for Disease Control and Prevention. (2011). NISVS: An overview of 2010 findings on victimization by sexual orientation. https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_victimization_final-a.pdf

Centers for Disease Control and Prevention. (2019). United States, high school risk behavior survey, 2019). https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=XX

Chapman, E. N., Carnes, M. & Kaatz, A. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. Journal of General Internal Medicine, 28(11), 1504–1510. https://doi.org/10.1007/s11606-013-2441-1

11 Works Cited

Choi, S.K., Gates, G., Shelton, J., & Wilson, B.D.M. (2015). Serving Our Youth 2015: The Needs and Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Experiencing Homelessness. Los Angeles: The Williams Institute with True Colors Fund.

Clare, E. (1999). Exile & pride: Disability, queerness, and liberation. South End Press.

Clark, N., Ferlatte, O., Fridkin, A., Grace, D., Giesbrecht, M., Hankivsky, O., Hunting, G. & Rudrum, S. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International Journal for Equity in Health, 13, 119. https://doi.org/10.1186/s12939-014-0119-x

D'Augelli, A. R. & Grossman, A. H. (2007). Transgender youth and life-threatening behaviors. Suicide & life-threatening behavior, 37(5), 527–537. https://doi.org/10.1521/suli.2007.37.5.527

Durso, L. E., Johnson, K. L. & Lick, D. J., (2013). Minority stress and physical health among sexual minorities. Perspectives on Psychological Science, 8(5), 521–548. https://doi.org/10.1177/1745691613497965

Ellsworth, D., Mendy, A. & Sullivan, G. (2020, June 23). How the LGBTQ community fairs in the workplace. McKinsey & Company. https://www.mckinsey.com/featured-insights/diversity-and-inclusion/how-the-lgbtq-plus-community-fares-in-the-workplace

Emlet, C.A., Erosheva, E.A., Fredriksen-Goldsen, K.I., Goldsen, J., Hoy-Ellis, C.P., Kim, H., Muraco, A., & Petry, H. (2011). The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults. LGBT Aging Center. https://www.lgbtagingcenter.org/resources/pdfs/LGBT%20Aging%20and%20Health%20Report_final.pdf

Galupo, M. P., & Resnik, C.A. (2016). Experiences of LGBT microaggressions in the workplace: Implications for policy. T Köllen (Ed.). Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity. (271-280). Vienna: Springer. https://doi.org/10.1007/978-3-319-29623-4

Gates, T. G. (2016). When supervisors and managers tolerate heterosexism: Challenges, opportunities, and implications for workplace advocacy. T. Köllen (Ed.). Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity. (481-492). Vienna: Springer. https:doi.org/10.1007/978-3-319-29623-4

Gruchow, P. (2012). Letters to a young madman: A memoir. Levins Publishing.

Hankivsky, O. (2012). An intersectionality-based policy analysis framework. Institute for Intersectionality Research and Policy, Simon Fraser University.

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

Harvard T.H. Chan School of Public Health, National Public Radio, Robert Wood Johnson Foundation. (2017 November). Discrimination in America: Experiences and views of LGBTQ Americans. https://legacy.npr.org/documents/2017/nov/npr-discrimination-lgbtq-final.pdf

Hennepin County Public Health. (2019 December 1). Survey of health of all the population and environment (SHAPE), 2018: Hennepin county adult data book. https://www.hennepin.us/-/media/hennepinus/your-government/research-data/shape-2018/shape-databook-2018-v4.pdf

11 Works Cited

Human Rights Campaign. (2018). A workplace divided: Understanding the climate for LGBTQ workers nationwide. https://hrc-prod-requests.s3-us-west-2.amazonaws.com/files/assets/resources/AWorkplaceDivided-2018.pdf?mtime=20200713131850&focal=none

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The report of the 2015 U.S. transgender survey (USTS). National Center for Transgender Equality. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

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

Lambda Legal. (2010). When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV. https://www.lambdalegal.org/publications/when-health-care-isnt-caring

McFadden, C. & Crowley-Henry, M. (2016). A systematic literature review on trans*careers and workplace experiences T. Köllen (Ed.). Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity. (63-82). Vienna: Springer. https:doi.org/10.1007/978-3-319-29623-4

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674 5

Minnesota Department of Health (MDH). (2019). Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018: Report to the legislature 2019. Retrieved from https://www.health.state.mn.us/communities/equity/reports/legislativerpt2019.pdf

Minnesota Department of Health (MDH). (2019). HIV/AIDS Statistics - 2019. Retrieved from https://www.health.state.mn.us/diseases/hiv/stats/2019/index.html

Mykhyalyshyn, I. & Park, H. (2016 June 16). L.G.B.T. people are more likely to be targets of hate crimes than any other minority group. New York Times. https://www.nytimes.com/interactive/2016/06/16/us/hate-crimes-against-lgbt.html

NAMI. (n.d.) Your journey: Identity and cultural dimensions of Black and African Americans. nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

Nosek, B. A., Riskind, R. G. & Sabin, J. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. American journal of public health, 105(9), 1831–1841. https://doi.org/10.2105/AJPH.2015.30263

Rainbow Health Initiative. (2016) Voices of health: A survey of LGBTQ health in MN. https://rainbowhealth.org/wp-content/uploads/2021/06/Final-VOH16-Full-Report.pdf

Rainbow Health Initiative. (2018) Voices of health: Full report. https://rainbowhealth.org/wp-content/uploads/2021/06/2018-Full-Report.pdf

Russomanno, J., & Jabson Tree, J. M. (2020). Food insecurity and food pantry use among transgender and gender non-conforming people in the Southeast United States. BMC public health, 20(1), 590. https://doi.org/10.1186/s12889-020-08684-8

Rothenberg, P.S. (Ed.). (2010). Race, class, and gender in the United States (8th ed.). Worth Publishers.

11 Works Cited

Sawyer, K., Thoroughgood, C. & Webster, J. (2016). Queering the gender binary: Understanding transgender workplace experiences. T. Köllen (Ed.). Sexual orientation and transgender issues in organizations: Global perspectives on LGBT workforce diversity. (21-42). Vienna: Springer. https:doi.org/10.1007/978-3-319-29623-4

Substance Abuse and Mental Health Services Administration. (2012). A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals. https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4104.pdf

U.S. Equal Employment Opportunity Commission (U.S. EEOC). What you should know: The EEOC and protections for LGBTQ+ workers. https://www.eeoc.gov/laws/guidance/what-you-should-know-eeoc-and-protections-lgbtq-workers

Waters, E. (2017). Lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence in 2016. National Coalition of Anti-violence Programs (NCAVP). http://avp.org/wp-content/uploads/2017/11/NCAVP-IPV-Report-2016.pdf 14

Williams, N. D., & Fish, J. N. (2020). The availability of LGBT-specific mental health and substance abuse treatment in the United States. Health services research, 55(6), 932–943. https://doi.org/10.1111/1475-6773.13559.

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