



**Advancing Effective Communication,
Cultural Competence, and
Patient- and Family-Centered Care**

*for the Lesbian, Gay, Bisexual,
and Transgender (LGBT) Community*

A Field Guide

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The Joint Commission Mission

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INTRODUCTION

The role of effective communication and patient-centeredness in providing safe and high-quality health care to diverse patient populations is well accepted. Effective patient–provider communication has been linked to an increase in patient satisfaction, better adherence to treatment recommendations, and improved health outcomes.¹ Patient-centered care “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.”² (p.48) Combining the elements of effective communication and patient-centeredness into care delivery has been shown to improve patients’ health and health care.³

Many resources and initiatives have been devoted to assist hospitals in efforts to advance cultural competence, improve communication, and provide equitable and more patient-centered care to several diverse patient populations. However, until recently, patients who are lesbian, gay, bisexual, and transgender (LGBT) have been an often overlooked community of health care consumers.

LGBT people and their families reside in every county in the United States. The LGBT community is as diverse as the nation and includes members of every race, ethnicity, religion, mental capacity, physical ability/disability, age, and socioeconomic group.⁴ Although estimates vary, approximately 3.5% of American adults identify as lesbian, gay, or bisexual, while 0.3% are transgender.⁵ Not only do the members of this community share the health concerns of the rest of the population, they also face a number of significant additional health risks.

Like many other populations identified as at-risk or disadvantaged, research has

demonstrated that LGBT individuals experience disparities not only in the prevalence of certain physical and mental health concerns, but also in care due to a variety of factors, including experiences of stigma, lack of awareness, and insensitivity to their unique needs.⁶ These disparities include the following^{7–9}:

- Less access to insurance and health care services, including preventive care (such as cancer screenings)
- Lower overall health status
- Higher rates of smoking, alcohol, and substance abuse
- Higher risk for mental health illnesses, such as anxiety and depression
- Higher rates of sexually transmitted diseases, including HIV infection
- Increased incidence of some cancers

In addition, LGBT patients face other barriers to equitable care, such as refusals of care, delayed or substandard care, mistreatment, inequitable policies and practices, little or no inclusion in health outreach or education, and inappropriate restrictions or limits on visitation.⁹ These inequalities may be even more pronounced for LGBT people from racial/ethnic minorities¹⁰ or due to other characteristics such as education level, income, geographic location, language, immigration status, and cultural beliefs. Experiences of discrimination and mistreatment have, in many cases, contributed to a long-standing distrust of the health care system by many in the LGBT community and have affected their health in profound ways.⁶

Many groups have worked to increase awareness and focus efforts at the national, state, local, and organization levels to better understand the health care needs of the LGBT community, the persistence of stigma and discrimination, and the need for more data and

A Note About Terminology

While each letter of the acronym *LGBT* refers to a distinct population with unique needs, this field guide uses *LGBT* as an umbrella term to refer to the community as a whole. *Lesbian, gay,* and *bisexual* refer to sexual orientation—*transgender* refers to an individual’s gender identity or gender expression. Transgender is used in this guide to refer to individuals whose gender identity or gender expression differs from their assigned sex at birth or any prevailing ideas of masculinity or femininity (see “Terminology” in this section and the Glossary for expanded definitions).

information about LGBT population health and practices. Although this work has resulted in recent federal, state, and local initiatives and recommendations that are designed to obtain more information and to improve the care provided to the LGBT population (see Appendix C, “Laws, Regulations, and Executive Materials,” page 51), we cannot afford to wait for these recommendations to take hold before we begin to address the needs of LGBT patients and families. In the health care setting—an environment that is already a source of considerable fear, stress, and anxiety—LGBT patients today too often bear the additional burdens of discrimination and feeling unwelcome, vulnerable, and invisible.¹¹ Fortunately, there are practices and strategies that health care providers and hospitals can implement to begin building trust and making the health care environment more welcoming, inclusive, and safe for LGBT patients and their families.

To ensure quality care, all patients, regardless of social or personal characteristics, should be treated with dignity and respect in health care settings and should feel comfortable providing any information relevant to their care, including information about sexual orientation and gender identity. This field guide is a compilation of strategies, practice examples, resources, and testimonials designed to assist hospital staff in improving quality of care by enhancing their efforts to provide care that is more welcoming, safe, and inclusive of LGBT patients and families.

About The Joint Commission

Since its inception, The Joint Commission has promoted nondiscrimination in patient care and every day works toward fulfilling the vision that “all people always experience the safest, highest quality, best value health care across all settings.”¹² The Joint Commission continually strives to better understand the

needs of individual patients and populations as they relate to health care disparities and to provide guidance for hospitals as they attempt to provide patient- and family-centered care.¹³ Many initiatives and efforts have been made, past and present, toward this end (see Table 1-1, “Time Line: Joint Commission Efforts Past and Present,” on page 3).

In 2011, new and revised standards designed to promote patient-centered communication were published in the Joint Commission’s *Comprehensive Accreditation Manual for Hospitals* (see Appendix B, page 41). The patient-centered communication standards include revised elements of performance that prohibit discrimination based on sexual orientation, gender identity, and gender expression, and that ensure access to a support person of the patient’s choice, which are critical issues to the LGBT community. In addition to the revised standards, The Joint Commission published *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* in August 2010. This comprehensive document is intended to inspire hospital staff to integrate concepts from the fields of communication, cultural competence, and patient- and family-centered care into organizations. The *Roadmap for Hospitals* contains recommendations specific to the LGBT population, including an inclusive definition of *family*, and also provides resources related to the care of LGBT patients.¹³

Although Joint Commission standards and *A Roadmap for Hospitals* are designed to encompass many salient issues in LGBT health care, the need to provide more information, guidance, and education to health care organizations to address specific LGBT issues was apparent. In January 2010, with funding from The California Endowment, The Joint Commission began to build on its efforts

Table 1-1. Time Line: Joint Commission Efforts Past and Present

2003	In 2003, The Joint Commission conducted a gap analysis of its accreditation standards in comparison to the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS). The results indicated that although there were many Joint Commission standards that addressed the issues highlighted in the CLAS standards, the requirements were less prescriptive.
2004	The Joint Commission, with funding from The California Endowment, began the Hospitals, Language, and Culture: A Snapshot of the Nation (HLC) study in 2004. The HLC study was a qualitative cross-sectional research project that explored how 60 hospitals nationwide provide care to culturally and linguistically diverse patient populations.
2005	As part of a public policy initiative, The Joint Commission convened a Health Literacy and Patient Safety Roundtable in 2005. The Roundtable resulted in the publication of the white paper, <i>What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety</i> . This white paper presented recommendations and interventions to improve patient understanding of complex medical information for individuals with low health literacy or limited English proficiency (LEP).
2007	The HLC study released its first research report in March 2007, <i>Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings</i> . The report provided insight into the challenges, activities, and perspectives of hospitals and contained recommendations for hospitals, policymakers, and researchers to improve care to diverse populations. Findings are presented within the context of a research framework, which includes the following domains: leadership, quality improvement and data use, workforce, patient safety and provision of care, language services, and community engagement.
2007	The Joint Commission received funding from The Commonwealth Fund to examine the characteristics (for example, impact, type, causes) of adverse events for LEP and English-speaking patients. Based on adverse event data from six Joint Commission-accredited hospitals, LEP patients were more likely to experience adverse events with detectable harm than English-speaking patients. The adverse events experienced by LEP patients were also more frequently caused by communication errors than for English-speaking patients. This study was published in the February 2007 <i>International Journal for Quality in Health Care</i> in an article titled "Language proficiency and adverse events in U.S. hospitals: A pilot study".
2008	The second HLC report, <i>One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations</i> , presented current practices that hospitals are using to provide care and services to diverse patients. This report, released in April 2008, includes a self-assessment tool that organizations can use to initiate discussions about their needs, resources, and goals for providing the highest quality care to every patient served.
2008	In 2008, The Joint Commission, with funding from The Commonwealth Fund, began the development of accreditation requirements for hospitals to advance the issues of effective communication, cultural competence, and patient- and family-centered care. The project was designed to improve the safety and quality of care for all patients through new and revised accreditation requirements and to inspire hospitals to adopt practices promoting patient-centered communication.
2009	In October 2009, The Joint Commission's Standards and Survey Procedures Committee of the Board of Commissioners approved new and revised standards for patient-centered communication. The patient centered standards are discussed in Appendix B.
2010	The Joint Commission published a monograph to help hospitals integrate communication, cultural competence, and patient- and family-centered care practices into their organizations. The monograph, titled <i>Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals</i> , was supported by a grant from The Commonwealth Fund. In September of 2010, with funding from The California Endowment, The Joint Commission convened a panel of stakeholders to discuss the promotion of effective communication, cultural competence, and patient- and family-centered care specifically to the lesbian, gay, bisexual, and transgender (LGBT) community.
2011	The patient-centered communication standards were published in the <i>2011 Comprehensive Accreditation Manual for Hospitals (CAMH)</i> . Surveyors began evaluating compliance with these standards in January 1, 2011, but findings were not factored into an organization's accreditation decision until July 1, 2012. However, elements of performance 28 and 29 under RI.01.01.01, which require access to a support person and non-discrimination of care, had an earlier implementation date of July 1, 2011. The Joint Commission released another monograph, <i>Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community</i> based on recommendations from the September 2010 convening. The development of the monograph was supported by The California Endowment.

to promote health equity and patient-centered care, focusing specifically on the needs and concerns of LGBT patients. This field guide is a product of this project, and its development is described below.

Development of the LGBT Field Guide

To better understand the needs of LGBT patients, several professional associations, key stakeholders, and advocacy groups in the area of LGBT health care were invited to convene for a one-day LGBT stakeholder meeting (see “Expert Advisory Panel” in the Acknowledgments section, page v). The goal of the meeting was to identify and discuss how to advance effective communication, cultural competence, and patient- and family-centered care specifically for the LGBT community. The *Roadmap for Hospitals* was used as a framework for the discussions. Participants were asked to build upon recommendations and practice examples in the *Roadmap for Hospitals* and tailor these with specific suggestions and strategies geared toward the unique health needs and concerns of those in the LGBT community. Recognizing that a hospital’s ability to advance these issues rests on its state of organizational readiness, participants were asked to categorize strategies and recommendations within the context of the following five domains*:

- Leadership
- Provision of Care, Treatment, and Services
- Workforce
- Data Collection and Use

* The domains for the *Roadmap for Hospitals* were created by incorporating elements from the following frameworks: The Joint Commission’s “Hospitals, Language, and Culture Framework,” the American Medical Association’s *Ethical Force Program™ Consensus Report: Improving Communication—Improving Care*, the National Quality Forum’s *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency*, the National Research Corporation (NRC) Picker’s “Eight Dimensions of Patient-Centered Care,” The Commonwealth Fund’s attributes of patient-centered primary care practices, and Planetree’s acute-care components of the Planetree Model.

† Many of the terms were adapted from the Institute of Medicine’s *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington, DC: National Academies Press, 2011). See also references in the Glossary.

- Patient, Family, and Community Engagement

Information from the meeting was synthesized, and strategies were expanded and augmented by recommendations from current research, literature, and professional groups, as well as environmental, legal, and regulatory trends. In addition, testimonials and examples were collected from a variety of sources to inform the development of this field guide.

Terminology†

An expanded Glossary of terms is included at the end of this field guide. Knowledge of the following frequently used terms is important to understand the recommendations and strategies identified throughout this guide.

LGBT

The acronym LGBT stands for lesbian, gay, bisexual, and transgender and is an umbrella term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation (also, LGBTQ and LGBT community) (see the Glossary for expanded definition).

Sexual Orientation

The preferred term used when referring to an individual’s physical and/or emotional attraction to the same and/or opposite gender. Sexual orientation describes how people locate themselves on the spectrum of attraction. Someone who feels a significant attraction to both sexes is said to be bisexual. A man entirely or primarily attracted to men is said to be gay, and a

woman entirely or primarily attracted to women is said to be lesbian (see the Glossary). It is important to note that sexual orientation, which describes attraction, is distinct from gender identity or gender expression.

Gender Identity

One's basic sense of being male, female, or other gender (for example, transgender or gender queer). Gender identity can be congruent or incongruent with one's sex assigned at birth based on the appearance of external genitalia.

Gender Expression

Characteristics in appearance, personality, and behavior, culturally defined as masculine or feminine.

Transgender

People whose gender identity or gender expression differ from their birth sex or prevailing ideas of masculinity and femininity are often called transgender. Although transgender is an umbrella term that includes people who cross-dress and people who otherwise express themselves in unconventional ways from their birth sex, it is often used to refer to transsexuals—people who live as a sex not associated with their birth sex after a process known as “transitioning.” Although some transsexuals describe themselves as “trans,” others

simply say they are male or female, depending on the sex to which they have transitioned.

How to Use This Guide

Every hospital and health care organization is unique. Whether an organization is just beginning to address the needs of LGBT patients and families, or has worked to develop a culture of inclusivity for years, this field guide can be a resource. Just as in the original *Roadmap for Hospitals*, there is no one approach that works best; The Joint Commission encourages hospitals to adopt a combination of the strategies and practices discussed and to use these examples as a foundation for creating processes, policies, and programs that are sensitive and inclusive of LGBT patients and families. The Joint Commission is not putting forth new requirements, rather we are providing guidance for hospitals and health care organizations and identifying important issues for consideration—many of the recommendations go above and beyond what is required in our accreditation standards.

This document is intended to complement the many other valuable and influential resources created by other organizations working to improve health systems and care for LGBT communities and families. In addition, it is

Suggested Uses for the Field Guide

As an Organizational Self-Assessment Tool

- ✓ To inform or revise policies, procedures, and practices
- ✓ To identify gaps or areas needing improvement for quality improvement efforts
- ✓ To evaluate compliance with relevant laws, regulations, and standards
- ✓ To identify risk or patient safety issues
- ✓ To identify or revise strategic initiatives or outreach efforts
- ✓ To help develop staff and patient survey questions

As an Educational Resource

- ✓ Can be posted on intranet for easy reference and accessibility by staff
- ✓ Can be assigned as required reading for key staff (either in portions or entirety)
- ✓ Can be used as a basis for discussions in unit or departmental meetings
- ✓ Can be used as a basis for focus group discussions (patients and staff)
- ✓ Can be incorporated into general staff or medical staff orientation or other trainings

intended to be used in conjunction with other efforts to advance effective communication, cultural competence, and patient- and family-centered care for **all** patients. As hospitals and health care organizations become more welcoming, inclusive, and responsive to the needs of all their diverse patients and families, they will develop into more patient-, family-, and community-centered organizations, able to provide higher-quality health services to all.

As in the original *Roadmap for Hospitals*, each chapter in this guide contains both recommended issues to address (illustrated with check boxes) and practice examples (illustrated with round bullets), as shown:

☐ Recommended Issues to Address

These are broad, overarching principles that hospitals should address to meet the unique needs of their LGBT patients and families.

- **How-to information:** These contain strategies, methods, and practice examples that are designed to help hospitals care for LGBT patients.

The appendixes contain educational information regarding applicable Joint Commission standards; current laws, regulations, and executive materials; and a resource guide. This field guide also includes a Glossary.

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CHAPTER ONE

Leadership

***Leadership:** Leaders must clearly articulate a hospital's commitment to meet the unique needs of its patients, and establish an organizational culture that values effective communication, cultural competence, and patient- and family-centered care.*

The role of leadership in shaping an organization's culture is critical. Leaders craft the mission and vision for an organization and reinforce it through their behaviors. Leaders at every level of the organization set the tone for a culture that is inclusive and welcoming, a culture that promotes patient-centered care, and a culture that demonstrates equitable treatment of all patients and staff.

It is ultimately the responsibility of leadership to bring the patient and family perspective directly into the planning, delivery, and evaluation of health care.¹ Sexual orientation and gender identity are among the many factors that affect patient experiences before, during, and after interactions with health care providers. Leaders have a responsibility to ensure that the needs of lesbian, gay, bisexual, and transgender (LGBT) populations are accounted for in their efforts to provide patient-centered and equitable care.

- **Integrate unique LGBT patient needs into new policies or modify existing policies.** Leadership should review all policies to make sure the concepts of equitable and patient-centered care for LGBT patients are reflected.
 - **Develop or adopt a nondiscrimination policy that protects patients**

from discrimination based on personal characteristics, including sexual orientation and gender identity or expression.

Leaders must send the message that any discrimination is unethical, unacceptable, and will not be tolerated. The Joint Commission requires that all hospitals prohibit discrimination based on personal characteristics, including sexual orientation and gender identity or expression.* In addition, many states and some cities forbid discrimination based on sexual orientation and/or gender identity and expression.² Posting, disseminating, and publicizing the nondiscrimination policy (for example, on the hospital's Web site, in written material, and on packets) will communicate that nondiscrimination is an organization policy, regardless of whether or not anti-discrimination protections are included in state laws and regulations.

- **Develop or adopt a policy ensuring equal visitation.** The hospital should develop a written policy identifying visitation[†] rights and procedures. Visitation rights include the right to receive visitors designated by

* As of July 1, 2011, The Joint Commission requires that organizations accredited under the hospital and critical access hospital programs prohibit discrimination based on many factors, including sexual orientation and gender identity or expression. (See the *Comprehensive Accreditation Manual for Hospitals*, Update 1, January 2011, and the *Comprehensive Accreditation Manual for Critical Access Hospitals*, Update 1, January 2011.)

[†] The Centers for Medicare & Medicaid Services (CMS) updated their Conditions of Participation (CoPs) in January 2011 for hospitals and critical access hospitals (CAHs) to require equal visitation for patients. These CoPs are found in the *Code of Federal Regulations for hospitals* at 42 C.F.R. § 482.13(h) and for critical access hospitals at 42 C.F.R. § 485.635(f). Section 482.13(h) states: "A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation." Section 485.635(f) states: "A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation." (See also Appendix C, "Laws, Regulations, and Executive Materials," for additional guidance issued by CMS in September 2011.)

Almost every major American medical association has promulgated ethical rules that prohibit discrimination of LGBT people in the practice of medicine, recognizing that such discrimination is harmful to patients' health.³

the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex partner), another family member, or a friend. (For more information on domestic partners and relationship recognition, see the Joint Commission standards in Appendix B and see the Glossary.)

- **Develop or adopt a policy identifying the patients' right to identify a support person of their choice.**

Patients have the right to access a support person during their hospital stay for emotional support, provided it does not interfere with the rights of other patients or interfere with the care process.¹ The support individual is a person *of the patient's choice*, and may or may not be the person's surrogate decision-maker or legally authorized representative.* (See the Joint Commission standards in Appendix B.)

- **Integrate and incorporate a broad definition of family into new and existing policies.**

Define *family* to explicitly include any individual that plays a significant role

in the patient's life, such as spouses, domestic partners, significant others (of different sex and same sex), and other individuals not legally related to the patient.[†] Use this expanded definition in all hospital policies, including those that address visitation (see above), access to chosen support person, identification of surrogate decision-makers, and advance directives.¹ (See also Chapter 2, "Provision of Care, Treatment, and Services," and Appendix C, "Laws, Regulations, and Executive Materials."[‡])

- **Demonstrate ongoing leadership commitment to inclusivity for LGBT patients and families.**

- **Monitor organizational efforts to provide more culturally competent and patient- and family-centered care to LGBT patients, families, and communities.**

Determine how to measure the impact of organizational efforts to provide more effective care to LGBT patients and families. Organizational assessments can and should be used to gather information and monitor effectiveness of any quality improvement efforts.[§] Solicit

* Hospitals and critical access hospitals are required to allow a family member, friend, or other individual to be present with the patient for emotional support during the length of stay, and this is a person chosen by the patient. Hospitals that use Joint Commission accreditation for deemed status purposes are required to have written policies that address procedures regarding visitation rights. These hospitals are also required to inform the patients of their visitation rights. Visitation rights include the right to receive visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. (See also Appendix B, page 41, for Joint Commission standards.)

[†] Family involvement is a critical issue for LGBT patients and families. In some cases, biological family members may disapprove of the patient's same-sex relationship and may try to exclude the patient's partner from visitation or decision making. Exclusion of a primary caregiver may compromise patient adherence with treatment recommendations. When treating children with same-sex parents, staff should include both parents in discussions about the child's health care, considering legal parentage only if there is a dispute about who should be included.

[‡] The provision of care to LGBT families must comply with applicable federal, state, and local laws. See Appendix C, "Laws, Regulations, and Executive Materials."

[§] The Human Rights Campaign (HRC) conducts an annual survey, the Healthcare Equality Index (HEI), that rates how equitably health care organizations treat LGBT patients and employees and that can be used as an organizational assessment tool. The HEI focuses on four main policy areas: patient nondiscrimination, visitation, cultural competency training, and employment nondiscrimination. Participation is open to the full range of health care organizations, including hospitals and clinics, among others. For more information and additional resources, visit the HRC Web site at <http://www.hrc.org/heil/>.

feedback from staff, patients, and the community as to how the organization is doing in meeting unique patient needs. Consider adding LGBT-specific questions to patient perception surveys, incident reports, and workforce surveys; conducting focus groups; and monitoring grievance/complaint information. (See *also* Chapter 4, “Data Collection and Use”; Chapter 5, “Patient, Family, and Community Engagement”; and Appendix D, “Resource Guide.”)

- **Develop clear mechanisms for reporting discrimination or disrespectful treatment.**

All levels of staff, as well as patients, need to understand the process for reporting discrimination or disrespectful treatment. Grievance processes for patients should be posted in high-traffic areas. (See *also* Appendix B for Joint Commission standards for complaint and grievance processes.)

- **Develop disciplinary processes that address intimidating, disrespectful, or discriminatory behavior toward LGBT patients or staff.**

Staff should be aware that any discrimination is unacceptable and that they will be held accountable.

- **Identify an individual directly accountable to leadership for overseeing organization efforts to provide more culturally competent and patient-centered care to LGBT patients and families.**

Designating a person with direct and obvious accountability can help to underscore the organization’s commitment to provide culturally competent and patient- and family-centered care to the LGBT community. This individual should work with staff to obtain suggestions and

feedback on how to improve communication with LGBT patients and families.

- **Appoint a high-level advisory group to assess the climate for LGBT patients and make recommendations for improvement.**

This group can assist in identifying service gaps, as well as areas of good or excellent performance, and can help generate ideas to better meet patient needs. This information can be utilized for performance and quality improvement activities.

- **Identify and support staff or physician champions who have special expertise or experience with LGBT issues.**

Recognize staff members who have been exemplary in providing sensitive care to LGBT patients and families. These champions can be instrumental in modeling behavior and providing information and guidance to other clinicians and staff members.

“Respect for all is interwoven throughout our organization.

We clearly communicate to our providers and staff what our mission means in an open manner. This is our policy, when we are here, this is who we are and what we do—we check our biases at the door.”

—Vice President, Human Resources at a Midwest hospital

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CHAPTER TWO

Provision of Care, Treatment, and Services

***Provision of care, treatment, and services:** The health care organization, in striving to meet the individual needs of each patient, must embed the concepts of effective communication, cultural competence, and patient- and family-centered care into the core activities of its care delivery system. The needs of the lesbian, gay, bisexual, and transgender (LGBT) community as a whole, and the needs of each subpopulation (lesbians, gay men, bisexual men and women, and transgender people), must be considered in the provision of care, treatment, and services.*

The provision of health care is a complex multidisciplinary process that requires assessing patient needs, planning and providing care, and coordinating care, treatment, and services.¹ The patient's experience of receiving care begins at the first point of contact with the health care system and extends to discharge or transfer and beyond. For an organization to be ready to meet patients' needs, processes must be in place to effectively communicate with patients and to provide care that is responsive to their unique needs.

Sexual orientation and gender identity can impact a patient's health and well being in a variety of ways. An understanding of the patient's identity and behaviors can lead to more appropriate care, targeted risk-reduction counseling and screenings, and targeted treatment and referrals.² Care that is responsive to the unique needs of LGBT patients can enhance the patient-provider relationship and help ensure that patients seek routine and follow-up care.

□ **Create a welcoming environment that is inclusive of LGBT patients.**

It is important for the hospital's environment to support the diversity of the patients it serves. Many studies have demonstrated that LGBT patients and families survey their surroundings to determine if the environment is one in which they feel welcome and accepted.⁴ Provid-

ing a welcoming environment can set the tone for the entire health care encounter.

- **Prominently post the hospital's nondiscrimination policy or patient bill of rights.**

As discussed in Chapter 1, this policy should articulate that equitable care will be provided regardless of a patient's sexual orientation, gender identity, or expression. Posting the nondiscrimination policy in registration, waiting, or other high-traffic areas can demonstrate the hospital's commitment to equitable care for LGBT patients.

- **Waiting rooms and other common areas should reflect and be inclusive of LGBT patients and families.**

Brochures and other available reading material should include topics relevant to LGBT patients as well as general brochures. LGBT-relevant magazines, posters, and information about local LGBT resources should be available. Décor and images depicting couples and families should include same-sex partners, same-sex parents, and LGBT families. LGBT-friendly symbols, such as the rainbow flag, the pink triangle, or Safe Zone sign, can be displayed in waiting areas, on placards and forms, or on staff badges and can immediately signal a culture of acceptance.



“We Treat Everyone the Same Here . . .”

This is a common statement yet does not necessarily indicate inclusive treatment and services for LGBT patients and families. Instead, it can imply that there is no need to acknowledge individual differences. It is important to indicate that patients can expect to be treated fairly and without discrimination, but also that their sexual orientation and gender identity will be taken into account, when appropriate, within the delivery of health care.³

- **Create or designate unisex or single-stall restrooms.**

Patients whose appearance might not conform to gender stereotypes may feel more comfortable and safe in a single-stall or unisex restroom. Design or clearly identify at least one such restroom. These single-stall or family restrooms can also serve parents caring for opposite-sex children, disabled people accompanied by opposite-sex caregivers, and any other patients wishing to use them. **Note:** *Although making a unisex restroom available is an important signal of acceptance, patients should be permitted to use restrooms that comport with their gender identity and should not be required to use the unisex restroom.*

- **Ensure that visitation policies are implemented in a fair and nondiscriminatory manner.**

As discussed in Chapter 1, equal visitation rights should be established for all patients. However, it is important to underscore that when these policies are implemented, the process by which visitors are permitted in the hospital is identical for both same-sex and different-sex parents and partners. Access should not be more arduous for same-sex partners and parents than it is for different-sex partners and parents. Any denials of access should be clearly medically supported (see the Joint Commission standards in Appendix B and see Appendix C, “Laws, Regulations, and Executive Materials”).

- **Foster an environment that supports and nurtures all patients and families.**

A welcoming environment is one in which all patients and families feel comfortable expressing love and support for one another. The health care encounter can be a time of consid-

erable stress, fear, and anxiety. Be aware that visible discomfort on the part of staff or other patients in the presence of displays of affection or support can exacerbate an already difficult situation for LGBT families. Determine mechanisms for handling patient-to-patient discrimination while preserving the dignity of all involved.

“Two of my friends are a gay couple, but until I took the LGBT training, I didn’t realize how much they worry. I mean, it never occurred to me that they might not comfort each other—even hold hands—in the hospital because someone might see them and treat them badly. It broke my heart when I heard this, and when I asked my friends about it, they confirmed it. I can’t imagine not holding my husband’s hand if he were in pain, and as a nurse, I want to make sure gay people do not have to worry about supporting each other in my hospital!”
—Nursing Supervisor, Kansas

- **Avoid assumptions about sexual orientation and gender identity.**

Remember that any patient can be LGBT, regardless of appearance, behavior, age, self-identification, socioeconomic status, religion, race, ethnicity, ability/disability, or culture.

- **Refrain from making assumptions about a person’s sexual orientation or gender identity based on appearance.**

Do not rely on external appearances to determine the sexual orientation or gender identity of a patient. Information about a patient's sexual orientation or gender identity should come only from the patient. Incorrect assumptions about a patient's sexual orientation or gender identity can interfere with the establishment of trust and rapport and can lead to inappropriate care. Be aware that a patient wearing a wedding ring may be partnered with another man or woman, and someone whose appearance is typically masculine or feminine may have transitioned to another gender. It is not always possible to determine by appearance if a patient is transgender or is struggling with gender identity. If you are unsure of a person's gender identity, or how they wish to be addressed, ask gender-neutral questions for clarification, such as, "How would you like to be addressed?" or "What name would you like to be called?"

- **Be aware of misconceptions, bias, stereotypes, and other communication barriers.**
While an understanding of a person's sexual orientation or gender identity is important, this information alone does not say anything about a patient's family relationships, religion, class, socioeconomic status, beliefs, race, ethnicity, ability/disability, behaviors, or other factors that may impact their health and well-being. Avoid assumptions about any of these based on stereotypes, misconceptions, or bias (see Sidebar 2-1, right).
- **Recognize that self-identification and behaviors do not always align.**

How an individual identifies and what behaviors he or she engages in can be fluid and change over time. For example, a man may identify as heterosexual but engage in sex with other men, or a woman may identify as a lesbian but has had relationships with men in the past. In addition, the ways in which people use identity labels often vary among cultural, racial, ethnic, socioeconomic, and age groups.⁵ Refrain from making assumptions about patients' health needs based on identification alone.

□ **Facilitate disclosure of sexual orientation and gender identity but be aware that this disclosure or "coming out"* is an individual process.**

Hospitals and providers should make it as easy as possible for patients who choose to self-identify, but need to remember that this decision is up to the individual patient.

- **Honor and respect the individual's decision and pacing in providing information.**
Be aware that patients may or may not choose to self-identify and allow them to provide the information at their own pace.
- **All forms should contain inclusive, gender-neutral language that allows for self-identification.**
Admitting, registration, and all other patient forms should provide options that are inclusive of LGBT patients and families and should allow LGBT patients to self-identify if they choose to do so. For example, provide options such as "partnered" under "relationship status." For parents, use terminology such as parent/guardian, which is inclusive of same-sex parents who

SIDEBAR 2-1. Self-Reflection Exercises

The Fenway Institute has a sample self-reflection exercise titled "Self-Reflection or Group Discussion Exercises: Attitudes About Sexual Orientation and Gender Identity" available at http://www.fenwayhealth.org/site/DocServer/Handout_1-B_Attitudes_Assessments.pdf?docID=4201.

Straight for Equality in Healthcare from Parents, Families and Friends of Lesbians and Gays (PFLAG) contains information to help identify and overcome barriers. Go to <http://community.pflag.org/page.aspx?pid=1130>.

* *Coming out* is the process of acknowledging to oneself and/or others that an individual is lesbian, gay, bisexual, and/or transgender.

may or may not be biologically related to the child. (See also Chapter 4, “Data Collection and Use,” and Appendix D, “Resource Guide.”)

- **Use neutral and inclusive language in interviews and when talking with all patients.**

Interactions with patients that are sensitive and nonjudgmental will pave the way for more effective patient–provider communication and can make patients more comfortable with disclosing information relevant to their care. How a question is phrased can communicate acceptance and consideration for a range of partner or family relationships. Be aware of language or questions that assume heterosexuality, such as “Are you married?” or references to husbands or wives. When asking about family relationships, ask “Who are the important people in your life?” or “Who is family to you?” (For more information on interviewing patients and conducting a thorough health history, consult the *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients* from the Gay and Lesbian Medical Association [GLMA]; *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*; the American Medical Association’s video *Patient Sexual Health History: What You Need to Know to Help*, available at <https://extapps.ama-assn.org/viral/Physician.jsp>; and *10 Tips for Working with Transgender Individuals: A Guide for Health Care Providers* from the Transgender Law Center.)

- **Listen to and reflect patients’ choice of language when describing their**

“When I was training as a nurse, I encountered my first transgender patient. The nurse I was shadowing was clearly uncomfortable and it was making everyone else uncomfortable, particularly the patient. I finally pulled her aside and said, “This is terrible; your feelings are so obvious that it is affecting the patient. If you can’t handle this you should ask another nurse to step in.” I was a little worried to speak up but just felt so badly for our patient. The nurse was apologetic but admitted she was uncomfortable because this was the first transgender patient she had seen. Now that I am a nurse manager, I make sure to present different scenarios with hypothetical patients in our meetings and talk through how we can best provide care in each situation. In this way, everyone is prepared and ready to treat any patient who walks through the door.”
—Nurse Manager, Midwest hospital

own sexual orientation and how the patient refers to their relationship or partner.

Notice the language LGBT patients use to describe sexual orientation, gender identity, partner(s), and relationships and reflect the choice of terminology when appropriate.* Never assign a

A Note About Confidentiality

Patient information is protected by the Health Insurance Portability and Accountability Act of 1996. When someone discloses or staff otherwise become aware of someone’s LGBT status, this information should be treated as sensitive and confidential. For more information about patient confidentiality see Chapter 4, “Data Collection and Use,” and Appendix C, “Laws, Regulations, and Executive Material.”

* The Gay and Lesbian Medical Association’s *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients* advises that although LGBT people may use words such as queer to describe themselves, these and other words have been used in a derogatory way against LGBT individuals. These terms may have been reclaimed and used by some in the LGBT community, but they are not appropriate for use by health care providers who have not yet established a trusting and respectful rapport with their patients.

Special Considerations for LGBT Youth

In addition to the common challenges of being a teenager, LGBTQ* teens and youth face a number of unique challenges. For example, they may face a lack of support or outright rejection from people close to them, such as family members, friends, and classmates, or from people in authority, such as clergy people, teachers, and coaches. Many LGBTQ youth are subject to bullying, harassment, threats, and violence. According to the Institute of Medicine (IOM) report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for*

Better Understanding, LGBTQ youth (as a group) may experience higher rates of smoking, alcohol use, substance abuse, HIV and other STD infections, anxiety, depression, suicidal ideation and attempts, and eating disorders. Health care providers should be aware of these risks and be prepared with education, referrals, and resources—he or she may be the only adult confidant. The degree of safety, comfort, openness, and respect that LGBTQ youth patients feel often has an impact on their future access to health care, risk reduction, and help-seeking behaviors.² (See Appendix D, “Resource Guide,” for specific resources for LGBT Youth.)

Special Considerations for LGBT Seniors

LGBT elders have the same concerns about aging as the rest of the population in addition to important and unique challenges and concerns. Discrimination, fear of discrimination, stigma, and victimization within the health care system remain a problem for LGBT elders.⁴ According to the IOM report, LGBT elders are less likely to have children than heterosexual elders and are less likely to receive care from adult children. They may have higher rates of isolation due to a lack of family or social support. Because Social Security and most private pension plans do not provide spousal or survival benefits to unmarried partners, the disability or death of one partner may threaten the economic security of the surviving partner.⁴

LGBT seniors in residential facilities are particularly vulnerable to hostile or unwelcoming environments and may experience pressure to “go back into the closet”⁶ or risk being denied visitation with loved ones or rooming options. Fortunately, many initiatives are under way to address issues for LGBT seniors. Notably, in October 2010, SAGE (Services and Advocacy for GLBT Elders), in partnership with 10 leading organizations, launched the National Resource Center on LGBT Aging. This resource center serves as a comprehensive clearinghouse of information for providers of the aging population, LGBT organizations, and LGBT older adults. Visit the Web site at <http://www.lgbtagingcenter.org/index.cfm>. (See also Appendix D, “Resource Guide,” for more information.)

label to a person’s sexual orientation by inference.

- **Provide information and guidance for the specific health concerns facing**

lesbian and bisexual women, gay and bisexual men, and transgender people.

Although LGBT individuals may share some of the negative health consequences associated with the experience of being stigmatized and/or reluctance to seek

* The letter Q is sometimes added to the end of the acronym LGBT; the Q can refer to either *queer* or *questioning*. In contemporary usage, queer refers to an inclusive unifying sociopolitical, self-affirming umbrella term for people who are gay; lesbian; bisexual; pansexual; transgender; transsexual; intersexual; gender queer; or any other nonheterosexual sexuality, sexual anatomy, or gender identity (see the Glossary). This was historically a term of derision for gay, lesbian, or bisexual people. *Queer* has been embraced by many, although not all, in the LGBT community. *Questioning* can refer to individuals who are exploring their gender, sexual identity, sexual orientation, or all three. People who are questioning may be unsure, still exploring, and concerned about applying a social label to themselves for various reasons.

Special Considerations for Transgender Patients

Statistics vary on the number of transgender people in the United States. The transgender population includes not only transsexual people (see the Glossary), but also many who do not identify as transsexual but whose appearance does not conform to gender stereotypes.⁷ Although there may not be a large number of transgender patients seen in any one health care organization, this group of individuals has been exposed to very high levels of violence, social isolation, and discrimination.⁸ Discrimination in the provision of care, treatment, and services has caused many transgender patients to

delay or avoid necessary health care to the point of putting their overall health at risk. To provide more effective and appropriate care to transgender patients and for information about their unique medical needs, consult the Transgender Law Center's *10 Tips for Working with Transgender Individuals: A Guide for Health Care Providers*⁹ and the World Professional Association for Transgender Health (WPATH) Standards of Care at <http://www.wpath.org>. (See also Appendix D, "Resource Guide," for more information.)

medical care, each subpopulation has unique health concerns. Clinicians and other health care providers need to be prepared with information, guidance, screenings, and referrals for the conditions that affect the group as a whole and those that disproportionately affect each subpopulation.

- **Become familiar with online and local resources available for LGBT people.**
Consult Appendix D, "Resource Guide," for information and Web sites to obtain more information.
- **Seek information and stay up to date on LGBT health topics. Be prepared with appropriate information and referrals.**

Note: A review of the medical needs and clinical care guidelines of LGBT patients is beyond the scope of this document, but several resources are available to assist providers. In addi-

tion to previously mentioned resources (the GLMA's *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*; *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*; and the *Transgender Law Center's 10 Tips for Working with Transgender Individuals: A Guide for Health Care Providers*), see the American Medical Association's Advisory Committee on Gay, Lesbian, Bisexual and Transgender Issues; the Harry Benjamin Standards of Care from the World Professional Association for Transgender Health; and information about bisexual health at http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_bi. (See also Appendix D, "Resource Guide," for more information.)

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for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community*

CHAPTER THREE

Workforce

***Workforce:** The hospital and its staff, including the medical staff, must commit to meeting the needs of the diverse patients they serve.*

A hospital's ability to provide equitable, competent, and welcoming care to all patients rests squarely on its workforce. This chapter describes strategies a hospital can use to develop a workforce that is prepared to provide the best possible care to lesbian, gay, bisexual, and transgender (LGBT) patients. These steps are designed to achieve two key workforce goals: (1) Ensure that LGBT employees are treated in an inclusive and equitable manner; and (2) Ensure that all employees are able to provide equitable, competent, and welcoming care to LGBT patients and their families.

□ **Ensure equitable treatment and inclusion for LGBT employees.**

When a hospital takes steps to provide equitable treatment and inclusion for LGBT employees, it benefits the entire workforce.

- **Protect staff from discrimination that is based on personal characteristics, including sexual orientation, gender identity, or gender expression.**

Nondiscrimination protection is extremely important to LGBT employees as it influences their job decisions and helps them feel safe and comfortable in the workplace. In addition, a robust nondiscrimination policy promotes general workforce effectiveness by signaling that bias is not tolerated (see Sidebar 3-1, below).

“The lack of culturally competent providers is a significant barrier to quality health care for many LGBT people.”

—Kathleen Sebelius, U.S. Health & Human Services Secretary, response to the Institute of Medicine report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington, DC: National Academies Press, 2011).

SIDEBAR 3-1. Workplace Challenges Reported by LGBT Employees

Although an LGBT-inclusive nondiscrimination policy is fundamental to establishing an equitable and inclusive workplace, its presence alone does not guarantee fair and respectful treatment for LGBT employees. Examples of workplace challenges experienced by LGBT employees include the following:

- Being “outed” carelessly or maliciously
- Pressure to conceal LGBT status
- Uncertainty about whether, when, and to whom to “come out”
- Negative comments ranging from stereotyping, jokes, ridicule, and judgments to mockery, taunts, and abuse
- Distribution and posting of material hostile to LGBT people

- Harassment and/or ostracism
- Inappropriate and intrusive questions
- Limited availability of mentors and role models
- Denied and delayed promotions and pay increases
- Disproportionate and/or undesirable job assignments

Transgender employees can face additional challenges, including the following:

- Questioned about or denied bathroom use
- Being addressed as the wrong sex or by the wrong name

SIDEBAR 3-2. Affordable Health Care Coverage for Same-Sex Partners

More employers around the country are offering health care coverage to employees that have a same-sex partner (in states where they cannot marry). For example, 293 of the Fortune 500 companies offer same-sex partner health care benefits.² Detailed information about same-sex partner health care coverage (and Consolidated Omnibus Budget Reconciliation Act continuation of it) can be easily accessed and indicates the ease and affordability of providing equal coverage. In fact, some employers “gross up” the wages of employees whose same-sex partners are covered to compensate for the fact that the IRS does not view partners as family to each other, and tax the employer contribution to partner health care coverage as income to the employee (see http://www3.law.ucla.edu/williamsinstitute/pdf/Website_TaxPiece.pdf).

- **Equalize health care coverage for same-sex-partnered and transgender employees.**

Hospitals that offer health care coverage to the spouses of employees sometimes do not extend these same coverage options to employees who have a same-sex partner (in states where they cannot marry). These inequities can damage the health, finances, and morale of LGBT employees.¹ Health care benefits equality is seen as a key indicator of commitment to LGBT equity and is very highly valued by LGBT employees, particularly in hospital settings, where the benefits of health care coverage are particularly evident (see Sidebar 3-2, left).

- **Equalize all other hospital benefits.**

Hospitals should review all employee benefits and policies, beyond health care coverage, to ensure that same-sex-partnered employees (in states where they cannot marry) are treated identically to employees with spouses. Same-sex partners should be able to access benefits as easily as spouses; for example, same-sex partners should not be asked to provide proof of their relationship beyond what is required of spouses. In addition, hospitals should ensure that references to spouses also allude to domestic partners and that references to family are inclusive of same-sex partners, to the extent permitted by law. Examples of benefits that may require modification for LGBT equity are included in Sidebar 3-3, page 21.

- **Demonstrate commitment to LGBT equity and inclusion in recruitment and hiring.**

Hospitals that show commitment to LGBT equity and inclusion in recruitment and hiring can increase their pool of qualified applicants, ensure that the LGBT population in their service area is represented

in their workforce, and send a welcoming message to LGBT patients.

“I’ll never forget the day the hospital gave us domestic partner benefits. The board had to vote on them, so a group of us went to speak to them. One of us had lost her partner to breast cancer, and she talked about how different their last two years together would have been if she’d been able to cover her partner. Their health care bills were so high that they worried all the time—and still couldn’t afford everything she needed. Everyone had tears in their eyes after she spoke. And when the board voted to give us equal benefits, I called my partner, who’s self-employed, and found myself crying again—for joy.”
—Physician, California

- **Add LGBT-inclusive language to job notices.**

Examples include “LGBT candidates welcome” or “This hospital does not discriminate on the basis of sexual orientation or gender identity/expression.”

- **Attend LGBT job fairs, advertise in LGBT publications, and conduct outreach with LGBT groups.**

See Chapter 5, “Patient, Family, and Community Engagement,” for additional examples of outreach activities.

- **Include the hospital’s LGBT–inclusive benefits and policies in recruitment and hiring materials, both online and in print.**

In addition, feature images of LGBT employees (after securing appropriate permissions) and LGBT–related events.

- **Train human resources employees on general LGBT workplace concerns and the hospital’s LGBT–inclusive nondiscrimination statement, benefits, and policies.**

Human resources managers and recruiters should be able to respond knowledgeably and comfortably to questions from LGBT applicants and job candidates. In addition, information about LGBT workplace concerns and the organization’s LGBT–related policies and benefits should be incorporated into all training on recruitment and hiring.

□ **Educate staff on LGBT employee concerns.**

LGBT employees can face a wide variety of workplace challenges, and many might not be obvious except to LGBT individuals. See Sidebar 3-1 on page 19. Increasing awareness of these issues can pave the way for better working relationships among employees and to better-functioning workplace teams.

- **Provide information about LGBT workplace concerns in all appropriate training.**

Incorporate LGBT information in classes on supervision, effective communication, diversity/multicultural topics, sexual harassment, and nondiscrimination law and policy.

- **Offer LGBT training to key audiences.**

“It always seemed to me like we were a reasonably good place for LGBT people to work. This is a pretty gay-friendly area, and we don’t get that many formal complaints. But I set up a workshop on LGBT workplace issues because we were doing other diversity workshops for our managers. That’s when I heard about the ‘micro-inequities’ LGBT people face—feeling like they can’t mention their families, can’t bring in vacation photos, can’t say what they did over the weekend, and feeling like they have to overperform because they’re LGBT. I had no idea how much they worried about other people being uncomfortable, or losing out on opportunities and raises. It was really eye-opening for our managers, and now we really track what’s happening for LGBT employees and let them know they’re welcome here.”
—Human Resources Director, Pennsylvania

Examples include hospital leadership, human resources staff, managers, supervisors, legal department, diversity/equal employment opportunity/affirmative action staff, compliance officers, quality/performance improvement staff and risk management.

SIDEBAR 3-3. Examples of Benefits That May Require Modification for LGBT Equity (to the Extent Permitted by Law*)

- Retirement benefits for spouses (for example, survivor and continuation benefits, post-retirement health coverage)
- Sick leave and family medical leave for care of an ill spouse or child
- Bereavement leave
- Life insurance for spouses
- Discounts for spouses/families (for example, auto insurance, long term care insurance, memberships, tickets)
- Credit union memberships for spouses/families
- Tuition reductions and other education assistance for spouses/families
- Placement assistance for spouses
- Adoption/foster benefits for spouses
- Parenting leave for a spouse who is not the birth parent
- Policies prohibiting nepotism

* At the time of this writing, some limits exist under federal law with respect to providing equal treatment, due to the Defense of Marriage Act (DOMA). See <http://www.gpo.gov/fdsys/pkg/PLAW-104publ199/content-detail.html>.

A growing number of employers are updating their employee health plans to provide coverage for medically necessary transitions from one sex to another. The American Medical Association⁴ and a host of other health care organizations have called on employers to offer coverage for these transitions, for which there are established standards of care⁵ and clinical guidelines.⁶ Although this coverage serves a small number of employees, it is of critical importance to them and to all who care about the health of transgender people.⁷

- **Distribute to human resources staff online and print information about LGBT workplace concerns.**

The Human Rights Campaign report “Degrees of Equality” and Lambda Legal’s LGBT workplace toolkit are available for free download. (See also Appendix D, “Resource Guide.”)

- **Develop a plan to address the unique needs of transgender employees.**

Many transgender people in the workplace have experienced extremely high levels of bias and discrimination, and hospitals should be proactive in addressing the challenges typically faced by transgender employees, which can place employers at high risk.³ Hospitals should ensure that transgender employees who transition* (or previously transitioned) from one sex to another are treated respectfully by considering the following strategies:

- Provide training about transgender people for key staff, including human resources, senior managers, legal and compliance departments, security, and risk management professionals.
- Identify a “point person,” generally in human resources, to provide expertise and support around transitions and other transgender workplace needs.
- Create or have readily available guidelines to ensure smooth workplace transitions. These should include procedures for maintaining the employees’ confidentiality; changing email addresses, ID badges, and payroll and benefits records;

providing training to coworkers, as appropriate and requested; and speedily investigating and resolving complaints of discrimination and/or confidentiality violations.

- **Incorporate LGBT patient care information in new or existing employee and staff training.**

Hospitals should offer employees high-quality training that equips them with the tools to provide equitable, knowledgeable, and welcoming care for LGBT patients and their families. Training in LGBT patient care can also improve the hospital work climate, as employees become more knowledgeable about LGBT concerns. LGBT information could be incorporated into new employee orientation; sessions on legal requirements and hospital policy; quality, diversity, or cultural competence classes; and mandatory presentations on such topics as HIPAA (Health Insurance Portability and Accountability Act of 1996), advance directives, and sexual harassment. (See Sidebar 3-4, page 23, for additional suggested topics.)

- **Vary methods used to provide training.**

Use multifaceted approaches. For example, create slides for PowerPoint presentations, add LGBT content and links to Web sites, include LGBT education in grand rounds, conduct in-service trainings, show short videos, distribute LGBT health brochures, and/or include LGBT information in print material (one hospital, for example, placed a brochure titled “Straight Talk About LGBT Patients” in its packets for new employees). Consider stand-alone training to offer comprehensive information about LGBT health needs.

**Transition* refers to the process that many transgender people undergo to bring their outward gender expression into alignment with their gender identity. See the Glossary for more information

- **Update training and educational material on a regular basis.**

□ **Support staff development initiatives to maximize equity and inclusion for LGBT employees.**

A hospital can do much—at little or no cost—to maximize LGBT employees’ inclusion, effectiveness, productivity, and success. These initiatives promote a welcoming workplace culture and send a powerful message of equity and inclusion to LGBT patients.

- **Support an LGBT employee resource group (ERG), which can assist LGBT employees, provide expertise to hospital staff, and raise awareness of LGBT concerns throughout the organization.**

An ERG can offer LGBT employees mentoring and coaching, networking opportunities, information on programs or topics of particular interest (including same-sex partner tax issues, being “out” in the workplace, and coping with discrimination), and a host of other resources. See Chapter 5, “Patient, Family, and Community Engagement.”

- **Support forums for employees to freely and openly discuss any LGBT-related questions or concerns in a group setting to encourage learning.**

The hospital should encourage communication among all levels of staff in order to recognize and understand potential barriers to effective communication and treatment of LGBT people. Some staff may have long-standing prejudices or negative feelings about LGBT patients due to lack of familiarity, ignorance, or religious beliefs. Creating a forum that promotes honest and open dialogue among staff, where it is safe to explore these barriers and to

ask and answer questions in a safe and nonjudgmental way, can help facilitate more effective communication.

- **Commemorate LGBT events, such as Pride Month and National Coming Out Day, with educational programming, mentoring and networking opportunities, and other awareness-raising activities.**

“We haven’t had a lot of transgender patients yet, but we arranged training because we wanted to be ready. I’d heard that transgender patients have bad experiences, but I didn’t know what that meant until we had the presentation. When I heard about transgender patients being pointed at, having people ask them rude questions, being told to use bathrooms in other buildings, I realized we had to make sure our staff wouldn’t do those things. No one should have to go through that—no one. Now we talk about transgender patients in our HIPAA training, we’ve created unisex bathrooms, we’ve given our admitting staff and nurse managers information about transgender patients, and we’re going to bring the presenter back.”

—Patient Relations Director,
Connecticut

SIDEBAR 3-4. Suggested LGBT Topics to Cover in Training

- LGBT terminology and demographics
- LGBT history and background, particularly in the hospital’s service area
- State and local laws affecting LGBT people in health care settings
- Stories of LGBT-related bias and substandard care
- Systemic barriers to care for LGBT patients
- LGBT health disparities and inequities
- LGBT subpopulations
- LGBT clinical concerns
- LGBT health promotion and disease prevention
- LGBT mental and behavioral health concerns
- Communication and other interactions with LGBT patients
- Resources for follow-up learning

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CHAPTER FOUR

Data Collection and Use

***Data Collection and Use:** The health care organization must define what type of sexual orientation and gender identity data to collect, how to efficiently collect and protect these data, and how to use these data for service planning, quality improvement, and resource allocation.*

For health care organizations to improve the care they provide to all patients, they must collect and use accurate data. Data are helpful for informing policies and program development; evaluating the effectiveness of policies and programs; developing marketing, research, quality improvement, and community outreach initiatives; and responding to the changing needs of patient populations.¹ Most importantly, data are necessary to ensure the overall health and well-being of all patients. Understanding the characteristics of patients and patient populations can help hospitals identify and ultimately address disparities in health and health care and plan for services that meet unique patient needs (see Sidebar 4-1, below).

□ Identify opportunities to collect LGBT-relevant data and information during the health care encounter.

The major aspects of data collection relevant to lesbian, gay, bisexual, and transgender (LGBT) patient populations are often grouped together under the rubric of sexual orientation and gender identity data. There are numerous opportunities to collect these data during the health care encounter. Different aspects of LGBT identity may be relevant in different circumstances during the patient's health care experience. These aspects include relationship status, sexual orientation, sexual behaviors, sex, and gender identity.³ Voluntary and self-reported data on each of these aspects of LGBT identity can help providers better understand the

SIDEBAR 4-1. The LGBT Data Collection Gap

One of the major factors complicating the understanding of LGBT health disparities is a lack of data on sexual orientation and gender identity. Data collection regarding sexual orientation and gender identity has been limited by a number of challenges; however, initiatives are under way to improve data collection on LGBT populations at the national and state levels. The 2011 Institute of Medicine (IOM) report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, recommends that sexual orientation and gender identity data is collected on national and state health

and demographics surveys. In June 2011 the U.S. Department of Health & Human Services (HHS) announced that it will begin to incorporate questions on sexual orientation and gender identity on the National Health Interview Survey, which serves as the primary source of health information on the U.S. population. These questions will eventually serve as the basis for the development of department-wide standards on LGBT data collection. This initiative is part of the implementation of the Affordable Care Act, which directed the secretary of HHS to improve data collection on health disparities populations.²

backgrounds, experiences, and health needs of their LGBT patients.*

- **Identify a process to collect data at registration/admitting.**

Registration and admitting processes should allow for the designation of relationship status (such as identification of a same-sex spouse or domestic partner) and gender identity. Registration and admitting forms and processes may also allow for designation of patient support persons, visitors, emergency contacts, and representatives; and disclosure of the existence of relevant legal arrangements (including advance health care directives and marital and other legally recognized relationships, such as registered domestic partnerships[†]). (See Appendix D, “Resource Guide.”) Registration and admitting processes should identify ways to capture gender identity information, including indication of preferred name and gender pronoun, particularly if these identifiers are different from those noted on the patient’s legal documentation. Sidebar 4-2, page 27, provides an example of adding gender identification to electronic health records.

- **Identify a process to document self-reported sexual orientation and gender identity information in the medical record.**

Information regarding sexual orientation is usually provided in interactions

between patients and providers, through physician or interview notes, or during a health history. Determine mechanisms to capture this information in the medical record.[‡] This may involve adding new fill-in fields or drop-down menus to capture data elements.

Note: *Gathering patient-level data about sexual orientation and gender identity has been the subject of considerable interest and debate, and work is rapidly evolving on these issues. The growing concern about health care disparities and barriers to equitable care has demonstrated the need to collect such data, but the best ways to do so have not yet been established. Therefore, comprehensive recommendations on data collection methods are beyond the scope of this document. As advances are made in health information systems and in electronic health records, consideration should be given to the integration and alignment of sexual orientation and gender identity information data into all hospital information systems. (See Appendix D, “Resource Guide,” for more information on data collection.)*

- **Ensure that the disclosure of sexual orientation and gender identity information is voluntary.**

Forms and systems should provide opportunities to capture sexual orientation and gender identity in a routine

* It is important to note that challenges around the collection of sexual orientation and gender identity data may be further complicated when a patient is limited-English proficient (LEP), or faces other potential barriers to effective communication. For more information, please refer to The Joint Commission’s *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, and see Appendix D, “Resource Guide.”

[†] At the time of the publication of this guide, several jurisdictions recognize same-sex relationships, either by marriage, civil unions, domestic partnerships (see the Glossary), or reciprocal beneficiaries. For more information about relationship recognition for same-sex couples, visit Lambda Legal’s Web site at <http://www.lambdalegal.org/publications/articles/nationwide-status-same-sex-relationships.html>.

[‡] LGBT patients may be particularly conscious of protecting their privacy in medical health records, and this may be a factor in whether or not this information is shared. Be clear about how and what you will document in the record, and obtain the patient’s permission before doing so. If a patient requests that this information not be recorded, this request should be respected.

manner, without requiring the collection of these data if the patient is reluctant to disclose it or is reluctant to have this information entered into the medical record (see Chapter 2, “Provision of Care, Treatment, and Services”).

- **Train staff to collect sexual orientation and gender identity data.**

Staff training is a crucial component of successful efforts to appropriately collect and use sexual orientation and gender identity data. In addition to training on the methods and procedures that the health care organization uses to collect these data, the health care organization must ensure that staff can explain to patients why these data are important and how data will be used. Training should also emphasize that information collected about sexual orientation and gender identity will not be used to facilitate discrimination against the patient in any way (see Chapter 1, “Leadership”). (For staff training resources, consult the *Health Research and Education Trust Disparities Toolkit* on collecting race, ethnicity, and primary language data from patients. This toolkit offers online

resources that can help the hospital identify and address staff concerns.⁵ These resources may be adapted to assist staff in communicating effectively with patients about sexual orientation and gender identity data.)

- **Ensure that strong privacy protections for all patient data are in place.**

The privacy of patient data, including demographic data, is protected from inappropriate disclosure by the privacy rule of the Health Insurance Portability and Accountability Act (see Appendix C, “Laws, Regulations, and Executive Materials,” page 51). However, most LGBT patients are well aware that there are few legal nondiscrimination protections for them and their families in many parts of the United States.⁶ Assurances of patient privacy must be a central component of data collection on sexual orientation and gender identity. Any privacy protocols, particularly those involving electronic health records, must ensure that patient data are shared only with those who need access to these data in order to plan, coordinate, or assess the effectiveness of appropriate medical services. This

SIDEBAR 4-2. Example of Adding Gender Identification to Electronic Health Records

One hospital added transgender self-identification options when it adopted a new system for electronic health records. In this system, the admitting/registration screen displays the options “M” and “F” in the field labeled “Sex,” in order to match the options currently offered by private and government insurers. Staff enter in this field the sex indicated in the patient’s health insurance record or legal ID. If patients would like to indicate in the health record that they identify with a sex different from the one entered or that their birth sex is different from the one entered, this fact is noted in

another admitting/registration field, labeled “FYI.” This field offers two drop-down options indicating a patient’s birth sex and the sex with which the patient currently identifies: “Transgender MTF (male-to-female)” and “Transgender FTM (female-to-male).” If either of these options is selected, a bright yellow flag marked “FYI” blinks at the top of the patient’s record, and the information can be viewed by staff with access to the record. Staff can also enter in the “FYI” field the name by which a transgender patient prefers to be addressed, if it differs from the name on the patient’s health insurance record or legal ID.

The 2011 IOM report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, recommends that data on sexual orientation and gender identity should be collected in electronic health records. The IOM report recognizes that there are currently some obstacles to the collection of useful data on sexual orientation and gender identity, yet the committee encourages the Office of the National Coordinator for Health Information Technology within HHS to begin planning for the collection of these data as part of its meaningful-use objectives for electronic health records.

may include differential privacy settings that prevent certain parts of patients' charts from being seen by those who are not involved in the course of care, as well as clear procedures for requesting and granting access to patient records.

- **Add information about sexual orientation and gender identity to patient surveys.**

Patient surveys offer an opportunity for the hospital to begin building a confidential database of patient experiences and perceptions in order to learn more about the quality of care provided by the hospital from the perspective of different patient populations. Asking

patients to voluntarily share their sexual orientation and gender identity on patient surveys helps ensure that patient satisfaction data can be stratified by these populations and can help identify and track trends in patient experiences (see Sidebar 4-3, below). It may also provide an opportunity for patients to share experiences of discrimination or areas of concern about the services the hospital provides to its LGBT patients.

- **Use aggregated patient-level sexual orientation and gender identity data to develop or modify services, programs, or initiatives to meet patient population needs.**

SIDEBAR 4-3. Examples of Closed-Format Sexual Orientation and Gender Identity Questions

Sexual Orientation

Do you consider yourself to be:

Straight (heterosexual)
Gay or lesbian
Bisexual

Sexual Behavior

In the past (time period, such as one year), with whom have you had sex?

Men only
Women only
Both men and women
I have not had sex over the past (time period, such as one year).

Gender Identity (Two-Part Question)

What sex were you assigned at birth?

Male
Female

What is your gender? (Check all that apply)

Male
Female
Transgender, male to female
Transgender, female to male
Transgender, do not identify as male or female

Gender Identity (Transgender Status)

Are you transgender?

No
Yes, transgender male to female
Yes, transgender female to male
Yes, transgender, do not identify as male or female

Some data collection instruments provide a brief definition of transgender as part of the gender identity question. The following is a question with a definition that has been successfully used on general population surveys:

"Some people describe themselves as transgender when they experience a different gender identity from their sex at birth: for example, a person born with a male body but who feels female or lives as a woman. Do you consider yourself transgender?"

No
Yes, transgender male to female
Yes, transgender female to male
Yes, transgender, do not identify as male or female

□ **Use available population-level data to help determine the needs of the surrounding community.**

An awareness of the demographic composition of the community allows hospitals to plan for the services necessary to meet patient needs. Currently, limited data exist on LGBT populations, although recent initiatives should make more data available.

• **Use national- and state-level data on sexual orientation and gender identity to develop initiatives that address the health concerns of LGBT patients.**

Some state surveys collect sexual orientation and/or gender identity data, such as the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), which collects LGBT data in at least 13 states.* The youth corollary of the BRFSS, the Youth Risk Behavioral Surveillance System, also collects some data on lesbian, gay, and bisexual youth.⁷ In addition, some states collect information on sexual orientation and/or gender identity on their own state health surveys. The California Health Information Survey is one such example. For examples of data sets and state and national surveys that collect LGBT data, consult the Web site <http://www.gaydata.org/index.html> and the IOM report (*The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*), Table 3-2, "Recurring Federally Funded Surveys That Include LGB Measures."⁴

• **Conduct focus groups or interview community leaders, including LGBT community members and leaders, to identify changes in the demographics and needs of the surrounding community.**

• **Conduct community needs assessments that include LGBT demographics.**

Community needs assessments can help the hospital learn which groups are represented in its patient population and to ensure that the services and education it offers reflect the diversity of its patients and the broader community. One of the provisions of the Affordable Care Act requires charitable hospitals to conduct regular community needs assessments that take into account input from persons who represent the broad interests of the community served by the hospital.² Questions about sexual orientation, marital or other relationship status, and gender identity can be included as part of the battery of demographic questions (see Chapter 5, "Patient, Family, and Community Engagement").

* The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on a wide range of health-related behaviors. More information about the BRFSS can be found at <http://www.cdc.gov/brfss/index.htm>.

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CHAPTER FIVE

Patient, Family, and Community Engagement

***Patient, Family, and Community Engagement:** The health care organization must be prepared to respond to the changing needs and demographics of the patients, families, and community served. The health care organization can identify the need for new or modified services by being involved and engaged with patients, families, and the community.*

Health care organizations have a responsibility to serve all segments of the population and, therefore, must strive to understand the ever-changing health care needs of the patient populations within the communities they serve. It is important that lesbian, gay, bisexual, and transgender (LGBT) community members are not overlooked in the health care organization's community and outreach efforts. By actively engaging LGBT patients, families, and community members, the health care organization can better understand and respond to the experiences and health care needs of its LGBT patient populations. This, in turn, enables the organization to assess its ability to meet those needs, uncover service gaps, and identify needed improvements.

Reaching out to the LGBT community not only contributes to better patient care, it makes good business sense. Studies of LGBT purchasing decisions have demonstrated that the majority of gay and lesbian adults will choose brands that have a reputation for being friendly to LGBT individuals.¹ This is an important consideration as health care consumers have more access to information through the Internet and social media, and as health care reform efforts increase availability and choice. Health care organizations can directly and indirectly connect with LGBT community members and their families.

Collect feedback from LGBT patients and families and the surrounding LGBT community.

Health care organizations should engage LGBT patients and families and the surrounding LGBT community in discussions regarding available services and programs to determine whether these existing services meet LGBT patient needs.

- **Conduct confidential patient satisfaction surveys that include questions regarding sexual orientation and gender identity.**

The survey content may address the patient's overall experience with services, which services were used, how needs were met, and suggestions for improvement. Explore conducting surveys via phone or in person, in addition to mail, as some patients may not respond to written surveys (see Chapter 4, "Data Collection and Use").

- **Ask LGBT patients and families about staff responsiveness to their needs during care planning and treatment and include whether and how these needs were accommodated.**

Invite LGBT patients and family members to share their experiences with the hospital through focus groups or advisory councils. Establish a point of contact for community members to supply complaints or feedback.³ (See Chapter 1, "Leadership.")

It is important to understand the historical role of identity and community for LGBT individuals. The role of the community as a critical societal support in the context of LGBT health may be a more significant factor for LGBT individuals and families than for others within the hospital service area. In some situations and in some cultures, LGBT individuals may feel more accepted by their LGBT community than by their family of origin or religious affiliation.² The HIV/AIDS epidemic, the effects of social stigma, experiences of discrimination, and the tireless efforts of many to advance rights for LGBT persons have strengthened the sense of resilience and cohesiveness within the LGBT community.²

The Gay and Lesbian Medical Association (GLMA) offers an online provider directory with culturally competent physicians, therapists, nurses, dentists, and other providers searchable by location on GLMA's Web site: https://glmainpak.networkats.com/members_online_new/members_dir_provider.asp.

- **Encourage community input and collaboration by establishing a community advisory board.**

This advisory board could be comprised of a mixture of community members, stakeholders, representatives from the LGBT community, and LGBT organizations and report directly to hospital leadership.

- **Engage LGBT organizations to provide feedback on internal and external written material and policies to ensure that they are LGBT-inclusive.**

- **Ensure that communications and community outreach activities reflect a commitment to the LGBT community.**

Communication dissemination efforts and community outreach activities should emphasize the health care organization's services, programs, and initiatives that address the needs of the LGBT community. Conducting outreach activities specifically tailored to the needs of the LGBT community will help establish a partnership between the health care organization and the community, signaling a safe and welcoming environment for LGBT patients seeking health care, and demonstrating the organization's commitment to providing equitable and patient-centered care to all patients.

External Communications

- **Utilize the hospital Web site to communicate information about available services, programs, and initiatives to meet unique LGBT patient and family needs.**

In addition, consider posting a listing of any physicians on staff specializing in LGBT care. (See also Chapter 3, "Workforce.")

- **Expand marketing efforts to include LGBT audiences by publishing in LGBT media.**

Publicize information about available services to meet unique LGBT patient needs through community targeted marketing strategies and cultural media outlets, and LGBT media (see Chapter 3, "Workforce").

Community Outreach

- **Designate an individual or create a committee to address LGBT community outreach activities and to establish or maintain ties to community partners.³**

- **Ensure that existing community outreach activities are LGBT-inclusive.**

For example, if there are parental support groups offered, LGBT families should be welcome and encouraged to attend.

- **Establish partnerships with community health centers and other health care facilities in your community.**

LGBT community outreach activities could be conducted in partnerships with local community health centers and other hospitals. For example, consider sponsoring a health forum at your local LGBT community center. Go to <http://www.lgbtcenters.org> to find the community center closest to your hospital.⁴

- **Engage state hospital associations and state departments of health to determine areas of potential collaboration with regard to LGBT health issues.**

- **Consider participating in cultural competency programs for students in medical, nursing, and other allied health programs.**

For more information about LGBT inclusion in medical school curricula, please consult https://www.aamc.org/newsroom/reporter/feb11/174764/changing_times_for_lgbt.html and http://lgbt.ucsf.edu/services_health.html.

- **Consider sponsoring, participating, or providing educational resources to gay/straight alliances at local colleges or high schools (see Sidebar 5-1, below).**

□ **Offer educational opportunities that address LGBT health issues.**

Providing educational opportunities can build institutional knowledge on LGBT health issues within the community while directly and indirectly offering support to LGBT patients and their families. Educa-

tional forums also provide opportunities for exchanges between providers and LGBT community members.

- **Provide educational programs and forums that support the unique needs of the LGBT community (see Sidebar 5-2, below).**
- **Engage external LGBT community organizations in the development and review of existing educational programming to ensure that it is LGBT-inclusive.**

SIDEBAR 5-1. LGBT Youth Education

Many LGBT youth live with bullying as a part of their daily lives at school. Bullying puts their mental health and education at risk, not to mention their physical well-being.⁵ Gay, lesbian, and bisexual youth are up to four times more likely to attempt suicide than their heterosexual counterparts.⁶ By educating school staff

and students, a health care organization can act as a leader and a catalyst in creating a welcoming environment at school (see Appendix D, "Resource Guide," for more information on gay/straight alliances, bullying, LGBT youth; and the "It Gets Better" Project at <http://www.itgetsbetter.org/>).

SIDEBAR 5-2. Potential Educational Programs or Topics

- Programs that support unique psychosocial, physical, and mental health needs of LGBT youth
- Aging and end-of-life issues for LGBT seniors
- Adoption by same-sex couples or LGBT individuals
- LGBT-specific substance abuse forums
- Programs for transgender patients that supply background and education on the process of transitioning
- Educational programs about HIV/AIDS and accompanying counseling services
- Community education on sexually transmitted diseases (STDs) and sexually transmitted infections (STIs)
- Seminars or forums on advance health care directives
- Presentations from high-profile LGBT community members or physician champions offering professional and personal perspectives on health care issues faced by the LGBT community⁷
- Forums on transgender care for clinicians and patients*

* Much is still unknown in the world of transgender health. There are unique opportunities for patients and providers to learn from each other. Providers with expertise should work to share knowledge with both patients and other providers (for example, by conducting forums on the Harry Benjamin Standards of Care—see the World Professional Association for Transgender Health at <http://www.wpath.org/index.cfm>).

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Checklists to Advance Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community

Leadership Checklist

- Integrate unique LGBT patient needs into new policies or modify existing policies.**
 - Develop or adopt a nondiscrimination policy that protects patients from discrimination based on personal characteristics, including sexual orientation and gender identity or expression.**
 - Develop or adopt a policy ensuring equal visitation.**
 - Develop or adopt a policy identifying the patients' right to identify a support person of their choice.**
 - Integrate and incorporate a broad definition of family into new and existing policies.**
- Demonstrate ongoing leadership commitment to inclusivity for LGBT patients and families.**
 - Monitor organizational efforts to provide more culturally competent and patient- and family-centered care to LGBT patients, families, and communities.**
 - Develop clear mechanisms for reporting discrimination or disrespectful treatment.**
 - Develop disciplinary processes that address intimidating, disrespectful, or discriminatory behavior toward LGBT patients or staff.**
 - Identify an individual directly accountable to leadership for overseeing organizational efforts to provide more culturally competent and patient-centered care to LGBT patients and families.**
 - Appoint a high-level advisory group to assess the climate for LGBT patients and make recommendations for improvement.**
 - Identify and support staff or physician champions who have special expertise or experience with LGBT issues.**

Provision of Care, Treatment, and Services Checklist

- Create a welcoming environment that is inclusive of LGBT patients.**
 - Prominently post the hospital's nondiscrimination policy or patient bill of rights.**
 - Waiting rooms and other common areas should reflect and be inclusive of LGBT patients and families.**
 - Create or designate unisex or single-stall restrooms.**
 - Ensure that visitation policies are implemented in a fair and nondiscriminatory manner.**
 - Foster an environment that supports and nurtures all patients and families.**
- Avoid assumptions about sexual orientation and gender identity.**
 - Refrain from making assumptions about a person's sexual orientation or gender identity based on appearance.**
 - Be aware of misconceptions, bias, stereotypes, and other communication barriers.**
 - Recognize that self-identification and behaviors do not always align.**
- Facilitate disclosure of sexual orientation and gender identity, but be aware that disclosure or "coming out" is an individual process.**
 - Honor and respect the individual's decision and pacing in providing information.**
 - All forms should contain inclusive, gender-neutral language that allows for self-identification.**
 - Use neutral and inclusive language in interviews and when talking with patients.**
 - Listen to and reflect patients' choice of language when they describe their own sexual orientation and how they refer to their relationship or partner.**
- Provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people.**
 - Become familiar with online and local resources available for LGBT people.**
 - Seek information and stay up to date on LGBT health topics. Be prepared with appropriate information and referrals.**

Workforce Checklist

- Ensure equitable treatment and inclusion for LGBT employees.**
 - Protect staff from discrimination that is based on personal characteristics, including sexual orientation, gender identity, or gender expression.**

 - Equalize health care coverage for same-sex-partnered and transgender employees.**

 - Equalize all other hospital benefits.**

- Demonstrate commitment to LGBT equity and inclusion in recruitment and hiring.**
 - Add LGBT-inclusive language to job notices.**

 - Attend LGBT job fairs, advertise in LGBT publications, and conduct outreach with LGBT groups.**

 - Include the hospital's LGBT-inclusive benefits and policies in recruitment and hiring materials, both online and in print.**

 - Train human resources employees on general LGBT workplace concerns, LGBT-inclusive nondiscrimination statement, benefits, and policies.**

- Educate staff on LGBT employee concerns.**
 - Provide information about LGBT workplace concerns in all appropriate training.**

 - Offer LGBT training to key audiences.**

 - Distribute to human resources staff online and print information about LGBT workplace concerns.**

 - Develop a plan to address the unique needs of transgender employees.**

- Incorporate LGBT patient care information in new or existing employee staff training.**
 - Vary methods used to provide training.**

 - Update training and educational material on a regular basis.**

- Support staff development initiatives to maximize equity and inclusion for LGBT employees.**
 - Support an LGBT employee resource group (ERG), which can assist LGBT employees, provide expertise to hospital staff, and raise awareness of LGBT concerns throughout the organization.**

 - Support forums for employees to freely and openly discuss any LGBT-related questions or concerns in a group setting to encourage learning.**

Data Collection and Use Checklist

- Identify opportunities to collect LGBT–relevant data and information during the health care encounter.**
 - Identify a process to collect data at registration/admitting.**
 - Identify a process to document self-reported sexual orientation and gender identity information in the medical record.**
 - Ensure that the disclosure of sexual orientation and gender identity information is voluntary.**
 - Train staff to collect sexual orientation and gender identity data.**
 - Ensure that strong privacy protections for all patient data are in place.**
 - Add information about sexual orientation and gender identity to patient surveys.**
 - Use aggregated patient-level sexual orientation and gender identity data to develop or modify services, programs, or initiatives to meet patient population needs.**
- Use available population-level data to help determine the needs of the surrounding community.**
 - Use national- and state-level data on sexual orientation and gender identity to develop initiatives that address the health concerns of LGBT patients.**
 - Conduct focus groups or interview community leaders, including LGBT community members and leaders, to identify changes in the demographics and needs of the surrounding community.**
 - Conduct community needs assessments that include LGBT demographics.**

Patient, Family, and Community Engagement Checklist

- Collect feedback from LGBT patients and families and the surrounding LGBT community.**
 - Conduct confidential patient satisfaction surveys that include questions regarding sexual orientation and gender identity.
 - Ask LGBT patients and families about staff responsiveness to their needs during care planning and treatment and include whether and how these needs were accommodated.
 - Invite LGBT patients and family members to share their experiences through focus groups or advisory councils. Establish a point of contact for community members to supply complaints or feedback.
 - Encourage community input and collaboration by establishing a community advisory board.
 - Encourage LGBT organizations to provide feedback on internal and external written material and policies to ensure that they are LGBT-inclusive.
- Ensure that communications and community outreach activities reflect a commitment to the LGBT community.**
 - External Communications**
 - Utilize the hospital Web site to communicate information about available services, programs, and initiatives to meet LGBT patient and family needs.
 - Expand marketing efforts to include LGBT audiences by publishing in LGBT media.
 - Community Outreach**
 - Designate an individual or create a committee to address LGBT community outreach activities and to establish or maintain ties to community partners.
 - Ensure that existing community outreach activities are LGBT-inclusive.
 - Establish partnerships with community health centers and other health care facilities in your community.
 - Engage state hospital associations and state departments of health to determine areas of potential collaboration with regard to LGBT health issues.
 - Consider participating in cultural competency programs for students in medical, nursing, and other allied health programs.
 - Consider sponsoring, participating, or providing educational resources to gay/straight alliances at local colleges or high schools.
- Offer educational opportunities that address LGBT health issues.**
 - Provide educational programs and forums that support the unique needs of the LGBT community.
 - Engage external LGBT community organizations in the development and review of existing educational programming to ensure that it is LGBT-inclusive.

*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care
for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community*



Joint Commission Requirements Supporting Effective Communication, Cultural Competence, and Patient- and Family-Centered Care

Source: This appendix is adapted from the 2011 *Comprehensive Accreditation Manual for Hospitals (CAMH)* and *The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010).

Joint Commission standards have supported the provision of care, treatment, and services in a manner that is sensitive and responsive to individual patient needs for many years. Recognition of the role patients and their families play in patient safety promotes practices that increase patients' and families' ability to actively engage in their care. Because care spans a broad continuum and involves a complex interplay of both individual and system behaviors, the standards that support effective communication, cultural competence, and patient- and family-centered care are found throughout the *CAMH*.

This appendix presents existing standards and elements of performance (EPs) that relate to effective communication, cultural competence, and patient- and family-centered care for all patients, including those who are LGBT. These standards are up to date as of September 2011. Not all applicable standards can be covered in a brief appendix—for more detailed information about Joint Commission standards, please refer to the current *CAMH*.

Standards from the following *CAMH* chapters are included in this appendix:

- “Environment of Care” (EC)
- “Human Resources” (HR)
- “Information Management” (IM)
- “Leadership” (LD)
- “Provision of Care, Treatment, and Services” (PC)
- “Record of Care, Treatment, and Services” (RC)
- “Rights and Responsibilities of the Individual” (RI)
- “Transplant Safety” (TS)

Environment of Care (EC)

The Joint Commission EC standards primarily address the physical safety of the environment for patients, staff, and visitors. However, the chapter also recognizes that the physical environment needs to support patient

privacy and dignity, and foster ease of interaction. EC standards also support an environment that is compliant with the Americans with Disabilities Act, Occupational Safety and Health Administration (OSHA) regulations, and other environmental safety codes.

Joint Commission EC Requirements

EC.02.06.01 The hospital establishes and maintains a safe, functional environment.

Note: *The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.*

EP 1 Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Human Resources (HR)

Many recommendations to promote effective communication, cultural competence, and patient- and family-centered care include recommendations to build a diverse workforce through recruitment, retention, and promotion of diverse staff. Although the Joint Commission standards do not set this specific expectation, the standards expect that hospital staffing is consistent with the organization's mission. In addition, The Joint Commission expects the organization's leadership to define the qualifications and competencies of staff.

From this perspective, HR standards focus mainly on the specific skill sets and competencies that staff need to perform their job. Joint Commission standards address orientation on cultural diversity and sensitivity, and expect ongoing in-services and other education and training to be appropriate to the needs of the population(s) served and responsive to learning needs

identified through performance improvement findings and other data analysis. Staff must be aware of relevant policies and procedures, which could include the hospital's policies for meeting patient communication needs. Communication is recognized as a patient right but is also clearly part of the provision of safe care.

Joint Commission HR Requirements

HR.01.02.01 The hospital defines staff qualifications.

EP 1 The hospital defines staff qualifications specific to their job responsibilities.

Note 4: *Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. (Inclusion of these qualifications will not affect the accreditation decision at this time.)*

HR.01.04.01 The hospital provides orientation to staff.

EP 3 The hospital orients staff on the following: Relevant hospitalwide and unit-specific policies and procedures. Completion of this orientation is documented.

EP 4 The hospital orients staff on the following: Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented.

EP 5 The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.

EP 6 The hospital orients staff on the following: Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.

HR.01.05.03 Staff participate in ongoing education and training.

EP 1 Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.

EP 4 Staff participate in ongoing education and training whenever staff responsibilities change. Staff participation is documented.

EP 5 Staff participate in education and training that is specific to the needs of the patient population served by the hospital. Staff participation is documented.

HR.01.06.01 Staff are competent to perform their responsibilities.

EP 1 The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services.

Information Management (IM)

Every episode of care generates health information that must be managed systematically by the hospital. The health information system should accurately capture health information, and the information should be accessed by authorized users who will use health information to provide safe, high-quality care. Unauthorized access can be limited by the adoption of policies that address the privacy, security, and integrity of health information, which results in preserving confidentiality.

Joint Commission IM Requirements

IM.02.01.01 The hospital protects the privacy of health information.

EP 1 The hospital has a written policy addressing the privacy of health information. (See also RI.01.01.01, EP 7)

EP 2 The hospital implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

EP 3 The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. (See also MM.01.01.01, EP 1, and RI.01.01.01, EP 7)

EP 4 The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. (See also RI.01.01.01, EP 7)

EP 5 The hospital monitors compliance with its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

IM.02.01.03 The hospital maintains the security and integrity of health information.

EP 1 The hospital has a written policy that addresses the security of health information, including access, use, and disclosure.

EP 5 The hospital protects against unauthorized access, use, and disclosure of health information.

EP 8 The hospital monitors compliance with its policies on the security and integrity of health information.

Leadership (LD)

LD standards address the foundational elements that support effective systems for providing high-quality care, treatment, and services; the organization culture; systems and policy development; availability of resources; availability of competent staff; and ongoing evaluation of and improvement in performance. The organization support systems that allow for effective patient-provider communication, cultural competence, and patient- and family-centered care all hinge upon leadership

The mission of many hospitals is to meet the needs of the patient population and their communities. Leaders must reconcile these needs with the organization's resources and needs. For example, support for effective communication benefits not only the needs of the patient, but equally benefits the needs of the care providers and the hospital. The Hospitals, Language, and Culture: A Snapshot of the Nation study¹ found that several hospitals invested in language access services to improve communication because they recognized that the lack of available interpreters potentially contributed to patient flow problems, overuse of certain tests, and unnecessary readmissions.

In addition, experts in the area of patient- and family-centered care recommend that leaders bring the patient and family perspective directly into the planning, delivery, and evaluation of health care. Studies increasingly show that when health care administrators, providers, and

patients and families work in partnership, the quality and safety of health care rise, costs decrease, and provider and patient satisfaction increase.

LD standards support the concepts outlined in the Field Guide in many areas, including the following:

- Communication of the hospital's mission, including supportive systems to effectively communicate throughout the hospital and to the community
- The use of data to plan for and monitor care, treatment, and services
- Creation of a culture that supports patient and staff safety
- Compliance with applicable laws and regulations, including those that protect patients' rights, equal opportunity for workforce, and environmental regulations such as building and safety codes. (See Appendix C, "Laws, Regulations, and Executive Materials," page 51, for more information on some of the laws and regulations relevant to effective communication, cultural competence, and patient- and family-centered care.)

Many hospitals include in their mission and/or vision statements the commitment to serve their community. Often, it is this commitment that drives hospital leaders to embrace practices that support health equity.

Joint Commission LD Requirements

LD.02.01.01 The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.

Rationale for LD.02.01.01

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The purpose of the hospital's mission, vision, and goals is to define how the hospital will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the hospital is most likely achieved when it is understood by all who work in or are served by the hospital.

EP 3 Leaders communicate the mission, vision, and goals to staff and the population(s) the hospital serves.

LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the hospital.

Rationale for LD.03.01.01

Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Leaders demonstrate their commitment to quality and set expectations for those who work in the hospital. Leaders evaluate the culture on a regular basis. Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the hospital, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

EP 1 Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

EP 2 Leaders prioritize and implement changes identified by the evaluation.

EP 3 Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.

EP 4 Leaders develop a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.

EP 5 Leaders create and implement a process for managing disruptive and inappropriate behaviors.

EP 6 Leaders provide education that focuses on safety and quality for all individuals.

EP 7 Leaders establish a team approach among all staff at all levels.

EP 8 All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.

EP 9 Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.

EP 10 Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.

LD.03.02.01 The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Rationale for LD.03.02.01

Data help hospitals make the right decisions. When decisions are supported by data, hospitals are more likely to move in directions that help them achieve their goals. Successful hospitals measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.

EP 3 The hospital uses processes to support systematic data and information use.

EP 5 The hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services.

LD.03.03.01 Leaders use hospital-wide planning to establish structures and processes that focus on safety and quality.

Rationale for LD.03.03.01

Planning is essential to the following:

- The achievement of short- and long-term goals
- Meeting the challenge of external changes
- The design of services and work processes
- The creation of communication channels
- The improvement of performance
- The introduction of innovation

Planning includes contributions from the populations served, from those who work for the hospital, and from other interested groups or individuals.

EP 1 Planning activities focus on improving patient safety and health care quality.

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EP 3 Planning is systematic, and involves designated individuals and information sources.

EP 4 Leaders provide the resources needed to support the safety and quality of care, treatment, and services.

EP 6 Planning activities adapt to changes in the environment.

LD.03.04.01 The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Rationale for LD.03.04.01

Effective communication is essential among individuals and groups within the hospital, and between the hospital and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and services. Effective communication is timely, accurate, and usable by the audience.

EP 1 Communication processes foster the safety of the patient and the quality of care.

EP 3 Communication is designed to meet the needs of internal and external users.

EP 5 Communication supports safety and quality throughout the hospital.

EP 6 When changes in the environment occur, the hospital communicates those changes effectively.

LD.04.01.01 The hospital complies with law and regulation.

EP 2 The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.

LD.04.01.07 The hospital has policies and procedures that guide and support patient care, treatment, and services.

EP 1 Leaders review and approve policies and procedures that guide and support patient care, treatment, and services.

EP 2 The hospital manages the implementation of policies and procedures.

LD.04.01.11 The hospital makes space and equipment available as needed for the provision of care, treatment, and services.

Rationale for LD.04.01.11

The resources allocated to services provided by the hospital have a direct effect on patient outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the hospital.

EP 2 The arrangement and allocation of space supports safe, efficient, and effective care, treatment, and services.

EP 3 The interior and exterior space provided for care, treatment, and services meets the needs of patients.

EP 4 The grounds, equipment, and special activity areas are safe, maintained, and supervised.

EP 5 The leaders provide for equipment, supplies, and other resources.

LD.04.03.01 The hospital provides services that meet patient needs.

EP 1 The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.

LD.04.03.07 Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Rationale for LD.04.03.07

Comparable standards of care means that the hospital can provide the services that patients need within

established time frames and that those providing care, treatment, and services have the required competence. Hospitals may provide different services to patients with similar needs as long as the patient's outcome is not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Different settings, processes, or payment sources should not result in different standards of care.

EP 1 Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.

EP 2 Care, treatment, and services are consistent with the hospital's mission, vision, and goals.

Provision of Care, Treatment, and Services (PC)

PC standards address the cyclical process that allows care to be delivered according to patient needs and the hospital's scope of services. Joint Commission PC standards address care at various points across the care continuum. The Joint Commission recognizes the need for patients and families to be active and informed decision makers throughout the course of care. To establish this partnership between the care provider and patient, it is necessary to make sure that communication is effective.

Part of patient assessment includes the identification of patient learning needs. In addition, the assessment process may allow for comprehensive evaluation of other needs that may impact the patient's ability to engage with the care team. These needs are important to consider throughout the care continuum. The patient's communication needs, cultural perspective of health and health care, and previous experience with the health system all influence how the patient will respond to care. To foster a healthy relationship with the patient during the course of care, it is necessary to be sensitive and open to the patient's individual perspective. Many standards in the PC chapter support this.

Joint Commission PC Requirements

PC.01.02.01 The hospital assesses and reassesses its patients.

EP 1 The hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects.

Note: *In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.*

EP 2 The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.

Note: *Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.*

EP 4 Based on the patient's condition, information gathered in the initial assessment includes the following:

- Physical, psychological, and social assessment
- Nutrition and hydration status
- Functional status
- For patients who are receiving end-of-life care, the social, spiritual, and cultural variables that influence the patient's and family members' perception of grief

PC.01.03.01 The hospital plans the patient's care.

EP 1 The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.

PC.02.01.21 The hospital effectively communicates with patients when providing care, treatment, and services.

Note: *This standard will not affect the accreditation decision at this time.*

EP 1 The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1)

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Note 1: *Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.*

Note 2: *This element of performance will not affect the accreditation decision at this time.*

EP 2 The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03, EPs 1–3)

Note: *This element of performance will not affect the accreditation decision at this time.*

PC.02.02.01 The hospital coordinates the patient's care, treatment, and services based on the patient's needs.

EP 1 The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services.

EP 3 The hospital coordinates the patient's care, treatment, and services.

Note: *Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.*

EP 10 When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.

EP 17 The hospital coordinates care, treatment, and services within a time frame that meets the patient's needs.

PC.02.02.03 The hospital makes food and nutrition products available to its patients.

EP 9 When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

PC.02.02.13 The patient's comfort and dignity receive priority during end-of-life care.

EP 1 To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.

PC.02.03.01 The hospital provides patient education and training based on each patient's needs and abilities.

EP 1 The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

Record of Care, Treatment, and Services (RC)

The RC chapter contains information about the components of a complete medical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision making. Whether the hospital keeps paper records, electronic records, or a combination of both, the contents of the record remain the same.

Joint Commission RC Requirements

RC.02.01.01 The medical record contains information that reflects the patient's care, treatment, and services.

EP 1 The medical record contains the following demographic information:

- The patient's name, address, date of birth, and the name of any legally authorized representative
- The patient's sex
- The legal status of any patient receiving behavioral health care services
- The patient's communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1)

Note: *If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or*

legally authorized representative are documented in the medical record.

EP 4 As needed to provide care, treatment, and services, the medical record contains the following additional information:

- Any advance directives
- Any informed consent, when required by hospital policy
- Any patient-generated information

EP 28 The medical record contains the patient's race and ethnicity.

Note: *This element of performance will not affect the accreditation decision at this time.*

Rights and Responsibilities of the Individual (RI)

Hospital care must be provided in a manner that is respectful of individual values, beliefs, and preferences. While not all preferences can be accommodated, it is highly desirable to work with patients to achieve a negotiated solution when differences arise. The standards in the RI chapter highlight the need for patient engagement in health care. The patient is a key decision maker and a key source of information so that accurate assessment and diagnosis can be made. Patient rights standards support patient engagement in a manner that promotes understanding so that the provision of care is not compromised.

Joint Commission RI Requirements

RI.01.01.01 The hospital respects, protects, and promotes patient rights.

EP 1 The hospital has written policies on patients' rights.

Note: *For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.*

EP 2 The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1–3)

Note: *For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.*

EP 4 The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.

EP 5 The hospital respects the patient's right to and need for effective communication. (See also RI.01.01.03, EP 1)

EP 6 The hospital respects the patient's cultural and personal values, beliefs, and preferences.

EP 7 The hospital respects the patient's right to privacy. (See also IM.02.02.01, EPs 1–5)

Note: *This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, please refer to Standard IM.02.01.01.*

EP 28 The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

Note: *The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6–8.)*

EP 29 The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

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RI.01.01.03 The hospital respects the patient's right to receive information in a manner he or she understands.

EP 1 The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.

EP 2 The hospital provides language interpreting and translation services.

Note: *Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.*

EP 3 The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

RI.01.02.01 The hospital respects the patient's right to participate in decisions about his or her care, treatment, and services.

EP 1 The hospital involves the patient in making decisions about his or her care, treatment, and services.

RI.01.03.01 The hospital honors the patient's right to give or withhold informed consent.

Rationale for RI.01.03.01

Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, or services.

EP 12 The informed consent process includes a discussion about any circumstances under which information about the patient must be disclosed or reported.

Note: *Such circumstances may include requirements for disclosure of information regarding cases of HIV, tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention.*

EP 13 Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery.

RI.01.05.01 The hospital addresses patient decisions about care, treatment, and services received at the end of life.

EP 6 The hospital provides patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.

EP 8 Upon admission, the hospital provides the patient with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.

EP 9 The hospital documents whether or not the patient has an advance directive.

EP 10 Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.

EP 11 Staff and licensed independent practitioners who are involved in the patient's care, treatment, and services are aware of whether or not the patient has an advance directive. (See also RC.02.01.01, EP 4)

RI.01.06.03 The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

EP 1 The hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services within the hospital.

EP 2 The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. (See also PC.01.02.09, EP 1)

EP 3 The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. (See also PC.01.02.09, EPs 6 and 7)

RI.01.06.05 The patient has the right to an environment that preserves dignity and contributes to a positive self-image.

RI.01.07.01 The patient and his or her family have the right to have complaints reviewed by the hospital.

Rationale for RI.01.07.01

A business is often judged by how it handles dissatisfied customers; the same is true for health care organizations. Addressing complaints promptly helps to satisfy the needs of patients and their families during a vulnerable time in their lives, and may also prevent adverse events from occurring in the organization. Complaints can range from the straightforward, such as the temperature of the patient's room, to the complex, such as the patient's care being adversely impacted by practitioners' failure to effectively communicate. Regardless of the complexity of the complaint, patients and their families expect the organization to work toward a resolution as quickly as possible.

EP 1 The hospital establishes a complaint resolution process.

Note: *The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.*

EP 2 The hospital informs the patient and his or her family about the complaint resolution process.

Reference

1. Wilson-Stronks A., Galvez E.: *Hospitals, Language, and Culture: A Snapshot of the Nation Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2007. http://www.jointcommission.org/assets/1/6/hlc_paper.pdf (accessed Sep. 20, 2011).

EP 4 The hospital reviews and, when possible, resolves complaints from the patient and his or her family.

EP 7 The hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority.

EP 10 The hospital allows the patient to voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care.

Transplant Safety (TS)

The "Transplant Safety" chapter addresses considerations for donating and procuring organs and tissues. Because there are a variety of cultural beliefs and rituals associated with death, as well as beliefs about how the physical body should be cared for before and after death, it is important that these beliefs are considered when proposing organ donation and procurement. Staff should be trained to be aware and respectful of cultural and religious beliefs that may influence how a patient or family will respond to inquiries about organ donation.

Joint Commission TS Requirements

TS.01.01.01 The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues.

EP 5 Staff education includes training in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors.



APPENDIX C

Laws, Regulations, and Executive Materials

Federal statutes prohibit discrimination on the basis of race, color, national origin, age, disability, and sex in virtually all hospitals nationwide. Federal civil rights laws, however, do not specifically include sexual orientation and gender identity as prohibited bases. Nonetheless, skilled advocates have filed complaints against hospitals with federal courts and administrative agencies using existing federal civil rights laws to protect the rights of lesbian, gay, bisexual, and transgender (LGBT) Americans. For example, if a gay man goes to a hospital emergency room and suffers a denial of care or a substantial delay in care because the staff fears that he will expose them to HIV/AIDS, the denial or delay in care may constitute illegal disability discrimination under Section 504 of the Rehabilitation Act of 1973 (Section 504),¹ because the gay man is regarded as having a disability, HIV/AIDS.

Advocates for LGBT Americans also have filed complaints against hospitals with state and local courts and administrative agencies in jurisdictions that have antidiscrimination laws specifically including gender identity and sexual orientation² as prohibited bases. As health care professionals committed to providing culturally competent and patient- and family-centered care to all Americans, it is critical for hospital staff members to be aware

of federal, state, and local civil rights laws protecting LGBT Americans.³

The U.S. Department of Justice (DOJ), the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), and the HHS Centers for Medicare & Medicaid Services (CMS), each investigate federal civil rights complaints and related grievances against hospitals. OCR investigations may require hospital staff members to spend hundreds of hours responding to document requests, being interviewed by investigators, and participating in on-site visits.

To avoid possible violation findings and the potential termination of federal financial assistance,⁴ hospitals should implement policies and procedures consistent with federal civil rights laws. Appendix C provides basic background information on federal civil rights laws and related federal statutes.

1 29 U.S.C. § 794 (2002). Section 504 obligates recipients of federal financial assistance—such as hospitals that participate in the Medicare program—to ensure that persons with disabilities have equal access to their programs and services. Appendix C has been tailored to speak directly to “hospitals,” as opposed to “recipients,” because the vast majority of hospitals participate in the Medicare program or otherwise receive federal financial assistance from the U.S. Department of Health and Human Services.

2 See, e.g., *Doe v. District of Columbia Comm’n on Human Rights*, 624 A.2d 440, 445-46 (D.C. 1993) (where Howard University Hospital denied a patient’s access to its psychiatric unit, the D.C. Court of Appeals dismissed the patient’s sexual orientation discrimination claim under the D.C. Human Rights Act, holding that the denial of access to the psychiatric unit was impermissibly based on the perception that the patient was HIV-positive).

3 Depending on your location, there may be state or local laws that prohibit discrimination or impose other requirements related to culturally competent and patient- and family-centered care. For example, the District of Columbia and the following states have public accommodation antidiscrimination statutes that include sexual orientation as a protected basis: California, Colorado, Connecticut, Hawaii, Illinois, Iowa, Maine, Massachusetts, Maryland, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Washington, Wisconsin, and Vermont. See Elizabeth R. Clayton, Comment, *Equal Access to Health Care: Sexual Orientation and State Public Accommodation Antidiscrimination Statutes*, 19 Law & Sexuality 193, 195 n.15 (2010). Although hospital staff members should be aware of relevant state and local civil rights laws, Appendix C will focus on federal statutes available to protect LGBT Americans.

4 See, e.g., *United States Dep’t of Health and Human Serv. v. Westchester County Med. Ctr.*, No. 1357 (HHS Dep’t App. Bd. 1992), <http://www.hhs.gov/dab/decisions/dab1357.html>.

Laws and Regulations Included in This Section

- Emergency Medical Treatment and Labor Act
- Hill-Burton Act
- Section 1557 of the Affordable Care Act
- Title IX of the Education Amendments of 1972
- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990
- Health Insurance Portability and Accountability Act of 1996

Executive Material Included in This Section

- Centers for Medicare & Medicaid Services, Changes to the Hospital and Critical Access Hospital Conditions of Participation (CoP) to Ensure Visitation Rights for All Patients; Revised CoP Interpretive Guidelines for Hospitals and Critical Access Hospitals re: Patients' Representatives
- Centers for Medicare & Medicaid Services, Letter to State Medicaid Directors re: Same Sex Partners and Medicaid Liens, Transfers of Assets, and Estate Recovery
- HHS National Data Progression Plan for LGBT Data Collection
- Office of Personnel Management, Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace
- HHS Equal Employment Opportunity Policy and HHS Non-Discrimination Policy Statement

Emergency Medical Treatment and Labor Act (EMTALA)

Medicare-participating hospitals must meet the requirements of EMTALA.⁵ EMTALA requires such hospitals with dedicated emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such

an examination; and, if necessary, to provide either: (1) further examination and treatment to stabilize an individual's emergency medical condition, or (2) an appropriate transfer to a medical facility that can provide stabilizing treatment. If the stabilizing treatment for an emergency medical condition or labor is within the hospital's capability and capacity, the Medicare participating hospital with an emergency department is generally prohibited from refusing to examine and treat the individual with an emergency medical condition or labor. Medical screening examinations and stabilization must be provided regardless of the individual's ability to pay or status as uninsured. The requirements of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care.

The major provisions of EMTALA, as implemented, require Medicare participating hospitals with emergency departments to:

- Post signs in the emergency department specifying the rights of individuals with emergency medical conditions and women in labor who come to the emergency department for health care services and indicate on the signs that the hospital participates in the Medicaid program;
- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of the transfer;
- Maintain a list of physicians who are on-call to provide further evaluation and treatment necessary to stabilize an individual with an emergency medical condition;
- Provide an appropriate medical screening examination; and
- Provide necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity or an appropriate transfer to a medical facility that can provide stabilizing treatment.

In addition, Medicare participating hospitals with specialized capabilities are required to accept an appropriate transfer of an individual with an unstabilized emergency

⁵ 42 U.S.C. § 1395dd (2003). The EMTALA regulations are set forth at 42 C.F.R. § 489.24 and related requirements are at 42 C.F.R. § 489.20(l), (m), (q), and (r) (2009).

medical condition, regardless of whether the recipient hospital has an emergency department.⁶

An administrative complaint under EMTALA may be filed against a hospital with a State Survey Agency⁷ or a CMS Regional Office.⁸ The investigation of a hospital's policies and procedures is most often authorized by CMS after a complaint alleging an EMTALA violation is received. If the results of the complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions of EMTALA, a hospital may be subject to termination of its provider agreement with CMS and/or the imposition of civil monetary penalties (CMPs). CMPs may be imposed by the HHS Office of the Inspector General against hospitals or individual physicians for EMTALA violations.⁹

In addition to filing an administrative complaint, any individual who suffers harm due to a hospital's violation

of EMTALA may file a civil action in federal district court against the hospital for money damages and equitable relief.¹⁰ For example, in *Blake v. Richardson*,¹¹ the plaintiff was admitted to the Overland Park Regional Medical Center (OPRMC) emergency room, complaining of pain in his abdomen, which was eventually diagnosed as acute appendicitis. According to the plaintiff, the emergency room physician inquired as to the plaintiff's sexual orientation and the plaintiff disclosed his status as a gay man. The plaintiff alleged that as a result of the disclosure, the emergency room physician required him to consent to, and await the results of an HIV test, before he could receive any additional treatment. Once the results of the HIV test were obtained, an emergency appendectomy was performed on the plaintiff. Plaintiff's complaint alleged, among other things, that by treating him differently from similarly situated patients in the emergency room, OPRMC violated EMTALA. The United States District Court for the District of Kansas held:

Plaintiff alleges that, unless all appendicitis patients are ordinarily required to wait for the results of an HIV screen before being rushed to surgery, once his sexual orientation was discovered by defendants, plaintiff was singled out and treated differently than other similarly situated patients. Thus, plaintiff claims, by being forced to submit to, and await the results of, an HIV test prior to being admitted to surgery, OPRMC failed to administer the same level of treatment regularly provided to patients exhibiting acute appendicitis symptoms. The court finds these allegations sufficient to withstand defendants' motions to dismiss under the theories advanced therein. Defendants' motions to dismiss Count I [the EMTALA claim] are therefore denied.¹²

6 See CMS State Operations Manual, at App. 5 (July 16, 2010) ("Interpretive Guidelines—Responsibilities of Medicare Participating Hospitals in Emergency Cases"), http://www.cms.gov/manuals/Downloads/som107ap_v_emerg.pdf.

7 Additional information regarding the patient's or visitor's right to file a complaint with a State Survey Agency may be found at http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp.

8 Just as there are ten OCR Regional Offices, there are ten CMS Regional Offices. Each OCR Regional Office and each CMS Regional Office is responsible for investigating complaints (filed with its respective agency) in the following states: Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); Region II (New Jersey, New York, Puerto Rico, and the Virgin Islands); Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia); Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee); Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin); Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas); Region VII (Iowa, Kansas, Missouri, and Nebraska); Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming); Region IX (Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau); and Region X (Alaska, Idaho, Oregon, and Washington), <http://www.hhs.gov/about/regionmap.html>.

9 See CMS State Operations Manual, at App. 5.

10 See 42 U.S.C. § 1395dd(d).

11 No. 98–2576–JWL, 1999 WL 319082 (D. Kan. Apr. 1, 1999).

12 1999 WL 319082 at *3. In cases similar to *Blake*, where there is an EMTALA complaint and allegations that the hospital staff denied or delayed emergency medical services due to discrimination based on race, color, national origin, age, sex, or disability, CMS Regional Offices are required to investigate the EMTALA claims and refer the discrimination claims to OCR. See CMS State Operations Manual, at App. 5.

In summary, EMTALA requires Medicare participating hospitals with emergency departments to provide a medical screening examination to any individual—including an LGBT individual—who comes to the hospital’s emergency department and requests such an examination; and, if necessary, to provide—within its capability and capacity—further examination and treatment to stabilize the individual or an appropriate transfer to a medical facility that can provide stabilizing treatment. In addition, EMTALA requires Medicare participating hospitals with specialized capabilities to accept an appropriate transfer of an individual with an unstabilized emergency medical condition.

Hill-Burton Act

The Hill-Burton Act authorizes assistance for construction and renovation of public and nonprofit hospitals and other medical facilities.¹³ The Hill-Burton “community service assurance” provision requires each recipient of Hill-Burton funds to make services available to persons residing in the hospital’s service area without discrimination on the basis of “race, color, national origin, creed, or any other ground unrelated to the individual’s need for the service or the availability of the needed service in the facility.”¹⁴

To meet its community service assurance obligation, each Hill-Burton hospital:

- Must participate in the Medicare and Medicaid programs unless it is ineligible to participate.¹⁵
- Must make arrangements for reimbursement for services with principal state and local third-party

payors that provide reimbursement that is not less than the actual cost of the services.¹⁶

- Must post notices informing the public of its community service obligations in English and Spanish. If 10% or more of the households in the service area usually speak a language other than English or Spanish, the hospital must translate the notice into that language and post it as well.¹⁷
- May not deny emergency services to any person residing in the hospital’s service area on the grounds that the person is unable to pay for those services.¹⁸

Hospitals that received Hill-Burton funds are to make their facilities available “to all persons residing in the territorial area” and the courts have broadly construed this statutory provision.¹⁹ If a hospital does not comply with its Hill-Burton Act community service assurance obligation, a consumer or an advocate may file an administrative complaint with OCR. If OCR dismisses the administrative complaint or declines to bring a compliance action within one hundred and eighty (180) days of the filing of the complaint, the consumer or advocate may bring a private action in federal court.²⁰

Advocates are likely to marshal the Hill-Burton Act’s community service assurance obligation to challenge a covered hospital’s delay or denial of care due to discrimination on the basis of an individual’s sexual orientation or

13 The “Hill-Burton Act” is the popular name for the Hospital Survey and Construction Act, Pub.L. No. 79-725, 60 Stat. 1040 (1946), presently codified as Title VI of the Public Health Service Act, 42 U.S.C. §§ 291 et seq. (1970).

14 42 C.F.R. § 124.603 (2001). Although no new projects are now funded under the Hill-Burton Act, the “community service assurance” requirement continues indefinitely for projects that received funds.

15 42 C.F.R. § 124.603(c).

16 42 C.F.R. § 124.603(c).

17 U.S. Department of Health and Human Services, Office for Civil Rights, Fact Sheet: Your Rights Under the Community Service Assurance Provision of the Hill-Burton Act (June 29, 2006), available at <http://www.hhs.gov/ocr/civilrights/resources/factsheets/hillburton.pdf>.

18 42 C.F.R. § 124.603(b).

19 42 U.S.C. § 291c(e)(1); *Lugo v. Simon*, 426 F. Supp. 28, 35 (D.C. Ohio 1976) (“42 U.S.C. s 291c(e)(1) provides that applicants for funds are to make facilities available to all persons residing in the territorial area. Such language, unlike the free care provisions, is in absolute terms. No limitation is implied.”).

20 42 C.F.R. §§ 124.601 – 124.607.

gender identity. Accordingly, hospitals and other covered entities—that have received Hill-Burton funds and have continuing community assurance obligations—should review their policies to ensure that their services are made available to persons residing in the hospital's service area without discrimination on the basis of “race, color, national origin, creed, or any other ground unrelated to the individual's need for the service or the availability of the needed service in the facility.”²¹

Section 1557 of the Affordable Care Act

Section 1557 of the Affordable Care Act provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964²² (race, color, national origin), Title IX of the Education Amendments of 1972²³ (sex), the Age Discrimination Act of 1975²⁴ (age), or Section 504 of the Rehabilitation Act of 1973²⁵ (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.²⁶

Pursuant to Section 1557, hospitals receiving federal financial assistance are prohibited from discriminating on the basis of sex. Section 1557 states, in relevant part, that:

[A]n individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 . . . be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance . . .²⁷

Title IX of the Education Amendments of 1972

Title IX of the Education Amendments of 1972 states, in pertinent part, that:

No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.²⁸

Title IX prohibits gender discrimination against students enrolled in federally supported education programs,²⁹ including, but not limited to, most hospital-based education programs and clinical rotations for student nurses and other health professionals. OCR administratively enforces Title IX and its implementing regulations,³⁰ with the goal of eliminating discrimination on the basis of sex in any education program or activity that receives HHS financial assistance.

Although Title IX explicitly prohibits discrimination on the basis of sex, it does not explicitly prohibit discrimination on the basis of sexual orientation or gender identity.

²¹ 42 C.F.R. § 124.603 (2001) (emphasis added).

²² 42 U.S.C. §§ 2000d – 2000d-7.

²³ 20 U.S.C. §§ 1681 – 1688.

²⁴ 42 U.S.C. §§ 6101 – 6107.

²⁵ 29 U.S.C. § 794.

²⁶ 42 U.S.C. § 18116 (2010).

²⁷ 42 U.S.C. § 18116 (2010).

²⁸ 20 U.S.C. § 1681(a).

²⁹ See, e.g., *Gossett v. Oklahoma ex rel. Bd. of Regents for Langston Univ.*, 245 F.3d 1172, 1175-81 (10th Cir. 2001) (where a male student, who was dismissed from the nursing program, submitted witness affidavits indicating that female students were routinely given incompletes, as opposed to failing grades, the U.S. Court of Appeals for the Tenth Circuit reversed the district court's order dismissing the male student's Title IX gender discrimination claim).

³⁰ See 45 C.F.R. Part 86.

However, just as advocates marshal Title VII³¹ to protect the rights of LGBT individuals, advocates may also file Title IX complaints³² with OCR to protect the rights of LGBT individuals to be free from gender discrimination in hospital-based education or training programs.

In litigation, courts have generally assessed Title IX claims under the same legal analysis as Title VII claims.³³ Advocates have successfully brought Title VII claims where: (1) an LGBT individual suffered same-sex sexual harassment; or (2) an LGBT individual suffered discrimination³⁴ due to his or her nonconformity with sex stereotypes. For example, in *Oncale v. Sundowner Offshore Services, Inc.*,³⁵ the United States Supreme Court decisively held that same-sex sexual harassment is actionable harassment “because of sex” under Title VII. In *Oncale*, the male plaintiff was subjected to multiple instances of sexual harassment from members of an eight-man crew on an offshore oil platform, including threats of rape and “sex-related, humiliating actions.”³⁶ The Court, in rejecting a categorical exclusion

of same-sex sexual harassment claims under Title VII, focused on the evidentiary requirement that the nature of the offensive conduct must rise to the level of *discrimination because of sex*, regardless of the sex of the harasser and the harassed.³⁷ Since *Oncale*, advocates have experienced successes in bringing same-sex sexual harassment suits under Title VII.³⁸

Another seminal case defining discrimination “on the basis of sex”³⁹ is *Price Waterhouse v. Hopkins*,⁴⁰ in which the United States Supreme Court held that Title VII’s reference to “sex” encompasses both the biological differences between men and women, and gender discrimination—including discrimination on the basis of sex stereotyping. Some federal appellate courts have interpreted *Price Waterhouse* to protect LGBT individuals engaging in gender-nonconforming behavior, regardless of their sexual orientation,⁴¹ while other appellate courts have noted limitations on distinguishing

31 See, e.g., *Rene v. MGM Grand Hotel, Inc.*, 305 F.3d 1061, 1063-64 (9th Cir. 2002), cert. denied, 538 U.S. 922 (2003).

32 See, e.g., *Seiwert v. Spencer-Owen Cmty. Sch.*, 497 F. Supp. 2d 942, 953 (S.D. Ind. 2007) (“[I]t is conceivable that an individual could sustain a cause of action under Title IX if he were to demonstrate that he was being harassed – not because he was a homosexual, but because he was acting in a manner that did not adhere to the traditional male stereotypes.”).

33 See, e.g., *Gossett*, 245 F.3d at 1176. Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e et seq., is the primary federal law that prohibits gender discrimination, among other things, in employment.

34 Some courts, however, have held that Title VII does not protect LGBT individuals from discrimination solely based on their sexual orientation. See, e.g., *Medina v. Income Support Div.*, 413 F.3d 1131, 1135 (10th Cir. 2005); *Bibby v. Philadelphia Coca Cola Bottling Co.*, 260 F.3d 257, 261(3d Cir. 2001), cert. denied, 534 U.S. 1155 (2002); *Simonton v. Runyon*, 232 F.3d 33, 35-36 (2d Cir. 2000).

35 523 U.S. 75 (1998).

36 *Id.* at 77.

37 *Id.* at 80–81. The Court outlined three ways in which a plaintiff can show that an incident of same-sex harassment constitutes sex discrimination: (1) plaintiff can show that the alleged harasser made “explicit or implicit proposals of sexual activity”; (2) plaintiff can demonstrate that the harasser was “motivated by general hostility to the presence of [members of the same sex] in the workplace.”; (3) plaintiff may “offer direct, comparative evidence about how the alleged harasser treated members of both sexes in a mixed-sex workplace.” *Id.*

38 See, e.g., *Dick v. Phone Directories Co.*, 397 F.3d 1256, 1262-68 (10th Cir. 2005); *Schmedding v. Tnemec Co.*, 187 F.3d 862, 865 (8th Cir. 1999). For those plaintiffs that cannot provide sufficient evidence that the harassment was based on sex, rather than sexual orientation, courts have not extended protections. See, e.g., *Bibby*, 260 F.3d at 265.

39 20 U.S.C. § 1681(a).

40 490 U.S. 228 (1989).

41 See, e.g., *Rene v. MGM Grand Hotel, Inc.*, 305 F.3d 1061, 1063-64 (9th Cir. 2002), cert. denied, 538 U.S. 922 (2003) (“[A]n employee’s sexual orientation is irrelevant for purposes of Title VII. It neither provides nor precludes a cause of action for sexual harassment. That the harasser is, or may be, motivated by hostility based on sexual orientation is similarly irrelevant, and neither provides nor precludes a cause of action. It is enough that the harasser [has] engaged in severe or pervasive unwelcome physical conduct of a sexual nature.”).

claims based on gender stereotyping from those based on sexual orientation.⁴²

Moreover, several federal appellate courts have interpreted *Price Waterhouse* to protect transgender individuals engaging in gender-nonconforming behavior, regardless of their transgender status.⁴³ For example, in *Smith v. City of Salem*,⁴⁴ the plaintiff, a transgender woman employed by the Salem Fire Department, was subjected to harassment as she began to present in more “feminine dress and manner.”⁴⁵ This included comments from fellow employees regarding her allegedly unmasculine behavior and meetings of high-level supervisors who allegedly conspired to compel her to quit by subjecting her to several psychological screenings as a condition of continued employment.⁴⁶ Holding for the plaintiff, the U.S. Court of Appeals for the Sixth Circuit explained that “employers who discriminate against men because they *do* wear dresses and makeup, or otherwise act femininely, are also engaging in sex discrimination,”⁴⁷

because the discrimination would not occur but for the victim’s sex.⁴⁸

Federally funded hospital-based education programs should ensure—through nondiscrimination policies and formal training—that no student or prospective student is subjected to opposite-sex or same-sex sexual harassment, including, but not limited to, verbal abuse and name-calling. This principle has been well established in Title IX student-on-student sexual harassment cases.⁴⁹ For example, in *Montgomery v. Independent Sch. Dist. No. 709*,⁵⁰ the plaintiff high school student alleged that he was harassed by other students due to his sex and perceived sexual orientation. The plaintiff alleged that over an eleven-year period, his classmates called him “faggott,” “fag,” “gay,” “Jessica,” “girl,” “princess,” “fairy,” “homo,” “freak,” “lesbian,” “femme boy,” “gay boy,” “bitch,” “queer,” “pansy,” and “queen”⁵¹; physically assaulted him; and repeatedly touched him in a sexual manner. Upon review of the plaintiff’s allegations, the U.S. District Court for the District of Minnesota opined that the other students began tormenting plaintiff “based on feminine personality traits that he exhibited and the perception that he did not engage in behaviors befitting a boy.”⁵² Noting the defendant school district’s failure to effectively discipline the harassers, the District Court rejected defendant’s motion for summary judgment and held that plaintiff plead facts sufficient to establish a Title IX “claim

42 See, e.g., *Simonton*, 232 F.3d at 38 (“This [sex stereotyping] theory would not bootstrap protection for sexual orientation into Title VII because not all homosexual men are stereotypically feminine, and not all heterosexual men are stereotypically masculine.”).

43 See, e.g., *Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004) (finding a cause of action under Title VII where a transgender employee sufficiently plead claims of sex stereotyping and gender discrimination); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (applying *Price Waterhouse* and Title VII jurisprudence to an Equal Credit Opportunity Act claim and reinstating claim on behalf of a biologically male plaintiff who alleged that he was denied an opportunity to apply for a loan because he was dressed in “traditionally feminine attire”); *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000) (applying *Price Waterhouse* and Title VII to a Gender Motivated Violence Act claim, finding discrimination based on an individual’s failure to behave in the way expected of a particular gender).

44 378 F.3d 566 (6th Cir. 2004).

45 *Id.* at 572.

46 *Id.*

47 *Id.* at 574.

48 Even in light of *Price Waterhouse*, some federal appellate courts have declined to find a cause of action for transgender individuals under a sex stereotyping theory. See, e.g., *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1222 (10th Cir. 2005).

49 See, e.g., *Davis v. Monroe County Bd. of Educ.*, 526 U.S. 629, 631 (1999) (holding that student-on-student sexual harassment, if sufficiently severe, can rise to the level of actionable discrimination under Title IX).

50 109 F. Supp. 2d 1081 (D. Minn. 2000).

51 109 F. Supp. 2d at 1084.

52 109 F. Supp. 2d at 1090.

of harassment based on the perception that he did not fit his peers' stereotypes of masculinity."⁵³

In summary, federally funded hospital-based education programs may not refuse to admit or otherwise discriminate against students or prospective students on the basis of sex. These hospital-based education programs should ensure that no student or prospective student is subjected to sex discrimination, including harassment based on the individual's failure to conform to stereotypical notions regarding how persons of each gender should look or act.

Title VI of the Civil Rights Act of 1964

In March 2011 the Institute of Medicine (IOM) released *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, the first comprehensive overview of scientific research regarding the health of LGBT people. The IOM concluded, in part, that:

[I]n addition to stigma related to their sexual-minority status, LGBT individuals may face barriers to [health] care due to other characteristics, such as their racial/ethnic minority status, education level, income level, geographic location, language, immigration status, knowledge, and cultural beliefs. The intersection of these dimensions with the stigma associated with sexual- and gender-minority status results in unique barriers and challenges to accessing high-quality care for many LGBT individuals.⁵⁴

To better serve LGBT individuals who are limited English proficient (LGBT/LEP individuals), hospitals should ensure that their policies and procedures are in compliance with Title VI of the Civil Rights Act of 1964 (Title

VI).⁵⁵ Title VI prohibits race, color, or national origin discrimination in programs or activities that receive federal financial assistance. Hospitals receiving federal financial assistance may not, on the basis of race, color, or national origin:

- Deny services or other benefits provided as part of a health or human services program;
- Provide a different service or other benefit, or provide services or benefits in a different manner, from those provided to others under the program;
- Segregate or separately treat individuals in any matter related to the receipt of any service or other benefit;
- Utilize criteria or methods of administration which subject individuals to discrimination;
- Select a facility's site or location that excludes individuals or denies them benefits; or
- Deny an individual an opportunity to participate on a planning or advisory board.⁵⁶

In certain circumstances, the failure to ensure that LEP persons can effectively participate in, or benefit from, federally assisted programs and activities may violate the prohibition under Title VI against national origin discrimination. Specifically, the failure of a hospital receiving federal financial assistance to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in, or benefit from, the hospital's programs or activities may constitute a violation of Title VI.⁵⁷

55 42 U.S.C. §§ 2000d – 2000d-7. The HHS Title VI regulations are set forth at 45 C.F.R. Part 80. For a comprehensive discussion of the Title VI obligations of hospitals receiving federal financial assistance, see THE JOINT COMMISSION, ADVANCING EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE: A ROADMAP FOR HOSPITALS 65–76 (2010), <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>.

56 See 45 C.F.R. § 80.3(b).

57 See U.S. Department of Health and Human Services, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311, 47313 (Aug. 8, 2003) (hereinafter OCR LEP Guidance).

53 *Id.*

54 INSTITUTE OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING 64 (National Academies Press 2011) (hereinafter INSTITUTE OF MEDICINE).

Hospitals have two main ways to provide language assistance services to LEP persons: the written translation of vital documents (e.g., informed consent forms, complaint forms, intake forms with clinical significance, notices or eligibility criteria for hospital programs, and/or notices advising LEP persons of free language assistance services); and the provision of competent oral interpreters. Interpreters should be able to:

- Demonstrate proficiency in both English and in the other language and identify and employ the appropriate mode of interpreting (e.g., consecutive, simultaneous, summarization, or sight translation);
- Communicate information accurately in both languages about any specialized terms or concepts peculiar to the hospital's program or activity and of any particularized vocabulary and phraseology used by the LEP person;
- Understand and adhere to their role as interpreters without deviating into other roles—such as counselor or legal advisor—where such deviation would be inappropriate; and
- Understand and follow confidentiality and impartiality rules to the same extent as the hospital staff member or health professional for whom they are interpreting.⁵⁸

When serving LGBT/LEP individuals, it is particularly important for hospitals to ensure that their staff members, contractors, and interpreters are competent, professional, and sensitive to concerns about privacy and confidentiality.⁵⁹ Friends and family members (especially children) of LGBT/LEP individuals may not be competent to provide quality and accurate interpretations. Moreover, these LGBT/LEP individuals may feel particularly uncomfortable revealing or describing sensitive, private,

or confidential information to friends or family members.⁶⁰ When hospitals implement comprehensive language assistance programs, they decrease the risk of preventable adverse events in acute care settings and increase the quality of the health care that they provide to LGBT/LEP individuals.

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990

In a review of the literature on the incidence of disability in the LGBT community, the Institute of Medicine found that 47% of LGBT individuals aged 50 and older reported living with a disability. Given that more than half of all new HIV infections in the United States occur among men who have sex with men, it is likely that HIV/AIDS substantially influences the incidence of disability in the LGBT community.⁶¹

To better serve LGBT individuals who are living with a disability, hospitals should ensure that their policies and procedures are in compliance with Section 504 of the Rehabilitation Act of 1973⁶² and the Americans with Disabilities Act of 1990 (ADA).⁶³ Section 504 states that no qualified individual with a disability shall be excluded from, denied the benefits of, or be subjected to discrimination in any program or activity that receives federal

60 See OCR LEP Guidance at 47318 (“[W]here the LEP individual has declined the express offer of free language assistance and has chosen to use a family member, friend or other informal interpreter, if a recipient later determines that a family member or friend is not competent or appropriate, the recipient should provide competent interpreter services to the LEP person in place of or, if appropriate, as a supplement to the LEP individual’s interpreter.”).

61 Institute of Medicine, at 265–267.

62 29 U.S.C. § 794.

63 42 U.S.C. §§ 12101 *et seq.*

58 See OCR LEP Guidance at 47317.

59 See Institute of Medicine at 9.

financial assistance.⁶⁴ Title I of the ADA requires employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-related opportunities available to others.⁶⁵ Title II of the ADA requires state and local governments (e.g., public hospitals) to give individuals with disabilities an equal opportunity to benefit from all of their programs, services, and activities.⁶⁶ Title III of the ADA requires public accommodations and commercial facilities (e.g., private hospitals) to comply with the basic nondiscrimination requirements that prohibit the exclusion, segregation, and unequal treatment of individuals with disabilities.⁶⁷

OCR has historically adjudicated Title II of the ADA and Section 504 disability discrimination complaints filed on behalf of people living with HIV.⁶⁸ For example, in *United States Department of Health and Human Services v. Westchester County Medical Center*, a pharmacist interviewed for a position at the Medical Center and was scheduled for a pre-employment physical. After the physical, the Medical Center learned that the pharmacist was HIV-positive and declined to offer him a position. The Medical Center subsequently offered the pharmacist employment on a restricted basis where he would not be permitted to fill prescriptions for parenteral pharmaceutical products, which are normally administered by injection.

After investigating the pharmacist's administrative complaint, OCR found that the Medical Center had violated Section 504. When the Medical Center declined to take voluntary corrective action to resolve the complaint, proceedings were initiated to terminate federal financial assistance. After reviewing the brief filed by HHS and the amicus briefs filed by Lambda Legal Defense and Education Fund, Inc., and the American Medical Association, the HHS Departmental Appeals Board upheld the decision of the Administrative Law Judge that the Medical Center violated Section 504 in refusing to offer unrestricted employment to the pharmacist on the ground that he was HIV-positive; and ordered that all federal financial assistance to the Medical Center be terminated. Prior to the implementation of the order, the Medical Center and HHS settled the case.⁶⁹

Final regulations implementing Title II of the ADA (state and local government services)⁷⁰ and Title III of the ADA (public accommodations and commercial facilities)⁷¹ were published by the U.S. Department of Justice on September 15, 2010. The final rules contain new and updated requirements, including standards for service animals, hospitals' and other covered entities' obligations to provide auxiliary aids and services to persons

64 Section 504 is primarily enforced by OCR. The Section 504 regulations are set forth at 42 C.F.R. Part 84.

65 Title I of the ADA is enforced by the U.S. Equal Employment Opportunity Commission. The Title I regulations are set forth at 29 C.F.R. Part 1630.

66 Title II of the ADA is enforced by DOJ and OCR. The Title II regulations are set forth at 29 C.F.R. Part 35.

67 Title III of the ADA is enforced by DOJ. The Title III regulations are set forth at 29 C.F.R. Part 36.

68 These HIV/AIDS cases are summarized on the OCR Web site: <http://www.hhs.gov/ocr/civilrights/activities/examples/AIDS/hiv/aidscivilrightscases.html>.

69 See, e.g., *United States Dep't of Health and Human Serv. v. Westchester County Med. Ctr.*, No. 1357 (HHS Dep't App. Bd. 1992), <http://www.hhs.gov/dab/decisions/dab1357.html>.

70 See U.S. Dep't of Justice, *Nondiscrimination on the Basis of Disability in State and Local Government Services*, 75 Fed. Reg. 56164 (Sept. 15, 2010) (final rule).

71 See U.S. Dep't of Justice, *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 75 Fed. Reg. 56236 (Sept. 15, 2010) (final rule).

who are deaf or hard of hearing,⁷² and the 2010 Standards for Accessible Design (“2010 Standards”).⁷³ When implementing the 2010 Standards, hospitals and other covered entities should be aware that:

From September 15, 2010, to March 15, 2012, if a Title II entity (e.g., a public hospital) or a Title III entity (e.g., a private hospital) undertakes new construction or alterations, the entity may choose either the 1991 Standards or the 2010 Standards. Title II entities may also choose to use the Uniform Federal Accessibility Standards (UFAS).

On or after March 15, 2012, all newly constructed or altered facilities must comply with all of the requirements in the 2010 Standards.⁷⁴

The U.S. Department of Justice has advised that the 2010 Standards allow the hospital or other covered entity to voluntarily install accessible “unisex (or single-user) toilet rooms in alterations when technical infeasibility can be demonstrated. Unisex toilet rooms benefit people who use opposite sex personal care assistants. For this reason, it is advantageous to install unisex toilet rooms in addition to accessible single-sex toilet rooms in new facilities.”⁷⁵

72 When serving LGBT individuals who are deaf or hard of hearing, it is important that hospitals provide American Sign Language interpreters who are sensitive to concerns about privacy and confidentiality. For a comprehensive discussion of the Section 504 and ADA obligations of hospitals, see THE JOINT COMMISSION, ADVANCING EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE: A ROADMAP FOR HOSPITALS 65–76 (2010), <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>.

73 See U.S. Dep’t of Justice, 2010 ADA Standards for Accessible Design (Sept. 15, 2010), http://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards_prt.pdf.

74 See U.S. Dep’t of Justice, ADA 2010 Revised Requirements: Effective Date and Compliance Date (Feb. 16, 2010), http://www.ada.gov/revised_effective_dates-2010.pdf.

75 See U.S. Dep’t of Justice, 2010 ADA Standards for Accessible Design at 69 (Sept. 15, 2010), http://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards_prt.pdf.

In addition to benefiting individuals with disabilities, accessible unisex (or single-user) toilet rooms benefit mothers who are caring for their young sons, and fathers who are caring for their young daughters, as well as transgender individuals.

Health Insurance Portability and Accountability Act of 1996

The U.S. Department of Health and Human Services issued the *Standards for Privacy of Individually Identifiable Health Information* (“Privacy Rule”) to implement certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).⁷⁶ The Privacy Rule standards address the use and disclosure of individuals’ identifiable health information—called “protected health information”—by organizations subject to the Privacy Rule or “covered entities,” as well as individuals’ rights with respect to their health information. OCR is responsible for administering and enforcing the HIPAA Privacy Rule through voluntary compliance activities and civil monetary penalties.

A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected, while allowing the flow of health information needed to provide and promote high-quality health care and protect the public’s health and well-being. The Privacy Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek health care. Given that the health care marketplace is diverse, the Privacy Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

As hospitals develop internal policies and procedures to better serve the LGBT community, there are two significant issues which intersect with the Privacy Rule. First, if a hospital collects patient demographic information on sexual orientation and gender identity, what protections does the Privacy Rule provide? Second, how does the Privacy Rule safeguard the protected health information of LGBT individuals?

76 Pub. L. No. 104-191. The Privacy Rule may be found at 45 C.F.R. Parts 160 and 164, Subparts A and E.

A hospital or other covered entity may not use or disclose protected health information, including demographic information collected from an individual, except as permitted or required by the Privacy Rule.⁷⁷ Once information regarding a patient's gender identity or sexual orientation that is identifiable to a particular individual is held by a hospital or other covered entity, it becomes protected health information (in that all information that a covered entity creates or receives regarding individuals in the course of providing or paying for their health care is protected). Protected health information may only be used or disclosed: (1) with the individual's written authorization; (2) as otherwise expressly permitted or required by the Privacy Rule; or (3) after it is de-identified. There are several steps that covered entities must take to comply with the Privacy Rule, including:

- A covered entity must establish policies and procedures to safeguard a patient's protected health information.
- A covered entity must reasonably limit most uses and disclosures of protected health information to the minimum necessary to accomplish the intended purpose.
- A covered entity must have contracts in place with its business associates ensuring that they safeguard protected health information appropriately.
- A covered entity must have procedures to limit who can view and access a patient's protected health information.
- A covered entity must implement Privacy Rule training for its employees.⁷⁸

The Privacy Rule safeguards the protected health information of LGBT individuals, just as it safeguards the protected health information of other individuals. The Privacy Rule has specific provisions that address the circumstances under which a covered entity may share an individual's protected health information with family members or other persons involved in the individual's health

care or payment for health care. Under the Privacy Rule, so long as the individual does not object, a hospital or other covered entity is permitted to disclose "to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's health care."⁷⁹

Further, if a patient has a personal representative, a hospital or other covered entity must allow the patient's personal representative to inspect and receive a copy of protected health information about the patient in a medical or other record that the covered entity maintains, in accordance with the Privacy Rule⁸⁰:

- If under state, local or other applicable law, a person has authority to act on behalf of a patient who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative (except as noted in the last bullet below).
- A person can become a personal representative in several ways, including by the patient executing a health care power of attorney or another document that gives that person the authority to make health care decisions for the individual. State, local, or other

77 45 C.F.R. § 164.502(a).

78 A more detailed discussion of hospitals' obligations under the Privacy Rule may be found on OCR's Web site at <http://www.hhs.gov/ocr/privacy/index.html>.

79 45 C.F.R. § 164.510(b) (emphasis added). The following limitations apply to disclosures in this situation: If the individual is present for, or otherwise available prior to, such disclosure and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information only if it either obtains the individual's agreement; provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure. If the individual is not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of the individual's incapacity or an emergency, the covered entity may make the disclosure if it determines, in the exercise of professional judgment, that the disclosure is in the best interests of the individual. In doing so, the covered entity may disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care.

80 See 45 C.F.R. § 164.524.

applicable law may affect how a person becomes a personal representative.

- In general, if under state, local, or other applicable law, a parent, guardian, or person acting in loco parentis has authority to act on behalf of a patient who is an unemancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative. However, the minor has the authority to act as an individual, with respect to protected health information pertaining to a health care service, when the minor consents to the health care and no other consent is required by law; or the minor may lawfully obtain such health care without the consent of a parent, guardian, or person acting in loco parentis; or the parent, guardian, or person acting in loco parentis assents to a confidentiality agreement between the covered entity and the minor.⁸¹
- The personal representative of a minor child is usually the child's parent or legal guardian, according to state or local law. In cases where a custody decree exists, the personal representative is the parent(s) who can make health care decisions for the child under the custody decree.
- If the patient dies, the personal representative for the deceased is the executor or administrator of the deceased individual's estate, or the person who is legally authorized by a court or by state or local law to act on the behalf of the deceased or his or her estate.
- A hospital or other covered entity may choose not to treat a person as the patient's personal representative if the covered entity reasonably believes that the

81 Applicable law prevails over the provisions in the above bullet as follows. If, and to the extent *permitted or required* by an applicable provision of law, a covered entity *may* disclose to or grant a parent, guardian, or other person acting in loco parentis access to an unemancipated minor's protected health information. If, and to the extent, *prohibited* by an applicable provision of law, a covered entity *may not* disclose, or provide access to, protected health information about an unemancipated minor to a parent, guardian, or other person acting in loco parentis. Where the parent, guardian, or other person acting in loco parentis is not the personal representative and where there is no applicable access provision under applicable law, a covered entity *may* provide or deny access to a parent, guardian, or other person acting in loco parentis, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment. *See* 45 C.F.R. § 164.502.

patient has been or may be subjected to domestic violence, abuse, or neglect by such person or that treating such person as the personal representative could endanger the individual.⁸²

Centers for Medicare & Medicaid Services, Changes to the Hospital and Critical Access Hospital Conditions of Participation (CoP) to Ensure Visitation Rights for All Patients; Revised CoP Interpretive Guidelines for Hospitals and Critical Access Hospitals re: Patients' Representatives

On April 15, 2010, President Barack Obama issued a Presidential Memorandum on hospital visitation to the secretary of Health and Human Services. In the Memorandum, the president wrote:

[E]very day, all across America, patients are denied the kindnesses and caring of a loved one at their sides—whether in a sudden medical emergency or a prolonged hospital stay. Often, a widow or widower with no children is denied the support and comfort of a good friend. Members of religious orders are sometimes unable to choose someone other than an immediate family member to visit them and make medical decisions on their behalf. Also uniquely affected are gay and lesbian Americans who are often barred from the bedsides of the partners with whom they may have spent decades of their lives—unable to be there for the person they love, and unable to act as a legal surrogate if their partner is incapacitated.

For all of these Americans, the failure to have their wishes respected concerning who may visit them or make medical decisions on their behalf has real consequences. It means that doctors and nurses do not always have the best information about patients'

82 *See* 45 C.F.R. § 164.502(g)(5). In such cases, the covered entity would need to decide, in the exercise of professional judgment, that it is not in the best interest of the patient to treat the person as the patient's personal representative.

medications and medical histories and that friends and certain family members are unable to serve as intermediaries to help communicate patients' needs. It means that a stressful and at times terrifying experience for patients is senselessly compounded by indignity and unfairness. And it means that all too often, people are made to suffer or even to pass away alone, denied the comfort of companionship in their final moments while a loved one is left worrying and pacing down the hall.⁸³

In response to the Presidential Memorandum, the Centers for Medicare & Medicaid Services published, on November 19, 2010, a final rule, "Changes to the Hospital and Critical Access Hospital Conditions of Participation to Ensure Visitation Rights for All Patients."⁸⁴ In the preamble to the final rule, CMS concluded that restricted hospital visitation can effectively eliminate advocates for many patients, "potentially to the detriment of the patient's health and safety." CMS explained that:

An article published in 2004 in the *Journal of the American Medical Association* (Berwick, D.M. and Kotagal, M.: "Restricted visiting hours in ICUs: time to change." *JAMA*. 2004; Vol. 292, pp. 736–737) discusses the health and safety benefits of open visitation for patients, families, and intensive care unit (ICU) staff and debunks some of the myths surrounding the issue (physiologic stress for the patient; barriers to provision of care; exhaustion of family and friends) through a review of the literature and through the authors' own experiences working with hospitals that were attempting a systematic approach to liberalizing ICU visitation as part of a collaborative with the Institute for Healthcare Improvement. The authors of the article ultimately concluded that "available evidence indicates that hazards and problems

regarding open visitation are generally overstated and manageable," and that such visitation policies "do not harm patients but rather may help them by providing a support system and shaping a more familiar environment" as they "engender trust in families, creating a better working relationship between hospital staff and family members."⁸⁵

In the final rule, CMS used the Conditions of Participation in the Medicare program to require all Medicare- and Medicaid-participating hospitals and critical access hospitals (CAHs) to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary restrictions that the hospital or CAH may need to place on such visitation rights.⁸⁶ The final rule, which applies to all patients regardless of payment source, is set forth at 42 C.F.R. § 482.13:

(h) *Standard: Patient visitation rights.* A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

- (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.
- (2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner),

83 See Presidential Memorandum on Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies, 75 Fed. Reg. 20511 (Apr. 20, 2010).

84 See U.S. Dep't of Health and Human Serv., Centers for Medicare & Medicaid Serv., Medicare and Medicaid Programs: Changes to the Hospital and Critical Access Hospital Conditions of Participation to Ensure Visitation Rights for All Patients, 75 Fed. Reg. 70831 (Nov. 19, 2010) (final rule).

85 75 Fed. Reg. 70831, 70832.

86 The visitation rights provisions of the Conditions of Participation for hospitals are found at 42 C.F.R. § 482.13(h) (2011). The visitation rights provisions of the Conditions of Participation for CAHs (which mirror the visitation rights provisions for hospitals) are found at 42 C.F.R. § 485.635(f) (2011).

another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.⁸⁷

In the preamble to the final rule,⁸⁸ CMS stated that: (1) the patient has a right to formulate advance directives⁸⁹ and to have hospital staff and practitioners who provide care in the hospital comply with those directives⁹⁰; (2) the patient who believes his or her visitation rights have been violated may file a grievance through the hospital's internal grievance process; (3) the Medicare beneficiary patient—who believes his or her visitation rights have been violated and the quality of his or her care has been compromised—may file a complaint with the appropriate state Utilization and Quality Control Quality Improvement

Organization (QIO)⁹¹; (4) the patient or visitor who believes that a hospital or CAH is not complying with the final rule may file a complaint with the state survey agency responsible for oversight of the facility⁹²; and (5) the patient or visitor who believes that a hospital or CAH is not complying with the final rule may file a complaint with the body responsible for accrediting the facility.⁹³ In addition, noncompliance with the patient visitation provisions of the Conditions of Participation “could result in the provider’s termination from the Medicare program.”⁹⁴

In summary, to comply with the final rule on patient visitation rights, Medicare- and Medicaid-participating hospitals must inform the patient (or support person, where appropriate) of his or her rights, including visitation rights. The patient’s visitation rights include the right to receive visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient’s visitation rights also include his or her right to withdraw or deny consent, at any time, to receive visitors or a particular visitor. Notably, the final rule makes it clear that Medicare- and Medicaid-participating hospitals and critical access hospitals (CAH) may not restrict, limit, or otherwise deny visitation privileges on the basis of, among other things, sexual orientation or gender identity.

87 42 C.F.R. § 482.13(h). In the preamble to the final rule, CMS emphasized that hospitals and CAHs must ensure “that patient rights information is provided in a language and manner the patient understands.” 75 Fed. Reg. at 70834 (citing the OCR LEP Guidance).

88 See 75 Fed. Reg. at 70831–42.

89 The patient’s right to formulate advance directives is also set forth at 42 C.F.R. § 482.13(b)(3). CMS emphasized the continuing “need for individuals to establish an advance directive as described in 42 C.F.R. Part 489. As a legal document expressing the patient’s preferences in one or more areas related to medical treatment, an advance directive can designate the individual who is permitted to represent the patient, should the patient become incapacitated.” 75 Fed. Reg. at 70835.

90 In the preamble to the final rule, CMS stated that: (1) “a hospital or CAH must apply its [patient visitation] documentation policy equally for all patients and support persons”; (2) “documentation to establish support person status for the purpose of exercising a patient’s visitation rights should be required only in the event that the patient is incapacitated and two or more individuals claim to be the patient’s support person”; and (3) individuals may wish to maintain advance directives “on their person and/or maintain such documentation in an electronic database, such as an advance directive registry, that grants access to health care facilities in order [for the support person] to avoid leaving the patient’s bedside to obtain proof of support person status.” 75 Fed. Reg. at 70837.

91 The preamble to the final rule explained that additional “information regarding the Medicare beneficiary patient’s right to file a grievance or a complaint with a QIO may be found at the HHS Centers for Medicare & Medicaid Services Web site: <http://www.cms.gov/QualityImprovementOrgs/>.” 75 Fed. Reg. at 70832.

92 Additional information regarding the patient’s or visitor’s right to file a complaint with the state survey agency may be found at http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp.

93 For additional information regarding the patient’s or visitor’s right to file a complaint with The Joint Commission may be found at http://www.jointcommission.org/report_a_complaint.aspx.

94 75 Fed. Reg. at 70833.

In the April 15, 2010, Presidential Memorandum, HHS also was directed to issue guidance that clarifies existing regulatory requirements at 42 C.F.R. § 82.13, governing the right of a patient's representative to make informed decisions concerning the patient's care, and at 42 C.F.R. § 489.102(a), concerning advance directives.⁹⁵ On September 7, 2011, CMS issued a memorandum⁹⁶ and revised guidelines⁹⁷ to the State Survey Agencies that conduct hospital inspections to support enforcement of these existing regulations, as well as the new visitation regulations. The CMS memorandum regarding patients' representatives is quoted below:

- Notice of the patient's rights must be given to the patient or patient's representative. (§482.13(a)(1))
- Patients (or their representatives) have the right to participate in the development and implementation of their plan of care. (§482.13(b)(1))
- The right to make informed decisions regarding the patient's care may also be exercised by the patient's representative as permitted under State law. This right to make informed decisions includes being informed about the patient's health status, being involved in care planning and treatment, and being able to request or refuse treatment. (§482.13(b)(2))
- The patient has the right to formulate an advance directive, which may include delegation of the right to make decisions about the patient's care to a representative, as well as designation of a support person. The regulation further requires that notice be given to the patient concerning the hospital's advance

directives policy. (§482.13(b)(3), which references §489.102)

A family member or representative of the patient's choice must be promptly notified of the patient's admission to the hospital. (§482.13(b)(4))⁹⁸

In the revised guidelines, CMS indicated that it expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. The revised guidelines also address the situation where a patient is incapacitated, and there is no written advance directive on file or presented to the hospital. As quoted below, the guidelines state that:

- When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient's spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient's representative, the hospital is expected to accept this assertion, without demanding supporting documentation, and provide the required notice to the individual, unless:
 - More than one individual claims to be the patient's representative. In such cases, it would be appropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient's representative. The hospital should make its determination of who is the patient's representative based upon the hospital's determination of who the patient would most want to make decisions on his/her behalf. Examples of documentation a hospital might consider could include, but are not limited to, the following: proof of a legally recognized marriage, domestic partnership, or civil union; proof of a joint household; proof of shared or co-mingled finances; and any other documentation the hospital considers evidence of a special relationship that indicates

95 See 75 Fed. Reg. 20511, 20512.

96 See Memorandum from Thomas E. Hamilton, Director, Survey and Certification Group, CMS, to State Survey Agency Directors (Sept. 7, 2011) (hereinafter September 7, 2011 CMS Memorandum), http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_36%20part%20I.pdf.

97 See CMS Manual System, Pub. 100-07 State Operations Provider Certification, at App. A & App. W (Sept. 7, 2011), http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_36%20part%20II.pdf.

98 September 7, 2011 CMS Memorandum at 2.

- familiarity with the patient's preferences concerning medical treatment;
- Treating the individual as the patient's representative without requesting supporting documentation would result in the hospital violating State law. State laws, including State regulations, may specify a procedure for determining who may be considered to be the incapacitated patient's representative, and may specify when documentation is or is not required; or
 - The hospital has reasonable cause to believe that the individual is falsely claiming to be the patient's spouse, domestic partner, parent, or other family member.⁹⁹

Centers for Medicare & Medicaid Services, Letter to State Medicaid Directors re: Same Sex Partners and Medicaid Liens, Transfers of Assets, and Estate Recovery

When implementing comprehensive programs of person-centered discharge planning, hospitals should consider the unique discharge planning needs of older or disabled LGBT Americans, who may need placement in long term care or skilled nursing facilities. For example, Medicaid, which is the largest payer of nursing home services in the country, requires individuals in need of care to have exhausted most of their personal income and assets before qualifying for the long term care benefit. There are protections, however, that ensure that the spouse of a Medicaid nursing home resident may remain in the couple's home. While states may place liens on the property of an individual needing care,¹⁰⁰ if there is a spouse in the home, states must protect that spouse from having

a lien attached to their home.¹⁰¹ In the past, these protections did not always apply for same-sex couples.

However, on June 10, 2011, the Centers for Medicare & Medicaid services issued a letter to State Medicaid Directors clarifying that same-sex couples may be offered many of the same financial and asset protections available to opposite-sex couples when one partner is entering a long term care or skilled nursing facility. In the June 10, 2011, letter, CMS stated that liens against the property of a Medicaid beneficiary may not be imposed in instances where certain individuals are lawfully residing in the home. These individuals include a spouse, a child under age 21, an adult child who is blind or permanently disabled, or siblings of the Medicaid beneficiary who have an equity interest in the home and were residents there one year before the beneficiary was admitted to the medical institution.¹⁰² CMS clarified that these federal beneficiary protections are the "floor" for protections against impositions of liens, and not the "ceiling," as a state "can have a policy or rule not to pursue liens when the same-sex spouse or domestic partner of the Medicaid beneficiary continues to reside lawfully in the home."¹⁰³

CMS also reported that a state Medicaid plan must provide that, if an institutionalized individual or the spouse of an individual transfers assets for less than fair market value after the "look-back" period defined in 42 U.S.C. § 1396p(c), the state will calculate and impose a period of Medicaid ineligibility on the Medicaid beneficiary. A period of Medicaid ineligibility will not be imposed if the assets transferred were a home, and title to the home was transferred to a spouse.¹⁰⁴ In the June 10, 2011, let-

99 See CMS Manual System, Pub. 100-07 State Operations Provider Certification, at App. A (Sept. 7, 2011) (Interpretive Guidelines § 482.13(a)(1)), http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_36%20part%20II.pdf.

100 42 U.S.C. § 1396p(a)(1) (2009).

101 42 U.S.C. § 1396p(a)(2).

102 42 U.S.C. § 1396p(a)(2) (2009).

103 Letter from Cindy Mann, CMS Deputy Administrator, to State Medicaid Directors, at 2 (June 10, 2011) (hereinafter June 10, 2011 CMS Letter), <http://www.cms.gov/smdl/downloads/SMD11-006.pdf>.

104 42 U.S.C. § 1396p(c)(2)(A).

ter, CMS clarified that if a state determines that a period of Medicaid ineligibility would “work an undue hardship” on the Medicaid beneficiary, then the state can grant an undue hardship waiver.¹⁰⁵ CMS concluded that states “may adopt criteria, or even presumptions, that recognize that imposing transfer of assets penalties on the basis of the transfer of ownership interests in a shared home to a same-sex spouse or domestic partner would constitute an undue hardship.”¹⁰⁶

In addition, CMS reported that 42 U.S.C. § 1396p(b) (1) requires states to pursue estate recovery when a Medicaid beneficiary has received medical assistance under the state plan: (1) in cases where a lien has been imposed under the state’s lien authority; and (2) for recipients age 55 and over, who received nursing facility services, home and community based services, or related hospital and prescription drug services.¹⁰⁷ Any estate recovery may be made only after the death of the Medicaid beneficiary’s spouse¹⁰⁸; and the state must have procedures to waive estate recovery where it would create an undue hardship for the deceased Medicaid recipient’s heirs.¹⁰⁹ In the June 10, 2011, letter, CMS emphasized that states have the discretion to establish reasonable protections from estate recovery “applicable to the same-sex spouse or domestic partner of a deceased Medicaid recipient.”¹¹⁰

105 42 U.S.C. § 1396p(c)(2)(D).

106 June 10, 2011 CMS Letter, at 2–3.

107 June 10, 2011 CMS Letter, at 3.

108 42 U.S.C. § 1396p(b)(2).

109 42 U.S.C. § 1396p(b)(3).

110 June 10, 2011 CMS Letter, at 3.

HHS National Data Progression Plan for LGBT Data Collection

On June 29, 2011, the U.S. Department of Health and Human Services announced a national data progression plan for LGBT data collection.¹¹¹ The HHS LGBT data progression plan was motivated in part by the Institute of Medicine’s March 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, which documented LGBT health disparities and emphasized the need for LGBT data collection in federally supported surveys, as well as in electronic health records maintained by private health care providers.¹¹² In addition, the HHS LGBT data progression plan was informed by Section 4302 of the Affordable Care Act, which requires that all health care or public health federally conducted or funded surveys collect information on race, ethnicity, sex, primary language, and disability status, and provides HHS the opportunity to collect “any other demographic data as deemed appropriate by the Secretary regarding health disparities.”¹¹³

Office of Personnel Management, Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace

Prior to developing internal policies on the provision of nondiscriminatory health care to, and employment of, LGBT individuals, hospitals may find it useful to review the U.S. Office of Personnel Management’s (OPM) *Guidance Regarding the Employment of Transgender*

111 U.S. Dep’t of Health and Human Serv., Improving Data Collection for the LGBT Community, HealthCare.gov (June 29, 2011), <http://www.healthcare.gov/news/factsheets/lgbt06292011a.html>.

112 Institute of Medicine, at 9.

113 42 U.S.C. § 300kk(a)(1) (2010).

Individuals in the Federal Workplace (OPM Guidance).¹¹⁴
The OPM Guidance states that:

It is the policy of the Federal Government to treat all of its employees with dignity and respect and to provide a workplace that is free from discrimination whether that discrimination is based on race, color, religion, sex (including gender identity or pregnancy), national origin, disability, political affiliation, marital status, membership in an employee organization, age, sexual orientation, or other non-merit factors.¹¹⁵

The OPM Guidance advises that a transgender individual's gender transition will often include hormone therapy and living full-time in the gender role to which he or she is transitioning. The OPM Guidance discusses these specific issues:

- **Confidentiality and Privacy:** An individual's transition should be treated with as much sensitivity and confidentiality as any other individual's significant life experiences, such as marital difficulties.
- **Dress and Appearance:** An individual in transition should be permitted to wear the clothes associated with the gender to which the individual is transitioning.
- **Names and Pronouns:** An individual in transition should be addressed with the name and pronoun appropriate for his or her new gender.
- **Sanitary and Related Facilities:** For a transitioning individual, "once he or she has begun living and working full-time in the gender that reflects his or her gender identity, [he or she should be allowed] access to restrooms and . . . locker room facilities consistent with his or her gender identity. While a reasonable temporary compromise may be appropriate in some

114 See U.S. Office of Pers. Mgmt., *Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace* (May 27, 2011) (hereinafter *May 27, 2011 OPM Guidance*). The purpose of the *May 27, 2011 OPM Guidance* "is not to address legal rights and remedies, but instead to provide guidance to address some of the common questions that agencies have raised with OPM regarding the employment of transgender individuals in the federal workplace." *May 27, 2011 OPM Guidance* at 1, <http://www.opm.gov/diversity/Transgender/Guidance.asp>.

115 See *May 27, 2011 OPM Guidance* at 1.

circumstances, transitioning [individuals] should not be required to have undergone or to provide proof of any particular medical procedure (including gender reassignment surgery) in order to have access to facilities designated for use by a particular gender."¹¹⁶

HHS Equal Employment Opportunity Policy and HHS Non-Discrimination Policy Statement

When developing or modifying equal employment opportunity policies or nondiscrimination policies for patient care, hospitals might find the HHS Equal Employment Opportunity Policy and HHS Non-Discrimination Policy to be valuable resources. The HHS Equal Employment Opportunity Policy, as recently clarified by the secretary of Health and Human Services, includes a prohibition against employment discrimination on the basis of gender identity or sexual orientation:

The mission of the Department of Health and Human Services is to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. Fundamental to our mission is our obligation to honor the diversity of our workforce and ensure all employees are treated with respect and dignity.

I fully understand and support the value of diversity in improving organizational efficiency and effectiveness. My goal is to create a climate of innovation, opportunity, and success within the Department that capitalizes on the cultural, professional, ethnic, and personal diversity of our workforce.

Additionally, I am equally committed to the full and meaningful implementation of Equal Employment Opportunity policies for all HHS employees and applicants. My goal is to create an environment within HHS, free of discrimination, where all employees may work without fear of reprisal or discriminatory harassment; where qualified employees and applicants with disabilities receive reasonable accommodations; and

116 See *OPM Guidance* at 1–2.

where all employees are recognized for their individual performance and contributions to HHS, without regard to race, national origin, color, age, religion, sex (including pregnancy and gender identity), sexual orientation, disability (physical or mental), status as a parent, genetic information, or other non-merit factor.

I fully expect all employees and supervisors to adopt these goals. With your support and participation, we can ensure workforce diversity and equal opportunity are two of our greatest strengths.¹¹⁷

The HHS Non-Discrimination Policy Statement includes a prohibition against discrimination by HHS employees on the basis of gender identity or sexual orientation when serving beneficiaries of programs conducted by the Department:

It is the policy of the U.S. Department of Health and Human Services to serve all individuals who are eligible for its programs without regard to any non-merit factor. Accordingly, the Department does not tolerate discrimination by its employees when they are serving individuals who are eligible for its programs based on any non-merit factor, including race, national origin, color, religion, sex, sexual orientation, gender identity, disability (physical or mental), age, status as a parent, or genetic information.

All of the Department's employees are responsible for complying with this policy in discharging their job duties.

Individuals who believe they have been subjected to discrimination on an aforementioned prohibited basis should contact the relevant Operating Division's EEO Office or the Department's EEO Compliance and Operations Division.

If there is a finding of non-compliance with the non-discrimination policy set forth above, appropriate disciplinary action, ranging from counseling to

termination, will be taken against the employee who violated the policy.¹¹⁸

117 U.S. Dep't of Health and Human Serv., Equal Employment Opportunity Policy (March 2011), <http://www.hhs.gov/asa/eo/policy/>.

118 U.S. Dep't of Health and Human Serv., Non-Discrimination Policy Statement (April 2011), <http://www.hhs.gov/asa/eo/nondiscrimination/index.html>.



APPENDIX D

Resource Guide

Appendix D contains many Web sites, publications, reports, toolkits, and other resources that hospitals and health care organizations can use to obtain more comprehensive information to assist in their efforts to advance effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community. There are many different sources of information available; this is by no means an exhaustive list. Inclusion in this guide should not be considered as an endorsement, as the authors have not undertaken any evaluation of these resources. Many of the resources in each category contain information that might be pertinent in more than one heading; most have been listed in only one area to avoid duplication. These resources and links are up to date as of October 4, 2011.

Leadership

1. The Human Rights Campaign Foundation has several resources, including the following:
 - *Healthcare Equality Index 2011: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual and Transgender Patients and Their Families (HEI)* can be used as an organizational self-assessment and to improve the care that organizations provide for LGBT patients. The HEI focuses on four main policy areas: patient nondiscrimination, visitation, cultural competency training, and employment nondiscrimination. Available at http://www.hrc.org/files/assets/resources/HealthcareEqualityIndex_2011.pdf.
 - *A Call to Action for Healthcare Professionals to Advance Health Equity for the Lesbian, Gay, Bisexual and Transgender Community*. Provides information for health care professionals as to the importance of including LGBT patients and families in their health equity initiatives. Available at http://www.hrc.org/files/assets/resources/health_calltoaction_HealthcareEqualityIndex_2011.pdf.
 - *Breaking Down Barriers: An Administrator's Guide to State Law & Best Policy Practice for LGBT Healthcare Access* has recommendations on visitation policies, training on the importance of advance directives for LGBT families, education for LGBT families about advance directives, and medical decision making. Available at http://www.hrc.org/files/assets/resources/HRC_Foundation_-_Breaking_Down_Barriers_-_An_Administrators_Guide.pdf.
2. The Gay, Lesbian, Bisexual, and Transgender Health Access Project's *Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients* is a framework that addresses personnel, client's rights, intake and assessment, service planning and delivery, confidentiality, and community outreach and health promotion. Available at <http://www.glbthealth.org/CommunityStandardsofPractice.htm>.
3. The National Coalition for LGBT Health has many resources, including *Guiding Principles for LGBT Inclusion in Healthcare*. These principles highlight key health issues facing lesbian, gay, bisexual, and transgender individuals and communities to ensure health equity. Available at <http://glbthealth.webolutionary.com/sites/default/files/Guiding%20Principles.pdf>.
4. The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (Oak Brook, IL: Joint Commission Resources, 2010) contains leadership

recommendations and suggested frameworks, issues, and practice examples. Available at <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>.

5. The C-CAT is an organizational performance assessment toolkit from the Ethical Force Program® at the American Medical Association (AMA) designed to assist organizations in meeting the needs of a diverse patient population. Emphasizing the importance of patient-centered communication, the C-CAT provides a broad-based set of scores about an organization's communication climate and can help health care organizations assess how effectively they communicate. More information is available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources.page>.
6. The National Prevention Council, created through the Affordable Care Act and chaired by the U.S. Surgeon General, has developed the *National Prevention Strategy: America's Plan for Better Health and Wellness*. This 2011 publication includes references to the need for additional information about health issues within the LGBT subpopulations. Available at <http://www.healthcare.gov/center/councils/nphpphc/strategy/report.pdf>.
7. The U.S. Agency for Healthcare Research and Quality's Health Care Innovations Exchange includes an "Innovation Profile" about a comprehensive set of strategies developed by the University of California, San Francisco (UCSF) Medical Center. These communication protocols and inclusive policies, along with ongoing training, led to more equitable, culturally competent care for LGBT patients. Available at <http://www.innovations.ahrq.gov/content.aspx?id=2737>.

Provision of Care, Treatment, and Services

General LGBT Health

1. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* report from the Institute of Medicine was commissioned by the National Institutes of Health and provides an overview of LGBT health issues and research gaps and opportunities. Available at http://www.nap.edu/catalog.php?record_id=13128.
2. The Gay and Lesbian Medical Association (GLMA) *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients* provides guidance for assessing provider's practices, offices, policies, and staff training in regard to LGBT inclusivity and recommended actions to improve the access to quality care for the LGBT population. Available at http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf. GLMA's Web site contains many other resources and more information at <http://www.glma.org>.
3. Healthy People 2020, from the U.S. Department of Health and Human Services, is the government's 10-year agenda for improving the health of all Americans. One objective is to improve the health, safety, and well-being of LGBT individuals. A section specific to LGBT health is available at <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>.
4. *Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health* is available on GLMA's Web site and serves as a guide on LGBT health disparities and the challenges to overcome when addressing the health care needs of LGBT patients. Available at http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf.

5. The Centers for Disease Control and Prevention (CDC) Web site includes a page on LGBT health that offers links to more detailed information for each subpopulation. Available at <http://www.cdc.gov/lgbthealth/index.htm>.
6. The Fenway Institute Web site contains information and numerous resources available at <http://www.fenwayhealth.org>.
 - *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health* (American College of Physicians, 2008) contains guidelines to address clinical issues facing LGBT communities. Available at <https://www.acponline.org/atpro/timssnet/catalog/books/fenway.htm>.
 - *Learning Modules on LGBT Health* for health professionals and students contain information slides, handouts, and information on LGBT health topics and can be used alone or in conjunction with the more comprehensive *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*. Available at <http://www.lgbthealtheducation.org/training/learning-modules/>.
7. The Mautner Project is committed to improving the health of women who partner with women, including lesbian, bisexual, and transgender individuals, through direct and support service, education, and advocacy. More information and resources are available at http://www.mautnerproject.org/health_info/health_info_index.cfm.
8. *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population*, produced by Kaiser Permanente National Diversity Council for Kaiser Permanente, offers guidance on providing culturally competent care to LGBT populations. Available at http://www.audacityofpride.com/audacity_of_pride/Medical_resources_fles/KP%20LGBT%20handbook.pdf.
9. The American Medical Association's GLBT Advisory Committee Web page contains several resources, including a video on how to take a sexual health history, creating an LGBT-friendly practice, effectively communicating with LGBT patients, and understanding LGBT health issues. Available at <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-adv-adv-committee/glb-adv-resources.page>.
10. *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients* was developed by the Massachusetts Department of Public Health to assist health care providers and their facilities in better addressing LGBT needs. Available at <http://www.glbthealth.org/documents/SOP.pdf>.
11. Straight for Equality in Healthcare, from Parents, Families and Friends of Lesbians and Gays (PFLAG) provides information to assist health care workers in responding to the needs of the LGBT population. Available at <http://community.pflag.org/Document.Doc?id=297>.

More information and resources are available on the PFLAG Web site at <http://www.pflag.org>.
12. The National LGBT Cancer Network is a program that addresses the needs of all LGBT people with cancer and those at risk through education, training, screenings, and advocacy. More information and resources are available at <http://www.cancer-network.org/>.

LGBT Mental Health and Substance Abuse

13. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides an overview of substance abuse treatment issues surrounding LGBT patients, *A Provider's Introduction to Substance Abuse Treatment for*

Lesbian, Gay, Bisexual, and Transgender Individuals. Available at <http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>.

14. The National Alliance of Mental Illness (NAMI) Multicultural Action Center has numerous resources, fact sheets, recommendations, blogs, and information addressing LGBT mental health available at http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Resources/GLBT_Resources.htm.
15. The National LGBT Tobacco Control Network is an organization working to eliminate tobacco health disparities for all LGBT people. More information and resources are available at <http://www.lgbttobacco.org/resources.php>.
16. *Lesbians and Gay Men: Chemical Dependency Treatment Issues* (Routledge, 1993) addresses issues in the treatment of chemical dependency in lesbian and gay populations. Authors discuss special problems and describe actual clinical techniques for treating gays and lesbians. Available at <http://www.amazon.com/Lesbians-Gay-Men-Dependency-Treatment/dp/1560230363>.
17. The National Association of Lesbian and Gay Addiction Professionals (NALGAP) is a membership organization dedicated to the prevention and treatment of alcoholism, substance abuse, and other addictions in lesbian/gay/bisexual/transgender communities. Information is available at <http://www.nalgap.org>.
18. The American Psychological Association (APA) Lesbian, Gay, Bisexual, and Transgender Concerns Office (LGBTCO) Web site includes programs and services, publications, and other resources regarding LGBT health. Information is available at <http://www.apa.org/pi/lgbt/index.aspx>.
19. The PRIDE Institute offers mental health and substance abuse treatment and services for the LGBT community. More information and resources are available at <http://pride-institute.com/about/>.

Addressing the Needs of Aging and Elderly LGBT People

1. Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) offers a variety of resources designed to improve the lives of LGBT older adults. The SAGE Web site is located at <http://www.sageusa.org>, and available resources include the following:
 - The abbreviated version (“Snapshot Report”) of *Improving the Lives of LGBT Older Adults* has a section on health and health care for LGBT elders that provides a useful overview of health care issues specific to LGBT elders. Available at http://www.sageusa.org/resources/resource_view.cfm?resource=198.
 - *The HIV & Aging Policy White Paper* provides an overview of HIV and aging, with helpful information for providers to consider when caring for LGBT elders. Available at http://www.sageusa.org/resources/resource_view.cfm?resource=180.
 - “Facing Discrimination” is an article from *Provider* magazine that recommends that LGBT long term care organizations review their policies and training programs to accommodate LGBT elders. Available at http://www.sageusa.org/resources/resource_view.cfm?resource=166.
2. The report *Make Room for All: Diversity, Cultural Competency and Discrimination in an Aging America*, available on the National Gay and Lesbian Task Force Web site, examines considerations for LGBT elders now and in the future. Available at http://www.thetaskforce.org/reports_and_research/make_room_for_all.

3. The National Gay and Lesbian Task Force Policy Institute published *Outing Age: 2010*, a report that discusses public policy issues facing lesbian, gay, bisexual, and transgender elders. Available at http://www.thetaskforce.org/downloads/reports/reports/outingage_final.pdf.
4. *Long-Term Care and People Living with HIV*, a report from Lambda Legal, examines the complexities of providing adequate care to LGBT elders with HIV/AIDS. Available at http://www.lambdalegal.org/publications/factsheets/fs_long-term-care-and-people-living-with-hiv.html. The Lambda Legal Web site also features *LGBT Older Adults: Know Your Rights in New York State Nursing Homes*. Available at http://www.lambdalegal.org/publications/factsheets/fs_lgbt-older-adults-know-your-rights-in-ny-state-nursing-homes.html.
5. The policy brief *The Health of Aging Lesbian, Gay and Bisexual Adults in California*, from the UCLA Center for Health Policy Research, includes the first data published on aging LGB adults based on a large statewide population. Available at <http://www.healthpolicy.ucla.edu/pubs/files/aginglgbpb.pdf>.

Addressing the Needs of Bisexual Patients

1. The National Gay and Lesbian Task Force's Policy Institute has published several studies addressing issues specifically related to the bisexual community, including *Bisexual Health: An Introduction and Model Practices for HIV/STI Prevention Programming*. Available at http://www.thetaskforce.org/reports_and_research/bisexual_health.
2. The San Francisco Human Rights Commission LGBT Advisory Committee released a report, *Bisexual Invisibility: Impacts and Recommendations*, that identifies and examines issues regarding bisexual health and employment. Available at http://www.birequest.org/docstore/2011-SF_HRC-Bi_invisibility_Report.pdf.
3. The *Healthy People 2020* Bisexual Health Fact Sheet summarizes research on bisexual health, categorized by Healthy People 2020 topic areas. Available at <http://www.lgbttobacco.org/files/HP2020BisexualPeople.pdf>.
4. The BiNet USA Web site collects and distributes educational information on sexual orientation and gender identity, with an emphasis on the bisexual and pansexual and allied communities. Available at <http://www.binetusa.org/>.
5. Fenway Health's Bihealth Program provides community information, support, and referrals, as well as resources to assist practitioners in better serving their bisexual clientele. Available at http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_bi. In addition, Fenway Health provides *Tips for Health Care Providers When Working with Bisexual Clients*. Available at http://www.fenwayhealth.org/site/DocServer/bi_clients_tips_for_providers_2007.pdf?docID=4101.

Addressing the Needs of LGBT Youth

1. The GLBT National Help Center has a youth hotline and e-mail. Available at <http://www.glnh.org/talkline/index.html>.
2. Out & Equal Workplace Advocates also has several youth hotlines. Available at <http://www.outandequal.org/images/LGBT%20%20Youth%20Hotlines.pdf>.
3. The "It Gets Better" Project is a campaign featuring thousands of video messages aimed at helping LGBT teenagers who are victims of bullying. U.S. Department of Health and Human Services Secretary Kathleen Sebelius is

among the thousands of individuals who have posted video messages of support. Available at <http://www.itgetsbetterproject.com/>.

4. The Human Rights Campaign Web site includes several resources related to LGBT youth and the provision of care. Information on campus activism is available at <http://www.hrc.org/issues/youth-campus>. Also see the following:
 - *Same-Sex Parents and Consent for Treatment of a Minor: Patchwork Parenting Laws for LGBT Families* is available at <http://www.hrc.org/resources/entry/same-sex-parents-and-consent-for-treatment-of-a-minor>.
 - More resources and links for LGBT youth are available at <http://www.hrc.org/resources/entry/what-resources-do-other-lgbt-organizations-have-to-offer-young-people>.
5. The National Gay and Lesbian Task Force has information and resources for LGBT youth. Available at <http://www.thetaskforce.org/issues/youth>.
6. The Robert Wood Johnson Foundation features resources related to LGBT youth and health risks, including *Sexual Orientation Disparities in Longitudinal Alcohol Use Patterns Among Adolescents*. Available at <http://www.rwjf.org/vulnerablepopulations/product.jsp?id=38029>. Also offered is an article from the *Archives of Pediatrics & Adolescent Medicine*, "Sexual Orientation and Tobacco Use in a Cohort Study of U.S. Adolescent Girls and Boys," which presents information regarding tobacco use and LGB youth. Available at <http://www.rwjf.org/pr/product.jsp?id=14883>.
7. Publications from the Center for American Progress include two that are specific to LGBT youth:
 - *How to Improve Mental Health Care for LGBT Youth: Recommendations for the Department of Health and Human Services*. Available at http://www.americanprogress.org/issues/2010/12/mental_health_lgbt_youth.html.
 - *Providing a Lifeline for LGBT Youth: Mental Health Services and the Age of Consent*. Available at http://www.americanprogress.org/issues/2010/12/lifeline_lgbt_youth.html.
8. The PFLAG Web site provides a number of resources regarding LGBT youth, including the following:
 - *What Does Gay Mean: How to Talk with Kids About Sexual Orientation and Prejudice* offers age-appropriate practical guidance for parents and practitioners regarding ways to discuss sexual orientation. Available at <http://www.mentalhealthamerica.net/go/what-does-gay-mean>.
9. The Family Acceptance Project funded by the California Endowment works to decrease major health and related risks for LGBT youth, such as suicide, substance abuse, HIV, and homelessness—in the context of their families. Available at <http://familyproject.sfsu.edu/home>. Brochures and other resources available on the Family Acceptance Project's Publications page include the following:
 - A booklet, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children*, is available at http://familyproject.sfsu.edu/files/English_Final_Print_Version_Last.pdf.
 - "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults" (from the January 2009 issue of *Pediatrics*) highlights a link between rejecting behaviors of families toward LGBT adolescents and negative health problems in early adulthood. Available at <http://pediatrics.aappublications.org/content/123/1/346.full?ijkey=NrcY0H897IAU&keytype=ref&siteid=aapjournals>.

- “Family Acceptance in Adolescence and the Health of LGBT Young Adults” (from the November 2010 issue of the *Journal of Child and Adolescent Psychiatric Nursing*), is available at http://familyproject.sfsu.edu/fles/FAP_Family%20Acceptance_JCAPN.pdf.
 - “Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment” (from the November 2010 issue of *Developmental Psychology*) is available at http://familyproject.sfsu.edu/fles/FAP_School%20Victimization%20of%20Gender-nonconforming%20LGBT%20Youth.pdf.
 - *CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care* from the Child Welfare League of America offers guidelines for policy and practice for serving LGBT youth in child welfare and juvenile justice settings, including a chapter on health, mental health, and education services to LGBT Youth. Available at <http://www.lsc-sf.org/wp-content/uploads/bestpracticeslgbtyouth.pdf>.
10. The GSA (Gay-Straight Alliance) Network’s *Health and Success for Young Men of Color* offers suggestions for minimizing or eliminating barriers to young men’s health and success. Available at <http://www.gsanetwork.org/news/blog/health-and-success-young-men-color/08/18/11>.
11. The Trevor Project, a national organization focused on suicide prevention efforts among lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, offers guidance and resources that can aid hospitals to be community leaders in advancing safe, accepting, and inclusive environments at home and at school for LGBT youth. Available at <http://www.thetrevorproject.org/educatorslocalresources>.
12. The Web site [Stopbullying.gov](http://www.stopbullying.gov) includes an LGBT bullying Web page (<http://www.stopbullying.gov/topics/lgbt/>) that provides resources for children, parents, educators, the community, and health care professionals, including the following:
- *Roles for Health and Safety Professionals in Bullying Prevention and Intervention*, available at http://stopbullying.gov/community/tip_sheets/roles_for_health_safety_professionals.pdf
 - *Working with Young People Who Are Bullied: Tips for Mental Health Professionals*, available at http://stopbullying.gov/community/tip_sheets/mental_health_professionals_bullied.pdf

Addressing the Needs of Transgender Patients

1. The World Professional Association for Transgender Health’s *Standards of Care* has clinical guidelines for the care of transgender people. Available at <http://www.wpath.org/documents2/socv6.pdf>. Other resources and more information, including a provider directory, are available at <http://www.wpath.org/>.
2. The Transgender Law Center’s (TLC) *10 Tips for Working with Transgender Individuals: A Guide for Health Care Providers* supplies practitioners with information about the needs and experiences of the transgender population to improve quality of care and patient–provider outcomes. Available at <http://www.transgenderlawcenter.org/pdf/Provider%20fact%20sheet.pdf>.

Other transgender health care resources are available from TLC on their Web site: <http://transgenderlawcenter.org/cms/content/healthcare>.

3. The Gay and Lesbian Medical Association's Transgender Health Resources Web page includes resources for health care providers about transgender health issues. Available at <http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=948&grandparentID=534&parentID=938&nodeID=1>.
4. The Center of Excellence for Transgender Health at UCSF offers many resources for health care providers at <http://transhealth.ucsf.edu/>, including *Primary Care Protocol for Transgender Patient Care*. Available at <http://www.transhealth.ucsf.edu/trans?page=protocol-00-00>.
5. The *National Transgender Discrimination Survey Report on Health and Health Care* contains findings of a study conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, which identified disparities in health care, access, and outcomes for the transgender population. Available at http://www.thetaskforce.org/downloads/reports/reports/ntds_report_on_health.pdf.
6. The Human Rights Campaign Web site includes a Transgender Web page with links to several health-related articles, resources, and publications. Available at <http://www.hrc.org/issues/transgender.asp>.
7. The Lambda Legal Web site features two fact sheets from its upcoming guide to transgender rights, covering access to public restrooms and health coverage of transition-related care. Available at http://www.lambdalegal.org/publications/trans-toolkit/trt_equal-access-to-public-restrooms.html and http://www.lambdalegal.org/publications/trans-toolkit/trt_transition-related-health-care.html.
8. VA Boston Healthcare System's policy "Management of Transgender Veteran Patients" provides information regarding the appropriate treatment for transgender individuals for health care providers. Available at http://www.tavausa.org/Management%20of%20Transgender%20Veteran%20Patients_7.08.pdf.
9. The Trans Care Project, a joint initiative of the Transgender Health Program and Transcend Transgender Support & Education Society, produced Clinical Protocol Guidelines for Transgender Care, which includes seven sets of clinical guidelines, training frameworks, and consumer information booklets. Available at <http://transhealth.vch.ca/resources/careguidelines.html>.
10. *Medical Therapy and Health Maintenance for Transgender Men: A Guide for Health Care Providers* is a resource to assist health care providers in understanding medical issues surrounding transgender men, with discussions of hormone therapy and sex reassignment surgery. Available at http://www.nickgorton.org/Medical%20Therapy%20and%20HM%20for%20Transgender%20Men_2005.pdf.
11. The American Speech-Language-Hearing Association Web site includes a Voice and Communication Therapy for Transgender/Transsexual Clients page offering information on voice communication therapy for the transgender/transsexual population and supplying additional resources. Available at <http://www.asha.org/public/speech/disorders/TGTS.htm>.
12. The Web site TransGenderCare summarizes information gathered through treatment encounters at the Tampa Gender Identity Program specialty practice, with provider accounts and public domain data abstractions. Some of this information could be of interest to providers caring for transgender patients. Available at <http://www.transgendercare.com/>.
13. The American Cancer Society's *Transgendered and Transsexual Individuals: Access to Care and Cancer Disparity Fact Sheet* features high-level information for providers and patients and points out disparities to take into

consideration when providing or seeking care. Available at <http://www.globthealth.org/documents/FactSheetRevised-TransgenderedIndividuals.pdf>.

14. FTM International's Web site offers resources for providers and female-to-male transgender patients. Available at <http://www.ftmi.org/>.
15. The Disparities Solution Center at Massachusetts General Hospital includes several LGBT-specific resources for health care providers in *Caring for Transgender Patients: Resources from the Literature*. Available at http://googleext.partners.org/search?q=cache:mgPGYsMMwhsJ:www2.massgeneral.org/disparitiessolutions/z_files/Transgender%2520Lit%2520Search_JDN_3.28.11_FINAL.pdf+LGBT&site=MGH&client=MGH&access=p&ie=UTF-8&proxystylesheet=MGH_DISPARITIES&output=xml_no_dtd&oe=ISO-8859-1.

Information about Intersex Health

1. The Intersex Society of North America Web site includes various resources for providers. Available at <http://www.isna.org/>.
2. The American Psychological Association has a Web page that contains information to help answer questions about individuals with intersex conditions, including a link for more information. Available at <http://www.apa.org/topics/sexuality/intersex.aspx>.

Addressing the Needs of LGBT Persons with Disabilities and Special Needs

1. The National Coalition for LGBT Health's Web site includes a page titled Being LGBT with a Disability, which offers background information on the topic and applicable resources. Available at <http://lgbthealth.webrevolutionary.com/content/being-lgbt-disability>.
2. The organization Reach Out USA works to address disparities in health care and employment for the LGBT population with disabilities. Several resources are available on their Web site at <http://www.reachoutusa.org/>.

Workforce and LGBT Cultural Competency Resources

1. The University of California, San Francisco's Center for LGBT Health & Equity has created resources designed to assist health care professionals in providing knowledgeable, sensitive care to LGBT patients. Resources to aid institutions in creating a welcoming climate for LGBT students, faculty, and staff; curriculum and training resources for health professional schools; and other LGBT health resources are available on the Center's LGBT Resource Center Web page: http://lgbt.ucsf.edu/services_health.html.
2. The Fenway Institute offers comprehensive Learning Modules on LGBT Health for health professionals and students to facilitate the teaching of LGBT health topics. Available at http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_ins_fenway_EducPro_modules.

The Fenway Institute was also awarded a grant from the Health Resources and Services Administration to develop a national LGBT health training and technical assistance center for community health centers. For more information, see the press release available at <http://www.hrsa.gov/about/news/pressreleases/110906lgbttraining.html>.

3. Preliminary findings from the National Transgender Discrimination Survey, by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, highlight employment challenges for the transgender populations. Available at http://www.thetaskforce.org/downloads/release_materials/tf_enda_fact_sheet.pdf.
4. The Parents, Families and Friends of Lesbians and Gays (PFLAG) Web site contains several training and educational resources, as well as general information at their Workforce Fairness Web page <http://community.pflag.org/Page.aspx?pid=1275>). Also see the following:
 - The Straight for Equality in the Workplace competency training program addresses the issue of workplace fairness for LGBT employees. Available at <http://community.pflag.org/Page.aspx?pid=875>.
 - Straight for Equality in the Workplace: Advanced Skills for Enterprising Allies is a workshop that further explores the themes addressed in the Straight for Equality in the Workplace program. Available at <http://community.pflag.org/page.aspx?pid=1352>.
 - Straight for Equality Training Programs complement the Straight for Equality in Healthcare program and are based on the Straight for Equality in Healthcare resources. Available at <http://community.pflag.org/page.aspx?pid=979>.
 - Additional resources are also available on the PFLAG Web site on the Straight for Equality in Healthcare page: <http://community.pflag.org/page.aspx?pid=1130>.
5. The Human Rights Campaign Foundation (HRC) Web site offers several workforce-related resources, including the following:
 - *Degrees of Equality: A National Study Examining Workplace Climate for LGBT Employees* is a LGBT workplace climate assessment tool for assisting organizations in identifying LGBT employees and improving their work environments. In addition, HRC developed a series of toolkits designed to help improve the workplace environment for LGBT employees. Available at http://www.hrc.org/files/assets/resources/DegreesOfEquality_2009.pdf.
 - The Establishing Domestic Partner Benefits Web page outlines how to achieve domestic partner benefits in the workplace with applicable resources. Available at <http://www.hrc.org/resources/entry/establishing-domestic-partner-benefits>.
 - The Transgender-Inclusive Benefits for Employees and Dependents Web page provides detailed background and information on this topic. Available at <http://www.hrc.org/resources/entry/transgender-inclusive-benefits-for-employees-and-dependents>.
6. *The Consolidated Omnibus Budget Reconciliation Act: COBRA-Equivalent Benefit for LGBT Workers* Web page provides an overview of issues employers should consider when working toward making COBRA benefits available to employees with same-sex partners or spouses of employees. Available at http://www.hrc.org/issues/aging/cobra_benefit.htm.
7. *Pride in My Workplace: A Best Practices Guide for New York State Businesses to Support Lesbian, Gay, Bisexual, and Transgender Employees* provides best practices for creating an LGBT-inclusive workplace for employees. Available at <http://www.prideagenda.org/Portals/0/guide2.pdf>.

8. *Straight Talk About Gays in the Workplace: Creating an Inclusive, Productive Environment for Everyone in Your Organization* (Routledge, 2005) provides a practical approach to understanding and addressing LGBT issues in the workplace while increasing an organization's productivity. Available at http://www.amazon.com/Straight-Talk-About-Gays-Workplace/dp/1560235462/ref=sr_1_1?ie=UTF8&s=books&qid=1228857061&sr=1-1.
9. Several resources provided on Lambda Legal's Web site can assist employers with LGBT inclusivity workforce topics. Available at <http://www.lambdalegal.org/publications/toolkits.html>. Examples include the following:
 - *Creating an LGBT-Friendly Workplace* highlights steps employers can take to ensure that they are providing an LGBT-friendly workplace. Available at <http://data.lambdalegal.org/pdf/300.pdf>.
 - The worksheets from *Out at Work: A Toolkit for Workplace Equality* can help organizations assess whether they are an LGBT-friendly and HIV-friendly workplace. Available at http://data.lambdalegal.org/publications/downloads/out-at-work_worksheets.pdf.
10. LGBT training and educational resources are provided by Out & Equal Workplace Advocates who focus on working to end employment discrimination for lesbian, gay, bisexual, and transgender employees. For additional information visit their Web site at <http://www.outandequal.org/>.
11. The National LGBT Cancer Network developed a training program for LGBT cultural competence in health care on behalf of the NYC Health and Hospitals Corporation. An excerpt of the video included in the training and additional information can be found on their Web site. Available at http://cancer-network.org/cultural_competence_training/.
12. Among the training resources offered by Services and Advocacy for Lesbian, Gay, Bisexual and Transgender Elders (SAGE) are programs for the following three groups (information for all three is available at <http://www.sageusa.org/programs/training.cfm>):
 - Older Adult Providers—training for health care providers about creating a welcoming environment for LGBT older adults
 - LGBT Organizations and Groups—training and guidance that helps organizations to either create or expand programs for LGBT older adults
 - Older Adult Housing and Retirement Communities—training that assists organizations in creating a welcoming environment for LGBT older adults
13. Recommendations for health care providers on offering culturally competent care for LGBT people are provided on the Web site of Public Health—Seattle & King County. Available at <http://www.kingcounty.gov/healthservices/health/personal/glb/CulturalCompetency.aspx>.
14. The Human Rights Campaign, in partnership with the National Coalition for LGBT Health, the Gay and Lesbian Medical Association, and the Mautner Project, produced a video resource for health care providers, *Creating a Welcoming Space for LGBT Patients*. This video highlights how providers can make minor adjustments in their current practice to ensure LGBT inclusivity. Available at <http://www.hrc.org/video-4providers.wmv>.
15. The Gender and Health Collaborative Curriculum Project incorporated the work of faculty and students from six medical schools in Ontario, Canada, to create comprehensive, interactive online modules for training health care providers on the importance of being culturally competent. The modules also supply insight into such topics as

LGBT insider language, gay culture, and common health concerns in the LGBT community. Available at <http://www.genderandhealth.ca/en/modules/about/module-map.jsp>.

16. *Cultural Competency on Lesbian, Gay, Bisexual or Transgender (LGBT) Patients* is an article that addresses cultural competency considerations for physicians when treating LGBT patients in an emergency room setting. Available at <http://www.med-ed.virginia.edu/courses/culture/PDF/marcuschapter008lgbtrevisedgc.pdf>.
17. The Bronx Community Pride Center's Sexuality Matters: Providing Better Healthcare and Social Services for the Lesbian, Gay, Bisexual and Transgender Community workshop assists health care workers and medical students provide culturally competent medical care for LGBT patients. Continuing Medical Education (CME) credits are offered. Available at <http://www.bronxpride.org/what-we-do/community-outreach/sexuality-matters/>.
18. "The Gay Affirmative Practice Scale (GAP): A New Measure for Assessing Cultural Competence with Gay and Lesbian Clients" (from the April 2006 issue of *Social Work*) provides an assessment tool that providers can use to assess and improve their cultural competency when serving LGBT patients. Available at <http://www.safeguards.org/?p=61>.
19. The Mautner Project: The National Lesbian Health Organization offers a training program, Removing the Barriers, designed to increase awareness among practitioners about the LGBT population's health care needs, particularly women who partner with women. Available at http://www.mautnerproject.org/education/removing_barriers.cfm.
20. The National Center for Cultural Competence, Georgetown University, has several resources for LGBT patients and families. Available at <http://nccc.georgetown.edu/search.html>.

Data Collection and Use

1. *Improving Data Collection for the LGBT Community* is a fact sheet that details the Department of Health and Human Services (HHS) initiative to develop a national data progression plan. The plan is intended to begin the integration of sexual orientation and gender identity variables into HHS national surveys. Available at <http://www.healthcare.gov/news/factsheets/lgbt06292011a.html>.
2. The Williams Institute at the UCLA School of Law has many data collection resources:
 - *How Many People Are Lesbian, Gay, Bisexual and Transgender* is about quantifying LGBT people in the United States. Available at <http://wiwp.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/>.
 - *Best Practices for Asking Questions About Sexual Orientation on Surveys* is a comprehensive document that offers best practices for asking sexual orientation questions in surveys. Available at <http://wiwp.law.ucla.edu/research/census-lgbt-demographics-studies/best-practices-for-asking-questions-about-sexual-orientation-on-surveys/>.
 - *Estimating Populations of Men Who Have Sex with Men [MSM] in the Southern United States* describes findings from three models used to estimate the number of MSM in the 17 states and suggests the models could be used by others for population estimates. Available at <http://wiwp.law.ucla.edu/research/census-lgbt-demographics-studies/estimating-msm-population-southern-united-states/>.

- *Lesbians, Gays, Bisexuals, and Transgenders of Color Sampling Methodology: Strategies for Collecting Data in Small, Hidden, or Hard-to-Reach Groups to Reduce Tobacco-Related Health Disparities* describes tobacco use among LGBT and racial and ethnic minorities and supplies recommendations to help eliminate tobacco-related health disparities per discussions and lessons learned from researchers in the field. Available at <http://wiwp.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-of-color-sampling-methodology-strategies-tobacco-related-health-disparities/>.
3. The Fenway Center for Population Research in LGBT Health supports The Population Research in Sexual Minority Health (PRISM) Data Archive, which is a collaborative project of the Center for Population Research in LGBT Health and the Inter-university Consortium for Political and Social Research (ICPSR). PRISM makes high-quality datasets useful for analysis of issues affecting sexual and gender minority populations in the United States. Available at <http://www.icpsr.umich.edu/icpsrweb/FENWAY/datasets/>.
 4. The *LGBT Surveillance and Data Collection Briefing Paper* produced by the National LGBT Tobacco Control Network investigates the collection of smoking data from LGBT populations. Available at http://www.lgbttobacco.org/files/09FCH_DataCollection.pdf.
 5. *Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services* by the Center of Excellence for Transgender HIV Prevention at UCSF highlights the need to include transgender people in data collection procedures to ensure dissemination of valid information and production of meaningful prevention materials. Available at <http://q4ej.org/wp-content/uploads/transhealth-data-recommendation-2page.pdf>.
 6. The Center for American Progress memorandum “How to Close the LGBT Health Disparities Gap” provides an overview of the health disparities faced by LGBT populations and offers recommendations for capturing data on LGBT populations. Available at http://www.americanprogress.org/issues/2009/12/pdf/lgbt_health_disparities.pdf.
 7. The National Coalition for LGBT Health’s Web site offers *LGBT Inclusion in Federal Health Surveys*, an article that outlines the rationale for collecting data on the LGBT population. Available at http://lgbthealth.webolutionary.com/sites/default/files/LGBT%20Inclusion%20in%20Surveys_0.pdf.
 8. *An Important Note About Health Studies of the GLBT Community* provides an overview of the challenges in studying the LGBT population. Available at <http://www.kingcounty.gov/healthservices/health/personal/glb/studies.aspx>.
 9. Gaydata is a Web site maintained by the Program for Lesbian, Gay, Bisexual and Transgender Health at Drexel University. It provides a forum for sexual orientation and gender identity data sources and provides data collection guidance. Available at <http://www.gaydata.org/>.
 10. The *Health Research and Educational Trust Disparities Toolkit* supplies health care providers with information and resources regarding the collection of race, ethnicity, and primary language data from patients. Available at <http://www.hretdisparities.org/>.
 11. The *National Stakeholder Strategy for Achieving Health Equity* provides a common set of goals and objectives to help underserved groups reach their full health potential. The *Strategy* calls for increasing knowledge of health concerns for LGBT populations. Available at <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvi=1&lvid=33&id=286>.

12. The Human Rights Campaign uses the Healthcare Equality Index (HEI) survey to measure hospitals' progress in providing equitable care to LGBT patients on a variety of measures annually and publishes a report detailing the survey findings. The HEI includes questions specific to data collection. The most recent published survey report (*Healthcare Equality Index 2011: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual and Transgender Patients and Their Families*) is available at http://www.hrc.org/files/assets/resources/HealthcareEqualityIndex_2011.pdf.

Patient, Family, and Community Engagement

1. The Gay and Lesbian Medical Association (GLMA) offers Top Ten lists of the health issues that gay men, lesbians, and transgender persons should discuss with their health care providers. Available at <http://glma.org/index.cfm?fuseaction=Page.viewPage&pageId=947&grandparentID=534&parentID=938&nodeID=1>.
2. The Gay, Lesbian & Straight Education Network (GLSEN) is a national education organization working to ensure safe schools for all students, regardless of sexual orientation and gender identity. Brochures and information are available at <http://www.glsen.org/cgi-bin/iowa/all/about/index.html>.
3. The National Center for Culture Competence, in collaboration with the National Technical Assistance Center for Children's Mental Health of the Georgetown University Center for Child and Human Development and the American Institutes for Research, has produced a practice brief, *Helping Families Support their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children*. Available at http://nccc.georgetown.edu/documents/LGBT_Brief.pdf.
4. The Joint Commission's Speak Up™ campaign provides downloadable brochures designed to help patients navigate the health care encounter. These brochures are available in English and Spanish and are written at low health literacy levels. Available at <http://www.jointcommission.org/speakup.aspx>.
5. The National Association of Community Health Centers Special Population series offers guidance on providing care to specific populations. Information Bulletin 11, *Reaching Out to "Other" Special Populations: Providing Services to Lesbian, Gay, Bisexual and Transgender Patients*, addresses LGBT populations. Available at <http://www.nachc.com/client/LGBTInformationBulletinAugust20072.pdf>.
6. The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and Their Allies, based in Vancouver, British Columbia, Canada, developed a publication that provides guidance for educating health and social service professionals about the needs of LGBT people and LGBT communities. This publication, *LGBT Health Matters: An Education & Training Resource for Health and Social Service Sectors*, is available at http://www.sexualhealthcentresaskatoon.ca/pdfs/p_lgbt.pdf.
7. CenterLink: The Community of LGBT Centers contains a directory of LGBT community centers around the country. Available at <http://www.lgbtcenters.org>.
8. Equality Federation is a national alliance of state-based lesbian, gay, bisexual, and transgender advocacy organizations. Information is available at <http://www.equalityfederation.org/template.aspx?id=3>.
9. Rainbow Access Initiative is an all-volunteer organization that seeks to inform and educate health care and human service professionals about LGBTQ-specific health issues and to inform and educate the LGBTQ public about options they have in obtaining culturally competent treatment. Available at <http://www.rainbowaccess.org/>.

Materials for Welcoming Environments

1. The GLBT Health Access Project and the American Cancer Society provide brochures and fact sheets. Available at <http://www.glbthealth.org/AmericanCancerSocietyMaterials.htm>. The GLBT Health Access Project also offers an ad campaign/posters to raise awareness of LGBT discrimination. Available at <http://www.glbthealth.org/HAPMaterials.htm>.
2. Lambda Legal publishes an assortment of booklets; toolkits; brochures; short material on cases, issues, and campaigns; and more. Available at <http://www.lambdalegal.org/publications/>.
3. The Human Rights Campaign Web site has several resources, including sample nondiscrimination policy statements regarding sexual orientation and gender identity. These sample statements are available at <http://www.hrc.org/resources/entry/patient-non-discrimination-lgbt-inclusive-policy-statements-from-health>.
4. The Centers for Disease Control and Prevention (CDC) offers fact sheets on HIV/AIDS. Available at <http://www.cdc.gov/msmhealth/resources/fact-sheets.htm>.

*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care
for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community*



GLOSSARY

Adapted from Institute of Medicine: The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (Washington, DC: National Academies Press, 2011), and several other sources, as noted (see the “Glossary Sources” list on page 92).

Advance directive A document or documentation allowing a person to give directions about future health care or to designate another person(s) to make health care decisions if the individual loses decision-making capacity. Advance directives may include living wills, durable powers of attorney, do-not-resuscitate (DNR) orders, right-to-die documents, or similar documents listed in the Patient Self-Determination Act that express a person’s preferences.¹

Advocate A person who represents the rights and interests of another individual as though those rights and interests were the person’s own in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual’s needs.²

AIDS (acquired immunodeficiency syndrome) is generally used to refer to the most advanced states of HIV progression in which the human immune system becomes compromised, leaving the body susceptible to opportunistic infections it could otherwise defeat. For more information, consult the Web site <http://aids.gov/hiv-aids-basics/hiv-aids-101/overview/what-is-hiv-aids/#aids>.

Ally A friend, supporter, assistant, and collaborator. Being an ally to the gay, lesbian, bisexual, and transgender community means supporting equality in its many forms.²

Bisexual One whose sexual or romantic attractions and behaviors are directed at both sexes to a significant degree.

Closeted Refers to a state of secrecy or cautious privacy regarding one’s sexual orientation or gender identity.³

Coming out “Coming out of the closet,” or “coming out,” is a figure of speech that refers to lesbian, gay, bisexual, and transgender people disclosing their sexual orientation and/or gender identity.

Cross-dresser (or transvestite) Refers to an individual who wears clothing and adopts behaviors associated with the other sex for emotional or sexual gratification and who may live part time in the cross-gender role.

Cultural competence The ability of health care providers and health care organizations to understand and respond effectively to the cultural and language needs brought by the patient to the health care encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity, (2) assess themselves, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of individuals and communities served.⁴

Discrimination Differential treatment of a person because of group membership, such as sexual- or gender-minority status.

Disruptive and inappropriate behavior Conduct by staff working in the organization that intimidates others to the extent that quality and safety could be compromised. These behaviors, as determined by the organization,

may be verbal or nonverbal, may involve the use of rude language, may be threatening, or may involve physical contact.¹

Domestic partnership Some cities, counties, and states have passed ordinances or laws providing for domestic partnerships. The eligibility requirements (including whether heterosexual couples may enter a domestic partnership) vary from jurisdiction to jurisdiction, as do the legal rights and responsibilities attached to the status. In many jurisdictions, domestic partnerships have the same effect under state law as a marriage for purposes of assigning medical decision making and other responsibilities. For information regarding statewide domestic partnerships, and other relationship statuses available to same-sex couples in various jurisdictions, see <http://www.lambdalegal.org/publications/articles/nationwide-status-same-sex-relationships.html>.

Effective communication The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.⁴

Family Two or more persons who are related in any way—biologically, legally, or emotionally. Patients and families define their families.⁵ (For more LGBT-inclusive definitions

of *family*, see <http://www.hrc.org/resources/entry/lgbt-inclusive-definitions-of-family>)

Family of choice Refers to a person(s) or group of people an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin. In addition, it may include individuals such as significant others, domestic partners, friends, and coworkers.

Gay An attraction and/or behavior focused exclusively or mainly on members of the same sex or gender identity; a personal or social identity based on one's same-sex attractions and membership in a sexual-minority community.

Gender Refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex. Behavior that is compatible with cultural expectations is referred to as gender-normative; behaviors that are viewed as incompatible with these expectations constitute gender-nonconformity.³

Gender affirmation surgery Any surgery that one has in the course of transitioning from male to female or female to male, though not everyone who transitions obtains one or more surgeries. There are many different gender affirmation surgeries.

Gender expression Characteristics in appearance, personality, and behavior culturally defined as masculine or feminine. People with male anatomy may express themselves in more and less conventionally masculine ways, while people with female anatomy may express themselves in more and less conventionally feminine ways. Gender expression may or may not be congruent with one's sex assigned at birth based on the appearance of external genitalia.

Gender identity One's basic sense of being a man, woman, or other gender (such as

transgender). Although many people identify with the sex assigned at birth, some people with male anatomy identify as female, and some people with female anatomy identify as male.

Gender-nonconforming (GNC) Refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian, or bisexual.⁶

Gender queer (genderqueer) One who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms. Gender queer people may or may not avail themselves of hormonal or surgical treatments.⁷

Health care disparities Differences in medical care that are not due to differing clinical needs, patient preferences, or the appropriateness of the intervention.⁸

Heterosexual Refers to individuals who identify as "heterosexual" or "straight" or whose sexual or romantic attractions and behaviors focus exclusively or mainly on members of the other sex or gender identity.

History and physical Information gathered about an individual using a holistic approach for the purposes of establishing a diagnosis and developing a treatment plan to address physical health issues. (See The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* for more information.)

HIV or human immunodeficiency virus A retrovirus that targets the human immune system. Progression of HIV infection can lead to a serious compromise of immune system function, leaving the body open to opportunistic infections against which it could normally defend. For more information, consult the

Centers for Disease Control and Prevention at <http://www.cdc.gov/hiv/>.

HIV positive Refers to people who are living with HIV, although they may not have AIDS.

Homophobia A term used broadly to refer to hatred, fear of, or discrimination against people based on their sexual orientation.

Homosexual As an adjective, used to refer to same-sex attraction, sexual behavior, or sexual orientation identity. This term is considered outdated and derogatory by many in the LGBT community.²

HRT Abbreviation for hormone replacement therapy. Many transgender people take hormones as part of their transition, either from male to female, or female to male. However, some transgender people do not take hormones.

Intersex A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male.⁹

Joint Commission, The An independent, not-for-profit organization, The Joint Commission is dedicated to improving the safety and quality of health care through standards development, public policy initiatives, accreditation, and certification. The Joint Commission accredits and certifies more than 18,000 health care organizations and programs in the United States.¹

Lesbian As an adjective, used to refer to female same-sex attraction and sexual behavior; as a noun, used as a sexual orientation identity label by women whose sexual attractions and behaviors are exclusively or mainly directed to other women.

LGBT The acronym *LGBT* stands for “lesbian, gay, bisexual, and transgender” and is a term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation (also, “LGBT community”). Sometimes the acronym is depicted as “LGBTQ” to include those who may be questioning their sexual orientation or gender identity. There is no right or wrong way to order the letters (for example, GLBT or GLBTQ), and some people and organizations add additional letters, “Q” for *queer* and/or *questioning*, including “I” for *intersex*, and “A” for non-LGBTQ allies (for example, LGBTQQIA).¹⁰

Medical power of attorney A legal document that gives someone the authority to act on an individual’s behalf regarding health care decisions if he or she ever becomes incapacitated or unable to communicate.¹⁰

Medical record (or health record) 1. The account compiled by physicians and other health care professionals of a variety of patient health information, such as assessment findings, treatment details, and progress notes. 2. Data obtained from the records or documentation maintained on a patient or resident in any health care setting (for example, hospital, home care, long term care, practitioner office). Includes automated (electronic) and paper medical record systems.

Out Describes people who self-identify as gay, lesbian, bisexual, transgender in their public and/or professional life.²

Partner Refers to one’s significant other, boyfriend, girlfriend, husband, or wife without mentioning gender.

Patient An individual who receives care, treatment, or services. Synonyms used by various health care fields include resident, patient and family unit, individual served, consumer, health care consumer, customer, and beneficiary.

Patient- and family-centered care An approach to plan, deliver, and evaluate health care that is grounded in a focus on meeting the specific needs of patients and families. It entails developing mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centered care applies to all patients of all ages, and it may be practiced in any health care setting.⁴

Physical abuse Intentional mistreatment of an individual that may cause physical injury. Examples include hitting, slapping, pinching, and kicking, and may also include attempts to control behavior through corporal punishment.¹

Privacy (of information) The right of an individual to limit the disclosure of personal information.

Quality of care The degree to which care, treatment, or services for individuals and populations increases the likelihood of desired health or behavioral health outcomes. Considerations include the appropriateness, efficacy, efficiency, timeliness, accessibility, and continuity of care; the safety of the care environment; and the individual’s personal values, practices, and beliefs.¹

Queer In contemporary usage, queer refers to an inclusive unifying sociopolitical, self-affirming umbrella term for people who are gay, lesbian, bisexual, pansexual, transgender, transsexual, intersexual, gender queer, or any other nonheterosexual sexuality, sexual anatomy, gender identity. This was historically a term of derision for LGBT people. Queer has been reclaimed by many (although not all) in the LGBT community.

Questioning A person, often an adolescent, who has questions about his or her sexual orientation or gender identity. Some individuals eventually come out as LGBT, others do not (see Lambda Legal:

http://data.lambdalegal.org/publications/downloads/gdtb_basic-facts-about-being-lgbtq.pdf).

Sex Refers to a person's biological status and is typically categorized as male, female, or intersex (that is, atypical combinations of features that usually distinguish male from female). Generally understood as a biological construct, referring to the genetic, hormonal, anatomical, and psychological characteristics of males or females.

Sexual orientation The preferred term used when referring to an individual's physical and/or emotional attraction to the same and/or opposite gender. Sexual orientation describes how people locate themselves on the spectrum of attraction. Someone who feels significant attraction to both sexes is said to be bisexual. A man entirely or primarily attracted to men is said to be gay, and a woman entirely or primarily attracted to women is said to be lesbian. It is important to note that sexual orientation, which describes attraction, is distinct from gender identity or gender expression.

Staff As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organization, including those receiving pay (for example, permanent, temporary, part-time personnel, as well as contract employees), volunteers, and health profession students. The definition of *staff* does not include licensed independent practitioners who are not paid staff or who are not contract employees.¹

Straight Refers to a person who is attracted to a gender other than his or her own.

Surrogate decision-maker Someone appointed to make decisions on behalf of another. A surrogate decision-maker makes decisions when an individual is without decision-making capacity, or when an individual has given permission to the surrogate

to make decisions. Such an individual is sometimes referred to as a legally responsible representative.

Transgender People whose gender identity or gender expression differ from their birth sex or prevailing ideas of masculinity and femininity are often called transgender. Although transgender is an umbrella term that includes people who cross-dress and people who otherwise express themselves in unconventional ways for their birth sex, it is often used to refer to transsexuals—people who live as a sex not associated with their birth sex, after a process known as transitioning. While some transsexuals describe themselves as “trans,” others simply say they are male or female, depending on the sex to which they have transitioned.

Transition A term meaning the period of time when a transgender or transsexual person is learning how to cross-live socially as a member of the sex category different from the individual's birth-assigned sex, or is engaged in early hormone use. Some people use this term to describe their medical condition with regard to their gender until they have completed the medical procedures that are relevant for them.⁷

Trans man This usually means that the person was assigned female at birth but identifies as a man (sometimes referred to as female-to-male or FTM).

Transsexual A medical term applied to individuals who seek hormonal and (often, but not always) surgical treatment to modify their bodies so they may live full time as members of the sex category different from their birth-assigned sex (including legal status). Some individuals who have completed their medical transition prefer not to use this term as a self-referent. Avoid using this term as a noun: A person is not “a transsexual”; the individual may be a transsexual person.⁷

Trans woman This usually means that the person was assigned male at birth but identifies as a woman (sometimes referred to as male-to-female or MTF).

Two spirit A contemporary term that references historical multiple-gender traditions in many First Nations cultures. Many Native/ First Nations people who are lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming identify as Two-Spirit; in many Nations, being Two-Spirit carries both great respect and additional commitments and responsibilities to one's community.¹¹

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