CME CREDIT *EDUCATIONAL OBJECTIVE:* Readers will provide informed, appropriate, and culturally sensitive care to their lesbian, gay, bisexual, and transgender patients

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Best practices in LGBT care: A guide for primary care physicians

ABSTRACT

Lesbian, gay, bisexual, and transgender (LGBT) people have unique healthcare needs. While all LGBT people are at an increased risk for mental health and substance abuse disorders, certain health conditions vary by group. Overweight and obesity are more common in lesbian and bisexual women, whereas sexual minority men are at increased risk for infections such as human immunodeficiency virus (HIV) and syphilis. Breast, cervical, and prostate cancer screening should be offered to all LGBT individuals according to national guidelines and with consideration of a transgender person's natal and surgical anatomy.

KEY POINTS

Lesbian and bisexual women are at increased risk for overweight, obesity, tobacco use, and drug and alcohol use disorders. Clinicians should screen for these conditions regularly and provide appropriate referral.

Annual screening for HIV, syphilis, *Chlamydia*, and gonorrhea should be offered to men who have sex with men.

Pre-exposure prophylaxis against HIV infection may be appropriate for some at-risk individuals who can adhere to daily therapy.

"Screen what you have" is a rule that can help physicians to consider the appropriate screening services for transgender individuals.

Hormone therapy (estrogen and testosterone) can benefit transgender individuals who are changing their physical appearance to their affirmed gender.

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Primary care physicians are very likely to encounter lesbian, gay, bisexual, and transgender (LGBT) patients in their practice, and must be able to provide informed, appropriate, and culturally sensitive care.

Approximately 9 million people in the United States identify as lesbian, gay, or bisexual, and 700,000 adults are transgender.[1] In the 2013 National Health Interview Survey,[2] which queried 34,557 adults about their sexual orientation, 2.3% reported being lesbian, gay, or bisexual, with only slight differences according to age or sex: of those ages 18 through 44, 1.9% were gay or lesbian and 1.1% were bisexual; of those ages 65 and over, 0.7% were gay or lesbian and 0.2% were bisexual. By sex, 0.9% of women vs 0.4% of men identified as bisexual.[2]

This article identifies and corrects common myths about LGBT care, addresses disparities in healthcare access, and outlines a step-by-step approach for delivering comprehensive care to LGBT patients.

MYTHS ABOUT LBGT CARE

Myth #1: L = G = B = T

Although LGBT is a commonly used term, each group described by the abbreviation has its own unique healthcare needs. For example, lesbian and bisexual women are more likely than heterosexual women to smoke, and gay men are at increased risk for human immunodeficiency virus (HIV) and other sexually transmitted infections.[3,4] Transgender persons have high rates of suicide.[5]

Primary care of the LGBT patient needs to be individualized but also informed by the knowledge of distinct risks and behaviors associated with particular groups.

TABLE 1

Suggested questions for obtaining a sexual history

Consider questions inclusive of nonbinary identities—instead of asking whether the patient identifies as a man or a woman or as gay or straight, ask about anatomy and behavior, eg:

- Are you sexually active? (Explore what sexual activity means for the patient)
- With whom do you have sex? Men, women, or both?
- What parts of your body do you use when having sex with your partner(s)?
- Do you practice safer sex? (Explore what safer sex means for the patient)
  With primary partners?
  With casual partners?
- How do your partners identify their gender or sexual orientation?

TABLE 2

Gender identity terms and definitions

Sex—refers to the physical genotype and phenotype, without regard to the sense of self

Cisgender—relating to a person whose gender identity and biological sex correspond

Gender identity—inherent sense of being male or female regardless of genotypic, phenotypic, or biochemical sex; also referred to as affirmed gender

Genderqueer—one who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms. Genderqueer people may or may not avail themselves of hormonal or surgical treatments.

Sexual orientation—how a person identifies their physical and emotional attraction to others

Transgender—an umbrella term used to describe the discordance between a person's gender identity and expression and the cultural expectations based on the sex assigned at birth

Transsexual—an older term that originated in the medical and psychological communities and is typically ascribed to adults committed to making their bodies congruent with their gender identity. This term is still preferred by some people who have permanently changed or seek to change their body through medical interventions (including but not limited to hormone therapy and surgery).

Adapted from references 10, 11, 29, and 32

Sexual identity correlates closely but not completely with sexual behavior

Myth #2: Sexual orientation = sexual activity

Sexual identity correlates closely but not completely with sexual behavior; individuals may engage in same-sex behavior but not identify as lesbian, gay, or bisexual.[6,7] Many women who identify as lesbian have previously had sex with men, and men may have had same-sex encounters but consider themselves heterosexual.[8,9]

Since the risk of certain infections is related to sexual activity, providers should query patients about their sexual partners and practices in an open, nonjudgmental way, and avoid labeling patients solely according to sexual orientation. **Table 1** suggests questions to use when interviewing patients.

Myth #3: Sexual orientation = gender identity

Gender identity describes a person's inherent sense of being a woman, man, or of neither gender, whereas *sexual orientation* refers to how a person identifies their physical and emotional attraction to others.[10,11] Conflating the two concepts can alienate patients, lead to incorrect assumptions, and result in an underestimation of an individual's risk of sexually transmitted diseases.

Using questions such as "Are you sexually active with men, women, or both?" or "When you are sexually active, what parts of your body do you use?" with all patients, regardless of gender identity, will facilitate open and honest conversations that allow for appropriate counseling and risk assessment. **Table 2** lists commonly used gender-identity terms.

Myth #4: LGBT people have the same access to healthcare as heterosexual people

People who identify as lesbian, gay, bisexual, or transgender experience significant disparities in access to healthcare compared with cisgender heterosexual people. For example, lesbian women are less likely to receive the human papillomavirus vaccine, cervical cancer screening, and mammograms, and men in same-sex relationships are twice as likely to have unmet medical needs.[8,12] In a national survey,[5] 19% of transgender individuals reported that they had been refused healthcare. Among 152 transgender adults who described their experiences with the healthcare system, 7% reported receiving substandard care.[13]

We can eliminate these disparities by creating a welcoming environment for all patients (**Table 3**), and also by being aware of the specific services that should be offered to LGBT individuals.

TABLE 3

Creating a welcoming environment for LGBT patients

What to do	Why
Establish gender-neutral bathrooms and avoid restroom signage that specifically designates one gender or another	Transgender individuals should feel comfortable using a restroom that corresponds to their gender identity and expression
Avoid clinic names and signs that seem welcoming to only one gender (eg, Men's Health Center, Women's Health Center)	Gender-specific clinic names or centers may not appeal to or affirm gender-nonconforming people
Create initial patient intake forms that collect information on the patient's preferred name, pronoun, gender identity, sex assigned at birth, partner, and other family members	This information will help providers and staff address the patient correctly, both by name and pronoun
Create electronic health record forms that allow for collection of gender identity and natal sex that also include an anatomic inventory	This information will help providers address individuals' specific healthcare needs according to their natal sex and current anatomy

ADDRESSING THE NEEDS OF LGBT PATIENTS

Outlined here is an office-based approach for addressing the unique clinical concerns of adult LGBT patients. Not all of these issues need to or should be addressed at the first visit, and the sequence in which these steps are accomplished may vary.

Step #1: Screen for mental health disorders

Lesbian, bisexual, and gay people are more likely to experience depression and anxiety. According to the results of a large meta-analysis,[14] the prevalence of these conditions is 1.5 times higher in this population than in heterosexual people. Risk may vary according to group, with gay and bisexual men experiencing a higher lifetime prevalence of anxiety and depression than lesbian and bisexual women.[15] Suicidal attempts are also more common in gay and bisexual men, who have a lifetime risk four times higher than that of heterosexual men.[14]

LGBT patients experience significant disparities in access to healthcare

The risk of suicide is even higher among transgender people: 41% of surveyed transgender adults reported that they had attempted suicide, with higher rates in younger individuals.[5] Risk factors include experiences of harassment or physical or sexual violence, as well as poverty, low education level, and unemployment.[5] The risk of suicide in transgender people who served in the military is 20 times higher than that in the general veteran population.[16]

It is imperative to routinely screen LGBT patients for anxiety, depression, and suicidality and to refer them to mental health providers who are sensitive to LGBT patients' needs and concerns. Screening tools such as the Patient Health Questionnaire-2 (PHQ2), PHQ9A, PHQ9, and Generalized Anxiety Disorder 7-item scale (GAD7) are useful in screening patients for depression and anxiety in addition to mnemonics such as SIGECAPS (sleep, interest, guilt, energy, concentration,

appetite, psychomotor, suicidal thoughts or ideation).[17]

Although the same screening tools are used in cisgender heterosexual patients, factors contributing to the experience of depression or anxiety may be directly related to gender identity, gender expression, or sexual orientation. In a 2001 study, more lesbian, gay, and bisexual people reported lifetime and day-to-day experiences with discrimination than heterosexual people, and approximately 42% attributed this in part or in total to their sexual orientation.[18]

Step #2: Assess for substance use

Substance use is also more common in LGBT people. Lesbian and bisexual women have higher rates of tobacco abuse, exposure to second-hand smoke, and alcohol and drug dependence.[3,14] In one study, compared with heterosexual individuals, the odds of lifetime alcohol and substance use disorder was three times higher in lesbian women, and the odds of lifetime drug-use disorder was 1.6 times higher in gay men.[19]

In a survey of transgender people, 30% reported using tobacco compared with 20% of the US adult population, and 8% reported using alcohol or drugs to cope with mistreatment and bias.[5] In a study of transgender women in San Francisco, 58% used alcohol and 43% used substances, including marijuana, methamphetamine, and crack cocaine. Substance use significantly increased the odds of testing positive for HIV.[20]

Providers can eliminate disparities by creating a welcoming environment for all patients

Clinicians should carefully question LGBT patients about their use of alcohol, tobacco, and other substances and provide counseling and assistance with cessation. Several LGBT-specific resources can be used to aid patients in their efforts, and referral to substance abuse groups that are welcoming to LGBT people may increase cessation rates.[19,21]

Step #3: Offer appropriate screening services

Human papillomavirus (HPV). Like heterosexual women, lesbian and bisexual women are at risk of HPV infection, which is associated with cervical cancer and genital warts.[8] HPV can be transmitted in several ways, including skin-to-skin and digital-to-genital contact, as well as penile-vaginal intercourse. Lesbian and bisexual women may have acquired HPV from previous male sexual partners or from female-to-female transmission.[8] In a study comparing cervical cancer screening results among lesbian, bisexual, and heterosexual women, there was no significant difference in the odds for Papanicolaou (Pap) test abnormalities and only a minor decrease in the odds of HPV infection.[22] Lesbian and bisexual women should receive Pap and HPV testing according to current guidelines.

Other sexually transmitted infections, including herpes simplex virus 1, herpes simplex virus 2, *Trichomonas vaginalis*, syphilis, and hepatitis A, can be passed between female partners; risk may vary according to sexual practices.[23] Thus, providers should not assume that lesbian women are at low risk of these infections and should screen according to current guidelines.

The US Centers for Disease Control and Prevention (CDC) recommends annual screening for *Chlamydia* infection for all women under age 25, as well as those at increased risk for this infection (ie, those with a new sex partner or multiple sex partners).[24]

Breast cancer. Studies reveal that lesbian and bisexual women are less likely to receive mammograms, and they may have several risk factors that increase their risk for breast cancer, including overweight, obesity, and excessive alcohol intake.[12,18,25] Providers should discuss the risks and benefits of mammography and offer this screening service at appropriate intervals.

Screening in men who have sex with men

Men who have sex with men are at increased risk for several sexually transmitted infections, including HIV, syphilis, gonorrhea, *Chlamydia*, anal HPV, and hepatitis B and C.[4,9] The CDC recommends annual sexual health screening that includes serologic testing for HIV and syphilis, and urine, rectal, or pharyngeal testing for gonorrhea and *Chlamydia* according to sexual practices.[24]

In contrast, routine screening for anal HPV is not currently recommended because we lack data demonstrating that screening reduces mortality rates from anal carcinoma.[24,26] Nevertheless, the CDC acknowl-

edges that some clinicians may choose to perform anal Pap testing in patients who are at high risk, and guidelines from the New York City Department of Health and Mental Hygiene suggest annual anal Pap testing in HIV-positive men who have sex with men.[27]

According to the results of a systematic review,[28] a significant proportion of transgender women reported sexual practices that increased their risk for sexually transmitted infections, and 27.7% tested positive for HIV infection. In contrast, rates of HIV and risk behaviors were much lower among transgender men. Risk may be heightened in transgender women who have not had sexual reassignment surgery and who engage in insertive anal, vaginal, or oral intercourse.[28] An awareness of an individual patient's current anatomy and sexual practices is essential for providing appropriate counseling about sexually transmitted infections.

'Screen what you have'

When considering screening for breast, cervical, and prostate cancer, providers should consider an individual patient's surgical history and hormonal status. "Screen what you have" is an easy rule to help both patients and providers remember which services to consider.

Transgender men who have not had a mastectomy should discuss the risks and benefits of breast cancer screening and consider mammography as recommended by the American Cancer Society.[29] Similarly, cervical cancer screening should be performed according to current guidelines, although providers should be aware that this examination can cause significant anxiety and emotional distress for the patient.[30]

In transgender women, guidelines for breast cancer screening for those who were previously or currently treated with hormones are lacking. The University of California-San Francisco Center of Excellence for Transgender Health recommends mammography for patients over age 50 with additional risk factors (family history, obesity, estrogen and progestin use for more than 5 years).[31] Transgender women should be counseled about the risks and benefits of prostate cancer screening.

Step #4: Immunize, and promote healthy behaviors

Table 4 outlines the screening services, immunizations, and health behavior promotions that should be offered to LGBT patients.

Vaccinations. LGBT individuals should be routinely offered HPV vaccination through age 26, according to current guidelines.[24] Immunization against hepatitis A and B is also recommended for men who have sex with men, if they are not already immune.[24] Meningococcal vaccine should be given to men who have sex with men if they have an additional medical, occupational, or lifestyle risk factor.[32]

Physical activity should be encouraged, especially in lesbian and bisexual women, who are more likely to be overweight and obese.[25] In a recent study,[33] gay, lesbian, and bisexual youths (ages 12–22) reported 1.21 to 2.62 fewer hours of moderate or vigorous physical activity per week than their "completely heterosexual" counterparts, and were 46% to 76% less likely to participate in team sports, in part due to concerns about gender nonconformity. On the other hand, results from a recent national survey of adults ages 18 through 64 found no significant differences in physical activity according to sexual orientation.

Providers should address patients' perceived barriers to participating in exercise programs.[2]

Preexposure prophylaxis against HIV. A growing number of patients and health providers are asking about preexposure prophylaxis for HIV infection. The initial CDC recommendations for the daily use of emtricitabine-tenofovir were restricted to gay and bisexual men and men who have sex with men in serodiscordant relationships or in situations where the HIV status of the patient's partner was unknown.[34] Since then, the CDC has expanded the groups who may benefit from preexposure prophylaxis.[35] Assessment of the patient's ability to adhere to a daily oral medication regimen is central to its success. Patients should be screened for hepatitis, HIV, and renal and liver function before starting emtricitabine-tenofovir and should have these tests repeated at 3-month intervals if pre-exposure prophylaxis is continued.

41% of transgender adults reported that they had attempted suicide, with higher rates in younger individuals

TABLE 4

Screening and immunizations for sexual minority and transgender individuals

Screening service or immunization	Men who have sex with men	Women who have sex with women	Transgender men[a]	Transgender women[a]
Annual screening for gonorrhea, *Chlamydia*, syphilis (every 6 months if high risk)	Yes	*Chlamydia* screening for all women age < 25 Consider based on exposure and risk	Consider based on exposure and risk	Consider based on exposure and risk
Annual screening for HIV (every 6 months if high risk)	Yes	Consider based on exposure and risk	Consider based on exposure and risk	Consider based on exposure and risk
Offer HPV vaccination (up to age 26)	Yes	Yes	Yes	Yes
Give meningococcal vaccine (if additional risk factor is present)	Yes	Consider based on exposure and risk	Consider based on exposure and risk	Consider based on exposure and risk
Assess for immunity to hepatitis A and B, immunize if not immune	Yes	Consider based on exposure and risk	Consider based on exposure and risk	Consider based on exposure and risk
Screen for anxiety, depression, and other mental health disorders	Yes	Yes	Yes	Yes
Assess for substance use disorders (tobacco, alcohol, drug use)	Yes	Yes	Yes	Yes
Assess risk factors for breast cancer, offer mammography	Not applicable	Yes	Perform chest wall examination after chest surgery; otherwise mammography as recommended for cisgender women	Consider if previously or currently treated with hormone therapy and having additional risk factors (family history, obesity, estrogen and progestin use greater than 5 years)
Screen for cervical cancer at appropriate intervals (if no hysterectomy)	Not applicable	Yes	Yes	Not applicable
Assess risk factors for osteoporosis	Not applicable	Bone density testing starting at age 65 or earlier based on risk factors	Bone density at age 60 or earlier based on risk factors Consider in those not compliant with hormone therapy	Bone density at age 60 or earlier based on risk factors Consider in those not compliant with hormone therapy

[a] Transgender men are people with the XX genotype who identify as male; transgender women are people with the XY genotype who identify as female.

Step #5: Initiate or continue hormone therapy for transgender individuals

Hormone therapy often improves the quality of life for patients who desire to have their physical appearance align more closely with their gender identity.[29] Moreover, abruptly stopping hormone therapy can have significant psychological consequences.[36]

Clinicians should feel comfortable starting hormone therapy for patients who have been diagnosed with gender dysphoria by a mental health professional, can demonstrate knowledge about and outcomes of hormone therapy, and have lived as a member of the desired gender ("real-life experience") for at least 3 months, and preferably 12 months.[29] More recently, some practitioners have advocated prescribing hormone therapy for patients without the requirement for real-life experience or a formal letter from a mental health professional recommending hormonal therapy.[37] However, mental healthcare is recommended for any patient with moderate to severe mental health conditions, especially if not treated at the time of presentation.[37]

Providers should continue hormone therapy for patients who are already receiving it, while being aware of the appropriate treatment goals and monitoring parameters. The two main principles of hormone therapy for transgender patients are to reduce endogenous hormone levels and their associated sex characteristics and replace with hormones of the preferred sex.[29] Doses and formulations are similar to those used for treatment of hypogonadism. This topic has been reviewed by Spack.[10]

The only absolute contraindications to hormone therapy are estrogen- or testosterone-responsive tumors. Otherwise, hormone therapy can be initiated or continued with the patient's informed consent about its benefits and risks.

Estrogen therapy may increase the risk of thromboembolic disease, coronary artery disease, cerebrovascular disease, severe migraine headaches, liver dysfunction, and macroprolactinoma.[29] In a cross-sectional study of 100 transgender patients receiving hormone therapy, 12% of transgender women experienced a thromboembolic or cardiovascular event after an average of 11 years of treatment.[38] However, many of these patients had additional risk factors for these events, such as smoking. In contrast, results from a recent systematic review[39] indicated a much lower rate of venous thromboembolism among transgender women receiving estrogen therapy (1.7%–6.3%). Use of transdermal estrogen may minimize the likelihood of thromboembolic disease, and cessation of hormonal care in the perioperative period is advisable, especially for procedures with greater risk of venous thromboembolism.[39]

Transgender men are at risk of erythrocytosis (hematocrit > 50%) as a result of testosterone therapy. Although current guidelines indicate that testosterone may increase the risk of breast or uterine cancer, results from a recent systematic review[40] indicate that the overall cancer incidence in transgender men is not higher than in natal controls. Both estrogen and testosterone therapy increase insulin resistance and fasting glucose levels, whereas only estrogen increases triglyceride concentrations.[40]

For transgender women, estrogen levels should be maintained in the normal range for cisgender women of reproductive age (< 200 pg/mL), and testosterone levels should be suppressed to less than 55 ng/dL. Goal testosterone levels for transgender men are between 320 and 1,000 ng/dL and should be measured at intervals specific to the preparation used (ie, measured midway between injections for individuals treated with testosterone cypionate). Estradiol levels should be less than 50 ng/dL.[29] Transgender women and men should have estradiol and testosterone levels measured quarterly during the first year of treatment, and then every 6 to 12 months thereafter once goal levels are achieved.

Additional monitoring for transgender women includes measuring serum prolactin at baseline and after 12 months of therapy, and serum electrolytes for those taking spironolactone as antiandrogen therapy. Complete blood cell counts and liver function tests should be done every 3 months during the first year of testosterone therapy for transgender men, and then one to two times per year.[29] Reference laboratory values for the patient's affirmed gender should be used to assess response to therapy as well as effects on end-organ function.

Substance use is more common among LGBT people

The marked suppression of endogenous hormone levels that occurs during therapy may have adverse effects on the bone mineral density of both transgender women and men. Clinicians should assess patients' baseline risk for osteoporotic fracture at the time hormone therapy is started and consider bone mineral density testing if appropriate. For those at low risk for fracture, current guidelines recommend screening for osteoporosis starting at age 60.[29]

Providers should counsel patients who have recently initiated hormone therapy that some changes may occur gradually over time. While transgender women will notice a decrease in libido and spontaneous erections within the first 3 months of therapy, breast growth begins approximately 3 to 6 months after treatment is started. Similarly, for transgender men, fat redistribution occurs during the first 6 months of treatment, but facial and body hair growth occur more slowly and are at maximum 4 to 5 years after starting hormone therapy.[29] Amenorrhea typically occurs 1 to 6 months after starting hormonal therapy for transgender men.

The CDC has expanded the groups who may benefit from preexposure prophylaxis against HIV

Some patients may be interested in surgery to continue their physical transformation to the desired sex. Patients who have used hormone therapy and participated in a real-life experience or otherwise completed social transition by living as the affirmed gender for 12 months are considered eligible for surgery if they can demonstrate a good understanding of the cost, potential complications, and expected recovery time of the procedure. Guidelines also recommend that the patient demonstrate progress in work, family, and interpersonal issues regarding their new gender.[29] Available surgical options include breast augmentation, orchiectomy and penectomy, and vaginoplasty, clitoroplasty, and vulvoplasty for transgender women. Feminizing procedures include voice surgery, thyroid cartilage reduction, and facial feminization surgery. Transgender men may choose to have mastectomy, hysterectomy and salpingo-oophorectomy, vaginectomy, scrotoplasty and testicular implant placement, and implantation of a penile prosthesis. Additional virilizing surgeries include voice surgery and pectoral implants.[41]

Step #6: Screen for intimate partner violence

Intimate partner violence refers to physical, sexual, and psychological harm by a current or former partner or spouse, and it can occur in gay and lesbian relationships. In 2000, a National Violence Against Women survey found that 21.5% of men and 35.4% of women who reported living with a same-sex partner had experienced physical abuse.[42] More recent studies confirm rates similar to those in heterosexual relationships. In an online study,[43] 11.8% of men who have sex with men reported physical violence from a current male partner, and about 4% reported experiencing coerced sex.

Intimate partner violence is uniquely challenging for LGBT people. In addition to the commonly described methods an abuser uses to maintain power and control, forced disclosure or "outing"—publicly revealing someone's sexual orientation or gender identity—may result in additional psychological violence and harm. Survivors of intimate partner violence who are in same-gender intimate relationships often find that obtaining services through the police, judicial, and social services systems is challenging. Survivors may be required to disclose their sexual orientation or gender identity as part of filing a report or judicial order to obtain help or protection from the abuser. Many male and transgender survivors of intimate partner violence are unable to access traditional shelters. Female survivors may find that their same-sex abusers have the same access to resources and shelters that they do.

Intimate partner violence is associated with negative physical and mental health outcomes. Physical injuries such as bruises, fractures, and burns are some of the more obvious harms survivors sustain. However, the negative psychological impact on survivors cannot be overstated. LGBT individuals are at greater risk of depression and substance abuse as a result of intimate partner violence than their cisgender heterosexual counterparts. The stress resulting from stigmatization and discrimination can be exacerbated by intimate partner violence.[44] This can be seen in health outcomes of HIV-positive men who have sex with men, in whom abuse predicts interruptions in care, more advanced HIV disease, and HIV-associated hos-

pitalizations.[45]

We recommend that providers screen all LGBT patients for intimate partner violence. One commonly used tool is the **Partner Violence Screen**, which consists of three gender-neutral questions:

- Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom?
- Do you feel safe in your current relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

Like other screening tools for intimate partner violence, the Partner Violence Screen is more specific than sensitive.[46] Screening and discussions about intimate partner violence should be performed in a private, confidential manner while the patient is alone.

Providers who care for LGBT patients need to be aware of not only the medical and mental health sequelae of intimate partner violence but also the social and legal issues facing survivors. Familiarity with the available community resources and their limitations can better facilitate trust and patient care for those affected by intimate partner violence. In one study, the most frequent requests for assistance from sexual and gender minority survivors were for counseling, safe housing, legal assistance, and assistance navigating the medical system.[47] Providers should refer patients to LGBT-focused resources in their community as available, and when no such resources exist, initiate contact with standard domestic violence services, with patient consent, to ask about a program's ability to assist survivors of LGBT intimate partner violence.

National resources promoting health and resilience for LGBT patients

GLMA: Health Professionals Advancing LGBT Equality
www.glma.org
Health professional education conferences on LGBT health
Top 10 lists for LGBT patient healthcare issues
Educational resources for patients and providers
Directory of LGBT-sensitive health providers

Parents, Families, and Friends of Lesbians and Gays
http://community.pflag.org
Local chapters and events

Gay, Lesbian and Straight Education Network
www.glsen.org
Community chapters and events

Centerlink
www.lgbtcenters.org
Local member LGBT centers

Human Rights Campaign
www.hrc.org
Health Equality Index, a national LGBT benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBT patients, visitors, and employees

National LGBTQ Task Force
www.thetaskforce.org
Factsheets and infographics about LGBT communities

Center of Excellence for Transgender Health
http://transhealth.ucsf.edu
Evidence-based care guidelines and protocols for transgender people

National LGBT Health Education Center
www.lgbthealtheducation.org
Online training on many LGBT health topics, with live and on-demand webinars and learning modules with free continuing medical education and continuing education unit credit, downloadable content, and other resources

National Coalition of Anti-Violence Programs
www.avp.org
Training, technical assistance, support services and resources on reducing violence and its impact on LGBT and HIV-affected communities

IN A NUTSHELL

Optimizing the care of LGBT patients requires developing both clinical and cultural competency.

Initial steps for creating an inclusive and welcoming clinical environment include becoming familiar with local resources for LGBT patients (support groups, substance and alcohol cessation groups, mental health providers; see sidebar), providing education and training for support staff and nurses, and establishing gender-neutral bathrooms. Waiting areas should include literature relevant to LGBT patients and signage that is relevant to all patients, including gender-nonconforming individuals. Providers should offer all patients universal HIV screening initially and at clinically appropriate intervals and discuss preexposure prophylaxis with emtricitabine-tenofovir for at-risk individuals.

For transgender patients, addressing them

by their preferred name and pronouns is central to building rapport. General health maintenance is the same for transgender patients as for cisgender patients and can be guided by the adage "screen what you have." Hormonal care can be offered using an informed consent method consistent with the World Professional Association for Transgender Health Standards of Care.[48] Guidelines exist to assist providers in initiation and maintenance of hormonal care. Cross-gender hormonal therapy is initiated with low-dose medication that is gradually increased over time, with a goal of approximating the pubertal changes of the desired gender over a 2- to 3-year period. Some, but not all, patients may pursue various surgical procedures as part of their gender affirmation process.

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