

Reaffirmed July 2025



Working together to improve health care quality, outcomes, and affordability in Washington State.

LGBTQ Health Care Report and Recommendations

2018

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Executive Summary

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs.

Building a health care system that allows everyone to have a fair opportunity to be healthier is a goal across Washington State. Lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) people share common challenges and have health care needs distinct from those who do not identify as LGBTQ. LGBTQ people may also face access issues relating to health insurance coverage and policies that reinforce stigma within the health care system and across communities. These recommendations seek to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and through that effort to decrease health disparities.

The workgroup based recommendations in a whole-person care framework, taking into consideration a person’s multiple individual factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. We organize the recommendations under three focus areas:

- Communication, Language, and Inclusive Environments
- Screening and Taking a Social and Sexual History
- Areas Requiring LGBTQ-Specific Standards and Systems of Care

We recommend that all health care encounters occur using non-judgmental, non-stigmatizing language, body language, and tone. Our recommendations are oriented mainly to primary care, and we also include language directed to hospital settings, health plans, health care purchasers, and patients themselves.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Stigma and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care for people who identify as lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ). The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from December 2017 to September 2018.

See **Appendix B** for the LGBTQ Health Care workgroup charter and a list of members.

See **Appendix C** for results of the guideline and systematic review search.

Purpose Statement

Building a health care system that allows everyone to have a fair opportunity to be healthier is a goal across Washington State. Working toward greater health equity through focusing improvement activities on historically marginalized populations allows for targeted solutions to barriers to care and structural inequities.

Approximately 3.5% of Americans identify as lesbian, gay, or bisexual and 0.3% of American adults are transgender. Many additional people outside of the LGBTQ community have had same sex sexual experiences.¹ Lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) people share common challenges and have health care needs distinct from those who do not identify as LGBTQ.² While all people share baseline health care needs, the LGBTQ population is also at a higher risk for specific medical problems.³ Those who identify as LGBTQ are diverse and from many socioeconomic backgrounds, races, ethnicities, and cultures. Disparities can be magnified when LGBTQ persons are also part of a racial or ethnic minority, a fact important to policy initiatives and clinical care.⁴

LGBTQ persons experience elevated rates of depression, sexual abuse, smoking, and other substance use.^{5,6} Lesbian women are less likely to undergo certain screening tests for cancer (e.g., mammography to test for breast cancer, papanicolaou (pap) test for cervical cancer) and both men and women in same sex relationships are less likely to report insurance coverage.⁷

The health of bisexual and pansexual people has been studied even less than other gender and sexual minorities. We do know that bisexual women have higher rates of alcohol abuse, smoking, obesity, HIV & herpes infection, and are more often subject to intimate partner violence than heterosexual or lesbian women. Information from the Youth Risk Behavior Surveillance System shows that teen girls who have both male and female partners use condoms less often when they do have sexual intercourse with male partners than do teen girls who only have male partners (41.8% vs. 54%).

Men who have sex with men (MSM) and transgender persons who have sex with men are at elevated risk for human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). LGBTQ youth have higher rates of STIs (e.g., gonorrhea, chlamydia) due to increased likelihood of engaging in high-risk sexual behaviors.⁸ The Centers for Disease Control and Prevention (CDC) estimate that gay and bisexual men made up 70% of new HIV infections in 2016, with higher rates among those aged 25-34 and black and Hispanic/Latino gay and bisexual men.^{9,10} In Washington State, over 12,000 people are living with a diagnosed HIV infection and approximately 450 new cases were diagnosed each year from 2013 to 2016.¹¹

Many who identify as LGBTQ may not be comfortable or may have difficulty disclosing sexual and gender orientation to their health care providers.¹² Provider and patient assumptions, miscommunication, stigma, and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care.^{13,14} Difficulties resulting from these obstacles are often compounded by structural aspects of the health care system that neglect gender or sexual minorities (e.g., electronic medical records), and issues related to health insurance coverage and policies that reinforce stigma within the health care system and across communities.

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These recommendations seek to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and, through that effort, decrease health disparities. These recommendations are not intended to replace ongoing collaboration with the LGBTQ community to improve health care to this community.

Recommendations

The workgroup aims to develop recommendations with a manageable scope that can be adopted by clinics, hospitals, health systems, and health plans. Recommendations are based in a whole-person care framework, taking into consideration an individual's multiple factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. We recommend that all health care encounters should occur using non-judgmental, non-stigmatizing language, body language, and tone. Our recommendations are oriented mainly, but not exclusively, to primary care, and include recommendations directed to hospital settings, health plans, health care purchasers, and patients themselves starting on page 6.

We organize the recommendations under three focus areas with greater detail in the following sections:

Table 1: Summary of Focus Areas

Focus Area	Specific Areas for Improvement
Communication, Language, and Inclusive Environments	• Use of the patient's chosen pronouns, name, and gender identity. • Use of respectful terms for chosen family, HIV status, transgender people, and other areas. • Mirror appropriate and non-stigmatizing preferred terms used by patient to describe their body (i.e. a trans male patient may prefer "chest tissue" to "breast tissue"). • Support from electronic health record and health plan data. • Onsite access to gender-neutral restrooms. • Staff use of preferred pronouns on badges. • Use of diverse images and patient facing education materials (e.g., images of same-sex families or gender-diverse people on hallway posters, website, etc.) • Non-discrimination reflected in forms, protocols and employee training
Screening and Taking a Social and Sexual History	• Screening for the following: ○ Behavioral health concerns including depression, suicidality, anxiety, alcohol misuse, and drug use (by specific type as relevant to STI risk). ○ Intimate partner violence. ○ Tobacco use. • Social history using recommended minimum information with flexibility around language depending on patient population: ○ Sexual partners in last 12 months (e.g., men, women, both men and women, other/non-binary, none). ○ Type of sex (e.g., oral, vaginal, insertive or receptive anal sex). ○ History of sexually transmitted infections, by specific relevant type.
Areas Requiring LGBTQ-specific Standards and Systems of Care*	• Appropriate referrals and follow-up based on needs defined through screening and clinical evaluation (e.g., depression, other health concern). • HIV, HCV, or other STI screening. • Immunizations. • HIV pre-exposure prophylaxis based on risk assessment. • HIV treatment and engagement with care. • Appropriate cervical cancer screening and breast cancer screening for patients with cervical and breast tissue for whom screening would be appropriate. • Hormonal therapy, surgical care, and other services for gender minority depending on patient preference. • Information on appropriate community resources.

	• Include members of the LGBTQ community on patient advisory committees and governing bodies.
* Providers and health care systems should establish referral networks to provide these services when they cannot be provided within an individual practice.	

Specific Stakeholder Actions and Quality Improvement Strategies

Persons Who Identify as LGBTQ

These recommendations were created with LGBTQ persons as a priority. Due to this fact, the workgroup lists recommended actions for persons who identify as LGBTQ first. Although, this workgroup recognizes that the primary responsibility for creating change will be with the health care providers and health plans.

- Find a primary care provider that you feel comfortable talking with about your health care needs.
- Talk to your health care providers about your gender identity, preferred pronouns, chosen name, and chosen family. Using a Q card might help this conversation, more information [here](#).
- If you are insured, talk to your health plan about what services are covered. If you are insured as a dependent on another person's health plan, talk to your health plan about any concerns about the confidentiality of the health care you receive.
- Discuss your past sexual history including
 - The gender and sex of your sexual partners.
 - The type of sex you have had with past sexual partners – including oral, vaginal, and/or anal sex (e.g., top, bottom, versatile). This helps medical providers identify parts of your body that may require testing for sexually transmitted infections (STIs).
 - Any history of STIs.
- Talk to your provider about:
 - Any concerns that you might have about being down or depressed, especially if you have had thoughts of hurting yourself or others.
 - Your relationships with your partners including whether you have ever felt unsafe in the relationship(s) or experienced violence.
 - Any tobacco, alcohol, or drug use.
 - Whether HIV pre-exposure prophylaxis also known as PrEP might be right for you.
 - Whether you want or need screening for STIs.
 - How often to have regular cancer screenings.
 - Community resources that are available in your area.
 - How comfortable you feel in your provider's office including any feedback about access, staff use of chosen pronouns and name(s), access to restroom facilities, and any other issues.
 - Any concerns about the confidentiality of the care you are receiving, including any concerns about communications from your provider or health plan.
 - Consider conversation guides such as the Gay and Lesbian Medical Association's Ten Things Transgender Persons Should Discuss with their Health Care Providers available [here](#).
- Washington State has many resources for the LGBTQ community including:
 - [African Americans Reach and Teach Health Ministry](#) (Seattle, WA)
 - Seattle Children's offers a list of books for children to young adults [here](#).

- [City of Seattle LGBTQ Youth Resources](#)
- [Entre Hermanos](#) (Latino(a) LGBTQ community Seattle, WA)
- [Seattle's LGBTQ+ Center](#) (Seattle, WA)
- [Gender Justice League](#)
- [Ingersoll Gender Center Transition Resources](#) (Seattle, WA)
- [Lambert House resource for queer youth](#) (Seattle, WA)
- [Mountain West AIDS Education and Training Center Program](#) (Seattle, WA)
- [Odyssey Youth Center](#) (Spokane, WA)
- [The Rainbow Center](#) (Tacoma, WA)
- [Seattle Counseling Service](#) LGBTQ-focused community mental health agency (Seattle, WA)
- [Spokane Human Rights Commission](#) (Spokane, WA)
- [Spokane Transgender Advocacy and Local Leadership Community](#) (Spokane, WA)
- [We are 1](#) (King, Snohomish, and Pierce Counties)

Primary Care Providers

- **Communication, Language, and Inclusive Environments**
 - Use the patient's chosen pronouns.
 - Use the patient's chosen name.
 - Use the patient's preferred terms for body parts (ex. A transmale patient may prefer term "chest tissue" rather than "breast tissue")
 - Use appropriate terms and non-stigmatizing terms for sexual orientation and gender identity, HIV and other STIs, family members, and people who are transgender as outlined on page 15 and in **Appendix D**.
- **Screening and Taking a Social and Sexual History**
 - Ask about the patient's gender identity, chosen pronouns, and chosen name. This should ideally be done when the patient initially registers for care to facilitate inclusion of this information in the medical record and to ensure appropriate use of pronouns throughout the patient's care.
 - **Pediatrics:** Use the most updated version of the HEADSSS assessment that includes language on sexual orientation and on behaviors. More information [here](#).
 - Consider a patient's comfort level and be prepared to discuss how and why a sexual history is important and how patient confidentiality is ensured.
 - Take a social history that includes basic components of a sexual history. How to ask these questions and their depth should be flexible and will vary depending on practice environment and patient population. See examples on pages 17-18. Ideally, clinicians should obtain a sexual history as part of an initial new patient visit. Among men who have sex with men and transgender patients, these questions should be repeated at least annually. A basic sexual history should include the following core elements:
 - If patient has had sex with men, women, both men and women, and/or other/non-binary, or none.

- Types of sex including oral, vaginal, and insertive and receptive anal sex (i.e., top, bottom, or versatile)
- History of any previously sexually transmitted infections (STI) including:
 - HIV
 - HPV or Genital warts
 - Chlamydia
 - Gonorrhea
 - Hepatitis B
 - Hepatitis C
 - Syphilis
 - Trichomonas
- Concern about having contracted an STI (e.g., “Do you have any worry about having contracted an STI?”)
- Screen for the following during the medical history:
 - Behavioral health concerns including depression, suicidal ideation, and anxiety using a validated instrument (e.g., Patient Health Questionnaire 9 Item or 2 Item, Columbia Suicide Severity Scale, Generalized Anxiety Disorder 7-Item) annually.
 - Ideally behavioral health services should be integrated into primary care as outlined in the 2017 Behavioral Health Integration Report and Recommendations. If appropriate behavioral health services are not available onsite, develop a comprehensive referral network that includes providers specializing in issues specific to the LGBTQ population.
 - Intimate partner violence.
 - Tobacco use.
 - Alcohol and other drug use as outlined in the 2015 Addiction and Dependence Treatment Report and Recommendations following the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
- **Areas Requiring LGBTQ-Specific Standards and Systems of Care**
 - **HIV and STI screening:**
 - Follow the Washington State Sexually Transmitted Diseases screening guidelines for men who have sex with men and transgender persons available [here](#).
 - For all sexually active men who have sex with men, and transgender or nonbinary persons who have sex with men, including those engaging in any anal, vaginal or oral sex, these guidelines recommend at least annual screening for HIV and STIs.
 - Screening refers to testing in the absence of signs, symptoms or a known exposure to STI. Patients in long-term (> 1 year), mutually monogamous, HIV concordant relationships do not require HIV/STI screening.

- Providers should test for gonorrhea and chlamydial infection at all exposed anatomical sites of potential infection (i.e., pharynx, rectum, urethra/vagina, or other appropriate nonstigmatizing term).
- Screen all pregnant individuals for syphilis at the first prenatal visit, during the third trimester and at birth, rather than risk based approach to testing, given increasing rates of congenital syphilis. Follow [ACOG and CDC guidelines](#) for syphilis screening in pregnancy.
- Hepatitis C screening for those using injection drugs or off-market hormonal therapy. Providers should also consider HCV screening in MSM living with HIV and transgender persons who have sex with men.
- Men who have sex with men who have not been immunized should be screened for Hepatitis B once in their lifetime.
- Follow other age-appropriate screenings (e.g., Hepatitis C screening for those born between 1945 and 1965).
- Inform patients who test positive for HIV or other STIs that are reportable that their infections will be reported to public health and that they may be contacted by the Health Department.
- **Immunizations:** Men who have sex with men and transgender persons should generally receive immunizations based on recommendations for the general populations. However, because some vaccine preventable infections are more common among sexual and gender minorities, clinicians should ensure immunity or vaccination for Hepatitis A and B for men who have sex with men, transgender persons, and people living with HIV, Hepatitis C, or chronic liver disease as well as sexual partners of patients who have Hepatitis B.
 - Immunize all patients through age 26 for human papillomavirus (HPV), and all people living with HIV through age 45. Monitor for changes to this recommendation from national organizations.
- **Bacterial STI Prophylaxis**
 - **Doxy-PEP:** Doxycycline post-exposure prophylaxis (Doxy-PEP) should be provided to persons who would benefit the most while minimizing antimicrobial use. Recommend and discuss benefits and harms of using doxy-PEP with individuals who are at higher risk, including men who have sex with men and transgender women with a history of at least one bacterial STI (syphilis, gonorrhea or chlamydia) during the past 12 months, and men who have sex with men or transgender persons who take PrEP regardless of bacterial STI history. Engage in shared decision-making around doxy-PEP for other individuals, such as men who have sex with men and transgender women who have not had a bacterial STI diagnosed during the previous year, but will be participating in activities that will increase likelihood of exposure to STIs. Use clinical judgment and shared decision-making to guide use of doxy-PEP with other populations. Follow [CDC doxy-PEP guidelines](#) or more updated evidence-based information.
- **HIV:**

- **PrEP:** Ensure that patients who are men who have sex with men, who are transgender persons who have sex with men, or others who may be at risk know about PrEP.
 - Follow the [Washington State Department of Health and Public Health Seattle and King County PrEP Implementation Guidelines](#) for identifying people without HIV who might benefit from PrEP, and [US Public Health Services guidelines for the medical management of PrEP](#). (Please note that WA State guidelines recommend STI screening of men who have sex with men and transgender persons on PrEP every three months) Updated guidelines recommend STI screening every two months for those taking cabotegravir.
 - Most primary care medical providers should be able to prescribe oral PrEP and manage patients on oral PrEP. However, if a provider is unable to provide PrEP onsite, or the treatment plan includes long-acting injectable PrEP, develop a referral network to support the patient in finding accessible care. The WA State Department of Health funds PrEP navigators who can help patients find a medical provider who prescribes PrEP. More information can be found [here](#).
- Although not all primary care medical providers need to be able to provide primary care to people living with HIV, all primary care medical providers should:
 - Test for HIV according to national and WA State guidelines.
 - Routinely ask people living with HIV if they are currently taking antiretroviral therapy, in order to identify persons who need assistance linking to HIV care or increased support to promote their successful treatment.
 - Have systems in place to refer patients living with HIV for medical care. Ideally, all patients living with HIV should be on antiretroviral therapy.
- **Treatment:** Health care providers should follow current US Department of Health and Human Services (DHHS) guidelines for the treatment of persons living with HIV, available [here](#) with goal of viral suppression.
 - Health departments throughout WA State can assist health care providers and patients find HIV care and medical providers who can provide HIV care.
 - Providers should contact the WA State Department of Health or their local health department if they have patients who are not receiving regular care or are off antiretrovirals. Health departments have staff who can help link patients to care and access support services to increase their success in achieving HIV viral suppression.
 - For older patients living with HIV, consider the increased likelihood of comorbidities and need for earlier screening (e.g., bone density).
- **Cancer Screening:**

- Discuss regular, appropriate cervical cancer screening and breast cancer screening with patients with cervical and breast tissue for patients who are at higher risk of cervical and breast cancer including women who have sex with women or men and transgender men or genderqueer people who were assigned female at birth. People living with HIV should receive cervical cancer screening (PAP and co-testing for HPV) every 3 years.
- Discuss prostate cancer screenings with transgender women as outlined in the [2015 Bree Collaborative Prostate Cancer Screening Report and Recommendations](#)
- Discuss anal cancer screening for populations at high risk, such as men who have sex with men and transgender women or genderqueer people who were assigned male at birth living with HIV. Screening is recommended to start at age 35. Several groups should begin screening at age 45, including women and men who have sex with women living with HIV, men who have sex with men & transgender women without HIV. People with a history of high-grade squamous intraepithelial lesions (HSIL) or cancer should screen within a year of diagnosis. Solid organ transplant recipients should be screened 10 years after transplant.
- Engage in shared decision-making conversations around screening for anal cancer with people over 45 years of age with a history of one or more of the following: cervical or vaginal HSIL or cancer, perianal warts, persistent cervical HPV 16, or those with immunosuppression (rheumatoid arthritis, lupus, crohn's disease or ulcerative colitis)
- Screening includes digital anal rectal exam (DARE) and anal cytology and/or anal HPV testing. Abnormal results should be referred for high resolution anoscopy (HRA).
- Follow [NIH/CDC/IDSA](#) and [International Anal Neoplasia Society \(IANS\)](#) guidelines for anal cancer screening or most updated evidence-based guidelines.
- **Reproduction:** Discuss reproduction and contraception methods with patients as appropriate. Information on birth control across the gender spectrum is available [here](#). Other topics relevant to reproduction include sperm/egg banking, fertility treatments and options, counseling on all options including abortion. Providers should also feel comfortable performing a preconception counseling visit or refer to a provider who is able to perform these services. Patients on testosterone should be advised hormone therapy is contraindicated in pregnancy. Gender minority individuals should also have access to mental health support if needed. See [Appendix E](#). for resources related to family planning and fertility.
- **Hormone Therapy:** For patients wishing to access hormonal therapy, follow the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Non-binary People (2016) from the Center of Excellence for Transgender Health, Department of Family & Community Medicine, University of California, San Francisco, available [here](#).

- If unable to provide appropriate hormonal therapy onsite, develop a referral network to support the patient in finding accessible care.
- **Transitioning:** For patients who are transitioning for gender alignment, follow the guidelines outlined in the Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People as published by the World Professional Association for Transgender Health (WPATH), available [here](#), including services for:
 - Mental health
 - Hormone therapy
 - Reproductive health
 - Voice and communication therapy
 - Surgery
 - Postoperative care and follow up
 - Lifelong preventive and primary care

Clinics, Hospitals, and Health Systems

- **Communication, Language, and Inclusive Environments**
 - Train all staff about using patient's chosen pronouns and chosen name. Avoid using titles as appropriate.
 - Educate staff about respectful behavior within restrooms (e.g., not questioning patients or other staff members who are not gender conforming).
 - Provide gender-neutral restrooms within the facility.
 - Use staff preferred pronouns on badges or other visible areas.
 - Use images of diverse patients within the facility (e.g., images of same-sex families on hallway posters, on the website, or other marketing materials).
 - Revise forms and protocols (e.g., mission statement, employee materials) to reflect an open and affirming environment including non-discrimination in hiring practices.
- **Screening and Taking a Social and Sexual History**
 - Configure your system's electronic health record (EHR) to accurately reflect the patient's chosen pronouns, chosen name, and to allow for identification of patients who are at a higher risk of STIs and HIV (i.e., men who have sex with men, transgender people who have sex with men). This will require queryable data fields on gender or sex of sex partners. Such fields can then be used to promote and monitor standards of care, such as HIV/STI screening and PrEP use.
 - The Fenway: National LGBT Health Education Center has developed a 2016 resource Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records, available [here](#).
- **Areas Requiring LGBTQ-Specific Standards and Systems of Care**
 - Develop clear, appropriate referral networks for providers experienced in the care of transgender patients, including providers who can provide hormone therapy.
 - Develop clear, appropriate referral networks for PrEP and HIV treatment if unavailable onsite.
 - Institute quality improvement mechanisms that assure essential data elements related to gender affirming care are being captured
 - Consider quality metrics stratified by population group are measured, reported, and used as the basis of improving care outcomes for LGBTQ persons.
 - Consider identifying LGBTQ specialty providers (e.g., on the organization's website, when patients select medical providers)
 - **Community Resources:** Develop materials outlining appropriate community resources that may be applicable to your patient population or refer a patient to an appropriate resource such as those outlined in the section directed toward people who identify as LGBTQ.

Health Plans

- Identify the patient's primary care provider and be sure the patient knows who this is.
- Make information available that allows a patient to identify providers and specialists with experience in LGBTQ care.

- Health plans, in conjunction with community advocates, should develop a common set of competencies used to identify medical and behavioral providers who specialize in LGBTQ health services.
- Ensure equity in infertility treatment coverage for subscribers with same and opposite sex partners (e.g., not requiring 12 months if under 35 and 6 months if over 35 of non-covered clinically-supervised insemination prior to reimbursement if not in an opposite-sex relationship).
- Honor the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People health plan recommendations (e.g., masculinization surgery, not requiring behavioral health visits prior to hormonal therapy)
- Ensure appropriate referral networks for PrEP, HIV treatment, and hormonal therapy.
- Include performance and quality metrics in contracts with providers and other purchasing agreements, that promote viral load suppression pursuant to HRSA's [HIV/AIDS Bureau Performance Measures](#) (e.g. Effective Clinical Care Measure #338; National Quality Strategy #2082, 2083, 2079; and HEDIS MEASURE HVL-AD: HIV VIRAL LOAD SUPPRESSION
- Do not require a copay or deductible for appropriate HIV and other STI screening and PrEP. For many MSM and transgender patients quarterly screening is more appropriate.
- Do not require a copay, deductible, or out of network charge for HIV and other STI screening conducted at an STD clinic.
- Allow information technology systems to include a subscriber's identified gender (including non-binary selections) and chosen name (if different from birth gender and name).
- Configure claims systems so that healthcare services for transgender individuals are not denied based on the healthcare service not aligning with the binary gender assignment (for example, a hysterectomy for a transgender man should not be denied)
- Establish a simple process for individuals insured as dependents on another person's health plan (e.g., a minor using their parent's insurance) to access care confidentially using their insurance, and provide enrollees with clear and accessible information about how to access this process.
- Provide gender affirming care training to staff, particularly customer service representatives and others likely to provide support for enrollees seeking access to gender affirming care.
- Have adequate clinical review staff familiar with gender affirming care in order to ensure that preauthorization wait times for these services are comparable to wait times for other services.
- Provide clear, easy to understand guidance for providers explaining how to bill for gender affirming services in order to minimize delays to care and billing.

Employers

- Review recommendations to health plans and include similar language in your contracts.
- Employers can review the Human Rights Campaign (HRC) Corporate Equality Index (CEI) criteria to identify ways to improve workplace culture and conditions for its LGBTQ employees, including criteria related to workforce protections, inclusive benefits, supporting an inclusive culture and corporate social responsibility, and responsible citizenship. More information is available [here](#).

Washington State Agencies (e.g., Health Care Authority, Department of Health)

- Include performance and quality metrics in contracts with providers and other purchasing agreements, that promote viral load suppression pursuant to HRSA's [HIV/AIDS Bureau Performance Measures](#) (for example: Effective Clinical Care Measure #338; National Quality Strategy #2082, 2083, 2079; and [HEDIS MEASURE](#) HVL-AD: HIV VIRAL LOAD SUPPRESSION
- State agencies and government leaders should support and promote a robust public health infrastructure to meet the needs of all people in Washington State. This can be demonstrated through funding, legislation, communication, and advocacy.
- State agencies and government leaders should demonstrate the commitment to inclusiveness for LGBTQ people by addressing disparities in key domains, including:
 - Health care eligibility, such as covering same sex spouses/domestic partners and dependents of same sex couples.
 - Coverage, including coverage of services to support transgender individuals who are going through the gender affirmation process and equity in coverage for infertility treatment for same sex couples.
 - Accessibility, such as identifying and communicating about providers who specialize in treating LGBTQ individuals.
 - Ensure that individuals have the ability to access health care safely and confidentially
 - Affordability, such as providing first dollar coverage (i.e., not applying co-pays and deductibles) for STI screening.
 - Utilization, such as promoting prevention and treatment services particularly relevant to LGBTQ individuals (e.g., coverage of transitioning services, STI screening, preventive screenings).

Table 2: Recommendations for LGBTQ-Competent Health Care

Focus Area	Patient Perspective	Operational Details
Communication, Language, and Inclusive Environments	<i>The clinic in which I receive care is welcoming, uses terms like partner, uses my preferred name, and accommodates my needs such as having bathrooms in which I feel comfortable. Staff use preferred pronouns. I feel comfortable talking about my family.</i>	Current State: Patients and staff may be uncomfortable addressing one another. Forms and the language used by staff may use terms like husband/wife. Staff may have an underlying assumption that patients are heterosexual and cisgender (gender matches that assigned at birth) and ask questions in this manner. Intermediate Steps: Leadership at the organization prioritizes creating a welcoming and inclusive atmosphere through identification of goals, gaps between current care and goals, and is actively developing and implementing staff training to close this gap. Optimal Care: Patients receiving care at the organization feel comfortable that their sexual orientation and gender identity will be respected. Staff feel comfortable addressing new patients, asking about preferred pronouns and names, and are supported by an electronic health record that accurately reflects patient preference and includes queryable fields indicating the sex or gender of patients' sex partners. Staff use non-judgmental, non-stigmatizing language, body language, and tone.
Screening and Taking a Social and Sexual History	<i>I am asked about my sexual history and behaviors in a non-judgmental way. I feel comfortable discussing my sexual partners and history and my gender identity with my provider and care team.</i>	Current State: The experience of talking about previous sexual history and current sex partners may be jarring to some patients. Patients may feel they have to repeatedly remind the provider and care team of their sexual orientation or gender identity and not feel respected and supported. Patients may have concerns about the confidentiality of their information and not trust staff or the organization to have their best interests in mind. Intermediate Steps: Leadership sets clear clinical protocols for taking a sexual history that is appropriate to the organization's patient population. Providers and other staff are trained on asking about sexual history in a non-judgmental manner and clearly explain the reasons for additional questions (e.g., depression, suicidal ideation, alcohol use). Optimal Care: Providers take the time to explain the reasons for asking about sexual history and reaffirm that patient data is secure. Patients are seen as a whole-person, not as a single identity or a single diagnosis. Patients feel comfortable talking about their sexual partners, types of sex, and any concerns they have about pregnancy, sexually transmitted infections, or other issues. Behavioral health concerns including alcohol and drug use are discussed in this supportive environment as is tobacco use and intimate

		partner violence. Providers feel comfortable talking about next steps based on individual patient need and patients know who to contact with any questions, concerns, and about their referrals.
Areas Requiring LGBTQ-Specific Standards and Systems of Care	<i>My provider has talked about which next steps are appropriate for me including cancer screenings, hormonal therapy, or other referrals. If appropriate, I am offered pre-exposure prophylaxis for HIV. I fully understand PrEP, how to talk to my partner(s) about PrEP, and feel supported by my provider and care team. I can receive treatment for HIV on-site or through a supported referral.</i>	Current State: Patients may fall through gaps in care and be unclear as to how to access the care they need. Patients may feel they keep hitting roadblocks to their goals of care and have unmet needs. Intermediate Steps: The organization has begun to identify care that can be delivered on-site vs. care that requires a referral. Protocols for supporting patients who may need care off-site are developed and disseminated. Institute quality improvement mechanisms that assure essential data elements related to gender affirming care are being captured Optimal Care: Providers have clear pathways to support patient goals of care through onsite delivery or robust referral networks with warm handoffs. Patients feel respected and receive appropriate screenings. Systematic efforts are in place and monitored to ensure adherence to WA State HIV/STI screening guidelines. Medical providers discuss HIV pre-exposure prophylaxis with MSM and transgender patients who have sex with men, and either prescribe PrEP onsite or have established mechanisms for referring patients for PrEP. Patients who are HIV positive are able to access medication and care they need. Hormonal therapy is discussed as appropriate and delivered onsite or through a coordinated effort with another organization. Patients have a clear understanding of when they will see their provider and care team again and who to contact if they have questions. Quality metrics stratified by population group are measured, reported, and used as the basis of improving care outcomes for LGBTQ persons.

Details on Focus Areas

Communication, Language, and Inclusive Environments

Language has great potential to address and reduce or to reinforce stigma. Careful attention to terminology is especially important for populations who have been historically marginalized. Staff and organizations should create a welcoming environment using the patient's chosen pronouns, the patient's chosen name, and appropriate terms for family with support from electronic health record data that accurately reflects patient preference. The workgroup recommends following the Fenway: National LGBT Health Education Center 2016 resource Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records, available [here](#) and Center Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients, available [here](#).

The workgroup recommends the following sources for person-focused terminology although others currently being used by providers and sites are may also be appropriate:

- Sexual Orientation and Gender Identity. Anti- Violence Project: Sexual Orientation and Gender Identity available [here](#).
 - Example: *Gender: The wide set of characteristics that are constructed to distinguish between the two institutionally recognized sexes: male and female. Gender is not static and can shift over time.*¹⁵
- Referring to HIV. University of California San Francisco: HIV #LanguageMatters: Addressing Stigma by Using Preferred Language available [here](#).
 - Example: *Person living with HIV* rather than *HIV infected person*.¹⁶
- Family members. National LGBT Health Education Center Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients as outlined in **Appendix D**.
 - Example: *Spouse or Partner(s)* rather than *husband or wife*.
- People who are transgender. National Center for Transgender Equality: Transgender Terminology available [here](#).
 - Example: *Transgender: A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth. Transgender is a broad term and is good for non-transgender people to use. "Trans" is shorthand for "transgender." (Note: Transgender is correctly used as an adjective, not a noun, thus "transgender people" is appropriate but "transgenders" is often viewed as disrespectful.)*¹⁷

Building an inclusive environment starts with staff training and language and extends to the physical space of the clinic and exam rooms. Many of the national guidelines outlining recommended changes are included in **Appendix E: Crosswalk of Reviewed Guidelines**. At a minimum, the workgroup recommends:

- Use of the patient's chosen pronouns, the patient's chosen name, and gender identity.
- Use of respectful terms for chosen family, HIV status, transgender people, and other areas.
- Support from electronic health record and health plan data.
- Onsite access to gender-neutral restrooms.
- Staff use of preferred pronouns on badges.

- Use of diverse images (e.g., images of same-sex families or gender-diverse people on hallway posters, website, or other marketing materials).
- Non-discrimination reflected in forms and protocols (e.g., mission statement, employee materials).

Screening and Taking a Social and Sexual History

The workgroup recommends minimum standards for information gathering in the primary care visit including gender identity, preferred pronouns, chosen name and components of a basic sexual history. As patient populations vary across the state, the workgroup does not recommend a single set of sexual history questions, but provides examples that allow providers to ask patients about their sexual history in order to identify gender and sexual minorities and provide appropriate care. Providers should be prepared to explain the rationale behind screening.

	Examples	Comment
Gender identity	What is your gender? Male Female Transgender female to male Transgender male to female Non-binary/Gender Queer Something else What sex was recorded on your original birth certificate Male Female	Two questions identify transgender and gender nonconforming persons. Asked by medical providers and staff as an open-ended question (i.e. responses not read) Questions are best incorporated into registration materials.
Gender of sex partners	Do you have sex with men, women, or both men and women? What is the sex of your sex partners? Male (has penis) Female (has vagina) How would you describe the gender of your sex partners? Male Female Trans male Trans female Non-binary/other	Question is simple but does not identify transgender partners of non-binary partners explicitly. Question focuses on sex, not gender. Emphasis is on anatomy (i.e. presence of a penis or vagina). Does not identify transgender or non-binary partners. Asked as an open-ended question or can be reported on self-administered questionnaire. A question about the gender or sex of sex partners should be asked as part of initial patient visits and repeated

		annually in patients, if patients are diagnosed with an STI, and as needed based on provider discretion.
Type or sex - Anatomic sites of exposure	Do you have vaginal, oral, or anal sex? For men having anal sex: Are you a top, bottom, or versatile? (Top=insertive, bottom=receptive, versatile=both insertive and receptive)	Question can be limited to patients for whom STI extragenital STI screening is recommended (i.e. men who have sex with men, transgender persons). The goal is to identify anatomic sites to be tested.
History of STI	Have you ever had a sexually transmitted infection, like gonorrhea, syphilis, chlamydia, genital herpes or human papillomavirus? If yes, when did you last have that infection	Helps define frequency of recommended STI screening, need for PrEP, and possible need for suppressive or intermittent herpes therapy.

Of note, in 2016, the US Department of Health and Human Services added required questions on sexual orientation (i.e., lesbian or gay, straight, bisexual, something else, don't know, choose not to disclose) and gender identity (i.e., male, female, transgender male/female to male, transgender female/male to female, other, choose not to disclose) to the Uniform Data System.¹⁸ The questions above do not include questions about sexual orientation, instead focusing on sexual behavior itself. Sexual orientation is how a person describes their sexuality, which may or may not be the same as their behavior. Surveys of patients being asked questions about their sexual orientation and gender identify report these questions as acceptable and important for providers to know.^{19,20}

Behavioral health concerns including depression, suicidal ideation, and anxiety

Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#). High-quality behavioral health care should draw from trauma-informed care appropriate to an individual as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) [here](#). At a minimum, all patients should be screened for depression with a validated instrument such as the Patient Health Questionnaire Nine Question (PHQ-9) including a screening question for suicidal ideation (e.g., the ninth question of the PHQ-9, the first question of the Columbia Suicide Severity Rating Scale) and anxiety with a validated instrument such as the Generalized Anxiety Disorder Seven Item (GAD-7). If the patient screens

positive, a plan should be developed on the same day that includes continuous patient engagement in ways that are convenient for patients that may include a supported referral.

Intimate partner violence

The US Preventive Services Task Force recommends, *“that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services.”*²¹ The workgroup recommends that all LGBTQ patients be screened for intimate partner violence. Many tools are available for use and the workgroup does not recommend a specific tool other than it be validated. Available tools include Hurt, Insult, Threaten, and Scream (HITS), the Woman Abuse Screening Tool (WAST), the Partner Violence Screen (PVS), and others.²²

Tobacco use

All patients should be screened for tobacco use. If the patient screens positive, resources about quitting should be offered. The clinical pathway may follow the Agency for Healthcare Research and Quality’s Treating [Tobacco Use and Dependence](#).²³

Alcohol and other drug use

The Bree Collaborative also developed [recommendations around integrating the Screening, Brief Intervention, and Referral to Treatment \(SBIRT\) model into primary care, prenatal, and emergency room settings](#) in January 2014. The 2017 Behavioral Health Integration Report builds on and expands upon this previous Report. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically *“identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.”*²⁴ The workgroup recommends that all patients be screened for alcohol and drug use and if positive, be offered brief intervention onsite and referral to treatment if alcohol misuse and drug use is severe.

Areas Requiring LGBTQ-Specific Standards and Systems of Care

The workgroup recommends clinically appropriate next steps based on the risk profile obtained from screening or taking a social history.

For people who have receptive anal sex

The Centers for Disease Control and Prevention (CDC) developed clinical practice guidelines for HIV Pre-Exposure Prophylaxis in 2014. However, many felt the language to be not specific enough when referring to patient populations to be easily implementable. The CDC guidelines are available [here](#). In 2015, the Washington State Department of Health and Public Health Seattle and King County developed PrEP Implementation Guidelines²⁵ with more specific definitions that allow for easier adoption. The workgroup endorses these guidelines and recommends their use across Washington State. The guidelines are available [here](#).

More information from King County [here](#).

Information on the Washington State Department of Health Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP) [here](#).

Resources for referrals if unable to provide onsite:

- Please PrEP Me. For patients looking for HIV pre-exposure prophylaxis www.pleaseprepm.me/#

For people with cervical or breast tissue

Due to women who have sex with women being less likely to undergo screening tests for breast and cervical cancer, the workgroup felt it important to call out the United States Preventive Services Task Force (USPSTF) recommendations as follows:

USPSTF recommends “biennial screening mammography for women 50-74 years” but “against teaching breast self-examination.”²⁶ More information [here](#).

The USPSTF is currently updating recommendations on screening for cervical cancer. In 2011 the Task Force recommend “screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.”²⁷ More information [here](#).

HIV treatment or referral network if unavailable onsite

The workgroup recommends following the United States Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, available [here](#) (updated March 2018). The guideline reviews: baseline evaluation, laboratory testing, treatment goals, initiation of antiretroviral therapy, what to start, considerations for antiretroviral use in special patient populations, considerations for antiretroviral use in patients with coinfections, limitations to treatment safety and efficacy, and drug interactions. The workgroup also reviewed the 2016 United Kingdom national guideline on the sexual health care of men who have sex with men. This guideline is meant for providers

operating within the National Health Service and is not completely applicable to the United States health care system, but offers a good summary of recommendations around: history taking, identification of problematic recreational drug and alcohol use, STI and HIV testing in asymptomatic men who have sex with men, the management of men who have sex with men symptoms of sexually transmissible enteritis and proctitis, HPV infection and anal dysplasia in men who have sex with men, partner notification and men who have sex with, STI and HIV prevention for men who have sex with men in the clinic, and sexual problems and dysfunctions in men who have sex with men, that may not be covered in these recommendations.²⁸

Appropriate community resources

Many community resources exist for those who identify as LGBTQ in Washington State or that are available online. The workgroup recommends that practices develop materials outlining appropriate community resources that may be applicable to the patient population or be ready to refer a patient to an appropriate resource. Examples of resources include:

- [African Americans Reach and Teach Health Ministry](#) (Seattle, WA)
- Seattle Children's offers a list of books for children to young adults [here](#).
- [City of Seattle LGBTQ Youth Resources](#)
- [Gay City: Seattle's LGBTQ Center](#)
- [Gender Justice League](#)
- [Ingersoll Gender Center Transition Resources](#) (Seattle, WA)
- [Lambert House resource for queer youth](#) (Seattle, WA)
- [Mountain West AIDS Education and Training Center Program](#) (Seattle, WA)
- [Odyssey Youth Center](#) (Spokane, WA)
- [The Rainbow Center](#) (Tacoma, WA)
- [Seattle Counseling Service](#) LGBTQ-focused community mental health agency (Seattle, WA)
- [Spokane Human Rights Commission](#) (Spokane, WA)
- [We are 1](#) (King, Snohomish, and Pierce Counties)

Hormonal therapy or referral network if unavailable onsite

Specific clinical guidelines on hormonal therapy are out of the scope of this Report and Recommendation, however, the workgroup recommends following the Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2016) from the Center of Excellence for Transgender Health, Department of Family & Community Medicine, University of California, San Francisco, available [here](#). Additionally, UpToDate includes clinical articles on gender development and clinical presentation of gender nonconformity in children and adolescents [here](#) and management of gender nonconformity in children and adolescents [here](#).

Similarly, for patients who are transitioning for gender alignment, the workgroup recommends following the guidelines outlined in the Standards of Care for the Health of Transsexual,

Transgender, and Gender Non-confirming People as published by the World Professional Association for Transgender Health (WPATH), available [here](#), including services for:

- Mental health
- Hormone therapy
- Reproductive health
- Voice and communication therapy
- Surgery
- Postoperative care and follow up
- Lifelong preventive and primary care

If the clinic or site is unable to provide hormonal therapy or gender confirmation surgery onsite, an adequate referral network should be available to support the patient achieve goals of care.

Resources for referrals if unable to provide onsite:

- Ingersoll Gender Center health care providers:
<https://ingersollgendercenter.org/providers>

Other Work in Washington State

The workgroup is aligned with and builds from the End AIDS Washington campaign administered by the Washington State Department of Health. End AIDS Washington is a “*collaboration of community-based organizations, government agencies and educational and research institutions working together to reduce new infections in Washington by 50% by 2020.*”²⁹ The campaign started on World AIDS Day December 2014 from Governor Inslee’s proclamation. Recommendations were developed by a steering committee, available [here](#), with 11 goals including to:

1. Identify and reduce HIV stigma
 2. Reduce HIV-related disparities
 3. Implement routine HIV testing
 4. Increase access to pre-exposure prophylaxis (PrEP)
 5. Create health care that meets the needs of sexual minorities
 6. Improve HIV prevention and care for substance users
 7. Remove barriers to insurance and increase health care affordability
 8. Increase access to safe, stable, and affordable housing
 9. Deliver whole-person health care to PLWH
 10. Launch Healthier Washington for Youth
 11. Include meaningful community engagement and empowerment
- End AIDS Washington information available [here](#).
 - More information from the Department of Health [here](#).

Measurement

The workgroup recommends tracking the number of patients who identify as lesbian, gay, bisexual, and transgender. Additionally, [Healthy People 2020](#) includes two Lesbian, Gay, Bisexual, and Transgender Health related metrics:

- Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
- Increase the number of states, territories, and the District of Columbia that include questions that identify sexual orientation and gender identity on state level surveys or data systems

Healthy People 2020 acknowledges intersections with other topic areas including: breast cancer screening, bullying among adolescents, cervical cancer screening, condom use, educational achievement, health insurance coverage, HIV testing, illicit drug use, mental health and mental illness, nutrition and weight status, tobacco use, and [having a] usual source of care.

Appendix A: Bree Collaborative Members

Member	Title	Organization
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Carl Olden, MD	Family Physician	Central Washington Family Medicine, Yakima
Mary Kay O'Neill, MD, MBA		
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	MultiCare Health System
Colleen Daly, PhD	Director, Global Occupational Health, Safety and Research	Microsoft
Jake Berman, MD MPH	Medical Director for Population Health Integration	UW Medicine and UWM Primary Care and Population Health
Colin Fields, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
Darcy Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President, Safety & Quality	Washington State Hospital Association
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Kristina Petsas, MD MBA MLS	Market Chief Medical Officer, Employer & Individual	UnitedHealthcare
Nicole Saint Clair, MD	Executive Medical Director	Regence BlueShield
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premiera Blue Cross
Emily Transue, MD, MHA (Chair)	Chief Clinical Officer	Comagine Health
Judy Zerzan-Thul, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix B: LGBTQ Health Care Charter and Roster

Problem Statement

Approximately 3.5% of Americans identify as lesbian, gay, or bisexual and 0.3% of American adults are transgender.ⁱ Persons in these populations have distinct healthcare needs.ⁱⁱ In particular, men who have sex with men (MSM) and transgender persons who have sex with men are at elevated risk for HIV and other sexually transmitted infections. Additionally, lesbian, gay, bisexual, transgender, and questioning or queer (LGBTQ) persons can experience elevated rates of depression, sexual abuse, smoking, and other substance use.^{iii,iv} Stigma and lack of provider training and competency serve as barriers to providing consistent, high-quality medical care.^v

Aim

To align care delivery with existing evidence-based, culturally sensitive standard of care for LGBTQ people in Washington State and decrease health disparities.

Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- Age-appropriate screening and standard questions for clinicians to ask all patients about sexual behaviors, sexual orientation, and gender identity, with responses documented in structured health records.
- An inventory of health equity practices and competencies that improve care of sexual and gender minorities including around intersections of race, class, and other identities.
- Protocols, policies, and practices to improve the effectiveness and experience of health care services, and receipt of preventive services (e.g., appropriate cervical cancer screening), particular to LGBTQ patients.
- Implementation of guidelines to diagnose, prevent, and treat sexually transmitted diseases based on risk (e.g., screening men who have sex with men and transwomen who have sex with men, offering HIV pre-exposure prophylaxis (PrEP)) including for health care organizations, purchasers, payers, and medical professionals.
- Indicators and outcomes that health care organizations should monitor to evaluate success in improving the delivery and experience of healthcare services by LGBTQ patients.
- Implementation pathway(s) with metrics to monitor adoption and patient outcomes.
- Identifying other areas of focus or modifying areas, as needed.

Duties & Functions

The LGBTQ Health Care workgroup will:

- Develop a scope of work to bring to and be approved by the full Bree Collaborative.
- Research evidence-based and expert-opinion informed guidelines and best practices (emerging and established).

ⁱ Gates G. How many people are lesbian, gay, bisexual, and transgender? The Williams Institute University of California, Los Angeles. April 2011. Available: <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf>

ⁱⁱ Purcell DW, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. The open AIDS journal 2012; 6:98-107.

ⁱⁱⁱ Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. Annu Rev Clin Psychol. 2016 Mar 28; 12: 465–487.

^{iv} Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and Gender Minority Health: What We Know and What Needs to Be Done. American Journal of Public Health. 2008;98(6):989-995.

^v Whitehead J, Shaver J, Stephenson R. Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. Newman PA, ed. PLoS ONE. 2016;11(1):e0146139.

- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative or the workgroup chair.

The chair of the workgroup will be appointed by the chair of the Bree Collaborative.

The Bree Collaborative program director will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. The program director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members to be added at the discretion of the chair.

Name	Title	Organization
Dan Lessler, MD, MHA (Chair)	Chief Medical Officer	Washington State Health Care Authority
Olivia Arakawa, MSN, CNM, ARNP, RN	Parent Advocate	
Scott Bertani	Director of Policy	Lifelong AIDS Alliance
Kathy Brown, MD	HIV and PrEP Medical Director	Kaiser Permanente
LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
Michael Garrett, MS, CCM, CVE, NCP	Principal	Mercer
Chris Gaynor, MD, MA, FAAFP	Family Practice Clinician	Capitol Hill Medical
Matthew Golden, MD	Professor of Medicine/ Director, HIV/STD Program	University of Washington/ Public Health – Seattle & King County
Kevin Hatfield, MD	Family Practice Clinician	The Polyclinic
Corinne Heinen, MD	Physician Lead, UW Transgender Clinical Pathway	Department of Internal Medicine, Allergy & Infectious Disease University of Washington
Tamara Jones	End AIDS Washington Policy and Systems Coordinator	Department of Health
Kevin Wang, MD	Primary Care Clinician	Swedish Medical Group

Appendix C: Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	Improving Cultural Competence to Reduce Health Disparities (2016)
Cochrane Collection	Multi-media social marketing campaigns to increase HIV testing uptake among men who have sex with men and transgender women (2011) Behavioral interventions to reduce HIV transmission among sex workers and their clients in high-income countries (2011) Behavioral interventions can reduce unprotected sex among men who have sex with men (MSM) (2008)
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	U.S. Preventive Services Task Force: Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women (2015) International Association of Providers of AIDS Care: IAPAC guidelines for optimizing the HIV care continuum for adults and adolescents (2015) U.S. Preventive Services Task Force: Screening for suicide risk in adolescents, adults, and older adults in primary care (2014) Health Care for the Homeless (HCH) Clinician's Network: Adapting your practice: treatment and recommendations for unstably housed patients with HIV/AIDS (2013) Society of Obstetricians and Gynaecologists of Canada: Female sexual health consensus clinical guidelines (2012) British Association for Sexual Health and HIV: United Kingdom national guideline for gonorrhoea testing 2012 (2012) New York State Department of Health: Care of the HIV-infected transgender patient (2012) U.S. Preventive Services Task Force: Syphilis Infection in Nonpregnant Adolescents and Adults: Screening (2022) American College of Obstetricians and Gynecologists: Screening for Syphilis in Pregnancy (2024) International Anal Neoplasia Society: Consensus Guidelines for Anal Cancer Screening (2024) HHS Office of Aids Research: Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV (2024) AIDS Institute: Screening for Cervical Dysplasia and Cancer in People Living with HIV (2022)
Health Technology Assessment Program	n/a
Center for Disease Control and Prevention	Lesbian, Gay, Bisexual, and Transgender Health Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention (2024)
Institute for Clinical and Economic Review	n/a

BMJ Clinical Evidence Systematic Overview	HIV: primary and secondary prophylaxis for opportunistic infections (2010)
Veterans Administration Evidence-based Synthesis Program	Do have general guidelines for suicide prevention, adult mental health, and health disparities among adults with mental illness that cite studies including lesbian and gay participants. Not specific.

See additional guidelines in Appendix E.

Appendix D: Inclusive Family Language

Source: National LGBT Health Education Center. The Fenway Center. Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients

Old Language	Recommended update
Mother/Father	Parent(s)/Guardian(s)
Husband/Wife	Spouse/Partner(s)
Marital Status	Relationship Status: Single; Married; Partnered; Separated; Divorced; Widowed; Other
Living Arrangement	Alone; Spouse/Partner(s); Child(ren); Sibling; Parent(s)/Guardian(s); Group setting; Personal care attendant; Other
Sex/Gender: Male or Female	What is your current gender identity: Cisgender (sex matches that assigned at birth) Male; Cisgender Female; Transgender Male/Transgender Man/ Female-to-Male (FTM); Transgender Female/Transgender Woman/Male-to-Female (MTF); Genderqueer – neither exclusively male nor female; Other; Choose not to disclose. What sex were you assigned at birth on your original birth certificate: Male, Female, Choose not to disclose
Sexual Orientation	Do you think of yourself as: Straight or heterosexual; Lesbian, gay, or homosexual; Bisexual; Something Else; Don't Know; Choose not to disclose.
Family History	Use "Blood relative" in questions.
Nursing Mother	Currently nursing. This wording is inclusive of those who do not identify as a mother (or a woman), but who are currently nursing to be included in this response.
Female Only/Male Only	Remove sex-specific language and include "Not applicable" as a response option.

This workgroup recognizes the everchanging nature of language. A glossary of terms maintained by the Human Rights Campaign offers words and meanings that may be used when discussing sexual orientation and gender identity [here](#).

Appendix E: Family Planning and Fertility

All individuals and families should be empowered to make choices that are best for them around family planning and fertility. Options such as assisted reproductive technology, donor services, and inclusive counseling can help individuals and couples achieve their reproductive goals. Many clinics and organizations offer affirming care and guidance tailored to various identities and pathways to parenthood.

Cryopreservation: Cryopreservation is the process of freezing and storing sperm, eggs, or other gametes for future use. This technique is commonly used in fertility preservation for individuals undergoing medical treatments that may affect reproductive ability, such as chemotherapy or gender-affirming care, and for those planning to delay parenthood. It can also benefit people facing certain fertility challenges or those who want to provide more reproductive options for themselves or their partners. Local clinics fertility clinics, sperm banks and egg banks for Washington residents include the following:

- [Pacific Northwest Fertility](#) (Seattle, WA)
- [Seattle Children's Fertility Preservation Program](#) (Seattle, WA)
- [RMA Fertility Clinics](#) (Seattle, WA)
- [Overlake Reproductive Health IUI Fertility Clinic](#) (Bellevue, WA)
- [UW Medicine Fertility Clinics](#) (Seattle, WA)
- [Pinnacle Fertility](#) (Kirkland, Bellevue, Everett, Seattle, Tacoma, WA)
- [Center for Reproductive Health](#) (Spokane, WA)
- [POMA Fertility](#) (Kirkland, Bellingham, WA)
- [Seattle Sperm Bank](#) (Seattle, WA)
- [Cascade Cryobank](#) (Lynnwood, WA)

Interested individuals can also find sperm cryobanks through this national directory: [National Directory for Sperm Cryobanks](#)

Family Planning: There are a variety of options to support family planning, especially for LGBTQ+ individuals and families, offering a wide spectrum of pathways into parenthood. Sperm banks and egg banks play a crucial role for those pursuing fertility treatments, reciprocal IVF, or planning for surrogacy. Surrogacy agencies offer guidance and support for intended parents—including gay men, transgender women, single fathers and others —navigating the complex legal and medical processes of gestational or traditional surrogacy. Several resources are also available for adoption planning and support for people who are adopted.

Surrogacy Agencies/Organizations

- [Pacific Cascade Surrogacy](#) (Seattle, WA)
- [Pacific Northwest Fertility](#) (Seattle, WA)
- [NW Surrogacy Center](#) (Seattle, WA)
- [Giving Tree Surrogacy](#) (Seattle, WA)
- [American Surrogacy](#)
- [Men Having Babies](#)

Adoption Planning

- [Open Adoption & Family Services](#): Oregon & Washington (Seattle, WA, Portland, OR)
- [Adoption Mosaic](#) (support agency for adopted people)

Appendix F: Crosswalk of Reviewed Guidelines

	Type	Topics Addressed	Details
Guidelines for care of lesbian, gay, bisexual, and transgender patients 2005 Gay and Lesbian Medical Association www.glma.org/data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf	Clinical guidelines Structural guidelines	Health system environment Lesbians/bisexual women Gay/bisexual men	• Create a welcoming environment • Caring for lesbians and bisexual women: additional considerations for clinicians • Caring for gay and bisexual men: additional considerations for clinicians
Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records 2016 Fenway: National LGBT Health Education Center www.lgbthealtheducation.org/wp-content/uploads/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-EHRs-2016.pdf	Implementation guide	Electronic health records	• Includes recommended questions (sexual orientation, gender identity, name, pronouns) • Workflows for collecting data • Training staff
Resource Guide — Advancing Health Equity through Gender Affirming Health Systems 2017 Cardea www.cardeaservices.org/literature_195482/Advancing_Health_Equity_through_Gender_Affirming_Health_Systems	Tools for implementing gender affirming health systems	Health system environment	• Organizational Assessment for staff member (organizational values, governance, planning and monitoring/evaluation, communication, staff and provider development, organizational infrastructure, services) and community member • Glossary of terms
Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV 2018 United States Department of Health and Human Services https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf	Clinical guidelines	Adults and Adolescents living with HIV	• Baseline evaluation • Laboratory testing • Treatment goals • Initiation of antiretroviral therapy • What to start • Considerations for antiretroviral use in special patient populations • Considerations for antiretroviral use in patients with coinfections • Limitations to treatment safety and efficacy

2016 United Kingdom national guideline on the sexual health care of men who have sex with men 2016 British Association for Sexual Health and HIV http://journals.sagepub.com/doi/abs/10.1177/0956462417746897	Clinical guidelines	Men who have sex with men	• Drug interactions • History taking • Identification of problematic recreational drug and alcohol use • STI and HIV testing in asymptomatic MSM • The management of MSM with symptoms of sexually transmissible enteritis and proctitis • HPV infection and anal dysplasia in MSM • Partner notification and MSM • STI and HIV prevention for MSM in the clinic • Sexual problems and dysfunctions in MSM
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community 2011 The Joint Commission www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf	• Clinical guidelines • Structural guidelines • Change management • Tools (checklists)	Organizational leadership Health system environment	• Leadership • Provision of Care, Treatment, and Services • Workforce • Data Collection and Use • Patient, Family, and Community Engagement
Focus on Forms and Policy: Creating an Inclusive Environment for LGBT Patients 2017 Fenway: National LGBT Health Education Center www.lgbthealtheducation.org/wp-content/uploads/2017/08/Forms-and-Policy-Brief.pdf	Structural guidelines	Health system environment	• Discrimination and employment policies should include the terms “sexual orientation,” “gender identity,” and “gender expression.” • Collecting data • Taking routine sexual history • Reviewing organizational language • Recommended language for family members
Asking Essential Sexual Health Questions National Coalition for Sexual Health https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/asset/Asking-Essential-Sexual-Health-Questions.pdf	Clinical guidelines	All patients	• Adults: Essential questions to ask at least annually • Adults: Essential questions to ask at least once • Adolescents: Essential questions to ask at least annually • Additional questions to ask adolescents and adults

Pre-Exposure Prophylaxis (PrEP) Implementation Guidelines 2015 Washington State Department of Health and Public Health Seattle King County www.breecollaborative.org/wp-content/uploads/DOH-PHSC-PrEP-guidelines.pdf	Clinical guidelines	Men who have sex with men Transgender persons who have sex with men	- Identifying persons in whom to consider PrEP - Guidelines for initiating PrEP in HIV-uninfected persons: - Medical providers should recommend that patients initiate PrEP if they meet the following criteria - Medical providers should discuss initiating PrEP with patients who have any of the following risks
HIV testing and STD screening recommendations for men who have sex with men (MSM) 2017 King County www.kingcounty.gov/depts/health/communicable-diseases/hiv-std/providers/screening-testing-msm.aspx	Clinical guidelines	Men who have sex with men	- Sexual history - HIV and STD screening
Health Care for Transgender Individuals Committee Opinion 2011 American College of Obstetricians and Gynecologists www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals	Clinical guidelines	Female to male transgender individuals Male to female transgender individuals	- Creating a welcoming environment - Hormones, surgery, screening (e.g., cancer) for: - Female to male transgender individuals - Male to female transgender individuals
Supporting and Caring for Transgender Children 2016 Human Rights Campaign American College of Osteopathic physicians American Academy of Pediatrics www.hrc.org/resources/supporting-caring-for-transgender-children	Framework	Transgender children Parents of transgender children	- Defining terms - Review of policy debate

Providing Affirmative Care for Patients with Non-binary Gender Identities 2017 Fenway: National LGBT Health Education Center www.lgbthealtheducation.org/wp-content/uploads/2017/02/Providing-Affirmative-Care-for-People-with-Non-Binary-Gender-Identities.pdf	Structural guidelines Clinical guidelines	Health system environment Transgender and gender non-conforming people	• Understanding Non-binary Gender Identities • Glossary • Using Names and Pronouns • Barriers to care • Case scenarios • Best Practices: Creating an affirming environment for non-binary people
Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff 2013 Fenway: National LGBT Health Education Center www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf	Structural guidelines Clinical guidelines	Health system environment Health system environment Transgender and gender non-conforming people	• Training guidance • Background on transgender and gender non-conforming people • Clinical changes for addressing patients, using names and pronouns, if record name and sex do not match, apologizing for mistakes, respectful workplace culture
Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People 2016 Center of Excellence for Transgender Health, Department of Family & Community Medicine, University of California, San Francisco http://transhealth.ucsf.edu/protocols	Structural guidelines Clinical guidelines	Health system environment Transgender and gender non-conforming people	• Creating safe and welcoming clinical environment • Physical examination (e.g., pelvic exam) • Gender-affirming treatments and procedures • Hormone therapy • Pelvic pain (e.g., menses, testicular pain) • Gender non-conforming people • Diabetes • Bone health and osteoporosis • HIV • Hepatitis C • Other STIs • Silicone and hair removal • Fertility • Cancer screening • Behavioral health • Surgery

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People 2015 The World Professional Association for Transgender Health www.wpath.org/publications/soc	Clinical guidelines	Transgender and gender non-conforming people	• Definitions • Overview of Therapeutic Approaches for Gender Dysphoria • Assessment and Treatment of Children and Adolescents with Gender Dysphoria • Mental Health • Hormone Therapy • Reproductive Health • Voice and Communication Therapy • Surgery • Postoperative Care and Follow-Up • Lifelong Preventive and Primary Care
Guidelines on lenacapvir for HIV prevention and testing strategies for long acting injectable pre-exposure prophylaxis 2025 The World Health Organization https://www.who.int/publications/i/item/9789240111608	Structural guidelines Clinical guidelines	Long-acting injectable PrEP lenacapvir for adults and adolescents living with HIV	• Recommendations for new PrEP formulation long-acting injectable lenacapavir • Recommendations for rapid diagnostic tests for HIV testing for initiation, continuation and discontinuation of long-acting PrEP

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