Health Access Initiative

A training and technical assistance program to improve sexual health services for LGBTQ+ youth

ACKNOWLEDGEMENTS

The Health Access Initiative is a project of Michigan Forward in Enhancing Research and Community Equity (MFierce). This curriculum was developed by staff, faculty, and students at the University of Michigan School of Public Health, in collaboration with youth (MFierce Youth Advisory Board), members of community-based organizations and health centers that provide sexual health and other care services to LGBTQ+ youth (MFierce Steering Committee Members), and physicians who provide care to LGBTQ+ youth (MFierce Consultants).

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Dear Community Educator,

While visibility of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) individuals has increased, health inequities continue to disproportionately impact these communities. In Michigan, many LGBTQ+ people face tremendous discrimination, violence, and barriers to life's basic necessities: housing, employment, food, and health care. These social determinants perpetuate health inequities, especially among young, gay and bisexual men and transgender and gender non-binary youth. In response, the MFierce Coalition works to reduce the burden of sexually transmitted infections (STIs) among these communities.

We believe that approaches to addressing complex health issues should come from the communities most impacted. Working collaboratively with LGBTQ+ Youth Advisors, Steering Committee representatives from local community based organizations and the health department, public health practitioners, and physicians who serve LGBTQ+ youth, we created the Health Access Initiative, a free quality-improvement program for health centers and clinics to improve comprehensive, inclusive, and affirming sexual health care for LGBTQ+ youth. This curriculum is just one component of the overall Health Access Initiative program, which focuses on creating structural change by implementing and institutionalizing health-care setting programs, policies, and practices that can be linked to lowering health inequities. Since clients interact with many different staff members when seeking health care, change cannot come solely by training clinical care providers. Instead, we work with whole organizations, training as many staff members as possible, from front desk receptionists and outreach staff to social workers and medical assistants, as well as doctors and nurses. We also support health centers with improving their policies, programs, organizational systems, and other environmental factors through technical assistance after the trainings. After being implemented in ten clinics and health centers throughout Southeast Michigan, we engaged in an extensive feedback and editing process to improve the usability and adaptability of the program. As you implement this in your own communities, we welcome feedback, questions, and stories at healthaccessinitiative@umich.edu.

This training and the pre-requisite webinar, Cultural Humility Practices with LGBTQ+ Youth, evaluation tools, and the accompanying resources are best implemented alongside technical assistance to the sites to assist in identifying and changing or improving site-specific factors that impact care. This curriculum, LGBTQ+ Cultural Humility & Sexual Health Training for Health Center Staff Members, provides seven modules on topics related to LGBTQ+ experiences, client-centered care, and sexual health care. We developed this easy-to-use facilitator's manual and participant booklet to be delivered in a variety of health care settings. The materials can be used in their entirety or as various shortened versions. The interactive training includes modules with individual, partner, and group activities that can be adapted for small or large groups.

In this curriculum, we present a framework of cultural humility, that is, the life-long process of learning, critical self-reflection, and addressing power imbalances. Through this framework, staff members can work to develop and maintain respectful partnerships with patients and clients. The Health Access Initiative encourages participants to commit to being learners and reflective practitioners who develop and maintain respectful partnerships with young people who are seeking care at their facility. As we worked with LGBTQ+ youth, many said this is truly at the heart of providing comprehensive and affirming care.

As always, we welcome feedback, questions, and comments. We look forward to hearing how this program is changing the lives of LGBTQ+ youth with whom you work. Thank you for your dedication to ensuring LGBTQ+ youth have access to comprehensive and affirming care.

In community,

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Accompanying Materials

Webinar, accessible at mfierce.org

Resources created by MFierce, accessible at mfierce.org

HEALTH ACCESS INITIATIVE (HAI) PROGRAM OVERVIEW

The HAI intervention consists of a one-hour webinar and a two-hour in-person training, followed by site-specific technical assistance to improve clinic- and structural-level issues related to LGBTQ+ care.

Pre-requisite webinar – 1 hour
Participants should watch the one-hour webinar, *Cultural Humility Practices with LGBTQ+ Youth.* The webinar covers introduction to cultural humility, gender and sexuality, and LGBTQ+ experiences and terminology. The webinar is available at www.mfierce.org/healthaccessinitiativewebinar.

In-Person training – 2 hours
Module 1: Introduction to Training (Page 11)
Participants will review gender and sexuality concepts and LGBTQ+ terminology.

Module 2: Challenging LGBTQ+ Stereotypes and Biases (Page 14)
Participants will identify and discuss stereotypes of and biases against LGBTQ+ individuals and reflect on how biases impact the care of LGBTQ+ individuals.

Module 3: Patient-Centered Care (Page 19)
Participants will learn LGBTQ+ youth-specific considerations for practicing patient-centered care.

Module 4: Cultural Humility (Page 23)
Participants will review cultural humility concepts.
Participants will discuss cultural humility practices with LGBTQ+ youth patients.

Module 5: 7 Ps for Taking a Sexual Health History (Page 28)
Participants will learn the 7 Ps for taking a comprehensive and affirming sexual health history.

Module 6: Patient-Centered Prevention Counseling (Page 30)
Participants will learn the four main steps of patient-centered prevention counseling.
Participants will observe and discuss a simulated patient-provider interaction.

Module 7: Referrals and Resources (Page 33)
Participants will learn and discuss best practices in creating and maintaining a robust referral and resources system.

Q&A (Page 35)
Participants will have an opportunity to ask additional questions.
Participants may complete a brief training feedback form at this time.

Technical Assistance
Those providing the training portion of the Health Access Initiative should also provide site-specific technical assistance (TA) to participating health centers for a period of several months after the in-person training. TA may be unstructured and tailored to each site's needs, identified through meetings with a site liaison before and after the in-person training. TA may include providing materials related to LGBTQ+ sexual health, such as patient education materials, additional training resources for staff, posters, resources on creating inclusive environments; feedback on program materials or intake forms; and facilitating connections with other clinics and organizations.

PROGRAM DEVELOPMENT

Using principles of community-based participatory research (CBPR) and other community-engaged methods, the MFierce Coalition engaged in a three-year process to develop and implement structural strategies to reduce the burden of STIs on young, gay or bisexual young men and trans youth in Southeast Michigan. The coalition is comprised of LGBTQ+ Youth Advisory Board (YAB) members from the region, faculty and staff from the University of Michigan School of Public Health, and Steering Committee (SC) representatives from community-based organizations and local and state health departments. The Health Access Initiative is a free quality-improvement program for local health centers and clinics that focuses on the provision of comprehensive, inclusive, and affirming sexual health care for LGBTQ+ youth. It has two main components, training and technical assistance (TA). The training includes both an online and an on-site training. Technical assistance should be given for at least two months after the training to provide support to site-specific changes at the clinics. To develop and implement this program, we engaged in several processes:

Research and Community Engagement
Building on years of research and community programs, coalition members shared current epidemiological data in our region and reviewed research on the structural factors shaping HIV and STI disparities and evidence-based program development. To engage the broader communities, the coalition entered a four-month process of hosting 12 community dialogues throughout the region to inform the development of the intervention. Co-facilitated by coalition members, the dialogues engaged 173 participants in participatory activities to discuss community needs and priorities and to inform and provide feedback on potential interventions. Consulting with LGBTQ+ youth community members, program staff at various community-based organizations, representatives from state and local agencies, and other stakeholders, we honed in on several potential projects to address STIs in our communities that were relevant, timely, and feasible for our region. The coalition entered an internal decision-making process to determine our intervention and identified the limited access to comprehensive and sexual health care as one of the major factors driving high HIV and STI rates. From this, we decided to develop and implement the Health Access Initiative.

Development and Implementation
Our Youth Advisory Board and Steering Committee were heavily involved in the program development process. We also consulted with local health care providers and experts in health education, youth development, LGBTQ+ health, client-centered care, and sexual health. After several revisions and feedback from our YAB and SC, we began production of program materials. The one-hour online webinar, *Cultural Humility Practices with LGBTQ+ Youth*, features introductory terminology, concepts, and an overview of LGBTQ+ experiences. We also feature testimonies from our YAB members and local providers on culturally humble care for LGBTQ+ youth, everyday affirming and welcoming practices, and personal stories of youth navigating health care. Our on-site training materials include a high quality facilitator's manual and participant workbook. We have also included dozens of additional resources that were created through the technical assistance process for distribution.

The Health Access Initiative program was implemented in ten sites across our region including local health departments, community health centers, youth-specific health centers, school-based health clinics, pediatric clinics, and a clinic for youth living with or at risk of HIV. The two-hour on-site training was facilitated by a medical doctor, a Masters-level health educator, and a YAB member. YAB and SC

members and program staff observed trainings to provide continuous quality improvement of the trainings, inform the technical assistance process, and garner ideas for potential future interventions.

The technical assistance process took place in the two to three months following a clinic's on-site training to support with changes to policies, programs, practices, and other environmental factors. Staff from the School of Public Health provided TA with the assistance of YAB members. Through this process, staff and YAB members created dozens of high-quality resources for the clinics: resources for staff, resources for clients including palm cards and handouts, LGBTQ+ affirming posters, and digital media resources. One of the sites we worked with serves a large Arab-speaking population, so we worked with an Arabic translator to produce some of our materials in Arabic.

Evaluation

A mixed-methods approach was utilized to evaluate the HAI to understand the intervention's influence on individual and organizational behaviors and the clinic environment. This included a quantitative pre/post survey assessing changes in knowledge, attitudes, and practices, as well as feedback on training sessions, and in-depth interviews with site liaisons. Training feedback surveys and interviews with site liaisons indicate that the HAI intervention is highly feasible and acceptable for a wide range of healthcare settings that serve adolescents and emerging adults with varying levels of experience working with LGBTQ+ youth. Preliminary effectiveness data from the pre/post surveys indicated participating in the HAI was associated with meaningful improvements in providers' and staff's knowledge and attitudes, clinic practices, individual practices, and perceived environment with regard to LGBTQ+ youth. Analysis of in-depth interviews revealed that, overall, sites were satisfied with the TA provided through the HAI, and that it enabled their site to implement a number of environmental and policy changes to create a more welcoming and affirming environment for LGBTQ+ youth. Though additional research examining the long-term effects of the HAI on clinic and health outcomes is warranted, these initial feedings suggest that the intervention holds promise for addressing the needs of diverse clinics.

Revision

After implementation was complete, program staff engaged in a robust revision process to increase the usability and acceptability of the program in various settings. Our revision process included consultation with facilitators, YAB members, and implementation site liaisons, as well as reviewing feedback survey data and observation forms. We made several changes to the on-site training materials including creating optional modules, adapting language, and adjusting activities to suit different time constraints and settings.

Distribution of Materials

We have made our program materials and accompanying resources are available for free on our website, www.mfierce.org. In addition, we worked with the Michigan Social Work Continuing Education Collaborative and the Michigan Public Health Training Center to offer continuing education credits in Social Work, Nursing, and Certified Health Education Specialist for our online webinar. It is our hope that by reducing barriers to high-quality training materials, organizations, health centers, and clinics can improve the care and services they offer LGBTQ+ youth.

SUGGESTED FACILTIATOR QUALIFICATIONS

This on-site training works best with at least two facilitators. We recommend meeting with a liaison from the site where the training will occur to better understand their specific needs. This will inform which sections may need additional or less time.

We recommend a primary facilitator who has experience conducting trainings that address sensitive topics in group settings. This person should also have experience with health education, and knowledge of organizational change. Although not required, those with advanced degrees in public health or social work would be well-equipped to facilitate this training. They must have experience in and be knowledgeable of LGBTQ+ concepts, terminology, health issues, and the social determinants of health that impact LGBTQ+ youth. A high degree of knowledge of and comfort with discussing these topics is a required qualification, since the material presented in this training will stimulate discussion among participants, and the facilitator will need to be able to respond appropriately to questions or issues raised that may not be provided in this manual.

We also recommend including a facilitator who is an experienced clinician, such as a medical doctor, physician's assistant, or nurse practitioner with experience providing sexual health care. They should also be knowledgeable of LGBTQ+ health and have experience providing affirming care to LGBTQ+ youth. There are few medical or nursing programs that offer specialization in LGBTQ+ health. Often times, affirming providers seek additional training and knowledge outside or after schooling and take the time to build long lasting, trusting relationships with LGBTQ+ communities. The clinician facilitator can take the lead on medically-focused modules and answer questions about how to navigate real-world issues in the clinic. It is also helpful for clinicians and clinic staff to hear how other clinicians have been able to integrate these practices into the day-to-day operations at their clinic.

Finally, we strongly recommend the inclusion of LGBTQ+-identified youth in your training as an additional facilitator. This not only helps develop the skills of LGBTQ+ youth but it is helpful to have at least one individual who can directly speak to LGBTQ+ youth experiences. Through this process, we've learned it's also important for participants see youth as experts in their own experience. Depending on prior experiences, youth facilitators may need additional training or feedback.

GUIDE TO USING THIS CURRICULUM

The facilitator's manual is a meant to be a guide. For ease of use, we provide written script the facilitator can follow if they choose. Statements the facilitator should say aloud are written in normal text.

Bolded text is used to help with navigation and readability.

Directions to facilitator will be written in capital letters like STATE, ASK, ALLOW.

Notes to the facilitator are written in italics.

The following icons are used to denote characteristics about the module:

This module should be facilitated by a medical provider.

This module is mandatory.

This activity may lead to discussions that are sensitive in nature.

This module, activity, or questions are optional.

You may need additional time to complete this activity.

This module or activity may be shortened or cut depending on time.

These are suggestions to the facilitator

ADDITIONAL RESOURCES

National LGBT Health Education Center - Fenway Health
www.lgbthealtheducation.org/

Center of Excellence for Transgender Health
http://transhealth.ucsf.edu/

The Trevor Project
www.thetrevorproject.org

American Psychological Association
www.apa.org/helpcenter/sexual-orientation.aspx

Centers for Disease Control and Prevention's STD Treatment Guidelines
www.cdc.gov/std/tg2015/specialpops.htm

Adolescent Trials Network Transgender Resources
https://atnonline.org/public/TransYouthRes.asp

World Professional Association for Transgender Health (WPATH)
www.wpath.org

Health Access Initiative
In-Person Training

Facilitator Manual

Module 1: Introductions (15 minutes)

Objective: *Participants will review gender and sexuality concepts and LGBTQ+ terminology.*

STATE Hello and welcome everyone! My name is ____________________and I'm from_____________. My pronouns are ____________.

Introduce self and position/background/expertise.

ALLOW *Other facilitator(s) and instructor(s) to introduce themselves.*

STATE The main goal of today's training is to learn more about cultural humility practices for health center staff when working with LGBTQ+ youth. For this training, we will discuss:

- Some definitions of LGBTQ related terms
- Stereotypes
- Patient-centered care with LGBTQ youth
- Cultural humility
- Taking a sexual health history

Although parts of this training are focused on sexual health, everyone attending can take away skills and knowledge. Patient-centered care is relevant to all roles in the clinic setting– starting with a patient's first call to the office, through the registration process, in clinic interactions, when checking out, and even during follow-up. Those who are not direct clinical providers can serve as educators or as a resource for new providers and staff. We're happy to have all of you here today since all staff can contribute to improving the lives and health of LGBTQ+ youth.

ASK Any questions before we get started?

For sites that may not have a lot of experience with LGBTQ+ people, read the optional section of the introduction on the next page.

STATE We're going to start by reviewing gender and sexuality concepts and LGBTQ+ terminology, so that we are all on the same page. Just a quick note, these are some of the terms used but language is always evolving and it's okay to not know all the terms. All of us are continually learning.

When I say **LGBTQ+**, I mean lesbian, gay, bisexual, transgender, queer, questioning, and others who are sexual or gender minorities. For the purposes of this training, we'll use LGBTQ+ since it's widely recognized, but you may have also seen other versions of this acronym with fewer letters or other letters added.

We will also use the term **gay and bisexual young men**. You may have heard the term "men who have sex with men" in academic writing or clinical guidelines but in general, this term is not affirming to most people it has been applied to so we won't be using it today.

We use the term **transgender or trans** as an umbrella term for anyone whose gender identity is different from their sex assigned at birth. This may include someone who was assigned male at birth but identifies as a woman, transwoman or genderqueer.

We'll also use the term **gender nonconforming** to refer to people whose gender expression does not fit into society's conventional definitions of masculinity and femininity. Please note that not all gender nonconforming people identify as transgender; nor are all transgender people gender nonconforming.

I will do my best today to spell out all acronyms. If by chance I miss one and you aren't familiar with it, please let me know.

OPTIONAL ADDITIONAL DEFINITIONS

Sexual orientation refers to a person's sexual identity based on who that person is attracted to.

Queer is another term that many people have questions about. It is a broad term that includes people who are not straight and/or cisgender. This word is often used in a positive way by people who identify as queer; however, some people still feel that the word is an insult. It's best not to label others as queer unless they tell you that's how they want to be identified.

Gender identity is a person's deeply felt sense of their own gender. Someone could be female, male, both, neither or any other gender they feel most comfortable with. It's important to recognize that gender identity and expression are separate from sexual orientation, so a person's gender identity or expression does not dictate who they are attracted to.

Gender expression is how someone expresses their gender identity to other people and is often through behavior, clothing, hairstyles and/or voice.

Sex assigned at birth is the sex listed on a person's original birth certificate. This is most often based on physical genitalia present at birth.

Non-binary is a term for people who have a gender identity that isn't male or female. Non-binary people may identify as genderqueer, gender nonconforming or any other gender identity that's not a man or a woman.

Cisgender is a term used for people whose gender identity is the same as their sex assigned at birth. This would include someone who was assigned female at birth and identifies as a woman.

Lastly, **gender affirmation** refers to how some people make changes to affirm their gender identity. These changes can include social, medical and legal changes.

Social gender affirmation can include going by a different name and different pronouns (he/him/his, she/her/hers, they/them/theirs) or wearing different clothes.

Medical gender affirmation involves physical changes that could include puberty blockers, hormones and/or surgery.

Legal gender affirmation includes making legal changes to one's name and gender marker on identity documents. There are many different ways people affirm their gender and there is no right or wrong way to do so.

STATE Before we get started, I'd like to get to know everyone more. I want us to go around the room and state your name, your role (or area of interest) and what pronouns you use. People use pronouns as a way to signify their identity and out of respect, we try as best we can to use the pronouns people identity with. For example, I use ____________. We're all learning together so it's okay if you're unsure how to answer. Please try your best or say skip.

If this is a big group of people, only model pronouns and explain that people use pronouns as a way to signify their identity.

STATE People use pronouns as a way to signify their identity and out of respect, we try as best we can to use the pronouns people identity with. Using the pronouns people identify with communicates respect to that person and their identity. Some people may use she, him, her, hers or them, them, theirs or ze, hir, hirs. If you struggle with pronouns like they, them, theirs or ze, hir, hirs, try practicing them in different sentences, so that you can use them more easily in regular conversation. Some people also add their pronouns to their email signature, so that everyone knows your pronouns. It also normalizes the practice of identifying pronouns.

Module 2: Challenging LGBTQ+ Stereotypes and Biases (20 minutes)

Objectives: *Participants will identify and discuss stereotypes of and biases against LGBTQ+ individuals, begin to process how these stereotypes affect their interactions with LGBTQ+ youth, and reflect on how biases impact the care of LGBTQ+ individuals.*

STATE We will ground our later modules by first discussing how societal stereotypes and biases exist and impact the care of LGBTQ+ individuals. I know stereotypes and biases can be a lot to unpack and we won't be able to tackle it all today. These discussions can sometimes bring up a lot of emotion. If you feel the need to step out, feel free to do so. When I walked into this room today you saw me as [*insert visible identities here*], you have certain stereotypes about me. Some might be positive and some might be negative. We've all learned stereotypes about each other through various ways: maybe our upbringing, education, our current communities, or the media.

A stereotype is a widely held and oversimplified belief of a particular type or group of people. This impacts the way we interact with others because stereotypes can inform biases. A bias is a preference or tendency towards a certain perspective or ideology that conflicts with a person's ability to be unprejudiced.

We learned in the webinar that cultural humility is a process of learning, critical self-reflection, and addressing power imbalances. This is how we will orient ourselves in this training. There are things we will be ready to learn and also unlearn to better serve LGBTQ+ patients. To start, we'll do a few self-reflection exercises to explore how stereotypes and biases impact interactions between health center staff and LGBTQ+ patients.

Each of you have multiple identities or parts of who you are that contribute to your overall identity. I want everyone to think about stereotypes and assumptions that may be associated with your own identities. It can be any aspect of your identity—race/ethnicity, ability, gender, sexuality, ability, citizenship status, age, etc.

We're going to take about a minute and I want you to write down any stereotypes or assumptions you've heard or faced about yourself or the groups you identify with. We've provided you space to write on page 5 of your workbook. Later we'll talk about stereotypes associated with LGBTQ+ youth. We'll start by thinking about some of our own identities to relate how these stereotypes affect us, and later connect this to LGBTQ+ youth clients.

We will talk through some of these stereotypes in a few minutes, but you do not have to share unless you would like to. Does anyone have any questions?

ALLOW *Participants to write down responses for 1 minute.*

ASK Thinking about the stereotypes or assumptions people associate with you or the groups you identify with, if you feel comfortable doing so, raise your hand if you've been discriminated against because of your identity or some aspect of your identity?

ASK If someone is comfortable, could you briefly share how you felt when this happened, or how this affected you?

ALLOW *1-2 participants to share their experiences with the group, without going into too much detail. Provide validation for their responses and thank them for sharing. If no one wants to share, provide examples from your personal experiences.*

STATE Raise your hand if you have delayed going somewhere or delayed dealing with a situation because you anticipate facing discrimination or stereotyping?

Raise your hand if you have totally avoided a situation, person, or place?

Many people develop strategies to deal with overt or more subtle forms of discrimination they face or fear they will face in their lives, which can cause people to delay or avoid situations. For some people this can include delaying or avoiding health care.

Turn to page 6 in your workbook and we're going to do this exercise again, but now I want you to take about two minutes to write down any stereotypes or assumptions you've heard about LGBTQ+ people.

Being aware of these stereotypes and the impact they have is a way to engage with cultural humility. Unfortunately, we live in a society in which stereotypes and assumptions about others are widespread. Regardless of whether we believe these societal stereotypes, they have an impact on all of us.

These are things you've heard and not necessarily things you endorse. Again, we won't ask you to share unless you feel comfortable doing so.

Ok, let's take a couple minutes now to write those down.

ALLOW *Participants to write down responses for 2 minutes.*

ASK Now we're going to get these stereotypes out in the open and address them. Is someone willing to volunteer and share a stereotype they've heard about LGBTQ+ people?

ALLOW *A few participants to share stereotypes one at a time. Challenge each stereotype immediately after it is shared. Utilize your background knowledge and the information listed below to challenge the stereotypes raised by participants.*

ALLOW *Read 3-4 of the stereotypes below, pausing after each one and immediately challenging and dispelling these stereotypes and/or assumptions.*

STATE I'm going to name off a few more.

STATE **STEREOTYPE**: LGBTQ+ people don't want to have/can't have/shouldn't have/don't have children.
CHALLENGE: In reality, many LGBTQ+ people want to and do have children.

STEREOTYPE: Gender nonconforming individuals are confused and it is better for transgender people to present themselves in traditionally feminine or masculine ways.
CHALLENGE: Transgender, gender non-conforming, and cisgender people can express their gender in ways that may or may not conform to our socially constructed ideas of masculinity and femininity. This does not mean they that are confused. Not all transgender people express their gender in traditionally feminine or masculine ways. All people should express their gender in ways that feel most comfortable to them.

STEREOTYPE: LGBTQ+ youth are not religious.
CHALLENGE: LGBTQ+ youth have diverse religious affiliations and beliefs. Although it is true that some LGBTQ+ youth are not religious, for some religion plays a significant role in their lives.

STEREOTYPE: LGBTQ+ youth can choose not to be LGBTQ.
CHALLENGE: Being LGBTQ+ is not a choice. It can be harmful to try to change someone's sexual orientation and/or gender identity. It is also not possible to change another person's identity.

STEREOTYPE: Being transgender is a mental illness.
CHALLENGE: Being transgender is not a mental illness. However, transgender people do experience disproportionate rates of mental health issues such as anxiety and depression due to discrimination and a lack of acceptance.

STEREOTYPE: Gay men are all sexually active and promiscuous.
CHALLENGE: Not all men who identify as gay are sexually active. Promiscuous is a judgmental term and should not be used when talking with patients about their sexual behaviors.

STEREOTYPE: Only white youth are LGBTQ+.
CHALLENGE: Many LGBTQ+ youth are youth of color and they face additional discrimination due to racism and white supremacy.

STEREOTYPE: Bisexuality is a phase, not an identity.
CHALLENGE: As we mentioned in the webinar, bisexual is a sexual orientation identity commonly used by people who are attracted to both people of their same gender and another gender.

STEREOTYPE: STIs are not really a concern for lesbians.
CHALLENGE: Although the risks related to contracting STIs differs based on the type of sexual activity a person engages in, STIs are a concern for all people who are having sex.

STEREOTYPE: Asexual individuals are broken and need to be fixed.
CHALLENGE: Asexual people experience little or no sexual attraction. Asexual people lead healthy and satisfying lives.

STEREOTYPE: It is better for LGBTQ+ youth to be out.
CHALLENGE: It can be dangerous for LGBTQ+ youth to be "out" in certain places and it is never okay for another person to "out" someone who is LGBTQ+.

STEREOTYPE: Coming out is a one-time process.

CHALLENGE: Many LGBTQ+ people come out many times in their lives. LGBTQ+ people may come out at different times with different people and in different situations. Again, it is never okay for another person to "out" someone who is LGBTQ+.

STEREOTYPE: Everyone's sexual orientation and gender identity are 'fixed' and cannot change over their lifetime.
CHALLENGE: People experience both sexual orientation and gender identity in different ways. Some people do experience their sexual orientation and gender identity as fixed, while others experience changes in their sexual orientation and/or gender identity across their life course, which can be referred to as 'fluidity.' This does not make their current or former identity less valid. This change cannot be caused externally; that is, you cannot change someone's sexual orientation or gender identity.

STEREOTYPE: Kids do not really know they are transgender.
CHALLENGE: Although not all transgender people knew from a young age that their gender identity was different from their sex assigned at birth, some people know this about themselves and are able to articulate this to others from a very young age.

ASK We've named some of the stereotypes and assumptions out there. Now let's talk about how these could inform biases against LGBTQ+ youth. How might these impact an interaction between **front desk staff** and LGBTQ+ youth?

ALLOW *1-2 participants to respond*.

STATE *Participant responses. Be prepared to share how stereotypes affect interactions between front desk staff and new patients if participants don't provide responses. For example, if a staff member makes assumptions about a transgender patient and misgenders them, this may cause them to choose not to return for services.*

ASK As the patient moves from the registration area or waiting room to the exam room, how might stereotypes or assumptions impact **patient-provider interactions**?

ALLOW *1-2 participants to respond.*

STATE *Participant responses. Be prepared to share how stereotypes affect interactions between LGBTQ+ youth and their health care providers. For example, if a provider assumes that all gay and bisexual young men are sexually active or thinks they are promiscuous, they may also assume that these young men are only coming in for STI testing.*

ASK How might this impact LGBTQ+ youth's involvement with **programs and other services provided**?

ALLOW *1-2 participants to respond.*

STATE *Participant responses. Be prepared to share how stereotypes and biases affect interactions between LGBTQ+ youth and their health care providers. For example, if a program or service is designed for LGBTQ+ youth with the assumption that most LGBTQ+ youth are white, the service is unlikely to meet the needs of LGBTQ+ youth of color.*

STATE Stereotypes and/or biases about identity groups have a large impact on the way individuals are treated and valued in society, including impacting their health and their ability to access health care. It is important to recognize the stereotypes and biases we hold about others and challenge these stereotypes or biases so they do not impact the quality of care we provide.

ASK Does anyone have any questions or comments?

Module 3: Introduction to Patient-Centered Care (20 minutes)

Objective: *Participants will learn LGBTQ+ youth-specific considerations for practicing patient-centered care.*

If participants at the site you are training have a lot of knowledge on patient-centered care, focus on the issues indicated with the exclamation point icon. Refer all participants to their workbook to see the full list of general patient-centered care considerations.

STATE In this next section, we are going to talk about patient-centered care, specifically patient-centered care with youth populations. When I say patient-centered care, I am referring to care that focuses on the needs, priorities, and experiences of that individual patient. First, we'll talk broadly about things to keep in mind for all youth. Then, we'll talk specifically about LGBTQ+ youth.

On page 8 of your workbook, there is a page titled, "Patient-Centered Care," where you can jot down any notes if you'd like.

Think about your role as a provider, front desk staff administrator, or program director and what you do in order to meet youth's needs.

What things are important to do or keep in mind when providing patient-centered care to young people?

ALLOW *Participants to share aspects of patient-centered care with youth.*

Read only the bold title of each issue below. If there are questions, read the entire definition and elaborate with examples. Make sure to cover: patient priorities, privacy and confidentiality, trauma-informed and inclusive language.

STATE Some of these were mentioned in the webinar testimonials, however we wanted to make sure we covered these topics with you today. A summary of these is provided on page 10 of your workbook.

Understand patient's priorities.
Patient priorities might not be the same as provider priorities. Ask about patient's priorities and take those seriously. Show this through verbal and non-verbal affirmation

Uphold privacy and confidentiality (and limits thereof).
Make policies around privacy and confidentiality clear to the patient, especially regarding parents/guardians. Don't promise confidentiality when you can't provide it. Ask patients what name and pronouns they want a provider to use when talking to their parents/guardians. If patients are on parents' insurance, discuss what will be visible to parents. When possible, offer alternatives.

Participate in shared decision-making.
Involve youth in decision-making about their health.

Create a "no judgment zone".
Communicate to youth that they will not be judged for their behaviors or identities or anything else they share with you during a visit.

Make it easy for youth to share.
There can be many things that are difficult for youth to talk about with their providers. Build trust with youth and create a comfortable environment for them in your clinic.

Reduce barriers to care when possible.
Including assistance with transportation and flexible hours.

Use a trauma-informed approach.
Acknowledge that previous trauma impacts current health outcomes and behaviors. Give patients as much control and choice as possible. Greet patients while they are dressed. Ask before touching a patient. Actively avoid re-traumatization. Explain what you are doing and why.

Use inclusive language.
Use gender neutral pronouns (i.e., they/them/theirs) for everyone until they tell you what pronouns they use. Do not assume the gender of a patient's partner(s).

ASK Are there any questions about these? Is there anything else you would add to this list?

ALLOW *a few additional responses from participants*.

STATE Now we're going to talk specifically about the needs of LGBTQ+ youth. You can use page 9 in your workbook to jot down any notes from this brainstorming.

ASK What are some additional considerations that address the specific needs that LGBTQ+ youth might have when seeking medical or social services? Again, think about your role as a provider, front desk staff, administrator, etc. and what you do to meet the needs of your young LGBTQ+ patients.

ALLOW *Participants to share aspects of patient-centered care*.

STATE Now we'll think about the ways patient-centered care looks like with LGBTQ+ youth. Of course, the practices we just described for youth in general also apply to LGBTQ+ youth. We'll now discuss additional considerations for LGBTQ+ youth.

Read only the bold title of each issue below, then see if there are questions at the end. Use bullets if needed to clarify or summarize. Make sure to cover: impact of overt and subtle discrimination, affirm negative experiences, avoid discriminatory practices, affirm chosen name and pronouns, understand youth may not be out to others.

STATE There is also a summary handout of things to keep in mind when working with LGBTQ+ youth on page 11 of your workbook.

Be aware of the impact of overt and subtle discrimination
Many LGBTQ+ people face discrimination, violence, and invalidation because of their sexual orientation, gender identity, or gender expression. Long history of discrimination and lack of access within medicine and public health. Various forms of discrimination - from interpersonal to structural -lead many LGBTQ+ people to experience housing instability, food insecurity, and economic instability, which all impact health.

Affirm past negative experiences
LGBTQ+ youth may come in with negative expectations and distrust due to previous bad experiences related to their sexual orientation, gender identity or gender expression.
Be ready and willing to affirm those past negative experiences.

Work from an intersectionality framework.
Remember that there is a diversity of experiences and identities within the LGBTQ+ communities. LGBTQ+ people often hold multiple identities, including being people of color, having disabilities, or having a lower SES.

Avoid discriminatory clinic practices and interactions.
Create a welcoming and equitable environment for LGBTQ+ youth. Build trust with LGBTQ+ youth. Develop and implement non-discrimination policies and practices. Don't make assumptions about patients, including about sexuality, gender identity, anything related to sexual activity or lack thereof. This applies to all staff who interact with patients.

Affirm chosen name and pronouns.
Ask about and use patient's chosen name and pronouns. Ask patients in what situation or around whom they would like you to use their chosen name and pronouns. Consider updating your procedures to include space to collect chosen name, gender identity, sex assigned at birth and pronouns. Train all staff who interact with patients and hold them accountable for upholding.

Understand youth may not be "out" to others.
Don't disclose youth's LGBTQ identity without their permission. Recognize that youth may not have support from their families.

When you make a mistake, apologize briefly and move on
If you make a mistake about someone's pronouns, name, or identity, acknowledge the mistake by apologizing briefly and then moving on. Avoid excessive apologizing or explaining to the patient why you made the mistake. Don't put the participant in the role of telling you that it's okay.

Reduce barriers to care when possible.
Barriers to care for LGBTQ+ youth could include access to health insurance, ID requirements, and gatekeeping.

Assist patients in obtaining and/or changing IDs.
This may be especially important for transgender and gender nonconforming patients as well as undocumented patients.

Become knowledgeable about the additional considerations for transgender and gender nonconforming youth.
Become familiar with the informed consent model of care for gender affirmation services. Know where other gender affirmation services and resources exist. Provide these when needed.

ASK What else would you want to add?

ALLOW *A few responses from participants. Clarify when necessary.*

STATE LGBTQ+ youth may face discrimination based on their sexual orientation identity, gender identity and/or gender expression as well as discrimination based on race, ethnicity, socioeconomic status, national origin, age, ability, and religion, among other things.

Be aware that the discrimination LGBTQ+ youth face may not only be due to their sexual orientation identity or gender identity. Avoid discriminatory clinic practices and interactions for all aspects of youth's identity as well.

Next we are going to talk more about how to enact cultural humility principles and patient-centered care in the front desk setting.

Module 4: Cultural Humility (15 minutes)

Objectives: *Participants will review cultural humility concepts. Participants will discuss cultural humility practices with LGBTQ+ youth patients.*

STATE Engaging in cultural humility practices is one way to help ensure you are providing care that is truly patient-centered and respectful of the various identities and experiences of the patients you interact with. The webinar you watched prior to today's training focused on cultural humility practices with LGBTQ+ youth.

ASK Can someone give me a recap of what cultural humility is?

ALLOW A few responses from participants. Clarify when necessary.

STATE **Cultural humility** is the life-long process of learning, critical self-reflection, and addressing power imbalances. It is being lifelong learners and reflective practitioners who develop and maintain respectful partnerships with clients, patients and groups that advocate for others. Cultural humility differs from other culturally-based training frameworks such as cultural competence, because it focuses on self-humility rather than achieving a state of knowledge.

SOURCES: Tervalon & Murray-García, 1998, Journal of Health Care for the Poor and Underserved, 9(2), 117-125. Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. Journal of Counseling Psychology, 60(3), 353-366.

We will explore one way to practice cultural humility with transgender and gender nonconforming youth in this next activity. We'd like you to get into pairs and for the sake of time, please pair up with the person closest to you. Open your booklet to page 14, titled, "Practicing Cultural Humility with Transgender and Gender Nonconforming Youth."

ALLOW *Participants time to open up to the activity.*

STATE This is example of a brief interaction between a patient and front desk or registration staff. We're going to take about five minutes for you to read through the interaction and circle the response from clinic staff that you think are most appropriate for the situation. Keep in mind there are multiple appropriate answers. At the end, we'll talk through each set of responses from clinic staff as a group.

ASK Does anyone have questions?

ALLOW *Participants to write down responses for 5 minutes.*

Clinic interaction activity appears on the following two pages, please continue.

Practicing Cultural Humility with Transgender & Gender Nonconforming Youth

You will have 5 minutes to read through the following interaction and in each yellow box circle the response from front desk staff that you think is most appropriate for the situation.

SOURCE: Adapted version of role-play in "Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front Line Health Care Staff," from the National LGBT Health Education Center, a program of the Fenway Institute.

Front Desk: Good afternoon. How may I help you?

Sarah: Hello. I have an appointment with Dr. Suarez at 1pm.

Front Desk: Your name please?

Sarah: Sarah Banks.

Front Desk:

Circle your choice

1. Hmmm. There's nobody listed by that name.
2. If you're trans, I need to know your actual name.
3. Thank you. (pause) I'm sorry, but I don't have you listed here. Might your appointment be under a different name?
4. Is the name you go by different than what's listed on your insurance?

Sarah: Oh yes. It is probably under my old name. I've changed my name recently, but I guess it isn't in the records yet.

Front Desk:

Circle your choice

1. Okay, I only have a John listed here, but that can't be you. What's your birthdate and address?
2. I have a John listed here for 1pm. If this is your legal name, you should make appointments under this name. What is your birthdate and address?
3. Okay, it must not be. I have an appointment under John. Just to be sure we are using the correct records, would you mind giving me your birthdate and address?
4. Just to be sure I have the right record, what is your birthdate and address?

Sarah: Sure. It is November 1, 1992. I live at 10 Main St. in Durham.

Continue on next page.

Front Desk: Circle your choice	1. Great. Are you still with the same insurance? 2. Great, John. Are you still with the same insurance? 3. Is your insurance the same? 4. Okay, ma'am, is your insurance the same?
Sarah:	Yes
Front Desk: Circle your choice	1. Okay, thank you. I will put a note in your chart that your name is Sarah. I will also let Shavonne, the medical assistant, and Dr. Suarez know. For billing purposes, the insurance records will need to remain under your previous name until you make the change with your insurance yourself. Unfortunately, they won't us do that for you. However, Shavonne can refer you to a website on how to make that change. Do you have any questions? 2. Okay... Mr. Banks. For billing purposes, the insurance will still need to be under your previous name unless you make the change with your insurance yourself. Any questions? 3. Okay, it will be quite difficult to keep the records correct, so when you make appointments here, we'll need you to do that under John so we can avoid this in the future. Do you have any questions? 4. Thanks, Sarah. I'll make a note here to let the medical staff seeing you today know about your name change. For billing purposes, the insurance records will need to remain under your previous name unless you change it yourself. We have a pamphlet on that you can grab in the exam room. Do you have any questions?
Sarah:	No.
Front Desk:	1. Okay, you can have a seat and we'll call you when we're ready. 2. Okay, you can have a seat ma'am. 3. Okay, you can have a seat Mr. Banks. 4. Okay, we'll call you when we're ready Sarah.
Sarah:	Thanks.

STATE Let's read through the scenario and talk about the responses from clinic staff.

As you go through the questions, state the correct answer(s). At the end, you will add additional reflections.

ASK Can someone share what they chose for the first response from clinic staff?

ALLOW *One participant to share their response*.

ASK *Tell me a little bit about why you chose that specific response.*

ALLOW *One participant to share their reasons for choosing the response they chose.*

ASK Did anyone choose something different?

ALLOW *One participant to share their response.*

ASK Tell me a little bit about why you chose that specific response.

ALLOW *One participant to share their reasons for choosing the response they chose.*

STATE Great, let's talk about the next response.

Repeat above questions for all responses in clinic interaction activity.

The three questions below are optional. If you are short on time, skip to the 'STATE' section immediately following these questions.

ASK What else did others see in this scenario that the front desk person did well?

ALLOW *for 1-2 responses.*

ASK How did this interaction affirm the patient's gender?

ALLOW *for 1-2 responses.*

ASK What other phrases did people choose?

ALLOW *for 1-2 responses.*

STATE There are multiple appropriate answers because there are multiple culturally humble ways to enact patient-centered practice. I want to highlight a few things that went on in the scenario:

- In general, it helps to greet people with gender neutral phrases such as, "How can I help you?", "Hi there, what can I do for you?"
- Even if a patient has a stereotypically feminine or masculine name or presents themselves in traditional feminine or masculine ways, using Ms. or Mr. might not be appropriate and should be avoided.
- The front desk person immediately started using the patients self-identified name and used it consistently throughout.
- The front desk person did not convey judgment that this patient goes by a name that is different from the name listed in their record.
- When the front desk person realized there might be an incongruence in the names, they asked for clarity without blaming the patient. Affirming phrases include: "I have the appointment under a different first name. I just to be sure we are using the right records, would you mind giving me your birthdate and current address?", "Could your appointment be under a different name?", "Is the insurance you use associated with a different name?"
- The front desk person assured the patient that they are making a note of their name and that other medical staff would be notified. Make this standard practice at your clinic.

STATE This is not only one way to use cultural humility practices in patient-centered care. There are many other ways to enact cultural humility principles. We'll be discussing more in the next section on taking a sexual health history.

ASK Are there any final thoughts on this activity?

ALLOW *for responses.*

Module 5: The 7 P's for Taking a Patient-Centered Sexual Health History (10 minutes)

Objective: *Participants will learn the 7 Ps for taking a comprehensive and affirming sexual health history.*

This section is most successful when facilitators supplement or elaborate on the 7Ps with their background knowledge and expertise.

STATE In this next section, we'll talk about the 7 P's Approach to obtaining a sexual health history. These P's incorporate many of the concepts of patient-centered care and cultural humility that we have discussed.

Start with an introduction and permission. I might say to my patients: "I have some questions I want to ask you about your sexual health. These next questions are pretty personal and you can tell me if you don't want to answer them. I want you to know I'm not asking these to be nosy, but these questions are very important to your health. It's not my job to judge you, whatever you do is fine, sex is great, but I'd like to talk about what you are doing. Like the rest of our visit, this information is kept confidential. Sound good?" This lets the patient know what I will be doing and why, and prepares them for the conversation we will have about their sexual health.

We don't actually say all the 7Ps to patients. This is a framework for the conversation. The 7 P's stand for: positivity, partners, practices, protection, past history, pregnancy plans, and pleasure. It's important to remember this is a starting point and an example of what a comprehensive visit would look like. If you have limited time with a patient, you need to pick and choose what to say depending what seems to be the most urgent thing for that young person.

Read the definition of each P. Choose 1-2 example statements to elaborate. SOURCE: An adapted version of the Center for Disease Control and Prevention, A Guide to Taking a Sexual History. 2005. Available at https://www.cdc.gov/std/treatment/sexualhistory.pdf.

- **Positivity**: Preface a sexual history with a normalizing statement i.e. approach in a matter of fact, positive manner (which is not the same as encouraging sex). You could say:
    - "Sex and intimacy are normal parts of development"
    - "Whether someone has these desires or not is all okay"
    - "I'd like to figure out what feels good to you"
    - "Wherever you are is okay. Let's talk about it so whatever experience you are having is good and safe."

- **Partners**: Don't assume partner's gender or if a patient is monogamous.
    - "Are you having sex?"
    - "Who are you having sex with?"
    - "Who have you been having sex with lately?"

- **Practices**: This refers to sexual practices. Include discussion of anatomy used when having sex. Use patient's self-identified terminology for their body parts.

"To understand your risk for STIs, I need to know what kind of sex you are having. When you have sex, who does what?"

- **Pleasure**: It's important that people have sex that feels good to them.
  - "Are you having sex that feels good?"
  - "Do you have sex because you want to?"
  - "Do you enjoy sex?"
  - "Does sex feel good to you?"

- **Protection**: This refers to any types of protection the patient uses.
  - "Do you and your partner(s) use any kind of protection against STIs, such as condoms, lube, or other barriers?"
  - "What, if anything, do you use to protect yourself from STIs?"

- **Past History**: This gets at past history of STIs.
  - "When were you last tested for STIs?"
  - "What, if any, STIs have you had in the past?", "Did you receive your results?"
  - "Have any of your partners had an STI?"
  - "Are any of your partners worried they have an STI?"

- **Pregnancy Plans**: Ask about pregnancy plans AND desire. If this applies to the patient and their sexual partners:
  - "Are you and/or your partner(s) hoping or planning on becoming pregnant?"
  - "What are you doing to prevent pregnancy?"

STATE You may need to ask other additional questions, such as, "Do you use alcohol or any drugs when you have sex?", "Do you exchange sex for money, drugs, or a place to stay?"

Keep in mind and use the patient's terminology for their anatomy. Ask the patient if there's anything else that they would like to discuss. Be genuine. Youth are very good at knowing when people are not genuine.

ASK What else would you add? What's been helpful for you in your practice?

ALLOW *a few participants to respond.*

STATE We've included a summary of the 7 P's as well as STI screening guidelines for gay and bisexual young men and transgender people in your workbook on pages 17-20.

The 7 P's are a great way to remember all that providers should ask about when taking a sexual health history. If you aren't already asking about the 7 P's, these questions can be added into your current practices in a way that works best for you. There is a handout in your workbook listing the 7 P's and some suggested ways to bring up each P to your client.

ASK Does anyone have any questions about the 7 P's?

ALLOW *for questions.*

Module 6: Patient-Centered Prevention Counseling (30 minutes)

Objectives: *Participants will learn the four main steps of patient-centered prevention counseling. Participants will observe and discuss a simulated patient-provider interaction.*

Allow for 5-10 minutes reviewing patient-centered prevention counseling, 5 minutes for role-play and 15 minutes for discussion.

STATE After taking a sexual health history, you will have some of the information necessary to conduct patient-centered prevention counseling.

Patient-centered prevention counseling is an interactive, resource-intensive process directed at discussing a person's HIV and STI risk, situations where risk occurs, and personalized prevention strategies. Sometimes this type of counseling is called other things, such as risk reduction counseling or motivational interviewing risk reduction counseling.

To do effective counseling, it is important to use cultural humility practices and rely on the patient-centered care principles discussed earlier. Understanding the patient's priorities and meeting them where they are at while avoiding shaming or moralizing their behaviors will make risk reduction counseling far more effective and build your relationship with that patient.

If you open your booklet to page 22, we've provided you with a summary of recommendations for patient-centered prevention counseling, along with sample language you can use or modify for this purpose.

In general, patient-centered prevention counseling includes four basic steps. I'll read the steps and example language you can use.

1. Explore a menu of options for risk reduction.

- Always ask permission: "I'd like to talk about preventing STIs and what you think will work best for you. Is that alright with you?"
- "Can you share with me what you are doing now or thinking of doing to protect your sexual health?"
- "What's the best way you've found to protect yourself from STIs?"

2. Work with the patient to identify the risk reduction practices they think might work best.

- "If you'd like, I can offer some things that other people do to prevent STIs."
- "Let's say you're willing to try_________. How could you see that happening?"
- "Out of all these options, which do you think might work for you?"
- "Have you heard about PrEP, a pill that can prevent HIV?"

3. Strategize on how to make these risk reduction practices work in the patient's life.

- "What would need to happen to make using/doing __________ easier?"
- "Would it make sense to consider____________?"

- "Are you willing to think about how you might_______________?"

4. Summarize & agree on a plan moving forward.

- "Sounds like you identified ___________ as a way/ways to reduce your risk of STIs. Did I capture that correctly?"
- Let me see if I heard you. You said_______ might work for you. Was that right?
- How are you feeling about __________at this point?
- I'd like to talk about a few resources and referrals that might be useful to you to make these changes. Is that okay?

ASK Aside from the language we've provided, are there other phrases you've found helpful or that you've heard before?

ALLOW *a few participants to respond about their own practices.*

STATE We've offered some sample language because we know it can be difficult to come up with language on the spot. You can also put into your own words.

Patient-centered prevention counseling can be adapted to fit within your current prevention counseling techniques. It is important to remember that youth are more likely to adhere to prevention strategies that work for them and their lives.

STATE Prevention strategies will not be the same for all youth, so talking through this can help you and your patients find strategies that will allow them to stay healthy and prevent HIV and STIs.

ASK Does anyone have any questions before we move on?

ALLOW *for questions.*

Clinic Visit Role-Play Activity

STATE Now we'll put some of these ideas into practice. We'll do a quick role-play that demonstrates some affirming practices when taking a sexual health history and doing prevention counseling. We're only going to take about 5 minutes to demonstrate an abbreviated version of a sexual health history. During the role play, we want you to think about:

- What went well in this interaction?
- What could the provider improve upon?
- What assumptions, if any, were made?
- How did those assumptions affect the interaction?

This is a skill that we are all developing. Please feel free to ask questions and give feedback. This is just one example and it is not the only way to use the skills we have learned. All of you are learning and we, as providers, are also learning. This isn't going to be perfect.

On page 23 of your workbook, there is space to take notes as we role-play a quick sexual health history and prevention counseling interaction. All we know about the patient is their name is Jordan, their pronouns are they/them/theirs, and their gender identity is genderqueer. Remember that this is a shortened version of taking a sexual health history.

This role-play works best if it's improvised, however, the medical provider will call upon their experience taking sexual health histories. It should last for 3-5 minutes. We recommend you practice with another facilitator prior to the training. The medical provider in the scenario should be played by the medical provider facilitator. Jordan can be played by any other facilitator. It must include some elements of the 7 P's and prevention counseling. To guide the role-play, we've provided some key characteristics that should come up during the visit. You can add your own characteristics you wish to highlight.

- *Jorden doesn't have any symptoms*
- *Jordan has oral sex with cis men and trans women*
- *Jordan has anal sex (mostly bottom) with cis men and transwomen*
- *Jordan uses condoms and lube <u>some</u> of the time*
- *Jordan can't afford condoms and lube, partners don't always have them either.*
- *Jordan isn't sure how to talk with partners about using condoms and lube*
- *Jordan has not heard of PrEP*
- *Jordan might be interested in PrEP*

Depending on time, ask some of following de-brief questions after the role-play. Allow time for responses from participants.

ASK What stuck out to you in this scenario?
What went well?
Tell me what you saw that demonstrated aspects of patient-centered care.
How did the provider use the 7 P's?
Which ones did they leave out?
What could the provider improve upon?
What assumptions, if any, were made?

ASK After seeing this, how, if at all, might you change the way you take a sexual health history with youth?

ALLOW *for responses.*

STATE The key take away is that by incorporating the 7 Ps and prevention counseling steps we are able to have more fruitful conversations with patients and ultimately provide more comprehensive care.

ASK Any other reflections?

ALLOW *as many participants to respond as there is time for.*

Module 7: Referrals & Resources (5 minutes)

Objective: *Participants will learn and discuss best practices in creating and maintaining a robust referral and resources system.*

If there is not time to do this module, refer participants to their booklet.

STATE We have about 5 minutes left before we open it up for questions and we'd like to briefly discuss referrals and resource lists for LGBTQ+ youth. Referrals and resources are an important part of patient-centered care. We'd like to offer some recommendations for expanding your referral and resource lists and making them inclusive of LGBTQ+ youth. There are many things that are important to keep in mind when creating or updating your organization's referral or resource list.

- Make sure referral information is up to date, including location, hours, and services.
- Make your referral and resource lists available in multiple forms: paper, online, through text, etc.
- When referring to people to demographic-specific resources, such as support groups, be aware of the demographics of the groups and identity terms people use.
- Periodically recruit LGBTQ+ youth to review current referral lists and give new suggestions. Offer stipends for their time and expertise.
- Include a wide scope of referrals and resources when possible. Lists could include things such as:
    - Health insurance application assistance, including Medicaid
    - Food & housing assistance
    - Gender affirming services and care for transgender and gender nonconforming youth
    - LGBTQ+ friendly and affirming mental health providers
    - Resources on intimate partner violence
    - Transportation assistance

There is a handout on best practices for referrals in your workbook on page 25 that lists additional referrals and resources youth may need.

When you are offering referrals and resources to patients, we always want to ask for permission. One way to say that is, "I'd like to talk about a few referrals that I think might be useful to you. Is that okay?" or "Are you interested in taking home some resources with you?"

There will be times that you do not have or cannot find a referral for something you know your patient needs. In those cases:

- Set a dedicated recurring time (e.g. monthly) to look for new resources: Look online, network with colleagues, check listservs, ask youth themselves.
- Expand the geographic area to refer to places farther away. However, be aware that youth may not have access to transportation.

- For LGBTQ+ youth, offer any referrals that you have to meet that need, but explain the options available might not be LGBTQ+ friendly/inclusive.

ASK Does anyone have any questions about resources and referrals?

ALLOW *for responses.*

ASK Does anyone know of good resources or referral lists that may already be available in your area for LGBTQ+ youth?

ALLOW *for responses.*

Q & A (10 minutes)

***Objectives**: Participants will have an opportunity to ask additional questions. This time may also be used to have participants complete a training feedback form.*

For Q&A, it's helpful to re-direct questions related to LGBTQ+ youth experiences to the LGBTQ+ youth facilitator (if you have one). It is recommended you collect training feedback; the form may be distributed during the Q & A.

STATE We have about 10 minutes left before we pass out feedback forms and would like to take this time for any questions you might have.

ASK Does anyone have any questions about the training content or any questions for the facilitators?

ALLOW Participants to ask questions for 10 minutes.

Distribute feedback survey to all participants during the Q & A.

STATE When you are done with it, please bring it to _____________ who is collecting them. We'll wrap up the Q&A now to allow people some time to complete the feedback form. Before we part, I want to thank you for participating in today's training.

LGBTQ+ Cultural Humility &
Sexual Health Training for
Health Center Staff

Participant Booklet

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Training Overview

1. Introduction to Training
2. Challenging LGBTQ+ Stereotypes and Biases
3. Patient-Centered Care
4. Cultural Humility
5. 7 P's For Taking a Patient-Centered Sexual Health History
6. Patient-Centered Prevention Counseling
7. Referrals and Resources
8. Q & A

Introduction to Training

Challenging LGBTQ+ Stereotypes and Biases

Stereotypes

You will have a couple minutes to write down any stereotypes or assumptions you've heard or faced about yourself or the groups you identify with.

Stereotypes and/or assumptions associated with your own identities

Stereotypes

You will have a couple minutes to write down any stereotypes or assumptions you've heard or faced about LGBTQ+ people.

Stereotypes and/or assumptions associated with LGBTQ+ people

Patient-Centered Care

Patient-Centered Care

Things to keep in mind for all youth.

Patient-Centered Care

Things to keep in mind for LGBTQ+ youth.

Patient-Centered Care for All Youth

Things to keep in mind when providing patient-centered care.

UNDERSTAND PATIENTS' PRIORITIES

- Patient priorities might not be the same as provider priorities
- Ask about patient's priorities and take those seriously
- Show this through verbal and non-verbal affirmation

UPHOLD PRIVACY AND CONFIDENTIALITY AND LIMITS THEREOF

- Make policies around privacy and confidentiality clear to the patient, especially regarding parents/guardians.
- Don't promise confidentiality when you can't provide it.
- Ask patients what name and pronouns they want a provider to use when talking to their parents/guardians
- If patients are on parents' insurance, discuss what will be visible to parents. When possible, offer alternatives.

PARTICIPATE IN SHARED DECISION-MAKING

- Involve youth in decision-making about their health

CREATE A "NO-JUDGMENT ZONE"

- Communicate to youth that they will not be judged for their behaviors or identites or anything else they share with you during a visit.

MAKE IT EASY FOR PEOPLE TO SHARE

- There can be many things that are difficult for youth to talk about with their providers
- Build trust with youth and create a comfortable environment for them in your clinic

REDUCE BARRIERS TO CARE WHEN POSSIBLE

- Including assistance with transportation and flexible hours

USE A TRAUMA-INFORMED APPROACH

- Acknowledge previous trauma impacts current health outcomes and behaviors
- Give patients as much control and choice as possible
- Greet patients while they are dressed
- Ask before touching a patient
- Actively avoid re-traumatization
- Explain what you are doing and why.

USE INCLUSIVE LANGUAGE

- Use gender neutral pronouns (i.e., they/them/theirs) for **everyone** until they tell you what pronouns they use.
- Do not assume the gender of a patient's partner(s).

Patient-Centered Care for LGBTQ+ Youth

Additional considerations when providing patient-centered care to LGBTQ+ youth.

BE AWARE OF THE IMPACT OF LGBTQ+ DISCRIMINATION ON HEALTH

- Many LGBTQ+ people face discrimination, violence, and invalidation because of their sexual orientation, gender identity, or gender expression.
- There is a long history of discrimination and lack of access within medicine and public health.
- Various forms of discrimination - from interpersonal to structural -lead many LGBTQ+ people to experience housing instability, food insecurity, and economic instability, which all impact health.

AFFIRM PAST NEGATIVE EXPERIENCES

- LGBTQ+ youth may come in with negative expectations and distrust due to previous bad experiences related to their sexual orientation, gender identity or gender expression.
- Be ready and willing to affirm those past negative experiences.

WORK FROM AN INTERSECTIONAL FRAMEWORK

- Remember that there is a diversity of experiences and identities within the LGBTQ+ communities.
- LGBTQ+ people often hold multiple identities, including being people of color, having disabilities, or having a lower SES.

AVOID DISCRIMINATORY CLINIC PRACTICES AND INTERACTIONS

- Create a welcoming and equitable environment for LGBTQ+ youth.
- Build trust with LGBTQ+ youth.
- Develop and implement non-discrimination policies and practices.
- Don’t make assumptions about patients, including about sexuality, gender identity, anything related to sexual activity or lack thereof.
- This applies to all staff who interact with patients.

AFFIRM CHOSEN NAME AND PRONOUNS

- Ask about and use patient’s chosen name and pronouns.
- Ask patients in what situation or around whom they would like you to use their chosen name and pronouns.
- Consider updating your procedures to include space to collect chosen name, gender identity, sex assigned at birth and pronouns.
- Train all staff who interact with patients and hold them accountable for upholding.

UNDERSTAND YOUTH MAY NOT BE "OUT" TO OTHERS

- Don’t disclose youth’s LGBTQ+ identity without their permission.
- Recognize that youth may not have support from their families.

Patient-Centered Care for LGBTQ+ Youth

Additional considerations when providing patient-centered care to LGBTQ+ youth.

WHEN YOU MAKE A MISTAKE, APOLOGIZE BRIEFLY AND MOVE ON

- If you make a mistake about someone's pronouns, name, or identity, acknowledge the mistake by apologizing briefly and then moving on.
- Avoid excessive apologizing or explaining to the patient why you made the mistake.
- Don't put the participant in the role of telling you that it's okay.

REDUCE BARRIERS TO CARE WHEN POSSIBLE

- Including access to health insurance, ID requirements and gatekeeping.

ASSIST PATIENTS IN OBTAINING AND/OR CHANGING IDs

- This may be especially important for transgender and gender nonconforming patients as well as undocumented patients.

BECOME KNOWLEDGEABLE ABOUT ADDITIONAL CONSIDERATIONS FOR TRANSGENDER AND GENDER NONCONFORMING YOUTH

- Become familiar with the informed consent model of care for gender affirmation services.
- Know where other gender affirmation services and resources exist. Provide these when needed.

Cultural Humility

Practicing Cultural Humility with Transgender & Gender Nonconforming Youth

You will have 5 minutes to read through the following interaction and in each yellow box circle the response from front desk staff that you think is most appropriate for the situation.

SOURCE: Adapted version of role-play in "Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front Line Health Care Staff," from the National LGBT Health Education Center, a program of the Fenway Institute.

Front Desk: Good afternoon. How may I help you?

Sarah: Hello. I have an appointment with Dr. Suarez at 1pm.

Front Desk: Your name please?

Sarah: Sarah Banks.

Front Desk:

Circle your choice.

1. Hmmm. There's nobody listed by that name.

2. If you're trans, I need to know your actual name.

3. Thank you. (pause) I'm sorry, but I don't have you listed here. Might your appointment be under a different name?

4. Is the name you go by different than what's listed on your insurance?

Sarah: Oh yes. It is probably under my old name. I've changed my name recently, but I guess it isn't in the records yet.

Front Desk:

Circle your choice.

1. Okay, I only have a John listed here, but that can't be you. What's your birthdate and address?

2. I have a John listed here for 1pm. If this is your legal name, you should make appointments under this name. What is your birthdate and address?

3. Okay, it must not be. I have an appointment under John. Just to be sure we are using the correct records, would you mind giving me your birthdate and address?

4. Just to be sure I have the right record, what is your birthdate and address?

Sarah: Sure. It is November 1, 1992. I live at 10 Main St. in Durham.

Continued on next page.

Practicing Cultural Humility with Transgender & Gender Nonconforming Youth

Front Desk:

Circle your choice.

1. Great. Are you still with the same insurance?

2. Great, John. Are you still with the same insurance?

3. Is your insurance the same?

4. Okay, ma'am, is your insurance the same?

Sarah: Yes

Front Desk:

Circle your choice.

1. Okay, thank you. I will put a note in your chart that your name is Sarah. I will also let Shavonne, the medical assistant, and Dr. Suarez know. For billing purposes, the insurance records will need to remain under your previous name until you make the change with your insurance yourself. Unfortunately, they won't let us do that for you. However, Shavonne can refer you to a website on how to make that change. Do you have any questions?

2. Okay… Mr. Banks. For billing purposes, the insurance will still need to be under your previous name unless you make the change with your insurance yourself. Any questions?

3. Okay, it will be quite difficult to keep the records correct, so when you make appointments here, we'll need you to do that under John so we can avoid this in the future. Do you have any questions?

4. Thanks, Sarah. I'll make a note here to let the medical staff seeing you today know about your name change. For billing purposes, the insurance records will need to remain under your previous name unless you change it yourself. We have a pamphlet on that you can grab in the exam room. Do you have any questions?

Sarah: No.

Front Desk:

Circle your choice.

1. Okay, you can have a seat and we'll call you when we're ready.

2. Okay, you can have a seat ma'am.

3. Okay, you can have a seat Mr. Banks.

4. Okay, we'll call you when we're ready Sarah.

Sarah: Thanks.

7 P's for Taking a Sexual Health History

The 7 P s to Sexual Health History Taking

Positivity ***"Sex and intimacy are normal parts of development" "Whether someone has these desires or not is all okay" "I'd like to figure what feels good for you" "Wherever you are is okay. Let's talk about it so whatever experience you are having is good and safe."*** (Approach in a matter of fact, positive manner)

Partners ***"Are you having sex?" "Who are you having sex with?" "Who have you been having sex with lately?"***(Don't assume partner's gender. Don't assume patient is monogamous.)

Practices ***"To understand your risk for STIs, I need to know what kind of sex you are having. When you have sex, who does what?"***(Include discussion of anatomy used when having sex. Use patient's self-identified terminology for their body parts.)

Protection ***"Do you and your partner(s) use any kind of protection against STIs, such as condoms, lube, or other barriers?" "What, if anything, do you use to protect yourself from STIs?"***

Past History ***"When were you last tested for STIs?" "What, if any, STIs have you had in the past?" "Did you receive your results?" "Have any of your partners had an STI?" "Are any of your partners worried they have an STI?"***

Pregnancy Plans Ask about pregnancy plans **AND** desire. If this applies to the patient and their sexual partners: ***"What are you doing to prevent pregnancy?" "Are you and/or your partners hoping or planning on becoming pregnant?"***

Pleasure ***"Are you having sex that feels good?" "Do you have sex because you want to?" "Do you enjoy sex?" "Does sex feel good to you?"***

SOURCE: An adapted version of the Center for Disease Control and Prevention, A Guide to Taking a Sexual History. 2005. Available at https://www.cdc.gov/std/treatment/sexualhistory.pdf.

Taking a Sexual Health History

WITH ALL YOUTH:

Use understandable & non-judgmental language. Avoid overally technical terms or biased statements.

Use normalizing language. This means that you should use statements that normalize a range of behaviors. Ex. "Some patients here have difficulty with xyz. How is it for you?"

When possible, ask open-ended questions. As much as possible, or when it makes sense, ask questions that cannot be answered with a simple yes or no.

Reassure youth when they share about their sexual behavior. Youth may need reassurance and support from providers when talking about sex.

Be sex positive! Youth may feel embarassed or ashamed about their sexual behaviors. Let them know all kinds of sex, when consensual, can be healthy and feel good.

STI SCREENING GUIDELINES for Gay & Bisexual Young Men

The following screening tests should be performed at least annually for sexually active gay or bisexual men including those living with HIV. If people are considered at higher risk for STIs or HIV, testing should occur every 3 to 6 months for most STIs.

Chlamydia

- At least annually for sexually active gay or bisexual men at sites of contact (urethra, rectum) regardless of condom use
- Every 3 to 6 months if at increased risk

Gonorrhea

- At least annually for sexually active gay or bisexual men at sites of contact (urethra, rectum, pharynx) regardless of condom use
- Every 3 to 6 months if at increased risk

Syphilis

- At least annually for sexually active gay or bisexual men
- Every 3 to 6 months if at increased risk

Herpes

- Type-specific serologic tests can be considered if infection status is unknown in gay or bisexual men with previously undiagnosed genital tract infection

HIV

- At least annually for sexually active gay or bisexual men if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test

Hepatitis B Screening

- All gay or bisexual men should be tested for and vaccinated against Hep B

Hepatitis C Screening

- Annual HCV testing in gay or bisexual men with HIV infection
- Other gay or bisexual men if risk factors are present

STI SCREENING GUIDELINES for Transgender People

Current guidelines recommend that providers should assess STD- and HIV-related risks for their transgender patients based on current anatomy, sexual behaviors, partners, and substance use. Because of the diversity of transgender people regarding surgical affirming procedures, hormone use, and their patterns of sexual behavior, providers must remain aware of symptoms consistent with common STDs and screen for asymptomatic STDs on the basis of behavioral history and sexual practices. Recommendations for management of confirmed STIs does not differ from those for non-transgender people. Screening intervals should be based on risk, with screening every three months in individuals at high risk (multiple partners, condomless sex, transactional sex/sex work, sex while intoxicated).

SOURCES

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR Recomm Rep 2015;64(No. RR-3): 1-137.

Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at www.transhealth.ucsf.edu/ guidelines.

National LGBT Health Education Center, The Fenway Institute, National Association of Community Health Centers. Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers; November 2015 edition. Available at http://www.lgbthealtheducation.org/wp-content/uploads/COM-827-sexual-history_toolkit_2015.pdf

Patient-Centered Prevention Counseling

Patient-Centered Prevention Counseling

Patient-centered prevention counseling is an interactive, resource intensive process directed at discussing a person's STI risk, situations where risk occurs, and personalized goal-setting strategies.

It is most effective when it is empathetic and appropriate to the patient's culture, language, sexual orientation identity, sexual behaviors, gender identity, age, ability, and developmental level.

1. **Explore a menu of options for risk reduction.**
   - Always ask permission: I'd like to talk about preventing STIs and what you think will work best for you. Is that alright with you?
   - Can you share with me what you are doing now or thinking of doing to protect your sexual health?
   - What makes that feel like a good fit in your life?
   - Tell me about some things you think might work for you.
   - What's the best way you've found to protect yourself from STIs?
   - What have you tried?
   - You said condoms didn't work well for you. Tell me more about why that is.
   - I think it's great you are already doing ________.

2. **Work with the patient to identify the risk reduction practices they think might work best.**
   - If you'd like, I can offer some things that other people do to prevent STIs.
   - Let's say you're willing to try ________. How could you see that happening?
   - Out of all these options, which do you think might work for you?
   - I can give options, but what you decide to do is up to you.

3. **Strategize on how to make these risk reduction practices work in the patient's life.**
   - What would need to happen to make using/doing _______ easier?
   - What issues do you think might come up?
   - Would it make sense to consider ________?
   - Are you willing to think about how you might ________?

4. **Summarize and agree on a plan moving forward.**
   - Sounds like you identified ________ as a way/ways to reduce your risk of STIs. Did I capture that correctly?
   - Let me see if I heard you. You said ________ might work for you. Was that right?
   - Of the things we have discussed, is there a strategy you are willing to try between now and the next time we meet?
   - It's great that you are thinking about ________.
   - How are you feeling about ________ at this point?
   - Where does all this leave you?
   - What do you think you'll do?
   - What other questions do you have?
   - I'd like to talk about a few resources and referrals that might be useful to you to make these changes. Is that okay?

Sexual Health History & Prevention Counseling Role Play

During the role-play, please think about...

What went well in this interaction?

What could the provider improve upon?

What assumptions, if any, were made?

How did those assumptions affect the interaction?

Did the provider ask about all 7Ps?

Anything else you noticed?

NOTES:

Referrals and Resources

Referral Best Practices

Referrals and resources are an important part of patient-centered care. Here are some recommendations for expanding your referral and resource lists and making them inclusive of LGBTQ+ youth.

Things to keep in mind:

- Make sure referral information is up to date (location, hours, services).
- Make your referral list available in multiple forms: paper, online, text, etc.
- When referring people to demographic-specific resources, such as support groups, be aware of the identity terms people use.
- Periodically recruit youth to review current referral lists and give new suggestions. Offer stipends for their time and expertise.
- Include a wide scope of referrals when possible. Lists could include things such as:
    - Health insurance application assistance, including Medicaid
    - Food & housing assistance
    - Gender affirming services and care for transgender and gender nonconforming youth
    - LGBTQ+ friendly and affirming mental health providers
    - Resources on intimate partner violence
    - Transportation assistance

Other referrals or resources youth may need are: Translation services, legal assistance, immigration services, disability services, childcare services, spiritual or religious groups, professional development, internship opportunities, educational opportunities such as, scholarships and mentorship, and financial assistance.

There will be times that you do not have or cannot find a referral for something you know your patient needs. In those cases:

- Set dedicated time to periodically look for new resources: Look online, network with colleagues, check list serves, ask youth themselves.
- Expand the geographic area to refer to places further away. However, be aware that youth may not have access to transportation.
- For LGBTQ+ youth, offer any referrals that you have to meet that need, but explain the options available might not be LGBTQ+ friendly/inclusive.

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