Linking Cultural Competency with Health Disparities in the LGBTQ Population AND Why PT Should Care

Sept. 16, 2017

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Learning Objectives

Participants will be able to:

- Articulate the critical link between inclusive cultural competency education and health equity.
- Use common terms when providing care to patients who may identify as a sexual and/or gender minority.
- Identify specific health disparities for our LGBTQ patients and understand the need to screen our patients appropriately for best practice health care delivery.
- Identify strategies and resources to assist in making participants’ own facilities more welcoming and inclusive.

Cultural Competency =
Cultural Convergence =
Cultural Humility

You can improve access to care for LGBTQ patients by training all staff, including clinical, administrative, and front-line employees, in practices that create an inclusive and welcoming environment for LGBTQ people.

Cultural competency education is variable within each profession and, furthermore, research literature in these professions lacks the intersections of LGBTQ almost completely!

Cultural Competency Defined

- “Cultural competence is a set of behaviors, attitudes, and policies that come together in a continuum to enable a health care system, agency, or individual rehabilitation practitioner to function effectively in trans-cultural interactions. In practice, cultural competence acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, the need to be aware of the dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.”

- Cross, Bazron, Dennis, and Isaacs (1989).
Advocating a Change for all Health Professional Education

Traditional cultural competency education and health disparity research (Sears, 2012)
- Focus has been singular or predominant sources of oppression (Keller, 2009)
- It has left out or marginally considered social forces and contexts

Taking the approach of using culture as the central focus for education (excluding social contexts) may perpetuate health disparities
- Ignores social categories and statuses
- Reinforces stereotypes

Advocating a Change

Using the intersectional framework brings in the ignored social locations to the conversation on, ultimately, how all the intersections affect health

Expanding education to include “LGBTQ”

Intersectional framework as a basis allows:
- Redefinition of health “to affirm identity and sexuality as important components of personhood” (Eckstrand, 2014)
- Allows context to be given to “not only sexual orientation and gender identity/expression, but also to HOW these constructs interact with other aspects of identity and culture across the lifespan.” (Eckstrand, 2014)
- The intersection of these identities is the very basis of the diversity in folks who are/may be LGBTQ and directly contributes to that individual’s health needs (Eckstrand, 2014).

Why Talk Specifically about LGBTQ Health?

- Culturally competent care delivery requires us to acknowledge that health disparities exist with certain populations (the LGBTQ population is one)
- APTA has been largely silent in its inclusivity of the LGBTQ population in any cultural competency education
- Physical therapist have an ethical responsibility to help “eliminate disparities” in the health status of people of diverse cultural backgrounds, including folks who are LGBTQ

Why Talk Specifically about LGBTQ Health?

- APTA lists 5 constructs of cultural competency: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire; these should be applied to our LGBTQ patients.
- The literature has often considered LGBT topics mainly in relation to disease and abnormality, neglecting aspects such as patient-centered health promotion and individualized care following diagnosis.

Addressing LGBT Competent Care

Duke Doctor of Physical Therapy Gay-Straight Alliance
(start at 4:32)
I am not aware that anyone close to me knows or suspects my sexual orientation. My son once hinted at it but not in recent years. At my death, they will probably find tell-tale clues.

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**Recent PT literature opinions published**

- **May 2012: PT In Motion:**
  - “The issues specific to that community have absolutely no bearing on the practice of physical therapy. Whether members of that community are our patients or fellow therapists, I cannot foresee any problems or needs that would arise that are any different from any other population. Members of the LGBT community do not deserve any special treatment. Just because I cannot condone the choice they have used to define themselves does not mean I cannot be charitable toward them. This is not hate. If anything, it is a higher form of love.”

- **Aug 2012: PT In Motion (additional comment to above):**
  - I am not sure why we keep discussing the LGBT [lesbian, gay, bisexual, transgender] community in a magazine for the physical therapist community. Can we move on to a new topic? We all have different values. It’s not necessary to agree with them. When patients walk through your clinic door, you should treat their musculoskeletal dysfunctions, not interview them about their sexual biases.

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**SILENCE in the Healthcare Literature Regarding LGBTQ Health Disparities**

Silence perpetuates the invisibility of LGBT communities and families which in turn continues health disparity (Black RM, 2001).

- “Nursing Silence on LGBT Issues: The Need for Emancipatory Efforts” (Eliason et al., 2010)
  - Only 0.16% of articles focused on LGBT health (8 of ~5,000)
  - LGBT Medical Education Research Group, Stanford University
    - 150 of 176 schools responded
    - Median report LGBT related content in entire curriculum = 5 hours
    - 9 reported 0 hours during preclinical years
    - 44 reported 0 hours during clinical years

**Overwhelming silence in Physical Therapy, Occupational Therapy, Speech Therapy Research**

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**Recent Position Paper in JOPTE:**

Lesbian, Gay, Bisexual, and Transgender Inclusion in Physical Therapy: Advocating for Cultural Competency in Physical Therapist Education Across the United States (Copti et al., 2016)

- First of its kind paper in our profession addressing this population health concerns, disparities, and professional education recommendations

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**Cultural Competency in Terminology**

- APTA lists 5 constructs of cultural competence:
  - Cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire
  - The basis of cultural competency is respect and use of common and respectful language when communicating with patients
  - The “umbrella” of LGBTQ and breaking it down
  - Our language helps create a “safe and welcoming” environment for our LGBT patients.
Institute of Medicine (IOM) Recommendations for Research and Education

- Studies should examine challenges that LGBT individuals face during 4 life stages: childhood, adolescence, early middle age, and later adulthood.
- Studies should examine the health effects of stigmatization and bias on sexual and gender minorities.
- Studies taking an “intersectional perspective” should examine the health status of LGBT individuals in the context of their racial, ethnic, economic, and geographic diversity.
- Studies taking a social ecology perspective should look at how the health of LGBT individuals is affected by their community and interpersonal relationships.

Best Practice Wording for Demographic Information on Health Intake Forms

- The 2011 Institute of Medicine report on LGBT health recommends the collection of sexual orientation and gender identity data in EHRs as part of the meaningful use objectives for the EHR Incentive Program run by the Office of the National Coordinator for Health Information Technology and the Centers for Medicare and Medicaid Services. The report recommends that questions be standardized to allow for the comparison and pooling of data to analyze the specific health needs of LGBT people.
- What we ask on forms/don’t ask on forms sends a very important message about whether we care about the whole individual or not.

Best Practice Wording for Gender Identity/Expression (Two Step):

- What is your current gender identity (check all that apply):
  - Male
  - Female
  - female-to-male (FTM)/Transgender Male/Trans man
  - Male-to-female (MTF)/Transgender female/trans woman
  - Genderqueer, neither exclusively male nor female
  - Additional Gender Category/other, please specify
  - Decline to Answer, please explain why

- What sex were you assigned at birth on your original birth certificate (check one):
  - male
  - Female
  - Decline to answer (please explain why)

Definitions

Health Disparity
- any health difference identified that is closely linked with social or economic disadvantage.

Health Equity
- Attainment of highest level of health for all people. Achieving this requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and elimination of health and health care disparities.
Contextual Factors Influencing folks who are LGBT that contribute to health disparities

- History of LGBT folks in the U.S.
- Effects of stigma, laws, policies, demographic factors, and barriers to care
- Lack of demographic information, even today
- LGBT individuals face barriers to care related to sexual and transgender stigma, and some are further marginalized by additional barriers such as racial/ethnic minority status, low income, immigrant status, and limited English proficiency.

- These are interrelated:
  - Example: historical events have directly contributed to stigmatization of nonheterosexual and gender-variant folks (DSM mental disorder until 1973; legal landscape even today)

Broad Overview of Health Disparities With Direct Effect on Physical Rehabilitation of Individuals

- Lesbians:
  - Significantly more likely to be overweight or obese than women of any other sexual orientation
  - Puts lesbians at higher risk for secondary outcomes of these conditions (ie type 2 diabetes, CAD, stroke, OA, breast and colon cancer)
  - Cancer: Women in relationships with women significantly greater risk for fatal breast cancer than women in relationships with men
  - Lesbians and bisexual women may use preventative health care services less frequently than heterosexual women

- Men Who have Sex with Men (MSM):
  - Disproportionately high risk for HIV infections, HPV infections and HPV-related anal cancer

- Bisexuals
  - Research is grossly inadequate in this population
  - One study indicated higher risks (also in lesbians and gay men) of suicidal ideation and suicide attempts, depression, eating disorders, intimate partner violence, obesity, asthma, and life dissatisfaction
  - Smoking - 27-71% higher in bisexual men and gay men; 70-350% higher in bisexual women and lesbians

- Transgender People
  - The most disparities exist in this population; but research is inadequate
  - Less likely than LGB counterparts to have health insurance
  - Higher occurrence of discrimination by health care providers
  - Other health burdens that disproportionately affect this population: HIV infection, victimization, mental health issues, suicide
  - >50% of transgender patients report having to teach their providers about transgender medical care
  - Important to “treat the parts the patient has” (born with, but may not associate with)

- Life-span Demographics:
  - By 2050, it’s estimated that LGBT people >65 y/o will account for one in 13 elders in this country
  - ~1/3 of all people currently living with HIV or AIDS are 50 y/o or older
  - LGBT youth - very little research
  - Disproportionately likely to be homeless; to experience more negative outcomes

To Treat Me, You Have To Know Who I Am

"Although my doctor knew all about me, each encounter with new people—blood draws, ultrasound, breast x-ray, etc.—had the basic anxiety of the procedure and layered on that, the possibility of homophobia and having to watch out for myself."

"Since my biological family refuses to have any contact with me it is essential to my health and survival that they understand that my partner is MY FAMILY and when they treat him as such my outcomes are better.”

The Health Care Experience

- "Although my doctor knew all about me, each encounter with new people—blood draws, ultrasound, breast x-ray, etc.—had the basic anxiety of the procedure and layered on that, the possibility of homophobia and having to watch out for myself.”

- "Since my biological family refuses to have any contact with me it is essential to my health and survival that they understand that my partner is MY FAMILY and when they treat him as such my outcomes are better.”
The Health Care Experience

- “[My partner] as generally welcomed but treated as a ‘friend’ not a ‘spouse’ and care-taker. She was never really offered the emotional support by the treatment team as I noted other (straight) patient’s partners and care-givers were.”
- “I was fortunate enough to be referred to healthcare workers who acknowledged my relationship and included my partner in all aspects of treatment. Had this not been the case it would have made a stressful situation that much worse...”

Case Study

How Do you Approach Your Subjective with the Patient?
What concerns do you have regarding differentials?

- Discussion
- Share Suggestions

Physical Therapy Literature

Recommendations:
Curriculum content should highlight:
- the appropriate usage of language and terminology for people who are LGBTQ,
- evidence of health care disparities and challenges faced by people who are LGBTQ, and
- active training in understanding the unconscious (implicit) bias of health care providers and how bias can affect both the treatment of patients and students. (Copti, 2016)

Conclusion

All levels of commitment from health profession education is necessary in addressing the health care needs of all people, including people who are or may be LGBT and/or gender nonconforming.

Our professional education has been extremely scarce when it specifically comes to cultural competency with our LGBT and/or gender nonconforming patients. The recommendations coming out from numerous national institutes and associations implores all health care professionals to be inclusive of our LGBT and gender nonconforming patients, as well as to start collecting data to better inform population health in general.
Conclusion

Once we understand the intersect between the patient who may avoid seeking physical rehabilitation, who risks greater injury for fear of discrimination, AND the potential to make an impact/make a difference in that patient’s life simply by having cultural competency immersed in curriculum and in practice...

Change will happen.

References

- APTA Blueprint for Diversity, 2014

Questions?

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