



## **L.A. Gay & Lesbian Center**

Report From  
The Second Annual  
Lesbian, Gay, Bisexual  
and Transgender  
Health Roundtable

March 29, 2001

## **ACKNOWLEDGMENTS**

The L.A. Gay & Lesbian Center extends its appreciation to all of the community health advocates, researchers, health care providers, governmental representatives and funders who contributed their time to not only make this event a success but also for their tireless work in addressing the spectrum of LGBT health issues and pushing the LGBT health movement forward. Additionally, the L.A. Gay & Lesbian Center extends its gratitude to GlaxoSmithKline for partnering with the Center by providing the financial resources to allow this annual event to be a reality.

The staff of the Gay & Lesbian Center's Department of Policy & Public Affairs, Health & Mental Health Services Department, Development Department and Legal Services Department are applauded for their contributions to organizing this event and giving their time to assist in managing the logistics of the Roundtable.

The Roundtable could not have happened without the excellent presentations given by Dr. Robert Bolan, Dr. Dawn Harbatkin, Dr. Ronni Sanlo, Dr. Alicia Matthews, Rick Jung, Dr. Nancy Kennedy, Dr. Brad Austin, Cornelius Baker and Dr. Suzanne Haynes. Their presentations stimulated critical thought and provided the frame for discussions throughout the day.

In particular, special thanks are given to the key organizers of the event and to the facilitators whose leadership and skills moved discussions forward constructively and ensured that each voice was heard. These incredible people are Carmen Canto, Laurie Drabble, Richard Diaz and Brie Dean.

The staff of the Davidson Conference Center at the University of Southern California—especially Robin Kaufman—provided excellent services and facilities that allowed the Roundtable to run smoothly.

## **INTRODUCTION**

March 29, 2001  
L.A. Gay & Lesbian Center  
Los Angeles, California

The L.A. Gay & Lesbian Center hosted the second annual Lesbian, Gay, Bisexual and Transgender Health Roundtable on March 29. Immediately following the Roundtable, the L.A. Gay & Lesbian Center also hosted a meeting of the National Coalition for Lesbian, Gay, Bisexual and Transgender Health. The Coalition convened for its first summit at the Gay & Lesbian Center's Village at Ed Gould Plaza to set an advocacy agenda for the upcoming year. Both events brought together national leaders in health policy, service delivery and research to look at ways of improving the health and well-being of lesbian, gay, bisexual and transgender (LGBT) people.

Presenters at this year's Health Roundtable included Dr. Robert Bolan, Medical Director of the L.A. Gay & Lesbian Center's Lambda Medical Group and representatives of the federal Department of Health and Human Services: Dr. Nancy Kennedy and Brad Austin, of the Substance Abuse and Mental Health Services Administration, and Dr. Suzanne Haynes, of the Office on Women's Health. Also presenting were Cornelius Baker, of Whitman-Walker Clinic in Washington, D.C., Rick Jung of the Gill Foundation, Dr. Ronni Sanlo, University of California Los Angeles, Dr. Alicia Matthews, University of Chicago, and Dr. Dawn Harbatkin, of the Callen-Lorde Community Health Clinic.

## **PURPOSE**

The 2001 Roundtable built on the momentum from the previous year's successful event and the resulting document, "Advancing Gay and Lesbian Health: A Report from the Gay and Lesbian Health Roundtable." The widely disseminated document provides an extensive summary of presentations, discussions, and recommendations emanating from the first roundtable. Besides identifying specific shortfalls in health care for LGBT people, the report makes recommendations to fill those gaps and identifies areas that require further study. Additionally, the report notes that improving health care and research for the underserved LGBT community would rely heavily on increased funding and changes in public policy.

This year's discussion expanded on the recommendations contained in the previous report and explored the role of existing models of primary care delivery, research on LGBT health, policy and funding. Representatives from federal health agencies stressed the importance of accessing existing funding streams in an era of competing health needs, demands and budget tightening. They highlighted the importance of working through government channels, using language and data that let LGBT health needs resonate with federal agency heads, rather than alienate them or assuming opposition, and concentrating on the need to address health outcomes through understanding of risk factors and broad determinants of health. Private foundation funders spoke about the need for education for philanthropic organizations about how LGBT health care fits into their mission and funding philosophies, and how primary care fits into an overall approach for improving community health.

# **I. DELIVERY OF QUALITY PRIMARY CARE TO LGBT COMMUNITIES**

## **A. LGBT primary care presentations**

### **1. Robert Bolan, M.D., Medical Director, Lambda Medical Group, L.A. Gay & Lesbian Center**

Dr. Robert Bolan presented on the model of services utilized by Lambda Medical Group, the primary care services arm of the Gay & Lesbian Center, which opened in September 1998 to offer services in the following areas: geriatrics, adult and adolescent medicine, pediatrics, mental health and alternative insemination.

A demographic breakdown of the patients for 1999 and 2000 shows that more males utilized services at Lambda Medical Group than females. In 2000, there was a dramatic increase in male patients seen in the age groups of 20-34, 35-44, and 45-64. However, in the same year, the number of female patients only showed a dramatic increase in the age group of 20-34. Unduplicated client data also shows for the period of July 1, 2000 through June 30, 2001 that the racial/ethnic demographics are as follows: 5% of patients are African American; 4% are Asian/Pacific Islander; 15% are Latino(a); 10% are Native American, 65% are White; and 1% are of unknown race/ethnicity.

Dr. Bolan described his view of appropriate health as one with a definition that should fit all populations. When looking at health behaviors and barriers, some will affect LGBT folks more than others. In order to raise the standard of our health and health care, we must lead the way in research and teaching. Appropriate health care begins with a nonjudgmental provider who respects the patient and efficiently obtains all information relevant to making a timely diagnosis and treatment plan. Because sexuality is central to a person's functioning and well-being, the ability to discuss sexual and relationship matters comfortably with a medical provider is essential for comprehensive medical care.

To discuss health behaviors, Dr. Bolan suggests considering a few givens for the purposes of discussion: Seeking health care is a health behavior; accept the Healthy Living project suggestions that are appropriate (e.g., not smoking cigarettes, use of alcohol in moderation); an LGBT person's health behaviors may be modified by factors related to their sexuality. Several factors contribute to determining health behaviors including whether the risk to be avoided or good to be gained is personally relevant, whether there are competing or more immediate desires or needs, the person's sense of self worth, belief in self efficacy, economic barriers and potential cultural conflicts.

Barriers to healthy behaviors and health care can be societal, rooted in the LGBT community or caused by the health care field. Societal barriers include the general sense of rejection experienced by many LGBT people by the dominant culture of anything that is not heterosexual. Other societal barriers include rejection based on race and ethnicity, class, education, and the lack of legal status for partner relationships and child custody.

Within the LGBT community, barriers to health promotion and care also exist. Examples of this include the absence of gay senior images and the images of LGBT people of color in gay media, popular culture's promotion of an idealized, youth-focused body type, a minimal focus on loyal coupling, a minimal focus on parenting, mentoring and continuities, the stigmatization of health disabilities, the denial of true HIV/STD risks and alcohol and drug abuse.

Health care providers also create or exacerbate barriers to care due to lack of education about LGBT-specific issues and sometimes provider bias. Examples of these barriers include assuming a patient is heterosexual, lack of inquiry about important relationships, lack of inquiry about secrecy or experiences of stigmatization, overt discrimination and focusing on sexuality when it is not the health issue at hand. One of the most significant barriers to LGBT health caused by health providers is the lack of population-specific knowledge—the general lack of knowledge of health issues faced by the LGBT community which include screening for Hepatitis in gay men and neglecting to inquire about peno-vaginal intercourse among self-identified lesbians.

Dr. Bolan emphasized the importance of documenting and teaching culturally competent care to advancing the health of the LGBT community. He stated that the essential facts of culturally competent health care could be taught and modeled and recommended that medical schools and residencies accept responsibility for this task. Crucial to this is seeking out and encouraging LGBT/allied students to work on these issues. To move forward, we must document our health status through rigorous research on our community, curriculum development and standards of care and teach these in academic training and community-based settings.

## **2. Dawn Harbatkin, M.D., Medical Director, Callen-Lorde Community Health Center**

Dr. Harbatkin is the Medical Director for the Callen-Lorde Community Health Center in New York City. Callen-Lorde provides a multitude of health services including primary care focusing on lesbian health, HIV/AIDS, Transgender health, health outreach to teens and senior health services and social services covering mental health and counseling to address both the physical, mental and emotional needs of their patients. As an integral part of these services, health education is an essential component of their model of health care that “seeks to empower patients to become educated health care consumers.”

Dr. Harbatkin presented on the model and clientele demographics of Callen-Lorde. This center provides services to a diverse range of clients across age, insurance status, geography, gender, and race and ethnicity. As an example, for the month of February 2001, all age ranges were seen at Callen-Lorde with the highest percentage, 39%, for the age group of 25-35 and the lowest percentage, 3%, for individuals 66-or-above. In terms of insurance status, 37% of patients self-paid; 36% had private insurance; 10% were under the AIDS Drug Assistance Program (ADAP); 8% were under Medicare; 6% utilized the HOTT (Health Outreach to Teens subsidy program); and 4% were under Medicaid. Patients came from all boroughs of New York City, with the highest percentage, 48%, from Manhattan. Patients from surrounding counties and states including New Jersey, Connecticut and Pennsylvania also utilize services from Callen-Lorde, highlighting the need for LGBT-specific health services. In regard to gender, 28.5% were male; 16.3%, female; 3.8%, transgender; 0.4%, other; and 51% did not disclose. With regard to race and ethnicity, 61% were not reported, 21% were White, 8% were African American, 7% were Hispanic/Latino(a) and 1% was Asian/Pacific Islander.

Dr. Harbatkin identified four major access issues for the LGBT community. She identified confidentiality of a patient’s sexual orientation or gender identity. Another is sensitivity to the health issues that a patient may raise. Closely related to sensitivity is having a certain level of competence in both medical and mental health issues faced by the LGBT community. Often providers do not know what to screen for or how being LGBT may present different health risks than the heterosexual population. Another key issue is the lack of insurance coverage that includes unmarried partners who do not qualify under their partner’s insurance or LGBT people who can’t otherwise afford private insurance. Additionally, most health insurers do not cover medical procedures that are sought out by members of the transgender community such as hormone supplements and genital reassignment surgery.

Dr. Harbatkin described specific issues faced by the lesbian community. These issues included problems with mental health and stress, substance use including tobacco use, and nutrition and exercise. She also stated that gynecological health issues including pregnancy planning were of particular concern. Additionally, lesbians possibly may be at a higher risk for breast and cervical cancer, which is often overlooked by providers.

Specific health issues that are faced by gay men include higher risk for hypertension and heart disease, anorectal cancer, HIV/AIDS and other STDs. An increasing concern in the gay male community is the rising use of substances such as methamphetamines, MDMA, alcohol and tobacco. Similar to lesbians, gay men may also suffer higher incidence of mental health problems and stress.

Members of the transgender community also face unique issues. Many individuals face serious health risks associated with injection hormone therapy if the process is not monitored by a physician, including unmonitored side effects, complications from impure “street” hormones and risk of disease transmission from shared needles. Additionally, medical issues dealing with injection hormone therapy and surgical interventions place members at higher health risk. Also, there is little to no preventive care available to the transgender community, as most primary care providers do not have the knowledge or sensitivity to make these services available. Additionally, similar to gay men and lesbians, many transgender individuals face problems with mental health and substance use.

An issue that is just coming to the forefront is the health of LGBT seniors. From the little data we have on this topic, we know that information suggests that LGBT seniors often suffer from isolation and lack of family. Many LGBT seniors face invisibility, rejection, neglect and isolation as well as discrimination from within and outside the LGBT community. Seniors often fear disclosure of their sexual orientation or gender identity due to the effect it may have on their living situation or the reaction of their health care provider. The developmental challenges of coping with end of life issues are compounded by the lack of social services specifically geared or sensitive to the needs of LGBT seniors. Many seniors face problems with substance use and mental health.

LGBT youth also face specific issues that are often related to their developmental process. Many are questioning their sexual orientation, gender identity or identity as a whole. This process can have adverse effects on an individual’s mental health and propensity toward risk taking. Many are also coping with issues of coming out and possible rejection by their peers and family. This relates to incidence of violence experienced by many youth in the home, among peers, and from sexual partners. Many LGBT youth face problems with substance use including tobacco use and participate in sexual risk taking.

## **B. Primary care breakout discussions proceedings**

The following questions were asked in two separate breakout discussion sessions. Each group discussed the questions for one hour with 30 minutes per each question.

### **Primary care question 1:**

What type of efforts could help improve the provision of LGBT quality primary care that is culturally competent, geographically accessible, provided in the language needed, etc.? Who should be involved and/or initiate these efforts?

### **Primary care question 2:**

What internal LGBT community barriers and external barriers exist to provide primary quality care to LGBT minority groups (i.e. transgender, people of color, families, children/youth, seniors, and disabled)? What ideas or approaches could help overcome these barriers?

The discussion in both primary care groups produced global suggestions that address the spectrum of issues that would respond to the posed questions in terms of the gaps and barriers and needed efforts. They provide comments and recommendations on the strategies and steps which could be utilized to consolidate community resources at all levels; thus continuing to advance access as well as the quality of primary care for all sectors of the LGBT community; including those specific to LGBT ultra vulnerable sectors (i.e., transgender, seniors, women, youth, bisexual, immigrants) of a sub-culture community already underserved within the mainstream health care delivery models.

Ideas and recommendations presented seem to cover efforts to be made both individually and organizationally, as well as within and outside the LGBT community, providing a picture that represents a commitment and concerted effort at all possible levels. These ideas and recommendations are closely tied to recommendations made at the 1999 Roundtable, while an emphasis appeared in the 2000 Roundtable in statements and recommendations that seem to reflect the desire and a will for collaborative partnerships and a move to action.

## **1. Areas of focus to improve the quality of competent primary care for the LGBT Community.**

### **a. Education and training.**

To increase culturally competent care for LGBT communities, education should begin at the level of medical school. For continuing education—medical boards, academic health and accreditation bodies in medical schools and other health profession school centers need to include LGBT health as a component of the standard curriculum. This curriculum should include not only LGBT health issues, but also practice trainings on how to appropriately serve LGBT patients. Many of these models exist and are being used in several medical schools across the country. Organizations such as the Gay and Lesbian Medical Association and the National Coalition for LGBT Health serve as resources on where to identify LGBT curricula. Additionally, the Healthy People 2010 Companion Document for LGBT Health contains a broad range of health issues pertaining to the LGBT community including topics such as tobacco use, cervical and breast cancer, hepatitis and substance abuse.

In addition to medical schools, mainstream clinics and health organizations were identified as needing to be a place of focus for LGBT health training among the medical and support staff components. LGBT appropriate protocols should be developed for dissemination to mainstream clinics and for training to ensure that the delivery of care is effective, pertinent, sensitive, and confidential. When working with underserved populations such as people of color or transgender individuals, targeted efforts must be made to hire and train professionals who have the capacity and ability to work with all underserved groups, and address their health needs. Representatives from underserved populations need to be sought out and at the table if not as service providers, at least as opinion leaders involved in service and outreach planning.

An integral part of medical and continuing education must be courses that address and facilitate understanding of LGBT cultural competency, issues of race/ethnicity, linguistic competency and socioeconomic status. Often within LGBT health clinics and occasionally among mainstream service providers, LGBT cultural competency is addressed without a complete appreciation of these known determinants of health. Many different cultural competency guides based on race/ethnicity, socioeconomic status and age already exist.

Efforts are also needed to ensure that sexual orientation and gender identity issues are added to existing standards of care and best practices. Concomitantly, race/ethnicity, class and linguistic health determinants need to be incorporated into LGBT health courses and training in order for health care providers to understand the complexity of the LGBT community and the different experiences of stigma lived by LGBT people. By addressing these issues, health care providers will learn how to provide effective and sensitive care to the many different communities that constitute the overall LGBT community. Mainstream health care community providers should be challenged to include these standards and best practices to provide sensitive and appropriate health services for all LGBT community sectors.

### **b. Practice.**

The health of the LGBT community would benefit greatly if there were a broader shift to preventative medicine. A focus on health promotion and preventative medicine such as regular check-ups, pap smears and testicular exams would provide the LGBT community with a first step to addressing the continuum of care for our community. Health itself is much more than diagnosis, prescription and medical care and it encompasses more than just physical care but also emotional and mental health. Focusing on all of these aspects of care would increase the wellness of the LGBT community in the long run. Key to achieving this is developing and promoting LGBT specific models of wellness and primary prevention. Comprehensive complimentary LGBT services should also include alternative health services and not be confined to traditional western medicine. Additionally, newer technologies such as web-based health and wellness sites and outreach are already being utilized to disseminate health information and promote self-care, and these efforts need to be fostered and refined.

Infrastructure is key to providing quality primary care for the LGBT community. More resources should be invested in developing solid and consistent structures that support the provision of high-quality health care. Standards of LGBT health care should be established as a part of this infrastructure for health care delivery. Acknowledging the scarcity of resources to accomplish this and to avoid dividing communities by funding streams, collaborative efforts are needed to strategize around how to access funding at a local, state, regional and national level to create this infrastructure and develop standards of care. Health care providers need to look beyond HIV funding streams and begin searching for other funding opportunities in agencies such as the National Institutes of Health, the Substance Abuse and Mental Health Administration and the Office of Minority Health.

Outreach efforts are needed to underserved areas to ensure that the health needs of populations such as people of color; aging; the disabled and the rural population are being addressed within discussions of LGBT health care needs. These underserved populations should be brought to the table and represented at conventions, conferences and policy discussions to ensure that their needs, perspectives and what they have to offer are part of any LGBT health care discussion.

## **II. UTILIZING AND ADVANCING LGBT HEALTH RESEARCH FOR THE PROVISION OF PRIMARY CARE**

### **A. LGBT health research presentations**

#### **1. Ronni Sanlo, Ph.D., Director, UCLA LGBT Campus Resource Center, Los Angeles, California**

Dr. Sanlo opened up her presentation with a discussion of why there should be a focus on the health needs of the LGBT college student population. Many of the students may not be visible—not only in a health care setting, but also to other services provided by the university. The majority of students are youth and possibly more vulnerable; many may resist health care. Most LGBT college populations are multicultural and diverse in other ways, thus affording population-based research opportunities. Additionally, focused attention and research must document the experiences of discrimination and harassment faced by many students. Finally, the CDC and the Public Health Service recently determined college students to be a particular population unto themselves. As such, specific health programs should and will be established to study and determine the needs and health issues of this population.

One of the best surveys of LGBT youth comes from the 1995 Massachusetts Youth Risk Behavior Survey administered by both the CDC and the state. Results from this survey begin to describe the lived experience of LGBT youth in high school. LGBT youth were found to more likely miss school out of fear of discrimination, harassment and violence. They were also more likely to have their property damaged at school or to be threatened with a weapon at school. LGBT high school students also had increased number of suicide attempts and higher use of alcohol, tobacco or other drugs.

In college, Dr. Sanlo identified specific issues that LGBT youth are dealing with or what services they need. For gay youth, she identified the need for anonymous HIV and STD testing, access to safer sex information, and places to obtain free condoms. Dr. Sanlo also noted that issues faced by gay athletes need to be examined, including fear of disclosure and possible harassment. Other areas that have health implications for student health include the prevalence of public sex environments on campus and the assumption of many campus providers that gay or bisexual male students are HIV-positive.

Dr. Sanlo highlighted three main issues affecting lesbian youth. Many lesbian youth are assumed to be heterosexual during their provider visits and wrongly prescribed birth control when they say they are sexually active. Some women who have sex with both women and men don't perceive themselves as being at risk for an unwanted pregnancy or STDs. Campus providers need to be trained to discuss birth control issues in a culturally competent manner that does not assume heterosexuality. Lesbian youth also need access to safer sex and STD/HIV information and testing. Also, research has shown that lesbians may be at higher risk for breast and cervical cancer. Campus providers who are knowledgeable of these issues may encourage healthy behaviors such as screening and self-exams to assist with early detection.

Many of the transgender students lack health care coverage through student health insurance that is adequate to meet their needs. For example, lack of coverage of hormone treatment can disrupt the transition process if a student cannot afford the treatment on his or her own. The most crucial issue during a medical visit, however, is provider sensitivity to a transgender individual.

Ending, Dr. Sanlo had some recommendations for providers on college campuses. She stated the oft-cited estimate of five to ten percent of the student patient population is LGBT and that this has serious implications for the provision of care. Providers need to seek a broader understanding of orientation versus behaviors, sexual/gender identity versus a person's sexual behaviors. Providers as well as clinic staff need to create a welcoming environment that includes intake forms, information that shows both opposite sex and same sex couples and that is free from heterosexual bias. Providers should be educated about the different cultural competencies not just around sexual orientation and gender identity but also those that arise with different race/ethnicities. To provide quality care, the health care providers should separate their personal beliefs from the patient and make no assumptions about one's behavior or health needs. To comfort a patient, the provider should discuss confidentiality with a student and offer an evaluation form.

## **2. Alicia Matthews, Ph.D., Assistant Professor, University of Chicago, Chicago, Illinois**

Dr. Matthews' presentation focused on the impact of having a negative experience with a primary care provider. She and her colleagues performed a study<sup>1</sup> that measured the consequences of experiencing a negative interaction while receiving health care services. The participants in the study were mostly female and tended to be African American and homosexual with an average age in the forties.

Dr. Matthews stated that overall, frequent negative experiences were associated with increased stress, perceptions of lower quality health care and a decrease in the utilization of health care services. Interestingly, being gay or lesbian was associated with more negative experiences with the health care system, increased expectancy of having a negative experience in a health care setting and avoiding health care services after encountering a negative experience.

Dr. Matthews stated that these results have serious implications for improving the quality of care for people of color and the LGBT community. To address this, she expressed the need to develop standards of care and document best practices that can be used in all health care settings for people of color and the LGBT community. In regards to improving research in the LGBT community, she suggested that community-based organizations build partnerships with research institutions to create models of community-based research. Additionally, she expressed the importance of having the diverse communities of the overall LGBT community at the table when beginning to plan, direct or frame a new research initiative.

### **B. Research breakout discussions proceedings**

The following questions were asked in two separate break out sessions. Each group discussed the questions for one hour with 30 minutes per each question.

#### **Health research question 1:**

What existing resources (e.g., practice-based data, standards of care) can be used, and how, to improve provision of primary care to traditionally underserved LGBT communities (i.e., transgender, people of color, families, children/youth, disabled, seniors)?

#### **Health research question 2:**

What external and internal barriers exist to gathering existing/new research resources for utilization and implementation in health practice? What ideas or approaches could help overcome these barriers?

Three main themes emerged during the discussions on key issues in LGBT health research. First was the utilization of existing research resources, recognizing that we are at a developmental stage that has evolved and resulted in essential tools and information for advancing the state of the art in research. Secondly, and conjunctively was the recognition of existing gaps, barriers or needs to continue to advance in all areas of LGBT research including research collaborations and partnerships that are representative of the diverse mosaic that makes up the LGBT community. Third and weaved throughout the previous two themes was a stated interest by roundtable participants to provide the strategies to utilize and mobilize existing resources and fill in the gaps.

### **1. Areas of focus to advance LGBT health research.**

#### **a. Utilization of existing research resources.**

Participants emphasized the need to find resources that are currently being used for research and evaluation programs in the LGBT community. In addition to finding resources, that dissemination strategies need to be developed and implemented so that organizations and individuals can be regularly updated on available resources. An example of this is the coordinated research currently being done within the LGBT community on tobacco use. Another example is funding for health research available through the National Institutes of Health and that agencies need to be more informed of research funding opportunities and educated on the best strategies to apply for this funding.

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<sup>1</sup> Impact of Negative Experiences in Health Care Settings on Satisfaction, Stress, and Health Care Utilization, Alicia Matthews, Ph.D., Clara Manfredi, Ph.D., Jessica Tartaro, B.S., Patty Delaney, M.A., and Dana Brandenburg, B.A.

LGBT measurements and methodologies need to be applied in the tracking of Healthy People 2010 (HP 2010) goals and objectives. HP 2010 involves the major national health surveys conducted by the Department of Health and Human Services. Currently, 29 objectives of HP 2010 include sexual orientation. It is essential that LGBT-specific questions are included in these federally administered national surveys so health information is collected on the LGBT community. Examples of these surveys are the National Health Interview Survey, National Health and Nutrition Examination Survey and the Youth Risk Behavior Surveillance System. They assess global health indicators as well as broad determinants of health—housing, socioeconomic status—that intersect with sexual orientation, gender identity and sexual behavior to shape health and well-being. A better understanding of the interplay of these variables will highlight different health needs of groups within the LGBT community.

Another important resource is the Healthy People 2010 LGBT Companion Document. This document is a powerful tool that can be used by advocates for policy and programmatic development and advocacy toward inclusion of sexual orientation and gender identity in national and local population-based studies or surveys. Researchers can use the Companion Document to devise strategies for the broader inclusion of the LGBT community in health research. It is critical that this tool be disseminated and presented widely to maximize its impact on LGBT health—for policy and advocacy, as well as for program planning, development, implementation, and evaluation.

#### **b. Existing gaps, barriers, or needs.**

##### Data Collection in the LGBT Community.

Collecting reliable and generalizable data on the LGBT community is a challenging task. It is difficult to identify the LGBT population, making randomized sampling problematic, if not sometimes impossible for studies. Additionally, researchers use different surveying methodologies and different variables to capture sexual orientation and gender identity. This often makes it difficult to capture and analyze data that apply to the entire LGBT community. LGBT-specific standards for measurement need to be developed and disseminated for wide application in research methodology. This would permit more rigorous valid data to be collected, and reliable comparisons made across LGBT populations. LGBT-specific standards for measurement would also provide opportunities to further utilizing LGBT research resources through meta-analyses of existing data or data from single studies. At the present time few studies exist that assess best practices, community-based programs and service delivery models. Without this information, it is more difficult to improve existing services or increase access to care.

##### Lack of LGBT Research.

Due to the paucity of research on the LGBT community in general, researchers are in a catch-22 situation in advancing research on our community. Much of the current data on health disparities, access to care and quality of care come from anecdotal or non-representative samples. Without rigorous quantitative and qualitative data from randomized studies and population-based samples, the ability to apply for research funding from federal and other sources continues to be compromised. Much of the current health data available on the LGBT community does not contain analysis of the health status of the different sub-groups that constitute our community (bisexual, transgender, race, ethnicity, geography, disability, age, etc.). Research on bisexuals and transgender/transsexual populations is currently almost non-existent. Many studies that include the lesbian and gay community are unwilling to include transgender issues and rural populations are overlooked with the focus being on large urban areas.

##### Clearinghouse.

LGBT health research would greatly benefit from a national clearinghouse developed to compile LGBT information, documents, research and data for the information that does exist, including university LGBT studies programs. Having a centralized location for this information will facilitate access, dissemination and collaboration. The clearinghouse could widely distribute information via email and the Internet. The clearinghouse could also play a major role in presenting research information in way that is accessible to the general population, to make it useful for communities and community based providers. As part of the clearinghouse, community-based journals modeled after the American Journal of Public Health can be created for LGBT health.

### **c. Strategies to utilize and mobilize existing resources and to fill in the gaps.**

#### Resources.

At the federal level, several strategies were identified to push an LGBT health agenda forward. As mentioned before, the HP 2010 companion document is not only a powerful tool for advocacy but also a valuable resource for writing grants, developing programs and identifying further resources. Though sexual orientation and gender identity are only included marginally in the HP 2010 document itself, this is the first time the LGBT community has been prioritized in the Health and Human Services long-range plan for the nation's health agenda. The document should be used as a lobbying tool to leverage future funding for LGBT health programs and research. A crucial step to ensuring that sexual orientation and gender identity is not removed in the future is to hold DHHS accountable to data collection efforts on the LGBT community. To achieve this, the HP 2010 LGBT Companion Document and the 29 objectives in HP 2010 that include sexual orientation need to be used as tools by LGBT community health advocates when lobbying key public officials.

The National Institutes of Health is also a relatively untapped resource for LGBT health research and programs. Community-based agencies need to familiarize themselves with other funding sources for underserved populations including the National Institutes of Health and the Office of Minority Health. Agencies need training on the best strategies for applying for grants from these institutions. Agencies should also broaden their scope of research to include both qualitative and quantitative studies. Within federal grant programs, community advocates need to lobby for LGBT representation on review panels that allocate funding to different proposals. Additionally, each National Institutes of Health division has an advisory body that sets the research agenda. Individuals on those panels need to be informed of LGBT health issues and pressure should be applied for LGBT representation on those panels.

At the state and local level, advocates should organize for an LGBT presence on advisory boards to major health organizations. Additionally, LGBT representation should be advocated for on state and county task forces charged with improving access to and quality of health care. In doing so, advocates, researchers and health care professionals should review how other groups have organized, to avoid duplicating efforts. Many professional organizations such as the Gay and Lesbian Medical Association, the American Psychological Association, and the American Public Health Association have caucuses or work groups focusing on LGBT health issues. These groups should be brought in to discussions and involved in efforts to lobby for greater research opportunities and funding.

#### Methodology.

Other strategies to harness existing resources and improve the field of LGBT health involve exploring how to accurately collect data on sexual identity, sexual orientation, sexual preferences, bisexuality and gender identity. Studies should use consistent variables to collect this data so results can be compared. Variables also need to be clear about whether or not they are trying to ascertain identity, behavior, emotions, thoughts and fantasies. Methodological discussions need to begin addressing how to collect accurate data on under-researched topics and populations including bisexuals, transgender individuals, people of color, families, children/youth, the disabled, rural communities, low-income individuals, undocumented immigrants and seniors. Members of these under-researched groups need to be at the table when studies are designed through the evaluation process. Also, methodologies should be mindful of the shame or sex phobia people may have when discussing or filling out a survey on sexuality. Many patients are hesitant to disclose their gender identity or sexual orientation in research and clinical settings due to confidentiality concerns. Another methodological barrier offered was that, particularly in community based research settings, many research participants don't feel safe that their participation or input in a study will not affect the services they receive.

A critical methodological issue is the inclusion of macro health determinants such as housing and socioeconomic status in surveys along with LGBT-specific questions. These broad health determinants have been overwhelmingly shown to affect the health of populations and their synergistic interactions with sexual orientation and gender identity need to be better understood. This will provide a better and more accurate picture of the health of diverse LGBT communities.

Finally, it was offered that methodologies should begin looking at unconventional research objectives outside the model of medical pathology and begin to examine topics such as resiliency, community networks and alliances and how they impact health outcomes. Additionally, cross-disciplinary approaches to research can reveal data and information that otherwise may be overlooked.

### Collaboration & Community-Based Research.

The group discussions offered a myriad of input in this area, as well as other breakout discussion areas throughout the day. This strategy was weaved in various discussions. Community-based research initiatives should be explored through collaborative research projects between academic centers, universities, and community based agencies. Collaborative research projects should involve the community at stake from the beginning of the planning process through the evaluation. Research is not carried out in a vacuum and often health issues most relevant to a population are not studied due to lack of communication between the researchers and community members, especially starting in the planning stages. There is a lack of infrastructure for strong communication between researchers and community members. However, close communication between the researchers and community members is necessary to ensure that those who are underserved in the LGBT community are reached or included for participation. Models for collaboration need to be developed with critiques from various minority groups such as LGBT people of color or seniors on the ways in which honest collaborative research can be developed and accomplished. This information needs to be distributed widely and considered in any community-based research project.

Community advisory boards (CAB) should be a core part of any community-based research. The formation and sustained presence of CABs should be facilitated and supported by both researchers and community members. Community members need to take an active role to: 1) review protocols for appropriateness of LGBT research, 2) review questions so that questions are pertinent and relevant to communities, and 3) ensure buy-in and participation from communities that will be impacted.

Collaborative linkages can be made between different research projects at the local, state, or national level to address the problem of small sample sizes often seen in LGBT research. This will provide more representative and generalizable data that can in turn be used to leverage funding for more research.

CABs can also create accountability between community members and researchers and assist with the methodology development, choosing relevant language so accurate information is gathered. They also can assist with the dissemination of results to make sure data returns to community members.

Staff from non-LGBT-specific community based organizations (CBOs) should be asked to be on LGBT CBO advisory boards. This provides an opportunity to identify allies and possible agencies with an interest in collaborative research. Additionally, heads of LGBT agencies and CBOs should participate on non-LGBT specific advisory boards and consumer commissions other than HIV-related bodies.

Health research discussion participants also offered the following model questions for discussion between researchers, academics, and community members when beginning any research initiative:

- Why are LGBT research discussions important for community-based organizations?
- How does the community benefit from the research or evaluation?
- Who should participate in the research and discussion about LGBT research/evaluation?
- How will the research findings be disseminated when the research or evaluation is completed?

Another way of facilitating buy in and collaboration for research from community members is information sharing, or offering and providing articles that are accessible to the general public about the results of a study. This could come in the form of articles written for a community or agency newsletter.

Collaborations with faith-based community agencies should also be included to provide for the establishment of infrastructure through faith-based advisory boards. With the Bush Administration's focus on faith initiatives, the LGBT community should take advantage of the heightened awareness of the role of faith-based programs in the delivery of services. Many LGBT individuals are part of faith communities and can be served through local religious organizations. There already exist many prevention curriculum and other effective health program models established in faith-based agencies.

The local LGBT media is one more important sector that should be further involved in community research collaborations. Agencies can play an active role in increasing participation on editorial boards with a focus on LGBT related health issues. This is another way in which information can be disseminated. The friendly LGBT press is a poorly utilized and untapped community resource. Various LGBT media reach different segments of the LGBT population and can serve as an easy venue for information dissemination.

Researchers should consider collaborations with managed care networks as they pose a great resource for data on the LGBT community. Additionally, researchers should look to non-LGBT health agencies and institutions that are willing to collaborate on studies. Not all members receive care from LGBT health centers. Many receive their care through managed care networks and will be missed in studies only focused on LGBT health centers.

Finally, research institutions should include guidelines and funds to support the involvement of researchers with the communities their research is impacting. Researchers often do not have funds to sustain ongoing communication and collaborations within the communities they are conducting their research. Guidelines and resources should be adjusted to support and enhance community sustained community participation. This is area in which both community-based agencies and researchers can join efforts to advocate and make mention in their communications with research institutions at all levels, on the importance of funding available to promote and enhance research partnerships.

#### Common language.

Often in research partnerships and collaborations, language and professional jargon are significant barriers to collaborative efforts between researchers and community agencies. As a general strategy for inclusion of community members in any forum where research is being discussed, researchers need to avoid jargon and speak plainly to a common denominator, inviting questions for clarification and deeper understanding. Researcher should understand that part of their role is to educate and be educated about the results and impact of the study that is being conducted. Terms and technical or professional jargon may not connect or resonate with folks from various community sectors such as people of color or seniors. Researchers and agency practitioners, when seeking information, need to use language that will establish trust, facilitate understanding and foster collaboration.

In agency-based research, researchers should also frame their proposal in an appealing way for providers and their agencies, demonstrating relevancy and utility. One example of this is being able to relate and include capacity building or program expansion efforts into research initiatives, since research studies can both ascertain the health status of a community, and also be utilized for program development.

### **III. POLICIES IMPACTING LGBT PRIMARY CARE**

#### **A. LGBT health policy presentations**

##### **1. Cornelius Baker, Executive Director, Whitman Walker Clinic, Washington, D.C.**

Cornelius Baker began his presentation by describing the state of national government and the current political climate. Because of the shift in administrations, there isn't much room for negotiation on lesbian, gay, bisexual, and transgender health issues nor civil rights issues. He described the American populace as being a group that tends to vote less "right" or conservatively. However, he described the Democratic Party as being pushed more and more to the right. He stated that in order to move an LGBT health agenda forward, the LGBT community must figure out how to bring in the power of the majority in alignment with our goals. This could be accomplished through strategic alliances and collaborations over specific issues. He expressed the need to define our local agendas first then state and national and to do the local work first. Once there are recorded successes with local officials, these victories can be used to lobby for change at the state then federal level. The agenda we push forward should incorporate both our legislative and philosophical goals.

##### **2. Dr. Suzanne Haynes, Senior Science Advisor, Office of Women's Health, Washington, D.C.**

Dr. Suzanne Haynes started off her presentation by providing strategies on how to approach federal officials and allies. She stated that it would benefit the LGBT community to assume that LGBT health is a part of the Department of Health and Human Services agenda. To educate officials and market LGBT health studies, community health advocates should site all LGBT federal health documents as there are now finally some in existence. In addition to the HP 2010 Companion Document on LGBT Health, and the 1999 Institute of Medicine Lesbian Health Study, other LGBT documents exist and it would be effective for advocates to cite these federally sponsored sources. Additionally, they should refer to the Health and Human Services committee on LGBT health disparities to let other officials know there is a certain level of internal HHS activities occurring around LGBT health. Additionally, numerous association and academic journals, including the American Journal of Public Health, the American Journal of Epidemiology and the American Journal of Psychology have released studies and entire issues documenting LGBT health status and disparities. These studies should be referenced in grant proposals, literature reviews and when speaking with public officials.

Dr. Haynes suggested that, in advocacy efforts and in writing grant proposals, we use terms that are measurable and standardized, and avoid controversial terms that may unnecessarily close doors or invite increased scrutiny. Community jargon that has meaning to advocates may have less meaning for federal funders and can hinder the goal of getting projects and research accepted. For example, LGBT health issues can be framed in "sexual minority" language. This strategy better positions the LGBT community to demonstrate need for funding through Minority Health Research initiatives being set up by the National Institutes of Health. Community advocates should make sure that sexual minorities are a part of this research institute and that LGBT research and program development move forward.

#### **B. Policy breakout discussion proceedings**

The following questions were asked in one afternoon policy breakout session. The group discussed the questions for one hour with 30 minutes per each question.

##### **Policy question 1:**

Considering the current political climate (private, governments, local, state, and federal levels), what approaches and means can be developed and/or utilized to affect and support primary care policies?

##### **Policy question 2:**

What approaches have been successful and/or what opportunities do these political environments create?

## **1. Strategic approaches in health policy to affect and support LGBT primary care.**

The policy afternoon breakout discussion reflected the involved participation of the morning in that policy has already been an overarching issue weaved through the primary care practice and research discussion, as evidenced by the proceedings of these previous areas. This provided for a more broad policy discussion.

In general, participants offered that the LGBT community should take a proactive attitude in working with the federal administration to further an LGBT health agenda. At present, the LGBT community has invaluable resources including the Health People 2010 LGBT Companion Document and the LGBT issue of the American Journal of Public Health to use in beginning discussions with members of the new administration. These tools can be used to help define and clarify a national LGBT health agenda that focuses on elimination of health disparities: parity in funding for services and research, access to care for all communities within the LGBT community and culturally competent care. In pushing an agenda forward, the LGBT community needs to strategize on how to advocate for these policies in the framework of “compassionate conservatism” and decide what can and cannot be compromised.

We need to continue to work within the LGBT community side to protect allies that have supported institutional and infrastructure development (e.g. DHHS Office of LGBT Health) so that we sustain what has been accomplished as we move to further the LGBT policy agenda. It is crucial that advocacy efforts are as much accomplished on the local and state level as they are at the federal level. Local efforts can be used or modeled to further a national agenda. Additionally, grassroots activism at the local level, including constituent visits, can create opportunities to bring allies into local politics and eventually national efforts.

Critical to moving forward with a national LGBT health agenda is the inclusion of the various sectors that constitute the diverse LGBT community. Focusing on inclusion, forging and developing realistic coalitions and alliances with other underserved communities is an effective strategy to begin accessing entitlement based funding. Experts and opinion leaders from these groups should be brought to the table to share information and work to incorporate LGBT health components within existing programs. The LGBT community cannot assume that it already has diverse coalitions to accomplish this work. As a community we need to actively and consistently collaborate and build trusting relationships that enable all of us to address issues of race/ethnicity internally. Without this important internal community work, the work of devising a health agenda for the LGBT community will be incomplete.

The LGBT health leadership infrastructure needs to include people of color experts. LGBT people are underserved and intersect with other ethnic groups. Existing health disparities have more variance based on group experience and levels of oppression and marginalization. Additionally, people of color experts at the helm can help address and help discuss health disparities with groups such as the Congressional Black Caucus and the Congressional Hispanic Caucus. As these groups already significantly address health disparities based on community experience, their assistance stands to significantly assist not only LGBT people of color but also the overall LGBT community.

In addition to focusing on behavior questions, the term sexual orientation needs to be included in our advocacy efforts as it has mental health implications. Sexual orientation and behavior are not mutually exclusive. When using terms such as sexual orientation, the LGBT community needs to consider how language is interpreted or understood since some communities do not identify with the word “gay.” For example, many African-American men don’t identify with the label “gay” and prefer the term “same gender loving.”

As a practical strategy and as the LGBT policy agenda moves forward, community advocates should understand the power of writing letters on letterhead to heads of agencies thanking them for publishing state-of-the-art information on LGBT health. Additionally, community advocates should produce and utilize issue papers and position statements for use at the state and local level.

## **2. Strategic approaches for achieving a successful LGBT policy agenda.**

It is important to be pragmatic when approaching policy making for the LGBT community. Currently, the LGBT community has the history of culturally specific organizations that have organized around health to help guide advocacy efforts. The LGBT community needs allies that are self-identified and also needs to bring grassroots people with them to help educate policy makers, including long-time allies and new policymakers, about LGBT health. The LGBT community needs to utilize legislative ideas and language to speak on behalf of the community. An example of this can be framing LGBT health as a minority health issue and taking advantage of the fact that many legislatures often want to champion “minority” issues. As part of any advocacy effort, the LGBT community would benefit greatly from utilizing the media more globally on health issues to highlight critical health issues and mobilize support. The media should also be used to highlight best practices and programs that are successful in improving health outcomes for the LGBT community.

This is a time to be innovative with advocacy and policy efforts and to focus on what can be achieved. A Republican government should not be automatically assumed to be homophobic. The LGBT community needs to be smart and aware of how to work with this administration and understand that they are seeking conservative voices within ethnic groups and other communities. To a good extent, it should be assumed that LGBT health is a part of the government’s priorities when working to build alliances with federal officials.

## **IV. FUNDING AFFORDABLE PRIMARY CARE FOR LGBT GROUPS**

### **A. Funding LGBT health programs presentations.**

#### **1. Rick Jung, Program Officer, Gill Foundation**

Rick Jung started his presentation off by describing the Gill Foundation and its programs. The Gill Foundation is the largest specifically LGBT foundation in the country and is based in Denver, Colorado. Currently, the Gill Foundation funds about \$1.5 million or less to non-urban areas. The foundation is starting up a people of color initiative covering organizations in urban areas. The initiative will provide technical assistance to people of color organizations and organizations attempting to expand their services to more people of color. He stressed that strategic partnerships between community organizations and foundations are essential. He also expressed the importance of community organizations partnering with each other when applying for funding. Mr. Jung also stated that in order for foundations to fund the most critical programs, they must hear community feedback not only through grant reporting but also through general conversations that inform foundations of the priority issues.

Dr. Nancy Kennedy began her talk by describing two key populations targeted by the Substance Abuse and Mental Health Services Administration (SAMHSA): underserved and vulnerable. Using the definitions from Hash's "Serving a Multicultural Nation," HCFA, 1998: New York Academy of Medicine, underserved people are those who do not receive services to which they are entitled and that are known to improve health (e.g., immunizations); vulnerable people are those for whom there are greater than normal barriers in accessing the health care system (e.g., LGBT, ethnic minority groups).

#### **2. Dr. Nancy Kennedy, Director of managed Care, and Dr. Brad Austin, Senior Program Officer, Substance Abuse and Mental Health Services**

Dr. Kennedy expressed the importance of addressing the entire continuum of health care including prevention, treatment and maintenance when looking at the overall health and wellness of the LGBT community. She then explained the public health model, which consists of three modes of prevention: primary, secondary, and tertiary. Each mode maintains a unique purpose that is implemented with specific activities. The purpose of primary prevention is to prevent an occurrence from happening. This is accomplished through health promotion and education informing individuals of specific protections against deleterious health behaviors. The purpose of secondary prevention is to reduce the duration of ill health. Secondary prevention is implemented through detection and screening for ill health and early diagnosis and treatment. The goal of tertiary prevention is to limit impairment and prevent reoccurrences. This is achieved through rehabilitation and by optimizing the coping skills of the individual and the patient's ability to adjust.

Dr. Brad Austin described the scope of several LGBT health concerns including smoking, alcohol or substance use and coming out issues faced by youth. From the OAS, SAMHSA, National Household Survey of 1990, it was found that 38.1% of lesbians smoked cigarettes as compared to their straight counterparts of whom only 22% smoked (Skinner, W.F., Trilogy Project, AJPH, 1994, 84:8). From the same surveys, 35.4% of gay men were found to be smokers where as 26.1% of straight men were found to be smokers.

In terms of youth coming out, from the 1995 Massachusetts Youth Risk Behavior Survey (YRBS), MA Department of Education, it was found that 47.6% of LGB youth were found to use alcohol heavily or have five or more drinks within the past 30 days. Alternately, only 33.2% of straight youth were found to have heavy alcohol use in the past 30 days. LGBT students were also found to experience a great degree of harassment in school. From the 1993 report, "Making Schools safe for Gay and Lesbian Youth: Report of the MA Governor's Commission," over 97% of lesbian or gay youth heard homophobic remarks from their peers. The 1997 Massachusetts YRBS found that over 31.2% of 4,159 high school students who identified as lesbian, gay or bisexual were threatened or injured with a weapon. Comparatively, only 6.9% of straight youth experienced such threats or injury. Unique problems faced by LGBT youth include homelessness, survival sex and estrangement from parents after revealing their sexual orientation. In 1988, Cramer and Roach found that a high degree of LGBT youth experienced estrangement and detachment from their parents after revealing their sexual

orientation. If rejected by their parents, LGBT youth had a higher risk of becoming homeless (Krucks, 1991) and entering into prostitution (Coleman, 1989). In 1994, Nelson found that roughly 25-40% of homeless adolescents self-identify as gay or lesbian.

Dr. Kennedy and Dr. Austin provided roundtable participants with invaluable information regarding specific SAMHSA resources and initiatives addressing LGBT Issues:

From the Center for Mental Health Services (CMHS):

- Grant: Violence Prevention/Resilience Development School and Community Action Grants: L.A. Gay & Lesbian Center: Safe Haven Project – reduce anti-gay harassment and violence in five high schools of student leaders and victims.
- White Paper: violence against Gay, Lesbian and Bisexual Youth – Dr. Marshall Forestein summarized the existing research on violence against LGB youth and the impact of such violence on the mental health of the victim and his/her family.
- Report: States that Address One or More Cultural Competence-Related Matters in their Managed Care Purchasing Specifications: Gay and Lesbian Care Proficiency – Iowa: substance abuse sector only.

From the Center for Substance Abuse Prevention (CSAP):

- Report: “State of the Science Paper” – Substance Use and Abuse in LGBT Populations, Hughes, T. and Eliason, M.
- Web Pages: LGBT at NCADI  
[www.health.org/features/lgbt/index.htm](http://www.health.org/features/lgbt/index.htm)
- Resource Guide to LGBT Populations – Second edition; available on-line and hard copy.
- Training: Preventive Interventions and Managed Care: Roles in a Changing Health Care System.
- RADAR Site: Lesbian and Gay Community Services Center of New York.

From the Center for Substance Abuse Treatment (CSAT):

- TCE and TCE/HIV Program.
- Recovery Community Support Program – Speak OUT!: LGBT Voices for Recovery.
- The Northwest Regional Workshop: HIV Prevention Approaches for Alcohol and Drug Use among Men who Have Sex with Men.
- Southern California Conference on Stimulant Abuse and Gay Men.
- Methamphetamine: Moving Research Findings into Clinical Practice.
- Methamphetamine Regional Conference (Portland, OR).
- Comprehensive Community Treatment Program: West Hollywood, CA: Friends Research Institute.
- Knowledge application Program (KAP) LGBT Workshop.
- LGBT Internal Task Force.
- GFA Announcements.
- CSAT Guidelines on Accreditation of Opioid Treatment Programs.
- Paper: “Substance abuse Treatment as HIV Prevention for Men who Have Sex with Men” Authors: Shoptaw, S. and Frosch, D.
- TIP 37: Substance Abuse Treatment for Persons with HIV/AIDS.  
An Introduction to Substance Abuse Treatment for LGBT Individuals (2001).

## **B. LGBT funding breakout discussion session proceedings**

The following questions were asked in one afternoon break out session. The group discussed the questions for one hour with 30 minutes per each question.

### **LGBT funding question 1:**

What strategies can be developed or utilized at local, state, federal (private and governmental) levels to identify, access and sustain funds for community clinics, medical practices, county training programs and other health programs that address the needs of the LGBT community?

### **LGBT funding question 2:**

What are the funding external barriers (of grantors, foundations) as well as internal LGBT community barriers to overcome in efforts to identify access and sustain funds for healthcare and health programs for the LGBT community?

## **1. Funding strategies for advancing LGBT health and healthcare.**

### **a. Diversification of funding streams.**

LGBT health organizations and centers should begin to direct efforts and tap into mainstream funding sources. In order to accomplish this, health care providers and advocates need to learn and keep track of various types of federal, state, and local funding that could be used for LGBT health services or health programs. At the federal level there are formula block grants, discretionary and congressional earmarked funds that are available for prevention work, HIV, or other activities that could include LGBT Health. Internally, LGBT health centers and organizations should develop a system that tracks and publicizes grant deadlines and keep a record of which grants funded LGBT health initiatives. LGBT Health Centers, organizations and health organizations should advocate at all levels of government for more direct funding to support LGBT health services, program evaluation, research and infrastructure support. Additionally, health advocates should push for funds to be redirected from mainstream sources such as private insurance, managed care and other sources not specifically geared to LGBT health. These sources of funding should be used in collaboration, when possible, with existing sources to bolster services.

Ideally, agencies should avoid the patchwork or piecemeal approach to funding and attempt to devise a long-range fundraising plan with diversified funding streams that is sustainable over time. A diversified funding approach needs to include non-conventional types and sources of funding including funds that can be donated by corporations such as pharmaceutical companies for infrastructure costs and other sources that are not specifically geared to LGBT health services. Within each agency, leadership should identify and determine the overall legislative philosophical goals and objectives in terms of funding program needs. This type and level of forethought can help sustain the viability of agency programs and healthcare services.

To diversify funding streams and tap into new resources, it is essential to make concerted efforts to think outside of the box and create collaborative partnerships and coalitions focusing on healthcare access for all LGBT community groups. This collaborative approach should be integrated in a strategic plan to diversify at all levels for funding, policy and programming. This plan should be developed and implemented by healthcare coalitions at the national level, local healthcare associations including community clinics and community centers, and various LGBT advocacy and professional community groups and associations. Through organized collaborative efforts, advocacy will more likely be effective.

### **b. Educating donors and funders.**

Prior to applying for funding, agencies should perform an internal assessment of who their clientele is and who does not utilize their services. Performing this assessment will help the agency to better understand the effectiveness of their programs and what the next steps are to either expanding, downsizing or starting new programs. Agencies need to educate funders about the health needs of the LGBT community and demonstrate how they fit in with funder mission, goals and

funding objectives. Before approaching funders, agencies need to have internal dialogue and to educate donors about ethical issues concerning the funding of public health programs. An example of this is corporate sponsorships from tobacco and alcohol of health programs being at odds with public health. Health organizations or centers need to strategize for a diverse balanced approach in corporate sponsorships.

Foundations and LGBT community members and organizations need to educate each other about the language used to describe both programmatic needs and grant applications. LGBT organizations should use this language to describe agency programs and any strategic planning. Foundations also need feedback from the community and need to be educated on the program vision and needs of LGBT centers or organizations. To help funders understand the needs within the LGBT community, it would behoove LGBT community organizations to utilize a common language when describing the work of an organization.

Another important issue that agencies should consider when applying for funding is sustainability of the program or services. Many funders don't provide funds for basic agency infrastructure, making technical assistance a necessity to help agencies continue to develop their infrastructure. As agencies implement their proposals, technical assistance is often required to develop basic information systems (i.e. databases) to continue building their programs or services. It is important to make funders aware of this. For instance, funders can earmark and include proposal monies for evaluation, data tracking and management systems. By including these earmarked funds in the proposal, both the evaluation needs and infrastructure support will be met.

Managed care funds also present another opportunity for LGBT health centers and organizations. To begin tapping into these resources, LGBT centers and clinics should educate themselves about managed care funding. HMOs also stand to benefit from working with LGBT health centers. HMOs could advertise and market their services more specifically to members of the LGBT community. Additionally, working with HMOs also opens the door to discussions about possible collaborations to provide health care services that are LGBT-specific, appropriate and sensitive. The development of LGBT-specific standards of care, risk factors, and assessment protocols needs to be a core part of this discussion. LGBT organizations should target both for-profit health insurance programs as well as free programs while keeping a balanced perspective that health care is a right.



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