CORNERSTONE
WHOLE HEALTHCARE ORGANIZATION, INC.

Pride in Idaho Care Neighborhoods Roadmap

A Guide For Healthcare Communities

Thank You

Thank you to Valor Health, Primary Care Development Corportation, Family Medicine Residency of Idaho, and Dr. Neil Ragan for all the invaluable contributions to this work. Thank you to Cambia Health Solutions for funding this project.

CORNERSTONE
WHOLE HEALTHCARE ORGANIZATION, INC.

CAMBIA health foundation

Valor Health

PRIMARY CARE DEVELOPMENT CORPORATION

FAMILY MEDICINE RESIDENCY OF IDAHO

The following “roadmap” was created by Cornerstone Whole Healthcare Organization, INC (C-WHO) in partnership with Valor Health and the Pride in Idaho Care Neighborhoods (PiICN) Consortium with funding from the Cambia Foundation to support other communities across the state and country in developing more inclusive, safe, and culturally appropriate care environments for all marginalized rural community members. Our model demonstration happens to focus on LGBTQ+ patients and neighbors. However, we want to emphasize that

this model is designed to be used with other communities within rural areas who may face inequity, discrimination, or systemic barriers to whole health and wellness.

This may include racial/ethnic minorities, migrant farmworkers, individuals with serious mental illness, religious minorities, and others.

The roadmap is intended to present lessons learned, emerging best practices, and resources discovered in the development and implementation of the PiICN model. Our hope is that this information can accelerate the creation of similar neighborhoods of care based on our successes and challenges.

-The C-WHO Team

We would highly encourage you to explore the entire guide in detail but we get it, you are super busy trying to improve rural health in so many ways. In acknowledgement of all the balls you are juggling and how much work it can be to keep systems and programs running we have summarized our top lessons from the work to get you off to the races.

The PiICN Team's Top Five Lessons

1. Have a provider champion but have more:

We get it. Provider champions are awesome. They can really drive the work in so many ways. However, just as you might have your colorectal cancer screening champion or diabetes management champion you do not ask them to manage every patient screened or at risk for those conditions. It is the same with LGBTQ+ care in rural areas. You must train the entire team to develop capacity for safe, appropriate, and inclusive care. This creates safe systems instead of just safe people and we want to ensure that from the time a patient steps in your door, they feel cared for and included. At the same time build out external referral partners who can work with you to meet patient needs in varying levels of complexity and intensity.

2. Start with language:

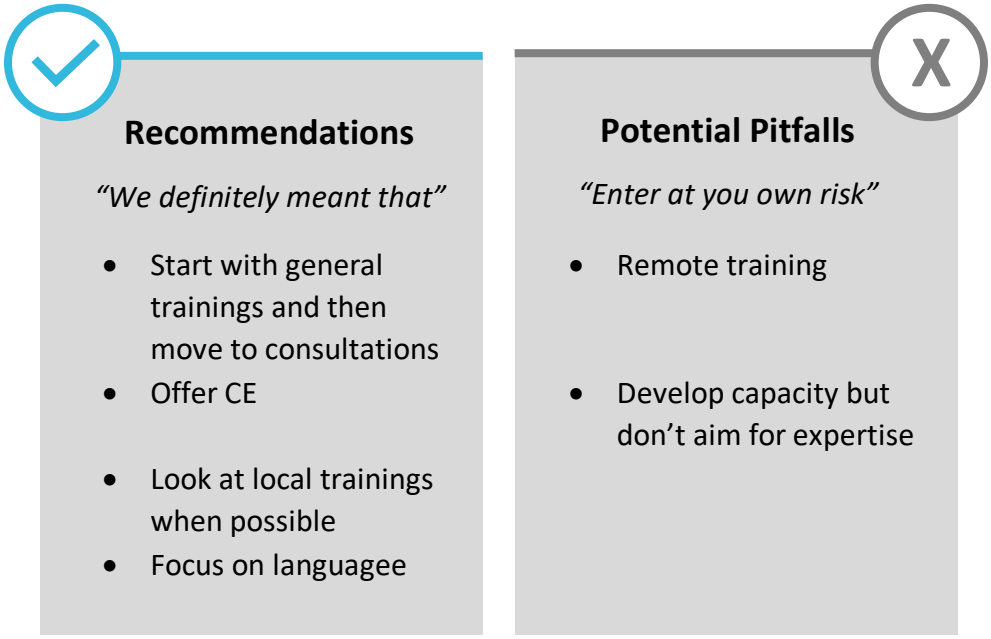
We found that in training all staff members, participants were so thankful for a basic overview of how to utilize respectful language. We acknowledge that some team members may not be a part of communication circles in which respectful language is used and may truly lack the basic terms to initiate a care experience for a patient that feels welcoming and safe. By starting with language, we give our teams the foundation to communicate effectively with our patients without pathologizing or judging identity.

3. Count it:

Okay, we know, one more measure, one more data point is one too many. You are being asked to measure everything all the time. But we promise, this one is important. Take a good look at how sexual orientation/gender identity (SOGI) is being documented in the patient health history or intake information. Do not just stop there, look at how often the question is being asked. Use this information to shift your workflows to make questions about SOGI standard.

TRAINING: The PiICN Team initially proposed the in-person delivery of several training modules Care Basics 2 (Andrew Philip), Belief Reconciliation (Kent Corso), and Suicide Prevention (Kent Corso). Rapidly after the project was designed and announced, the United States entered into COVID-19 quarantine precautions. This significantly shifted the trajectory of

the training design as the team quickly pivoted to deliver essential content remotely. Below, key observations are shared and detailed.



Start with general trainings and move to consultations: The PiICN team found it helpful to level-set through some basic care delivery skill building (preferred pronouns, health history taking, etc) and then move into specific questions regarding areas of practice with participating trainees. This allowed participants to build language to ask questions regarding their practice.

Offer CE: As a general rule, a team can offer a few things to help make it easier for provider and administrators to give up a piece of their very busy days: food, continuing education, and payment. With this opportunity, feel free to explore food and a participation stipend if resources allow. However, for the purposes of this activity, the PiICN team could only offer continuing education.

Look at local trainers when possible: We have found that local providers like people who have similar experience or understand the practice/community environment. Many national and international trainers are very well aware of the issues in local communities and able to train accordingly, but local perspective gives more credibility to a presenter in the rural setting.

Focus on language: Change formal and informal words. By that we mean update your policies to explicitly protect LGBTQ+ individuals from discrimination and train staff on which words are appropriate, which are not, and how to use these words. A recent national survey reported, 9% of LGB respondents and 21% of transgender respondents indicated that a care provider had "used harsh or abusive language" with them in a care setting (Mirza and Rooney, 2018). So do not assume your staff and clinicians know how to use inclusive terms or what they mean. Many of us have the opportunity to engage in media, education and additional content that helps us

stay on top of preferred language that creates safe environments. Many team members do not or may not choose to engage in optional training on LGBTQ+ care. Do not let it be an option. Surveys of LGB populations suggest that approximately 8% will forgo medical care because of concerns of discrimination while 23% of transgender patients did not seek care because of a concern of mistreatment (Mirza and Rooney, 2018, James et al, 2016). While this was out of our hands, it was not ideal in that some sensitive topics perhaps would have experienced better engagement in an in-person setting. Remote worked out okay but when in doubt, opt for in-person when training on sensitive topics.

Develop capacity but don't aim for expertise: This one might be a little tricky but hear us out. Rural communities often face the challenge of lack of experts. The big population centers have the subspecialists, the translators with 10 languages, and the consulate just within a few blocks. This means that most have some proximity, if not outright access, to expertise. Rural care providers and community groups on the other hand wear many hats. The social worker is also the behavioral health consultant is also the care coordinator is also the food pantry manager. This generalization is part of the joy of living and working in rural areas and creates a personal connection between residents that might be less common in more population areas. However, in doing work that specifically focuses on a particular marginalized population the temptation is too easy to simply train up that one dedicated person so she can wear "patient population expert" in addition to her many other hats.

We have learned that a better approach is to enhance the comfort and capacity of all engaged clinical and non-clinical community members to provide care for the patient population by establishing shared language, safe and inclusive practices, and interpreting standards of care for marginalized groups.

From there, we worked with network members to begin to identify the right thresholds for referring out. For example, a primary care provider in the network really wanted to help transgender patients transition closer to home when possible. But she didn't feel comfortable managing hormone therapy on her own. We trained her in appropriate language, inclusive history taking and assessment, and on resources for consultation on hormone therapy. This allows the patient what he needs to be treated with respect in his own community and also relieves the primary care provider of the need to be "the expert".

CONSORTIUM DEVELOPMENT:

The PiICN Consortium was launched in March of 2020, just as COVID-19 was completing shifting the landscape of care providers and community services across the country. Despite these challenges over 20 community partners from disciplines such as behavioral health, education, local government, and hospital care attended the virtual meeting and participated in

discussion. The project team celebrated this as a major success in outreach to aligned agencies and leaders. However, two months later (with the April meeting cancelled due to COVID-19 response) meeting attendance was down to only the project staff. This presented a significant opportunity for the project team to reconsider the approach. The group decided relaunch with an assessment and some updates from the anchor institution on improvement activities to serve as a model and a jumping off point for other potential partners.

Recommendations

"We definitely meant that"

- Utilize an organization or systems assessment to gauge areas for improvement
- Leverage anchor and spoke site contact to grow membership

Potential Pitfalls

"Enter at you own risk"

- Meet in person if you can
- Have some examples of what the hub is doing to start

Utilize an organizational or systems assessment to gauge areas for improvement: It is relatively easy to reflect on the general state of care for marginalized community members and think "we need to do better". It is harder to think about what it is that "we" need to do. In the initial PiICN Consortium meeting, the project staff did a good job at getting people in the seat to talk about a shared interest in/commitment to better serving LGBTQ+ patients. However, without direction that did not generate much momentum. Therefore the team recommends starting with an assessment of participating agencies or the community/system as a whole to give some

guidance to the group as they pursue collective action. This Is how one recipient of our survey responded to the question, What specialty services for LGBTQIA individuals (and what types are needed? ***"More education. A safe place to go and learn about how to stay safe mentally, physical, and sexually in relationship within the community. Nearly all sexual health information is catered toward straight couples."*** See the Appendix of this document for more information on potential assessments.

Leverage anchor and spoke site contacts to grow membership: If you are reading this as a health system in a rural area, consider yourself as an anchor. If you are another type of agency, consider finding yourself an anchor. An anchor, should be a well-trusted health system within the community with ties to other community resources (clinical and non-clinical). Utilize the anchor to build out activities and connections to other community sites that can become a part of your inclusive care network moving forward.

Meet in person if you can: Virtual meetings are great for a lot of reasons (convenience, less travel time, safety, yoga pants) but may not be ideal for developing a mission driven consortium aimed at developing collective capacity to better care for marginalized community members. This is especially true in smaller communities where it may be even more important to leverage personal connectedness to promote momentum around a shared vision.

Have some examples of what the hub is doing to start: A hub agency should be a local leader (check), with credibility (check), a clear vision for better serving marginalized patients (check), and identifiable steps taken to better engage the marginalized patient population (no check). While Valor Health started the PiICN Project with a drive to improve the health of LGBTQ+ patients through collaborative system development, it became clear early on that as a leader they had the opportunity to serve as an example (utilize an inclusive hiring policy, reframe sexual health history practices, etc) before asking care partners to take on these activities as well. With a time machine, the PiICN Team would go back and make sure that the hub site could point to some activities as a guide for other consortium members.

CARE COORDINATION:

Recommendations

"We definitely meant that"

- Utilize technology to trigger care coordination entry point
- Focus on health history as a starting point
- Reinforce a strong health history constantly
- Think about consultation services

Potential Pitfalls

"Enter at you own risk"

- Training doctors before Mas
- Not reaching out to tertiary or specialty care centers early
- Not thinking about spectrums of care

Utilize technology to trigger care coordination entry point: The electronic health record (EHR) is almost like another team member in the experience of healthcare now. It communicates (sometimes great, sometimes poorly), it triggers treatment options (sometimes well, sometimes not), and tracks patient data across the care experience (sometimes accessible, sometimes not). However, the EHR is so ubiquitous in healthcare that documentation and tracking of marginalized identities in the EHR is essential. By making coordination of care automatic based on selected identity, it takes some of the opportunities for stigma or personal bias out.

Focus on health history as a starting point: Acknowledging a marginalized identify is critical to assisting the healthcare and service system to framing services in a safe, appropriate, and responsive manner. Some identities may be more "silent" than others. For example, it is not always apparent if someone identifies as transgender or in a religious minority. This is how one recipient of our survey answered the question, What value do you see in providing information about sexual orientation and gender identity as a patient and how do want to be asked?, ***" Sexuality is part of the whole person. I would like to be asked this in the same manner that providers and clinicians ask about other social histories. This is rarely asked."***

By making sure that health history workflows contain key questions about identity that may inform the care process, networks can take a crucial first step in providing better care and services.

Reinforce a strong health history constantly: With provider and staff turnover it can be hard to maintain initial momentum when it comes to including SOGI information in the health history, using that information, and updating it as necessary. We were fortunate (kind of-for those of you who have been through an EHR conversion!) to go through major EHR updates through the project. This resulted in constant retraining needs. While this wasn't our intention, it really helped keep SOGI data collection front of brain for all. We would recommend using huddles, staff training, and other brief training/communication opportunities to do 5-10 maintenance sessions with the team.

Think about consultation services: Don't have providers who are trained in PrEP or HRT? While we think it is a great idea to start to cultivate some of those clinical skills locally, that doesn't preclude your team from providing patients with appropriate care close to home. Our team started HRT by using a telehealth consultation model with a group of family medicine providers in our population center who have a transgender health program. Including these providers in patient consultation and treatment really took the pressure off of our team as they learned while letting patients stay in their geographic and treatment comfort zones with their own established providers. Win, win, win!

Training doctors before MAs: It is tempting to skip right ahead to care providers when we talk about redesigning healthcare delivery systems. It is what we did. They are certainly the focal point of most people's care experience. However, when we took a few steps back we realized that the medical assistants (MAs) and other care support staff were really one of the first points of contact. Often, MAs are also in contact with patients for more time than providers. While it is still essential to work with providers to improve the capacity for care. Community networks should think about targeting the frontline workers in care systems in initial outreach and development.

Not reaching out to tertiary or specialty care centers early: We get it. We are a rural community who does a whole lot on our own. Our team started out with a vision of being a self-contained beacon of inclusive and safe care for LGBTQ+ patients. Some days we still work with that vision in mind. However, the possibilities for our neighbors and patients only truly started to open up when we started reaching out to the large specialty care centers in our region and we started to recognize that we could collaborate together to identify resources for patients and actively serve them. We were lucky enough to be connected with the University of Utah's Transgender Health Program. In our discussions, we quickly recognized that they had the same goals we did

and a whole lot more specialized training. With the combination of their expertise for the population of focus and our expertise in our patients' needs and context of experience, we were able to make a fantastic team of providers and consultants. It became a bridge between our small community and the resources of a tertiary care center. Make no mistake, we do not just ship every patient off to Salt Lake City for care. Instead, we now have the confidence to support them as we are able close to home and refer them out when we need to, knowing that a team of their local providers and specialty providers will be working together to get them the care they need.

Not thinking about spectrums of care: As we mentioned above, we began with a noble vision of delivering the safest, best, most appropriate care to our community members, in-house. This is still a part of our group's goal but now it is within the context of considering the spectrum of care and services for patients. This did not become clear until our second year of work when a trainer was speaking about how family practice providers should think about providing care to LGBTQ+ patients.

> **"There are some things everyone has within scope of practice, there are some things you need a little extra training to do, and there are things that only your surgeon buddy or endocrinologist study partner should do",**

he said. Now in retrospect, this seems pretty simple, but it really helped organize our thinking around how to create not only networks but spectrums of services for rural marginalized community members. Take for example an undocumented youth in a school setting. The school counselor should definitely be able to enroll her in classes. With a little extra training, the school counselor could help provide some basic counseling on how to access specific services for her family within the community and help her to coordinate those resources. But we would certainly never ask the counselor to represent the young girl as an immigration lawyer. When you start thinking about what you can and cannot do within your community, think about what is possible with a little bit more training and deliver that training. What is not possible, identify the resource and call them. Make those relationships and connections to help serve your community as the need arises. This forms your spectrum of services and will help guide all partners in making informed decisions about how to best support our neighbors.

ENGAGEMENT:

Recommendations

"We definitely meant that"

- Talk to both urban and rural peers who are doing a good job

Potential Pitfalls

"Enter at you own risk"

- Not having a clear process for assessing authentic commitment to an engagement in inclusive and appropriate care

Do you really want to provide inclusive care?

Talk to both urban and rural peers who are doing a good job: It is not easy to build a network of engaged providers from scratch. Believe us, we tried. Instead, think about talking to others who have done the work in other communities. Their community partners may have connections in your area. At the very least, they can help you brainstorm who to talk to. We loved cross-walking resources with nearby FQHCs, Planned Parenthood, the National Rural Health Association, University of Utah, and faith-based organizations.

Not having a clear process for assessing authentic commitment to and engagement in inclusive and appropriate care: "Do you want to provide inclusive care to LGBTQ+ patients?"… Few would answer "no" outright. So the question becomes, how to make sure we are including care network partners that are truly invested in the process and not just agencies that want to promote more referrals? We didn't ask ourselves this question until almost a year into this work. So heed our advice (please) and ask yourself the question early and often. Our team realized we had to ask the question when agencies were very interested in becoming part of the network and would commit to being a part of a the work but we saw little participation in development activities or cues/signals to suggest they were actively developing the capacity to do so. Whether your community is working on supporting migrant farmworkers, patients diagnosed with serious mental illness, or LGBTQ+ patients, identifying true allies is critical. However, you hardly want to tokenize that commitment. It is an action not a piece of paper that reads "ally". For us that meant eventually asking our partnered agencies to start by completing an assessment of internal practices. This checklist let them know what they were doing right and where they could improve their practices to better serve the LGBTQ+ community. By completing the assessment, and working with us to identify actionable next

steps to be better, we were able to see who was committed to the journey versus who just wanted to do lip service to the idea.

ASSESSMENT:

The PiICN Team utilized a human-centered design approach to identifying opportunities **with** the target service population instead of "for" or "to" them. This started with in-depth information gathering, resource mapping, and focus-grouping. Next the team moved on to assessing the hub's capacity and practices for providing inclusive care. Assessment was crucial to the team's overall success and continuously helped guide direction for the group.

Recommendations

"We definitely meant that"

- Scan the environment
- HEI adjustment
- Ask legal

Potential Pitfalls

"Enter at you own risk"

- Don't overlook individual assessments
- Don't jus focus-group: involve
- Use templates from other work (see appendix)
- Assess your care teams early instead of late

Scan the environment: The PiICN team-initiated activities by outreaching the potential partner organizations and surveying the service environment within Emmett, ID. This process helped identify key gaps (no dedicated resources) and also potential allies in the effort.

Don't just focus-group: involve: The PiICN team started engagement by simply requesting information from key informants/target patient groups. We anticipated using this information to inform our strategy. However, we found that we should have used this opportunity to ask individuals to become involved in consortium activities. Not only is their lived experience critical to informing improvement strategies but they have the most credible voices among the target service community.

HEI adjustment: The Healthcare Equality Index is a great tool. A really, really great tool. But when we looked at it, it didn't quite fit our rural community and what we were seeking to accomplish. It felt like it was designed for big systems with lots of unified providers. So we took

the HEI and made it fit us. We modified the HEI into a checklist (see Appendix B. Modified HEI) that worked for our site and would love it if you used it. Or even better, take it and make it better!

Ask legal: The marginalization of vulnerable community members is complex but almost always connected to some systemic structures. This is often embedded in the law. For the scope of this work, we worked within the bounds of existing laws (although it may have sparked some interest in working to change the law in our civic lives). It is important that as you begin this work, you consider and understand (either through your own research or consultation with legal counsel) the laws that are associated with your efforts. We realized through a few use cases that it would be very hard to document SOGI data for a minor without their parents having access to that information due to the laws within our state. This created a conundrum. We should document because SOGI information is important for treatment. However, that could endanger or disrupt a youth's home life with parents or guardians if that information has not been disclosed previously. In understanding the law better, we were able to determine how important it is to

Council LGBTQ+ youth in our state on their parent/guardian's access to their medical record so they feel empowered to decide what should and shouldn't be documented.

Don't overlook individual assessments: In this work, we know it is important to not call anyone out. However, we also know that team members may not be as inclined to change if they do not see gaps in knowledge. In advance of training, ask your group questions about specific terms, treatment availability, and individual comfort. This will allow you to see where individual gaps may be to target training topics but also gently guide your target audience to the need for additional training (especially for those in the neutral or opposed camps). We found that when we didn't do this, participants were apt to say that they didn't need training because they were up to date and knew everything there was to know (surprise!... not to pick on anyone, we know that this is human nature). While this could be considered a good practice in general for all capacity development, it seems particularly relevant to enhancing skills for supporting marginalized or vulnerable populations for whom there is likely to be more preexisting stigma and less general knowledge about strategies to provide appropriate treatment.

Use templates from other work: We did a lot of piecing together of assessments and questions from the beginning to make sure we used something that felt appropriate to our setting. While this seemed like the right approach, in retrospect we could have used something more general. Each identity has its own experience with marginalization, stigma, and discrimination but many themes are universal. We have adapted both a focus group and individual interview template

generously provided by the Oregon Health and Sciences University (see Appendix A). This can serve as a starting point for working with any vulnerable identity in rural communities.

Assess your care teams early instead of late: We thought a lot about how to do assessments and collect data from the larger community at the beginning of the project but failed to really assess individual experiences and viewpoints at the start. This could have really informed our work from the beginning as we thought about how to promote internal engagement. For example, when we did survey clinic teams almost a year into the project we learned that almost all staff thought they did a great job talking to patients about sexual orientation and gender identity but that their colleagues carried high levels of bias impacting care. We also learned that providers recognized almost no external resources for referral. An example survey and results can be found here.

DATA:

Recommendations

"We definitely meant that"

- Interrogate workflow and template for SOGI data capture
- Train Mas early on SOGI data capture
- Scrubbing charts to determine who is collecting SOGI data and how often

Potential Pitfalls

"Enter at you own risk"

- Small sample size of respondents to community survey
- Not foreseeing the stigmatizing responses to the staff survey
- Data challenges with EMR
- State policies create barriers

Interrogate workflow and template for SOGI data capture: There was a lot of work required to pull the necessary data from the backend of the EMR. An assumption was made early on that since there was a template for SOGI data within the EMR that it would be accurate if we could just find and report on the appropriate elements. We found out quickly that the data was very inconsistent, and we had to do a lot more digging to determine where the disconnect was. It was a combination of factors as is usually the case. There were workflow issues, a lack of

education related to SOGI data capture and a need to continually stress the importance of collecting this data for all new patients and at the annual wellness exam, even if it was captured in the past.

Train MAs early on SOGI data capture: One of the primary goals of the project is to train the entire staff on inclusivity and to develop a stigma free environment. Through our data exploration, as described above, we learned that there was a lack of consistency in SOGI data collection. Some MAs were doing an outstanding job and others were not collecting it at all. This highlighted the need for early engagement and training rather than exploring the data first. These two things could have been done in parallel with training activities occurring while we were familiarizing ourselves with the data.

Scrubbing charts to determine who is collecting SOGI data and how often: A key component to us unraveling what was really happening with data collection was doing a detailed chart scrub to see whether the SOGI data was being collected in the manner that the data was suggesting. For instance, we had a range of 3% to 100% collection among the PCPs, which seemed surprising. What we found after a deep dive into the charts was that, in many cases, the questions weren't being asked. Rather, the responses given in previous visits were copied over, without checking with the patient to see if anything had changed. This led us to completely rethink the training and engagement process.

We needed to identify champions at all levels of care that could continuously coach those who weren't fully engaging in. the

Small sample size of respondents to community survey: We surveyed the LGBTQ+ community to find out if they felt supported in their daily lives at home, school, receiving medical care and with first responders. We had a small sample size (n = 10) and 60% that were under the age of 18. This created some barriers to broadly understanding the challenges that the community is facing, but it did uncover some important insights. Primarily, it was that there were a lot of feeling of shame within their families and community as well as concern for personal safety. There were also several that expressed their unwillingness to share their sexual orientation or gender identity with their medical team because they were under 18 and their parents would potentially see it since they can access their medical records. This suggests that even if we create a safe and welcoming medical environment these patients aren't going to receive the care that they need.

Not foreseeing the stigmatizing responses to the staff survey: There were several concerning responses on the staff and provider survey regarding their feelings about the LGBTQ+ population. The responses were anonymous, but they reinforced that there is a lot of work to be done. When we reviewed the data, we weren't prepared with a plan for how we should address the concerns we were all feeling. We decided to debrief and come back to the table

with recommendations, but it was a pretty big blow to the team at that moment. We have made significant progress, but there are also some setbacks, as with all things.

Data challenges with the EMR: All EMRs present challenges, but the multi-faceted nature of the data conditions for this project were significant. SOGI data is not something that is consistently collected, and many care team members are uncomfortable asking these questions. This makes it difficult to validate data accuracy even in the best of circumstances. We iterated on the data reporting process several times as we uncovered additional discrepancies. This did slow down our ability to recommend and implement changes to the system, workflows and training protocols.

State policies create barriers: The fact that so many of the survey respondents mentioned that they are hesitant to have an honest conversation with their provider because of the fear that their family will find out suggests that there needs to be policies in place to protect the LGBTQ+ population. Parents can readily access all of their children's medical records until they are 18, leaving them to choose between receiving the services they need and being "outed" against their will. This is how one recipient of our survey answered the question, What would help you access care more easily and comfortably, ***" A support system in the community and the option for children under 18 to have their parents leave the room if they are no out to their family, as I previously was not and therefore never told my doctors."*** This is not something that we can solve in the short term, but it should be something that we all continue to advocate for.

Appendix A. Focus group questions (Andrew Philip, PhD, PCDC)

PiICN Focus Group

Experience in the local community (which help color the other items) including:

1. Experience (including comfort and perceived safety) in being "out"

2. In school, at work, in the ED, with law enforcement/responders, etc.

3. Perceived attitudes, responses and support from others

4. Congregation/where and how do you seek out other members of the LGBTQIA community

Experience in health care:

1. Where do you get care (may be different for different needs, e.g., behavioral health vs primary care vs sexual/repro health)

2. Experience of the environment of care (signage, waiting areas, etc.)

3. Comfort in and experience of disclosing sexual/gender identity to health care staff (consider difference roles, e.g., PCP, nursing, front desk)

4. What clinical services are offered/accepted Health care preferences?

5. Perceived need for specialty services for LGBTQIA individuals (and what types)?

6. Where do you WANT to get care?

7. Is there perceived value in providing information about SOGI and how do you want to be asked?

8. Would you be comfortable with providing information via different formats (such as electronically or in person; to PCP vs front desk; in waiting area/exam room/at home)?

9. Comfort with shared medical records and level of detail in the record?

10. What would help you access care more easily and comfortably?

11. What services do you want/need that you are not getting or cannot access now?

PiICN Focus Group Summaries

Focus Group/Individual Interview Question Template *(Modified from the OHSU Transgender Health Program).*

The template is intended to be used by communities in surveying residents about their experiences with the identity targeted for the work.

Identity and Friendship:

What do you like best about being (IDENTITY)? What do you love about your life?
How many other (IDENTITY) are you friends with?
Do you tend to hang out with other (IDENTITY) people or are you spending more time with (NON-IDENTITY) people? If you have experienced this, what makes it hard to make friends as a (IDENTITY) person?

School and Work:

What problems do you see for (IDENTITY) in school or work?

Of the (IDENTITY) students/colleagues you know, how many are affected by these problems? Everyone, three quarters, half, or just a few?

Why do you think these things happen?

How can the people at your school or job help more?

Medical Care:

What can you tell us about why this is so hard for you and your friends?

What would make it easier to [e.g. go to the doctor more often]?

Mental Health:

Who are the people in your lives that talk with you about your feelings/mental health or to help you out when you are down?

What helps when you are feeling anxious or depressed or what have you said or done with your friends or family that are depressed that seems to help?

Appendix B. Modified HEI

The Healthcare Equality Index

Adapted from Human Rights Campaign https://www.hrc.org/hei

Four core objectives:

- Ensure foundational non-discrimination protection for patients, client, visitors and staff in patient and staff policies and provide cultural competency training on LGBTQ-inclusion
- Demonstrate progress toward inclusion on LGBTQ patient/client care services and support
- Cultivate an inclusive workplace by providing LGBTQ-inclusive employee policies and benefits
- Demonstrate engagement with and public commitment to the LGBTQ community

Criteria 1 – Non-Discrimination and Staff Training	
Patient Non-Discrimination	
a. LGBTQ-inclusive Patient/ Client Non-Discrimination Policy • Policy must include the terms "sexual orientation" and "gender identity and expression" (or "gender identity")	1
b. Patient/Client non-discrimination is communicated to patients/clients and staff • Policy is shared in two ways with the public, typically online and in-print	1
• Policy is shared with staff in at least one way	1
Equal Visitation (where applicable)	
a. Equal Visitation Policy • Policy must allow the patient's visitor of their choice	1
b. Equal Visitation Policy is communicated to patients and staff • Policy is shared in two ways with the public, typically online and in-print	1
• Policy is shared with staff in at least one way	1
Employment Non-Discrimination	
a. LGBTQ-inclusive Employment Non-Discrimination Policy • Policy must include the terms "sexual orientation" and "gender identity or expression" (or "gender identity")	1
b. Employment Non-Discrimination Policy is shared with the public • Policy is shared with the public in at least one way	1
Staff Training	
a. Training in LGBTQ Patient-Centered Care • leadership in the organization has complete LGBTQ Patient-Centered Care education.	

• Staff training in LGBTQ-related topics, including staff who provide "first point of contact" (see addendum for training options)	

Criteria 2 –Patient Services and Support	
LGBTQ Patient Services & Support	
• Have a written strategy or plan for reducing health disparities among LGBTQ patients/clients and/or incorporate LGBTQ patients/clients into your plan for reducing all disparities	1
• Visible images and materials are in the reception area that are inclusive of LGBTQ people and issues.	
• Marketing materials include images and messages to represent LGBTQ people.	
• Even if agency does not currently have patients that openly identify as LGBTQ, service providers still work from the assumption that there are LGBTQ patients	1
• Have an internal planning or advisory committee focused on LGBTQ care issues	1
• Publicly make LGBTQ-knowledgeable and -friendly providers known as such to interested patients/clients or provide a confidential mechanism to make LGBTQ-specific referrals	1
• Provide some LGBTQ-specific clinical services	1
• Provide educational LGBTQ-related health information and/or links to LGBTQ health education or service resources from outside organizations on the facility's website	
• Create and distribute a LGBTQ health education brochure or other print materials about specific health topics and how they impact LGBTQ people (not an LGBTQ services brochure for marketing purposes)	
Transgender Patient Services and Support	
• Have a written policy (or policies) that specifically outline procedures aimed at eliminating bias and insensitivity, and ensuring appropriate, welcoming interactions with transgender patients/clients	
• Offer some transgender-specific clinical services	1
• Have a specific program or position to provide patient/client navigation/advocacy services to transgender patients	1
• Offer all gender restrooms in public areas for patients and visitors and/or have clear posted signage indicating a policy that allows individuals to use the restroom that aligns with their gender identity	1
Patient Self-Identification	
• Intake forms allow for patient to write in sexual orientation, gender identity and preferred pronouns	1

• Electronic health records (EHR) offer explicit options to capture patient's current gender identity if it differs from the sex they were assigned at birth.	1
• Two-question process is used to collect gender identity information (i.e. first asking current gender identity and then asking sex assigned at birth)	1
• Training is provided to staff on how to collect and record gender identity data in facility's EHR system	1
• EHR captures the patient's pronouns in use AND prominently displays these pronouns in the banner or a pop-up so that front line staff and providers will see this information	1
• EHR captures the patient's name in use if it differs from their legal name AND prominently displays this name in the banner or a pop-up so that front line staff and providers will see this information	1
• EHR offers an explicit way to capture a patient's organ inventory	
• EHR offers explicit options for capturing patient's sexual orientation if they choose to provide that information	1
• Employees are provided training explicitly reminding them that LGBTQ status is confidential patient information	1
• EHR offers explicit options for recording parents that are inclusive of same-sex parents and other diverse families	
• EHR offers explicit options for recording relationship status with an un-married partner	1
Medical Decision Making	
• Organization explicitly informs patients of their right to designate any person of their choice, including an un-married partner, as medical decision-maker	1
• Organization offers employee training related to medical decision making that includes LGBTQ-specific information	

Criteria 3 – Employee Benefits and Policies	
Equal Benefits	
• Health insurance policy's definition of spouse includes same sex spouses and the same documentation is required for enrollment of same and different sex spouses	1
• Healthcare benefits are provided to domestic partners	
• FMLA-equivalent benefits allow employees to take family and medical	1
• leave to care for domestic partners as well as the children of a domestic partner, regardless of biological or adoptive status	
• Bereavement leave allowed in the event of the death of a domestic partner or their partner's immediate family	
Additional Support for LGBTQ Employees	

• Organization has written gender transition guidelines documenting supportive policies and practices on issues pertinent to a workplace gender transition	1
• Organization has an officially recognized LGBTQ employee resource group	
• Organization has a diversity & inclusion office, diversity council or working group focused on employee diversity that specifically includes LGBTQ diversity as part of its mission	
• Anonymous employee engagement or climate surveys allow employees the option to identify as LGBTQ	
• Anonymous employee engagement or climate surveys include question(s) related to LGBTQ concerns	
• Confidential human resources information system (HRIS) captures sexual orientation and/or gender identity (if voluntarily disclosed) along with other demographic information such as race and gender	1
• Commemorate an LGBTQ Awareness Day for employees at the facility	
• Have explicitly LGBTQ-inclusive hiring efforts	
• Organization has openly LGBTQ people serving in high level visible leadership positions	
Healthcare Benefits Impacting Transgender Employees	
• Provide at least one health plan to all employees that affirmatively and explicitly covers medically necessary health services for transgender people, including gender transition-related treatment	

Criteria 4 – Patient and Community Engagement	
LGBTQ Community Engagement and Marketing	
• Support one or more LGBTQ related events or initiatives in the facility's service area	
• Engage in LGBTQ-inclusive marketing or advertising to the LGBTQ community	
• Organization has publicly supported LGBTQ equality under the law through local, state, or federal legislation or regulations.	
Understand the Needs of LGBTQ Patients and Community	
• Patient satisfaction surveys allow patients the option to identify as LGBTQ	
• Patient satisfaction survey include LGBTQ related questions	
• Organization works with external LGBTQ organizations or community	
• Staff members to assess LGBTQ health needs or address LGBTQ-health related concerns	
• Support LGBTQ health-related research	
• Include external LGBTQ community member(s) on a governing or community advisory board	

Total LGBTQ Healthcare Equality Score	**30**

Criteria 5 – Responsible Citizenship (25 points deducted from score for any large-scale official or public anti-LGBTQ activity)	
• revoking inclusive LGBTQ policies or practices;	
• facilitating the continued practice of healthcare providers that provide or promote LGBTQ related treatment or services to that have been discredited by mainstream medical and mental health organizations, including, but not limited to, “conversion therapy”;	
• engaging in proven practices that are contrary to the facility's written LGBTQ patient or employment policies;	
• advocating for public policies or regulations that would be detrimental to LGBTQ equality and/or health	
• or directing charitable contributions or other public support to organizations whose primary mission includes advocacy against LGBTQ equality or care.	

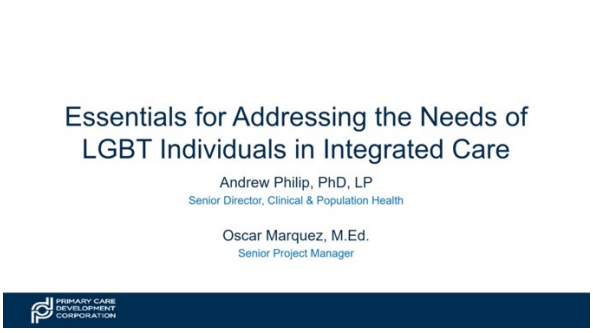
Final Healthcare Equality Score	30

0-20 Your agency has several areas to address in becoming more inclusive in serving LGBTQ clients. Your agency's lack of LGBTQ inclusive initiatives is likely creating barriers to services for your clients. Taking this assessment is a step in the right direction. Use these results to identify areas in need of improvement and create a plan to make changes within your agency that will aid in working towards a more inclusive environment for the diverse LGBTQ community you serve.

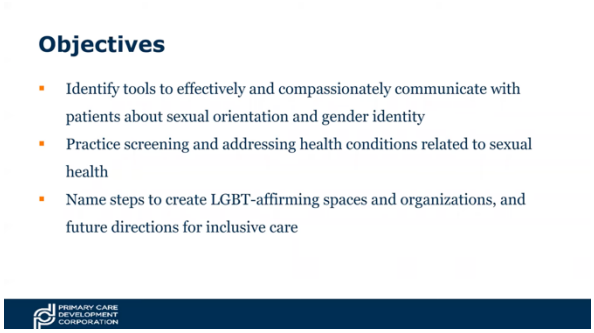
21-37 Your agency is working towards creating more inclusive services for LGBTQ clients, but there are still areas of improvement that need to be addressed. Review your responses and find your agency's strengths and areas of growth. This information can be used to create a strategic plan to continue your agency's efforts to create a more inclusive environment for your LGBTQ clients.

38-59 Your agency has done considerable work towards becoming more inclusive to the LGBTQ community you serve. It is important to remember that the work is never done. There will always be areas of growth within each agency, and our knowledge of the LGBTQ community is always evolving. Continue the work you have been doing thus far and use this assessment to identify areas where your agency can grow.

Idaho Integrated Behavioral Health Network 2020

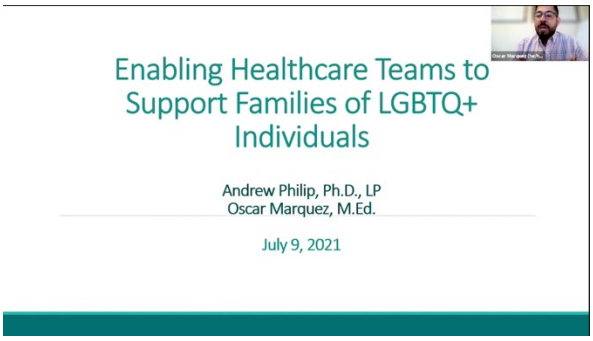


https://youtu.be/Qch85NOYItg



https://youtu.be/8I0UzwO8XFg

Idaho Integrated Behavioral Health Network 2021



https://www.youtube.com/watch?v=-wMoPlSDiKc

https://youtu.be/d6dw6lNTt-o