ADDRESSING THE HEALTH NEEDS OF SEX AND GENDER MINORITIES in New Mexico

NEW MEXICO DEPARTMENT OF HEALTH

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Table of Contents

Introduction and Background 3-5

Specific Populations and Contexts 6-12
- Transgender and Gender-Nonconforming People 6
- Incarcerated SGM People 7
- Older SGM People 7
- SGM Youth 9
- Gay Men and Men Who Have Sex with Men 10
- SGM People of Color 12

Recommendations 13-26
- Sexual Orientation and Gender Identity 13
- SGM Competent Health Services 16
- Increase SGM Consumer Participation 21
- Increase SGM Access to Care 22
- Foster Government and Stakeholder Collaboration 24

Appendices 27

Acknowledgments 27

References 28-30

Introduction and Background

Sexual and gender minority (SGM) populations[i], including lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, suffer from numerous disparities in physical and mental health, as well as access to and use of health services.

These disparities are not only the result of SGM-specific health risks. They are more importantly a result of minority stress resulting from ongoing exposure to stigma, discrimination, violence toward socially marginalized groups, unequal treatment and lack of culturally-competent care in healthcare systems.[1,2] They are also related to significant gaps in Sexual Orientation and Gender Identity (SOGI) data that are key to designing, implementing, and securing funding for high quality healthcare services and interventions for SGM people.

In recognition of these gaps, the National Institutes of Health recently affirmed in its 2016 "Strategic Plan to Advance Research on the Health and Well-being of Sexual and Gender Minorities" that a better understanding is needed of SGM health needs, how they change throughout the lifespan, and how they are affected by other factors such as race, ethnicity, and socioeconomic status.[3]

In 2015, the New Mexico Department of Health (NMDOH) convened a task force to author a report on the needs of SGM people and to offer suggestions to address them. The task force included representatives from NMDOH and other state programs (Human Services Department, Children Youth and Families Department, Aging and Long-Term Services Department, University of New Mexico [UNM] Health Sciences Center), as well as volunteers from a range of community-based organizations that serve or collaborate with SGM populations in New Mexico. In this report, we describe the context that engenders health disparities among SGM people, discuss issues affecting specific groups within the SGM population and suggest steps to address these disparities and improve the health of New Mexico's SGM citizens.

[i] To remain inclusive yet consistent, the National Institutes of Health has recently opted to use "Sexual and Gender Minority," or (SGM). This umbrella term "encompasses lesbian, gay, bisexual, and transgender (LGBT) people, as well as those whose sexual orientation and/or gender identity varies, those who may not self-identify as LGBT (e.g., Queer, Questioning, Two-Spirit, Asexual, men who have sex with men [MSM], Gender-variant), or those who have a specific medical condition affecting reproductive development (e.g., individuals with differences or disorders of sex development (DSD), who sometimes identify as intersex)."1

Sexual and Gender Minority Health in New Mexico

In the State of New Mexico, about 3% of the adult population and about 10.5% of high-school aged youth identify as a sexual minority.[ii] This population includes numbers of racial/ethnic minorities (primarily Native American and Hispanic people) proportionate to the general population of the state (about 56%).[4] While lesbian and gay adults tend to have a higher level of educational attainment than their heterosexual counterparts, fewer have a household income greater than $20,000. Nearly a third of the state's sexual minority population live in rural areas, where there tends to be shortages of both physical and behavioral health services.[5,6]

Studies show several notable disparities in physical and mental health and quality of life for SGM people in New Mexico. Though chronic conditions and risk factors (e.g., cardiovascular disease [CVD], obesity and diabetes) are not necessarily more common among this population, sexual minority New Mexicans have reported higher rates of asthma, smoking, binge drinking, disability, depression, anxiety, and attempted suicide, than heterosexual New Mexicans.

In 2011, almost a quarter of bisexual adults had attempted suicide, a rate that was four times higher than that of the heterosexual population in New Mexico, while the rate among lesbian and gay people was almost twice that of heterosexual people. Sexual minority New Mexicans also report higher rates of intimate partner violence and life dissatisfaction than heterosexual cisgender adults.[5] These disparities can be attributed in part to widespread and life-long experiences of social stigma, harassment and discrimination, and increased risk-taking that can contribute to poor mental health, especially for young people. Negative reactions to a SGM identity by parents and others has been shown to increase poor mental health and substance misuse among youth. "Self-medicating" behaviors can also result in higher rates of tobacco, drug, and alcohol use among SGM people than among their heterosexual cisgender counterparts.

While sexual minorities in New Mexico do not report lower rates of access to and use of preventive health services and health insurance than the heterosexual cisgender population, perceptions or fear of discrimination can discourage SGM people from obtaining treatment for health issues. These issues include seeking preventive care (such as vaccinations, tests for HIV and sexually-transmitted infections [STIs]),

[ii] Population estimates for gender minority New Mexicans are not yet available.

mammograms and other cancer screenings.[7] Some SGM people face explicit discrimination from their healthcare providers. For example, one study shows that up to 39% of transgender people face some type of harassment or discrimination when seeking routine healthcare.[8] Thus, even when providers appear concerned and welcoming, SGM patients may not feel safe disclosing their status without explicit encouragement due to previous experiences of discrimination.

The health disparities literature pertinent to SGM people consistently references historical trauma, privilege, violence, and systemic reinforcement of heteronormativity as root causes of these disparities. Many SGM people have had numerous experiences of discrimination based on their sexual orientation or gender identity and expression. This can lead to a lack of trust, reluctance to access care, and unwillingness to share personal information with providers, even when this information is essential to appropriate care. Some SGM individuals, particularly those who are transgender or gender nonconforming (GNC), experience violence in multiple contexts, including during their attempts to access medical care. Even when quite ill, these individuals may make the decision to avoid care rather than face repeated humiliation or physical violence.

Moreover, SGM people often lack access to healthcare settings and healthcare providers that are fully attentive to their specific experiences and needs. Historically, SGM people have been excluded from the protections and quality of care afforded to heterosexual and cisgender people.[iii] Today, they still encounter negative attitudes and behavior from providers and their staff. These range from overt discrimination to subtle slights and insults. Because of previous experience, SGM individuals who do access care are looking for signs that the people and organizations they interact with are supportive of them and will provide a safe space for them to share all aspects of their identity, and where they can receive compassionate, supportive care.

Unfortunately, social stigma contributes to a lack of awareness about the SGM status of patients among even the best-intentioned healthcare providers who may assume that if a patient does not immediately volunteer this information, it is unimportant. This results in missed diagnoses and lost opportunities for doctors to address SGM-specific health and service delivery needs.

Many SGM New Mexicans who participated in town hall meetings and focus groups in 2014 as part of the Sexual and Gender Equity (SAGE) Health Project stated that they do not disclose their SGM status to healthcare providers unless specifically asked. Providers noted that they do not routinely ask patients about their SGM status unless the patient raises the issue.[9] This "don't ask, don't tell" situation may lead to instances where providers do not have the information they need to provide appropriate screening, diagnosis, and care to SGM patients.

Discrimination and stigma among healthcare providers also contribute to a lack of data and a dearth of curricula on SGM people and their specific needs within medical schools and in other health and behavioral health fields. Students who work with SGM patients exhibit more positive attitudes toward, and more extensive knowledge of SGM people and their health needs. A lack of adequate training among healthcare providers contributes to substandard care and uncomfortable healthcare environments for SGM patients.[7]

[iii] Cisgender is a recently coined word that refers to people whose sex assigned at birth aligns with their current gender. The word was created as a neutral opposite of "transgender."

Specific SGM Populations and Context

In addition to the general issues discussed above, specific groups in the SGM population have unique experiences and needs. These include transgender/gender-nonconforming (GNC) individuals, incarcerated SGM people, older SGM adults, SGM youth, gay men or other men who have sex with men (MSM), and SGM people of color.

Transgender/Gender-Nonconforming People

Due to their small numbers and a lack of reliable research, limited data are currently available on the health status and healthcare utilization of transgender/GNC people in New Mexico. However, the National Center for Transgender Equality (NCTE) and the National Gay and Lesbian Task Force's now seminal 2011 report entitled 'Injustice at Every Turn' found that transgender/GNC people nationally suffered from much higher rates of HIV infection, smoking, drug and alcohol use and suicide attempts than the general population.

The NCTE did an update to this survey in 2015 based on 27,715 participants living across the US, in US territories and on overseas US military bases. Thirty-nine percent of respondents experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the U.S. population. Among the starkest findings is that 40% of respondents have attempted suicide in their lifetime, which is nearly nine times the attempted suicide rate in the U.S. population (4.6%). Respondents also encountered high levels of mistreatment when seeking healthcare. In the year prior to completing the survey, 33% of those who saw a healthcare provider had at least one negative experience related to being transgender including being verbally harassed or refused treatment because of their gender identity. Additionally 23% of respondents reported that they did not seek the healthcare they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person and 33% did not go to a healthcare provider when needed because they could not afford it.[10] The recent survey data underscores the alarming health disparities that adversely impact transgender/GNC people here in New Mexico and nationwide.[11]

At the same time, transgender and GNC people experience widespread and persistent barriers to accessing high quality medical care, mostly due to explicit and implicit discrimination and a lack of education among providers and their staff about the needs and experiences of transgender/GNC patients. The 'Injustice at Every Turn' survey reported that 19% of participants had been refused medical care due to their transgender or GNC status, with even higher numbers among transgender/GNC people of color. Fifty percent of the sample reported having to teach their medical providers about

transgender care. Survey participants reported that when they were sick or injured, many postponed medical care due to discrimination (28%) or inability to afford it (48%). Twenty percent were subjected to harassment in medical settings and 2% were victims of violence in a doctor's office.[10]

Incarcerated SGM People

While current rates of incarceration among SGM New Mexicans are not known, studies show that SGM people are incarcerated at disproportionately high rates nationwide. About 238,000 lesbian, gay, and bisexual people are currently incarcerated in the United States. This corresponds to an incarceration of 1,882 per 100,000 lesbian, gay, bisexual (LGB) people, compared to 612 per 100,000 for the general population. Similarly, the National Transgender Discrimination Survey found that 16% of transgender adults have been in a prison or jail, compared to 2.7% of all adults who have ever been in prison and 10.2% of all adults who have been under any kind of supervision in the criminal justice system.[12]

At the same time, interactions with justice institutions present tremendous health and mental health risks to SGM people. For example, a 2011/2012 Bureau of Justice Statistics report states that more than 200,000 youth and adults are sexually abused in prisons, jails and juvenile detention facilities each year. Of those, prisoners who identified as "non-heterosexual" were 3 times as likely to report sexual abuse, which can lead to post-traumatic stress disorder, depression, and substance abuse.[13] Many SGM inmates are also placed in solitary confinement or protective custody because they are deemed to be vulnerable to violence by other inmates. Long periods of solitary confinement can lead to adverse mental health outcomes for SGM people.[14]

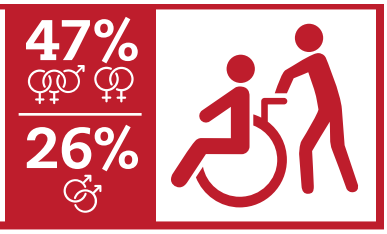
Incarceration presents particularly significant problems for transgender and GNC individuals, who are generally housed with others who share their sex assigned at birth, rather than their current gender identity. A study of California prisons found that transgender women in men's prisons were 13 times more likely to be sexually abused than other prisoners.[15] Additionally, transgender inmates report that they do not receive the medical care necessary for their well-being. This includes continued hormone treatment for transgender people diagnosed with gender dysphoria, deprivation of which is considered cruel and unusual punishment under the Eighth Amendment.[14]

Older SGM People

Older SGM people represent a growing segment of the SGM population whose health and healthcare needs are not adequately addressed. In New Mexico, LGB people are generally younger than the general population, yet 7% of lesbian and gay people and 8.5% of bisexual people are over the age of 65.[5] Nationwide, one study estimates that there are more than 2.4 million LGBT adults over the age of 50, a number that is steadily growing.[16]

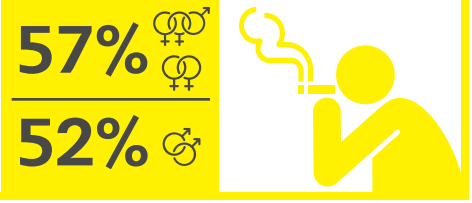
Older SGM people experience health disparities when compared to the straight cisgender population, including disparities that are found in younger populations and persist with age, as well as disparities that may emerge later in life.[17] One study using data from the Washington State Behavioral Risk Factor Surveillance System found the following disparities:

1. A higher likelihood of disability (47% increased likelihood for older lesbians and bisexual women and 26% for older gay men compared to their heterosexual counterparts).

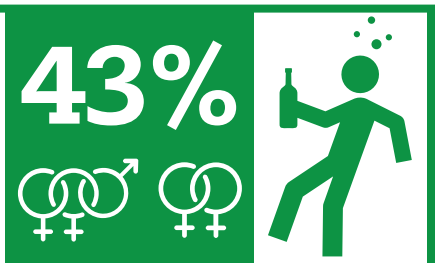


2. Poor mental health (40% increased risk for older women and 77% for older men compared to heterosexuals of the same age).

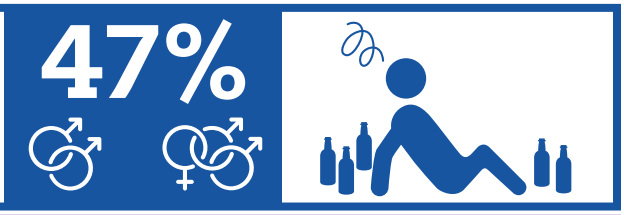
3. Smoking (57% more older lesbians and bisexuals and 52% more older gay men smoked than comparable heterosexual populations).



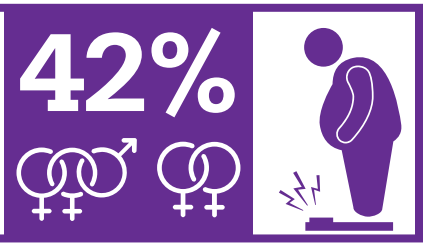
4. Excessive drinking (i.e., four or more drinks on a single occasion in the past month for women and five or more for men) was reported by older lesbians and bisexual women with a 43% greater frequency than heterosexual women.



5. Excessive drinking by older gay and bisexual men with 47% greater frequency than straight men.



6. Older gay and bisexual men were less likely than heterosexual men to meet the criteria for obesity; older lesbians and bisexual women were 42% more likely to be obese than their heterosexual counterparts.



Disparities that emerge later in life are heightened risk of cardiovascular disease among lesbian and bisexual women (37% greater likelihood than straight women) and poor physical health among gay and bisexual men (38% greater likelihood to experience 14 or more days of poor physical health in the previous 30 days than heterosexual men).

Other studies of older SGM people indicate that these individuals may contend with specific challenges accessing appropriate medical care and taking care of themselves. Previous experiences with discrimination from healthcare providers may make older SGM people reluctant to seek care. [18,19] Many SGM seniors also live alone and do not have children, increasing their isolation and making them reliant on friends and other social supports for care at home.[20] Older SGM people have experienced discrimination when looking for long-term care options, including higher pricing for retirement homes and differential treatment in availability.[21,22]

For the small but growing population of older transgender and GNC people, existing health disparities and challenges in accessing high quality medical care are compounded by the aging process. In a 2012 publication, Services & Advocacy for GLBT Elders (SAGE) stated that many older transgender/GNC people have experienced a lifetime of stigma and discrimination from healthcare providers. This leads them to avoid accessing care and go untreated, even as their medical needs increase with age. For individuals transitioning later in life, the processes of beginning hormone treatment and transition-related surgeries in this age group are not well-studied. The long-term effects of hormone treatment on older people are also little known. Finally, paying for transition-related medical care can be a significant burden on older people as Medicare does not cover transition surgeries.[23]

SGM Youth

In New Mexico, 10.5% of youth identify as LGB. An additional 3.4% of youth report that they are not sure of their sexual orientation. Here and throughout the nation, SGM youth suffer disproportionately from negative health and psychosocial outcomes. These include low self-esteem, self-mutilation, depression, suicide, and substance use when compared to their heterosexual and cisgender counterparts.[24-29] Population-based surveys confirm that sexual minority high school students are more likely than their peers to be threatened or injured with a weapon at school and to skip school due to safety concerns.[30-33] Among sexual minority youth who participated in the 2015 New Mexico Youth Risk and Resiliency Survey, 31% were bullied on school property in the past 12 months compared to 15.7% of heterosexual youth.

Sexual minority youth are also more likely to be punished at school, a fact not explained by participation in illegal or transgressive behaviors.[34] Finally, students and youth thought to be SGM are less likely than peers to receive support from teachers and other adults at school and are more likely to get low grades.[35]

This population also reports high levels of negative life experiences and related negative health outcomes. In a first-of-its-kind survey of 10,000 SGM youth, the Human Rights Campaign found that several key determinants of minority stress (e.g., verbal harassment, bullying, non-accepting families, and negative societal messaging regarding gender and sexual difference) disproportionately affected their health and well-being.[36] In New Mexico, LGB youth are nearly 2.5 times more likely to have attempted suicide than heterosexual youth. LGB youth are also more likely to engage in risky behaviors that include:

1. Smoking (38.8% of LGB youth compared to 13.6% of heterosexual youth)
2. Binge drinking (33.9% of LGB youth compared to 17.8% of heterosexual youth).

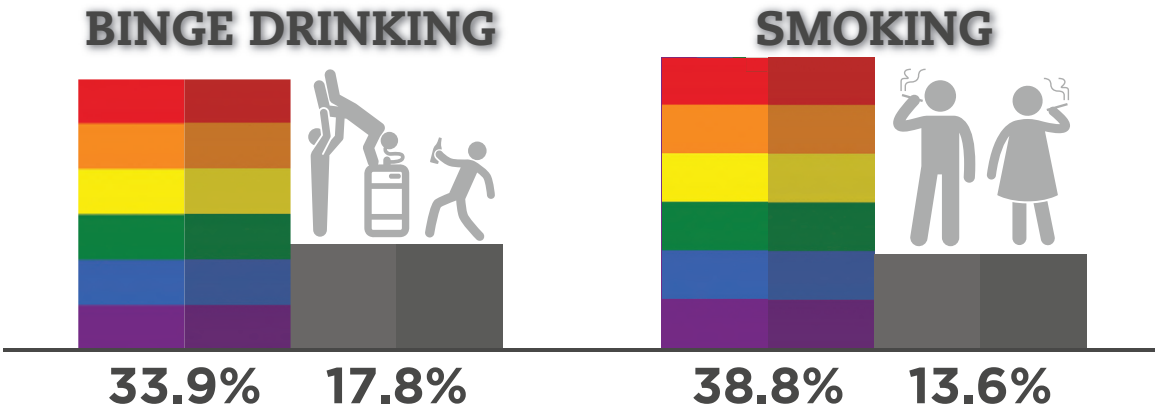
Youth who are unsure of their sexual orientation experience similar disparities as LGB youth (e.g., 33.1% smoke cigarettes and 26.8% binge drink).[37]

The New Mexico Youth Risk and Resiliency Survey began including information about gender identity in the fall of 2017, and those data are being analyzed; however, research conducted outside of New Mexico strongly suggests that such experiences are intensified for transgender and GNC youth.[38-40] The 'Injustice at Every Turn' report indicates that experiences of being bullied, harassed, assaulted, or expelled from school because of being transgender or GNC correlated with a 10% increase in reported suicide attempts (51% compared to 41% of the whole transgender/GNC sample), especially when these behaviors were perpetrated by teachers.

Gay Men and Other Men Who Have Sex with Men

Gay men and other men who have sex with men (MSM) are affected by disproportionately high rates of HIV infection and other sexually transmitted infections compared to other groups. According to the New Mexico Department of Health (NMDOH), more than 70% of both existing and new diagnoses of HIV in the state occur in this population.[41]

The NMDOH HIV prevention activities have narrowed in recent years due to shifting priorities of the Centers for Disease Control and Prevention (CDC). There is no longer



support for vital prevention programs targeting general or low-incidence populations. Instead, programming focuses primarily on HIV testing and counseling of populations with high HIV incidence and for persons living with HIV to help prevent the transmission of the virus to others. Interventions for HIV prevention for persons who are negative now focus only on gay/bisexual men, other MSM, and transgender persons who have male sexual partners. Within this category, prevention activities targeting gay/bisexual/MSM people use one of two evidence-based models promoted by the CDC: Mpowerment (a program for men 18-29 that is currently being used in Albuquerque and Las Cruces) and Many Men, Many Voices (3MV) workshops, which are being offered in many locations around the state.

A series of principles guide the Mpowerment model. They include:

1. Personal and community empowerment;
2. Diffusion of new behaviors through social networks;
3. Peer-influence;
4. Putting HIV prevention within the context of other compelling issues for young gay/bisexual men (e.g. social issues);
5. Community building; and using gay-positive approaches.

Many Men, Many Voices is a seven-session, group-level HIV and STD prevention intervention originally designed for black gay men. The intervention addresses factors that influence the behavior of men who have sex with men (including cultural, social, and religious norms), interactions between HIV and other sexually transmitted diseases, sexual relationship dynamics and the social and psychological influences that racism and homophobia have on HIV risk behaviors. The 3MV workshops are designed to be delivered by two culturally competent facilitators in groups of up to 12 clients. The activities in use for transgender people come from the Sisters Informing Sisters on Topics about AIDS model (SISTA). The SISTA project is a social-skills training intervention originally designed for African American women. It is comprised of five 2-hour sessions and delivered by peer facilitators in a community-based setting. The sessions are gender specific and culturally relevant and include behavioral skills practice, group discussions, lectures, roleplaying, prevention video viewing and take-home exercises.

Information on each of these evidence-based interventions can be found at the following CDC website: www.effectiveinterventions.org.

SGM People of Color

In New Mexico, the racial/ethnic make-up of SGM people essentially mirrors the general population, including a majority (56%) of non-White persons. These individuals comprise a multiply marginalized population, as they experience the intersection of discrimination and disparity resulting from both racism and heterosexism.[42] Moreover, SGM people of color may experience stigma and exclusion within LGBT spaces, like community events, gay bars, and dating services, because of their race and ethnicity, as well as within racial/ethnic minority communities because of their SGM status.[42]

Studies of minority stress show that the daily experiences of stress in the form of discrimination, violence, and microaggressions are cumulative.[1] This means that people who are exposed to multiple forms of minority stress are thus especially at risk of negative mental and physical health effects. The Center for American Progress reports that SGM people of color suffer from the combined impact of reduced access to employer-provided insurance and a lack of affordable healthcare and insurance options.[7] They also experience a lack of cultural competency in how SGM and race/ethnicity issues are addressed by healthcare providers. The Center for American Progress sites seminal data collected from the 2009 California Health Interview Survey that show that of the more than 20,000 adults interviewed, LGB Latino adults were least likely to have health insurance or a regular source of basic healthcare. While African-American LBG adults were most likely to have diabetes as well as to delay or not get a needed prescription or a mammogram, Asian or Pacific Islander LGB people were most susceptible to psychological distress. The Center further observes that little data exist specifically on the health of transgender/GNC people of color, although one study shows that they experience substantially higher rates of HIV diagnosis than White transgender/GNC people or cisgender people of color.

Recommendations

The task force recognizes that implementation of the following recommendations will require significant resources and coordination among government and private agencies. We suggest that this work is essential to increasing health equity for SGM New Mexicans and thus well worth the investment. Because of the complexity of the work, we suggest that a position be created to coordinate and track progress on this work.

Sexual Orientation and Gender Identity

Include sexual orientation and gender identity demographic questions at every level of data collection throughout New Mexico State Government.

Healthy People 2020, a national health promotion and disease prevention initiative through the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, includes important objectives for population-based data systems to collect data on SGM populations (https://www.healthypeople.gov/). The NMDOH has collected sexual orientation health data among adults for a decade and has recently added questions on sexual orientation to its Youth Risk and Resiliency Survey. However, there are still gaps in the data needed to make informed public health decisions (such as information on substance abuse, mental health disparities, and healthcare utilization among SGM people). This lack of reliable and accurate data critically limits stakeholders (e.g., policymakers, government agencies, healthcare systems, community-based organizations, and healthcare providers) from understanding the health issues affecting SGM people and limits the development of public policies and programs to improve their health and well-being.

Pathways to Implementation

Inclusion of SOGI (Sexual Orientation and Gender Identity) Data:

Health systems and public agencies should use tested, high quality, and germane questions to identify SGM people. The NMDOH has experience in collecting this information through the New Mexico Behavioral Risk Factor Surveillance System and the Youth Risk and Resiliency Survey and can be available as a resource. Health systems and public agencies (e.g., health, law enforcement, courts, correctional facilities and education) should be encouraged to assess whether SOGI information can be added as part of the demographic information in their data collection, health surveys, etc. The SOGI data should be collected where appropriate and relevant, along with other demographic data (see Appendix A).

Health systems and public agencies should ensure the analysis of relevant health and social disparities using SOGI data by identifying and designating someone to analyze these data. They should also commit to disseminating new SOGI information to the community and stakeholders in a way that is easily accessible and understandable. Finally, health systems and public agencies should use the data to prioritize resources and funding based on disparities identified by the data.

Improving Health Information Technology Infrastructure in the State:

To facilitate and ensure the dissemination of data on SGM people and their health, New Mexico must expand its Health Information Technology (HIT) services, establish data exchange policies, and align exchange capabilities. The use of electronic health record (EHR) systems greatly enhances the ability of providers to collect and exchange data. However, New Mexico's rural and frontier areas can often lack providers, connectivity, and the basic resources needed to implement and maintain EHR systems. In 2013, the Office of the National Coordinator for Health Information Technology (ONC) estimated that

53% of all New Mexico physician practices, including primary care, use an EHR. The rate among rural/frontier area providers is 35%. Behavioral health providers have lagged with only around 21% of organizations nationally adopting EHRs.

Providers can take advantage of the Meaningful Use (MU) incentives under Medicaid, which serves 40% of the general population, to adopt EHR systems. Without the MU incentives, the financial burden and lack of IT staff for healthcare providers can be insurmountable, especially for those in the frontier areas where resources are scarce. The resource issue can also affect the ability for smaller physician and behavioral health practices to adopt EHRs.

Improving Use of EHRs Within Clinical Environments:

EHR adoption alone does not guarantee successful usage or quality of data. Adoption needs to be accompanied by a review of clinical workflow to ensure best practices are incorporated. Additionally, on-going training is required to place emphasis on the quality of the data entered into the system and to assist clinical staff in progressing from a "basic use" level to a "higher level of sophistication." For an EHR to reach its full usage potential, technical assistance should be provided for clinical business process workflow, staff training, and technical functionality of the software. Effective use of EHRs will improve patient care coordination, including notification of specific changes in a patient's medical condition and path of care, such as admission, discharge and transfer to/from an emergency setting. Utilizing patient health information from multiple providers involved in an individual's care can help decrease redundancy in laboratory and other testing, inform primary care providers of health issues outside their purview, and support better coordination of care.

SGM Competent Health Services

Ensure access to SGM culturally competent physical and behavioral health services.

Cultural competency is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural continuum. Cultural competence involves:

1. Valuing diversity,
2. Avoiding stereotypes,
3. Managing the dynamics of difference,
4. Acquiring and institutionalizing cultural knowledge,
5. Adapting to diversity and cultural contexts in communities.

While SGM people experience many barriers to culturally competent care, we believe that most providers intend to provide quality care and fail to do so because they lack the necessary training and experience. Training of providers, administrators and support staff has been demonstrated to significantly improve not only their understanding of the causes of health disparities affecting SGM people, but also their commitment to taking steps to address these disparities within their offices and institutions. In addition to ameliorating these gaps, structural issues need to be addressed to make medical offices and institutions more welcoming and accessible for members of sexual and gender minority SGM populations.

Pathways to Implementation

Education and Training:

In 2014, The American Association of Medical Colleges (AAMC) published *Implementing Curricular and Institutional Climate Changes to Improve Healthcare for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD*.[43] This volume includes a list of competencies required to treat members of SGM populations. This document should be used as a guide for the inclusion of appropriate material in the curricula of medical education programs in New Mexico, as well as the curricula for training nurses and pharmacists. Students in graduate medical education should also receive training on the needs of sexual and medical minorities with the focus being on their specialty and the specific issues they are likely to address in their practice. One of the barriers to this work is the feeling among many medical educators that they are not

prepared to write curricula focused on the needs of SGM people. Consulting in this area may be necessary so that the contents of these trainings can be developed by specialists in SGM health in collaboration with the educators responsible for residency and other training programs.

For physicians and other medical professionals already in practice, training needs to be offered in various formats. This training should include continuing medical education (CME) credits so that health professionals will have increased motivation to participate fully in these opportunities. Again, the content can be based on the competencies suggested in the AAMC volume.

Many of the issues experienced by people trying to access healthcare involve how they are treated by staff other than their provider and the language used to address and refer to them and their families. Non-medical staff who work in medical facilities also must be trained in the needs of SGM patients. This training should focus on basics of sexual and gender identity, and an understanding of how to use appropriate and respectful language when working with SGM patients.

Monitoring and Evaluation:

People and organizations who provide healthcare and social services to the public should be required to demonstrate awareness of the needs of people who identify or are identified as members of SGM populations and to adhere to a list of guidelines designed to increase access and quality of care for members of this population. The guidelines should be developed with the input of experts in the SGM community. To ensure access to culturally competent care, it is also critical to:

1. Collect data on policies, practices, and trainings that are implemented.
2. Monitor the types of educational materials provided or policies developed.
3. Track how many providers participate and successfully complete identified trainings.
4. Identify whether a policy, practice, or training was effectively implemented.

The main purpose of monitoring and evaluation is to support continuous program improvement. Through this process, it is possible to identify whether recommended actions continue to be the right interventions, whether they are being done well, and whether anyone is better off.

Licensing Boards Should be Part of Implementation:

New Mexico licensing boards have varying requirements for healthcare practitioner continuing education. It is important to note that each licensing board (i.e., nurses, doctors, osteopathic physicians, behavioral health providers, optometrists, pharmacists, dentists and dental staff, podiatrists, or midwifes) has its own set of rules and licensing requirements. Few boards require that practitioners take continuing education (CE) courses in cultural competency. The New Mexico Board of Social Work Examiners is one of the only boards to have explicit requirements, which include six hours in cultural awareness for licensees. Each licensing board should encourage regulated professionals to seek out these courses (such as free CE courses in cultural competency and specifically SGM competency) that are available either in person or online.

In New Mexico, Managed Care Organizations (MCOs) that contract with the State Government to administer Medicaid services are required to have a Cultural Competency/Sensitivity plan in place. This ensures the provision of culturally competent

services directly and through contracted providers and subcontractors. These agreements cover services to members with a hearing impairment, a physical or developmental disability, a speech or language disorder, diverse cultural and ethnic backgrounds, or Limited English Proficiency. These agreements also apply to all members, regardless of gender, sexual orientation, or gender identity. Importantly, the MCO agreements require that cultural competence training focuses on member services staff and contract providers, including primary care physicians, care coordinators, and case managers, and the training and education are ongoing. These contractual requirements could serve as an example to other state agencies or organizations that also contract providers and other staff for healthcare services.

Non-discrimination Policies and Practices:

Several National Standards and pieces of Federal legislation have outlined appropriate policies and practices to ensure that members of the SGM population do not experience discrimination in health environments. Examples include:

- The Federal Government promotes National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to help eliminate disparities in healthcare access and utilization due to inequities based on language, ethnicity, and race.
  These Standards were developed as a blueprint for individuals and organizations to implement services that will advance health equity and help eliminate health disparities, and are applicable to SGM people. The key standards include:

1. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
2. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
3. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes to inform service delivery.
4. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
5. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
6. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

- Section 1557 of the 2010 Patient Protection and Affordable Care Act (ACA) prohibits sex discrimination in healthcare, which includes gender identity and sex stereotyping. Any health program or activity that receives funding or is conducted by the U.S. Department of Health and Human Services is required to comply with Section 1557. Individuals cannot be denied healthcare or health coverage based on sex, including gender identity and sex stereotyping. Individuals must be treated consistently with their gender identity, including access to facilities. Sex-specific healthcare cannot be denied or limited just because the person seeking such services identifies as belonging to a gender that does not align with his/her biological sex.

Since Section 1557 recently went into effect, it is important to educate and inform healthcare providers, agencies, organizations, and consumers on the requirements of this provision.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

However, education alone does not ensure that this provision will be implemented appropriately. For example, Christus St. Vincent Regional Medical Center in Santa Fe, NM, worked with consultants in 2014 to update the questions on their patient intake and history forms to better serve SGM patients. The updated forms allow patients to record the sex assigned to them at birth, their current gender identity, and their sexual orientation. Questions about relationships and sexual history were also updated to include options that better reflect the realities of some SGM people.

Before implementation of these changes, there was concern that non-SGM patients would respond negatively or be confused by the questions. Once the changes were in place, actual problems were minimal. However, two years after the changes were implemented, it was reported that hospital staff were assigning gender identity based on what they perceived during patient interaction, rather than asking patients to answer the question.

At least one transgender patient who was previously identified correctly as female had her gender changed to male through this practice, leading to extreme anger and distress as well as several missed appointments. To guard against such negative outcomes, it is important that hospitals and clinics undergo routine monitoring to assess if SOGI data are being effectively collected, analyzed and used to increase client access and quality of care.

Regardless of what changes may occur to Federal requirements for the provision of healthcare services, it will be important for providers and organizations to maintain policies and practices that prohibit sex discrimination, and that these policies and practices continue to be implemented in a way that promotes healthcare access and utilization.

Other National Standards include: The Joint Commission Requirements (2012); National Committee on Quality Assurance HEDIS (2014); Americans With Disabilities Act (1990); Title VI of the Civil Rights Act (1964); and Executive Order 13166 (2000).

Evidence-based or Culturally-tailored Interventions:

Healthy People 2020 calls for achieving health equity (i.e., the elimination of health disparities) through interventions in the five key areas of the social determinants of health:

1. Health and healthcare,
2. Social and community context,
3. Education,
4. Economic stability, and
5. Neighborhood and built environment.

(Refer: https://www.healthypeople.gov/).

Because work in this area is mostly quite recent, very little has been published to support specific curricula and interventions. In New Mexico, the Sexuality and Gender Equity (SAGE) Health Project, the New Mexico Community AIDS Partnership (NMCAP), the Pacific Institute for Research and Evaluation (PIRE),[44-46] and various programs at the UNM9 have been undertaking research on the needs of patients who identify or are perceived as belonging to the SGM population. We expect that significant research will be conducted and published in this area over the next few years. Because of work already done, New Mexico has the potential to be a national leader in the area.

Other Specific Recommendations:

Because many factors affecting access to care are structural, the state should:

1. Monitor hospitals, clinics, and behavioral health providers to assure that they include sexual orientation and gender identity and expression as protected classes in their patient non-discrimination policies;
2. Include questions about SGM identity on patient intake and history forms; and ensure that all patient documents are reviewed for language that discriminates against these populations.
3. Give providers a checklist that lists steps they can take to assure that their offices are welcoming to SGM individuals and monitor steps taken to implement items included on the list.

1. The use of community liaisons, navigators or Community Health Workers should be explored as a way to help SGM patients access care and services. Recent research suggests that such models can be of benefit to SGM people in New Mexico.[46] Individuals providing these services to other populations at individual hospitals and clinics should be trained in the specific needs and resources relevant to SGM patients. The creation of regional or statewide resources that focus specifically on the needs of SGM patients should be explored.

2. Various formats and media should be explored to educate SGM New Mexicans about the resources available to them in healthcare and behavioral health services. These might include publications, web-based information and public educational events.

Increase SGM Consumer Participation

Increase SGM access to care by increasing community health literacy and the use of health navigators.

While it is essential to increase the availability of SGM-specific care and the ability of the broader healthcare and behavioral health systems to treat SGM patients, it is also essential to work with community members to help them understand the various access points for services. This can be accomplished through community education designed to increase health literacy, and using professionals trained and tasked with supporting SGM individuals in their efforts to access appropriate care.

Increase SGM Access to Care

Increase access to SGM-focused behavioral health services, community-based prevention, early intervention and support services, especially for rural, poor, and youth populations.

Access to SGM-focused and affirming community-based prevention, early intervention, and support services must be improved for SGM New Mexicans through a multitude of pathways. The effectiveness of the systems already in place must be enhanced. Community-based providers must be empowered to establish trusting, affirming relationships, through which they can help develop resilience and self-acceptance. This is to be consistent with evidence-based practice for improving health outcomes for SGM New Mexicans. There is an especially profound need for behavioral health services that can be accessed easily. In other words, services should be accessible from wherever people are and with the technology they have (whether it is a traditional phone, a smart phone, or a computer).

Pathways to implementation

Increase access to existing services and increase the variety of services:

Currently in New Mexico, the following resources are available to support prevention and early intervention for behavioral health concerns:

1. N'MPower
2. Teen N'MPower
3. MPowerment (Las Cruces)
4. The Transgender Resource Center of New Mexico
5. UNM LGBTQ Resource Center
6. Stonewall QSA at New Mexico State University
7. UNM Truman Health Services
8. Southwest Care Center
9. Fierce Pride
10. Identity Inc.
11. The New Mexico Genders and Sexualities Alliance Network at the Santa Fe Mountain Center.

To increase the awareness of and access to these resources, support networks should be developed in each county with resource

information provided to county leaders, healthcare providers, and educators. Ideally, each county would designate an SGM liaison or coordinator responsible for establishing and maintaining this information, and the various county liaisons would develop a statewide network for the gathering and dissemination of this data. Counties that implement these programs should be highlighted and celebrated. This liaison model could also exist in state agencies and in organizations providing services to the public.

Identify and Cultivate Culturally Competent Behavioral Health Resources and Develop a Statewide Referral Network:

Given the magnitude of mental health and substance use disparities outlined in this report for SGM people of all ages, it is notable that there is no formally vetted list or network of behavioral health providers in New Mexico who are SGM-affirming or who offer specialized services for this population.

Developing resources in this area would support increased, more beneficial referrals for behavioral health services. It is essential that primary care providers, emergency medicine providers, and others know where they can safely refer SGM patients in need of behavioral and mental health and substance use treatment services. It is important that SGM patients understand that they will be received well and provided with high quality, culturally appropriate care and services.

Providers who are already prepared to provide culturally competent care to SGM clients should be identified. Providers who have an interest in serving this population but lack the experience or education to do so should be provided with training and support to prepare them for this work. The referral network could be made available to providers of both healthcare and behavioral health services to facilitate appropriate referrals for SGM patients.

The New Mexico Behavioral Health Services Division's Screening, Brief Intervention, and Referral to Treatment Program

The New Mexico Behavioral Health Services Division's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program currently integrates behavioral health specialists trained in brief interventions into medical practices throughout the state. The SBIRT offers direct access to short-term counseling, increasing access to early intervention for mental and behavioral health concerns. This program should be expanded to internal medicine, family practice, and pediatric clinics, emergency rooms and urgent care clinics statewide.

All providers associated with this program should be trained in the needs and experiences of SGM patients and should be provided with information on the SGM Referral Network described above.

Enhance, Expand, Add, and Adapt Model Programs to New Mexico:

Gold standard or promising practices can be adapted to the needs of local SGM populations. These may include:

1. Encouraging the collection of qualitative data within each county (e.g., surveys with SGM individuals, employers, medical providers, and county leaders) to determine specific needs and barriers to accessing services and local resources for SGM people.
2. Exploring the use of social media and public media campaigns to increase awareness of SGM issues and provide support to SGM people.

3. Developing comprehensive anti-bullying legislation and state or local policies based on nationally available models to promote access to care and support, as well as providing adequate funding and oversight to ensure that they are implemented and followed properly.
4. Exploring programs and service models being used in other parts of the country to assess their relevance and fit to local needs.

Telemedicine or Telehealth:

The physical reality of New Mexico means that many people of all ages have no access to behavioral health services near their homes, making distance and transportation significant barriers to care. Remotely accessible healthcare services can make services available to SGM people wherever they are located. These may include online services created specifically for youth and teenagers who may need to access services without their parents' participation (for example those without insurance, and possibly without transportation). Such services can be their first link to help.

Local Access to Basic Care:

SGM people experiencing poverty are especially lacking in access to behavioral healthcare unless they happen to be connected to a social services agency, such as Healthcare for the Homeless in Albuquerque. Otherwise, they are unlikely to access any care except in emergencies. This is also true for many New Mexicans living without insurance or with insurance that provides only minimal behavioral health benefits. One possible response to this need is the development of behavioral health "outlets" in local stores that are easily accessible and covered by Medicaid and most insurance. This approach may also help address the stigma attached to accessing behavioral health services in locations identified with these services.

Foster Government and Stakeholder Collaboration

Foster government and stakeholder collaboration to reduce health disparities and ensure implementation.

Historically, SGM people have been excluded from state decision-making processes related to their health and healthcare. However, the inclusion of an SGM voice is vital to the successful implementation and uptake of SGM-relevant services and interventions intended to reduce health disparities.

To achieve successful statewide implementation of recommended practices, it is important to engage a wide representation of stakeholders. New Mexico must take advantage of existing partnerships among individuals, state agencies and statewide organizations, local governments, healthcare groups, providers, provider associations, and community and consumer advocacy groups.

Pathways to Implementation

The task force encourages the participation of diverse SGM stakeholders ("consumers") and community partners in statewide health services and planning as well as educational and program development activities.

Structures that promote clear communication, a shared understanding of roles and responsibilities, equitable decision-making, proactive problem-solving, and the building of trust can facilitate SGM stakeholder engagement and support for SGM-specific initiatives.

Potential barriers to engagement include lack of trust and respect, devaluation of SGM stakeholder input and recommendations, inequitable distribution of resources, conflicting priorities and beliefs, struggles over funding, and time consumption.[47]

Successful engagement will likely require processes of bidirectional learning. As an example, state partners may benefit from training in minority stress mechanisms which can be provided by community partners. These partners in turn may benefit from assistance in analyzing and applying different types of data to prioritize, develop, implement, and evaluate initiatives to enhance health and well-being. Leadership skills and non-stereotyping cultural competency training for all will also help strengthen planning efforts.

The state should consider allocating resources to address structural barriers, such as distance and transportation, that can impede SGM stakeholder participation in planning events. Bureaucratic meeting formats may also require modification to allow flexibility to give all stakeholders—especially those new to statewide planning processes—an equal chance to express opinions and concerns.

Establish a Lead Organization:

A lead organization or team could be formed to establish a work plan and identify targets and to facilitate ongoing stakeholder engagement. Some goals of the lead organization could include:

1. Obtaining community-level feedback.
2. Identifying ways to support training and education.
3. Identifying collaborative efforts to achieve identified targets.
4. Establishing regular communication about efforts and progress.

Adapt Existing Stakeholder Engagement Processes:

The NMDOH partnered with the Human Services Department from 2014-2016 on a project to transform health and healthcare with the goal of achieving the Triple Aim:

1. Lowering the per capita cost of healthcare,
2. Improving the patient experience of care, and
3. Improving population health.

The project involved a stakeholder engagement process that could be adapted for other initiatives, and serve as a model for statewide implementation of recommended interventions. Partners throughout the state can help achieve one aspect of the Triple Aim—improving the patient experience of

care—by ensuring the delivery of SGM culturally competent physical and behavioral health services. The Health System Innovation Final Design that details the stakeholder engagement process can be accessed at: https://nmhealth.org/about/asd/opa/sim/.

The Health System Innovation model is just one approach that can be adapted, and is currently being reviewed by groups such as the New Mexico Public Health Institute as a strategy for engaging stakeholders in the planning process. In addition, the Agency for Healthcare Quality and Research has issued a report that identifies five priority methods for engaging stakeholders.[48]

These methods include:

1. Online collaborative platforms;
2. Product development challenges;
3. Online communities;
4. Grassroots community organizing; and
5. Collaborative research (like Community-Based Participatory Research).

For agencies or organizations working with SGM people, these models reinforce the need to use appropriate and accessible technology; to use innovative methods to engage stakeholders in identifying, planning, developing and implementing interventions; to establish networks and facilitate communication; and to integrate stakeholder feedback in a way that results in practices and policies that reflect the needs and interests of SGM people.

Appendices

Appendix A: Measuring SOGI (Sexual Orientation and Gender Identity) by Domain

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