Enhancing Quality Primary & Specialty Care: Improving the Health Care Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) Patients at UPMC Community Medicine, Inc.

by

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BA in Organizational Communications, University of Akron, 2018

Submitted to the Graduate Faculty of

the Department of Health Policy and Management

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Health Administration

University of Pittsburgh

2021

UNIVERSITY OF PITTSBURGH

GRADUATE SCHOOL OF PUBLIC HEALTH

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Abstract

Healthcare systems' success depends largely on providing high-quality and effective care based on the patient's experience through the system and their consequent outcomes. Today, however, providers at UPMC Community Medicine, Incorporated (CMI) lack the necessary competencies to provide culturally competent care to LGBTQ+ patients; subsequently, resulting in LGBTQ+ invisibility, limited access to healthcare services, and a lack of knowledge to address the affirmative care that LGBTQ+ people need to achieve the best health outcomes. For this reason, and as healthcare reform towards a value-based system continues to be a significant concentration of system leaders, improving quality to socially disadvantaged patient populations only will seek to improve patient care. This case analysis aims to identify health disparities that affect the LGBTQ+ patient population and discuss the public health intervention measures undertaken at CMI to better prepare the provider workforce by developing a patient care model for LGBTQ+ patients to have better health outcomes.

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1.0 INTRODUCTION

Social acceptance of lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people in the United States has vastly improved over recent decades; however, LGBTQ+ individuals continue to face daily prejudice and discrimination–mainly due to sex stigmatization, religious conservatism, heterosexism, homophobia, and transphobia that shape health and other social institutions (Commissioner for Human Rights, 2011). These negative experiences, coupled with a patient's lack of access to culturally affirming and informed clinical provider services, have led to multiple health disparities and poorer health outcomes for LGBTQ+ populations. In 2016, the LGBTQ+ community was identified as a "health disparity population" by the National Institute on Minority Health and Health Disparities, partly because individuals who identify as LGBTQ+ have less access to health care (Gillespie, 2020). Research provided by the Williams Institute of UCLA School of Law (2019) shows that of the United States population, 4.5% (i.e., approximately 14,769,000 people) identify as LGBTQ+. LGBTQ+ people are diverse–encompassing all races, ethnicities, ages, religions, and socioeconomic statuses from all over the country. As more individuals come out as members of the LGBTQ+ community, healthcare accessibility is vital to minimize health disparities within the LGBTQ+ population, given the higher risk associated for gay people, compared to their heterosexual counterparts, for sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), mental health disorders, alcohol and substance abuse, and increased risk of cancer due to decreased screenings (Fenway Institute, 2016). Understanding the LGBTQ+ patient experience, from the patient's perspective, is critical to improving overall health by fostering a cultural, patient-centered care model.

Patient experience encompasses the range of interactions patients have with the health care system, including their care from health plans and doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities (Agency for Healthcare Research & Quality, 2017). Patient-centered primary care is more actively becoming a core tenet of care and service delivery, as individual positive patient experiences are linked to better health outcomes and care coordination. Nguyen & Yehia (2015) claims, "Patient disclosure of sexual orientation to their providers has the potential to improve health outcomes and to ensure that opportunities for risk-appropriate preventive care are not missed." However, a lack of preventative medicine and primary care access for the LGBTQ+ patient population may cause subsequent gaps in care, leading to late-stage or often overlooked diagnoses. Additionally, heteronormative assumptions (that is, inferences based on heterosexual identity, binary gender roles, and individual experience) may negatively affect physician-patient relationships and treatment if providers and staff do not have adequate training, tools, and resources to provide cultural affirming care (Law et al., 2015). Consequently, there is an increased demand in the healthcare market to establish gender-inclusive, high-quality health services, decrease inequities, and maximize LGBTQ+ patients' experience.

The University of Pittsburgh Medical Center (UPMC, 2020)–a $21 billion not-for-profit healthcare provider and insurer based in Pittsburgh, Pennsylvania–is committed to providing high-quality care. However, the integrated delivery and finance system has lacked modernized, diversity-driven resources and referral workflows for the LGBTQ+ patient population to navigate the healthcare system. UPMC Community Medicine Incorporated, a subdivision of the health services division, initiated a new workgroup to

confront the health inequities of the LGBTQ+ patient population by equipping providers and staff with the cultural competence to deliver safe care and tools to increase the quality of care, expand access, and improve the physician-patient experience. This essay will describe the programs initiated within UPMC Community Medicine centered on the patient experience of LGBTQ+ patients by providing quality affirming care.

2.0 ISSUES STATEMENT

The LGBTQ+ community faces a multitude of barriers to access and receive healthcare, resulting in myriad health disparities, including disproportionately high rates of sexually transmitted infections (including HIV), substance abuse, mental health issues, and social determinants of health. Healthcare systems' success depends largely on providing high-quality and effective care based on the patient's experience through the system and their consequent outcomes. Today, however, providers at UPMC, by and large, lack the necessary competencies to provide culturally competent and sensitive care to LGBTQ+ patients, subsequently resulting in LGBTQ+ invisibility and lack of knowledge to address the affirmative care that LGBTQ+ people need to achieve the best health outcomes. As healthcare reform towards a value-based system continues to be a significant concentration of system leaders, UPMC must address the social and physical determinants of their LGBTQ+ patient's health by educating providers and staff on the health disparities affecting this community, implement culturally competent training, and modify practice policies and environments to be inclusive of attaining the highest level of health and patient experience.

3.0 LITERATURE REVIEW

3.1 HEALTH DISPARITIES AMONG LGBTQ+ PEOPLE

In the United States, sexually transmitted infections (STI's) occur at a high rate among sexually active gay and bisexual men who have sex with men (MSM). This includes STI infections for which effective treatments are available (i.e., chlamydia, gonorrhea, syphilis, trichomoniasis, and NGU) and for which no cure is available (i.e., HIV, Hepatitis A, Hepatitis B, and HPV). While the CDC estimates that MSM account for just 4% of the US male population, adolescent and adult gay and bisexual men made up 69% of the 37,832 new HIV diagnoses in the US in 2018 (CDC, 2020). Breaking these diagnoses down by race and ethnicity, African Americans are most affected by HIV– accounting for 42% of all new diagnoses. The CDC also states that anal sex is the riskiest type of sex for getting or transmitting HIV, and most gay and bisexual men get HIV from having anal sex without protection—such as using a condom or taking prescription medicine (pre-exposure prophylaxis or PrEP) to prevent HIV (Gillespie, 2020). When taken as prescribed, PrEP has shown to reduce the risk of contracting HIV by close to 99% (CDC, 2020). Increased access to PrEP services for patients can sharply reduce new HIV infections to end the HIV epidemic.

Separate from the disproportionate rates of HIV, many studies have indicated high rates of behavioral health disparities within the LGBTQ+ community than in non-LGBTQ+ groups. One 2016 study published by the Kaiser Family Foundation found that LGBTQ+ individuals are 2.5 times more likely to experience a mental health disorder in their lifetime compared to heterosexual individuals (Kates, 2016). On the other hand, another study found older LGBTQ adults face several unique challenges, including the combination of

anti-LGBTQ stigma and ageism–approximately 31% of LGBTQ older adults report depressive symptoms; 39% report serious thoughts of taking their own lives (Fredriksen-Goldsen, 2011). More alarmingly, studies have found the rate of suicide attempts is four times greater for lesbian, gay, and bisexual youth and two times greater for questioning youth than that of heterosexual youth (Kann et al., 2016). Access to culturally sensitive behavioral health and suicide resources for LGBTQ+ people remains a critical priority for clinicians to address these healthcare disparities.

While limited research exists on cancer rates within the LGBTQ+ community, the National LGBT Cancer Network (n.d.) states communities are "disproportionately affected by cancer." Anal cancer is a relatively rare cancer in the general population (approximately two people diagnosed out of every 100,000 people each year); however, among men who have sex with men (MSM), the incidence of anal cancer is significantly more prevalent and increasing annually (National LGBT Cancer Network, n.d.). Current estimates are that HIV-negative MSMs are 20 times more likely to be diagnosed with anal cancer (i.e., rate of 40 positive anal cancer diagnoses among MSMs patients). However, HIV-positive MSMs are up to 40 times more likely to screen positive for this rare cancer, resulting in 80 cases per every 100,000 people (National LGBT Cancer Network, n.d.). Healthcare professionals, too, struggle as to how and whether they should screen for anal cancer given a standardized protocol in reference to the primary target demographics does not yet exist, hence, contributing to another disparity.

Further, a research study conducted by the Journal of Women's Health found that 65% of gynecologists are uncomfortable screening transgender patients (Unger, 2015). Participation in cancer screenings and prevention are the most effective methods of

reducing cancer-related morbidity and mortality; however, cancer detection, diagnosis, and treatment are only effective if both patients and providers know what they should be screening for based on the elevated risks within the LGBTQ+ community. Despite having higher risk factors for select cancer types, the LGBTQ+ community are less likely to access care and utilize preventative services based on prior experiences of discrimination and stigma in a healthcare setting, leading to the avoidance of routine healthcare. For example, research conducted by the Journal of General Internal Medicine found that lesbian and bisexual women and transgender men were 50% more likely to get routine cervical cancer screenings if they felt welcome or were out to their provider (Peitzmeier et al., 2014). For these reasons, healthcare providers must educate themselves on the known increased health risks to navigate their patients care towards utilizing the appropriate preventative services.

3.2 THE CULTURAL-AFFIRMING CARE SERVICE MODEL

Given that the LGBTQ+ community faces several barriers to accessing healthcare, including denial of service, lack of provider knowledge, and discrimination, healthcare providers should treat the LGBTQ+ community under a tailored service model by eliminating heteronormative standard practices. Research led by Anna Morenz, MD, et al. (2020), on community-based approaches to health equity for LGBTQ+ people highlights the importance of a service model to provide a foundational level of cultural training to all patient-facing staff (clinical and nonclinical), aligning electronic health records (EHR) to collect population health and gender identity data, and develop clinical treatment protocols for providers to more quickly eliminate gaps in care. Implementing a service model that promotes the cultural needs and treatment protocols of a gender-

diverse community can significantly enhance health systems' capacity to address this inadequately serviced population; thus, increasing the quality of care. Morenz et al. developed a suitable, cross-sectional model for healthcare providers to implement to combat these challenges, as described in their 2020 article, *"A Blueprint for Planning and Implementing a Transgender Health Program."*

Morenz's service model emphasizes a hierarchical organizational approach to design and manage an LGBTQ+-centered health program through a community advisory board (i.e., clinical champion model). Champions are responsible for gaining buy-in from colleagues and assessing the community needs to design services within the organizational capacity and scope. According to Morenz et al. (2020), this model promotes comprehensive in-house services within an academic medical center tailored to the local transgender and gender-diverse community through three primary domains: (1) case management, (2) gender and sexual identity affirming primary care, and (3) administrative support. The aims of the program align primary medical care with mental health counseling, substance use disorder treatment, HIV and sexually transmitted infection (STI) prevention and treatment, integrating case management for accessing basic needs like food and housing, legal and advocacy services for insurance coverage and name/gender changes on identity documents (Morenz, 2020). The administrative support functions to aid LGBTQ+ patients with navigating insurance programs and helping clinicians coordinate referral services.

3.3 ORGANIZATIONAL CHANGE MODEL TO PROMOTE LGBT INCLUSION

Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to

Preventative, Primary, and Specialist Care (Eckstrand, 2016), is a leading publication that contains expertise from physicians renowned for their work in LGBT health; filling an informational void about the practical health needs of LGBT patients in healthcare settings. As LGBT individuals experience disparities in access and receiving healthcare, organizational inclusivity advances across the healthcare system must address myriad aspects to reduce these barriers for an increased patient experience. Eckstrand identified the healthcare system-based practice setting can be broken down into three broad categories to address the obstacles: (1) physical, (2) systemic, & (3) interpersonal environments.

1) Physical components reference the initial LGBTQ+ patient impression within the clinical space, such as welcoming décor, physical facilities, and patient flow in navigating the healthcare system.
2) Systemic components reference the clinic operations crucial to the LGBTQ+ patient experience, such as establishing a mission statement and nondiscriminatory practices, clinical competencies, knowledge of resources, and quality assurance.
3) Interpersonal components reference the relational interactions between people, mainly healthcare providers and patients, for LGBTQ+ patients to interact, build trust, and feel safe.

Eckstrand lays the foundation for integrating LGBT health into systems-based practices by examining the impact of LGBT health-related institutional climate, culture, and access in improving inclusivity and equitable care through the utilization of organizational change models. According to Eckstrand (2016), "organizational change

models guide the transition of an institution from its present to a desired future state, helping them to address why change should occur, how it should happen, and what actions and resources are required to produce the intended outcomes." The Eckstrand, Lunn, and Yehia Organizational Model of LGBT Inclusion underline the necessary elements for provider organizations to initiate LGBT organizational change: Organizational Champions, LGBT Organizational Priority, Value Continuous Learning, Value LGBT Equality & Inclusion, and LGBT Organizational Resources. Actionable steps towards fostering the change process include leveraging resources, promoting change management, exchanging information, measuring and reporting disparities, relationship building (i.e., physician-patient relationships), and living the organization's values. In adopting this model's usage, health organizations can create and support meaningful culture change to improve the health and health experiences of LGBTQ+ patients.

3.4 LGBTQ+ PATIENT-CENTERED CARE MODELS IN PRACTICE

Many LGBTQ+ people avoid seeking preventative care and urgent care of life-threatening conditions in fear that healthcare clinicians and systems will not provide support services. However, selective community organizations and health systems have recognized the increased demand to address the LGBTQ+ populations' unique health needs and concerns following increased community expansion. The organizational approaches vary from small independent clinics to more extensive, regional hospital system outreach. Presently, Central Outreach Wellness Center, Allegheny Health Network, and the Cleveland Clinic are examples of organizations that have successfully integrated LGBTQ+ care models by aligning resources and clinical expertise in practice.

Central Outreach Wellness Center is an independent, physician-owned outpatient group serving Southwestern Pennsylvania with four federally grant-funded clinic locations. Founded by Dr. Stacy Lane in 2015, the practice specializes solely in lesbian, gay, bisexual, transgender, and queer health, with services ranging from culturally competent gay health care, HIV & STI primary care Suboxone/needle exchange assistance. Unlike traditional healthcare models, the practice offers several free lab tests at the point of care and case management services for patients to obtain insurance and pharmacy coverage, lab testing, and housing services through federal grant utilization, so patients need not worry about the cost. Embedded in the practice includes a resource and referral center for patients in need of rehab for drug and alcohol abuse, mental health referrals, community outreach, and other social programs to address the high prevalence of health disparities in Allegheny and surrounding counties.

Allegheny Health Network is a 13-hospital academic health system based in Western Pennsylvania and the primary regional competitor to UPMC. This hospital system was one of the first integrated delivery systems in Western Pennsylvania to launch a “Center for Inclusion Health” to increase access and eliminate barriers that prevent various marginalized populations from seeking care. Spearheaded by an Inclusion Health Medical Director, this center contributes to the development of inclusion health-focused faculty specializing in accessible care to several underserved populations, including the LGBTQ+ community. Rather than emphasize one given population, this center aims to increase access for various vulnerable populations by educating providers on the complex cultural health needs people face in accessing care. This commitment has led to the formation of featured programs offered by the Center for Inclusion Health, such as

primary care services for HIV-positive patients, hepatitis-C positive patients, transgender patients, Immigrant/Refugee patients, homeless patients, and known substance abuse patients.

The Cleveland Clinic, located in Cleveland, Ohio, is a non-profit multispecialty academic medical center, presently ranked No. 2 on the "U.S. News Best Hospitals Honor Roll" for their world-renowned clinical patient care. Unlike Allegheny Health Network's approach, Cleveland Clinic's model addresses LGBTQ+ healthcare by installing its "Center for LGBTQ+ Care" at the Lakewood Family Health Center. Operating as a department under the Community Commitment Division, the LGBTQ+ institute provides comprehensive, sub-specialty care services designed for gay and bisexual men, lesbian and bisexual women, transgender medicine, LGBTQ+ youth, and other gender-affirming options. Some of these services include specialized primary care, cross-sex hormone therapy, mastectomies, facial feminization procedures, and orchiectomies performed by a trained medical professional team with expertise in this field. This model supports a concierge-like service by providing a designated safe and welcoming environment for patients to access various healthcare services, thus, decreasing health disparities.

4.0 CASE ANALYSIS & METHODS

4.1 UPMC COMMUNITY MEDICINE, INCORPORATED (CMI)

This quality improvement program initiative was completed within UPMC Community Medicine, Incorporated (CMI), a large medical group within the broader UPMC Health Services Division (***FIGURE 1***), comprised of ambulatory-based providers specializing in Family Medicine, Internal Medicine, Geriatric Medicine, Gastroenterology, Pulmonology, Orthopaedic Surgery, Dermatology and Otolaryngology delivering clinical care across Western Pennsylvania from urban Pittsburgh to rural locations. CMI employs 467 physicians, 213 advanced practice providers, and 2,392 staff embedded within 221 physician practice site locations. The division is separated into eight regions – North, South, East, West, Central Pittsburgh, Horizon/Jameson, Bedford, and Northwest.

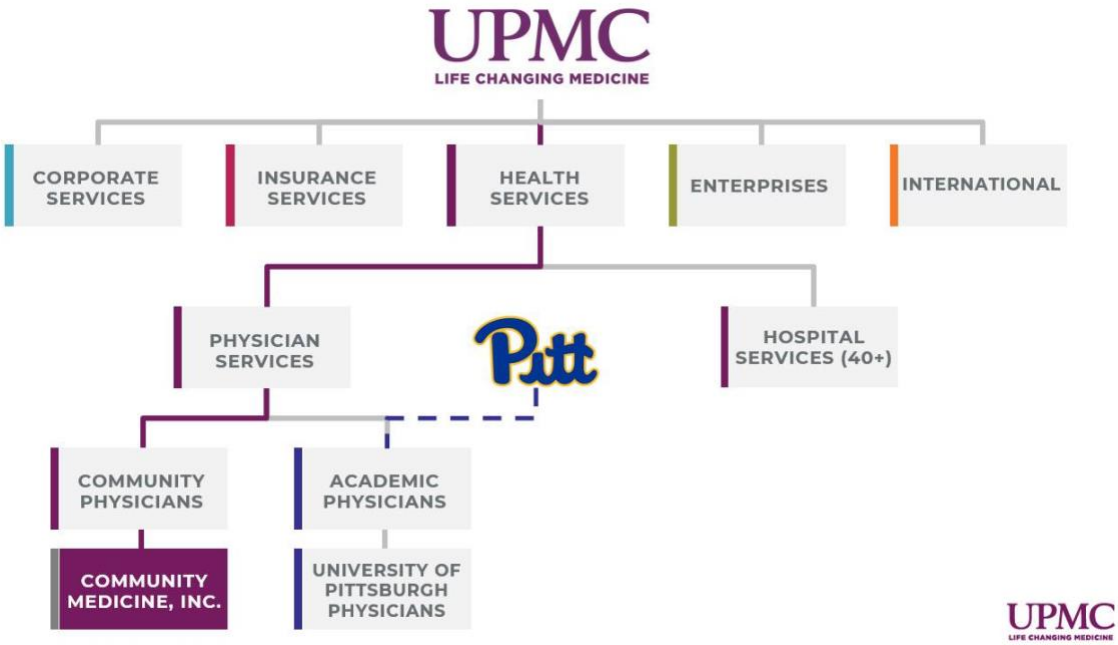

FIGURE 1: *UPMC HEALTH SERVICES DIVISION STRUCTURE – CMI*

Historically, Community Medicine has recognized the essential need to focus on patient satisfaction by using their “Patient Experience Committee,” which coordinates broad improvement initiatives and patient satisfaction programs to enhance patient experience and staff engagement. Patient-centered care is paramount, as positive patient experiences are linked to better health outcomes and care coordination (Agency for Healthcare Research & Quality, 2017). Patient experience is becoming a core principle of care and service delivery, but previous negative healthcare experiences have discouraged LGBTQ+ individuals from obtaining care. As the focus on social determinants of health over time has increased, the amplified need to address these determinants has served as an influence to create new models of care. Addressing social determinants of health is vital to improving well-being and reducing longstanding disparities in health and health care. Organizations as large as UPMC pose difficulty in executing a comprehensive approach to addressing social determinants of health, given no one department or person is accountable for streamlining population-specific care models. Recognizing the need to address social determinates of health in the LGBTQ+ community and the lack of provider knowledge about the health needs at UPMC for LGBTQ+ patients, CMI expanded the Patient Experience Committee to create the “CMI LGBTQ+ Health Initiatives Workgroup.”

The workgroup’s installation began in July 2020, starting with two committee chairs: one physician lead and one administrative resident to the administration team. For two months, the workgroup increased to include additional clinicians with expertise in these areas from Community Medicine and the University of Pittsburgh Physicians (UPP) and other executive administrators/director level personnel from within Community Medicine interested in LGBTQ+ health. The group has since expanded to twelve voluntary

members, which meet monthly to discuss various integrated care delivery methods to combat health disparities by designing new programs that ensure LGBTQ+ patients have adequate access and feel supported when seeking healthcare services at UPMC. The strategic goals for the workgroup include: (1) Improving healthcare access to primary and specialty care for the LGBTQ+ community, (2) partner with integrated system divisions and health plans to coordinate gender-inclusive referrals, (3) create health maintenance modifiers leveraging UPMC's Electronic Health Record (Epic) to reduce care gaps, and (4) develop medical education training targeted for providers and cultural awareness exercises for staff to enhance their knowledge, skills, and abilities to increase the quality of care within the LGBTQ+ community.

4.2 CMI PROVIDER SURVEY ON LGBTQ+ PATIENT HEALTH

A brief, non-experimental electronic survey on LGBTQ+ health was developed by committee chairs and disseminated via email to all UPMC Community Medicine Physicians and Advanced Practice Providers in Primary and Specialty Care at the end of July 2020 (***APPENDIX A***). The study comprised of both multiple-choice and open-ended short answer questions intended to: (1) create a baseline interest in providers' desire to provide culture affirming LGBTQ+ care, (2) develop an understanding of providers' attitudes, knowledge, and willingness to improve how they treat LGBTQ+ patients, and (3) prioritize resources/educational tools for clinicians and staff to increase their total quality focus. Of the 680 surveys administered to all employed CMI providers, respondents include 88 physicians & 39 APP's (n=127), yielding a response rate of 19%. Of this number, 92 expressed interest in acquiring an affirming provider designation for patients to identify physicians and advanced practice providers that offer gender-

competent care. Additionally, of the responses returned, 96 provided comments in the open response section of the survey, which provided insight for the group on the individual challenges providers face in care treatment along with key areas of opportunity for the workgroup to focus (***APPENDIX B***). Given that UPMC Community Medicine is predominately made up of Internal and Family Medicine providers, it is not surprising that most participants identified as practicing medicine in Primary Care (79%). In comparison, the other respondents classified their care domain as specialty care (21%). ***FIGURE 2.***

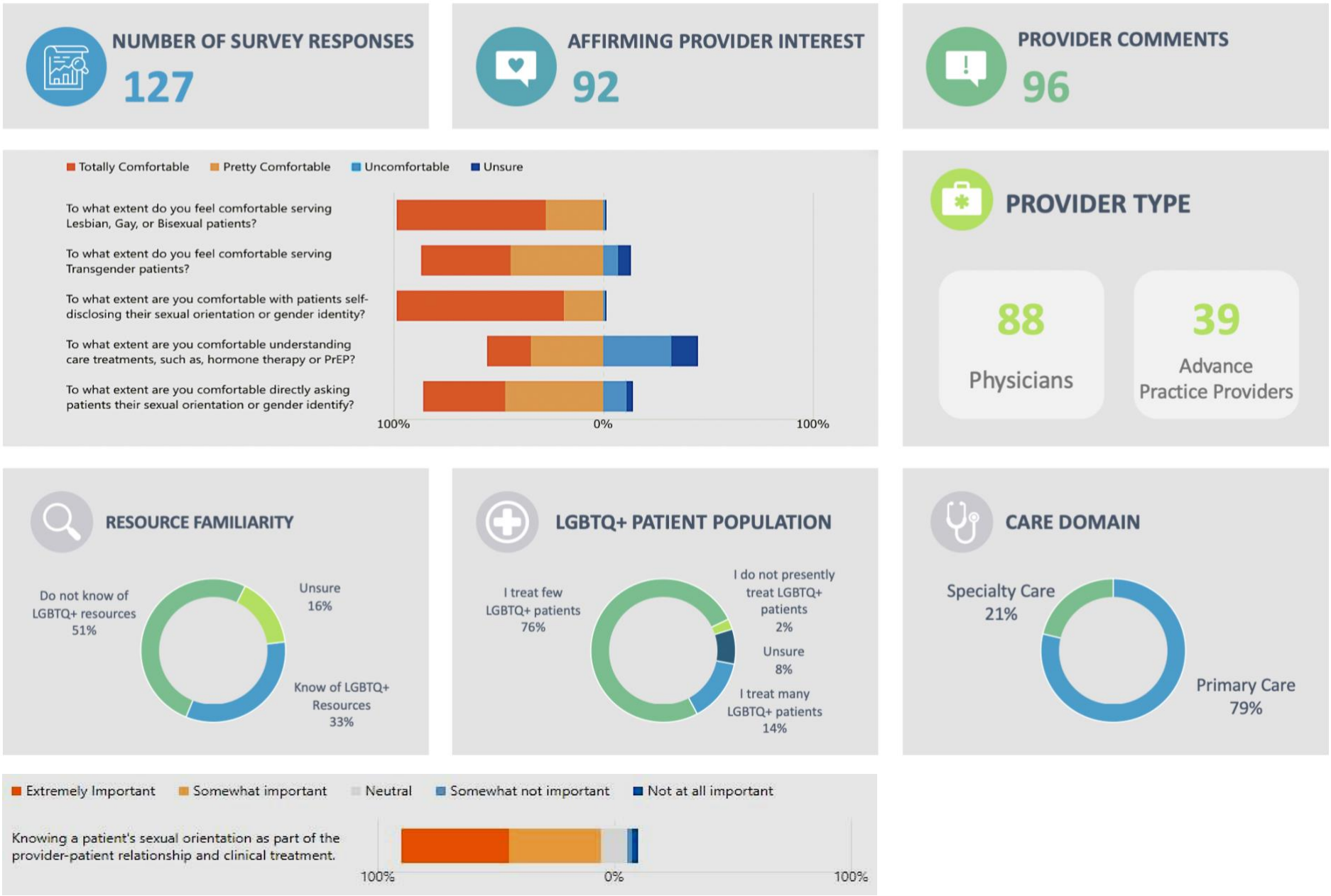

FIGURE 2: *CMI LGBTQ+ HEALTH SURVEY RESPONSE DATA*

Overwhelmingly, CMI providers reported high levels of comfort in serving lesbian, gay, and bisexual patients with having expressed being “totally comfortable” (70%) or “pretty comfortable” (28%). At the same time, just 2% believe they would feel uncomfortable or unsure. Providers reported slightly lower numbers concerning serving transgender patients in fear of not knowing how to navigate their medical treatment properly. Yet, the majority of respondents still reported being “totally comfortable” (42%) or “pretty comfortable” (45%). To better comprehend the current LGBTQ+ patient population within Community Medicine, providers were asked to identify how many LGBTQ+ patients they currently treat as part of their practice panel. The survey revealed that a vast number of physicians and advanced practice providers treat LGBTQ+ patients (90%) – with 76% attesting to treating “few LGBTQ+ patients” and 14% stating they “treat many LGBTQ+ patients.” Only 2% described themselves as “not presently treating LGBTQ+ patients” or were unsure (8%).

Community Medicine providers recognize knowing a patient’s sexual orientation is essential in their clinical treatment & diagnosis – with 84% of respondents reporting that they believe it is clinically meaningful as part of the provider-patient relationship. While providers are generally comfortable (86%) asking patients directly “about their sexual orientation or gender identity,” respondents reported higher levels of comfort when the patient divulges this information on their own accord. When asked about their comfort levels in patients’ self-disclosure in sexual orientation or gender identity, virtually all CMI providers say they are comfortable (99%) – with 80% stating they are “totally comfortable” and 19% saying they are “pretty comfortable.”

CMI providers acknowledge that the resources available to them in the treatment of their LGBTQ+ patient panels are limited – with one-third of clinicians stating they "do not know of LGBTQ+ resources" (51%) or unsure (16%). Comparatively, the other third (33%) confirm they are aware of resources. When asked to describe their level of comfort in prescribing medication treatments such as pre-exposure prophylaxis (PrEP) for HIV prevention or hormone replacement therapy (HRT) for transgender people who are transitioning, CMI providers were split – with 45% together leaning more towards "uncomfortable" and "unsure." Nonetheless, 34% described themselves as "pretty comfortable," and just 20% felt "totally comfortable" in these care treatments.

Based on the responses obtained from Community Medicine providers, there is suggestive interest in providing LGBTQ+ patients with culturally affirming care; however, as we learned from the survey, there are areas of opportunities to increase resources and education in support of LGBTQ+ health equity. In response to the survey findings, UPMC Community Medicine has sought ways to participate in healthcare reform for LGBTQ+ people by incorporating new training and educational resources for clinicians to ultimately improve clinical outcomes and reduce health disparities for better patient experiences.

4.3 CMI LGBTQ+ PATIENT EXPERIENCE TRIANGULAR RELATIONSHIP MODEL

UPMC Community Medicine conceptualized a triangular relationship model (***FIGURE 3***) composed of three primary contributors that advance the LGBTQ+ patient experience: (1) The Integrated Delivery System, (2) Patients, and (3) Staff Engagement & Physician Alignment. As these areas intersect, their relationship highlights the core areas of opportunities and focalizing influences, which, when considered, are critical

success factors in contributing towards the CMI LGBTQ+ Health Initiative's strategic provision of optimal patient experience and care through utilization of new patient-centered programs. These chief opportunities include: (1) Continuing Education & Total Quality Focus, (2) Cultural Affirming Patient Care, and (3) Navigating the Health System.

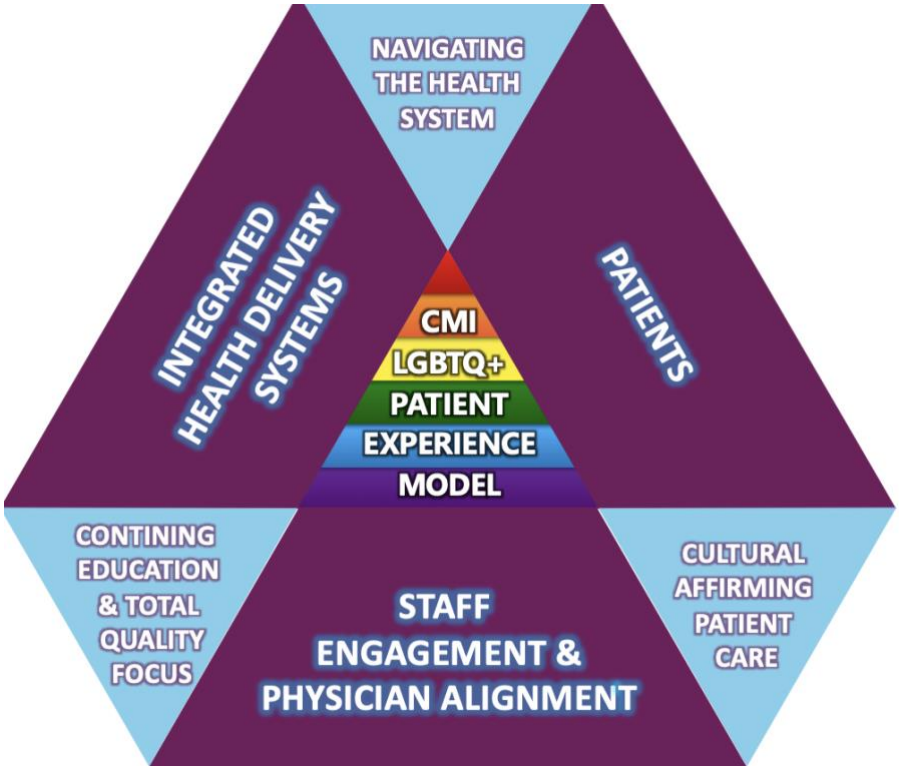

FIGURE 3: *UPMC CMI LGBTQ+ PATIENT EXPERIENCE MODEL*

4.4 CONTINUING EDUCATION & TOTAL QUALITY FOCUS

In light of the survey response data, the CMI LGBTQ+ Health Initiatives workgroup created a Primary Care Educational Webinar Series in partnership with the Center for Continuing Education and various physician experts to address continuing education & total quality focus. The workgroup hosted its first two online sessions in January 2021 for all CMI employed physicians, advanced practice providers, and UPMC Shadyside family medicine residents on clinical treatment topics focused on administering hormone

replacement therapies (HRT) for transgender patients undergoing transition and prescribing PrEP to combat the high prevalence of HIV for gay men. The webinar series was designed to advance LGBTQ+ healthcare by inviting UPMC experts or other partners to present on the latest clinical advances, bench-to-bedside research, and best practices in the care delivery of patients; thus, adding to the physician's knowledge base on various clinical benefits and health maintenance when administering treatments. Both agendas were strategically designed to emphasize the cultural importance of culturally affirming, quality-driven care and increase inclusivity for patients to achieve the highest level of health and patient experience. All clinician attendees were prescribed 1.5 CME certification credits through UPMC's Center for Continuing Education (CCE) to renew their medical credentials, depending on their accrediting body licensure.

By developing a curriculum designed to help clinicians with a wide range of topics on best practices, CMI can increase awareness for their provider workforce on the various aspects of delivering LGBTQ+ patient-centered care and apply it in their everyday practice. Based on these two initial webinars' success and attendance (60+ clinicians for each event), the CMI LGBTQ+ Health Initiatives Workgroup plans to partner with the CCE to offer future webinars and learning modules that feature other key topics on LGBTQ+ health every quarter. Future topics to be provided as part of CMI's continual efforts to serve better our LGBTQ+ patients and community members include: (1) Behavioral Health of LGBTQ+ patients, (2) LGBTQ+ Youth, (3) LGBTQ+ Older Adults, (4) Lesbian & Bisexual Women, and (5) Gay & Bisexual Men. These trainings will cover such topics as the "coming out" process as it relates to behavioral health, legal issues, and specific clinical guidance for addressing the needs of each of the LGBTQ+ subgroup populations.

4.5 CULTURAL AFFIRMING PATIENT CARE

Healthcare providers can have unconscious biases about sexual orientation and gender identity in their work, even if they do not realize it. Ultimately, these providers may not feel comfortable serving the LGBTQ+ community, which may pose difficulty in developing a successful relationship for patients if they do not have the necessary tools and resources made available to identify providers whose practice is culturally affirming. According to the American Medical Association (n.d.), “the relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patient's welfare.” Despite LGBTQ+ patients’ ability to receive care services from any provider of their choosing, cultural and language considerations play a significant role in which provider(s) patients choose to trust in their care. Aligning the provider workforce with educational materials on LGBTQ+ health-related concerns can increase the quality of physician-patient relationships to LGBTQ+ individuals; however, these goals vastly depend on the provider’s ability to holistically attend to the patient’s mental, social, and physical health needs and well-being while respectfully affirming to their gender identity interpersonally; also known as ‘gender-affirming care’ (De Vries et al., 2020).

One CMI provider advocated for increased educational opportunities on the survey response, notably stating, “Patients often feel judged or that their provider may already be biased. Some patients come into an appointment with their guard up, and I would like to shift this belief to become an advocate for this patient population and understand how to speak to them…It is not something we were ever taught in med school or residency.”

In light of this response, the CMI LGBTQ+ Health Initiatives Workgroup, in partnership with UPMC Health Plan, is actively developing a three-module affirming provider certification program (separate from the primary care clinical education CME series) to increase affirming patient care competencies for providers–allowing patients to experience higher satisfaction in their provider choice. In this patient-focused course, providers and staff will learn the key terms when considering sex, gender, gender identity, and sexual orientation and strategies and skills to provide quality health care in their daily practice. Upon successful completion, providers will be awarded a badge on their online UPMC “Find a Doctor” (Kyruus) profile and equip patients with the tools necessary to filter culturally affirming competent providers for enriched physician-patient relationships.

4.6 NAVIGATING THE HEALTH SYSTEM

Navigating the healthcare arena can be exceptionally nerve-wracking for LGBTQ+ patients, especially as many do not seek preventative care treatment in fear of awkward or judgmental encounters. Research has shown a disproportionately high prevalence of HIV/AIDS, mental health concerns, substance misuse, and co-morbidities among the LGBTQ community (UCLA Health, 2020). Managing these diseases can pose challenges for providers who do not have access to the right resources, referrals, or prior experience addressing these health determinants. Based on the short answer responses obtained from the survey, the CMI LGBTQ+ Health Initiatives workgroup recognized the greater need to align the electronic health record with updated clinical decision support as a tool for reducing LGBTQ+ health disparities.

In partnership with the UPMC Associate Chief Medical Information Officer (Dr. Gary Fischer) and EPIC Ambulatory Health Record team, the CMI LGBTQ+ Health Initiatives workgroup is actively working to construct myriad smart phrases, best practice advisories, and health maintenance modifiers (i.e., a clinical alert that can be added to a patient's electronic medical record to help healthcare providers identify and implement necessary health screenings). These clinical decision support tools will primarily trigger increased warnings for HIV screenings, transgender-specific cervical or prostate assessments, depression screenings, and various medication adherence guidelines (such as PrEP or HRT) to combat the high prevalence of health disparities. When implemented tactfully, these tools help guide providers' clinical decisions, reduce errors, and improve care treatment plans' adherence.

5.0 PUBLIC HEALTH RELEVANCE

The foundation of public health is to provide equitable access to care by addressing social determinants of health that target affected patient populations and establishing new models of care that guarantee every patient receives the right care, in the right way, every single time. Informed care services enhance physician-patient relationships and can positively impact the many social and physical health disparities affecting this community. Eliminating Lesbian, Gay, Bisexual, Transgender, and Queer health disparities is imperative to improve the health and healthcare access of LGBTQ+ patients by enhancing efforts at the health system level, implementing an LGBTQ+ Health Initiatives Committee comprised of both clinicians and administrators safeguards a sustained commitment to improving the patient experience by facilitating the necessary resources and workflows to navigate the health system safely. These contributions will ultimately increase positive patient outcomes, subsequently decreasing health disparities and providing an expansion in the overall health and well-being of the LGBTQ+ community.

6.0 LIMITATIONS

The effects described in this case study are based on interventional and prospective observational studies towards improving the quality of health outcomes and patient experience within the LGBTQ+ community. Despite the known risks, there is limited research on LGBTQ+ health to navigate care, which poses difficulties in developing a streamlined care delivery model that targets the LGBTQ+ patient population. Additional research in meeting the unique primary care and specialty needs of the LGBTQ+ community is warranted, particularly given the evolving impacts of social determinants of health and the healthcare system's role to understand each complexity. Noteworthy enough, all initiatives were new to the division and tested for efficacy rather than implemented based on proven success. This study is, therefore, subject to three main design limitations: (1) confounding biases in the completion of the educational modules which influence our model estimates, (2) provider biases–both conscious and unconscious, and (3) lack of LGBTQ+ community voice.

This program's success is based principally on a provider's willingness to participate in the educational opportunities and providing gender-affirming care. The effectiveness of the program is, therefore, subject to both confounding and provider biases. The completion of these modules does not necessarily result in the provision of affirming care for which providers are measured to a standard in the care of their LGBTQ+ patients. Thus, these controls are subject to failure based on confounding variables. Future considerations of these interventional methods should incorporate more accountability on physicians and healthcare systems towards a designated, measurable standard in the treatment of LGBTQ+ patients. However, these conclusions lead to

another effect limited by implied biases. Community Medicine physicians and advanced practice providers with an unconscious or conscious bias against lesbian, gay, bisexual, transgender, and queer individuals due to sexual stigma (i.e., social stigma against people because of their beliefs, identities, or behaviors based on sex) present a barrier towards participation under the current model. Providers who expressed interest and fully engaged in increasing the health and patient experience within the LGBTQ+ community are less likely to stigmatize sex, thus, yielding higher participation results than those who were less interested.

Limited by the resources available to communicate with our current LGBTQ+ patient population, this case study only surveyed UPMC Community Medicine providers. It may be perceived as paternalistic–assuming that the providers know what is best for the community–by excluding the LGBTQ+ community's voice in the program's design. In developing these programs, multiple stakeholder voices are imperative to influence change. Although a few representatives from the CMI LGBTQ+ Health Initiative Committee are dual members of the LGBTQ+ community and patients to CMI, extensive patient survey data would benefit future decision-making. As healthcare shifts towards a patient-centered care model, provider organizations like UPMC recognize the increased need to incorporate the patient's voice and community perspective into program design meaningfully. Future considerations to address this limitation include introducing an LGBTQ+ patient advisory board to UPMC Community Medicine. This solution could represent a vital interface between the LGBTQ+ community and providers, providing patients with an avenue for providers to directly listen to the community's needs, which in return may impose a certain degree of accountability.

7.0 CONCLUSION

Healthcare providers have the responsibility and power to recognize the unique health and well-being issues affecting lesbian, gay, bisexual, transgender, and queer people by fostering a culturally competent, patient-centered care model. Existing studies demonstrate that health disparities in the LGBTQ+ community stem from limited access to preventative care, lack of knowledge or experience of healthcare providers in treating LGBTQ+ patients, or past negative experiences. Experiences of past discrimination or the expectation of a negative encounter with primary care or subspecialty providers have served to marginalize LGBTQ+ people, causing subsequent gaps in care, leading to late-stage or often overlooked diagnoses. Eliminating barriers to care and improving LGBTQ+ health outcomes are achievable by understanding their unique health needs at the health system level; however, these goals are only attainable by partnering with our provider and staff workforce synchronously to develop the necessary tools for LGBTQ+ patients to identify culturally competent providers. UPMC Community Medicine providers are engaged and want to provide LGBTQ+ centered patient care with one affirming, “I think that not just providers, but all clinical staff need a better understanding and acceptance of the LGBTQ+ community and the additional needs that this community may require. In addition, I think that providers as well need better education and understanding of the specific clinical needs and issues that the LGBTQ patients may face that are specific to that community and how we can do a better job at providing that care.”

As demonstrated in this case analysis, UPMC Community Medicine is taking comprehensive approaches to become a preferred provider for LGBTQ+ patients by

launching its “CMI LGBTQ+ Health Initiatives Workgroup” to review patient care, validated with the knowledge guided by structural analysis, existing research, programming implementation, and reshaping quality-driven care delivery services in which LGBTQ+ people are represented. The UPMC Community Medicine provider survey results helped shed light on several crucial issues by developing a baseline understanding of today’s population management practices related to improving the quality of care provided to LGBTQ+ patients. The quantitative and qualitative response data obtained suggest the pathway towards improving LGBTQ+ health may be enhanced by creating a program at the system level synergistically with providers, staff, and patients to impact health outcomes. These broad-based approaches to integrating gender-affirming care and patient-centered delivery are challenging; however, strategic alignment between the patient, provider, and integrated delivery health systems can drastically improve patient experience and address the social and physical determinants of health LGBTQ+ patients face, among other barriers.

In moving forward, CMI’s LGBTQ+ Health Initiatives Workgroup, if approved for additional funding support by UPMC corporate finance, intends to become a “Center of Excellence” under the UPMC Wolff Centers’ direction with an established Program Manager and Medical Director to streamline these operational practices and various other LGBTQ+ patient-centered projects across the entire UPMC Health Services Division (physician & hospital care delivery services). In doing so, this operational approach will capture increased market share potential of the LGBTQ+ community to ensure that LGBTQ+ patients across all divisions, and indeed all patients, have access to attain the highest possible level of health under a UPMC culturally competent provider’s care.

APPENDIX A – SURVEY QUESTIONS

1) *What type of medical provider are you?*
   a) *Physician (MD/DO)*
   b) *Advanced Practice Provider (CRNP/PA)*
2) *Which care domain describes your medical practice?*
   a) *Primary Care*
   b) *Specialty Care*
3) *Are you interested in acquiring an "LGBTQ+ affirming provider" designation?*
   a) *Yes*
   b) *No*
4) *What does your LGBTQ+ patient population look like?*
   a) *I treat many LGBTQ+ patients*
   b) *I treat few LGBTQ+ patients*
   c) *I do not presently treat any LGBTQ+ patients*
   d) *Unsure*
5) *Are you familiar with local organizations and national resources available to support the health and wellness of LGBTQ+ patients beyond our clinical care?*
   a) *Yes*
   b) *No*
   c) *Unsure*
6) *Of the following statements below, please describe your level of clinical importance.*

	Extremely important	***Somewhat important***	***Neutral***	***Somewhat not important***	***Not at all important***
Knowing a patient's sexual orientation as part of the provider-patient relationship and clinical treatment.	O	O	O	O	O

7) *Of the following statements below, please describe your level of comfort.*

	Totally comfortable	***Pretty comfortable***	***Uncomfortable***	***Unsure***
To what extent do you feel comfortable serving lesbian, gay, or bisexual patients?	O	O	O	O
To what extent do you feel comfortable serving transgender patients?	O	O	O	O
To what extent are you comfortable with patients self-disclosing their sexual orientation or gender identity?	O	O	O	O
To what extent are you comfortable understanding care treatments, such as, hormone therapy or PrEP?	O	O	O	O
To what extent are you comfortable directly asking patients their sexual orientation or gender identity?	O	O	O	O

OPEN RESPONSE:

8) *What additional resources would help you in the care treatment of LGBTQ+ patients?*

9) *What hesitations, challenges, or barriers do you see in the clinical treatment for patients within this population?*

10) *Do you have any ideas, questions, or other comments regarding this initiative?*

APPENDIX B – SUMMARY HIGHLIGHTS: PROVIDER'S OPEN RESPONSES

What additional resources would help you in the care treatment of LGBTQ+ patients?
"Resources for Other LGBTQ friendly providers and specialists for appropriate and comfortable referrals for patients."
"I would like education on the health issues, hormone Rx and needs of transgender individuals. Additionally, would like an update on sexual and physical issues that are unique to LGBTQ individuals."
"Support for rural providers."
"Adequate insurance coverage for reasonable treatments. A better (current) list of surgeons. More local bottom surgeons. THE ABILITY TO HAVE NONBINARY GENDER IN EPIC?! Also, the ability to have pronouns. I have written to various parties about this before."
"More information with details regarding pronouns, orientation, etc., how to approach the topic of sexual orientation, information regarding screening, chronic care, etc., listing of specialists in the area / network that we can provide safe, trusted referrals to."
"CME concerning caring for LGBTQIA patients, trans resources and CME including information about initiating hormone treatment."
"I would like to know about prevention such as rectal pap smears. Also, I would like to know more about medications and side effects and referrals to surgeons in the area to direct the patient."
"Knowledge of community resources available that I could forward to them following d/c from the hospital."
"Quick links or hormone protocols like from UCSF. List of social support resources available to patients (who can help them change their name, who can help with insurance issues with changes in gender, gender affirming counseling options, gender affirming psychiatry resources, transbuddy referrals, etc.)"
"i would love an educational session to assist my knowledge base regarding medical therapies unique to these populations along with behavioral health information."
"Continuing education hours devoted to care/ treatment for the LGBTQ patient."
"Allowing our patients to self-identify and see these changes in EPIC...I hear it is coming soon. We are currently developing our own protocols to assist these patients. We are also working on making our practice more transgender affirming and I am committed to this work. We'd love a printed list of providers who do transgender surgeries at UPMC for ease of referrals and HT as well."

What hesitations, challenges or barriers do you see in the clinical care treatment for patients within this population?
“I think that not just providers, but all clinical staff need a better understanding and acceptance of the LGBTQ + community and the additional needs that this community may require. In addition, I think that providers as well need better education and understanding of the specific clinical needs and issues that the LGBTQ patients may face that are specific to that community and how we can do a better job at providing that care.”
“EHR system documentation, identifying resources to help with appropriate evaluation and behavioral health support before initiating hormonal therapy. Our practice as a whole has many LGB patients but fewer identified transgender patients and the one physician who cared for most of them left 1 year ago and our practice is trying to catch up. Getting office staff on board for changes."
“Hospital admission for transgender patients. I had transgender (male to female) who was very anxious about being on a hospital floor with a roommate. Also, as discussed above, understanding surgery options for transgender patients and what that means for HM testing appropriate for them.
“not much training received even during fellowship in endocrinology, but now they do include in national meetings.”
"In general, reluctance to seek treatment for fear of ridicule or lack of acceptance. Personally, a barrier has been lack of knowing resources or ways to help my patients navigate the system. I also think more support/education on managing hormone replacement therapy would be very helpful for me.”
“Overcoming patients' understandable unease with the medical system, not being able to direct patients to good local resources, insurance barriers, inconsistency in provider comfort at multiple provider practice.”
“In our clinical practice, there seems to have been the most hesitation/ discomfort with relating to transgender patients in the past, both on the patient side as well as the provider side. I feel that we could educated ourselves better to understand the needs of these patients.”
“I do not personally know of any specialist providers that provide hormone therapy, and I am not trained to provide it myself. I am not up to date regarding prescribing PrEP. I do not know of any local organizations/national resources that support LGBTQ+ health and wellness.”
"I'm so committed to this population and look forward to developing a plan in the future to not only make these patients feel more comfortable in my practice but increase their healthcare access for an overall healthier life. I look forward to the EPIC updates, which currently is the biggest barrier in our office."
“Patients often feel judged or that their provider may already be biased. Some patients come into an appointment with their guard up, and I would like to shift this belief to become an advocate for this patient population and understand how to speak to them…It is not something we were ever taught in med school or residency.”
“Overall lack of resources and patient education materials.”

Do you have any ideas, questions, or other comments regarding this initiative?
“Just excited to see we are focusing on this.”
“Wearing a rainbow sticker on our nametags to let patients know we are LGBTQ affirmative. Outreach to the community to show our support for the LGBTQ community.”
“It's a great idea, I’ll help in any way i can. I'm a member of the LGBT community.”
“’Push’ notification of learning modules, podcasts.”
“Providers are a small part of the treatment team. All office staff need education for patients to feel comfortable and welcome.”
“I would want to know what is expected of affirming providers as if I was required to provide medications, I don’t feel comfortable prescribing due to the complexities of the issues with the risk of those medicines Then I would not want to participate.”
“We provide HIV care at our office and see a fair number of LGBTQ+ patients. We have started a curriculum; it would be great to offer these modules so that providers and residents are receiving the same education.”
“I would appreciate receiving a list of endocrinologists in the area that provide hormone therapy.”
"I'd like to be involved in this care and am thrilled this is a priority from UPMC, the health plan, and CMI. Thank you! I've begun screening my own patients for preferred name and pronouns and it is going very well."
“Really excited about this initiative, thank you. Please be sure to include patients from the LGBTQIA+ community in the conversation. We shouldn't be guessing what patients need. We should be hearing from them what they need/want. "
“I think this is a great initiative. Again, a webinar or lecture series for providers would be great? I feel uncomfortable at times in not feeling i truly understand my LGBTQ patients, i don't want to offend them by misspeaking or addressing them with an incorrect term but not addressing it at all may be perceived worse.”
“Are there specialty referral sources for assist with hormone and counseling management, also navigating uncooperative or unsupportive parents/and legal issues with getting teens appropriate support while under parents care.”
“New patient packet updates to include gender or sexual identity.”
“I was trained to provide PrEP with Truvada in the past. I haven’t kept up with that since Descovy was introduced. I may be willing to provide this treatment again if an in-service was provided as a refresher. I am not however interested in providing hormone therapy, that should be done under the care of an endocrinologist.”

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