AM:STARs
Adolescent Medicine: State of the Art Reviews

LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities

Michelle Forcier, MD, MPH
Joanna D. Brown, MD, MPH
Robert T. Brown, MD

Editors

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LGBTQ YOUTH: ENHANCING CARE
FOR GENDER AND SEXUAL MINORITIES

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LGBTQ YOUTH: ENHANCING CARE FOR GENDER AND SEXUAL MINORITIES

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Preface

LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities

We are very happy to introduce *Adolescent Medicine: State of the Art Reviews: LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities. AM:STARs* continues its effort to update the community on gender and sexual minority health every 10 years.[1,2] This issue of *AM:STARs* covers the health and social well-being of gender and sexual minority youth in the context of the evidence, experience, resources, and culture of today and offers guidance as to how health care providers can best care for this population. We appreciate the time, energy, and expertise that our authors have shared with us. Their work, which is showcased in this volume, provides new information and resources and promotes best practices in a continuing effort to create a culture that recognizes the dignity and integrity of a wonderfully dynamic and diverse community of youth and families.

In 2018, health care providers in the United States face a number of critical health and social issues that affect our patients, families, and professional responsibilities. It is a time of widely swinging views on the meaning of health care as a right or economic privilege and resultant legislative wrangling on how to represent a vast number of competing constituents and stakeholders. It is a time that has seen recent, dramatic shifts in the visibility of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people and the acceptance of LGB rights, culminating in the national legalization of gay marriage in 2015. It is a time during which gender and sexual health services have undergone rapid, transformative changes while still contending with some restrictive, discriminatory responses that seek to limit resources and care. Lastly, sociocultural issues related to privilege, socioeconomic status, race, and ethnicity have become more visible and further demonstrate the confluence of forces that affect the health and indeed the lives of a vulnerable population.

This issue of *AM:STARs* will review optimal primary care for LGBTQ youth and will initiate sophisticated discussions about clinical conundrums, clinical and social paradigm changes, and the present and future situations of gender-affirming surgical care. The authors will review minority stress theory and other psychosocial paradigms that inform language, therapies, and approaches not just to clinical care but also to research, legislation, and advocacy. Some articles will cover the most recent data regarding health risks and review the historically negative health outcomes of which health care providers need to be aware

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when caring for all youth, including LGBTQ youth. Articles on sexually transmitted infections and substance use will review recent trends and data as well as resources to counteract and decrease these comorbidities. Authors reflecting on minority stress and hot topics in mental health provide comprehensive overviews, offer more questions, and most importantly present readers with strategies to promote resilience and strength among youth.

Additionally, we are proud to remember that our gender and sexual minority youth are not just patients providing clinical cases and research outcomes; they are also our children, teens, and young adults living and often thriving despite complex social contexts. Articles on community networking offer resources and tools to work with youth and families outside of the medical setting, promoting healthier communities. Our innovative article on narrative medicine offers a new paradigm and techniques to enhance our interactions with gender and sexually diverse youth, providing a new approach to better hear our patients and thus improve their care. Our authors have looked not just at the literature and evidence but also at our practices, social networks, and communities, taking to heart our obligation to serve as educators, mentors, leaders, and advocates for our gender and sexual minority youth.

We thank you, the reader, for your time and attention, and we hope that this issue of *AM:STARs* both informs and empowers health care providers to engage and advocate for this dynamic and growing youth population. We acknowledge the wisdom from colleagues and advocates who understand and promote intersectionality, including the metaphors and experience that the Reproductive Justice movement gives us to promote self and bodily autonomy, incorporating "issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns."[3] Most of all, we thank our patients, their parents, and the families who inspire us to continue to learn more, to listen to youth, to respect and even celebrate human development with its capacity for individuality and diversity, and to admire and honor the honesty, courage, and humanity our youth and families display, just by being their best authentic selves.

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"Life's not worth a damn
Till you can say, 'Hey world, I am what I am'"

"I Am What I Am" by Jerry Herman from *La Cage aux Folles*

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Primary Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

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INTRODUCTION AND BACKGROUND

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and other youth who have sexual contact with the same sex, comprise a substantial portion of youth as a whole.[1] It is highly likely that any physician or other health care provider (hereafter referred to as primary care clinicians [PCCs]) offering care in a primary care setting to this age group will have the privilege of offering care to the dynamic, diverse, and complex group of LGBTQ adolescents and young adults. Many sexual and gender minority youth struggle with the stigma associated with their identities, and some may, relatedly, engage in high-risk behaviors.[2] Yet LGBTQ youth can be quite resilient and grow to be healthy adults.[3]

The American Academy of Pediatrics and other organizations have issued guidelines for addressing the needs of the LGBTQ population.[1] Yet many PCCs still may not ask about sexual orientation or gender out of lack of comfort or education, or bias; and many LGBTQ youth do not "come out" to their PCCs.[4,5] Although it is not the task of the PCC to ensure every LGBTQ youth discloses their attractions or identity during the clinical visit, PCCs do have an opportunity to make sure they, their office staff and practices, and their clinical processes and procedures make LGBTQ youth feel as welcome and safe as possible in high-quality medical homes.[5]

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Epidemiology

Data regarding sexual orientation, attraction, and behavior are typically self-reported and vary by survey. What is clear is that there are many sexual minority youth throughout the United States. Recent statistics from the National Survey of Family Growth revealed that 19% of young women age 18 to 24 reported any same-sex sexual behavior.[6] Regarding sexual orientation, almost 8% of young adult females reported they were bisexual, whereas just under 2% reported they were homosexual, gay, or lesbian. Among young men age 18 to 24 years, 6.6% reported any same-sex sexual contact. Almost 3% said they were homosexual or gay, and 2.5% reported bisexual identity. Youth risk behavior data from 2015 revealed that, among female and male high school students, 6% identified as bisexual, 3.2% were unsure of their sexual identity, and 2% identified as gay or lesbian.[7] Just under 2% reported having had sexual contact with the same gender only, whereas almost 5% had had contact with both sexes; almost 50% reported no sexual contact.

Population-based data are scant as to the number or proportion of transgender youth. One recent publication extrapolated from data for individuals age 18 and older found that 0.6% of adults identified as transgender and estimated that 0.7% of adolescents between the ages of 13 and 17 (150,000 people) may identify as transgender.[8] Other data suggest about 1% of youth may be transgender.[9]

Behavior and Development

Sexual orientation often does not correlate with sexual behavior. Many female youth who identify as lesbians have had heterosexual sex, and many gay male youth have had sex with women.[1] The trajectories of sexual development vary by gender. Adolescent girls often have same-sex encounters before opposite-sex encounters, at an average of age 14 or 15.[3] Adolescent boys are more likely to have an opposite-sex encounter before a same-sex encounter, with the same-sex encounter occurring at age 13 or 14 on average.[3]

Patient-Centered Medical Homes for LGBTQ Youth

Primary care visits and practices play a central role in meeting the health needs of youth and managing and monitoring their care. The patient-centered medical home (PCMH) is a modern model for high-quality primary care and has received extensive attention over the past 2 decades.[10-12] This framework promotes care that is accessible, high quality, patient- and family-centered, team-based, coordinated, comprehensive, compassionate, continuous, and culturally effective, and is delivered in an atmosphere of trust and mutual responsibility (Table 1).[13,14]

Table 1
PCMHs for LGBTQ youth

PCMH features[a]	Application to care for LGBTQ youth
Accessible	Access can refer to clinical encounters, health-related assistance outside the clinic, and information. Convenience is important (eg, along a bus line), as are evening and weekend hours. There should be as few barriers as possible to making appointments (eg, requiring an immunization record before making an appointment or requiring that parents/guardians bring youth to every visit will limit access). Texting and phone availability can enhance access. Outreach (eg, meeting with school nurses and counselors) or speaking to youth groups in the community are additional ways of optimizing access.
Continuous	Scheduling systems should be in place so that LGBTQ youth (and all youth) see the same primary care clinician (PCC) when they come to the practice and are able to develop a therapeutic relationship over time. This enhances trust and improves quality of care.
Comprehensiveness and team-based	"One-stop shopping" may be particularly helpful for LGBTQ youth (eg, having integrated behavioral health, with counseling and psychiatric prescribing, in the same location as medical care). Other services (eg, social work, sexual/reproductive health education, nutrition counseling) can be brought in depending on the population's needs. The care team should be composed thoughtfully with delineation of patient-care roles. A care coordinator, PCC, nurse, and social worker might make sense for some LGBTQ youth, whereas a psychiatrist or nutritionist might be added for others.
Family- and patient-centered	Every aspect of practice design should be cognizant of patient health needs and preferences. To obtain feedback, physicians should survey adolescents and young adults, including LGBTQ youth, about their health care experiences and satisfaction. Consider organizing LGBTQ focus groups, or bringing in youth and family advisors, to provide input to shape the practice milieu and services.
Coordinated	Although some LGBTQ youth may have few health problems, some may see a number of specialists or have behavioral concerns that require coordination. PCCs and office staff may need to reach out to schools, TGD care physicians, mental health professionals, surgeons, and other specialists. This can be approached systematically but always requires substantial time. Medical home networks often provide enhanced payments to cover the cost of some of this work. Some states have health information exchanges that are helpful in this regard.
Compassionate	Above all, PCCs and office staff must work with each and every LGBTQ youth with the respect, dignity, and caring they deserve.

Continued

Table 1 *Continued*

PCMH features[a]	Application to care for LGBTQ youth
Culturally effective	A number of LGBTQ youth face the added complexity of being part of another minority or another stigmatized group. For example, they may be black or Latino/a, an immigrant, or low-income. Negotiating and coping with these intersecting identities can be especially difficult. Practices and PCCs must be trained and facile in welcoming young people of diverse backgrounds. Posters that display youth of different races/ethnicities, pamphlets in multiple languages, and sliding fees are other measures primary care practices can take.
Quality of care/population management	Many practices create registries to support patients who have specific health needs and to allow for targeted outreach to those who have not been coming in for care. Although it may not make sense to make an LGBTQ registry, registries that track issues that many LGBTQ youth face, such as depression, chlamydia screening, or obesity/disordered eating, will support high-quality care for these patients.

LGBTQ, lesbian, gay, bisexual, transgender, and questioning; PCMH, patient-centered medical home; TGD, transgender and gender diverse.

[a] From American Academy of Pediatrics. The medical home. *Pediatrics.* 2002;110:184-186; and American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf. March 2007. Accessed October 6, 2017.

Terminology

In this article, the term LGBTQ will be used to describe youth who identify as lesbian, gay, bisexual, transgender or gender diverse (TGD), and questioning. The terms YMSM and YWSW will be used to describe young men who have sex with men and young women who have sex with women, respectively. "Sexual minority youth" may be used to describe LGBQ youth, YMSM, and YWSW, whereas "gender minority" may, like TGD, refer to people whose gender is different from the sex into which they were born or who have non-binary gender identities.

Importance of Confidentiality

Confidentiality is a critical component of adolescent health encounters for all youth in creating a safe and supportive environment.[15,16] Some research suggests that for the most vulnerable youth, concerns about confidentiality may be a critical reason for forgoing health care, which suggests that for LGBTQ youth, privacy assurances are particularly important.[17] Provision of confidential services

requires attention to all aspects of a patient's visit, including design of physical space at the front desk and check-in/check-out procedures, electronic health record design, paperwork, office staff training, clinician communication, and billing.[16] PCCs should familiarize themselves with their state's laws regarding confidentiality so that they can accurately convey parameters to patients and families.

The Primary Care Health Maintenance Visit

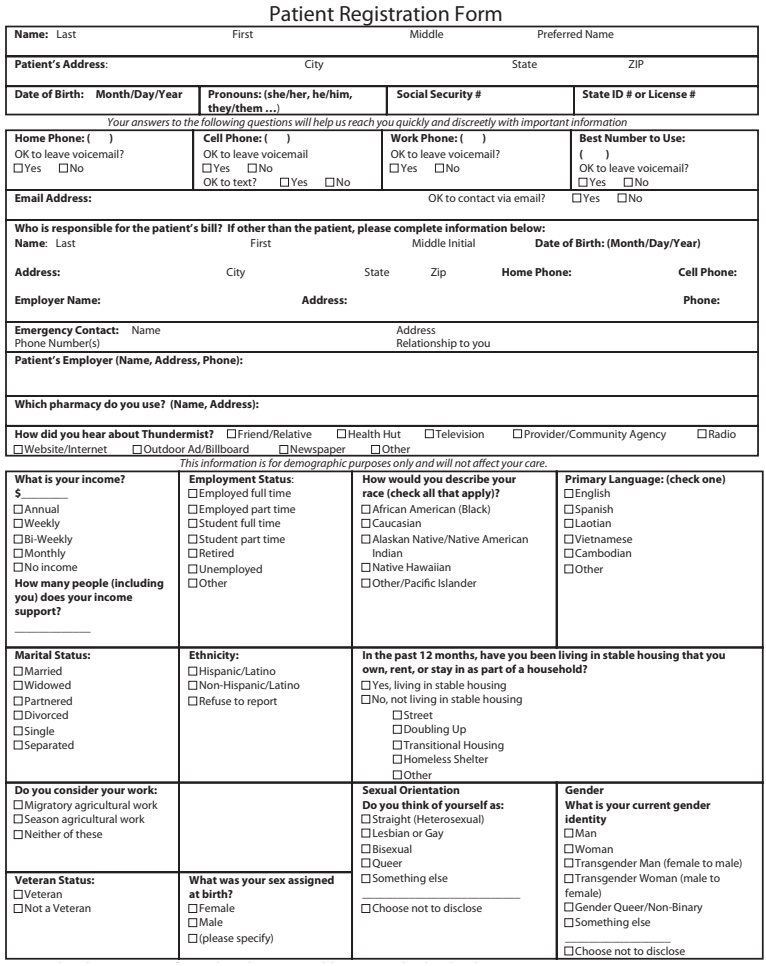
Because health maintenance visits are typically the most comprehensive visits, this article will focus on them. Sections and elements of the guidance provided here apply to acute care and chronic disease management with LGBTQ youth as well. The article will travel, step-by-step, through a clinical visit, starting with the milieu, then the patient interview, the physical examination, screening and laboratory testing, and counseling; it also will address aspects of primary care and medical home provision that extend beyond the in-person encounter. Literature about the health of LGBTQ youth will be integrated into the section on the psychosocial interview to inform the discussion.

THE PRIMARY CARE OFFICE MILIEU

The physical environment of the practice is a reflection of the values of the PCC and the health care organization and can influence a patient's level of comfort before any interaction with the PCC. Therefore, it is crucial to provide nonverbal cues that signal acceptance of diversity. Many organizations, including the Gay and Lesbian Medical Association (GLMA) and Fenway Health, recommend creating and prominently displaying a non-discrimination policy that includes protections for sexual and gender minorities.[18,19] The waiting area and examination rooms should include LGBTQ, youth friendly, and other pertinent materials (eg, educational brochures on topics of homophobia, coming out, safer sex). The office should have single occupancy or gender neutral bathrooms.[20]

A primary care office also can avoid heterocentrism and cisgender bias by offering paperwork and intake forms with demographic categories sensitive to LGBTQ identities and lifestyles (Figure 1). In collecting patient data, practices should include multiple options for gender and sexual orientation and should consider including options for "other" with space for the patient to elaborate.[20] A number of experts and organizations recommend the "2-step" method for obtaining gender data, inquiring about both current gender identity and gender assigned at birth.

An office staffed by sexually and ethnically diverse employees may further encourage patient comfort by reinforcing a commitment to and acceptance of diversity. Primary care practice employees (ie, everyone with whom the patient



Patient Registration Form

Name: Last First Middle Preferred Name

Patient's Address: City State ZIP

Date of Birth: Month/Day/Year | **Pronouns: (she/her, he/him, they/them …)** | **Social Security #** | **State ID # or License #**

Your answers to the following questions will help us reach you quickly and discreetly with important information

Home Phone: ( ) OK to leave voicemail? ☐Yes ☐No

Cell Phone: ( ) OK to leave voicemail ☐Yes ☐No OK to text? ☐Yes ☐No

Work Phone: ( ) OK to leave voicemail? ☐Yes ☐No

Best Number to Use: ( ) OK to leave voicemail? ☐Yes ☐No

Email Address: OK to contact via email? ☐Yes ☐No

Who is responsible for the patient's bill? If other than the patient, please complete information below:

Name: Last First Middle Initial **Date of Birth: (Month/Day/Year)**

Address: City State Zip **Home Phone:** **Cell Phone:**

Employer Name: **Address:** **Phone:**

Emergency Contact: Name Address
Phone Number(s) Relationship to you

Patient's Employer (Name, Address, Phone):

Which pharmacy do you use? (Name, Address):

How did you hear about Thundermist? ☐Friend/Relative ☐Health Hut ☐Television ☐Provider/Community Agency ☐Radio ☐Website/Internet ☐Outdoor Ad/Billboard ☐Newspaper ☐Other

This information is for demographic purposes only and will not affect your care.

What is your income? $_____
☐Annual
☐Weekly
☐Bi-Weekly
☐Monthly
☐No income
How many people (including you) does your income support?
_____

Employment Status:
☐Employed full time
☐Employed part time
☐Student full time
☐Student part time
☐Retired
☐Unemployed
☐Other

How would you describe your race (check all that apply)?
☐African American (Black)
☐Caucasian
☐Alaskan Native/Native American Indian
☐Native Hawaiian
☐Other/Pacific Islander

Primary Language: (check one)
☐English
☐Spanish
☐Laotian
☐Vietnamese
☐Cambodian
☐Other

Marital Status:
☐Married
☐Widowed
☐Partnered
☐Divorced
☐Single
☐Separated

Ethnicity:
☐Hispanic/Latino
☐Non-Hispanic/Latino
☐Refuse to report

In the past 12 months, have you been living in stable housing that you own, rent, or stay in as part of a household?
☐Yes, living in stable housing
☐No, not living in stable housing
☐Street
☐Doubling Up
☐Transitional Housing
☐Homeless Shelter
☐Other

Do you consider your work:
☐Migratory agricultural work
☐Season agricultural work
☐Neither of these

Sexual Orientation
Do you think of yourself as:
☐Straight (Heterosexual)
☐Lesbian or Gay
☐Bisexual
☐Queer
☐Something else
_____
☐Choose not to disclose

Gender
What is your current gender identity
☐Man
☐Woman
☐Transgender Man (female to male)
☐Transgender Woman (male to female)
☐Gender Queer/Non-Binary
☐Something else
_____
☐Choose not to disclose

Veteran Status:
☐Veteran
☐Not a Veteran

What was your sex assigned at birth?
☐Female
☐Male
☐(please specify)

Fig 1. Sample LGBTQ-friendly primary care patient registration form.
LGBTQ, lesbian, gay, bisexual, transgender, and questioning. (Used with permission from Thundermist Health Center, Rhode Island.)

may interact, from parking attendants and custodial staff, to administrative and clinical staff) should be trained and sensitive to LGBTQ issues.[1] Employees should be fluent in gender and sexual orientation terminology.[1,20]

Patient outreach and marketing to LGBTQ-specific media and Web sites, and to community institutions that serve youth, allow sexual and gender minority youth and their families to know that a primary care practice is available and welcoming. For example, the GLMA lists LGBTQ-friendly physicians on a national level.[21] At the local level, physicians should identify and use resources for publicity, coordination of care, and referral.

THE INTERVIEW

The primary objective of the clinical interview is to create a safe, open, honest, and affirming dialogue between the patient and the PCC. Deutsch, in an online resource for TGD care, advocates that PCCs approach each patient with an attitude of "cultural humility" devoid of judgment or preconceptions.[20] Cultural humility promotes a positive rapport, allowing adolescents and young adults to feel comfortable telling their story and disclosing their LGBTQ status if and when they are ready. This approach also facilitates the PCCs' ability to identify strengths as well as health risks.[22]

It is important that the youth have time with the PCC alone without their parent or guardian in the examination room, and that the topic of confidentiality be discussed.[23] If the patient's parent or guardian is in the room at the beginning of the visit, the PCC should, as part of the discussion, explain the importance of confidentiality before excusing the parent/guardian. When communicating with parents and guardians, PCCs should be careful not to "out" adolescents that have not yet disclosed their gender/sexual minority status to them. If the visit begins with the adolescent or young adult alone, the discussion about confidentiality can happen with the patient individually. Such conversations should cover the importance of privacy for high-quality care and limits.[16]

PCCs should explain that they are LGBTQ friendly and, if not yet known, ask the youth's preferred name and pronoun, which may reveal gender minority status. Sexual minority status may come to light later, when sexual health is addressed. PCCs should not make assumptions regarding the adolescent or young adult's lifestyle, sexuality, or gender identity.

To develop trust and comfort, it generally works best to proceed in an interview from less sensitive to more sensitive material. Some start their adolescent/young adult interviews by asking about strengths or activities, eliciting some of the social history early on. Often, though, PCCs will review any chief complaint(s), relevant medical presenting information, and past history before moving to the comprehensive psychosocial interview. One useful method of organization is the "HEEADSSS" assessment format, a mnemonic for *home, education* and *employment, eating,* peer-related *activities, drugs, sexuality, suicide/depression,* and *safety* from injury and violence.[24]

Home

The PCC should determine with whom the adolescent lives and whether the youth feels safe in that environment. If the patient is known to be sexual or gender minority, the PCC may ask if the patient has revealed this information to family and friends and what were their reactions. Adolescents who are LGBTQ are at risk for family rejection, which may lead to homelessness.[1,15,23] These adolescents also